

# Program for Children with Special Health Care Needs (HCP)



FY 14

## HCP Training Companion Documents

Revised 12/17/2013



Colorado Department  
of Public Health  
and Environment



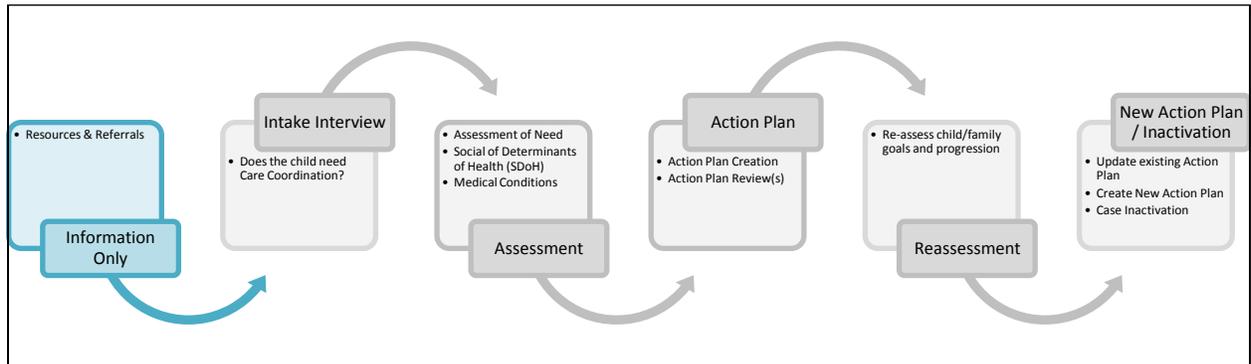
# Program for Children with Special Health Care Needs (HCP)

## HCP TRAINING COMPANION DOCUMENTS

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## Information Only



### Purpose

The Information Only form is a tool to be used to track and gather information about informal calls received from families, providers, and/or other community agencies who request information, resources, and/or referrals. The Information Only form can be filled out by anyone in the LPHA office, including HCP Care Coordinators or front desk staff.

These encounters may vary in number and length depending on the information being requested. It is valuable to be able to capture the number of these encounters and the amount of time being spent per call to help plan for staffing needs. In addition, by monitoring the type of information being requested/given, an LPHA can have data to support and determine if there is an unmet need in the community or if additional resources need to be developed to address a need.

Ultimately, data collection/data entry of 'Information Only' fields is optional and up to each individual LPHA. However, if an LPHA opts to not enter 'Information Only' into CDS, it is their responsibility to find another way to track and report the number of 'Information Only' encounters. The benefit to using CDS to track and report this information is that your agency is able pull reports that provide data about the population you are serving. Your agency should decide which fields to enter for every 'Information Only' encounter.

### FY14 Changes and CDS Data Entry:

1. 'Information Only' is no longer "nested" within the Intake Interview process. Information only now has a separate form and is a stand-alone document. The form has been streamlined and data collection requirements have been reduced.
  - The intent of the 'Information Only' form is to collect general information about the population calling, the information being requested and given, and the amount of time being spent to provide the caller with this information. The intent is no longer to collect detailed information about each caller. Because of this, the form provides several "optional" data entry fields (client name and birthday, contact information, address, etc). If the caller provides you with this information, or if it is appropriate to ask for this information, there is room to document it on the form. It is not; however, required that you collect this information for every caller; nor are these optional fields built into CDS.

**Client Information: [OPTIONAL: collect if applicable]** ←

Last Name:  First Name:  Middle Name:  Suffix:  Gender:

Birth Date:

**Contact Information: [OPTIONAL: collect if applicable]** ←

Phone: (  )  -  Type:   Check if preferred

(  )  -  Type:   Check if preferred

E-Mail:  @   Check if preferred

Name:

- ‘Information Only’ in CDS is no longer nested within the Intake Interview. In CDS, Information Only can now be found at the top of the screen along the top row of tabs.
  - LPHAs will now have the ability to report on the number of encounters, the type of information being requested and given, and amount of time being spent on these critical interactions.



- The ‘Information Only’ screen in CDS has been updated to mirror the form to the greatest extent possible.

**Information Only** Site:  [New Record](#)

Interviewer Name & Title

Interviewer Name:  Method of Contact:  E-mail  Phone

Date of Interview:   Home Visit  Other

Office Visit

Requestor

Describe who is requesting information:

Community Partner  Health Care Provider  Dont Know/Not Sure

Father  Mother  Refused

Friend/Neighbor  Other Relative  Didn't Ask



**Information Only**

**Information Being Requested By:**

**Describe who is requesting information:**

<input type="checkbox"/> Community Partner	<input type="checkbox"/> Health Care Provider	<input type="checkbox"/> Don't Know/Not Sure
<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Refused
<input type="checkbox"/> Friend/Neighbor	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Didn't Ask
<input type="checkbox"/> Foster-Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Step-Parent	

**How Did Caller Hear About HCP?**

**How did caller hear about HCP? (select as many as apply)**

<input type="checkbox"/> 211	<input type="checkbox"/> Friend	<input type="checkbox"/> Public Health Department
<input type="checkbox"/> BIAC	<input type="checkbox"/> HCP Specialty Clinic	<input type="checkbox"/> School
<input type="checkbox"/> Brochure	<input type="checkbox"/> Healthy Communities	<input type="checkbox"/> Specialty Provider
<input type="checkbox"/> Board of Community Education Services (BOCES)	<input type="checkbox"/> Hospital – Children's Hospital	<input type="checkbox"/> Support Group Services
<input type="checkbox"/> CICP	<input type="checkbox"/> Hospital - Other	<input type="checkbox"/> Website – CDPHE
<input type="checkbox"/> CHP+	<input type="checkbox"/> Human Services	<input type="checkbox"/> Website – LPHA
<input type="checkbox"/> Community Center Boards	<input type="checkbox"/> Individual Services Support Team	<input type="checkbox"/> Website – Other
<input type="checkbox"/> Community Partner	<input type="checkbox"/> Medical Provider – Clinic	<input type="checkbox"/> Work
<input type="checkbox"/> CRCSN Notification	<input type="checkbox"/> Medical Provider – Primary	<input type="checkbox"/> Don't Know/Not Sure
<input type="checkbox"/> Family Member	<input type="checkbox"/> Medical Provider – Specialty	<input type="checkbox"/> Refused
<input type="checkbox"/> Family Voices	<input type="checkbox"/> Medical Provider - Other	<input type="checkbox"/> Didn't Ask
	<input type="checkbox"/> Other Public Health Program	<input type="checkbox"/> Other

**Information Requested:**     English     Spanish     Other Language

**Describe information requested by caller (select as many as apply):**

<input type="checkbox"/> Adult Education	<input type="checkbox"/> Home Health Services	<input type="checkbox"/> Primary Care/Medical Home
<input type="checkbox"/> Audiology	<input type="checkbox"/> Hospital – Children's Hospital	<input type="checkbox"/> RCCO
<input type="checkbox"/> Child Care	<input type="checkbox"/> Hospital - Other	<input type="checkbox"/> Recreational Activities
<input type="checkbox"/> Community Services	<input type="checkbox"/> Housing	<input type="checkbox"/> Referral to Other County/Agency
<input type="checkbox"/> Dental	<input type="checkbox"/> Insurance	<input type="checkbox"/> Respite
<input type="checkbox"/> Developmental Screening	<input type="checkbox"/> Legal Issues	<input type="checkbox"/> School
<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Medical Provider – Specialty	<input type="checkbox"/> Specialty Care
<input type="checkbox"/> Emotional Support	<input type="checkbox"/> Medical Supplies	<input type="checkbox"/> Support Group Services – All
<input type="checkbox"/> Employment	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy – Occupational
<input type="checkbox"/> Family Leadership	<input type="checkbox"/> Mental/Behavioral Health	<input type="checkbox"/> Therapy – Physical
<input type="checkbox"/> Financial Assistance	<input type="checkbox"/> Nutrition/Dietary	<input type="checkbox"/> Therapy – Speech
<input type="checkbox"/> HCP Care Coordination	<input type="checkbox"/> Other Public Health Services	<input type="checkbox"/> Transition
<input type="checkbox"/> HCP Specialty Clinic	<input type="checkbox"/> Parent Education	<input type="checkbox"/> Transportation
<input type="checkbox"/> Head Start	<input type="checkbox"/> Parent Support	<input type="checkbox"/> Vision
		<input type="checkbox"/> Other

Language client requested information should be presented to client in

The 'information requested' section is not intended to be read to the family: Instead, the question responses are there as a reminder of supports and services that families typically use. Allow the family to tell their story and check responses as appropriate.



**Information Only**

**Age of Child:**

**Age of Child** (select only one):

0 – 3 years     
  3 – 5 years     
  5 – 18 years     
  18 – 21 years

**Information Given:**

**Describe information given to caller** (select as many as apply):

<input type="checkbox"/> Adult Education	<input type="checkbox"/> Home Health Services	<input type="checkbox"/> Primary Care/Medical Home
<input type="checkbox"/> Audiology	<input type="checkbox"/> Hospital – Children’s Hospital	<input type="checkbox"/> RCCO
<input type="checkbox"/> Child Care	<input type="checkbox"/> Hospital - Other	<input type="checkbox"/> Recreational Activities
<input type="checkbox"/> Community Services	<input type="checkbox"/> Housing	<input type="checkbox"/> Referral to Other County/Agency
<input type="checkbox"/> Dental	<input type="checkbox"/> Insurance	<input type="checkbox"/> Respite
<input type="checkbox"/> Developmental Screening	<input type="checkbox"/> Legal Issues	<input type="checkbox"/> School
<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Medical Provider – Specialty	<input type="checkbox"/> Specialty Care
<input type="checkbox"/> Emotional Support	<input type="checkbox"/> Medical Supplies	<input type="checkbox"/> Support Group Services – All
<input type="checkbox"/> Employment	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy – Occupational
<input type="checkbox"/> Family Leadership	<input type="checkbox"/> Mental/Behavioral Health	<input type="checkbox"/> Therapy – Physical
<input type="checkbox"/> Financial Assistance	<input type="checkbox"/> Nutrition/Dietary	<input type="checkbox"/> Therapy – Speech
<input type="checkbox"/> HCP Care Coordination	<input type="checkbox"/> Other Public Health Services	<input type="checkbox"/> Transition
<input type="checkbox"/> HCP Specialty Clinic	<input type="checkbox"/> Parent Education	<input type="checkbox"/> Transportation
<input type="checkbox"/> Head Start	<input type="checkbox"/> Parent Support	<input type="checkbox"/> Vision
<input type="checkbox"/>		<input type="checkbox"/> Other

**Client Information: [OPTIONAL: collect if applicable]**

Last Name:      
 First Name:      
 Middle Name:      
 Suffix:      
 Gender:

Birth Date:

**Contact Information: [OPTIONAL: collect if applicable]**

Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_  Check if preferred  
 (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_  Check if preferred  
 E-Mail: \_\_\_\_\_@\_\_\_\_\_  Check if preferred  
 Name: \_\_\_\_\_

Client Information and Contact Information is optional. Collect this information if:

- It is provided
- It is required in order to follow-up with resources or referrals

Optional sections are found on the paper form only; they are not built into CDS.



**Information Only**

**Address Information: [OPTIONAL: collect if applicable]**

Street:	
City:	
State:	Zip:
County:	
Additional Information:	

**Notes: [OPTIONAL: collect if applicable]**

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**Time Spent on "Information Only" Process:**

**Time Spent (on whole "information only" process; including phone call, required research and/or follow up):**

15 minutes  
 30 minutes  
 45 minutes  
 60 minutes  
 1 hour 15 minutes  
 1 hour 30 minutes  
 1 hour 45 minutes  
 2 hours

**"Information Only" Process:**

Interviewer Name & Title:  Date of Interview:	<b>Information Only – Method of Contact:</b> <input type="checkbox"/> E-mail <input type="checkbox"/> Phone <input type="checkbox"/> Home visit <input type="checkbox"/> Other <input type="checkbox"/> Office visit
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Reviewed By (Name & Title):	Date of Review:
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Proceed to Intake Interview:  Yes  No

Address Information and Notes are optional. Collect this information if:

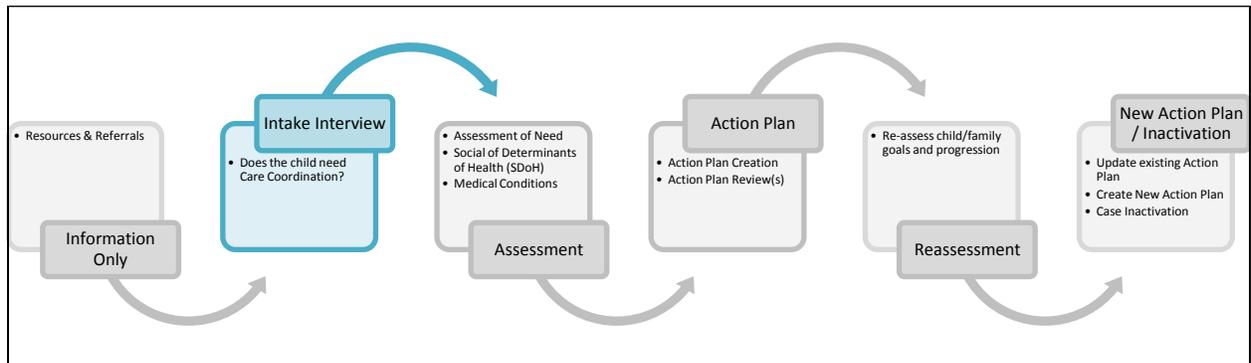
- It is provided
- It is required in order to follow-up with resources or referrals

Optional sections are found on the paper form only; they are not built into CDS.

Time Spent includes the initial phone call, any required research or follow-up, and any subsequent phone calls

This section is provided for cases when a non-care coordinator is providing 'Information Only' services. An HCP Care Coordinator should review the 'Information Only' form to assure that the client does/does not need HCP Care Coordination. The HCP Care Coordinator should follow-up with the family as appropriate or as contact information is available.

## Intake Interview



### Purpose

The 'Intake Interview' is the first core component of the HCP Care Coordination model. The HCP Care Coordinator uses the Intake Interview to identify and support the family's strengths, concerns, culture, and values. It also is used to collect baseline data about HCP clients before care coordination activities begin. The HCP Care Coordinator must conduct an Intake Interview with each child/youth and their family who may want or benefit from care coordination and the Intake Interview must be completed prior to proceeding through the rest of the model. If a care coordination client has been inactivated in CDS and needs to resume care coordination at a later date, a new Intake Interview must be conducted and documented before continuing to Assessment (the next phase in the model).

### FY14 Changes

1. The 'Intake Interview' has been streamlined. This includes:
  - Improvements to overall flow
    - i. Clarifying questions that were unclear
    - ii. Combining questions that were alike or similar
    - iii. Moving questions to other phases of the HCP Care Coordination model, such as Assessment or Action Plan.
  - Reviewing all answer responses to insure all appropriate responses are included.
  - The overall look and feel of the Intake Interview has been maintained. Overall, the changes for FY14 are minor and are intended to help improve the Intake Interview process and require less time of our Care Coordinators.

2. The 'Intake Interview' screen in CDS has been updated to mirror the form to the greatest extent possible.

The screenshot shows the 'Integrated Data System (IDS) - Training' interface. The top navigation bar includes 'HOME', 'SEARCH', 'REPORTS', 'PROVIDERS', 'BROADCAST MESSAGES', and 'INFORMATION ONLY'. The user 'Kelsey Mefford' is logged in. The main content area displays the profile for 'WHITE, SNOW', DOB: 7/15/2013, 2 mo Female #331. The profile includes contact information, primary address (123 Happy Happy Lane, Denver, Colorado), and primary contact (White, Snow). A purple arrow points to the 'Intake Interview' option in the left sidebar. An 'HCP Summary' table is also visible.

HCP Summary	
Intake Interview Completed:	None
Assessment Completed:	09/02/2013
Assessment Reviewed:	None
Action Plan Completed:	09/12/2013
Action Plan Reviewed:	None
Six Month Review Due Date:	03/02/2014

The screenshot shows the 'Integrated Data System (IDS) - Training' interface with the 'Intake Interview' screen. The top navigation bar includes 'FAVORITES', 'LAST 10', 'CLOSE ALL TABS', and 'ID#'. The user 'Kelsey Mefford' is logged in. The main content area displays the 'Intake Interview' screen with a purple arrow pointing to the 'Add New' button. Below the 'Add New' button is a table with columns for 'Interview', 'Referral', 'Updated', and 'By'.

Interview	Referral	Updated	By
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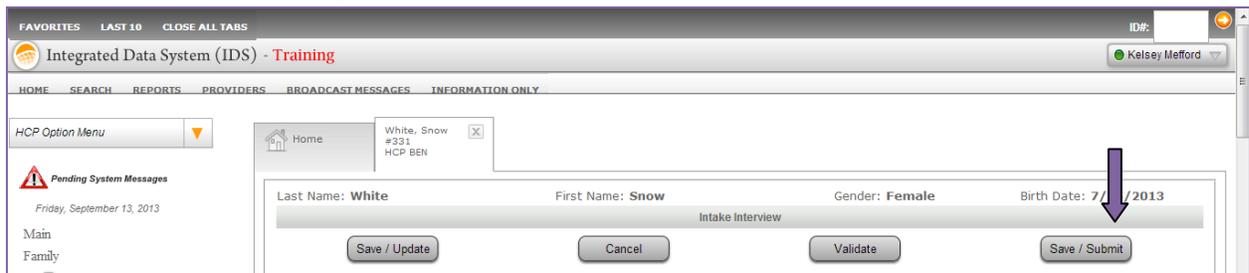
- By restructuring the Intake Interview in CDS, it should improve the amount of time previously required for data entry. There is now a reduced number of steps and a reduced number of screens required to navigate in order to enter a client's intake interview.

3. CDS will now allow the LPHA data entry user to *Save/Update* and *Save/Submit*.

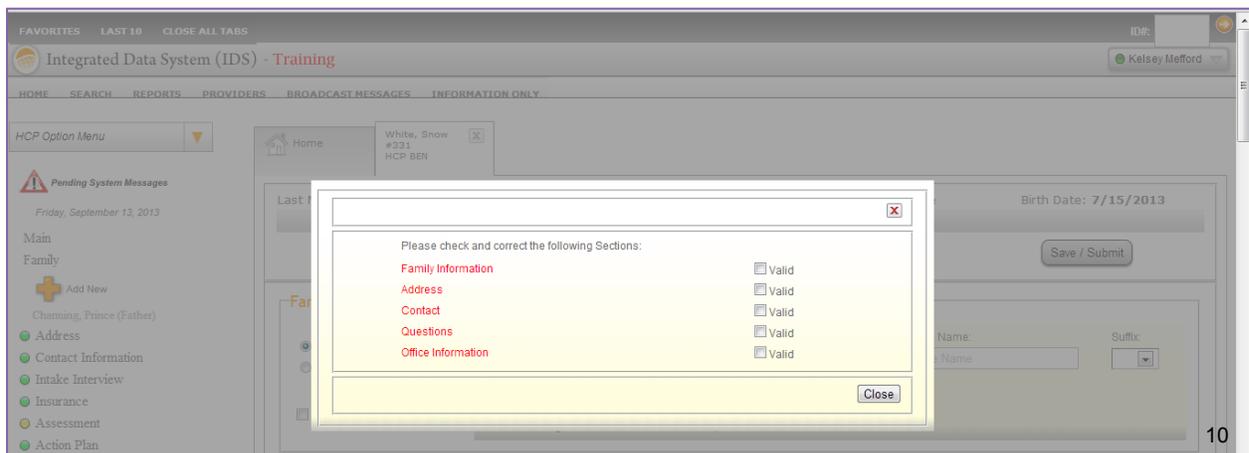
- The *Save/Update* feature allows the user to have the ability to enter pieces or parts of the Intake Interview and come back to it at a later time.



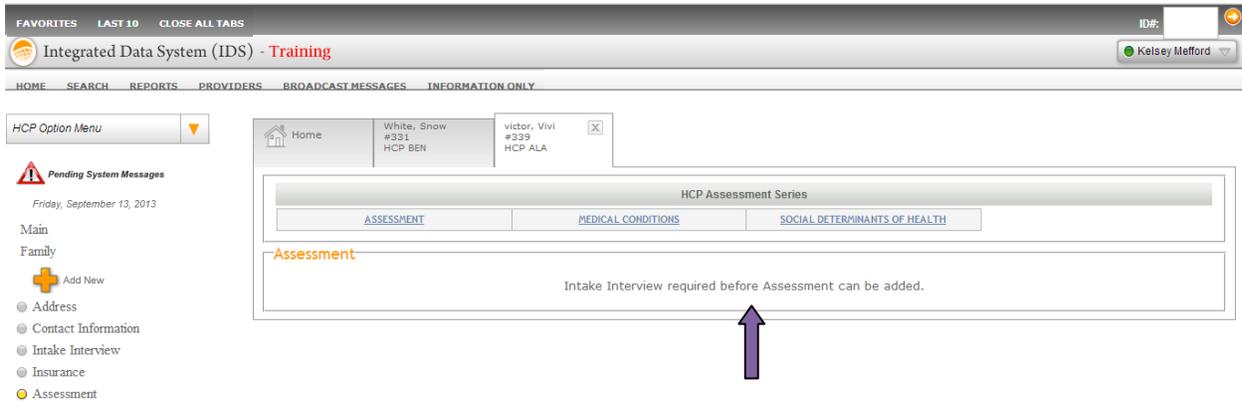
- The *Save/Submit* feature allows the user to officially submit a completed Intake Interview. All fields must be completed prior to selecting *Save/Submit*. Once *Save/Submit* has been selected, the Intake Interview will be locked for editing and no further changes can be made.



4. CDS now has a *Validate* feature. By using this feature, the user is able to review their progress in the data entry process and will be given a list of fields that are still required prior to the user selecting *Save/Submit*.

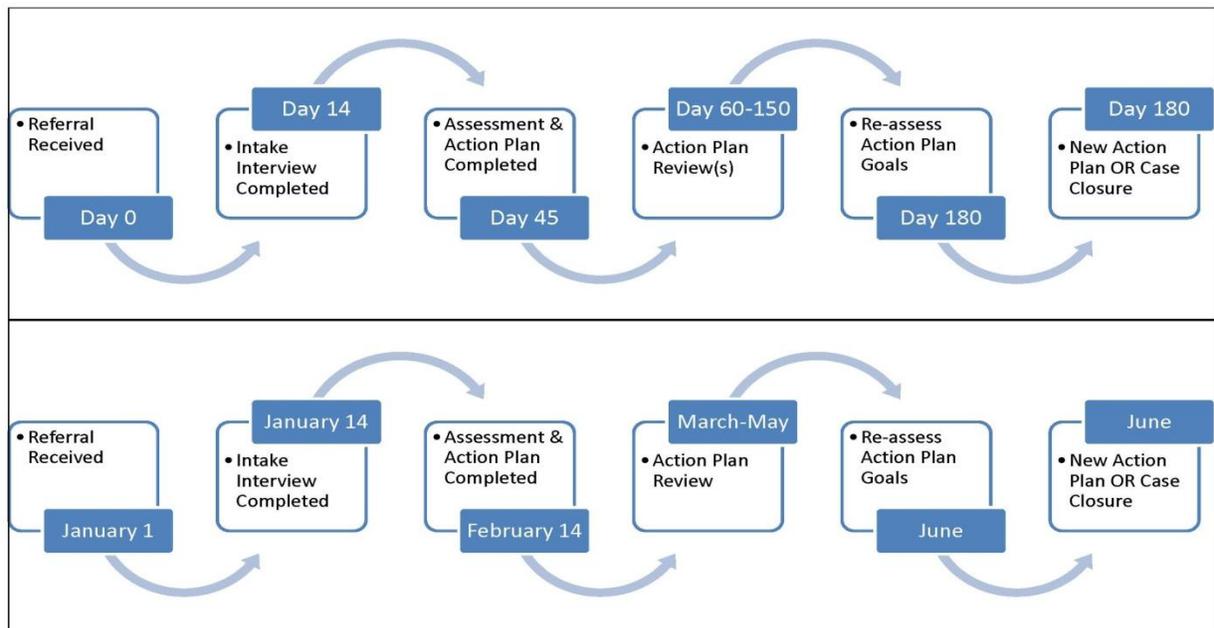


- A completed, *Submitted*, Intake Interview is required to be entered into CDS prior to CDS allowing the user to move on to the Assessment and Action Plan phase of the HCP Care Coordination Model.



- The overall HCP Care Coordination Model has not been changed.

### Timeline for Delivery of Service – Intake Interview



Timeline for Delivery of HCP Care Coordination Services

Ideally, the Intake Interview should be completed within 2 weeks of the initial referral or within 2 weeks of an Information Only call that has been determined to need HCP Care Coordination services.



**Care Coordination Intake Interview**

**Client Information:**

Last Name:  First Name:  Middle Name:  Suffix:  Gender:

Birth date:

**Family Member Information:**

Last Name:  First Name:  Middle Name:  Suffix:

**Relationship to Client:**

Mother  Friend  
 Father  Dept. of Human Services  
 Grandparent  Other  
 Sibling  Don't Know/Not Sure  
 Other Relative  Refused  
 Step-Parent  
 Foster-Parent  
 Check if Legal Guardian

**Language Spoken in Household (primary):**

<input type="checkbox"/> English	<input type="checkbox"/> Indonesian	<input type="checkbox"/> Romanian
<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Japanese	<input type="checkbox"/> Russian
<input type="checkbox"/> Arabic	<input type="checkbox"/> Karen	<input type="checkbox"/> Somali
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Korean	<input type="checkbox"/> Spanish
<input type="checkbox"/> Chinese (Mandarin)	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> French	<input type="checkbox"/> Nepali	<input type="checkbox"/> Other
<input type="checkbox"/> Hindi	<input type="checkbox"/> Polish	<input type="checkbox"/> Don't Know/Not Sure
<input type="checkbox"/> Hmong	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Refused

Interpreter Needed:  Yes  No

Language should indicate the primary language spoken in the household, not the specific language of the youth/child.

**Address Information:**

Primary Mailing Address:		Secondary Mailing Address:	
Street:		Street:	
City:		City:	
State:	Zip:	State:	Zip:
County:		County:	
Additional Information:		Additional Information:	

**Contact Information:**

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_  Check if preferred  
 (\_\_\_\_) \_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_  Check if preferred  
 E-Mail: \_\_\_\_\_@\_\_\_\_\_  Check if preferred



## Care Coordination Intake Interview

### Question

1. Do you have a place where you regularly take your [child/youth] for health care?

- Yes
- No
- Don't Know/Not Sure
- Refused

2. If your [child/youth] needed to see a specialist or medical provider, was seeing a provider a problem for any reason?

- Yes
- No
- Don't Know/Not Sure
- Refused

3. In your opinion, how is the overall communication and working relationships between all of the people who provide medical care and services to your child?

- Excellent
- Good
- Fair
- Poor
- Don't Know/Not Sure
- Refused

4. In your opinion, are you included in decisions made about [child/youth]'s health care?

- Always
- Sometimes
- Never
- Don't Know/Not Sure
- Refused

5. During the past 6 months, has [child/youth] gone to a hospital emergency room?

- Yes
- No
- Don't Know/Not Sure
- Refused

If yes, how many times in the past 6 months? # \_\_\_\_\_

6. Does [child/youth] currently have any public or private health insurance?

- Yes
- No [skip to question 9]
- Don't Know/Not Sure [skip to question 9]
- Refused [skip to question 9]

Places like a clinic or doctor's office where they know the child well and are familiar with the health history.

Drop-in clinics (such as Walgreens and Supermarkets) where the physician is unfamiliar with the child and health history is not considered a site for "regular" health care.

Did they have trouble getting an appointment or have to wait a long time to get one?

Does the primary care provider, therapists, specialists, etc talk to each other and share information?

7. Insurance type (select as many as apply)

<input type="checkbox"/> Medicaid → <input type="checkbox"/> CHP+ <input type="checkbox"/> Private Insurance <input type="checkbox"/> Tricare <input type="checkbox"/> Other <input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Refused	If Medicaid, select only one: <input type="checkbox"/> SSI <input type="checkbox"/> Waiver <input type="checkbox"/> HMO <input type="checkbox"/> Straight
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8. Does [child/youth]'s health insurance pay for all of the health services [he/she] needs?

Yes [skip to question 10]  
 No  
 Don't Know/Not Sure  
 Refused

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9. Does [child/youth] use any assistance, discount, or charitable programs that help pay for the services [he/she] currently needs?

Yes  
 No  
 Don't Know/Not Sure  
 Refused

---

10. What other supports or services do you need to manage your [child/youth]'s needs?

<input type="checkbox"/> Adult Education <input type="checkbox"/> Audiology <input type="checkbox"/> Child Care <input type="checkbox"/> Community Services <input type="checkbox"/> Dental <input type="checkbox"/> Developmental Screening <input type="checkbox"/> Early Intervention <input type="checkbox"/> Emotional Support <input type="checkbox"/> Employment <input type="checkbox"/> Family Leadership <input type="checkbox"/> Financial Assistance <input type="checkbox"/> HCP Care Coordination <input type="checkbox"/> HCP Specialty Clinic <input type="checkbox"/> Head Start	<input type="checkbox"/> Home Health Services <input type="checkbox"/> Hospital – Children's Hospital <input type="checkbox"/> Hospital – Other <input type="checkbox"/> Housing <input type="checkbox"/> Insurance <input type="checkbox"/> Legal Issues <input type="checkbox"/> Medical Provider – Specialty <input type="checkbox"/> Medical Supplies <input type="checkbox"/> Medication <input type="checkbox"/> Mental/Behavioral Health <input type="checkbox"/> Nutrition/Dietary <input type="checkbox"/> Other Public Health Services <input type="checkbox"/> Parent Education <input type="checkbox"/> Parent Support	<input type="checkbox"/> Primary Care/Medical Home <input type="checkbox"/> RCCO <input type="checkbox"/> Recreational Activities <input type="checkbox"/> Referral to Other County/Agency <input type="checkbox"/> Respite <input type="checkbox"/> School <input type="checkbox"/> Specialty Care <input type="checkbox"/> Support Group Services – All <input type="checkbox"/> Therapy – Occupational <input type="checkbox"/> Therapy – Physical <input type="checkbox"/> Therapy – Speech <input type="checkbox"/> Transition <input type="checkbox"/> Transportation <input type="checkbox"/> Vision <input type="checkbox"/> Other
--	---	--

Things like Shriners and Children's Charity Program. Consider programs that are specific to your community.

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The response categories are not intended to be read to the family: Instead, the question responses are there as a reminder of supports and services that families typically use. Allow the family to tell their story and check responses as appropriate.



**Care Coordination Intake Interview**

11. Has the family/referral source indicated a need for support in any of the following areas?

- Yes       No

If Yes, check the appropriate box(s) below:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Adult Education         | <input type="checkbox"/> Home Health Services           | <input type="checkbox"/> Primary Care/Medical Home       |
| <input type="checkbox"/> Audiology               | <input type="checkbox"/> Hospital – Children’s Hospital | <input type="checkbox"/> RCCO                            |
| <input type="checkbox"/> Child Care              | <input type="checkbox"/> Hospital – Other               | <input type="checkbox"/> Recreational Activities         |
| <input type="checkbox"/> Community Services      | <input type="checkbox"/> Housing                        | <input type="checkbox"/> Referral to Other County/Agency |
| <input type="checkbox"/> Dental                  | <input type="checkbox"/> Insurance                      | <input type="checkbox"/> Respite                         |
| <input type="checkbox"/> Developmental Screening | <input type="checkbox"/> Legal Issues                   | <input type="checkbox"/> School                          |
| <input type="checkbox"/> Early Intervention      | <input type="checkbox"/> Medical Provider – Specialty   | <input type="checkbox"/> Specialty Care                  |
| <input type="checkbox"/> Emotional Support       | <input type="checkbox"/> Medical Supplies               | <input type="checkbox"/> Support Group Services – All    |
| <input type="checkbox"/> Employment              | <input type="checkbox"/> Medication                     | <input type="checkbox"/> Therapy – Occupational          |
| <input type="checkbox"/> Family Leadership       | <input type="checkbox"/> Mental/Behavioral Health       | <input type="checkbox"/> Therapy – Physical              |
| <input type="checkbox"/> Financial Assistance    | <input type="checkbox"/> Nutrition/Dietary              | <input type="checkbox"/> Therapy – Speech                |
| <input type="checkbox"/> HCP Care Coordination   | <input type="checkbox"/> Other Public Health Services   | <input type="checkbox"/> Transition                      |
| <input type="checkbox"/> HCP Specialty Clinic    | <input type="checkbox"/> Parent Education               | <input type="checkbox"/> Transportation                  |
| <input type="checkbox"/> Head Start              | <input type="checkbox"/> Parent Support                 | <input type="checkbox"/> Vision                          |
|  |   | <input type="checkbox"/> Other                           |

12. Is anybody else providing care coordination services for [child/youth] at this time?

- Yes  
 No  
 Don’t Know/Not Sure  
 Refused

If yes, ask:

Who else is providing care coordination? (select as many as apply)

- Community Centered Board
- Early Intervention/Board of Community Education Services (BOCES)
- Family Voices Colorado
- Friend
- Hospital
- Medical Provider
- Other Local Public Health Agency
- Private Agency
- RCCO
- School
- Self or Family Member
- Other Community Partner
- Don’t Know/Not Sure
- Refused

Question 11, along with response categories, is not intended to be read to the family: It is for the interviewer to fill out based on what you’ve heard the family/referral source say thus far.

Question responses are there as a reminder of supports and services that families typically use. Allow the family to tell their story and check responses as appropriate.

13. Is the current amount of care coordination [child/youth] is receiving enough to meet most or all of your family's needs?

Yes  
 No  
 Don't Know/Not Sure  
 Refused

---

14. Does [child/youth] need HCP Care Coordination services?

Yes  
 No  
 Don't Know/Not Sure  
 Refused

**Office Information:**

Interviewer Name & Title:	Intake Interview – Method of Contact: <input type="checkbox"/> E-mail <input type="checkbox"/> Phone <input type="checkbox"/> Home visit <input type="checkbox"/> Other <input type="checkbox"/> Office visit
Date Interview Completed:	

Referral Taken By (Name & Title):	Referral Source:
Date of Referral:	Name: Phone: Fax: E-mail:

**Referral Source:** (select as many as apply)

<input type="checkbox"/> 211	<input type="checkbox"/> Friend	<input type="checkbox"/> Public Health Department
<input type="checkbox"/> BIAC	<input type="checkbox"/> HCP Specialty Clinic	<input type="checkbox"/> School
<input type="checkbox"/> Brochure	<input type="checkbox"/> Healthy Communities	<input type="checkbox"/> Specialty Provider
<input type="checkbox"/> Board of Community Education Services (BOCES)	<input type="checkbox"/> Hospital – Children's Hospital	<input type="checkbox"/> Support Group Services
<input type="checkbox"/> CICP	<input type="checkbox"/> Hospital - Other	<input type="checkbox"/> Website – CDPHE
<input type="checkbox"/> CHP+	<input type="checkbox"/> Human Services	<input type="checkbox"/> Website – LPHA
<input type="checkbox"/> Community Center Boards	<input type="checkbox"/> Individual Services Support Team	<input type="checkbox"/> Website – Other
<input type="checkbox"/> Community Partner	<input type="checkbox"/> Medical Provider – Clinic	<input type="checkbox"/> Work
<input type="checkbox"/> CRCSN Notification	<input type="checkbox"/> Medical Provider – Primary	<input type="checkbox"/> Don't Know/Not Sure
<input type="checkbox"/> Family Member	<input type="checkbox"/> Medical Provider – Specialty	<input type="checkbox"/> Refused
<input type="checkbox"/> Family Voices	<input type="checkbox"/> Medical Provider - Other	<input type="checkbox"/> Didn't Ask
	<input type="checkbox"/> Other Public Health Program	<input type="checkbox"/> Other

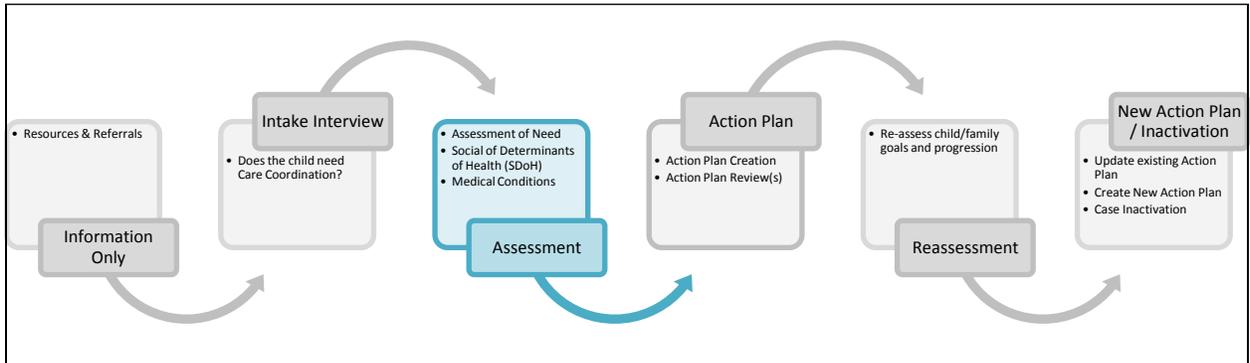
Did this proceed from the 'Information Only' process?       Yes       No  
Intake Interview stopped before completed?       Yes       No

Date Interview Completed' always refers to the date the actual interview took place, not the date the Intake was entered into CDS.

If at any time the family chooses to end the interview and there is no intent to come back to complete it, the HCP Care Coordinator should check indicate this by checking one of these boxes.

The HCP Care Coordinator should then enter what information was provided by the family into CDS (including checking this box).

## Assessment of Need



The 'Assessment' is the second core component of the HCP Care Coordination model. The Assessment provides an opportunity to explore, build, and strengthen the relationship with the family, as well as learn about and consider the child/youth's special health care needs and the family's concerns, strengths and goals. An initial Assessment must be completed for each child/youth that is new to HCP Care Coordination. This assessment is to be completed prior to creating an Action Plan and will be reviewed every six months until the child/youth no longer has need of care coordination services.

There are three (3) components to Assessing Need:

1. Care Coordination Assessment Form (Assessment)
2. Documenting Medical Conditions
3. Social Determinants of Health (SDoH) Worksheet

### The Assessment

#### Purpose

The HCP Care Coordinator interviews the family and records his/her findings on the Assessment. The Assessment is a tool used by the HCP Care Coordinator to guide the conversation through several domains & sub-domains in order to ascertain where the HCP Care Coordinator might be able to identify potential community resources, or provide a referral, coaching, and/or education.

#### FY14 Changes

1. New Columns: "Assessed and No Concern", and "Date Need Identified"
2. Track/Record "Method of Contact"
3. Columns Reordered

The screenshot shows the 'Care Coordination Assessment' form from the Health Care Program for children with Special Needs. The form includes fields for 'Last Name', 'First Name', and 'Date of Birth'. It also has sections for 'Date Assessment Completed', 'Assessment Completed By (Name & Title)', 'Family Member', 'Date Assessment Reviewed', and 'Assessment Reviewed By (Name & Title)'. A section for 'Assessment - Method of Contact' includes checkboxes for 'Home', 'Office Visit', 'Phone', and 'Other'. At the bottom, there is a table with columns for 'Family Strengths & Concerns', 'Assessed and No Concern', 'Date Need Identified', 'Priority for Action Plan', and 'Comments'. Three purple arrows point to the 'Assessed and No Concern', 'Date Need Identified', and 'Priority for Action Plan' columns, indicating the changes mentioned in the text.

As a reminder, the Assessment form can be modified; however, LPHAs are encouraged to always incorporate these domains:

- |                             |                        |                    |
|-----------------------------|------------------------|--------------------|
| • Family Strengths/Concerns | • Education            | • CYSCHN Therapies |
| • Insurance Type(s)         | • CYSHCN Medical       | • Basic Needs      |
| • CYSHCN Emotional          | • CYSHCN Developmental |                    |

*This tool is not intended to be read to the family: Instead, the tool is intended to serve as an opportunity to discuss and chart all of the health, educational, developmental, psychological, and socio-economic needs a family may have.*

As you talk through the domains and sub-domains, take notes regarding family strengths and needs. Check the “Priority for Action Plan” box if you think that the domain and/or sub-domain is a priority area. *Sub-domains checked here will later be prioritized with the family and the first one or two items should be placed on the initial Action Plan.*

Over time and through additional contact with the family, other needs may surface. Use the “Date Need Identified” box to document the date you discussed the sub-domain with the family. Check the “Priority for Action Plan” box if you determine, with the family, that the area should be placed on a future action plan.

**Medical Conditions and SDoH Worksheets**

In addition to completing the Assessment Form, you will also document the child/youth’s Medical Conditions and complete the SDoH worksheet.

**Medical Conditions**

***Purpose***

The Medical Conditions Form is a resource that is not required by the HCP Program but may help guide HCP Care Coordination activities and identification of potential resources and/or referrals. *Although not required, documentation in CDS will allow your agency to pull reports in the future that will better define the population you are serving.*

The document contains the child/youth’s name and date of birth, as well as a listing of common CYSHCN Medical Conditions. Each of these fields can be documented within CDS.

Health Care Program  
for children  
with Special Needs  
*Together we'll find the way.*

**CYSHCN Medical Conditions**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Select all that apply.**

<input type="checkbox"/> Allergies (severe)	<input type="checkbox"/> Fetal Alcohol Syndrome
<input type="checkbox"/> Arthritis or other joint problems	<input type="checkbox"/> Gastrointestinal problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Genitourinary problems
<input type="checkbox"/> Attention deficit disorder or attention deficit hyperactivity disorder (ADD or ADHD)	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Autism Spectrum Disorder (including Asperger’s disorder, pervasive development disorder)	<input type="checkbox"/> Hydrocephalus/anencephaly/microcephaly

## Social Determinants of Health

### Purpose

The Social Determinants of Health form consists of six (6) questions that can impact health outcomes. The answers to these questions should be discussed and documented during the assessment process. SDoH fields are required to be reported in CDS and should be used by the HCP Care Coordinator to help identify appropriate resources for the child/youth and family. Like the Medical Conditions Form, the SDoH document also contains the child/youth's name and date of birth.

Questions 3-4 on the (SDoH) Worksheet are used to calculate Federal Poverty Levels (FPL). The FPL is also used by HCP Specialty Clinic Coordinators to calculate sliding scale fees for Regional Rural Specialty Clinics.

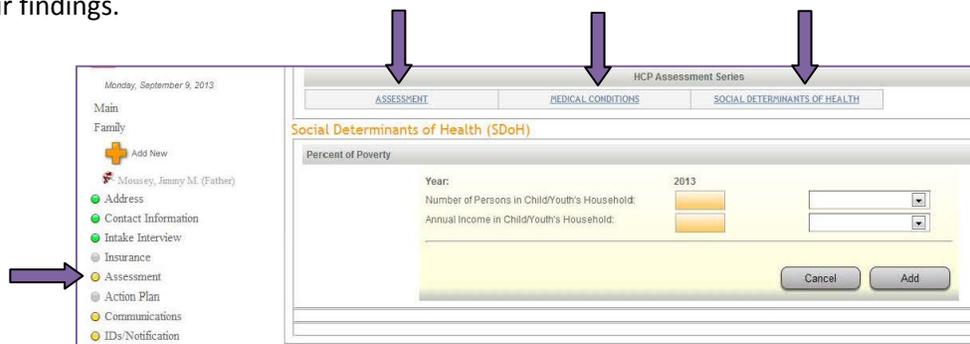
For FY14, CDS screens were designed to "mirror" paper forms to the greatest extent possible; in order to minimize data entry and to support the "minimum necessary" clause of HIPAA, some fields exist on paper that were intentionally not built into the CYSCHN data system.



1. Hispanic Ethnicity [of child/youth]: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Refused
2. Single parent household: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Refused
3. Number of persons in [child/youth]'s household: (Used to determine % FPL) # _____ <input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Refused
4. Annual income in [child/youth]'s household: (Used to determine % FPL) \$ _____ <input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Refused

### Documenting the Assessment process in CDS

Every child/youth who receives active HCP Care Coordination must have an Assessment on file (electronic or paper) which has been documented in CDS. Once you click the "Assessment" tab on the menu tree to the left of the screen, you will be taken to the following screen. Notice that there are now three (3) horizontal tabs as part of the HCP Assessment Series. Click through these tabs to document your findings.



**CDS data entry requirements for Assessment include:**

1. Date Assessment Completed
2. Assessment Completed by (name and title)
3. Method of Contact

The screenshot shows the 'Assessment' tab of the HCP Assessment Series form. It features a 'Date Assessment Completed' field with a date picker, an 'Assessment Completed By' dropdown menu, and a 'Method of Contact' section with radio buttons for E-mail, Home Visit, Office Visit, Phone, and Other. There are 'Close' and 'Add' buttons at the bottom right.

**CDS data fields for Medical Conditions include:**

1. Condition (matches list in form)
2. ICD9 Code (Category, Type and ICD9)

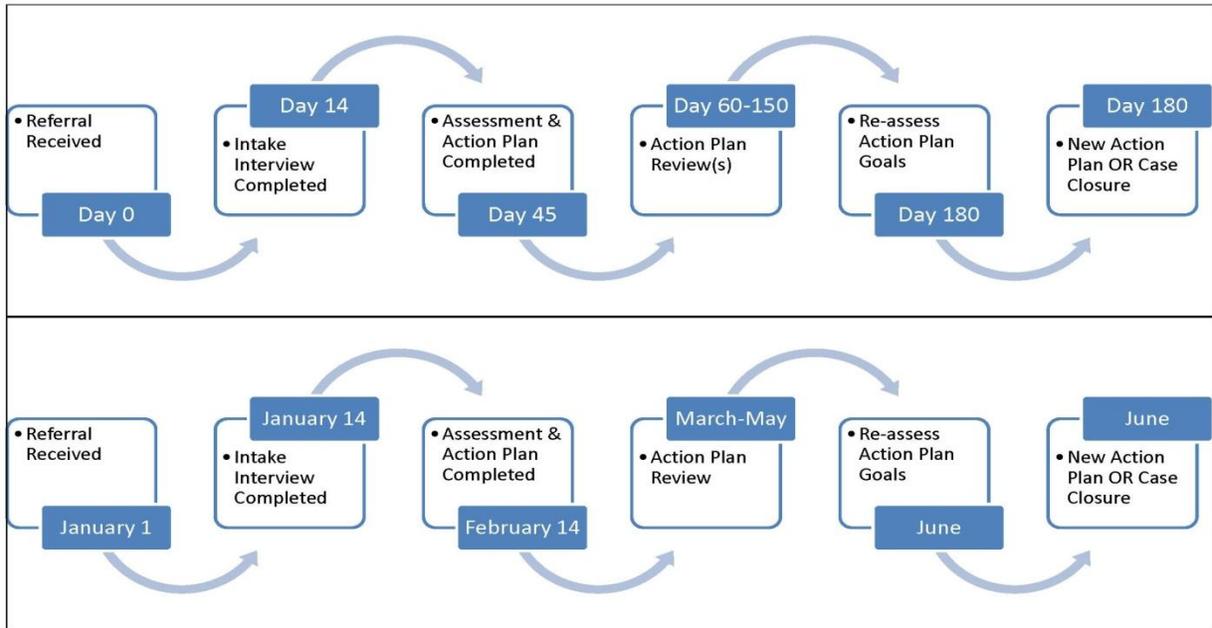
The screenshot shows the 'Medical Conditions' tab of the HCP Assessment Series form. It includes a 'Condition' dropdown menu and an 'ICD9 Code' section with fields for Category, Type, and ICD9, along with a search button. There are 'Close' and 'Add' buttons at the bottom right.

**CDS data entry requirements for SDoH include:**

1. Percent Poverty
2. General
3. Ethnicity

The screenshot shows the 'Social Determinants of Health (SDoH)' tab of the HCP Assessment Series form. It includes a 'Percent of Poverty' section with a text input field and an 'Add New' button. The 'General' section has dropdown menus for 'Single Parent Household' (set to 'No'), 'Age Range of Biological Mother (at child/youth's birth)' (set to '17 Years Or Older'), and 'Highest Education Level in Child/Youth's Household' (set to 'Dont know/Not Sure'). There is also an 'Add or Edit Hispanic Ethnicity' link. The 'Record Information' section shows 'Updated: 9/3/2013 3:20:00 PM' and 'Created: 9/28/2013 3:31:00 PM'. A 'Save' button is at the bottom right.

*Timeline for Delivery of Service - Assessment*



*Timeline for Delivery of HCP Care Coordination Services*

Ideally, the Assessment is completed within 30 days of the Intake Interview.



### Care Coordination Assessment

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Date Assessment Completed:

Date Assessment Reviewed:

Assessment Completed By (Name & Title):

Assessment Reviewed By (Name & Title):

Family Member:

Family Member:

Assessment – Method of Contact:  Home  Office Visit  Phone  Other

Family Strengths & Concerns	Assessed and No Concern	Date Need Identified	Priority for Action Plan	Comments
CYSHCN/Family Concerns				
Family Activities Together				
Other Children or Adults with Special Health Care Needs in Household				
Self-Advocacy Skills				
Health Literacy				
Community Support				
Cultural Health Beliefs				
Other				
<b>Insurance Type(s)</b>				
Medicaid				
CHP+				
SSI				
Straight				
Waiver				
Private				
Discount Programs				
Self-Pay				
Other				

Name and DOB are pre-populated in CDS

Required Documentation in CDS

Each blue row represents a "Domain" that should be discussed with the family

Each blue row represents a "Sub-Domain". The sub-domains are representative of common areas of discussion and serve as guides/reminders during the conversation.

Track/Record "Method of Contact" each time to create or update the Assessment



**Care Coordination Assessment**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

CYSHCN Medical	Assessed and No Concern	Date Need Identified	Priority for Action Plan	Comments
Dental				
Durable Medical Equipment/Modifications				
Home Health Services				
Medications				
Nutrition				
Vision				
Other				
<b>CYSHCN Developmental</b>				
Developmental Status				
Developmental Testing or Screenings				
Hearing				
Motor				
Speech				
Other				
<b>CYSHCN Emotional</b>				
CYSHCN's Social/Emotional Status				
CYSHCN's Relationship with Family				
Family's Relationship with CYSHCN				
Other				

**New Columns:**

- “Assessed and No Concern” - enter a date in this box if the sub-domain was discussed and determined NOT to be an area of concern.
- “Date Need Identified” – enter the date this item was discussed and determined to be an area of concern.
- “Priority for Action Plan” - check this box if it is determined that this sub-domain is a priority.

Priorities are determined in partnership with the family.



**Care Coordination Assessment**

Last Name: **JAMES** First Name: **JOHNNY** Date of Birth: 07 / 08 / 2000

CYSHCN Therapies	Assessed and No Concern	Date Need Identified	Priority for Action Plan	Comments
Behavioral				
Mental Health Specialists				
Occupation Therapy				
Physical Therapy				
Speech Language Pathology				
Vision				
Recreational, Massage, Developmental				
Other				
<b>Education</b>				
School Name/Grade				
Learning Style				
504 Plan				
Early Intervention Services (IFSP)				
Part B (IEP)				
Special Education				
Transition Plan		9/1		Mom concerned about johnny's self-care
Other				

SAMPLE

Use the comments area to make quick notes during your conversation with the family



## Care Coordination Assessment

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

Basic Needs	Assessed and No Concern	Date Need Identified	Priority for Action Plan	Comments
Clothing				
Employment				
Electricity				
Family Planning				
Food				
Income				
Housing				
Phone				
Other				

Know your community resources. Knowing your partners, eligibility requirements and community-based resources will help you identify potential resources and referrals for families.

Educate and coach families to increase self-sufficiency, skills/knowledge, and increase independence. Care coordination is not about the Care Coordinator doing everything for families ... everyone should have a role.



### CYSHCN Medical Conditions

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

**Select all that apply.**

<input type="checkbox"/> Allergies (severe)	<input type="checkbox"/> Fetal Alcohol Syndrome
<input type="checkbox"/> Arthritis or other joint problems	<input type="checkbox"/> Gastrointestinal problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Genitourinary problems
<input type="checkbox"/> Attention deficit disorder or attention deficit hyperactivity disorder (ADD or ADHD)	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Autism Spectrum Disorder (including Asperger's disorder, pervasive development disorder)	<input type="checkbox"/> Hydrocephalus/anencephaly/microcephaly
<input type="checkbox"/> Blood problems (such as anemia, sickle cell disease, hemophilia)	<input type="checkbox"/> Immune system disorder
<input type="checkbox"/> Brain injury (acquired)	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Brain injury (traumatic)	<input type="checkbox"/> Learning problems
<input type="checkbox"/> Cardiac defect	<input type="checkbox"/> Limb reduction anomalies
<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Mental health problems – diagnosed (such as depression, bipolar disorder, personality disorder, schizophrenia)
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Mental health/behavioral problems - undiagnosed
<input type="checkbox"/> Chromosomal disorders & genetic syndromes (other than Down syndrome)	<input type="checkbox"/> Metabolic disorders
<input type="checkbox"/> Chronic ear infections	<input type="checkbox"/> Migraines or frequent headaches
<input type="checkbox"/> Circulatory system problems (excluding cardiac problems)	<input type="checkbox"/> Movement disorders (such as Tourette syndrome, tics)
<input type="checkbox"/> Cleft lip and/or palate	<input type="checkbox"/> Musculoskeletal disorders
<input type="checkbox"/> Congenital anomalies	<input type="checkbox"/> Neoplasms - benign
<input type="checkbox"/> Connective tissue disorders (such as osteogenesis imperfecta)	<input type="checkbox"/> Neoplasms - malignant
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neurofibromatosis
<input type="checkbox"/> Degenerative neuromuscular disorders (including muscular dystrophy)	<input type="checkbox"/> Neurological disorders
<input type="checkbox"/> Developmental delay - cognitive	<input type="checkbox"/> Newborn Intensive Care Unit (NICU) graduate
<input type="checkbox"/> Developmental delay – global	<input type="checkbox"/> Obesity
<input type="checkbox"/> Developmental delay - motor	<input type="checkbox"/> Prematurity (<37 weeks by date)
<input type="checkbox"/> Developmental delay - speech	<input type="checkbox"/> Respiratory conditions
<input type="checkbox"/> Developmental disability	<input type="checkbox"/> Skin & subcutaneous tissue problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Spina bifida
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Spinal disorders
<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Spinal injuries
<input type="checkbox"/> Endocrine disorder (other than diabetes)	<input type="checkbox"/> Trouble hearing/deafness
<input type="checkbox"/> Epilepsy or seizure disorder	<input type="checkbox"/> Trouble seeing/blindness
<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Unknown/other conditions

ICD-9 Codes (Optional)

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The more conditions, the higher the complexity.

This list is representative of common conditions of CYSHCN; the list is not exhaustive.

Agencies that choose to document ICD codes may do so on this form and/or within CDS.



**Social Determinants of Health (SDoH)**

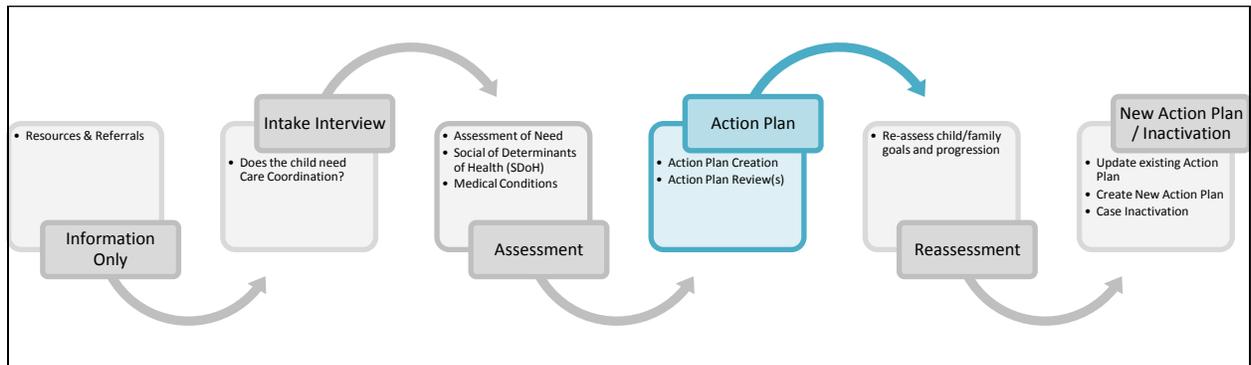
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

<p>1. Hispanic Ethnicity [of child/youth]:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know/Not Sure</p> <p><input type="checkbox"/> Refused</p>								
<p>2. Single parent household:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know/Not Sure</p> <p><input type="checkbox"/> Refused</p>								
<p>3. Number of persons in [child/youth]'s household: (Used to determine % FPL)</p> <p># _____</p> <p><input type="checkbox"/> Don't Know/Not Sure</p> <p><input type="checkbox"/> Refused</p>								
<p>4. Annual income in [child/youth]'s household: (Used to determine % FPL)</p> <p>\$ _____</p> <p><input type="checkbox"/> Don't Know/Not Sure</p> <p><input type="checkbox"/> Refused</p>								
<p>5. Highest education level in [child/youth]'s household:</p> <table border="0"> <tr> <td><input type="checkbox"/> 8<sup>th</sup> Grade or Less</td> <td><input type="checkbox"/> Some College</td> </tr> <tr> <td><input type="checkbox"/> Some High School</td> <td><input type="checkbox"/> College Graduate</td> </tr> <tr> <td><input type="checkbox"/> High School Graduate</td> <td><input type="checkbox"/> Don't Know/Not Sure</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Refused</td> </tr> </table>	<input type="checkbox"/> 8 <sup>th</sup> Grade or Less	<input type="checkbox"/> Some College	<input type="checkbox"/> Some High School	<input type="checkbox"/> College Graduate	<input type="checkbox"/> High School Graduate	<input type="checkbox"/> Don't Know/Not Sure		<input type="checkbox"/> Refused
<input type="checkbox"/> 8 <sup>th</sup> Grade or Less	<input type="checkbox"/> Some College							
<input type="checkbox"/> Some High School	<input type="checkbox"/> College Graduate							
<input type="checkbox"/> High School Graduate	<input type="checkbox"/> Don't Know/Not Sure							
	<input type="checkbox"/> Refused							
<p>6. Age range of biological mother [at child's birth]:</p> <p><input type="checkbox"/> 16 years or younger</p> <p><input type="checkbox"/> 17 years or older</p> <p><input type="checkbox"/> Don't Know/Not Sure</p> <p><input type="checkbox"/> Refused</p>								

Questions 3 & 4 are used to calculate % Federal Poverty Level.

Assessing the socio-economic status is important: socio-economic status impacts health outcomes.

## Action Plan



### Purpose

A written 'Action Plan' is the third core component of the HCP Care Coordination model. The Action Plan is intended to be a family-friendly, take-away document and is developed in partnership with the child/youth, their family, the HCP Care Coordinator, the child/youth's primary care provider and any other ancillary service providers when appropriate. The HCP Care Coordinator must document a written Action Plan for each child/youth and their family who is receiving active care coordination.

As a reminder, the Action Plan document can be modified; however, LPHAs are encouraged to always incorporate the following:

- Overarching Goal Statement
- 1 – 2 Care Coordination Goals, including desired outcomes
- Next Steps (detailed)
- Person(s) responsible
- Target Date
- List of priorities to be addressed at a later time

### FY14 Changes

For FY14 the Action Plan will always contain the HCP Goal that a "Family will be confident in coordinating and advocating for their child's healthcare needs". All HCP Care Coordination goals and activities should support this overarching goal. Action Plans will also be pre-populated in CDS and available for download to a Word document. This configuration will allow HCP Care Coordinators to prepare written Action Plans and add to the plans as needed. Fields that will pre-populate include:

- First Name / Last Name
- Date of Birth
- Three potential goals, based on results of questions 1, 8 and 10 of the Intake Interview. Those questions and resulting goals are:
  - **Question 1:** Do you have a place where you regularly take your [child/youth] for health care? **Action Plan Goal:** [Child/Youth] will have a primary care provider and medical home for all of his/her regular health needs.

- **Question 8:** Does [child/youth’s] health insurance pay for all of the health services [he/she] needs? **Action Plan Goal:** Family, along with their Care Coordinator, will determine the availability of additional resources to help meet needs.
- **Question 10:** What other supports or services do you need to manage your [child/youth]’s needs? **Action Plan Goal:** Family demonstrates ability to identify and obtain resources necessary for management of [child/youth]’s needs.

***Why a written Action Plan?***

The use of a written action plan is a family-centered practice that supports “proactive, planned and comprehensive care coordination”.

There are several outcomes related to the use of an Action Plan:

- children/youth and their families develop self-care skills
- decreased duplication of services
- increased family self-sufficiency
- development of cross-organizational relationships

To achieve such outcomes, Action Plan goals should always be written with a family and not for the family and documented on the Action Plan. Goals should developed based on information obtained in the intake interview and assessment and participants should each leave with a clear understanding of their role in reaching identified and prioritized goals. Next steps designed to help the family understand what needs to be done, and by whom, in order to achieve that goal.

The HCP Care Coordinator must review and update the Action Plan as frequently as needed in order to help the child/youth and their family achieve or make progress on established goals.

***How do I support a child/youth’s progress through an Action Plan?***

A HCP Care Coordinator can support achievement of Action Plan goals by:

- identifying potential community resources
- providing referrals for services and or resources
- prioritize – with the child/youth and their family – no more than 1 or 2 goals at a time
- coaching, and/or educating families
- tracking referrals and progress
- setting regular progress check-ins in order to build relationship through contact – accomplish more within the new focused approach

***Reaching Our Goals – Where to now?***

HCP Care Coordinators should begin preparing families from the very start of services that the end goal is for the family to become self sufficient and rely increasingly less on care coordination.

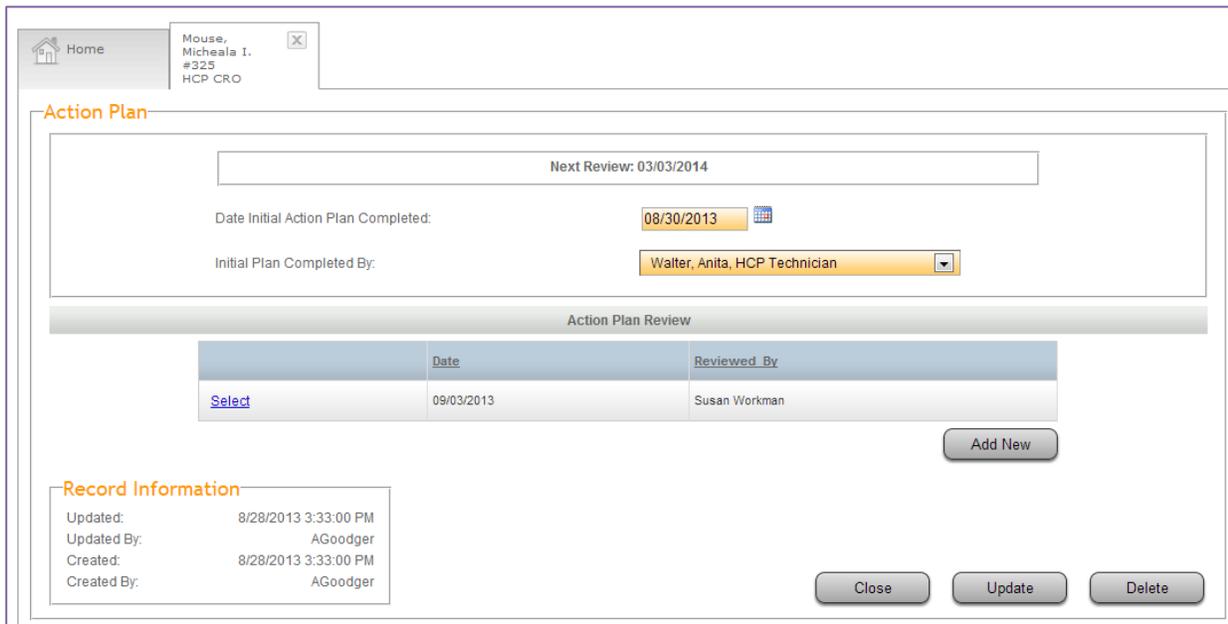
If all goals have been met, and no other priority areas can be identified, the child/youth should be discharged from HCP Care Coordination and marked Inactive in CDS. We call this case inactivation.

If there are additional priority areas or if new areas are identified through reassessment, the HCP Care Coordinator should work with the child/youth to prioritize the new areas and create new goals. These new priority areas and goals should be documented on a new Action Plan and the process begins again.

**Documenting in the CYSHCN Data System (CDS)**

Every child/youth who receives active HCP Care Coordination must have an Action Plan on file (electronic or paper) which has been documented in CDS.

Action Plans are created, viewed (date and Care Coordinator only), and updated on the ‘Action Plan’ screen. HCP Care Coordinators should document reviews of Action Plans until goals on an Action Plan are met.



Once goals are met, if new goals are identified and prioritized, the HCP Care Coordinator should add a new Action Plan and review as described before.

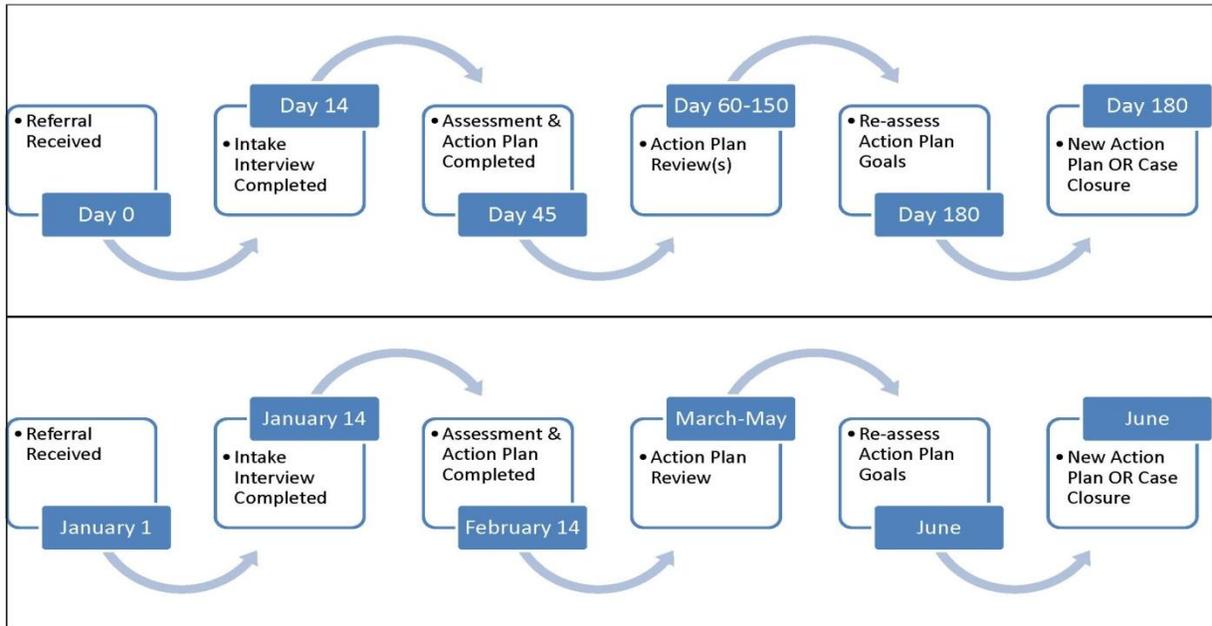


**CDS data entry requirements for Action Plan include:**

1. Date Action Plan Completed and/or Date Action Plan Review Completed
2. Assessment Completed by (name and title)

Action Plans can be populated from this screen. A populated Action Plan can also be downloaded to Word or PDF from the Reports tab. Documents downloaded in Word can be edited, saved and printed.

*Timeline for Delivery of Service - Action Plan*



*Timeline for Delivery of HCP Care Coordination Services*

Ideally, the Action Plan is created within 45 days of the Intake Interview. Progress towards meeting goals identified on the action plan (or completion of goals) should aim to be reached between day 60-150 (month two-five).



## Care Coordination Action Plan

Insert Your Logo Here

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ }  
 Date Action Plan Completed: \_\_\_\_\_  6 Month Review Completed Review Date: \_\_\_\_\_ }  
 Family Member: \_\_\_\_\_ Phone #: \_\_\_\_\_ }

**HCP Goal:** Family will be confident in coordinating and advocating for their child's health care needs.

<b>GOAL #1</b> <i>What is it that the family/child wants or needs? Include goal statement and desired outcome.</i>			
<b>Next Steps:</b> <i>List action/ interventions that will help achieve this goal.</i>			
	<b>Person(s) Responsible</b>	<b>Target Date</b>	<b>Complete Date</b>
a.			
b.			
<b>GOAL #2</b> <i>What is it that the family/child wants or needs? Include goal statement and desired outcome.</i>			
<b>Next Steps:</b> <i>List action/ interventions that will help achieve this goal.</i>			
	<b>Person(s) Responsible</b>	<b>Target Date</b>	<b>Complete Date</b>
a.			
b.			

**CDS Report**  
 CDS will auto-fill this area. Care Coordinators can export a savable and printable WORD document.

**CDS Documentation**  
 CDS will auto populate up to 3 pre-determined goals, based on the answers entered for questions 1, 8, and 10 in the Intake Interview.

Action Plan Date and Review Date are required.

**Goals**  
 We recommend having no more than 2-3 goals at a time. Write S.M.A.R.T. goals.

**Next Steps**  
 This section includes information to help the family achieve their goals.

**Persons Responsible**  
 Identify who is responsible, including co-responsibilities: Family (child/youth + parent), Parent, Youth, Care Coordinator, etc.

**Target Date**  
 Be realistic & follow-up regularly.

<b>GOAL #3</b> <i>What is it that the family/child wants or needs? Include goal statement and desired outcome.</i>			
<b>Next Steps:</b> <i>List action/ interventions that will help achieve this goal.</i>			
	<b>Person(s) Responsible</b>	<b>Target Date</b>	<b>Complete Date</b>
a.			
b.			

Other priority areas that the Family/[child/youth] would like to visit between now and the 6 month review:

1	
2	
3	

I participated in the development of and agree with the above Child/Family Action Plan. \_\_\_\_\_ Date: \_\_\_\_\_  
 Copy to: Family / Copy to: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 HCP Care Coordinator: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Other Priority Areas**

List additional concerns/needs identified during the intake interview or assessment that weren't prioritized into the above 2-3 goals.

During the Six-Month Review (or sooner), the care coordinator should discuss these other priority areas with the family and determine if they are still and priority.

**Family Centered Approach**

Always work with the family to prioritize goals, including any newly identified concerns.

Avoid use of jargons and acronyms. Keep the family at the center of your work.

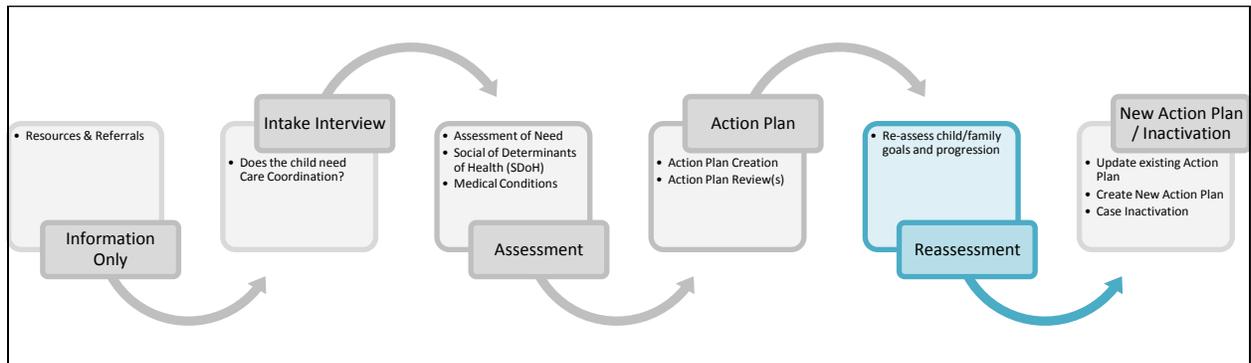
**Copy to Family**

Be clear with directions, expectations, timelines and persons responsible.

**Copy to**

any other relevant providers/agencies working with the family, according to your agency HIPAA policies.

## Six-Month Review



### Purpose

The six-month review is the fourth component of the HCP Care Coordination model. HCP Care Coordinators must complete a six-month review of a child/youth's progression through the HCP Care Coordination model. This reassessment is a comprehensive review of the activities that have commenced during this period.

1. A review of strengths and concerns should be completed by reviewing the child/youth's most recent Assessment Form and Action Plan and should occur after any of the following events:
  - a. Child/youth and their family's situation or conditions change
  - b. Child/youth and family have achieved the established goals, as identified on the written Action Plan
  - c. Six months has elapsed since the last assessment
2. The six-month review should result in one of the following activities or outcomes:
  - a. Identify barriers to achieving established goals and updated the Action Plan for continued progress
  - b. Identify new priorities and goals resulting in the creation of a new Action Plan
  - c. Case Inactivation

A major benefit of the six-month review is the opportunity for the HCP Care Coordinator to assess the situation with the family:

- Has there been follow through on the part of responsible parties?
- Have goals been met?
- What barriers have the child/youth and their family come up against, preventing them from achieving their goals?

The six-month review also provides an opportunity to assess the appropriateness of the goal(s), modify the goal(s) if needed, and try again. If a family has not accomplished their goals, nothing new should be added to their plan without careful consideration and consideration. At this time, the HCP Care Coordinator may need to help the family re-prioritize goals, and identify new resources and or goals. An Action Plan should never have more than one or two goals at a time. If there are additional areas of concern, or areas identified by the family as a priority, the HCP Care Coordinator should work with the

family to prioritize the goals, set deadlines, and revisit goals further down the list as short term goals are met.

### Documenting in the CDS

Every child/youth who receives active HCP Care Coordination must have a Six-Month Review on file (electronic or paper) for every consecutive six months that the child/youth is being actively care coordinated. The Reviews must be documented in CDS. This also includes documenting a consecutive Review of the Action Plan.

### CDS data entry requirements for Six-month review include:

1. Date Re-assessment Completed
2. Re-assessment Completed by (name and title)
3. Method of Contact

The screenshot displays the 'HCP Assessment Series' form in a web-based interface. At the top, there are tabs for 'ASSESSMENT', 'MEDICAL CONDITIONS', and 'SOCIAL DETERMINANTS OF HEALTH', with 'ASSESSMENT' currently selected. Below the tabs, the 'Assessment' section contains the following fields:

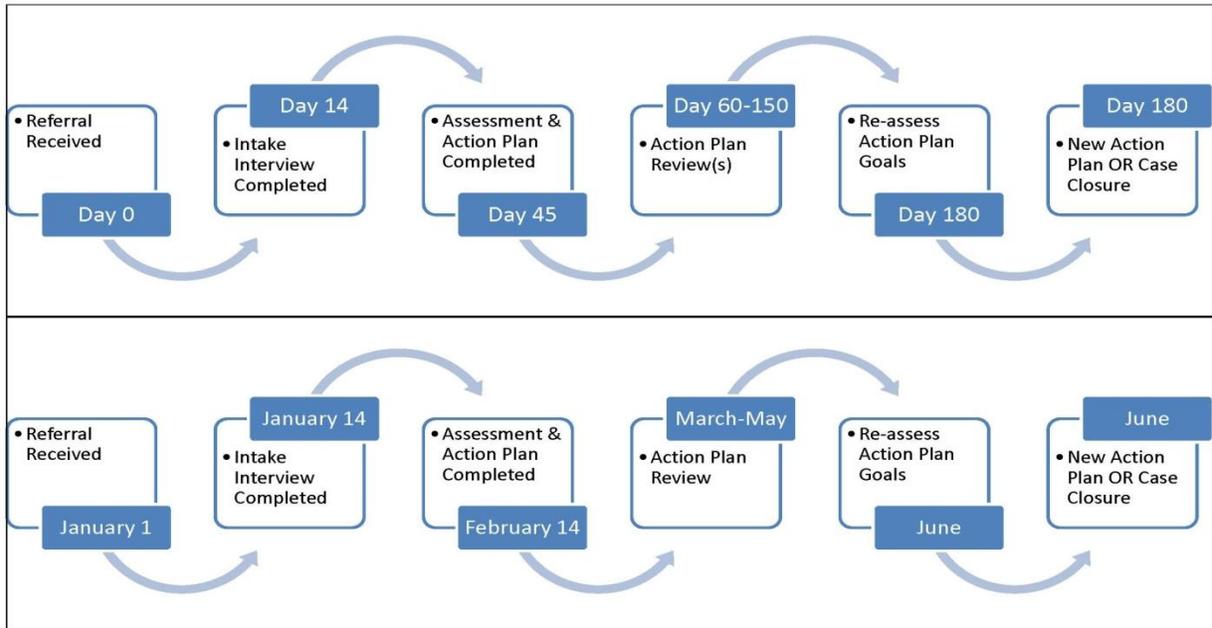
- Date Assessment Completed:** A date picker showing 08/20/2013.
- Assessment Completed By:** A dropdown menu showing 'Oswald, Rebecca, Nu'.
- Method of Contact:** Radio buttons for 'E-mail', 'Home Visit' (selected), 'Office Visit', and 'Phone'.

Below this is the 'Assessment Review Detail' section, which includes:

- Date Assessment Reviewed:** An empty date picker.
- Assessment Reviewed By:** An empty dropdown menu.
- Method of Contact:** Radio buttons for 'E-mail', 'Home Visit', 'Office Visit', and 'Phone'.

At the bottom right of the form, there are two buttons: 'Close' and 'Add'.

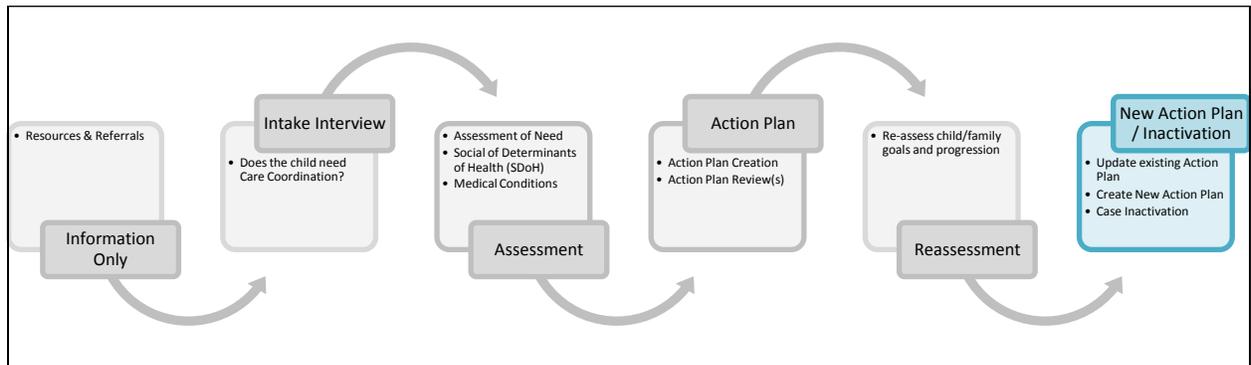
*Timeline for Delivery of Service – Six-Month Review*



*Timeline for Delivery of HCP Care Coordination Services*

The Six-month review should occur six months after the date the client was initially referred to HCP Care Coordination.

## Case Inactivation



### Purpose

The fifth core component of HCP Care Coordination is 'Inactivation'. After the six-month review, if it is determined that all priorities and goals have been achieved by the family and no further priorities or goals are identified, the HCP Care Coordinator and family should consider Inactivation. It is important that all parties understand that the family can return to HCP Care Coordination at any time, should the need arise.

Questions to ask when considering Inactivation:

- Does child/youth need the intensity of services HCP Care Coordination provides?
- Can care coordination activities be transitioned to the child/youth's primary care provider or another community-based agency?

Clients not receiving active care coordination must be inactivated in CDS. Active care coordination is defined as a child/youth moving through the HCP Care Coordination model and having a current Action Plan.

HCP Summary	
Intake Interview Completed:	None
Assessment Completed:	None
Assessment Reviewed:	None
Action Plan Completed:	None
Action Plan Reviewed:	None
Six Month Review Due Date:	None

FAVORITES LAST 10 CLOSE ALL TABS ID#: [ ]

Integrated Data System (IDS) - Training Kelsey Mefford

HOME SEARCH REPORTS PROVIDERS BROADCAST MESSAGES INFORMATION ONLY

HCP Option Menu

**Pending System Messages**  
Friday, September 13, 2013

Main  
Family  
Add New  
Address  
Contact Information  
Intake Interview  
Insurance  
Assessment  
Action Plan  
Communications  
IDs/Notification

HCP

Home White, Snow #331 HCP BEN victor, Vivi #339 HCP ALA

**Client**

Last Name: victor First Name: Vivi Middle Name: Suffix: Gender:   
 AKA Last Name: AKA First Name: AKA Middle Name:   
 Birth Date: 09/03/2013 Hispanic Ethnicity: Active:  Yes  No

**Record Information**

Updated: 9/13/2013 12:10:00 PM  
 Updated By: kmefford  
 Created: 9/13/2013 12:10:07 PM  
 Created By: kmefford

Cancel Update

FAVORITES LAST 10 CLOSE ALL TABS ID#: [ ]

Integrated Data System (IDS) - Training Kelsey Mefford

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Home White, Snow #331 HCP BEN victor, Vivi #339 HCP ALA

**Client**

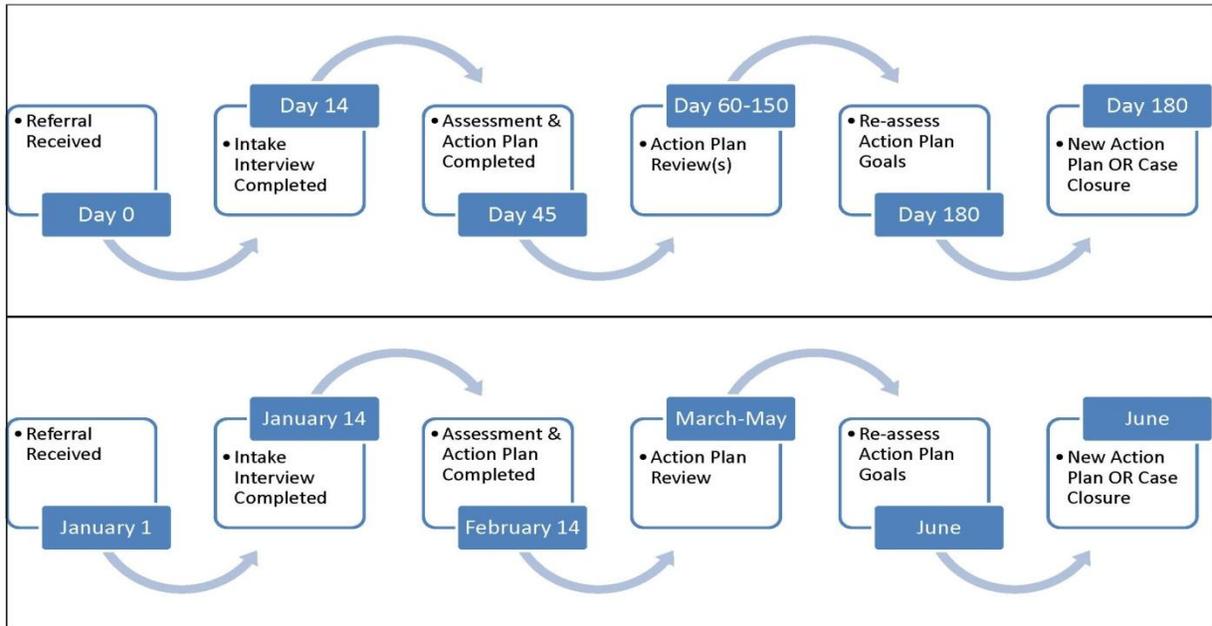
Last Name: victor First Name: Vivi Middle Name: Suffix: Gender:   
 AKA Last Name: AKA First Name: AKA Middle Name:   
 Birth Date: 09/03/2013 Hispanic Ethnicity: Active:  Yes  No  
 Inactive Reason: [ ]

**Record Information**

Updated: 9/13/2013 12:10:00 PM  
 Updated By: kmefford  
 Created: 9/13/2013 12:10:07 PM  
 Created By: kmefford

Cancel Update

*Timeline for Delivery of Service – Case Inactivation*



*Timeline for Delivery of HCP Care Coordination Services*

At the six-month review, if it is determined that all priorities and goals have been achieved by the family and no further priorities or goals are identified, the HCP Care Coordinator and family should consider Inactivation.