Client Name ______________________________________ Birth Date ________________

Care Coordinator ___________________________________ Agency _________________

Adult Learning

Initiation
Client identifies adult learning need(s). Date __________

Partner with client to establish and review educational and/or career goals. Document goal(s) and desired outcome(s).

Goals: _____________________________________

Assist client in registering for training or educational course:

□ Gather necessary documentation for registration.
□ Determine if client needs to take an assessment or placement exam & schedule exam date.
□ Use Education Pathways as appropriate.

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

Monitor client's progress with educational program. At a minimum of every 2 weeks confirm that client is attending classes and document progress in client record.

Progress Checks:

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Completion
Confirm that client successfully completes stated educational goal:

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

Date ________________

Date Finished Incomplete ___________
Reason ____

Supervisor's Signature _______________________________________ Date ______________

February 23, 2018

PCHI © Copyright Reserved

Client Name ____ Birth Date ________________

Care Coordinator ____________________________________ Agency __________________

Behavioral Health

Initiation
Client with diagnosed behavioral health issue(s).
Date ______________

Document behavioral health issue(s). ________________
____
Use Education Pathways as appropriate.

Schedule initial appointment for appropriate level of behavioral health service based on client's need.
Date _______________

Completed Appointment #1: Date _____________
Service _____________________________
Completed Appointment #2: Date _____________
Service _____________________________
Completed Appointment #3: Date _____________
Service _____________________________

Completion
Client has kept three scheduled behavioral health appointments.
Date ________________

Monitor any follow-up appointments with the Medical Referral Pathway after this Pathway is completed.

Date Finished Incomplete _____________
Reason ____

Supervisor's Signature ____ Date _________________

 PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Developmental Referral

Initiation

Child with suspected developmental delays.

Date ______________

Reason for referral ______________________________

____

□ Explain Part C services and review family's rights.

□ Explain agency options available to obtain a developmental evaluation.

□ Obtain parental/guardian consent for evaluation.

□ Partner with primary care provider to obtain a prescription and assist family with scheduling developmental evaluation.

Schedule developmental evaluation appointment.

Date _________________

□ Educate caregivers about the importance of keeping appointment. Use Education Pathways as appropriate.

Completion

Document the date and results of completed developmental evaluation.

Date ________________

Results _______________________________________

____

____

Date Finished Incomplete ____________

Reason ____

Supervisor's Signature ____ Date ________________

February 23, 2018

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

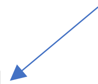
Care Coordinator ____________________________________ Agency ___________________

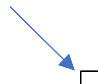
Developmental Screening

Initiation
Any child up to 5 years of age. Child should be screened at a minimum of every 6 months using the age appropriate ASQ or ASQ-SE. Date ______________

□ Educate the family about the importance of developmental milestones. Make sure to document appropriate Education Pathways.
□ Obtain verbal consent from parent/guardian to do developmental screening.

Completion
Child successfully screened using the age appropriate ASQ or ASQ-SE. Record test and results. Date ____________





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

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

Circle ASQ Screen used: 2 4 6 8 9 10 12 14 16 18 20 22 24 27 30
33 36 42 48 54 60

____ Communication ____ Gross Motor
____ Fine Motor ____ Problem Solving
____ Personal-Social

Circle ASQ-SE Screen used: 2 6 12 18 24 30 36 48 60 Total Score ________

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ______________________________________ Date _______________

February 23, 2018

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Education

Initiation

Education Pathway initiated by community care coordinator. Date ______________

Document the HUB approved evidence-based education provided.

____

____

□ Document required assessments, education format, and pre- and post-tests as appropriate to the topic.

Completion

All required components are completed and documented.
Date ____________

Education Format (circle): Handout Talking Points Video Slides Other ____________

Pre-Test Score _____________

Post Test Score ____________

Assessment _______________

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ____ Date ________________

PCHI © Copyright Reserved

Client Name ____ Birth Date ________________

Care Coordinator ____________________________________ Agency __________________

Employment

Initiation
Client is requesting assistance in obtaining a job.
Date ____________

□ Education and work history
- Previous work experience ____________________
  ____
  ____
- Educational level completed__________________
- Employment goals (special training needed for desired job) ___________________________
  ____
  ____
  ____

□ Identify barriers to employment (felony record, financial constraints, etc.) Document Education Pathways as appropriate.

Care coordinator works with client to confirm that résumé is completed. Date ________________

Care coordinator works with client to monitor job applications at least every 2 weeks and record.

Progress Checks:
Date:__________
Date:__________
Date:__________
Date:__________
Date:__________
Date:__________
Date:__________
Date:__________
Date:__________

Confirm date of hire and place of employment.
Date ________ Place ______________________________

Completion
Client has found consistent source of steady income and is employed more than 30 days from date of hire.
Date_______________

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ____ Date ________________

 PCHI © Copyright Reserved

Client Name ____ Birth Date __________________

Care Coordinator _______________________________________ Agency ____________________

Family Planning

Initiation
Client has requested help with getting a family planning method. Date _______________

□ Document HUB approved education about family planning with the Education Pathway.

Schedule appointment for family planning.
Date ________________

Completion 1 (Permanent or LARC)
Confirm that client kept appointment and document family planning method. Date _________________
Method ____________________________________

Pathway is complete if tubal ligation, Essure, vasectomy, IUD, implant, shot or other form of long-acting reversible contraceptive (LARC) is obtained.

Completion 2 (Individual Control)
Confirm that client kept appointment and document family planning method. Date _________________
Method ____________________________________

If client has chosen a method other than a permanent method or LARC, then Pathway is complete when client has successfully used the method for more than 30 days from the start date.
Follow-up date ________________
Confirmation that family planning method is still being used ___ Yes ___ No

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ____ Date ________________

PCHI © Copyright Reserved

Client Name ____ Birth Date ________________

Care Coordinator ____________________________________ Agency __________________

Health Insurance

Initiation

Client needs health insurance. Date ___________

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

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

Completion

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

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

  Insurance _______________________

  Number _________________________

  Date ____________________________

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ____ Date _______________

PCHI © Copyright Reserved

Client Name ____ Birth Date ________________

Care Coordinator ____________________________________ Agency __________________

Housing

Initiation

Client needs affordable and suitable housing. Date ____________

Check all reasons why housing is required:

□ Eviction	□ Safety Issue(s)
□ Homeless	□ Too many for living space
□ Domestic Violence	□ Financial
□ Poor rental history	□ Discrimination
□ Fire/Natural Disaster	□ Disability
□ Self-imposed (pets)	□ Lead
□ Poor location to access services	□ Other ______________

Partner with client to contact appropriate housing organization and schedule an appointment. Date _______________________

Housing organization____________________________

□ Help client remove barriers and document Pathways used.

Confirm that client kept appointment. Date ____________
Name and phone number of contact person if client is placed on a waiting list. Phone _____________________
Name____

□ Follow up with housing contact person at least bi-weekly to monitor housing progress and record in client's chart. Document completion of related Educational Pathways with client.

Progress Checks:

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Date:__________

Document date client moves into housing unit. Date_____________
Address____

Completion

Confirm that client has moved into and maintained a suitable and affordable housing unit for more than 30 days from the move-in date. Date____________

Date Finished Incomplete ___________
Reason ____

Supervisor's Signature ____ Date ______________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Immunization Referral

Initiation

Immunization record reviewed, and child is confirmed to be behind on immunizations or no record is available. Date______________

Confirm appointment scheduled with provider or clinic to update immunization status.

Provider: ____

Appointment Date: ________________________________

Educate family about the importance of immunizations and maintaining an up-to-date record. Check educational tool(s) used:

Ages 0-10

- □ *Your Child Thanks You*
- □ *Why Risk It*
- □ *What Is Your Reason*

Ages 11-18

- □ *Immunization is the Best Protection*
- □ *HPV Did You Know?*

Completion

Child is up-to-date (UTD) on all age-appropriate immunizations. Monitor immunization status at all visits. Date______________

- □ UTD on all
- □ UTD without influenza

Document how records were obtained and reviewed.

- □ Family's record
- □ ImpactSIIS
- □ Other electronic registry
- □ Health care provider
- □ Health department
- □ Other________________

Date Finished Incomplete ___________

Reason ____

Supervisor's Signature ____ Date ______________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Immunization Screening

Initiation

Any child less than 18 years of age. Date_________________

Determine immunization status by using the child's immunization record:

- If record is available, use "***Checking a Vaccine Record***" Tool or document confirmation from ImpactSIIS registry.
- Document how records were obtained and reviewed.
  - □ Family's record
  - □ Health care provider
  - □ ImpactSIIS
  - □ Health department
  - □ Other electronic registry
  - □ Other________________

Educate family about the importance of immunizations and maintaining an up-to-date record. Check education tool(s) used:

Ages 0-10

- ❑ *Your Child Thanks You*
- ❑ *Why Risk It*
- ❑ *What Is Your Reason*

Ages 11-18

- ❑ *Immunization is the Best Protection*
- ❑ *HPV Did You Know?*

Completion

Immunization record reviewed and documented.

1. Child is up-to-date (UTD) on all age-appropriate immunizations. Date_________________________
   - ❑ UTD on all
   - ❑ UTD without influenza
2. Child is behind on age-appropriate immunizations. Document reasons why and start Immunization Referral Pathway.
3. Document that no records are available, and the steps taken to get records, and open the Immunization Referral Pathway.

Date Finished Incomplete ____________

Reason ____

Supervisor's Signature ______________________________________ Date ______________

PCHI © Copyright Reserved

Client Name ______________________________________ Birth Date ________________

Care Coordinator __________________________________ Agency __________________

Lead

Initiation

Any child between 12 – 72 months of age. Children are recommended to be tested at 12 and 24 months (check one).

- □ 12 months
- □ 24 months

or

- □ Lead testing status unknown (12 – 72 months)
- □ Lead testing not done (12 – 72 months)
- □ Other ____________________

□ Provide lead education to all families with young children and/or expectant mothers. Use Education Pathway.

If available, provide date and result of most recent lead test.

Date_________ Results___________________________

Check all that apply:

- □ Child is on Medicaid
- □ Child lives in high risk zip code area

If child is not on Medicaid, and does not live in high risk zip code area, then complete Lead Assessment Tool:

- □ Assessment is positive
- □ Assessment is negative

Schedule appointment for blood lead screening.

Date_________________

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

- □ Elevated: $\geq$ 5 µg/dl → Refer to health department.
- □ Non-elevated: $<$ 5µg/dl

Date________________

Date Finished Incomplete ____________

Reason ____

Supervisor's Signature ____ Date ______________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Medical Home

Initiation

Client needs an ongoing source of primary care.
Date______________

Determine and record client's payer source:

- □ Medicaid
- □ Medicare
- □ Private Insurance
- □ Self Pay
- □ Other __________________

1. Identify provider ____________________________
2. Assist client in scheduling appointment.
   Date___________________
3. Document Education Pathways as appropriate.

Completion

Confirm that appointment was kept. Date_____________

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ____ Date ________________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Medical Referral

Initiation

Client needs a health care appointment or service.
Document type of service needed – use codes.
Date _______________ Code __________________

□ **Educate** client about the importance of regular health care visits and keeping appointments. Document education with appropriate Education Pathway.

Appointment scheduled for health care service.
Date _________ Provider_____________
Service ________________________________

Completion

Verify that appointment was kept. Date _____________

Code Numbers for Type of Medical Referral:

1. Advanced Directives
2. Behavioral health services
3. Breastfeeding services and support (classes, pump, etc.)
4. Dental
5. Disease management and support services, including education
6. Equipment assistance
7. Family Planning and reproductive health
8. Hearing
9. Home Health services
10. Immunizations
11. Labs
12. Medication assistance
13. Nutritional services
14. Occupational therapy
15. Physical therapy
16. Primary care ____________
17. Procedures (Ultrasound, MRI, x-ray, etc.)
18. Rehabilitation (cardiac, pulmonary, etc.)
19. Sexually transmitted infections
20. Specialty care ___________
21. Speech and Language
22. Substance abuse services (detox, medication assisted treatment, sober housing, etc.)
23. Treatment (chemotherapy, radiation, etc.)
24. Vision

Date Finished Incomplete ___________
Reason ____

Supervisor's Signature ____ Date ______________

PCHI © Copyright Reserved

Client Name ____ Birth Date __________________

Care Coordinator ____ Agency ____________________

Medication Assessment

Initiation
Client is taking prescribed medication(s).
Date________________

□ Complete the Medication Assessment Tool 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 Tool to client's primary care provider or pharmacist. Date_____________

Verify with primary care provider that Medication Assessment Tool was received. Date________________

□ If medication issues are identified by health care provider, then initiate Medication Management Pathway.

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ____ Date ________________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Medication Management

Initiation
Client is not taking medication(s) as prescribed.
Date___________
Referral Source __________________________________

Schedule appointment with prescribing provider to complete medication reconciliation and patient education.
Date_______________

Care coordinator schedules follow-up appointment in the home. Date_______________

Medication Assessment Tool completed in client's home and sent to provider.
Date________________

Provider reviews Medication Assessment Tool:
□ Medication correct
□ Medication is not correct – Schedule appointment with provider. Date __________

NOTE: Medication Assessment Tool and provider visits are repeated until provider confirms that medication is correct. (Steps 2 – 5)

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

Date Finished Incomplete ___________
Reason ____

Supervisor's Signature ____ Date _______________

PCHI © Copyright Reserved

Client Name ____ Birth Date __________________

Care Coordinator ____ Agency ____________________

Postpartum

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

Appointment scheduled with provider.
Date_______________

NOTE: Complete Family Planning Pathway and Education Pathways as appropriate.

Confirm that postpartum appointment was kept.
Date_______________

Date Finished Incomplete _____________
Reason ____

Supervisor's Signature ____ Date _________________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Pregnancy

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

NOTE: Document all pregnancy related education with Education Pathways.

Confirm first prenatal appointment with prenatal provider. Provider______________________________

- First prenatal appointment date_________________
- Estimated due date___________________________
- Number of completed prenatal appointments to date (including 1st prenatal) ________________________
- Concerns___________________________________
  ____

Confirmed **completed** pregnancy-related appointments that happen after the Initial Checklist.

Prenatal appointments:

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Date:___________

Completion
Healthy baby ≥ 5 lbs. 8 ounces (2500 grams)

Birth date______________ Weight________________
Gestational Age_________

Check one: Singleton_____ Twins_____ Triplets+_______

***Please remember to complete the Birth Information Tool.**

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ____ Date ______________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Social Service Referral

Initiation
Client needs a social service. Document type of service needed - use codes. Date_________ Code__________

□ Provide education as needed to keep appointment. Document Education Pathway(s) as appropriate.

Appointment scheduled with social service provider or to receive other services. Date_________________
Provider/Service______________________________

Completion
Verify that client kept scheduled appointment and/or received services. Date_______________________

Code Numbers for Type of Service

1. Child care services
2. Child development services (Part C, Help Me Grow, Head Start)
3. Child or elder abuse services
4. Clothing – ongoing resource for clothing
5. Citizenship – resource to obtain citizenship
6. Day care/respite services
7. Educational services and supports (not using Adult Learning PW)
8. Employment –employment resource (not on Employment PW)
9. Family crisis services (emergency shelter, red cross, etc.)
10. Fatherhood program and support services
11. Financial support – resource to financially assist with identified risk factor
12. Food stability – ongoing resource for food stability
13. Household items, including furniture
14. Housing services –housing resource (not on Housing PW)
15. Identification services (birth certificate, driver's license, ID, etc.)
16. Intimate partner violence support services
17. Legal services
18. Literacy – intervention and educational services
19. Medical debt support
20. Parenting education classes and support
21. Phone – resource to obtain phone services
22. Safety equipment – (Examples: cribs, safety equipment for elders, car seats, locked cabinets for guns, bike helmets, fire extinguisher)
23. Translation services – ongoing resource for translation services
24. Transportation – ongoing resource for transportation
25. Utilities – ongoing resource for utility support

Date Finished Incomplete ____________
Reason ____

Supervisor's Signature ______________________________________ Date ________________

PCHI © Copyright Reserved

Client Name ____ Birth Date _________________

Care Coordinator ____________________________________ Agency ___________________

Tobacco Cessation

Initiation

Client states that he/she is a tobacco user.

Date______________________

Provide HUB approved tobacco cessation Education Pathways.

Use the 5 A's to guide discussion:

1. **Ask** - Identify and document tobacco use status at every visit.
2. **Advise** - In a clear, strong, and personalized manner, urge client to quit.
3. **Assess** - Is the client willing to make a quit attempt at this time?
4. **Assist** - For the client willing to make a quit attempt, refer for counseling and pharmacotherapy to help him or her quit.
5. **Arrange** - Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.

Date__________ Referral________________________

Review 5 A's. Ask about reduction in tobacco use at each home visit. Document any reduction in use:

□ No reduction

□ 25% less Date____________

□ 50% less Date____________

□ 75% less Date____________

□ Quit Date____________

Completion

Client has stopped using tobacco products for one month.

Date__________

Date Finished Incomplete ____________

Reason ____

Supervisor's Signature ____ Date ________________

February 23, 2018

PCHI © Copyright Reserved