Colorado Care Coordination Resource Guide

June 2013

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BACKGROUND

"Quality problems and spiraling costs have resulted in widespread interest in solutions that improve the effectiveness and efficiency of the health care system. Care coordination has been identified by the Institute of Medicine as one of the key strategies for potentially accomplishing these improvements".[1]

Care coordination has been described as a deliberate effort to organize patient care activities between two or more participants involved in the patient's care in order to facilitate the delivery of health care services[2], with this effort extending beyond typical care coordination between a primary care practitioner and another health care provider to include cross-system coordination[3].

Families of children with special health care needs, vulnerable populations, individuals with complex needs and those with acute or chronic physical or mental health issues often experience limited access to a single provider who can coordinate the necessary multiple sources of care. This often results in an inefficient use of resources, as well as the loss of quality services and increased health care expenditures for individuals, families and providers.[4] Care coordination is a necessary foundation to achieving the "triple aim" of health reform: improved individual experience of care (including quality and satisfaction), improved population heath and per capita cost control (IHI, 2011).

The costs of providing care coordination services are appreciable but not prohibitive. Standardization of care coordination practices is essential because it makes the care coordination process more amenable to quality improvement interventions.

Data is beginning to emerge related to care coordination. The preponderance of studies released during the last six years is very suggestive that care coordination has a positive impact on the well-being of both the child and family. While the results derive from a variety of settings and diverse populations, the conclusions reached are strikingly similar. Authors observed:

- Decreased emergency department visits
- Reduction in hospitalizations and number of hospital days
- Improved clinical outcomes
- Better integrated and more comprehensive care, with timely preventative care
- Ongoing health promotion and disease prevention consultation
- Appropriate use of community resources
- Integration of the family within the community
- Supportive and enjoyable family-child relationship

[1] McDonald, K.M., Sundaram, V., Bravata, D.M., Lewis, R., Lin, N., Kraft, S., McKinnon, M., Paguntalan, H., & Owens, D.K. Care Coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-020017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

[2] Myers D, et al., *The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care*, AHRQ Publication No. 11-M005-EF.

[3] Henderson M and Kaye N, *Policies for Care Coordination Across Systems: Lessons from ABCD III*. National Academy for State Health Policy. May 2012.

[4] McDonald KM, Sundaram V, Bravata DM, Lewis R, Lin N, Kraft S, McKinnon M, Paguntalan H, Owens DK. Care Coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

- Accessible and safe home environment
- Appropriate and accessible family health care
- Understanding of medical conditions, treatments and medications
- Active participation in child's Individual Family Service Plan (IFSP) and Individual Education Plan (IEP)

The Resource Guide is intended for three audiences:

1. Families/consumers of care coordination-related services
2. Care coordinators and providers of services[5]
3. Systems-level agencies that develop care coordination policies and programs6.

While each of these groups can use this document to develop an understanding of the different and varied perspectives involved in care coordination, specific uses include:

1. Families/consumers may use this document to understand values and qualities behind care coordination, as well as an educational and advocacy tool when accessing and managing care coordination services.
2. Care Coordinators and Providers may use this document as a foundation to maximize health care outcomes and use resources efficiently when coordinating care.
3. Systems-level professionals may use this document to make decisions about how to coordinate care in a way that minimizes their financial risks and maximizes the care that families receive.

The Resource Guide is structured in two sections:

- Section I, *Defining Care Coordination: Recommendations for a Sustainable and Meaningful Care Coordination System* presents the definition, functions and expected outcomes of care coordination as developed by Colorado's Care Coordination Community of Practice. This section also provides recommendations for action to bring Colorado towards a more dependable, quality and cost-effective model of care coordination.

- Second II, *Care Coordination Tools and Resources* offers a set of practical documents, tools, forms and resources to assist in the development and implementation of care coordination.

For information on this initiative, please contact:

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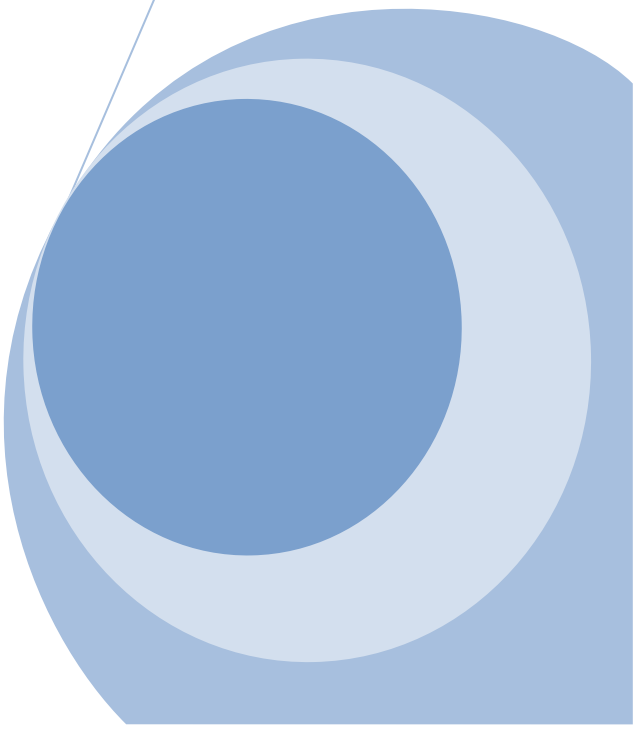
[5] Examples of the types of coordinators and providers for whom this document would be useful include: Health Care Program for Children with Special Needs (HCP) coordinators, patient navigators, service coordinators, case managers, social workers, mental health clinicians and consultants, therapists, nurses, and primary care physicians.

[6] Examples of systems-level partners may include Regional Care Coordination Organizations(RCCOs)/Accountable Care Organizations (ACOs), Health Care Program for Children with Special Needs (HCP), Colorado's Collaborative Management Program (CMP), Early Childhood Councils, and state departments involved in policy and program activities related to service delivery for children and their families.

SECTION I

Defining Care Coordination

Recommendations for a Sustainable and Meaningful Care Coordination System



COLORADO'S CARE COORDINATION COMMUNITY OF PRACTICE

Colorado's Care Coordination Community of Practice emerged from the work of Project BLOOM for Early Childhood Mental Health's *Linking and Aligning System of Care and Medical Home* initiative which began in 2004 and has grown to be a collaborative public/private effort across the domains of health, mental health, family support and developmental disabilities. The Community of Practice is facilitated by JFK Partners/University of Colorado School of Medicine and has sustained a core group of participants who have worked to develop and vet a common understanding and expectation of care coordination in Colorado.

The mission of this community of practice is to offer the definition, values, functions and outcomes of care coordination to be accepted across all sources of such service and provide care coordination guidance and resources for those involved with care coordination throughout Colorado serving children, youth and their families. This work is part of Goal 2, Objective 1 of the Colorado State Plan for Prevention, Intervention and Treatment Services for Children and Youth, 2010-2013.

This document has been developed in the framework of the system that supports and provides care coordination. It is not intended to stand alone without consideration of the context of the system and related care coordination efforts.

A. Care Coordination Community of Practice Goals

1. To develop a definition of care coordination and to identify the functions and outcomes of care coordination
2. To offer guidance and a framework for Colorado regarding care coordination through this Colorado Care Coordination Resource Guide based on best known and promising practices
3. To be a resource to collaborative conversations among entities providing care coordination
4. To embed this care coordination work into care coordination efforts across various disciplines

B. Care Coordination Community of Practice Leadership Team

The Leadership Team for the Care Coordination Community of Practice

Molly Benkert, MS, RN-BC, CBIS Health Care Program for Children with Special Needs/Denver Health and Hospitals	**Tessa Kranski, B.A., Extern** JFK Partners/University of Colorado Anschutz Medical Campus
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Barbara Deloian, PhD, CPNP, IBCLC President/CEO, Special Kids, Special Care, Inc.	**Kelsey Minor, MPH** Health Care Program for Children with Special Needs/Prevention Services Division/ Colorado Department of Public Health and Environment
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Sarah Davidon Hoover, M.Ed. JFK Partners/University of Colorado Anschutz Medical Campus	.

The Care Coordination Community of Practice also included participation and input from the following organizations:

- JFK Partners, University of Colorado School of Medicine
- Colorado Department of Health Care Policy and Financing
- Colorado Department of Public Health and Environment

- Family Voices Colorado
- Denver Health and Hospitals
- Jefferson County Public Health
- Special Kids, Special Care
- Tri County Health Department

C. Care Coordination Definition, Values, Functions, and Outcomes

1. Care Coordination Definition

Care coordination addresses interrelated behavioral, developmental, educational, financial, medical and social needs to optimize health and wellness outcomes. Care coordination is a person and family-centered, assessment-driven, team activity designed to meet the needs and preferences of individuals while enhancing the care giving capabilities of families and service providers; matching the level, type and timing of care coordination to families' needs.

2. Care Coordination Values

- To provide a team-based, partnership approach
- To make a commitment to provide family-centered care
- To build on the strengths of the family in developing the plan
- To share pertinent and appropriate information (between all providers and the family)
- To provide accurate and understandable information to everyone involved in the care coordination plan
- To utilize culturally responsive practices
- To recognize that families have different levels and types of care coordination needs
- To match the type and timing of care coordination to the family's needs
- To recognize that parents are the continuity between, and have the authority of, managing the services and supports they receive
- To involve the family in contributing to the description of specific activities
- To be available and accessible as needed over time

3. Care Coordination Functions (to be provided to match the level of care coordination needed as defined on page 15 of this document)

- Assess, with the family and individual, strengths as well as unmet needs across life domains
- Identify all sources of referrals, services, and supports; facilitate connections with these sources and manage continuous communication across these sources
- Identify desired outcomes of the family/individual
- Develop a comprehensive written plan of care and services with the family/individual that includes a plan to address family and or individual goals
- Reassess and modify the comprehensive written plan of care regularly with the family/individual
- Establish accountability or negotiate responsibility for desired outcomes
- Provide information around purpose and function of recommended referrals, services and supports
- Support and facilitate transitions including transitions in and out of care coordination
- Share knowledge and information and facilitate communication among participants in family/ individual care

4. Care Coordination Outcomes

Well-being and Satisfaction

- Achieve family/individual goals
- Reduce percentage of unmet needs
- Increase family/individual satisfaction
- Increase provider satisfaction
- Improve healthy family functioning
- Increase family knowledge

Process

- Ease access to resource information
  - Increase individual/family and provider access to information about available resources
  - Increase positive individual/family "teach-back" skills as demonstrated
- Enhance communication among providers/family/community partners
  - Increase documentation of action plan use and oversight
- Provide single point of entry into multiple services

Community and Relationship Supports

- Improve relationships with family and friends
- Improve parent-child relationships
- Increase positive social supports
  - Access to community resources including recreation, transportation, spiritual, legal and education

Functional Essentials

- Increase self-management skills
- Increase functional abilities
  - Increase functional assessment, school attendance/success and the ability to perform activities of daily living
- Support achievement of developmental trajectory
  - Achieve functional levels and mark milestones
- Meet basic needs and essentials including income, home, utilities, food, clothing, insurance, transportation and child care

Physical and Mental Health and Development

- Enhance communication between family and all sources of service and support
  - Reduce percentage of children seen by specialist without information from PCP and reduce percentage of children seen by PCP without information from consultation/specialist
- Increase measures of health
  - Reach health goals and increase family perception of individual's health
  - Increase activity, developmental screening and health promotion (Early and Periodic Screening, Diagnosis, and Treatment Guidelines, American Academy of Pediatrics and Bright Futures Guidelines)

- Increase percentage of all children screened for developmental delays and sensory deficits by select periodic well-child visits and/or school entry
- Improve access to health and mental health care

5. **Costs of Care**
   - Reduce emergency department visits
   - Reduce hospitalizations/hospital length of stay
   - Reduce redundancy and duplication of tests, services
   - Reduce repeat data gathering by service providers through increased care team efficiency
   - Reduce caregiver work days lost

D. Essential Qualities of Care Coordination

Care coordination services are centered on the following five essential qualities: Relationship-Building, Culturally Competent Care, Family Focused and Strengths-Based Services, Active Interagency Collaboration/Information and Referral and Process and Outcomes Evaluation.[7]

1. **Relationship –Building-** Building the quality of the relationship between the family, the provider and the care coordinator provider(s) as a foundation to providing and receiving effective and efficient care coordination services is essential. A high quality family-provider-care coordinator relationship includes the following activities:
   - Developing mutual trust and respect
   - Maintaining open communication (making it okay to ask questions)
   - Listening for the unasked questions
   - Offering anticipatory guidance in a sensitive and thoughtful manner

2. **Culturally Competent Care** -Working within the culture of the family, as well as between providers' cultural systems is essential to providing and receiving effective and efficient care coordination services. This includes the following activities:
   - Providing culturally responsive care
   - Supporting the concept of "cultural brokerage" (If the care coordinator is not fluent in the language and culture of the family, partner with someone who can understand and interpret these needs)
   - Interpreting languages across systems
   - Building a culture of open communication

3. **Family-Focused and Strengths-Based Services.** "A family-centered approach in which there is a respect and acceptance of family diversity, promotion of the family as a decision maker and collaboration with professionals and programs that are responsive to family needs is essential"[8]. There is a need to create and coordinate care based on the strengths of the family and with the family as the center of this process. This concept includes the following activities:
   - Identifying, screening and assessing the needs and strengths of the family, youth and

[7] As identified by the Colorado Linking and Aligning Forum, May-August, 2008. Denver, CO
[8] Jackson, Finkler, Robinson, A case management system for infants with chronic illnesses and developmental disabilities. Children's Health Care 1992; 21(4):224-232.

children while recognizing that the levels of such fluctuate over the course of a lifetime

- Coordinating a written individualized and shared plan that the family is satisfied with and able to articulate and make revisions to reflect fluctuations over time
- Providing information and education to the child and family that addresses the concerns and priorities of the family, while also providing anticipatory guidance
- Assisting family with transitions (i.e., from early childhood to preschool, provider to provider, child to adult services, community to community, etc.)
- Participating in and supporting communication among team members that is family-centered and encourages the family to be a partner in health care decision making 9

4. **Active Interagency Collaboration/Information and Referral**. Coordination and collaboration among agencies involved in a family's care coordination includes the following activities:
   - Coordinating a written individualized and shared plan that the family is satisfied with and able to articulate and collaborate with all providers to make revisions that reflect fluctuations in the child/youth's life course
   - Collaborating with all providers to continuously monitor the goals of the plan
   - Identifying, navigating and making referrals to appropriate services and supports
   - Participating in and supporting a system for children and families to obtain information and referrals about insurance, community resources, non-medical services, education and transition to adult providers
   - Participating in and supporting communication among team members that is family-centered and encourages the family to be a partner in health care decision making[10]
   - Navigating through and collaborating across systems and contributing to joint planning
   - Providing outreach services
   - Disseminating and sharing useful information and linking resources
   - Working on a continuum of coordination from basic referral to high fidelity wraparound in a system of care
   - Identifying insurance coverage

5. **Process and Outcomes Evaluation**. There is a need for ongoing evaluation of care coordination services which includes the following activities:
   - Using institutionalized processes and tools that result in documentation of outcomes of care coordination for families and situations where outcomes did not occur
   - Monitoring the outcomes of the plan on a continual basis
   - Providing families desired information in a format accessible to them
   - Using data to improve and/or sustain services.

[9] Adapted from Medical Home Standard #4. See Appendix 1. Colorado Medical Home Standards
[10] Adapted from Medical Home Standard #5. See Appendix 1. Colorado Medical Home Standards

E. General Recommendations

1. Employ a well-trained, experienced person with at least a baccalaureate degree as the care coordination team leader
2. Ensure care coordination functions are known to client/family
3. Promote and have access to a client-centered electronic personal health record for improving care coordination and allowing 24/7 access to information
4. Ensure care coordination is funded and has a statewide infrastructure to ensure equitable access
5. Apply the Colorado Medical Home Standards (Appendix 1) and the System of Care Values and Guiding Principles (Appendix 2) throughout the provision and receipt of care coordination services
6. Adopt a "no wrong door" process by which families and consumers access care coordination services
7. Identify and participate in the development of outcomes and support the monitoring and evaluation of these outcomes
8. Request, develop, and use culturally competent practices
9. Engage in continued multi-disciplinary assessment in order to identify unmet needs

F. Recommendations for Families and Individual Recipients of Care Coordination

1. Advocate for your child by making your child's and your family's needs known to providers
2. Help facilitate and encourage communication among your child's and family's providers
3. Participate in the development of individualized planning and role definition among provider;
4. Maintain comprehensive records of child's provider contact information and services receive;
5. Seek support from other families with children with special health care needs
6. Participate in family education services

G. Recommendations for Providers of Services involved with Care Coordination

1. Form a partnership with families and commit to providing family-centered care
2. Provide ongoing communication with families about their children's care
3. Discuss provider and family expectations with families
4. Provide child and family education around care coordination services
5. Help families access the tools and resources necessary for them to maintain comprehensive records of their child's providers and services received
6. Complete a thorough and individualized assessment for each family, while providing a continual assessment of a family's top priorities when assisting them with system navigation
7. Monitor the accomplishments of child and family outcomes and partnerships with families
8. Include in the individualized child and family plan an outline of the roles and expectations of providers
9. Assist families with transitions (i.e., early childhood to preschool, child to adult services, provider to provider, etc.)
10. Identify appropriate resources and make referrals
11. Form a partnership and collaborate with other providers; and the care coordinator
12. Be aware of all the services the family is receiving in order to ensure effectiveness and avoid duplication

H. Recommendations for Systems Level Agencies and Collaboratives

1. Hold a summit to bring together those working on policies and systems for care coordination to ensure an understanding of the network of care coordination activities
2. Develop a template that articulates the range of expectations and roles for different providers in order to build infrastructure and increase the opportunity for data collection
3. Adhere to the American Nurses Association expectations for care coordination providers (http://www.nursingworld.org/carecoordinationwhitepaper)
4. Provide core training for professionals and families to include the following:
   a. Overview of key systems and services, including specific government programs
   b. Relationship-building skills
   c. Cultural competency
   d. Overview of the quality of life for those living with disabilities
5. Establish communication pathways for coordination among education, and health and behavioral health systems
6. Support all elements of service delivery
7. Develop processes whereby the evaluation of outcomes and quality can be established;
8. Create standards that allow for flexibility in the implementation of care coordination consistent with local resources and values
9. Share accountability across agencies, with particular attention to the state's implementation of the Affordable Care Act and pursue a shared funding stream
10. Prioritize funding for research on care coordination outcomes
11. Review of Request for Proposals for child and youth programming to determine possibilities of streamlining resources
12. Develop a process for information sharing across systems

SECTION II

Care Coordination Tools and Resources

These tools and resources are primarily intended for care coordinators and providers of human services (hereafter referred to as providers) who are beginning to build, or who want to evaluate, their capacity to provide care coordination. Examples of the types of providers for whom this toolkit would be useful include: mental health specialists, physical therapists, occupational therapists, substance abuse specialists, family physicians, pediatricians, nurses, licensed social workers, as well as care coordinators, service coordinators, navigators and family advocates. Thus, the following tools and resources are designed to be used as a comprehensive resource guide when working directly with families in a variety of settings and professions across Colorado. However, families/consumers can use these tools as a guide for developing expectations about their care and as an advocacy tool when interacting with their care coordinators or health care providers. Systems-level agencies can also use these tools as a document to make policy and programmatic decisions based on the included recommendations. The Care Coordination Community of Practice recognizes that there are a variety of available resources related to the components of this toolkit, yet 3-5 resources per section were chosen at this stage of toolkit development so as not to overwhelm the user.

NOTE: This kit includes examples of tools that providers may find useful in their work with families. In using the kit, it is not a requirement to use any particular tool. It is the expectation that providers may use any of the tools as a new implementation to the care they provide and/or that some tools may provide useful additions to the tools currently being used. Please keep in mind that if a tool has established reliability and validity, that may be compromised if it is not used as it was originally intended.

Toolkit Organization

The Toolkit is divided into four main sections:

1. Concepts of Screening and Assessment
2. Quality Assurance
3. Permission for Information Sharing
4. The Comprehensive Plan of Care

Terminology and the Importance of Collaboration

The developers of this toolkit recognize that the term *care coordination* or *care coordinator*, while referring to a similar concept and role, respectively, differ across disciplines and systems (examples are noted below). The toolkit is meant to be all-inclusive to those providers working with families who have children with special health care needs and who are in need of a variety of services, regardless of the level of intensity of need. This wide variety of terms illustrates the need for collaboration among existing and future care coordination-related initiatives. Thus, one intention of this toolkit is to foster communication and partnerships between service providers working with the same families.

Systems, people and processes that may utilize care coordination functions

- Case management/case managers
- Child Welfare Family Service Plan
- Clinical providers of care
- Coaches
- Continuum of care
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

- Holistic care
- Individualized Family Service Plan (IFSP)
- Individual treatment plan
- Integrated care
- Juvenile Justice
- Medical Home
- Patient Navigators
- Service coordination
- System of Care
- Wraparound/Facilitators

1. Concepts of Screening and Assessment

Care Coordination Screening refers to a short general systematic review of common areas of concern for a child or for the family in order to determine the need for care coordination as well as potential areas of unmet need or concern that can be addressed by care coordination. *Care Coordination Assessment* is an in-depth, comprehensive interview that includes the child's and parents' physical, developmental, and psychosocial health as well as the family's available basic resources, access to community resources and utilization of these resources. The *Care Coordination Assessment* also provides the guidance to an individualized care coordination plan for referrals, resources, educational interventions and services that will be provided and coordinated.

Screening that includes the level of need for care coordination is an important part of the overall care coordination process. This section includes suggested resources for conducting screening, assessment and prioritization (including determination of level of care coordination).

A. Levels of Care Coordination

1. **Information, Resource and Referral**- Based on screening, this level of care coordination provides information on resources, assistance with accessing local community agencies or specialty services depending on the families identified need and may include scheduling appointments and initiating or resolving insurance issues.
2. **Support or Consultation**-Based on assessment, this level of care coordination provides assistance depending on the individual and family identified needs as well as needs identified by the provider. Includes surveillance over time, health and life style teaching, guidance and counseling, improving self-care and self-advocacy skills as well as care coordination/care management.
3. **Intensive Care Coordination/Wraparound**-Also based on assessment, this level of care coordination focuses on ongoing and in-depth support for families who struggle with complex health, medical and psychosocial needs.

Matrix of Services- provides an overview of how these different types of care coordination services might be utilized on behalf of families.

<table>
<tr><td rowspan="2">Medical Concerns</td><td colspan="6">Developmental/Psychosocial/Mental Health Concerns
LOW ← → HIGH</td></tr>
<tr><td>Stable family unit; Single Developmental Concerns</td><td>Single parent w/ family support system Developmental Concern</td><td>Single parent w/o family support system Developmental Concern</td><td>Single patient w/ mental health or developmental issues</td><td>Foster Care Involvement/parent or caregiver with medical and/or mental health concerns</td><td>Homelessness Significant Mental Health Issues</td></tr>
<tr><td>LOW Health concerns
STABLE chronic health concern</td><td colspan="3">• Information, Resource, and Referral
• Support or Consultation</td><td colspan="3">• Intensive Care Coordination/
• Wraparound Facilitators</td></tr>
<tr><td>MULTIPLE chronic concerns or unstable health concerns</td><td colspan="3">• Support Services
• Intensive Care Coordination/
• Wraparound Facilitators</td><td colspan="3">• Support Services along with Intensive Care Coordination
• Wraparound Facilitators</td></tr>
<tr><td>SIGNIFICANT health concerns; FREQUENT- ER or hospitalization
TECHNOLOGY dependent</td><td colspan="3">• Intensive Care Coordination/
• Wraparound Facilitators</td><td colspan="3">• Intensive Care Coordination/
• Wraparound Facilitators</td></tr>
</table>

B. Suggested Resources for Conducting Screening, Assessment and Prioritization

1. The Children with Special Health Care Needs (CSHCN) Screener/Child and Adolescent Health Measurement Initiative (CAHMI) Screener -The CSHCN Screener is a five item, parent-reported tool designed to identify children with special health care needs. This screener helps to identify those children or adolescents who may be most in need of assistance in the coordination of their health care as well as community support systems. The items are based on the federal Maternal and Child Health Bureau's definition of children with special health care needs.

2. Colorado Family Support Assessment -Used by the Colorado Family Resource Centers, the purpose of the Colorado Family Support Assessment is to learn about the level of support needed by families across various areas of life through discussion and dialogue initiated by a family advocate. Both the family and the family advocate provide input into the assessment. This assessment is intended for families who are receiving more intensive and long-term family support services, and includes 16 domains, some of which are healthcare access, housing, food, and mental health.

3. Cultural Competence Health Practitioner Assessment-The Cultural Competence Health Practitioner Assessment (CCHPA) was developed by the National Center for Cultural Competence (NCCC) at the request of the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. The CCHPA is intended to enhance the delivery of high quality services to culturally and linguistically diverse individuals and underserved communities. It is also intended to promote cultural and linguistic competence as an essential approach for practitioners in the elimination of health disparities among racial and ethnic groups. The CCHPA can be completed online at the link above.

4. The Colorado Department of Public Health and Environment's Health Care Program for Children with Special Needs (HCP) website includes the following tools and resources in the "Guidelines and Forms/Tools for LPHA" section**:**
   - ***HCP Care Coordination Policy and Guidelines*** *(* Under HCP Policy and Guidelines**)**
   - ***Care Coordination Talking Points and Intake Interview (English and Spanish)-***The intake interview is intended for families/children with special health care needs. It can be used as a screening tool to identify the need and receipt of care coordination services. It is intended to be used in conjunction with the HCP Care Coordination Talking Points (Under HCP Care Coordination Tools)
   - ***HCP Care Coordination Flow Chart-***A graphic description of the HCP care coordination process (Under HCP Care Coordination Tools)
   - ***HCP Care Coordination Assessment-***The assessment is the second core component of the HCP Care Coordination model. After the intake interview is completed, the assessment provides an opportunity for the care coordinator to continue to explore, build and strengthen the relationship with the family. The assessment considers the child or youth's special health care needs along with the family's concerns, goals and strengths. The assessment, whose end product is a written care plan, can be used to monitor a patient's progress toward specific long/short-term goals and is updated and revised as necessary. (Under HCP Care Coordination Tools)

5. Phases, Activities, and Skill Sets of the Wraparound Process: Strengths, Needs, Culture, and Vision Discovery (section 1.3a) -The Phases and Activities of the Wraparound Process represent the results of a research project intended to clarify the types of activities that must be included in a full wraparound process. It is one component among a set of materials produced by the National Wraparound Initiative, a project with a goal to clearly operationalize and define this important and innovative model for working with families. This document focuses on what needs to happen in wraparound and how the work is accomplished. Merely accomplishing the tasks is insufficient unless this work is done in a manner consistent with the

10 Principles of Wraparound which are:

1. Family voice and choice
2. Team-based planning
3. Community-based setting
4. Culturally relevant
5. Individualized planning
6. Strengths-based focus
7. Natural supports
8. Continuation of care
9. Systems collaboration
10. Outcome-based process

The "Strengths, Needs, Culture and Vision Discovery" section in this process is an example of a comprehensive assessment. Following this model would allow the care coordinator or provider of services to engage in a dialogue with the family about their experiences, thus enabling the ability to identify appropriate community resources to meet the family's needs.

2. Quality Assurance

Colorado is recommending the use of tools for measurement of expected outcomes of care coordination to provide a useful way to ensure standardization of assessment towards achieving outcomes. These tools are based on a review of national care coordination measurement and assessment tools including:

- AHRQ Care Coordination Measures Atlas
- The National Quality Forum's Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination
- The Commonwealth Fund's Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework
- Care Coordination for Children and Youth with Special Health Care Needs: A Descriptive Multi-site Study of Activities, Personnel Costs and Outcomes

Historically, quality measurement has relied primarily on clinical process measures. Under the guidance of the Department of Health and Human Services National Strategy for Quality Improvement in Health Care measures increasingly focus on clinical outcomes and patient-reported outcomes and experience.

The National Quality Forum's main Steering Committee urged greater use of the patient or family as a data source for measuring healthcare outcomes. The patient's voice is not readily captured in traditional health records and data systems, yet the beneficiary of healthcare services is often in the best position to evaluate the effectiveness of those services.

In consideration of the measurement tools listed above, and a literature review of almost 100 care coordination measurement tools, systems and instruments, the Pediatric Medical Home Family Survey is recommended as the tool that most closely aligns with the outcomes delineated in this resource toolkit.

A matrix (Appendix 4) has been developed that crosswalks the expected care coordination outcomes with related items on the Pediatric Medical Home Family Survey, and is intended for use by care providers to

measure and/or track the satisfaction levels of the families they serve within the context of the measurement outcomes. It is developed as a tool that can be administered to families while they are in the office and can be used either in pieces or in its entirety depending on the outcomes the provider wishes to measure.

Additionally, the following resources provide support to quality improvement and quality measurement activities:

1. **Cultural and Linguistic Policy Assessment (CLCPA)-** The Cultural and Linguistic Competence Policy Assessment (CLCPA) was developed by the National Center for Cultural Competence (NCCC) at the request of the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Service (DHHS) to assist community health centers to advance and sustain cultural and linguistic competence. The CLCPA is intended to support health care organizations to improve health care access and utilization, enhance the quality of services within culturally diverse and underserved communities, and promote cultural and linguistic competence as essential approaches in the elimination of health disparities. The NCCC has also developed a companion Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument that provides step-by-step instructions on how to conduct an organizational self-assessment process.

2. **Family-Centered Care Self-Assessment Tool-**The Family-Centered Care Self-Assessment Tool, developed by Family Voices, is not designed to provide a score, but is meant as an opportunity for reflection and quality improvement activities related to family-centered care within outpatient health care practices. It can also be used by families to assess their own skills and strengths, the care their children and youth receive, and to engage in discussions within health care settings and with policy makers in organizations, health plans and community and state agencies about ways to improve health care services and supports.
   The tool is intended to assess care for all children and youth and also has some questions that are specific to the needs of children and youth with special health care needs and their families. Questions on the tool address the ten components of family-centered care and the key aspects of family/youth/provider partnerships.

3. **National Initiative for Children's Healthcare Quality (1)** Medical Home Index **and (2)** Medical Home Family Index -The Medical Home Index (MHI) is a validated self-assessment and classification tool developed by the Center for Medical Home Improvement that is designed to translate the broad indicators defining the medical home (accessible, family-centered, comprehensive, coordinated, etc.) into observable, tangible behaviors and processes of care within any office setting. It is a way of measuring and quantifying the "medical home-ness" of a primary care practice. The MHI is based on the premise that "medical home" is an evolutionary process rather than a fully realized status for most practice settings. The MHI measures a practice's progress in this process. The Medical Home Family Index is a companion survey intended for use with a cohort of families of children and youth with special health care needs who receive care in a designated practice. This tool gives the practice a valuable perspective while allowing corroboration of the practice's self-assessment (as reported on the Medical Home Index).

4. The Comprehensive Plan of Care

This section includes examples of how a care plan can be organized. Care plans for both practitioners and parents are included.

a. **Colorado Department of Public Health and Environment's Health Care Program for Children with Special Needs (HCP) Action Plan-** "Guidelines and Forms/Tools for LPHA" Section, HCP Care Coordination Tools
The HCP care coordination program uses information from the screening and assessment to develop a written patient care plan that includes patient goals, as well as care coordinator and patient activities required to meet those goals. It is a family-friendly, take-away document memorializing the family's goals related to their care coordination needs, specific activities, or next steps, to achieve the goals, and persons responsible for taking the next steps.

b. **National Center for Medical Home Implementation-** Building Your Care Workbook
A major role of a care notebook is to help parents/caregivers maintain an ongoing record of their child's care, services, providers, and notes. This care notebook is a great tool in empowering families to become the experts on their child's care. It is also a way to maintain the lines of communication between the many providers and services that help care for a child and their family. Health professionals recommend that parents/ caregivers bring a care notebook to all medical appointments, therapies, care conferences, on vacations, etc. Health professionals can encourage the use of these notebooks by either having them available at the first office visit, upon discharge from the hospital or in the waiting room on a resource table. This notebook should be a team responsibility. Office staff should offer families assistance in filling out the various forms. Medical offices can copy visits, checkups, immunization records, specialist reports, clinical pathways, and give them to families to insert into the notebook.

c. **The Wraparound Plan-** Wraparound uses a framework of universal life domains in identifying family needs: health/mental health, family relations, education, housing, income, transportation, legal, social/recreational, civic, and spiritual. During the initial phase of Wraparound, the facilitator has the lead in ensuring a systematic understanding of the family, the vision they hold for their lives, and their priority needs to be addressed through the intensive planning process. The priority needs identified by the family during the discovery process provide the starting point for team-based collaborative planning. Through brainstorming and identification of resources, these family needs are systematically addressed through the ongoing phases of the wraparound process. The focus of Wraparound care coordination is the completion of activities identified in the comprehensive, written plan that fully integrates all services, resources, and supports available to the child and family, and provides the roadmap for meeting their needs.

5. Permission for Information Sharing

As discussed above, children with special health care needs often require multiple service providers. In order to provide care efficiently and effectively, it is important that the various providers coordinate referrals and services provided, as well as participate in the creation and evaluation of the care plan. However, the family must agree to the sharing of their child's health information.

This section includes an example of forms that give permission for the sharing of personal information, as well as information about The Health Insurance Portability and Accountability Act (HIPAA). This section also includes basic rules to follow when sharing information and guidance regarding informed consent and items to be included in consent forms.

a. **The Health Insurance Portability and Accountability Act (HIPAA) -** HIPAA is a federal law that protects the privacy of personal health information. The Office for Civil Rights, under the U.S. Department of Health & Human Services, enforces HIPAA. Families must give permission before personal health information can be shared with the following:
   - Employers
   - Health care providers
   - Hospitals
   - Insurance companies
   - Schools
   - State and federal agencies
   - Any other entity requesting health information

   The Colorado Department of Human Services, Alcohol and Drug Abuse Division HIPAA Workgroup, and Colorado Mental Health Services published a Colorado HIPAA Manual "to inform providers about HIPAA and assist them in their efforts towards HIPAA compliance." Click here for Federal Guidance on HIPPA.

b. **Information Release Form: Family Education Rights and Privacy Act-**The Family Educational Rights & Privacy Act (FERPA) is a federal law that protects the privacy of student education records, both financial and academic. For the student's protection, FERPA limits release of student record information without the student's explicit written consent; however, it also gives the student's parent(s)/guardian the right to review those records if the parent(s)/guardian claim the student as a dependent on their federal income tax return. This form may be necessary when collaborating with a child's educational services.

c. **Guidance on Informed Consent-**The State of Colorado's Children and Youth Information Sharing Collaborative, consisting of representatives of several state departments, community partners, and family representatives, work in partnership with the Governor's Office of Information Technology and the Colorado Office of the Attorney General to review federal and state laws regarding privacy and confidentiality to develop an updated, state-of-the-art Authorization-Consent to Release Information that is HIPPA and FERPA compliant.

   State of Colorado Guidelines for Information Sharing-
   Governor's Office of Information Technology, 2010

   Privacy and information sharing policies provide transparency, protect participating agencies, and facilitate information sharing. These policies strengthen confidence among individuals in the ability of a service provider to handle information appropriately and support service provision in the sharing of information. Further, attention given to the development and implementation of informed consent policies by service providers may prevent possible harm to individuals, public criticism, lawsuits, and legal liability.

A care coordination provider should institute a process for obtaining informed consent for information release that provides adequate verbal and written notice and is linguistically appropriate. Most laws regarding confidentiality of agency records allow disclosure of personal information with written informed consent of the individual, youth, parent(s), or legal guardian. Whenever possible, written, informed consent is the preferred method for obtaining authorization to disclose confidential information.

Informed consent requires that the individual or their legal guardian provide consent with a full understanding of what information is likely to be shared, with whom and under what circumstances, what information can be released to whom without their consent, and consequences for unauthorized disclosure. To ensure that the consent is "informed", participating agencies need to be aware of any cultural or linguistic factors that may impact the individual's ability to understand the consent process, including the need for interpretive services.

For providers that interact regularly in the provision of services for an individual, it is recommended to agree on a common informed consent process that provides adequate written and verbal notice and a consistent approach among the participating organizations.

A common consent form used by all participating agencies reinforces the common informed consent process. Included in the consent form should be items such as:

- Identifies the individual(s) who the information is about.
- Identifies the agency that is disclosing the information.
- Clarifies the information sharing purposes – to include language broad enough for all collaborative members' needs.
- Defines the reasons for disclosing the information.
- Identifies the agencies that will access or receive the information.
- States the expiration date of the consent to release information or the circumstances upon which the consent automatically expires.
- Identifies the ways that the disclosed information will be used – again, to cover all collaborative members' needs.
- Delineates the limitations on the disclosure and/or use of the information.
- Describes agency practices regarding sharing of non-confidential, as well as confidential information.
- Explains the manner in which consent can be revoked.
- Policies for the individual to review their information.
- Lists the grievance procedures for suspected unauthorized disclosure or use of the information.
- Outlines the penalties for unauthorized disclosure or use of the information.

The elements noted above are a common set found in relevant statues and regulations. The consent form can also include language explaining that once an agency discloses information to another pursuant to the individual's written consent, the original agency is not responsible for any subsequent disclosures. However, participating agencies need to agree on the penalties and processes for any such unauthorized disclosure or use of confidential information. Once agreed upon, a copy of these penalties and processes must be provided to the individual.

Despite assurance of privacy protection, an individual may not want specific personal information disclosed. When an individual refuses to provide consent, in part or in total,

they should not be denied services based on their refusal unless the information is necessary to determine eligibility for services. It is the provider's responsibility to ensure that the individual or their legal guardian understands that they are not required to consent to the release of any personal information; the consequences, if any, of not providing consent; and, if their refusal may hinder the delivery of services.

Guidance When Sharing Information

Adapted from the Practitioner's Guide for Consent for Juvenile Information Sharing

National Juvenile Information Sharing Initiative, 2012

- Identify how much information to share — more is not always better! If you don't know, ask your supervisor/privacy officer or data steward.

- Distinguish the facts being shared versus an opinion. Find out what documents/information should be included when being asked to share.

- ***SHARE WHAT YOU KNOW – NOT WHAT YOU THINK YOU KNOW***

- Ensure that you are giving the right information to the right person — who are they? What is their role and responsibility? Do they have a 'need to know' what they are asking for?

- Ensure that you are sharing the information securely.

- ***NEVER SEND CONFIDENTIAL OR PERSONALLY IDENTIFIABLE INFORMATION VIA AN OPEN EMAIL SYSTEM***

- Inform the child or youth/family that information is being shared and why. Be sure that you are not creating or increasing their risk of harm by doing so!

- Respecting the strengths and needs of families, and by including them as partners in the process, will return successful outcomes for everyone!

When Sharing Information, consider the following:

1. Is the information 'critical' to the well-being of the child, youth or family?
   (Recommendation: Share critical information quickly!)

2. Does the purpose of the request for information sharing, type of information to be shared, parties involved and timelines for sharing the information warrant 'how and when' you will share this information?
   Recommendation: Consider your agency's policy on how information will be delivered. Can you send it via secure e-mail, regular mail, electronic data exchange, facsimile or EFax?

3. Is this information going to be re-disclosed to other parties or agencies?
   Recommendation: Find out what the rules and penalties are for re-disclosing the information.

The information being shared is NOT yours BUT SHARE IT LIKE IT IS!

SECTION III

INDEX

List of Acronyms

AAP	American Academy of Pediatrics
ACO	Accountable Care Organization
BPHC	Bureau of Primary Health Care
CAHMI	Child and Adolescent Health Measurement Initiative
CCHPA	Cultural Competence Health Practitioner Assessment
CLCPA	Cultural and Linguistic Competence Policy Assessment
CLCPA	Cultural and Linguistic Competence Policy Assessment
CMP	Collaborative Management Program
CSHCN	Children with Special Health Care Needs
DHHS	Department of Health and Human Service
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FERPA	Family Educational Rights & Privacy Act
HCP	Health Care Program for Children with Special Needs
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
IEP	Individual Education Plan
IFSP	Individual Family Service Plan
MHI	Medical Home Index
NCCC	National Center for Cultural Competence
PCP	Primary Care Physician
RCCO	Regional Care Coordination Organizations

List of Resources

Accountable Care Collaborative-Colorado	http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246
Agency for Healthcare Research and Quality's (AHRQ) Care Coordination Measures Atlas	AHRQ Care Coordination Measures Atlas
American Academy of Pediatrics	http://www.aap.org
Bureau of Primary Healthcare	http://bphc.hrsa.gov
Child and Adolescent Health Measurement Initiative	http://www.cahmi.org/
Centers for Disease Control and Prevention	http://www.cdc.gov/
Colorado Department of Human Services	http://www.colorado.gov/CDHS
Colorado Medical Home Initiative	www.coloradomedicalhome.org
Early Periodic Screening, Diagnostic and Treatment (EPSDT)	www.colorado.gov
Healthcare Program for Children with Special Needs (HCP) Website	www.hcpcolorado.org
Health Information Portability Act (HIPPA)	http://www.hhs.gov/ocr/privacy/index.html
Health Resources and Services Administration	http://www.hrsa.gov/
National Quality Forum	www.qualityforum.org
National Center for Cultural Competence	nccc.georgetown.edu
Medicaid	http://www.medicaid.gov
Regional Care Collaborative-Colorado	http://www.colorado.gov/cs/Satellite?c=Content_C&childpagename=HCPF%2FContent_C%2FHCPFArticleDetailView&cid=1251594453058&pagename=HCPFWrapper
United States Department of Health and Human Services	http://www.hhs.gov/

SECTION V

Appendices

Appendix 1 Colorado Medical Home Standards

Standard 1. Provides 24 hour 7 day access to a provider or trained triage service.

Standard 2. Child/family has a personal provider or team familiar with their child's health history.

Standard 3. Appointments are based on condition (acute, chronic, well or diagnostic) and provider can accommodate same day scheduling when needed.

Standard 4. A system is in place for children and families to obtain information and referrals about insurance, community resources, non medical services, education and transition to adult providers.

Standard 5. Provider and office staff communicates in a way that is family centered and encourages the family to be a partner in health care decision making.

Standard 6. Provider and office staff demonstrate cultural competency.

Standard 7. The designated Medical Home takes the primary responsibility for care coordination.

Standard 8. Age appropriate preventive care and screening are provided or coordinated by the provider on a timely basis.

Standard 9. The designated Medical Home adopts and implements evidence based diagnosis and treatment guidelines.

Standard 10. The child's medical records are up to date and comprehensive, and upon the family's authorization, records may be shared with other providers or agencies.

Standard 11. The Medical Home has a continuous quality improvement plan that references Medical Home standards and elements.

From the Colorado Medical Home Initiative (CMHI) http://coloradomedicalhome.org/

Appendix 2 System of Care Values and Guiding Principles

Core Values

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care

Guiding Principles

The following[1] represent the foundational principles of the system of care philosophy. Systems of care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

[1]Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Excerpted from the Colorado Family Resource Center Association. Colorado Family Support Assessment Assessment and Measurement Tool for Family Self-Reliance January 2010

INSTRUCTIONS FOR COMPLETING

THE COLORADO FAMILY SUPPORT ASSESSMENT

The Colorado Family Support Assessment (CFSA) includes 16 domains. Each domain should be assessed on a standard five-level scale ranging from "thriving" to "in crisis". As can be seen below, the assessment also includes domain-specific definitions for each of the five levels, which are intended to assist the user and the family to accurately assess the family in each domain area. The assessment can be completed online in ETO or on paper, whichever is more convenient and comfortable for the family. Additional follow-up assessments would ideally occur using the timeline given on pages 5 and 6 of this document. There is a not applicable (N/A) option available for all of the domains.

Domains used by Family Resource Centers in Colorado:

- ***Adult Education:*** Assesses adult academic, institution-based achievements.
- ***Childcare:*** Assesses the client's ability to obtain appropriate childcare, both in terms of access to the childcare and financial resources to purchase the childcare.
- ***Child Education:*** Assesses both access to and engagement in educational institutions by any and all children in the family.
- ***Employment:*** Assesses the nature of the job or career in which the client is employed and considers the permanency and stability of the employment, as well as the benefits that accompany the employment.
- ***Family Relationships:*** Assesses the safety of relationships in the household as well as the family's ability to communicate and to support through safe, stable, supportive relationships.
- ***Financial:*** Assesses the income adequacy of the client to meet basic needs, as well as to save and potentially make some non-essential purchases.
- ***Food:*** Assesses the client's ability to obtain appropriate food, both in terms of knowledge about how to access food and financial resources to purchase the food if necessary.
- ***Health Care Access:*** Assesses need for health care, as well as access to both health care and medical insurance coverage for all family members.
- ***Housing:*** Assesses the ability of the client to obtain appropriate housing of choice based on their circumstances.
- ***Legal:*** Assesses whether or not the client has any pressing legal issues and, if so, whether or not they have the knowledge, skills, and resources to work towards getting the legal issues resolved.
- ***Mental Health:*** Assesses the emotional well-being of the client.
- ***Parenting Skills:*** Assesses the individual's skills and approach to child-rearing and is focused on the parent's perceived or observed abilities rather than the child's behavior.
- ***Substance Use:*** Assesses whether or not the individual is using alcohol and/or prescription drugs in an appropriate manner. Any use of illicit drugs are considered in-crisis and unsafe.
- ***Support Network:*** Assesses the nature of the individual's immediate interpersonal relationships, especially the extent to which they form a foundation for the individual in times of crisis.
- ***Transportation:*** Assesses whether or not the individual has appropriate, safe, and reliable access to transportation (whether by car, bus, or reliance on friends and family).
- ***Utility Assistance:*** Assesses stability of utility services for the individual/family, including ability to pay for expenses associated with these services.

(in the Family Development Matrix Outcomes Model for Measuring Family Progress-
Using the CFSA- shelter, food and clothing, transportation and mobility, health and safety, social and emotional health, finances, family relations, community relations, adult education and development, child education and development, and immigration and resettlement)

The design and layout of the CFSA is intended to enable family workers and families to track both status at a given point in time, as well as *progress* over time. It is common for programs to track progress by completing the assessment as identified in the timeline on page 6 of this document. Further, by assessing multiple domains at one time, the CFSA enables users to identify potential linkages or relationships among different domains. As a result, this approach provides a holistic and dynamic picture of a family's progression relative to self-reliance, thereby contributing to efforts to provide appropriate and relevant support and referrals to each family on an individual basis.

The CFSA is intended as a case management tool, to be completed through on-going conversations with families. A worksheet for each domain is provided below with key issues to consider, including guiding questions for use with families. These questions are offered as suggestions only; family workers should be encouraged to use their skill and judgment to assess each domain in an appropriate manner, suited to individual families.

DOMAIN DESCRIPTIONS

Domain Name: Adult Education

What does it measure: Assesses adult academic, institution-based achievements.

Quick Tip: Sometimes different adults in the family have different educational needs. If this is the case, please complete this domain with the adult in mind who needs the most support in this area.

Guiding questions:

- What is the highest level of education that you have completed?
- Are you generally able to read, write, and do basic math computations?
- Are you currently enrolled in educational classes or programs? If so, for what?
- Do you have personal educational goals that you would like help working on?

CFSA Domain: Adult Education

1 **Thriving** **Family/ individual is thriving!**	2 **Stable** **Family/ individual is stable, safe and moving toward thriving**	3 **Safe** **Family/ individual making progress toward stable life situation**	4 **Vulnerable** **Support needed to help family/individual move toward stability**	5 **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or members of my family have completed college or trade school programs have improved our economic and social opportunities.	I and/or members of my family are currently in education (beyond high school or GED) or training classes to improve our life situation.	I and/or members of my family have a high school diploma or have completed my GED, literacy, and/or ESL classes.	I and/or members of my family are enrolled in GED, literacy, and/or ESL classes that are improving our skills.	I and/or members of my family (want, need, would like to improve) our language or literacy skills. We are not enrolled in any educational programs.

Domain Name: Childcare

What does it measure: Assesses the client's ability to obtain appropriate childcare, both in terms of access to the childcare and financial resources to purchase the childcare.

Quick Tip: Sometimes children in the family have various childcare needs. If this is the case, please complete this domain with the child in mind who needs the most support in this area.

Guiding questions:

- Do you have childcare for your child/children?
  - If so, is your childcare reliable, affordable and high quality?
  - If not, have you had difficulty finding childcare?
- Do you feel that you know what to look for when selecting childcare?
- Do you have any concerns about your current childcare provider?
- Do you know if you are eligible for a childcare subsidy?
  - If you are eligible, do you know how to access the childcare subsidy program?

CFSA Domain: Childcare

1 **Thriving** **Family/ individual is thriving!**	2 **Stable** **Family/ individual is stable, safe and moving toward thriving**	3 **Safe** **Family/ individual making progress toward stable life situation**	4 **Vulnerable** **Support needed to help family/individual move toward stability**	5 **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or members of my family are able to afford and know how to select quality childcare.	I and/or members of my family have reliable, affordable childcare and don't need assistance in this area.	I and/or members of my family have access to government support to cover our childcare costs; but our choices of childcare services are limited.	I and/or members of my family have childcare that is unaffordable or unreliable and we need assistance in this area.	I and/or members of my family have no childcare services and we need assistance in this area.

Domain Name: Children's Education

What does it measure: Assesses both access to and engagement in educational institutions by any and all children in the family.

Quick Tip: Sometimes children in the family have various educational needs. If this is the case, please complete this domain with the child in mind who needs the most support in this area.

Guiding questions:

- Is/are (all of) your child/children currently enrolled in school?
- Is/are (all of) your child/children attending classes on a regular basis?
- Do you know how to get information about the schools in your community?

CFSA Domain: Children's Education

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
All of my/our children are in school and are performing at or above developmentally appropriate levels (or grad level).	All of my/our children are in school and are making progress toward developmental and educational goals.	All of my/our children are in school, however one or more of them is/are not achieving to age level goals.	Some, but not all of my/our children are in school or other educational programs. They are making limited educational progress and we could use assistance in this area.	My/our children are not in school or any other educational programs. We need assistance in this area.

Domain Name: Employment

What does it measure: Assesses the nature of the job or career in which the client is employed and considers the permanency and stability of the employment, as well as the benefits that accompany the employment.

Quick Tip: Sometimes family members have various employment needs. If this is the case, please complete this domain with the adult in mind who needs the most support in this area.

Guiding questions:

- Are you currently employed?
- How long have you been working for your current employer?
- Is your employment situation temporary or permanent?
- Does your employment situation provide sufficient pay
- Does your employer provide benefits for you and/or your family?
- Have you been employed in other jobs?

CFSA Domain: Employment

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or members of my family have permanent, full time job(s) with benefits that meet our family's needs.	I and/or members of my family have full time job(s) with a liveable wage and some benefits.	I and/or members of my family have full time job(s) with few or no benefits. My (our) wages are not enough to live on.	I and/or members of my family have seasonal, temporary or part time job(s) that do not provide a liveable wage or benefits.	I and/or members of my family currently do not have employment.

Domain Name: Family Relationships

What does it measure: Assesses the safety of relationships in the household as well as the family's ability to communicate and to support other family members through safe, stable, supportive relationships.

Guiding questions:

- Are you currently experiencing relationship challenges? If so, do you think these challenges impact your ability to live day-to-day?
- Are any of your close relationships unstable, unsafe or violent?
- Are you currently receiving support that you need to build strong, positive relationships? If not, would you like to receive support to build more positive relationships within your close family circle?
- Do you know how to access services in your community that would support positive relationships?

CFSA Domain: Family Relationships

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
My relationships with my family and/or significant other are stable, supportive and loving.	My relationships with my family are becoming healthy and stable, with improved communication and support.	My family and I are working to improve our relationships and support from others.	My family does not have a lot of support from others. Some of our relationships may, potentially, become unsafe.	My relationships with some of my family members are unstable, unsafe and/or violent.

Domain Name: Financial

What does it measure: Assesses the income adequacy of the client to meet basic needs, as well as to save and potentially make some non-essential purchases.

Quick Tip: Sometimes family members have various incomes and various needs around income. If this is the case, please complete this domain with the family member in who needs the most support in this area.

Guiding questions:

- Do you have income from employment?
- Do you have income from disability or SSI?
- Do you have income other than employment or disability?
- Does your income allow you to purchase the items/services that you need for daily living?
- Do you have difficulty budgeting your income to cover your basic needs?

CFSA Domain: Financial

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support need to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or members of my family have enough income to cover our needs and to regularly save money.	I and/or members of my family meet my (our) basic needs and manage debt without support.	I and/or members of my family meet my (our) basic needs with government support; we are learning to budget.	I and/or members of my family do not have enough income and/or have difficulty budgeting. I (we) receive government support.	I and/or members of my family do not have any income.

Domain Name: Food

What does it measure: Assesses the client's ability to obtain appropriate food, both in terms of knowledge about how to access food and financial resources to purchase food.

Guiding questions:

- Where do you get most of the food that you and/or your family eat on a daily basis?
- Have you had difficulty getting enough food in the recent past?
- Do you receive food stamps or other food assistance?
- Are you aware of resources providing food assistance in your community?
- Are you able to afford to buy the foods that you would like?
- Do you know how to prepare the food that you get?
- Do you feel that you have the resources you need to make healthy food choices for yourself and/or your family?

CFSA Domain: Food

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/ individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or my family can afford to purchase nutritional food for all of my family.	I and/or my family can afford to purchase basic food without government support.	I and/or my family receive occasional support/assistance to have enough food to cover our needs.	I and/or my family are able to afford enough food with the help of food stamps or other regular support.	I and/or my family have no food. I (we) rely on support of others for free or low cost food.

Domain Name: Health Care Access

What does it measure: Assesses need for health care, as well as access to both health care and medical insurance coverage for all family members.

Guiding questions:

- Do you or anyone in your family have emergency health problems or concerns?
- Do you know where to go when you need health care?
- Are you able to access health care when you want it?
- Do any or all of your family members have health insurance coverage?
- Are you generally able to pay for your health care expenses relatively easily?

CFSA Domain: Health Care Access

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
All members of my family have access to health care and dental care when needed.	All members of my family have access to health care when needed but it strains our budget.	Some members of my family have access to health care when needed.	My family does not have health insurance and/or access to health care.	My family needs health care immediately but do not have insurance or access to it.

Domain Name: Housing

What does it measure: Assesses the ability of the client to obtain appropriate housing of choice based on their circumstances.

Guiding questions:

- Tell me a little bit about where you are currently living
- Is this where you'd like to be living?
- Are you able to pay your rent or mortgage without assistance?
- Do you feel you have options available related to your living situation?
- Are you living in temporary or transitional housing at the moment?
- Are you unable to afford your current housing?
- Do you feel safe where you live?

CFSA Domain: Housing

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical** **(urgent situation)**
I and/or my family have safe, adequate and affordable housing.	I and/or my family have housing that is government subsidized and is safe and adequate for our needs.	I and/or my family have a stable home that is not affordable and is inadequate or unsafe for our needs.	I and/or my family are housed in transitional-temporary housing and cannot afford my current rent/mortgage.	I and/or my family are currently homeless or facing possible eviction.

Domain Name: Legal

What does it measure: Assesses whether or not the client has any pressing legal issues and, if so, whether or not they have the knowledge, skills and resources to work towards getting the legal issues resolved.

Quick Tip: Sometimes family members have various legal needs and not all family members may need services in this area. If this is the case, please complete this domain with the adult in mind who needs the most support in this area.

Guiding questions:

- Do you have any issues that may require a lawyer to resolve (divorce, discrimination, child support)?
- Do you currently have legal representation for any issues?
- Are you getting the help that you need to deal with those legal problems?
    - If not, do know where to get legal help in your community?

CFSA Domain: Legal

1 **Thriving** **Family/ individual is thriving!**	2 **Stable** **Family/ individual is stable, safe and moving toward thriving**	3 **Safe** **Family/ individual making progress toward stable life situation**	4 **Vulnerable** **Support needed to help family/individual move toward stability**	5 **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or my family have no pending or new legal issues. We know where to access help if needed.	I and/or my family have successfully completed my legal issue(s) and know where to access affordable legal assistance.	I and/or my family are in compliance with any pending legal issues and/or cases, but they are not fully resolved.	I and/or my family are involved in the legal system currently and need assistance in order to resolve the issue(s).	I and/or my family have unresolved legal issues that need immediate attention such as; divorce, charges, child support, etc.

Domain Name: Mental Health

What does it measure: Assesses the emotional well-being of the family and/or all family members.

Quick Tip: Sometimes family members have various needs surround mental health services. If this is the case, please complete this domain with the adult in mind who needs the most support in this area.

Guiding questions:

- Are you currently experiencing mental health challenges? If so, do you think these challenges impact your ability to live day-to-day?
- Are you currently receiving the mental health care that you need?
- Do you know how to access mental health care services in your community?

CFSA Domain: Mental Health

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or my family feel good about our mental health. We don't need assistance in this area.	I and/or my family's mental health needs are being met. Any problems are expected responses to normal stress.	I and/or my family have mental health issues and are working towards getting them met. We have access to free or affordable services.	I and/or my family have difficulty with some of the activities in my/our day-to-day life. We don't know where to receive help and would like some assistance in this area.	I and/or my family are having emotional difficulties with daily living. I/we don't know where to go to receive help.

Domain Name: Parenting Skills

What does it measure: Assesses the individual's skills and approach to child-rearing and is focused on the parent's perceived and observed abilities rather than the child's behaviour.

Quick Tip: If parenting skills vary within the family, please complete this domain with the parent in mind who needs the most support in this area. Parenting skills can be assessed through self-report or direct observation.

Guiding questions:

- Do you feel confident in your ability to care for your child/ren?
- Have you experienced difficulty providing your child/ren with the care and/or enrichment experiences that you would like to?
- Would you like to have additional support about parenting and/or child development?
- Do you know what resources on parenting and child development are available in your community?

CFSA Domain: Parenting Skills

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or members of my family have well developed parenting skills and confidence in our knowledge.	I and/or members of my family have adequate parenting skills, have taken a parenting class, and/or know how to access assistance in this area.	I and/or members of my family have some parenting skills. We could use some assistance in this area.	My and/or my family's parenting skills are growing and I/we could benefit from a parenting class.	I and/or members of my family are new to parenting and/or not familiar with the child development skills needed to become confident parents.

Domain Name: Substance Abuse

What does it measure: Assesses whether or not the individual is using alcohol and/or prescription drugs in an appropriate manner. Any use of illicit drugs are considered in-crisis and unsafe.

Quick Tip: Sometimes family members have various needs surrounding their substance use. If this is the case, please complete the matrix with the adult in mind who needs the most support in this area.

Guiding questions:

- Do you drink alcohol on a regular basis?
    - If so, how often?
- Are you currently using any drugs?
    - If so, how often do you use them?
- Have you missed any family events or work commitments because you were drinking or using?
- Would you like to reduce your consumption of alcohol and/or drugs?
- Do you know what resources are available in your community to help you deal with alcohol and/or drug abuse?

CFSA Domain: Substance Abuse

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or my family do not have an drug/alcohol problems.	I and/or my family have successfully dealt with one or more of our member's drug or alcohol use in the past. Currently, we do not have any issues in this area.	I and/or my family are dealing with drug or alcohol use issues currently and participating in free or affordable services.	I and/or a family member's alcohol or drug use has a negative effect on our family/friends and we need assistance in this area.	I and/one or more of my family members are severely dependent on a substance (drugs or alcohol) and have not sought help with this issue.

Domain Name: Support Network

What does it measure: Assesses the nature of the individual's immediate interpersonal relationships, especially the extent to which they form a foundation for the individual in times of crisis.

Guiding questions:

- Who do you turn to when you have an emergency or need help?
- Do you have family and/or friends that help support you in your life?
- Do you have people in your life that you feel you can always count on to help you when you need it?
- Do you feel that you are able to offer help and support to your own family and/or friends?

CFSA Domain: Support Network

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or my family have a healthy support system amongst us and are able to offer help to support others.	I and/or my family have strong support from friends and family. We know where and when to access resources.	I and/or my family have some support from friends and family when in need.	My family/friends can be supportive but may not have the resources to help when needed.	I and/or my family have no support from family or friends.

Domain Name: Transportation

What does it measure: Assesses whether or not the individual has appropriate, safe, and reliable access to transportation (whether by car, bus or reliance on friends and family).

Quick Tip: If family members have different needs surrounding transportation, please complete this domain with the family member in mind who needs the most support in this area.

Guiding questions:

- Do you have access to transportation when you need it? If yes, what type of transportation do you have access to?
- Have you had difficulty getting transportation to work or other important appointments recently?
- How often do you or your family members have difficulty getting transportation when you need it?
- Are you aware of the public transportation services available in your community?

CFSA Domain: Transportation

1 **Thriving** **Family/ individual is thriving!**	**2** **Stable** **Family/ individual is stable, safe and moving toward thriving**	**3** **Safe** **Family/ individual making progress toward stable life situation**	**4** **Vulnerable** **Support needed to help family/individual move toward stability**	**5** **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or my family have a vehicle that is insured and readily available.	I and/or my family have transportation that is available most of the time and meets our basic travel needs.	I and/or my family have limited transportation available. Drivers may not be licensed; vehicle may not be insured.	I and/or my family have transportation available, but it is limited, inconvenient and unaffordable. We do not have a car of our own.	I and/or my family currently have no access to public or private transportation.

Domain Name: Utility Assistance

What does it measure: Assesses stability of utility services for the individual/family, including ability to pay for expenses associated with these services.

Guiding questions:

- Do you currently have power at your home?
- Have you been issued a shut-off notice for any utilities?
- Do you ever find paying your energy bill difficult?
- Are you receiving support from any of the available energy assistance programs?
    - If not, are you aware of the energy assistance programs available in your community?
        - Would you be interested in getting more information about these programs?

CFSA Domain: Utility Assistance

1 **Thriving** **Family/ individual is thriving!**	2 **Stable** **Family/ individual is stable, safe and moving toward thriving**	3 **Safe** **Family/ individual making progress toward stable life situation**	4 **Vulnerable** **Support needed to help family/individual move toward stability**	5 **In-Crisis** **Immediate support is critical (urgent situation)**
I and/or my family pay the energy bill on an ongoing basis.	I and/or my family are usually able to pay the energy bill, but occasionally have emergencies.	I and/or my family have trouble paying our bill during the months that energy use is higher.	I and/or my family receive energy assistance (LEAP, EOC, etc.) because I/we have trouble paying the energy bill on an ongoing basis.	I and/or members of my family have received a shut-off notice or an outstanding bill with no resources to pay it.

Colorado Family Support Assessment

1. Adult Education:

(1) I and/or members of my family have completed college or trade school programs have improved our economic and social opportunities

(2) I and/or members of my family are currently in education (beyond high school or GED) or training classes to improve our life situation.

(3) I and/or members of my family have a high school diploma or have completed my GED, literacy, and/or ESL classes.

(4) I and/or members of my family are enrolled in GED, literacy, and/or ESL classes that are improving our skills

(5) I and/or members of my family (want, need , would like to improve) our language or literacy skills. We are not enrolled in any educational programs.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

2. Childcare

(1) I and/or members of my family are able to afford and know how to select quality childcare.

(2) I and/or members of my family have reliable, affordable childcare and don't need assistance in this area

(3) I and/or members of my family have access to government support to cover our childcare costs; but our choices of childcare services are limited.

(4) I and/or members of my family have childcare that is unaffordable or unreliable and we need assistance in this area

(5) I and/or members of my family have no childcare services and we and need assistance in this area

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

3. Children's Education

(1) All of my/our children are in school and are performing at or above developmentally appropriate levels (or grade level)

(2) All of my/our children are in school and are making progress toward developmental and educational goals

(3) All of my/our children are in school, however one or more of them is/are not achieving to age level goals

(4) Some, but not all of my/our children are in school or other educational programs. They are making limited educational progress and we could use assistance in this area

(5) My/our children are not in school or any other educational programs. We need assistance in this area.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

4. Employment:

(1) I and/or members of my family have permanent, full time job(s) with benefits that meet our family's needs.

(2) I and/or members of my family have full time job(s) with a livable wage and some benefits

(3) I and/or members of my family have full time job(s) with few or no benefits. My (our) wages are not enough to live on.

(4) I and/or members of my family have seasonal, temporary or part time job(s) that do not provide a livable wage or benefits

(5) I and/or members of my family currently do not have employment

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

5. Family Relationships

(1) My relationships with my family and/or significant others are stable, supportive and loving.

(2) My relationships with my family are becoming healthy and stable, with improved communication and support.

(3) My family and I are working to improve our relationships and support from others.

(4) My family does not have a lot of support from others. Some of our relationships may, potentially, become unsafe.

(5) My relationships with some of my family is/are unstable, unsafe and/or violent.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

6. Financial:

(1) I and/or members of my family have enough income to cover our needs and to regularly save money.

(2) I and/or members of my family meet my (our) basic needs and manage debt without support.

(3) I and/or members of my family meet my (our) basic needs with government support; we are learning to budget.

(4) I and/or members of my family do not have enough income and/ or have difficulty budgeting. I (we) receive government support.

(5) I and/or members of my family do not have any income.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

7. Food

(1) I and/or my family can afford to purchase nutritional food for all of my family.

(2) I and/or my family can afford to purchase basic food without government support.

(3) I and/or my family receive occasional support/assistance to have enough food to cover our needs

(4) I and/or my family are able to afford enough food with the help of food stamps or other regular support

(5) I and/or my family have no food. I (we) rely on support of others for free or low cost food.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

8. Health Care Access

(1) All members of my family have access to health care and dental care when needed.

(2) All members of my family have access to health care when needed but it strains our budget.

(3) Some members of my family have access to health care when needed.

(4) My family does not have health insurance and/or access to health care.

(5) My family needs health care immediately but do not have insurance or access to it.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

9. Housing:

(1) I and/or my family have safe, adequate and affordable housing

(2) I and/ or my family's have housing that is government subsidized and is safe and adequate for our needs

(3) I and/or my family's have a stable home that is not affordable and is inadequate or unsafe for our needs

(4) I and/ or my family are housed in transitional-temporary housing and cannot afford my current rent/mortgage.

(5) I and/or my family are currently homeless or facing possible eviction.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

10. Legal

(1) I and/ or my family have no pending or new legal issues. We know where to access help if needed.

(2) I and/ or my family have successfully completed my legal issue(s) and know where to access affordable legal assistance.

(3) I and/ or my family are in compliance with any pending legal issues and/or cases, but they are not fully resolved.

(4) I and/ or my family are involved in the legal system currently and need assistance in order to resolve the issue(s).

(5) I and/ or my family have unresolved legal issues that need immediate attention such as; divorce, charges, child support, etc.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

11. Mental Health

(1) I and/ or my family feel good about our mental health. We don't need assistance in this area.

(2) I and/ or my family's mental health needs are being met. Any problems are expected responses to normal stress.

(3) I and/ or my family have mental health issues and are working towards getting them met. We have access to free or affordable services.

(4) I and/ or my family have difficulty with some of the activities in my/our day-to-day life. We don't know where to receive help and would like some assistance in this area.

(5) I and/ or my family are having emotional difficulties with daily living. I/ We don't know where to go to receive help.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

12. Parenting Skills

(1) I and/or members of my family have well developed parenting skills and confidence in our knowledge.

(2) I and/or members of my family have adequate parenting skills, have taken a parenting class, and/or know how to access assistance in this area.

(3) I and/or members of my family have some parenting skills. We could use some assistance in this area.

(4) My and/or my family's parenting skills are growing and I/we could benefit from a parenting class.

(5) I and/or members of my family are new to parenting and/or not familiar with the child development skills needed to become confident parents.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

13. Substance Use

(1) I and/ or my family do not have any drug/alcohol problems.

(2) I and/ or my family have successfully dealt with one or more of our member's drug or alcohol use in the past. Currently, we do not have any issues in this area.

(3) I and/ or my family are dealing with drug or alcohol use issues currently and participating in free or affordable services.

(4) I and/or a family member's alcohol or drug use has a negative effect on our family/friends and we need assistance in this area.

(5) I and/one or more of my family members are severely dependent on a substance (drugs or alcohol) and have not sought help with this issue.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

14. Support Network

(1) I and/ or my family have a healthy support system amongst us and are able to offer help to support others.

(2) I and/ or my family have strong support from friends and family. We know where and when to access resources.

(3) I and/ or my family have some support from friends and family when in need.

(4) My family/friends can be supportive but may not have the resources to help when needed.

(5) I and/ or my family have no support from family or friends.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interest in this area _____

15. Transportation

(1) I and/ or my family have a vehicle that is insured and readily available.

(2) I and/ or my family have transportation that is available most of the time and meets our basic travel needs

(3) I and/ or my family have limited transportation available. Drivers may not be licensed; vehicle may not be insured.

(4) I and/ or my family have transportation available, but it is limited, inconvenient and unaffordable. We do not have a car of our own.

(5) I and/ or my family currently have no access to public or private transportation.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

16. Utility Assistance

(1) I and/or my family pay the energy bill on an ongoing basis.

(2) I and/ or my family are usually able to pay the energy bill, but occasionally have emergencies.

(3) I and/ or my family have trouble paying our bill during the months that energy use is higher.

(4) I and/ or my family receive energy assistance (LEAP, EOC, etc.) because I/we have trouble paying the energy bill on an ongoing basis.

(5) I and/or members of my family have received a shut-off notice or an outstanding bill with no resources to pay it.

(6) N/A – Not applicable

(7) N/R – Family declines to respond

Goal interests in this area _____

Our Family Development Plan:

We will now go back and choose the goals that are most important for you and/or your family to work on immediately.

We will put them in order of importance:

<table>
<tr><td colspan="2">Major Goal #

Strengths and resources the family has to assist them:</td><td colspan="2">Center services available:

Referral resources:</td></tr>
<tr><td colspan="2">Steps family will take to reach their goal:</td><td colspan="2">Step Family Development Worker will take:</td></tr>
<tr><td>Step 1:</td><td>Date to complete:</td><td>Step 1:</td><td>Date to complete:</td></tr>
</table>

Step 2:	Date to complete:	Step 2:	Date to complete:
Step 3:	Date to complete:	Step 3:	Date to complete:
Obstacles we may encounter:		What we can do to overcome these obstacles:	

Appendix 4 Care Coordination Outcomes Measurement Guide

The six care coordination measurement outcomes are listed at the beginning of this matrix along with their sub-outcomes so the practitioner can identify which outcomes they wish to measure and then locate those outcomes within the matrix (highlighted in dark grey). Listed below each measurement outcome (Care Coordination Outcome # -highlighted in dark grey) and sub-outcome (highlighted in lighter grey) are the questions (Q) that will address each area. For example, if the provider wishes to measure the outcome Process: Ease of Access to Resource Information (Care Coordination Outcome #2a), they will find this heading within the matrix and administer the items listed under this heading (Q24-Q30). Because some of the Questions measure multiple Outcomes, there are prompts provided at the beginning of the measurement (highlighted in light grey and preceded by ***) that identify which of the previously listed Questions (listed under other Outcomes) should be included in addition to the Questions provided below the identified Outcome. The questions provided in this matrix were selected from the Medical Home Family Index and Survey, which was developed out of the Center for Medical Home Improvement.

<u>Care Coordination Community of Practice Outcomes:</u>

1. Well-being and Satisfaction:
- a) Family/individual goals achieved
- b) Reduction in percentage of unmet needs
- c) Increase family/individual satisfaction
- d) Increase provider satisfaction
- e) Family functioning is healthy/improved
- f) Family feels knowledgeable

2. *Process*:
- a) Ease of access to resource information
  - i) Increased individual/family and provider access to information about available resources
  - ii) Increased positive individual/family "teach-back" skills demonstrated
- b) Enhanced communication among providers/family/community partners
  - i.) Increased documentation of care plan use and oversight
- c) Single point of entry into multiple services

3. *Community and Relationship Supports:*
- A) Improved relationships with family and friends
- b) Improved parent-child relationships
- c) Positive social supports
  - i) Access to community resources including: Recreation, Transportation, Spiritual, Legal, Education

4. *Functional Essentials:*
- a) Increased self-management skills
- b) Increased functional abilities
  - i) Increased functional assessment, school attendance/success, ability to perform activities of daily living.
- c) Support achievement of developmental trajectory
  - i) Functional levels achieved, milestones marked
- d) Basic needs and essentials are met that include the following: Income, Home, Utilities, Food, Clothing, Insurance, Transportation, Child care

5. *Physical and Mental Health and Development:*
- a) Enhance communication between family and all sources of service and support

i) Reduce percentage of children seen by specialist without information from PCP; reduced percentage of children seen by PCP without information from consultation/specialist.

b) Increased measures of health

i) Health goals reached, family perception of individual's health increased

c) Increase activity, developmental screening and health promotion (Early and Periodic Screening, Diagnosis, and Treatment Guidelines, AAP and Bright Futures Guidelines)

i) Increased percentage of all children screened for developmental delays and sensory deficits by select periodic well-child visits and/or school entry

d) Improve access to health and mental health care

6. ***Costs of Care:***

a) Reduce emergency department visits as indicated by reduced utilization of emergency departments

b) Reduce hospitalizations/hospital length of stay

c) Reduce redundancy and duplication of tests, services

d) Reduce repeat data gathering by service providers through increased care team efficiency

e) Reduce caregiver work days lost

Care Coordination Outcome #1: Well-being and Satisfaction					
Family/Individual Goals Achieved (a)					
Q1. When I call my provider or their office: (please answer for a, b, c and d)-*MHFIS ITEM # 2*					Measurement Outcomes Met
a. Staff know who we are	Never	Sometimes	Often	Always	1.a; 1.b; 1.c; 1.d; 1.e
b. Staff respect our needs and requests	Never	Sometimes	Often	Always	1.a; 1.b; 1.c; 1.d; 1.e
c. Staff remember any special needs or supports that we have asked for	Never	Sometimes	Often	Always	1.a; 1.b; 1.c; 1.d; 1.e
d. We are asked if there are any new needs requiring attention	Never	Sometimes	Often	Always	1.a; 1.b; 1.c; 1.d; 1.e
Q2. I am asked by our provider how my child's condition affects our family (e.g. the impact on siblings, the time my child's care takes, lost sleep, extra expenses, etc.) -*MHFIS ITEM # 5*	Never	Sometimes	Often	Always	1.a; 1.b; 1.c; 1.e; 3.a; 3.b
Q3. My provider and his/her staff work with our family to create a written care plan for my child.-*MHFIS ITEM # 8*	Never	Sometimes	Often	Always	1.a; 1.b; 2.b
Q4. What do you or your child currently need that you are not receiving? -*MHFIS ITEM # 40*					1.a; 1.b; 1.c; 1.e; 4.c; 4.d

Reduction in Percentage of Unmet Needs (b) ***In order to fully address this measure please add the following questions (Q5-15) in addition to the previous ones.					
Q5. Through this provider and/or their office I can get the health care that my child needs when we need it (including after office hours, on weekends and holidays). –*MHFIS ITEM # 1*	Never	Sometimes	Often	Always	1.b; 1.c; 1.e
Q6. I have seen changes made by my provider or his/her office as a result of my suggestions or those made by other families. -*MHFIS ITEM # 21*	Never	Sometimes	Often	Always	1.b; 1.c; 1.d

Q7. I know my provider or his/her office has conducted surveys, focus groups, or discussions with families (in the last two years) to determine if they are satisfied with their children's care. -*MHFIS ITEM # 22*	Never	Sometimes	Often	Always	1.b; 1.d
Q8. The behavior which best demonstrates the needed care and compassion I need from my child's provider is _____(fill in the blank). -*MHFIS ITEM # 24*					1.b
Q9. The frequency that I observe and experience this behavior (in #8) is? -*MHFIS ITEM # 25*	Never	Sometimes	Often	Always	1.b; 1.d
Q10. How difficult is it to take care of your child's chronic health condition(s) or disability? -*MHFIS ITEM # 9*	Not at all Difficult	A little Difficult	Somewhat Difficult	Very Difficult	1.b; 1.c; 1.e
Q11. During the last 3 months, how often have you worried about your child's health? -*MHFIS ITEM # 10*	None of the Time	A little of the Time	Some of the Time	Most of the Time	All of the Time	1.b; 1.c; 1.e; 5.b
Q12. How would you measure the level of stress experienced over the last year as a result of caring for your child? -*MHFIS ITEM # 14*	0 1 2 3 4 5 6 7 8 9 10 Mildest severity Most severe				1.b; 1.c; 1.e
Q13. Does your child's provider help to alleviate this stress (e.g. with services, supports or referrals to other resources)-*MHFIS ITEM # 15*	Always	Often	Sometimes	Never	1.b; 1.c; 1.e

Family Care Coordination Parents of children with chronic health conditions often do a variety of activities to coordinate care for their child. Some parents are new at this, others have been coordinating their child's care for years. Listed below are some of the care activities parents often do. Please read each activity and circle the response that best describes you and your family.

Q14. Describing how this medical condition affects my child's growth and development. –*MHFIS ITEM # 30*	Always	Often	Sometimes	Rarely	Never	NA	1.b; 1.c; 1.f
Q15. Taking action to correct poor care and services my child receives.–*MHFIS ITEM # 31*	Always	Often	Sometimes	Rarely	Never	NA	1.b; 1.c; 1.f

Increase Family/Individual Satisfaction (c) ***In order to fully address this measure, please include previous questions (Q) 1, 2, 4-6, 10-13 , and 15 in addition to the following.						
Q16. My provider asks me to share with him/her my knowledge and experience as the parent or caregiver of a child with special health care needs. -*MHFIS ITEM # 4*	Never	Sometimes	Often	Always		1.c; 1.f; 2.a
Q17. My provider listens to my concerns and questions.-*MHFIS ITEM # 6*	Never	Sometimes	Often	Always		1.c; 1.f
Q18. Office providers or staff who is involved with my child's care know about their condition, history, and our concerns and priorities. -*MHFIS ITEM # 14*	Never	Sometimes	Often	Always		1.c; 1.d, 6.d
Q19. How satisfied are you with the care coordination provided outside of the family that you receive for your child?-*MHFIS ITEM # 21*	Very Satisfied	Somewhat Satisfied	Dissatisfied	Very Satisfied	NA	1.c; 1.d

Increase Provider Satisfaction (d) ***In order to fully address this measure, please include previous questions (Q)1, 6, 7, 9, 18, and 19 in addition to the following.						
Q20. From my experience, I believe that my provider and the staff at his/her office have a commitment to provide the quality care and family supports that we need. -*MHFIS ITEM # 23*	Never	Sometimes	Often	Always		1.d
Practice Satisfaction: How would you rate the practice for each of the following qualities?						
Q21. The length of time waiting at the office. -*MHFIS ITEM # 35*	Excellent	Very Good	Good	Fair	Poor	NA	1.d

Family Functioning is Healthy/Improved (e) *******In order to fully address this measure, please include previous questions (Q)1a-d, 2, 4, 5, and 10-13 in addition to the following.						
Q22. During the last 3 months, how often have you worried about your child's chronic health condition or disability upon his or her siblings? -*MHFIS ITEM # 11*	None of the time	A little of the time	Some of the time	Most of the time	All of the time	1.e
Q23. During the last month, how often have your emotions (such as feeling depressed or anxious) interfered with your work, social activities, or daily routine? -*MHFIS ITEM # 16*	None of the time	A little of the time	Some of the time	Most of the time	All of the time	1.e; 3.a

Family Feels Knowledgeable (f) ***In order to address this measure, please use previous questions (Q)14-17.

Care Coordination Outcome #2: Process					
Ease of Access to Resource Information (a) ***(i) Increased Individual/Family and Provider Access to Information About Available Resources*** ***(ii) Increased Positive Individual/Family "Teach-Back" skills Demonstrated***					
Q24. My provider uses helpful ways to communicate (e.g. explaining terms clearly, helping us prepare for visits, e-mail, or encouraging our questions):-*MHFIS ITEM # 3*					
a. With me	Never	Sometimes	Often	Always	2.a.; 2.b
b. With my child	Never	Sometimes	Often	Always	2.a.; 2.b
Q25. My provider and his/her office staff (please answer a, b, and c): -*MHFIS ITEM # 10*					
a. Use and follow through with care plans they have created	Never	Sometimes	Often	Always	2.a.; 2.b
b. Use a care plan to help follow my child's progress	Never	Sometimes	Often	Always	2.a.; 2.b
c. Review and update the care plan with me regularly	Never	Sometimes	Often	Always	2.a.; 2.b
Q26. My provider has a staff person(s) or a "care coordinator" who will: -*MHFIS ITEM # 11*					
a. Help me with difficult referrals, payment issues, and follow-up activities	Never	Sometimes	Often	Always	2.a.; 2.b; 2.c; 3.c; 5.a; 6.b; 6.c
b. Help to find needed services (e.g. transportation, durable equipment or home care)	Never	Sometimes	Often	Always	2.a.; 2.b; 2.c; 3.c; 5.a; 6.b; 6.c
c. Make sure that the planning of care meets my child and my family's needs	Never	Sometimes	Often	Always	2.a.; 2.b; 2.c; 3.c; 5.a; 6.b; 6.c
d. Help each person involved in my child's care to communicate with each other (with my consent)	Never	Sometimes	Often	Always	2.a.; 2.b; 2.c; 3.c; 5.a; 6.b; 6.c
Q27. Someone at the office is available to review my child's medical record with me when or if I ask to see it. -*MHFIS ITEM # 13*	Never	Sometimes	Often	Always	2.a.; 2.b

Q28. Office staff help me to connect with family support organizations and informational resources in our community and state. – *MHFIS ITEM # 16*	Never	Sometimes	Often	Always			2.a.; 3.a; 3.b; 3.c
Q29. My provider assists me in finding adult health care services for my child. *–MHFIS ITEM # 18*	Never	Sometimes	Often	Always			2.a.
Q30. Finding the help I need to coordinate services for my child. *–MHFIS ITEM # 28*	Always	Often	Sometimes	Rarely	Never	NA	2.a.

Enhanced Communication Among Providers/Family/Community Partners (b) ***(i) Increased Documentation of Care Plan Use and Oversight*** ******* In order to fully address this measure, please include previous questions (Q)3, and 24-27 in addition to the following.							
Q31. Planning of care for my child includes: *-MHFIS ITEM # 7*							
a. The writing down of key information (e.g. recommendations, treatment, phone number)	Never	Sometimes	Often	Always			2.b
b. Setting short term goals (e.g. for the next three months)	Never	Sometimes	Often	Always			2.b
c. Setting long term goals (e.g. for the next year or more)	Never	Sometimes	Often	Always			2.b
d. Thorough follow-up with plans created	Never	Sometimes	Often	Always			2.b
Q32. My provider and staff work with our family to create a written care plan for my child. *-MHFIS ITEM # 8*	Never	Sometimes	Often	Always			1.a; 2.b
Q33. I receive a copy of my child's care plan with all updates and changes. *–MHFIS ITEM # 9*	Never	Sometimes	Often	Always			2.b
Q34. Communicating my concerns about my child's health needs to most professionals *-MHFIS ITEM # 33*	Always	Often	Sometimes	Rarely	Never	NA	2.b; 5.a; 5.c

Q35. Getting medical professionals to give us information that we can understand. *–MHFIS ITEM # 34*	Always	Often	Sometimes	Rarely	Never	NA	2.b; 5.a; 5.b
Q36. Provider(s) and staff have regular contact with you child's school staff. *-MHFIS ITEM # 37*	Excellent	Very Good	Good	Fair	Poor	NA	2.b

Single Point of Entry into Multiple Services (c)
******** In order to address this measure, please use previous question (Q)26.

Care Coordination Outcome #3: Community and Relationship Supports							
Improved Relationships with Family and Friends (a) ***In order to fully address this measure, please include previous questions (Q)2, 23 and 28 in addition to the following.							
Q37. My provider or his/her office staff sponsor activities to support my family (e.g. support groups, parent skill building or how to support other parents). *–MHFIS ITEM # 15*	Never	Sometimes	Often	Always			3.a; 3.b; 3.c; 3.c
Family Care Coordination Parents of children with chronic health conditions often do a variety of activities to coordinate care for their child. Some parents are new at this, others have been coordinating their child's care for years. Listed below are some of the care activities parents often do. Please read each activity and circle the response that best describes you and your family.							
Q38. Involving my child in regular recreational activities in the community. *–MHFIS ITEM # 27*	Always	Often	Sometimes	Rarely	Never	NA	3.a; 3.c

Improved Parent-Child Relationships (b) ***In order to fully address this measure, please use previous questions (Q)2, 28, and 37.

Positive Social Supports (c) ***(i) Access to Community Resources Including: Recreation, Transportation, Spiritual, Legal, Education*** ***In order to fully address this measure, please include previous questions. (Q)26, 28, 37, and 38 in addition to the following.							
Family Care Coordination Parents of children with chronic health conditions often do a variety of activities to coordinate care for their child. Some parents are new at this, others have been coordinating their child's care for years. Listed below are some of the care activities parents often do. Please read each activity and circle the response that best describes you and your family.							
Q39. Finding other parents to talk to who have children with similar conditions. *-MHFIS ITEM # 29*	Always	Often	Sometimes	Rarely	Never	NA	3.c

Care Coordination Outcome #4: Functional Essentials			
Increased Self-Management Skills (a)			
Caring for Your Child (The next five questions ask about your child's health needs and whether your child has a health condition. A health condition can be physical, mental or behavioral. Health conditions may affect a child's development, daily function or need for services).			
Q40. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do? *-MHFIS ITEM # 3*	Yes	No	4.a; 4.b
Q41. Does your child need or get special therapy, such as physical, occupational or speech therapy? *–MHFIS ITEM # 4*	Yes	No	4.a; 4.b; 4.c

Q42. Do you have any of the following specific concerns for your child? ***(Circle the number under the response that best describes your concern):***
-MHFIS ITEM # 18

	Never	**Seldom**	**Sometimes**	**Often**	**Always**	**N/A**	
a. Growth and development	1	2	3	4	5	6	4.a; 4.b; 4.c; 4.d
b. Ability to learn	1	2	3	4	5	6	4.a; 4.b; 4.c; 4.d
c. Participation in activities of his/her age group	1	2	3	4	5	6	4.a; 4.b; 4.c; 4.d
d. Ability to make healthy choices (e.g. activity, rest, diet, medicines)	1	2	3	4	5	6	4.a; 4.b; 4.c; 4.d
e. Self esteem/emotional well being	1	2	3	4	5	6	4.a; 4.b; 4.c; 4.d
f. The future	1	2	3	4	5	6	4.a; 4.b; 4.c; 4.d
Q43. How would you estimate the current overall severity of your child's special health care needs? *–MHFIS ITEM # 19*	0 1 2 3 4 5 6 7 8 9 10 Mildest severity Most severe						4.a; 4.b; 5.b
Q44. (If school age or older) Getting my child to take an active role as possible in health discussions and in decision making. *–MHFIS ITEM # 32*	Always	Often	Sometimes	Rarely	Never	NA	4.a; 4.b; 4.c

Increased Functional Abilities (b) ***(i) Increased Functional Assessment, School Attendance/Success, Ability to Perform Activities of Daily Living*** ***In order to fully address this measure, please include previous questions (Q)40-44 in addition to the following.		
Q45. During the past 12 months (1 year ago today) how many days did your child miss school because of their chronic health condition or disability? *–MHFIS ITEM # 17*	Write in number of Days_____	4.b

Support Achievement of Developmental Trajectory (c) ***(i) Functional Levels Achieved, Milestones Marked*** ***In order to address this measure, please use previous questions (Q)4, 41, 42, and 44.

Basic Needs and Essentials are Met that Include the Following: Income, Home, Utilities, Food, Clothing, Insurance, Transportation, Child Care (d) ***In order to address this measure, use previous questions (Q)4 and 42.

Care Coordination Outcome #5: Physical and Mental Health Development							
Enhance Communication Between Family and all Sources of Service and Support (a) ***(i) Reduce Percentage of Children Seen by PCP Without Information from Consultation/Specialist*** ***In order to fully address this measure, include previous questions (Q)26, 34, and 35 in addition to the following.							
Q46. When or if I ask for it, our Provider or office staff help me to: -*MHFIS ITEM # 12*							
a. Explain my child's needs to other health professionals	Never	Sometimes	Often	Always			5.a; 5.c; 6.b; 6.c
b. Get my child's school, early care providers or others to understand his/her condition	Never	Sometimes	Often	Always			5.a; 5.c; 6.b; 6.c
Q47. My provider and office staff organize and attend team meetings about my child's plan of care that include us and outside providers (when needed). *–MHFIS ITEM # 19*	Never	Sometimes	Often	Always			5.a; 5.b; 5.c
Q48. Clear directions for who to contact or where to go for aspects of your child's condition when they are not ill. *–MHFIS ITEM # 36*	Excellent	Very Good	Good	Fair	Poor	NA	5.a

Increased Measures of Health (b) ***(i) Health Goals Reached, Family Perception of Individual's Health Increased*** ***In order to fully address this measure, please include previous questions (Q)11, 35, 43, and 47 in addition to the following.					
Q49. In general, would you say your child's health is (Circle one)… -*MHFIS ITEM # 6*	Excellent	Good	Fair	Poor	5.b
Q50. Overall, how would you rank the severity of your child's condition or problem? *–MHFIS ITEM # 12*	0 1 2 3 4 5 6 7 8 9 10 Mildest severity Most severe				5.b

Increase Activity, Developmental Screening and Health Promotion (Early and Periodic Screening, Diagnosis, and Treatment Guidelines, AAP and Bright Futures Guidelines) (c) ***(i) Increased Percentage of all Children Screened for Developmental Delays and Sensory Deficits by Select Periodic Well-Child Visits and/or School Entry***			
The Care Coordination Community of Practice suggests adding the following question to address this Outcome: 51. Have you gone over the results of a developmental screening with your provider?	Yes	No	5.c

Improve Access to Health and Mental Health Care (d)			
Q52. Does your child have any kind of emotional, developmental or behavior problem for which he or she needs or gets treatment or counseling? -*MHFIS ITEM # 5*	Yes	No	5.d

Care Coordination Outcome #6: Costs of Care					
Reduce Emergency Department Visits as Indicated by Reduced Utilization of Emergency Departments (a)					
Q53. During the past year, how many separate times did your child require care in the Emergency Room? *–MHFIS ITEM # 24*	None	1-3 times	4-10 times	More than 10 times	6.a

Reduce Hospitalizations/Hospital Length of Stay (b) ***In order to address this measure, administer previous questions (Q)26 and 46.						
Q54. During the past year, how many separate times did your child have to stay in the hospital overnight? *–MHFIS ITEM # 25*	None at all	1-3 times	4-7 times	8-10 times	More than 10 times	6.b

Reduce Redundancy and Duplication of Tests, Services (c) ***In order to fully address this measure, administer previous questions (Q)26 and 46 in addition to the following.			
Q55. Is there a place that your child usually goes to when he/she is sick or you need advice about his/her health? *–MHFIS ITEM # 7*	Yes	No	6.c

Reduce Repeat Data Gathering by Service Providers Through Increased Care Team Efficiency (d) ***In order to address this measure, administer previous questions (Q)18 and 26d, 34, 46a, .

Reduce Caregiver Work Days Lost (e)						
Q57. In the past 3 months, how many days have you or anyone in your family had to stay home from work because of your child's chronic health condition(s) or disability? *–MHFIS ITEM # 26*	None	1-5 work days	6-16 work days	16 or more work days	No one is employed	6.e

Q58. Has anyone in your family been unable to work outside the home due to your child's health condition or disability? *–MHFIS ITEM # 39*	Yes	No	6.e