Connecting Those at Risk to Care

The Quick Start Guide to Developing Community Care Coordination Pathways

A Companion to the Pathways Community HUB Manual

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The information in the Connecting Those at Risk to Care quick start guide is intended to assist community care coordination initiatives in identifying at-risk individuals, clarifying their risk factors, and then ensuring risk factors are addressed using pathways and a pay-for-performance methodology. This guide is intended as a reference and not as a substitute for professional judgment. The findings and conclusions are those of the authors, who are responsible for its content, and do not necessarily represent the views of AHRQ. No statement in this guide should be construed as an official position of AHRQ or the U.S. Department of Health and Human Services. In addition, AHRQ or U.S. Department of Health and Human Services endorsement of any derivative products may not be stated or implied. None of the investigators has any affiliations or financial involvement that conflicts with the material presented in this guide.
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Overview

This Quick Start guide complements Pathways Community HUB Manual: A Guide To Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes, initially published in 2010 by the Agency for Healthcare Research and Quality (AHRQ). The publication provides a detailed overview of the Pathways Community HUB (HUB) Model. The HUB is a community care coordination approach focused on reducing modifiable risk factors for high-risk individuals and populations.

The HUB relies on community care coordinators (CCCs)—community health workers, nurses, social workers, and others—who reach out to at-risk individuals through home visits and community-based work. Once an at-risk individual is engaged, the CCC completes a comprehensive assessment of health, social, behavioral health, economic, and other issues that place the individual at increased risk. Each identified risk factor is tracked as a standardized Pathway that confirms the risk is addressed through connection to evidence-based and best practice interventions.

The Pathway is a tool for confirming that the intervention has been received and that the risk factor has been successfully addressed. The Pathway also serves as the quality assurance and payment tool, and it is used by the CCC to ensure that each risk factor is addressed and that outcomes have improved.

When this model is deployed across multiple agencies within a community, the centralized HUB helps agencies and CCCs avoid duplication of effort. The HUB serves as a communitywide networking strategy that helps isolated (“siloed”) programs become a quality-focused team to identify those at risk and connect them to care.

The HUB model was first developed by the Community Health Access Project (CHAP) in Mansfield, Ohio, with leadership from Drs. Sarah and Mark Redding. The model involves working across organizational silos within a community (CHAP worked with multiple stakeholders in three counties) to reach at-risk individuals and connect them to health and social services that yield positive health outcomes. The model is now part of a national network of community-based initiatives (Appendix A) working under a common set of national standards and certification developed by the Pathways Community HUB Institute.

This quick start guide is a reference and resource for public and private stakeholders engaged in improving the community care coordination system for identifying high-risk individuals; documenting their specific health, social, and behavioral health risk factors; and addressing those risks in a pay-for-performance approach. The HUB focuses on individuals and populations, and it provides coordination, measurement, and impact data that can help guide local and regional policies and reimbursement strategies. The target audience includes all those involved in the design, implementation, and financing of care coordination services, especially within the community setting.

This guide includes an overview of the process, as well as tools and resources needed to develop a HUB. Additional information on the HUB model and Pathways is available in the full manual.
Why Create a Pathways Community HUB?

A Pathways Community HUB is an effective strategy for achieving the goals of improved health, social, and behavioral health outcomes and reduced health care costs.

Reason #1: To Catalyze the Goals of Health Care Reform

The Patient Protection and Affordable Care Act is intended to improve population health and quality of care while containing costs. One of the key strategies for meeting these goals is the development of accountable care organizations (ACOs). ACOs need to provide the populations they serve with appropriate, timely access to high-quality, well-coordinated health and social services that improve health and contain health care costs. The HUB serves as a framework that can help communities and ACOs improve population health and lower costs.

Through communication, collaboration, and built-in incentives, the HUB increases the efficiency and effectiveness of care coordination services, especially in the community setting. Specific checklists and Pathways have been developed to ensure that at-risk individuals are identified, that their risk factors are assessed, and that each risk factor is tracked using a specific standard Pathway. Rather than allow providers of health and social services to continue functioning in isolated silos, the HUB requires them to work collaboratively, reaching out to those at greatest risk and connecting them to evidence-based interventions, with a focus on prevention and early treatment.

To ensure quality and accountability across all providers of care coordination services, the HUB acts as a central clearinghouse that “registers” and tracks at-risk individuals, making sure that their health, behavioral health, social, environmental, and educational needs are met. The HUB provides ongoing quality assurance that results in less waste and duplication of care coordination services, lower costs, improved health status, and fewer health disparities.

The HUB provides both an individual- and a population-focused approach to identify at-risk populations, assess their risk factors, and ensure that each modifiable risk factor is addressed with evidence-based or best practice interventions using Pathways. Payments in this model are closely tied to the production of positive outcomes (completed Pathways).

Reason #2: To Pay for Value, Not Volume

Communities that are ready to work toward an accountable system focused on identifying and reducing risk factors using the HUB model can face significant challenges. Connecting those at risk to timely, high-quality care requires expertise, accountability, and investment. Our current business model for providing care coordination services reimburses based on caseloads and chart notes. Care coordination contracts typically purchase “work products” and processes but are not tied to meaningful outcomes for the individual.

In January 2015, the U.S. Department of Health and Human Services (HHS) announced the next phase in improving health care. The next phase includes three components:

- Using incentives to motivate higher value care by increasingly tying payment to value through alternative payment models;
- Changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and
- Harnessing the power of information to improve care for patients.
The net cost of operating HHS in fiscal year 2012 was $855.5 billion, with most of those costs (more than 94 percent) related to Medicare and other health programs. A primary focus of the Government’s health care spending is to produce positive health outcomes; unfortunately, that is not the case. A 2013 brief by the Institute of Medicine summarized that “Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence, for young and middle-aged adults, and for older adults.”

A focus on assessing and addressing risk factors at the individual and population levels represents a substantial opportunity for improving health outcomes. Very little of the current funding is strategically focused on identifying and addressing the critical risk factors that produce adverse health outcomes.

**Reason #3: To Embrace a Comprehensive Approach Focused on Risk Factor Reduction**

Working to improve health outcomes requires more than access to medical care; it encompasses behavioral health, as well as social, environmental, and educational factors—the “social determinants of health.” All of these factors must be addressed in a holistic and comprehensive manner in order to improve health for an individual or a population. Some risk factors are addressed at the individual level: housing, smoking cessation, insurance, medical home, employment, adult education, and evidence-based parenting instruction. For each of these issues there are specific evidence-based and best practice interventions available that can address the risk factor.

There are also risk factors that need to be addressed at the population level, such as neighborhood safety, access to nutritious food, and environmental pollution. Population-level risk factors are recognized as also being critical interventions to improve outcomes. The HUB model primarily focuses on individually modifiable risk factors but can provide important data about the population’s health as well. As most identified risk factors responsible for adverse health outcomes are related to social determinants of health, a comprehensive approach is critical.

Current care coordination contracts are primarily focused on “work products” (e.g., caseloads, phone calls, forms completed) and not on connecting at-risk clients to services they need. In addition, there is no incentive for the multiple agencies providing care coordination services to communicate or collaborate with each other, leading to duplication and inefficiencies.

The HUB model provides the infrastructure to manage multiple sources of care coordination funding across the community network. The concept of “braided funding” is possible because of Pathways. One individual may receive care coordination through several health and social service agencies, but in the current system the duplication of service is not easy to identify. The HUB allows collaboration among funders to more fully support and address all the needs of an at-risk community member. Unnecessary duplication is identified and eliminated.

The Pathways methodology allows one care coordinator to work with a client to address multiple Pathways. The funding that supports each of these intervention areas can be organized by assigning specific funders to specific Pathways. For example, a health plan may pay for medically focused Pathways, while other agencies may pay for social service Pathways. There are examples of a broad array of care coordination funding streams within the current HUBs, including Medicaid, managed care plans, United Way, housing providers, health departments, behavioral health, property taxes, and others.
How To Create and Use a Pathways Community HUB

The HUB Model

A Pathways Community HUB represents a network of care coordination agencies focused on reaching those at greatest risk and addressing their identified risk factors. The care coordination agencies may represent any agency deploying community care coordinators (CCCs)—community health workers, nurses, social workers, or others—to reach out to individuals and to help them connect to care. Agencies include local community organizations, outreach centers, health departments, and care coordinators who are part of a community health center.

The central HUB agency is responsible for leading the network and developing the contracts and requirements for participating care coordination agencies. The HUB is responsible for ensuring that the national standards for Pathways Community HUBs are built into the accountability, function, and billing process for the network.

The HUB, by definition, is a neutral entity that does not directly provide care coordination services. The HUB gathers the multiple care coordination agencies together into an organized team, trains and supports them to identify those in the community at greatest risk, and assesses and tracks each modifiable risk with standardized Pathways. National HUB certification through the Pathways Community HUB Institute (HUB Institute) is becoming a greater focus and requirement of funders and policymakers.

The HUB usually employs two or three administrative staff and does not represent a large additional layer to the existing system. The cost savings that result from eliminating duplication, producing positive outcomes, and realizing related efficiencies far exceed any additional cost for this central organizational component of effective community care coordination. As noted, the HUB does not hire or deploy care coordinators but rather supports, coordinates, and tracks outcomes for all the agencies that do provide the direct on-the-ground, community-based care coordination.

Regional organization and tracking of care coordination

HUB—Client Coordination
- Demographic Intake
- Initial Checklist assign Pathways
- Regular home visits—checklists and Pathways completed
- Discharge when Pathways complete (no issues)
The Pathways Community HUB model is best summarized in three steps:

1. Find
2. Treat
3. Measure

1. Find
The HUB model represents a network of agencies that deploy CCCs, in a home-visiting methodology, to engage at-risk individuals in Pathways-focused care coordination. The central HUB of the network does not employ the care coordinators but serves as a central point of organization, quality measurement, tracking, and billing for the agencies that do. The HUB as a network is designed to specifically focus on at-risk individuals as defined by the community.

Communities considering this model need to complete, or have access to, a thorough, up-to-date community needs assessment to determine the population of interest. Examples of recommended strategies for the assessment process include geocoding of health and social data, risk-scoring methodology, screening tools, and key stakeholder surveys that encompass at-risk community members. When the HUB is operational, strategies must be developed not only to “find” the at-risk individuals, but also to engage them in care coordination services.

When a new client is discovered through referral or community outreach, all of the required paperwork to protect personal health information must be completed by the CCC and submitted before the client can be registered as a new client in the HUB. A key role of the HUB is to monitor and notify CCCs of any duplication of service. Once engaged, the CCC and individual are linked in the HUB, and the HUB will flag any further attempts to register that person for care coordination services. It may be appropriate for an at-risk individual to have more than one care coordinator, but the reasons behind that decision need to be clear.

The data collection process begins once an individual is engaged by a CCC. Initially, data are captured in a standardized demographic intake form and initial checklist. The checklist must represent a comprehensive assessment of health, behavioral health, and social service risk factors. There is flexibility in the way that different communities develop their checklists, but the information gathered should identify any of the risk factors that may lead to poor health outcomes.

2. Treat
For each risk factor identified, a specific standardized Pathway is assigned, and then each Pathway is tracked step by step through completion. An at-risk individual may have many Pathways being addressed simultaneously, reflecting multiple health and social issues identified by the CCC. The completion of each Pathway ensures the delivery of one or more evidence-based or best practice interventions to address the risk factor.

3. Measure
Pathways are the standardized outcome measurement tools the HUB tracks. As risk factors are identified and addressed, the Pathways are completed and a reduction in risk is recorded. HUBs need to have the capacity to measure and track an individual’s risk status over time. Some HUBs are looking at risk reduction in specific areas, such as health, behavioral health, social factors, and financial security, and
are using these data to study the impact of care coordination over time. A key element of health system transformation is this intense focus on what factors are actually causing the poor health outcomes in a community and how these factors can be addressed most quickly and cost effectively.

The effectiveness of Pathways used as a single measure and as a comprehensive group of measures has been tested and researched. The model and its impact affirm that like many other effective interventions that require more than one component, more than one risk factor must be addressed to demonstrate changes in health outcomes. The comprehensive nature of the assessment and the use of multiple Pathways are critical to achieving positive outcomes.5 The measurement of specific items within the Pathways and multiple specific Pathways was conducted by Westat as part of a National Institutes of Health initiative. Testing of single Pathways and groups of Pathways in further studies could be very beneficial to the development of this model.

To receive HUB certification by the national HUB Institute, a HUB must use the standardized Pathways. A complete list of the 20 approved Pathways, as well as a chart used with two of the Pathways, can be found in Appendix B. Pathways are specifically designed to be clear and concise. Although a new HUB is not required to use all 20 Pathways as it starts up, it is expected to gain experience with the Pathways and then develop new Pathways when needed, with the support of the HUB Institute. By standardizing the Pathways, HUBs can compare outcomes across care coordinators, agencies, communities, regions, and States. Standardization also allows the development of universal billing codes to tie payment to outcomes. In Ohio, Medicaid managed care plans have developed contracts based on Pathway completion.

Many communities want to track more comprehensive measures, such as overall reductions in emergency department visits, improvements in hemoglobin A1c, and reductions in hospital readmissions. The HUB continues to track individual Pathways but can also “bundle” Pathways together to achieve a larger objective. For example, to reduce emergency department visits, most individuals may need to receive:

- Ongoing primary care (Medical Home or Medical Referral Pathway);
- Help with medication (Medication Assessment or Medication Management Pathway);
- Education about their conditions, medication, or needed services (Education Pathway);
- Help with housing (Housing Pathway); and
- Help with barriers to connecting to other social services (Social Service Referral Pathway).

The Pathway bundle has a specific billing code, and funders can offer an incentive payment if all of the identified Pathways are successfully completed.

For a given individual, some Pathways may not be completed and the desired outcomes may not be reached. The Pathway still needs to be closed, but it is recorded by the HUB as “finished incomplete.” Pathway incompletion is actually very important data for the HUB to monitor. The CCC is required to document why the Pathway was not successfully completed. The HUB can track which Pathways are not completed and compile the reasons. For example, Pathways may not be completed because the resources are not available in a community. The community can use these data to evaluate gaps in services or other issues that can be addressed on a policy level.
Pathways are the metric that focuses on successful resolution of an identified issue. Pathways are also the mechanism the HUB uses to tie financial accountability to completion. Recent peer-reviewed publications have demonstrated a significant improvement in outcomes and cost savings using this model. We know that delivering health and social services from silos does not work. The HUB provides the infrastructure communities need to support multiple and diverse agencies and related resources so they can work collaboratively to address health inequities and achieve real improvements for at-risk individuals.

**Key Insights and Lessons Learned in Developing an Effective Community HUB**

Pathways Community HUBs start in a variety of ways. Most HUBs have developed through the efforts of a small group of community-focused individuals determined to make a difference for their most at-risk citizens. For example, in Albuquerque, New Mexico, the HUB started with two community organizers from the university and a county commissioner. The HUB in Toledo, Ohio, was built with the help of a local pediatrician and the director of a hospital network. The original HUB in Mansfield, Ohio, was built through collaboration with local physicians and community leaders. HUBs are transformative by design, and it takes a determined core group of individuals with vision and dedication to make a HUB a reality.

The HUB’s primary focus must be on finding those most at risk in the community and ensuring that risk is reduced, leading to better health outcomes and lower costs. It is essential that the right community partners be engaged in this process to allow appropriate connections to be established in building the network. A sense of community support and ownership is critical in lending ongoing support to the HUB. Most communities begin with a segment of the at-risk population, such as high-risk pregnant women, adults with multiple chronic conditions, or frequent users of hospital emergency departments. Once the infrastructure is in place, HUBs are designed to grow as the community gains experience with the model.

Pathway funders need to be engaged at the very beginning of the community discussion about implementing a HUB. Health plans, hospitals, social service agencies, ACOs, foundations, and other identified “Pathway purchasers” need to be involved in defining the at-risk population and standard Pathways to be used. It is a major transition for care coordination agencies to move from working in competitive silos to working as an unduplicated team with contracts and payments focused on outcomes. It is important to have adequate support and incentives in place to move communities toward this accountable, business-focused model.

Strong care coordination agencies that are effectively serving high-risk community members will usually find that their reimbursement is increased with the HUB approach. Agencies that are not successfully engaging at-risk individuals or that do not follow up to connect them to services will not do well with this model. Payment is based on outcomes, and agencies must be able to confirm that risk factors have been effectively addressed.

To achieve sustainability, the HUB must develop and work toward expanding the number of funders supporting the HUB network. Agreements with the funders are designed to reflect the risk identification and risk reduction components of the HUB model. The HUB Institute has developed coding strategies for Pathways that can be used with multiple funders to achieve “braided funding.” Individuals at high
risk for poor health outcomes have many different risk factors, and one funder usually cannot cover all the Pathways that need to be addressed. Identifying which funders will pay for specific Pathways is essential to developing braided funding and to adequately funding the CCC.

As CCCs in the field start to reach out and engage those at greatest risk, they begin the data collection process by completing the comprehensive assessment. As they use Pathways to address the risk factors identified by the assessment, they must have an effective data flow and evaluation methodology in place. Simple operational reports for CCCs, supervisors, and administrators are essential. These reports allow a quick view of how this “outcome production” process is moving along at all levels: individual, CCC’s caseload, agency, and across the entire HUB network. The reports are critical for the model to reach its maximum potential.

The questions that reports should answer include: “Are we reaching those at greatest risk?” “What risk factors are being identified within the population we are serving?” “How much time does it take to address these risk factors?” “Which care coordinators and which agencies are able to address the risk factors the fastest?” “What strategies are the most efficient care coordinators and agencies using to quickly address the risk factors?” “What risk factors are taking the longest to address or cannot be addressed, and what are the reasons?”

Getting effective technical support and carefully understanding the evidence-based standards and principles of the HUB model is essential to developing effective HUBs. The HUB Institute was created to provide technical assistance in key areas of model implementation, especially in support of the national standards. The original Community Care Coordination Learning Network (CCCLN), supported by AHRQ, provided the foundation for the development of the national certification process. There are also vendors available to provide operational support to HUBs with regard to implementation, training, technology, and contracting for care coordination services.

Newly developed and existing HUBs need to focus on and work toward national HUB certification. When the CCCLN evaluated HUBs that developed over the past 10 years, it found that as many as one-third were not successful or sustainable. HUBs that did not seek specific technical support for the model and did not focus on the evidence-based standards were unable to demonstrate outcomes. It is very difficult to make a case to funders to support the HUB infrastructure without demonstrating improved outcomes and reduced costs. HUBs that focus on the national standards and enroll in certification demonstrate significantly better outcomes and sustainability.

**Overview of the Pathways Community HUB Prerequisites and Standards**

HUB directors, public health leaders, third party payers, policymakers, and other community stakeholders have requested certification of the HUB model. This certification provides standards and expectations for HUB implementers and payers. The HUB Institute—with funding from the Kresge Foundation and in partnership with the Community Health Access Project, Communities Joined in Action, Georgia Health Policy Center, and Rockville Institute—is leading the HUB certification process.

Certification supports current and future HUBs by requiring (1) the evidence-based and best practice components known to be essential for high-quality community care coordination services and (2) an efficient regional infrastructure that can lead to improved health outcomes and reduced costs. The
standards support a basic framework of quality that encourages local variation and innovation within various cultural and geographic settings. Certification enables funders and policymakers to make wise investments in care coordination services that ensure quality, health improvement, and the value of contracted services.

The complete prerequisites and standards for HUB certification can be found at the HUB Institute Web page. This section highlights some of the key elements that are required.

**Governance Documents**

By definition, the HUB is a neutral and independent legal entity that has legal capacity to enter into agreements or contracts (Prerequisite #1). Many of the certification prerequisites and standards tie directly into the governance of the HUB, including the following items.

**Prerequisite #6**

- The HUB coordinates a network of care coordination agencies serving at-risk clients. The HUB must have legal documents describing the relationship between the HUB and care coordination agency members.
- The HUB model is designed to use what is already working in communities, including existing care coordinators and agencies. Most communities have funding in place for a variety of care coordination work, but the infrastructure for creating a network of agencies together is lacking.

**Prerequisites #8 and #9**

- The HUB must have contracts with a minimum of two payers to ensure comprehensive and sustainable care coordination services. Contracts must confirm that a minimum of 50 percent of all payments are related to an individual’s intermediate and final outcomes/Pathway steps.

**Prerequisite #10**

- The HUB must document that it complies with the Health Information Privacy and Accountability Act through training, policies, and signed agreements.

**Prerequisite #11**

- The HUB needs to operate in a transparent and accountable manner and needs to have policies around conflict of interest and distribution of referrals to care coordination agency members. It is a requirement that the HUB not directly provide care coordination services.

**Needs Assessment**

**Prerequisite #5**

- The HUB reviews and/or conducts community needs assessments. This assessment should include local data specific to medical, behavioral health, social, environmental, and educational factors and guide the HUB in its efforts to improve health and reduce inequities. The HUB needs to show how it uses the community needs assessment to identify the populations to be targeted for community care coordination services.
**Care Coordination Program Requirements**

The HUB creates agreements with each care coordination agency to delineate expectations around hiring, training, and supervision of CCCs. In addition, the administrative staff of the community agencies need training and support to become part of a network of agencies focused on finding those most at risk and connecting them to care. Experienced, capable, and creative HUB leadership is needed to help agencies move away from being competitive silos and make the transition toward functioning as a team.

**Standards #5 and #19**

- The HUB is responsible for monitoring the performance of its care coordination agency members and for improving the quality of care coordination services. Written agreements are required to ensure clarity and transparency of the roles of the HUB and care coordination agency members and the financial arrangements between them.

**Standard #6**

- Many of the HUB standards define policies and expectations for participating programs, agencies, and providers or for community care coordination services. Standard #6 requires the HUB to have operational policies and procedures in place that cover client enrollment, allocation and monitoring of referrals, documentation requirements, ratios of CCCs to clients, and other key operational items.

**Data Collection and Payment System Linked to Outcomes**

**Pathways**

**Prerequisite #7**

- The HUB is required to use standardized Pathways. Appendix B defines all 20 Pathways approved by the HUB Institute. Pathways must be used as defined, and new Pathways cannot be developed without submission to the HUB Institute for review. Pathways outline key stages required for the delivery of high-quality and efficient care coordination services. Each Pathway focuses on one significant client need or problem and identifies and documents the key steps that lead to a desired, measurable outcome. In addition, standardized Pathways allow research, evaluation, and best practices using standard metrics.

**Prerequisite #9**

- The 20 standardized Pathways link billing codes to Pathway steps. Payment for outcomes is a key component of the HUB model and promotes accountability, quality, equity, health improvement, and value. Contracts with payers must specify that at least 50 percent of all payments are related to an individual’s intermediate and final Pathway steps.

- Prior to the launch of HUB operations, a tracking and payment system must be developed that rewards participating organizations and individuals based on the completion of Pathways. Participating agencies within a HUB must be rewarded and incentivized to work in collaboration with other agencies to reach those at greatest risk and connect them to care, recognizing that those individuals require more time and expertise to serve.
• Community agency directors and staff must also receive basic training related to the HUB model. The invoices they submit are also reports of the outcomes achieved during the billing period. Understanding the connection between higher quality of service and the payment structure is critical to those administering and leading the care coordination agencies.

**Client Information**

Standard #13

• The HUB must collect client demographics and other relevant information to effectively address the medical, behavioral health, social, environmental, and educational needs of the at-risk client. Appendix C is an example of a demographic intake form, which is used to obtain key information about the client upon enrollment in the HUB. Checklists capture specific information about the client’s health and social issues at each face-to-face encounter. The checklists should document any identified risk factors and provide information for the initiation of Pathways.

A more comprehensive checklist is used at the initial visit, and shorter checklists are used on an ongoing basis to monitor changes between visits. Appendix D is an example of a checklist used for adult clients. Other client information can be gathered through standard tools or screens, such as the Patient Health Questionnaire 9 (PHQ9), a depression screener; Ages & Stages Questionnaire (ASQ); and Patient Activation Measure (PAM).

**Risk Assessment**

Standard #14

• To ensure an at-risk individual’s needs are being addressed and met—and an efficient use of limited resources—the HUB assesses and monitors each client’s risk factors. The HUB must be able to describe how risk measurement translates into intensity of care coordination services.

**Data System**

Standards #17 and #18

• The HUB tracks, monitors, and reports on client services and promotes collaboration, intersectoral teamwork, and community–clinical linkages. Although a complex data system is not mandatory, the HUB needs to develop accurate and efficient methods for tracking and monitoring data collection for at-risk clients. Most HUBs will rely on information technology to perform this task. Whatever approach is used, this system must ensure the protection of client information at all times.

• The HUB ensures that clients (1) are identified and engaged; (2) are evaluated to determine their needs, risk factors, and risk level; (3) have an individualized care plan; (4) are assigned to appropriate standardized Pathways; (5) are monitored through the completion of the appropriate Pathways; (6) receive home visits; (7) are reevaluated to determine needs, risk level, and service adjustments; and (8) are discharged when their needs are met. Communication and data sharing among practitioners, agencies, CCCs, and the client help ensure quality and continuity of services.
**Quality Assurance**

**Standard #8**
- The HUB is responsible for monitoring and improving the quality of care coordination services provided to those who are at risk. Therefore, the HUB must have a quality improvement plan and must regularly evaluate its services as well as those services provided by care coordination agency members. The HUB quality improvement plan should describe how quality improvement projects are selected, managed, and monitored. The HUB needs a communication strategy that covers planned quality improvement activities and processes and how updates will be communicated regularly to all involved.

**Standard #19**
- This standard emphasizes that the HUB must monitor the performance of its care coordination agency members and offer technical assistance to ensure quality and client safety.

**Community Care Coordinator Requirements and Training**

Many different types of professionals can serve as community care coordinators, including social workers, community health workers, nurses, and case managers. By definition, these individuals spend the majority of their time meeting face-to-face with clients in a community setting, including the home. To ensure the provision of high-quality services and effective collaboration across all providers, each HUB should develop basic human resource requirements for care coordinators, along with a comprehensive training program. Individuals receiving care coordination services are often dealing with complex health and social issues, and community care coordinators need adequate preparation. The HUB should have clear policies and procedures on all aspects of training, documentation, and accountability for results.

**Standard #9**
- The HUB model of care coordination focuses on improving health, advancing equity, improving quality, and eliminating disparities, and all HUB and care coordination agency personnel must complete cultural competency training.

**Standard #10**
- Community care coordinators are supported and supervised by a competent professional, working within the scope of his or her license. The level of supervision varies based on the training of the community care coordinator. It is required that community health workers have supervisors who review and sign off on documentation.

**Standard #12**
- Education, training, and support for community health workers and for community care coordinators other than community health workers are essential to achieve improved outcomes for those clients at risk. The HUB must provide documentation that community care coordinators meet the minimum training requirements required as part of certification.6
Closing Summary

The identification and strategic reduction of an individual’s risk factors represent an opportunity to address disparities and reduce costs. The Pathways Community HUB model builds the community infrastructure and provides the tools, standards, and strategies to implement this approach for individuals and populations. Across the Nation, there are effective and capable community organizers; with support, they can use existing resources to implement this HUB model and bring about transformative change.

References

**Additional Resources**


## Appendix A. Pathways Community HUBs From Network Involved in National Certification

**Learning Network HUBs With Provisional Certification**

<table>
<thead>
<tr>
<th>Name of Agency and Initiative</th>
<th>Address</th>
<th>Web Page</th>
<th>Names - Leadership</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Council of Northwest Ohio</td>
<td>3231 Central Park West Drive, Suite #200 Toledo, OH 43617</td>
<td><a href="http://www.hcno.org">www.hcno.org</a></td>
<td>Jan L. Ruma, M.Ed., CFRE, Vice President and HUB Director&lt;br&gt;Carly Miller, M.P.H., HUB Manager</td>
<td>(419) 842-0800&lt;br&gt;<a href="mailto:jruma@hcno.org">jruma@hcno.org</a></td>
</tr>
<tr>
<td>Pathways to a Healthy Bernalillo County</td>
<td>Bernalillo County New Mexico Office of Community Affairs University of New Mexico, Health Sciences Center Albuquerque, NM 87131</td>
<td><a href="http://hsc.unm.edu/community/pathways/">http://hsc.unm.edu/community/pathways/</a></td>
<td>Daryl Smith, M.P.H</td>
<td>(505) 272-0823&lt;br&gt;<a href="mailto:dsmith@salud.unm.edu">dsmith@salud.unm.edu</a></td>
</tr>
<tr>
<td>Saginaw Pathways to Better Health</td>
<td>Saginaw County Community Mental Health Authority 500 Hancock Saginaw, MI 48602</td>
<td><a href="http://saginawhub.org/">http://saginawhub.org/</a></td>
<td>Sandra Lindsey, CEO, SCCHMA/Director, Saginaw County Community Mental Health Authority&lt;br&gt;Barb Glassheim, Saginaw Pathways to Better Health Project Manager&lt;br&gt;Verbula Wheeler, Saginaw Community Care HUB Manager&lt;br&gt;Linda Tilot, Director, Care Management &amp; Quality Services, SCCHMA/ Centralized Access Home Visiting Hub</td>
<td><a href="mailto:barbglassheim@comcast.net">barbglassheim@comcast.net</a></td>
</tr>
</tbody>
</table>
### Learning Network HUBs Working Toward Provisional Certification

<table>
<thead>
<tr>
<th>Name of Agency and Initiative</th>
<th>Address</th>
<th>Web Page</th>
<th>Names - Leadership</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care Access Now</strong></td>
<td>7162 Reading Road Suite 1120 Cincinnati, OH 45237</td>
<td><a href="http://healthcareaccessnow.org">http://healthcareaccessnow.org</a></td>
<td>Judith Warren, M.P.H., Executive Director Laverne Wiley</td>
<td>(513) 707-5697 <a href="mailto:jwarren@healthcareaccessnow.org">jwarren@healthcareaccessnow.org</a></td>
</tr>
<tr>
<td><strong>Muskegon Community Health Project</strong></td>
<td>Muskegon Community Health Project/Mercy Health Partners 565 W. Western Avenue Muskegon, MI 49440</td>
<td><a href="http://www.mchp.org">http://www.mchp.org</a></td>
<td>Peter J. Sartorius, M.A., M.S., Health Project Planning and Grants Manager Judy Kell, M.P.A., HUB Director, West Michigan Therapy</td>
<td>(231) 672-3201 <a href="mailto:sartorip@mchp.org">sartorip@mchp.org</a></td>
</tr>
<tr>
<td><strong>Rio Arriba Health and Human Services</strong></td>
<td>1122 Industrial Park Road Española, NM 87532</td>
<td><a href="http://www.rachc.org">www.rachc.org</a></td>
<td>Lauren Reichelt, M.A., HUB Director</td>
<td>(505) 753-3143</td>
</tr>
<tr>
<td><strong>Central Ohio Pathways Community HUB COPCH (developed from the local CHAP program)</strong></td>
<td>35 North Park Street, Suite 132 Mansfield, OH 44902</td>
<td><a href="http://www.CHAP-Ohio.net">www.CHAP-Ohio.net</a></td>
<td>Dan Wertenenberger Michelle Moritz, B.S.N., RN Sarah and Mark Redding</td>
<td>(419) 525-2555 <a href="mailto:sredding@att.net">sredding@att.net</a></td>
</tr>
<tr>
<td><strong>Care Hub, a division of Ingham Health Plan-Serving Pathways to Better Health and Early Childhood</strong></td>
<td>5656 S. Cedar Street, Suite 130 Lansing MI 48911</td>
<td><a href="http://www.ihpmi.org/carehub">www.ihpmi.org/carehub</a></td>
<td>Lori Noyer, Project Coordinator Robin Reynolds, Executive Director</td>
<td>(517) 272-4179 (Noyer) 517 272-4175 (Reynolds) <a href="mailto:lnoyer@ihpmi.org">lnoyer@ihpmi.org</a></td>
</tr>
<tr>
<td><strong>Northeast Oregon Network (NEON)-NEON Pathways Community Hub</strong></td>
<td>1802 Fourth Street, Suite A La Grande, OR 97850</td>
<td><a href="http://www.neonoregon.org">www.neonoregon.org</a></td>
<td>Lisa Ladendorff, Executive Director Eric Griffith, Hub Coordinator</td>
<td>(541) 624-5101 (Ladendorff) <a href="mailto:lladendorff@neonoregon.org">lladendorff@neonoregon.org</a> (541) 624-5101 (Griffith) <a href="mailto:egriffith@neonoregon.org">egriffith@neonoregon.org</a></td>
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</table>
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).

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

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.

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.

**Completion**

Confirm that client successfully completes stated educational goal:
- Course/class completed
- Training program completed
- Quarter/semester completed

Start date

Educational goals

Date of first class

Check-in dates

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).

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

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

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

Initiation date

Referral Source
☐ Parent
☐ School
☐ Doctor
☐ Self-referral
☐ Other _______________________________

Appointment date

Agency/provider

Kept appointment date

Kept appointment date

Kept appointment date

Describe behavioral health issue(s): ________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Care coordination plans: ________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Record reason if Finished Incomplete: ____________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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

- Explain Part C services and review family’s rights.
- Explain agency options to obtain developmental evaluation. Refer child to Central Intake.

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

**Completion**
Document the date and results of completed developmental evaluation.

Results and recommendations:

- 
- 
- 
- 
- 
- 

Record reason if Finished Incomplete:

- 
- 
- 
- 

Start date

Reason for referral

Refereed to Central Intake

□ Yes  □ No

Scheduled date of evaluation

Education provided

□ Yes  □ No

Date of completed evaluation
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.

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.
<table>
<thead>
<tr>
<th>Client’s Name ________________________________</th>
<th>Date of Birth __________________</th>
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<tbody>
<tr>
<td>Community Care Coordinator ____________________</td>
<td>Agency __________________________</td>
</tr>
</tbody>
</table>

**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

### Document education provided
(Example: educational content—module, section, etc.)

### Document educational format used (check only one).
- [ ] 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.

Record reason if Finished Incomplete: ___________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

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
<table>
<thead>
<tr>
<th>Family Planning Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiation</strong></td>
</tr>
<tr>
<td>Client has requested information on family planning methods.</td>
</tr>
<tr>
<td><strong>Provide family planning education.</strong></td>
</tr>
<tr>
<td><strong>Schedule appointment with primary care provider or clinic</strong></td>
</tr>
<tr>
<td><strong>Followup with client</strong></td>
</tr>
<tr>
<td>Confirm that client kept appointment and document family planning method in chart. <strong>Pathway is complete if tubal ligation, vasectomy, IUD, implant, or shot given.</strong></td>
</tr>
<tr>
<td><strong>Completion</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Record reason if Finished Incomplete: ___________________________________________________________**

---

*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.

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

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.

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

Start date

Date application submitted

Date approved

Insurance

Number
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.

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.

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.

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

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

Record reason if Finished Incomplete: ___________________________________________________

____________________________________________________________________________________

**Start date**

Appointment scheduled

Appointment kept

Contact person

Contact number

Check-in dates

Completion date
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.

Educate family about the importance of immunizations.

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

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

Record reason if Finished Incomplete: ____________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Start date

Missing Immunizations:

Education provided
☐ Yes    ☐ No

Appointment dates

Completion date

Reviewer

Education provided

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

- 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).

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

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

**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.

Record reason if Finished Incomplete: ______________________________________________________

Start date

Immunization History From:
- Family’s record
- Electronic registry
- Health care provider
- Health department
- Other: _______________________

Education provided
- Yes
- No

Immunization records reviewer

Completion date

- Up to date
- Not up to date
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
   - [ ] Yes  [ ] No
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
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).

Determine payment source for health care.

Find appropriate primary medical provider options for payment source.

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

**Completion**
Confirm that appointment was kept.

---

Start date

Payment Source:
- [ ] Medicaid
- [ ] Medicare
- [ ] Private insurance
- [ ] Self-pay
- [ ] Other: _______________________

Medical provider

Date of initial appointment

Education provided
- [ ] Yes
- [ ] No

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)

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

Appointment scheduled with health care provider/clinic.

Completion
Verify with health care provider that appointment was kept.

Start date

Referral - Code

Education provided
☐ Yes   ☐ No

Appointment date

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: ________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
**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)**

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Can read the label</th>
<th>How many doses and knows how to get refills?</th>
<th>...</th>
<th>...</th>
<th>...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Client’s Name ____________________________________ Community Care Coordinator _________________________________________

Date of Birth ______________________________ Today’s Date _________________________ Agency _______________________________

<table>
<thead>
<tr>
<th>Name of Medicine &amp; Dose</th>
<th>Can open? yes/no</th>
<th>What is this medicine for? (client’s description)</th>
<th>How many doses each day? (client’s response)</th>
<th>Can read the label and knows how to get refills? yes/no</th>
<th>Comments</th>
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</table>

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

<table>
<thead>
<tr>
<th>Name of Medicine or Treatment</th>
<th>Can open? yes / no</th>
<th>What is this medicine or treatment for? (client’s description)</th>
<th>How many doses each day? (client’s response)</th>
<th>Can read the label and knows how to get refills? yes/no</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Client’s Name</td>
<td>Community Care Coordinator</td>
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<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Today’s Date</td>
<td>Agency</td>
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</table>

**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:**

________________________________________________________________________
________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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.

______________________________

Date information sent

☐ Fax
☐ HUB
☐ Mail
☐ Other________________

______________________________

Verification date

Medication concerns:

☐ Yes ☐ No

Record reason if Finished Incomplete: __________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

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

Completion

Verify with primary care provider that chart was received.

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

Date information sent
☐ Fax
☐ HUB
☐ Mail
☐ Other: _____________________________

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.

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.

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

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

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.

Schedule appointment with 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: ___________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Start date __________________
Date of delivery __________________
Date of appointment __________________
Health care provider __________________
Client’s Name ____________________________________ Date of Birth __________________

Community Care Coordinator ____________________ Agency ________________________

Pregnancy Pathway

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

Provide pregnancy education.

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

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

Start date
Education provided
☐ Yes  ☐ No

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

Prenatal care provider

Due date

Concerns

Date of birth

Birth weight

Gestational age (weeks)

Record reason if Finished Incomplete: ____________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
# Smoking Cessation Pathway

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<tr>
<th><strong>Initiation</strong></th>
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<tbody>
<tr>
<td>Client states that he/she is a cigarette smoker/tobacco user.</td>
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</table>

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.

**Record reason if Finished Incomplete:**

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<tr>
<th><strong>Start date</strong></th>
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<tr>
<td>Tobacco product</td>
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<tr>
<td>Amount</td>
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</tbody>
</table>

**Stages of Change Model – check stage:**
- [ ] Precontemplation
- [ ] Contemplation
- [ ] Action
- [ ] Maintenance
- [ ] Relapse

**Completion date**
- [ ] Self-report
- [ ] Lab test confirmation
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)*

Provide appropriate education and discuss the importance of keeping appointments.

**Appointment** scheduled with social service provider.

**Completion**
Verify that client kept scheduled appointment.

**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: ___________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
Appendix C. Sample Demographic and Referral Form

Richland Community HUB
Sample Demographic Form
Pregnant Client

Date: _________________________ Referred by: ________________________________

Client’s Name: _______________________________________________________________________

Address: _____________________________________________________________________________

Phone: ________________________ Alternate Phone: _________________________________

Client’s Date of Birth: ___________ Gender: M     F

Insurance Provider/Number: _____________________________________________________________

Reason for Referral: ___________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Is Client Pregnant? Y       N  Estimated Due Date: ________________________________
Estimated Weeks: _____________________________________________________________________
Date of 1st Prenatal Visit: _______________________________________________________________________

Referral Received by: _________________________________________________________________

Referral Assigned to: _______________________ on ______________

Referral Outcome: _______________________________________________________________________

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# Appendix D: Sample Adult Checklist

## Initial Adult Checklist

Visit Date: ________________  Start: ___________  End: _________  Visit Type: ___________________

Care Manager: ________________________________________________________________________

Name: _________________________________  DOB:  _______________________________________

Address: ________________________________  Phone:  ______________________________________

SSN: _____________________  Race: _________  Ethnicity:  _____________  Gender: □ M  □ F

Insurance _______________________________  Medicaid Number: ____________________________

Referral Date: ____________________________  Emergency Contact Number:  ___________________

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<tr>
<th>YES NO</th>
<th>Client Information</th>
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<tr>
<td></td>
<td>Are you single?</td>
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<td></td>
<td>If no: 1-significant other, 2-married, 3-separated, 4-divorced, 5-widowed, 6-other</td>
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|       | Do you rent your home or apartment? |
|       | If no: 1-own home, 2-live with relatives, 3-live with friends, 4-not from this area, 5-homeless, 6-other |

|       | Do you speak another language besides English at home? |
|       | If yes, do you need a translator for appointments? |

|       | Are you in school now? |
|       | If no: 1-college graduate, 2-high school diploma, 3-GED, 4-dropped out of high school, 5-other |

|       | Are you interested in finding a job? |
|       | If no: 1-employed, 2-on disability, 3-enrolled in a training program, 4-other |

|       | If disabled, what is the reason? |

|       | Do you need help with transportation to appointments? |
|       | What are you using now for transportation? |

|       | Do you have children? |
|       | If yes: How many? |
|       | How many children live with you? |
|       | Do any of your children have special needs? |

|       | Do you need help with child care? |

|       | Do you have any problems providing: |
|       | 1-housing, 2-food, 3-clothing, 4-utilities, 5-other |

|       | Do you have any legal issues? |
**YES  NO  General Health**

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<td><strong>Do you need health insurance for yourself?</strong></td>
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<td><strong>If no:</strong> Health insurance: ________________________________________________________</td>
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<td><strong>Do you need a family doctor?</strong></td>
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<td><strong>If no:</strong> Family doctor’s name ___________________________________________</td>
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<td><strong>Do you need a dentist?</strong></td>
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<td><strong>If no:</strong> Dentist’s name ___________________________________________</td>
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**If you don’t have a family doctor, where do you get your care?**
1-ER, 2-Urgent Care, 3-Walk-in Clinic, 4-Other ___________________________________________

**Previous illnesses:**
______________________________________________________________________________
_______________________________________________________________________________________

**Previous surgeries and hospitalizations:**
______________________________________________________________________________
_______________________________________________________________________________________

**Allergies:**
______________________________________________________________________________
_______________________________________________________________________________________

**YES  NO  Current Medical Issues**

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<td><strong>Are you currently being treated for any of the following conditions?</strong></td>
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<td><strong>1-infections, 2-asthma, 3-chronic medical conditions, 4-mental health conditions,</strong></td>
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<td><strong>5-mental retardation, 6-developmental disabilities or delays, 7-other:</strong> ________________</td>
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**Are you taking any medicines?**
1-prescribed by your doctor, 2-over the counter, 3-herbal or alternatives, 4-other______

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<td>List all medications:  __________________________________________________________</td>
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**YES  NO  Safety and Emotional Health**

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<td><strong>Do you use tobacco products?</strong></td>
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<td><strong>Does anyone smoke in your home?</strong></td>
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<td><strong>Do you drink alcohol?</strong></td>
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<td><strong>Do you use other substances?</strong></td>
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<td><strong>Are you stressed?</strong></td>
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<td><strong>Are you feeling depressed?</strong></td>
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<td><strong>Have you experienced emotional, verbal, or physical abuse?</strong></td>
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<td><strong>Do you have a working smoke detector?</strong></td>
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<td><strong>Are there any safety concerns in the home?</strong></td>
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<td>Describe:  __________________________________________________________</td>
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<td><strong>Is there a gun in the home? If yes, is the gun locked? Yes___ No___</strong></td>
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<td><strong>Are there any pets in the home?</strong></td>
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<td><strong>If children at home, ask: Do you read to your child(ren)?</strong></td>
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<td>If yes, how often? ____________________________________________________________</td>
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List all other agencies that you are working with now:

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NOTES
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Please add the following Pathway(s): [Represents the request from the care coordination agency to the HUB to add pathways to the Care Coordination Plan and tracking. List of Pathways here represents local set.]

__ Adult Education
__ Chemical Dependency
__ Depression
__ Employment
__ Family Planning
__ Family Violence
__ Health Insurance
__ Immunization Screening
__ Immunization Referral
__ Lead
__ Medical Referral ________________________________________________________________
__ Medication Assessment
__ Medication Management
__ Pregnancy
__ Postpartum
__ Smoking Cessation
__ Social Service Referral ____________________________________________________________
__ Suitable Housing
__ Other: _______________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Next home visit date: __________________________