CHQC MASSACHUSETTS CHILD HEALTH QUALITY COALITION

Care Coordination Strengths and Needs Assessment: Recommendations for a Structured Tool

The **MA Child Health Quality Coalition (CHQC) Care Coordination Task Force** has been working to develop strategies to improve and to measure the effectiveness of care coordination services delivered to Massachusetts children. The Task Force started by defining a set of **Key Elements** of high-performing pediatric care coordination. Subsequently, it has been testing implementation of the key components in a range of projects.

One identified priority for ensuring effective care coordination that has emerged from this implementation testing is the **use of a structured tool for completing a care coordination needs assessment with the family** (see Domain #1 of the Key Elements Framework). To support practices and programs looking to adopt such a tool, a small working group of care coordinators, case managers, family voices, and providers was convened to develop recommendations for a structured needs assessment tool (see working group members on p. 4).

Key recommendations:

While recognizing that every application will have different uses and strategies for their care coordination needs assessment, the working group identified a set of high-level domains that should be included on every structured tool. These comprise three key sections for the needs assessment tool:

A. **Demographics/child & family strengths and needs**
   5 domains: basic information, child/adolescent strengths, issues/concerns, family assets/stressors, consents/confidentiality

B. **Help Needed by domain (to be supplemented by checklists/examples/scripts)**
   6 domains: medical, behavioral, social, educational, financial/insurance, other (housing/ environmental/legal/etc)**.**

C. **Care Coordination *Action Plan***
   5 domains (for each CC need identified): action, goal, person responsible, time frame, status
   (A *Care Coordination* Action Plan differs from, but aligns with, a *Clinical* Action Plan. Items in the clinical plan may generate a Care Coordination Action Plan to ensure referrals and follow-up communication.)

Tool template:

The CHQC working group's recommendations have been embedded into a **Care Coordination Strengths and Needs Assessment Tool** template. Those engaged in improving care coordination services are encouraged to **adapt this tool** to meet the needs of their specific projects and practice environments, while working toward the crucial step of having a structured assessment process that ensure that all important issues are addressed.

Approaches when using the standardized tool:

Using a standardized tool for assessing care coordination strengths and needs is critical to ensure that important items are not missed. However, it is similarly important to understand that every patient and family is different, that the *approach* to gathering input on their strengths and needs and goals may need to be very different and that it will change over time. Thus, the best care coordination needs assessments will arise from ongoing partnerships between families and providers. The working group members therefore shared their vision for using a structured tool within a broader context, addressing some of the following issues:

- The needs assessment process is about **ongoing engagement**, **building a trusting relationship over time**. It is important not to view the needs assessment as a single time activity, but to recognize that **family circumstances are fluid**, what you may learn about their situation at one point can change over time. Expect input to evolve as conditions change and the relationship strengthens.

- The goal is to use a structured tool to ensure that key medical, behavioral, social and environmental needs are all touched upon and that an achievable Action Plan results from the needs assessment. But it is crucial to think through ***how*** **questions are asked** depending on each child/adolescent and family's circumstances. **Various approaches and adaptations** are needed based on family learning styles, communication preferences, health and health system literacy, and cultural perspectives, especially when discussing sensitive information.

- **Look for ways to promote transparency about the care coordination process**. It is not easy to ensure that families get the care coordination services they need. Look for ways to improve families' understanding of team roles to improve navigating the health care system. One priority is to identify a primary person the family can call for help – their ***care integrator*** – recognizing that for CYSHCNs this may be difficult, given the large numbers of providers they are seeing.

- A **prioritization process** may be required when developing the action plan for children with complex medical/behavioral conditions, identifying the most crucial issues to meet urgent short-term needs but also reflecting on priority care coordination services that will make the most difference in the long run.

Implementation perspectives:

A number of lessons learned have emerged from projects testing use of a structured care coordination strengths and needs assessment tool as part of broader efforts to develop an integrated care planning process. Distinguishing how the care coordination needs assessment differs from, but integrates with, clinical care assessments and planning is crucial. Clinical assessments by the physician translate into accompanying needs for care coordination services, which need to be integrated with assistance for families in accessing social support services. The Needs Assessment can be one vital component of the overall plan.

Lessons from a set of child-serving practices that participated in Massachusetts' CHIPRA Medical Home Learning Collaborative about how to integrate care coordination needs assessments and services into practice-based workflows can be found in the report **Improving Care Coordination Services in Pediatric Primary Care**, and include:

- Use small tests of change to refine the structured tool with patients
- Leverage pre-visit or intra-visit contacts with youth and families to collect information about the patient's and family's needs for care coordination.
- Pull information from registration/intake forms when possible.
- Process mapping can identify potential Electronic Health Record adaptations that may facilitate the process.
- Include updates to the care coordination needs assessment as part of routine updates to the care plan.
- Ensure the patient/family is provided with one designated care facilitator, a key contact to call if they have follow-up questions.

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Recommended Elements for a Structured Care Coordination Needs Assessment Tool

(See the Care Coordination Strengths and Needs Assessment Tool template for additional detail)

Section A: Demographics/Child & Family Strengths and Needs

Basic Information:

- Name (and what they prefer to be called), DOB, other identifiers
- Parent(s)/Guardian/Siblings
- Insurance
- Accommodations needed for visits
- Diagnosis and/or reason for referral, referral source
- Diagnosis &/or reason for referral, referral source

Child's strengths: *When patient is an adolescent, questions should be asked to them directly

- *What would you like us to know about your child/youth?*
- *What does he/she do well? Like? Dislike?*

Issues/concerns:

- *When it comes to your child, what matters most to you right now? Are there any form/ letters to be completed?*
- Priorities to be addressed TODAY
- Recent changes (incl new meds, ED visits/hospitalizations, injuries/complications since last visit?)

Family assets/stresses:

- *Who do you draw on for support in the time of need?*
- *Do you have concerns about not having a support system?*
- *What would you like us to know about you/your family?*
- *Are there any family problems/concerns that might affect your child?*

See sample checklists (eg separation/divorce, death/illness, work issues, substance abuse, violence exposures, siblings)

Consents:

- Any consent forms that need to be completed; permission to provide services, facilitate communication
- Identify information youth/family is NOT comfortable sharing

Section B: Help Needed by Domain

Medical/health care:

- Referrals needed, medications, functional status, self-care, DME, managing special health problems (growth/nutrition, sleep, etc)
- Reminders to include assessment of oral health needs
- Address Transition to Adult Care needs when patient age warrants

Behavioral:

- Help managing behavioral issues, meeting child's emotional needs
- Identify behavioral issues/risky behaviors as barriers to care
- For adolescent-age youth, address drugs or alcohol abuse and other risk-taking behaviors

Social:

- Making/keeping friends, family support network/caregiver needs, family issues (siblings, divorce, etc), parenting groups/ recreational programs/other community resources, domestic violence shelters, counseling services

Educational:

- Learning/school performance, IEP/504 plans/ADA/Individual Health Plans at school, educational advocates/lawyers, literacy, ESL, GED, tutoring, after-school pgm
- Make connections between school issues and mental health issues (home schooling, extended absences, home tutoring for suspensions… have to separate from medical reasons for absences
- Any release paperwork needed for school communications?

Financial:

- Understanding insurance, helping paying for things insurance doesn't cover, potential social service programs (disability, food stamps, WIC, child care/housing/transportation subsidies)
- Dental insurance warrants special consideration

Other (housing/environmental/legal/etc):

- Food, Housing, Independent Living, Utilities, Immigration, Transportation, Guardianship, Other Legal Issues

Section C: Care Coordination *Action Plan*

- **Action**
- **Goal**
- **Time Frame**
- **Person Responsible**
- **Status**

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The working group started by identifying existing tools being used for care coordination needs assessments and developing an inventory of assessment elements from each item in these tools. The recommendations, therefore, owe much to these projects. Special acknowledgement goes to all those who have shared their resources. See the **Compendium of Example Tools** for a full list of these valuable resources.

Care Coordination Needs Assessment Working Group Members	
Susan Betjemann, LICSW	Behavioral Health Integration Specialist, Yogman Pediatrics
Nancy Borreani	Family Support and Training Director, Families and Communities Together (N. Central Worcester CSA)
Barbara Chambers, RN, BSN	CM Team Lead, Pediatric Integrated Care Management Program (iCMP), Partners HealthCare
Jeanne Clapper	Home First Program, HMEA and Family Leader, CHQC
Donna Fruman	Pedi Case Manager, BCBSMA
Rachael Roy Gorton	MCPAP Care Coordinator, Tufts MC/Boston Metro Region II
Katherine (Kate) Hobbs Knutson, MD	formerly Assoc Medical Director/Psychiatry, Office of Clinical Affairs MassHealth; & Child & Adolescent Psychiatry, South Boston CHC
Yokaira Landon	Project LAUNCH Family Partner, Martha Elliot CHC
Mary Jane McKendry (in advisory role)	Case Management Society of New England (formerly VP, Clinical Affairs, Network Health)
Maria Mignone, RN, BSN	Pediatrics of Greater Salem (PAGS)
Noemia Monteiro	MYCHILD Family Partner, Bowdoin Street CHC
Kathleen Pietrowski, RN	Senior Clinical Consultant, HPHC
Beth Pond	Family Integration Specialist, Parent/Prof. Advocacy League (PPAL)
Jacqueline Rue	Project LAUNCH Family Partner, Codman Square CHC
Emma Smizik	Project Mgr, National Institute for Children's Health Quality (NICHQ)
Bonnie Thompson	Family Resource Specialist and CHIPRA Family Leader, Mass Family Voices at the Federation for Children with Special Needs
Care Coordination Task Force and CHQC Staff	
Rich Antonelli, MD, MS (CC Task Force Co-Chair)	Medical Director for Integrated Care Boston Children's Hospital
Barbara Leadholm (CC Task Force Co-Chair)	Principal, Health Management Associates, and former Commissioner DMH & Senior Advisor, MassHealth Office of BH
Gina Rogers	Consultant & Founding Director, MA Child Health Quality Coalition
Meredith Reynolds	Project Coordinator, CHQC
Hannah Rosenberg, MSc	Program Coordinator, Boston Children's Hospital

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