Appendix B. Community Hub Pathways

- Adult Education Pathway
- Behavioral Health Pathway
- Developmental Referral Pathway
- Developmental Screening Pathway
- Education Pathway
- Employment Pathway
- Family Planning Pathway
- Health Insurance Pathway
- Housing Pathway
- Immunization Referral Pathway
- Immunization Screening Pathway
- Lead Pathway
- Medical Home Pathway
- Medical Referral Pathway
- Medication Assessment Chart
- Medication Assessment Pathway
- Medication Management Pathway
- Postpartum Pathway
- Pregnancy Pathway
- Smoking Cessation Pathway
- Social Service Referral Pathway

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Adult Education Pathway

Initiation
Client identifies educational need(s).

_____
Start date

↓

Partner with client to establish/review educational goals. Document goal and desired outcomes.

_____
_____
_____
Educational goals

↓

Assist client in registering for training or educational course:

- Gather necessary documentation for registration.
- Determine if client needs to take an assessment/placement exam and schedule exam date.

_____
Date of first class

↓

Confirm that client is registered in class or training program and attends first class.

↓

Monitor client's progress with educational program.

- Confirm at least biweekly that client is attending classes and document progress.

_____
_____
_____
_____
_____
_____
_____
_____
Check-in dates

↓

Completion
Confirm that client successfully completes stated educational goal:

- Course/class completed
- Training program completed
- Quarter/semester completed

Record reason if Finished Incomplete: _____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Behavioral Health Pathway

Initiation
Client with behavioral health issue(s).

Initiation date

1. Identify referral source.
2. Document behavioral health issue(s) (Describe below)

Referral Source

- ☐ Parent
- ☐ School
- ☐ Doctor
- ☐ Self-referral
- ☐ Other_____

Schedule appointment for appropriate level of service based on client's need.

_____
Appointment date

_____
_____
Agency/provider

Completion
Client has kept **three scheduled appointments**. Monitor followup appointments with Medical Referral Pathway.

_____
Kept appointment date

_____
Kept appointment date

_____
Kept appointment date

Describe behavioral health issue(s): _____

_____

_____

_____

Care coordination plans: _____

_____

_____

_____

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Developmental Referral Pathway

Initiation
Child <3 years with suspected developmental delays—record reason for developmental referral.

_____
Start date

_____
_____
_____
_____
Reason for referral

↓

Explain Part C services and review family's rights.

Explain agency options to obtain developmental evaluation. Refer child to Central Intake.

Referred to Central Intake
☐ Yes ☐ No

_____
_____
_____
Reason given if "no"

↓

1. Obtain parent/guardian consent for evaluation.
2. Assist family with scheduling developmental evaluation and obtaining a prescription from primary care provider.

_____
Scheduled date of evaluation

↓

Provide education to caregivers regarding importance of keeping appointment.

Education provided
☐ Yes ☐ No

↓

Completion
Document the date and results of completed developmental evaluation.

_____
Date of completed evaluation

Results and recommendations: _____
_____
_____
_____

Record reason if Finished Incomplete: _____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Developmental Screening Pathway

Initiation

Child <3 years of age at risk for a developmental delay.

Child should be screened at least every 6 months using the age-appropriate ASQ or ASQ-SE.*

↓

Educate family about the importance of developmental milestones.

Obtain consent from parent/guardian to do developmental screening.

↓

Completion

Child successfully screened using the age-appropriate ASQ or ASQ-SE.

↙ ↘

No developmental concerns identified. Discuss findings with caregivers. Record date for next developmental screen.

Developmental concerns identified and discussed with caregivers. Start Developmental Referral Pathway.

_____

Start date

Education provided

☐ Yes ☐ No

_____

Date of screen

Circle ASQ Screen Used

2 4 6 8 9 10 12 14 16

18 20 22 24 27 30 33 36

Communication _____

Gross Motor _____

Fine Motor _____

Problem Solving _____

Personal-Social _____

Circle ASQ-SE Screen Used

6 12 18 24 30 36

Total Score _____

_____

Month/year for next screen

Record reason if Finished Incomplete: _____

_____

_____

* ASQ = Ages & Stages Questionnaire. ASQ-SE is the Social Emotional version.

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Education Pathway

Initiation

Education Pathway started by (check only one):

- ☐ Program-based curriculum
- ☐ Client requests assistance
- ☐ Referral from health care provider
- ☐ Referral from other provider
- ☐ Community care coordinator initiated

_____

Start date

↓

Document education provided

(Example: educational content—module, section, etc.)

_____

_____

_____

Education

↓

Document educational format used (check only one).

Format:

- ☐ Handout
- ☐ Talking points
- ☐ Video
- ☐ Other: _____

↓

Completion

Client reports that he/she understands educational information.

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Employment Pathway

Initiation
Client is requesting assistance in obtaining a job.

↓

Partner with client to identify:

1. Education and work history
   - Previous work experience
   - Educational level completed
   - Employment goals (special training needed for desired job)
2. Barriers to employment (felony record, financial constraints, etc.)

↓

Care coordinator will work with client to confirm that résumé is completed.

↓

Care coordinator will work with client to monitor applications submitted for employment.

↓

Completion
Client has found consistent source(s) of steady income and is employed over a period of 3 months.

_____
Start date

_____
_____
_____
Work history

_____
Educational level

_____
_____
_____
Employment goals

_____
_____
Barriers

_____
Date résumé completed

_____
_____
_____
_____
Dates applications submitted

_____
1 month

_____
2 months

_____
Completion—3 months

_____
Check-in dates

Record reason if Finished Incomplete: _____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Family Planning Pathway

Initiation

Client has requested information on family planning methods.

_____
Start date

Provide family planning education.

Education provided
☐ Yes ☐ No

Schedule appointment with primary care provider or clinic

_____
Date of appointment

_____
Provider or clinic

Followup with client

Confirm that client kept appointment and document family planning method in chart. **Pathway is complete if tubal ligation, vasectomy, IUD, implant, or shot given.**

_____
Date appointment kept

Family Planning Method

☐ Tubal Ligation (4)
☐ Vasectomy—partner (4)[i]
☐ IUD (4)
☐ Implant (4)
☐ Shot (4)

☐ Abstinence (5)
☐ Natural family planning (5)
☐ Pills (5)
☐ Patch (5)
☐ Ring (5)
☐ Diaphragm (5)
☐ Condom (5)
☐ Cervical cap (5)
☐ Spermicide (5)
☐ Other (5) _____

Completion

If client has chosen a method other than tubal ligation, vasectomy, IUD, implant, or shot, then Pathway is complete if client is still successfully using that method after 30 days.

Record reason if Finished Incomplete: _____

_____

_____

[i]The number 4 is a coding option; it is used for a permanent or long-acting reversible contraceptive. If these are chosen, the Pathway is finished once the procedure is complete. All the other methods ("5") are in a participant's control, and the Pathway is not finished until a followup check is done in 30 days to make sure she is still using the method chosen.

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Health Insurance Pathway

Initiation
Client needs health insurance.

_____
Start date

↓

Assist client and/or family in **completing forms** as directed and submit to appropriate agency.

_____
Date application submitted

↓

Confirm with agency that all forms have been received and have been completed properly.

↓

Completion
Arrange followup within 2-6 weeks of application submission to **confirm acceptance or denial** of insurance.

- If **denied, record reasons** in client's record and refer client to other community resources.
- If **accepted, document status**, including insurance number, in client's record.

_____
Date approved

_____
Insurance

_____
Number

Record reason if Finished Incomplete (reason denied and referral made):

_____

_____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Housing Pathway

Initiation
Client and/or family is identified to be in need of affordable and suitable housing.

_____
Start date

↓

Identify reason(s) housing is required: (check all that apply

- ❒ Eviction
- ❒ Homeless
- ❒ Domestic violence
- ❒ Lead
- ❒ Fire/natural disaster
- ❒ Self-imposed (pets)
- ❒ Discrimination
- ❒ Safety issue(s)
- ❒ Too many for living space
- ❒ Financial
- ❒ Poor rental history
- ❒ Poor location for access to services
- ❒ Disability
- ❒ Other: _____

↓

Partner with client to contact appropriate housing organization and schedule an appointment to meet and discuss housing options.

Help client prepare for meeting with required documentation, child care, transportation, etc.

_____
Appointment scheduled

_____
Appointment kept

↓

Care coordinator confirms that client kept appointment with housing organization.

If client is placed on a waiting list for housing, obtain name and phone number of contact person to follow up with regarding status.

_____
Contact person

_____
Contact number

↓

Follow up with housing contact person at least biweekly to monitor housing progress.

_____
_____
_____
_____
Check-in dates

↓

Completion
Confirmation that client and/or family has moved into an affordable suitable housing unit for a minimum of 2 months.

_____
Completion date

Record reason if Finished Incomplete: _____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Immunization Referral Pathway

Initiation
Client less than 18 years of age is confirmed to be behind on immunizations.

_____
Start date

Missing Immunizations:

_____
_____
_____
_____
_____
_____

Educate family about the importance of immunizations.

Education provided
☐ Yes ☐ No

Appointment(s) scheduled with provider or clinic for missed immunizations.

_____
_____
_____
Appointment dates

_____
Completion date

Completion
Client's immunization record reviewed and verified to be up to date.

_____
Reviewer

Record reason if Finished Incomplete: _____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Immunization Screening Pathway

Initiation
Any client less than 18 years of age

_____
Start date

- Determine immunization status by using the family's immunization record.
- If family is unable to provide records, obtain written consent from client's parents/guardians to request immunization record from provider(s).

Immunization History From:

- ☐ Family's record
- ☐ Electronic registry
- ☐ Health care provider
- ☐ Health department
- ☐ Other: _____

Educate family about the importance of immunizations and maintaining up-to-date record.

Education provided

☐ Yes ☐ No

Identify person trained in the current immunization protocols to review immunization status.

_____
Immunization records reviewer

Completion
Client's immunization record reviewed and verified.

1. Client is up to date on all age-appropriate immunizations. Monitor immunization status during routine visits. Record Pathway as complete.
2. Client is not up to date on all age-appropriate immunizations. Record Pathway as Finished Incomplete. Document reasons immunizations are behind and start the Immunization Referral Pathway.

_____
Completion date

- ☐ Up to date
- ☐ Not up to date

Record reason if Finished Incomplete: _____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Lead Pathway

Initiation
Any child more than 12 months old and any child with identified risk factors (see step #4).

↓

Provide **lead education** to all families with young children and/or expectant mothers.

↓

Find out if child has ever had a blood lead test and document results.

↓

Determine if child needs a blood lead test:

1. Medicaid
2. High-risk ZIP Code
3. **"Yes"** to any of the following questions:
   - Live in or regularly visit a house, daycare center, preschool, or home of a babysitter/relative built before 1950?
   - Live in or visit a house that has peeling, chipping, dusting, or chalking paint?
   - Live in or visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling?
   - Have a sibling or playmate who has or had lead poisoning?
   - Frequently come in contact with an adult who has a hobby or works with lead (e.g., construction, welding, pottery, painting)?

↓

Appointment scheduled with provider to do blood lead test.

↓

Completion
Confirm that appointment was kept and **document results** of lead blood test in client's record as:

- Elevated: ≥ 10 µg/dl
- Nonelevated: < 10 µg/dl

Refer to Health Department

_____
Start date

Education provided
☐ Yes ☐ No

_____
Results/date

Document all that apply:
1. Medicaid
   ☐ Yes ☐ No
2. High-risk ZIP Code _____

_____
3. Yes to survey questions (circle)

_____
Appointment date

Record reason if Finished Incomplete: _____
_____
_____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Medical Home Pathway

Initiation
Client needs a medical home (an ongoing source of primary medical care).

_____
Start date

↓

Determine payment source for health care.

Payment Source:
- ☐ Medicaid
- ☐ Medicare
- ☐ Private insurance
- ☐ Self-pay
- ☐ Other: _____

_____

_____

↓

Find appropriate primary medical provider options for payment source.

_____
Medical provider

↓

1. Obtain release of information from client.
2. Assist family in scheduling appointment.
3. Provide education about the importance of keeping the appointment.

_____
Date of initial appointment

Education provided
☐ Yes ☐ No

↓

Completion
Confirm that appointment was kept.

_____
Date of kept appointment

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Medical Referral Pathway

Initiation

Client needs a **health care appointment.**

Document type of appointment needed – use codes.

(Only ONE code per Pathway)

_____

Start date

_____

Referral - Code

↓

Educate client/family about the importance of regular health care visits and keeping appointments.

Education provided

☐ Yes ☐ No

↓

Appointment scheduled with health care provider/clinic.

_____

Appointment date

↓

Completion

Verify with health care provider that **appointment was kept**.

_____

Date appointment kept

_____

Document how appointment was verified

Code Numbers for Medical Referral Pathway

1. Primary Care
2. Specialty Medical Care _____
3. Dental
4. Vision
5. Hearing
6. Family Planning
7. Mental Health
8. Substance Abuse
9. Speech and Language
10. Pharmacy
11. Other, please specify in record _____

Record reason if Finished Incomplete: _____

_____

_____

Client's Name _____ **Community Care Coordinator** _____

Date of Birth _____ **Today's Date** _____ **Agency** _____

Medication Assessment Chart

STEP 1:

- ❒ On the chart below, list all the medications **currently used** by your client. Include all medications – prescription, over the counter, herbal, alternative, topical, eye drops, etc.
- ❒ Have your client and/or client's caregiver **open each** of the bottles or medication containers and note any difficulties in performing this task.
- ❒ Have your client and/or client's caregiver **identify** each medication. Ask them to describe what the medicine is for. How many doses of the medicine are to be taken each day?
- ❒ Discuss the **shape and color** of the medicine with your client or client's caregiver. Explain that they should notify the health provider if the shape and color of the pill changes to make sure they are using the correct medicine and/or dose.
- ❒ Have the patient and/or client's caregiver read the medication name on the label. Assess reading and memory problems. Review all parts of the label, including how to order refills.

Prescription Medications (need a doctor's prescription to get)

Client's Name _____ **Community Care Coordinator** _____

Date of Birth _____ **Today's Date** _____ **Agency** _____

Name of Medicine & Dose	Can open? yes/no	What is this medicine for? (client's description)	How many doses each day? (client's response)	Can read the label and knows how to get refills? yes/no	Comments

Over the counter medicines (no prescription needed), herbal or alternative treatments

Name of Medicine or Treatment	Can open? yes / no	What is this medicine or treatment for? (client's description)	How many doses each day? (client's response)	Can read the label and knows how to get refills? yes/no	Comments

Client's Name _____ **Community Care Coordinator** _____

Date of Birth _____ **Today's Date** _____ **Agency** _____

STEP 2 - Ask the following questions:

1. Are you having problems getting your medications? ☐ Yes ☐ No
   If yes – why?
   _____
   _____
   _____

2. Do you have problems paying for your medications? ☐ Yes ☐ No
   If yes – what can you afford?
   _____
   _____
   _____

3. Are you having any side effects from your medications? ☐ Yes ☐ No
   If yes – describe:
   _____
   _____
   _____

4. Do you use more than one pharmacy to get your medications? ☐ Yes ☐ No
   If yes – please list all pharmacies:
   _____
   _____
   _____

Notes:

_____
_____

_____ _____

Provider Signature Date

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Medication Assessment Pathway

Initiation

Client is taking prescribed medication(s).

_____

Start date

↓

Complete the **Medication Assessment Chart** with your client and/or client's caregiver:

1. Include all medications your client says he/she is taking right now (prescription, over the counter, herbal, alternative, etc.)
2. Record what your client says about the medication in his/her own words – even if it is different from the label.

↓

Send completed **Medication Assessment Chart** to client's primary care provider.

_____

Date information sent

- ☐ Fax
- ☐ HUB
- ☐ Mail
- ☐ Other_____

↓

Completion

Verify with primary care provider that chart was received.

If medication issues are identified by health care provider – initiate Medication Management Pathway.

_____

Verification date

Medication concerns:

☐ Yes ☐ No

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Medication Management Pathway

Initiation
Client is not taking medications as prescribed. (Record referral source)

_____
Start date

_____

_____
Referral source

Obtain list of medications client should be taking from: (check all that apply)

- ❒ Primary care provider
- ❒ Medication reconciliation form from hospital
- ❒ Medication reconciliation form from emergency department
- ❒ Pharmacist
- ❒ Other: _____

_____
Date information sent

- ☐ Fax
- ☐ HUB
- ☐ Mail
- ☐ Other: _____

_____

Visit client in his/her home and complete the **Medication Assessment Chart:**

1. Send completed Medication Assessment Chart and any reconciliation forms to client's primary care provider.
2. Schedule appointment with primary care provider – record date.

_____
Scheduled appt. date

Primary care provider completes medication reconciliation:

1. Care coordinator receives updated medication list.
2. Home visit scheduled within 3 business days to follow up.

_____
Date appointment kept with primary care provider

_____
Date information sent

- ☐ Fax
- ☐ HUB
- ☐ Mail
- ☐ Other: _____

_____

Visit client in his/her home and complete the Medication Assessment Chart – send completed chart to primary care provider for review.

Completion
Verify with primary care provider that client is taking medications as prescribed.

_____
Verification date

Record reason if Finished Incomplete: _____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Postpartum Pathway

Initiation
Client has delivered and needs to schedule a postpartum appointment.

_____
Start date

_____
Date of delivery

↓

Schedule appointment with health care provider.

_____
Date of appointment

_____
Health care provider

↓

Follow up with client:

1. Confirm that client kept appointment.
2. Document family planning method chosen in client's record.
3. Determine if client has any questions or concerns.

_____
Date postpartum appointment completed

_____
Family planning method

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Pregnancy Pathway

Initiation
Any woman confirmed to be pregnant through a pregnancy test.

_____
Start date

Education provided
☐ Yes ☐ No

Provide pregnancy education.

_____
Date of 1st PN appt. – set up by
☐ Client
☐ Care Coordinator

Schedule appointment with prenatal care provider:
- Date of 1st prenatal appointment
- Estimated due date
- Concerns identified

_____
Prenatal care provider

_____
Due date

_____
_____
_____
Concerns

Check on woman's prenatal appointments at least monthly.

_____
_____
_____
_____
_____
_____
_____

Completion
Healthy baby > 5 lbs 8 ounces (2,500 grams).
Document baby's birth weight, estimated age in weeks, and any complications

_____
Date of birth

_____
Birth weight

_____
Gestational age (weeks)

Record reason if Finished Incomplete: _____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Smoking Cessation Pathway

Initiation

Client states that he/she is a cigarette smoker/ tobacco user.

1. Determine where client is in the Stages of Change Model.
2. **Develop and document care plan in record:**
   - Precontemplation: Educate and motivate at each visit.
   - Contemplation: Set a quit date and discuss withdrawal symptoms.
   - Action: Frequent support visits (especially the first 2 weeks after quitting), coping strategies, and self-help materials.
   - Maintenance: Continue to ask about client's smoking status at each visit; continue education and encouragement.
   - Relapse: Reassure client that most smokers take several attempts before finally quitting → set another quit date.

For all clients - at EACH visit, stress the need to quit smoking:

- Discuss short- and long-term health, social, and economic benefits of quitting.
- Discuss and document any barriers identified.
- Discuss and document all options and refer if appropriate:
  - Self-help materials
  - Drug therapy
  - Smoking cessation programs

Completion

Client has stopped smoking/using tobacco products.

_____

Start date

_____

Tobacco product

_____

Amount

Stages of Change Model – check stage:

- ☐ Precontemplation
- ☐ Contemplation
- ☐ Action
- ☐ Maintenance
- ☐ Relapse

_____

Completion date

- ☐ Self-report
- ☐ Lab test confirmation

Record reason if Finished Incomplete: _____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Social Service Referral Pathway

Initiation
Client needs a social service referral.

Document type of service needed - use codes. ***(Only ONE code per Pathway)***

_____
Start date

_____
Code number

Education provided
☐ Yes ☐ No

↓

Provide appropriate education and discuss the importance of keeping appointments.

↓

Appointment scheduled with social service provider.

_____
Date of appointment

↓

Completion
Verify that client kept scheduled appointment.

_____
Date of kept appointment

_____
Document how appt. was verified

Code Numbers for Type of Service

1. Child Assistance
2. Family Assistance
3. Food Assistance/WIC
4. Housing Assistance
5. Insurance Assistance
6. Financial Assistance
7. Medication Assistance
8. Transportation Assistance
9. Job/Employment Assistance
10. Education Assistance
11. Medical Debt Assistance
12. Legal Assistance
13. Parent Education Assistance
14. Domestic Violence Assistance
15. Clothing Assistance
16. Utilities Assistance
17. Translation Assistance
18. Help Me Grow
19. Other: _____

Record reason if Finished Incomplete: _____

_____

_____

_____