

Completing the CHW/FP BH Plan**

<p>Step 1. The CHW/FP BH Plan must be completed for <u>EVERY</u> encounter with a patient, caregiver, school, or other service provider CHWs/FPs should respond to all questions and complete all necessary components of the plan as prompted in the EMR</p>			
<p>Step 2. Indicate reason(s) for CHW/FP contact or referral (select all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Assistance completing a screening tool (SWYC, PSC, etc.) <input type="checkbox"/> Universal touch/healthy parenting support <input type="checkbox"/> Request from patient/family <input type="checkbox"/> Request from PCP </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Request for support from other <input type="checkbox"/> Follow up on existing issue/referral <input type="checkbox"/> Free text to provide more detail if necessary </td> </tr> </table>		<input type="checkbox"/> Assistance completing a screening tool (SWYC, PSC, etc.) <input type="checkbox"/> Universal touch/healthy parenting support <input type="checkbox"/> Request from patient/family <input type="checkbox"/> Request from PCP	<input type="checkbox"/> Request for support from other <input type="checkbox"/> Follow up on existing issue/referral <input type="checkbox"/> Free text to provide more detail if necessary
<input type="checkbox"/> Assistance completing a screening tool (SWYC, PSC, etc.) <input type="checkbox"/> Universal touch/healthy parenting support <input type="checkbox"/> Request from patient/family <input type="checkbox"/> Request from PCP	<input type="checkbox"/> Request for support from other <input type="checkbox"/> Follow up on existing issue/referral <input type="checkbox"/> Free text to provide more detail if necessary		
<p>Step 3. Indicate goal(s) identified by family (select all that apply):</p> <input type="checkbox"/> Material needs support <input type="checkbox"/> Care coordination (e.g., navigation to/for EI, IEP or school-based services, CBHI, outpatient counseling, Autism or developmental delay evaluation, other) <input type="checkbox"/> Support to access to parent group or support <input type="checkbox"/> None, or free text to provide more detail if necessary			
<p>Step 4. Indicate the intervention(s) utilized in this encounter (select all that apply):</p> <input type="checkbox"/> Material needs support (for housing, food, and/or other community-based resources) <input type="checkbox"/> Care coordination (e.g., navigation to/for EI, IEP or school-based services, CBHI, outpatient counseling, Autism or developmental delay evaluation, other) <input type="checkbox"/> Support to complete screening tool or ADHD evaluation <input type="checkbox"/> Financial counseling, support for insurance (re-)enrollment, outreach to engage patient/family in care, introduce BRANCH, other			
<p>Step 5. Indicate the length of encounter (check one):</p> <input type="checkbox"/> 5 minutes or less, 6-15 min, 16-30 min, 31-45 min, 46-60 min, 61-90 min, over 90 min			
<p>Step 6. Indicate the treatment plan following the encounter (check all that apply):</p> <input type="checkbox"/> New/additional services needed <input type="checkbox"/> Continue with current services (defined as services in the past 12 months) <input type="checkbox"/> Further services offered but declined (STOP) <input type="checkbox"/> Issue resolved; routine follow up (STOP)			
<p>Step 7. If you select “New/additional services needed” in, indicate type(s) of new/additional services (check all that apply), and the identified need or concern which led to the referral for new/additional services:</p> <input type="checkbox"/> Continue with CHW/FP support <input type="checkbox"/> PCP follow-up <input type="checkbox"/> Integrated BHC follow-up <input type="checkbox"/> Other care team member follow-up <input type="checkbox"/> On-site specialty services <input type="checkbox"/> Off-site services	<p>If you select “Continue with current services” in, indicate what services the patient already receives (check all that apply):</p> <input type="checkbox"/> PCP management <input type="checkbox"/> Integrated BH services <input type="checkbox"/> On site (non-integrated) BH services <input type="checkbox"/> Other on-site services (i.e., care management) <input type="checkbox"/> Off-site BH services <input type="checkbox"/> EI, IEP, 504 Plan (established) <input type="checkbox"/> CBHI/IHT		

**Please Note: This document is a simple checklist meant to supplement the more comprehensive CHW/FP BH Plan Training Guide which can be found at <https://www.teamupforchildren.org/resources>.