Care Coordination Task Force
Needs Assessment Working Group

Compendium of Example Care Coordination Needs Assessment Tools

The Massachusetts Child Health Quality Coalition Care Coordination Task Force’s Framework -- Key Elements of High-Performing Care Coordination includes use of a structured care coordination needs assessment tool as one of its priority recommendations. To support adoption of this recommendation, the Task Force convened a working group to identify key components for such a tool. The working group’s recommendations distill key elements from a range of different tools, and can serve as a starting point for developing your own tool. This representative sample of example tools is provided as an additional reference, offering example formats and question wording with additional context as a supplement to the recommendations.

Tools from Medical Home/CYSHCNs

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National Center for Medical Home Implementation (NCMHI)/McAllister (2013)

Parent-Completed Screening Tool and Companion Youth-Completed Tool .................. 4
Shriners Hospitals for Children, Healthy and Ready To Work (HRTW) (2004)

Coordinator Referral Information Worksheet ................................................................. 5
Greenville Pediatrics (Alabama), Melissa Boswell, Care Coordinator (2013)

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Cambridge Pediatrics – Cambridge Health Alliance (2013)

Pre-Visit Contact (Update/Needs for Visit) ................................................................. 7
NCMHI, from Chapel Hill (North Carolina) Pediatrics/Jennifer Lail, MD

Checklist for Identifying Needs and Service Options for CSHCNs ............................. 9
MA HMEA Home First Pgm: adaptive equipment/assistive technology users/Jeanne Clapper

WE CARE Survey of Family Psychosocial Problems............................................... 10
Arvin Garg et. al. for Project HEALTH, Pediatrics (2007)

Nashaway Pediatrics Pre-Visit Survey and Companion Children’s Survey ............... 12

Getting to Know My Child ......................................................................................... 14
Parent-developed tool for creating a full “picture” of their child

Medical Home Assessment Information .................................................................... 15
CA Children Services Caregiver Contact Triage Form: LA County (2005)

Tools from behavioral health/health home program assessments

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Used within MassHealth/CBHI services
Individual Care Plan (ICP) -- MA Intensive Care Coordination (ICC) ........................................... 22
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Example from a MA Community Service Agency (CSA)

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CEDARR Family Work Plan -- IFIND (Initial Family Intake and Needs Assessment) ............... 28
Used in RI CEDAAR’s Health Home initiative (Form completed for a hypothetical patient)

Tools focused on transition to adult

Transition Screening Tool: Shriners Hospitals for Children ....................................................... 30

Transition Worksheet: Shriners St. Louis ..................................................................................... 31

Tools from Case Management programs

Comprehensive Needs Assessment (CNA) -- New Jersey ............................................................ 32
NJ Dept. of Human Services Case Management Workbook (Jan 2014)

Acknowledgements ...................................................................................................................... 35

NOTE: These tools are representative samples of the many example tools collected. Many other
tools have been reviewed, including tools from some of the following:

a) Examples from the case management field: Just one example tool is provided here. See Case
Management Society of America (CMSA) resources and workbooks for additional examples.

b) Examples from special programs/special populations: Specific examples of tools used for
children with behavioral health needs are provided here as they tend to have very useful
examples for covering strengths as well as needs and assessing some of the key non-medical
issues. Assessments for other populations such as tools used for new baby (Welcome Families)
and other home visiting programs and children with asthma, ADHD, and other chronic
conditions were also reviewed

c) Tools primarily focused on assessing acuity levels: A separate set of tools exist to support
identifying populations for developing a registry of children with complex needs or defining
eligibility criteria for extra services or special programs. These acuity screeners serve a
different purpose than the Care Coordination Needs Assessment tools, but some are hybrids
with questions that can also be useful for the CC needs assessment. See for example the CYSHCN
screener from Child and Adolescent Health Measurement Initiative (CAHMI), the Exeter
“HOMES” Complexity Index, and screeners such as those used for Serious Emotional Disturbance
(SED) Determination and Early Intervention Eligibility.
INSERT: Practice Name

1) What would you like us to know about your child/youth? 
   a. What does he/she do well? Like? Dislike?

2) What would you like us to know about you/your family?

3) Do you have any concerns or worries for your child/youth? Some examples below.
   - Their growth/development
   - Learning
   - Sleeping
   - Self-care
   - Making and keeping friends
   - Doing things for themselves
   - Falling behind in school
   - Behavior
   - The future
   - Playing with friends
   - Other (fill in)

4) Have there been any changes since we saw you last, such as a:
   - Brother of sister leaving home?
   - Separation or divorce?
   - Move to a new town?
   - Other (fill in)
   - Sickness or death of a loved one?
   - New job or job change?

5) Can we help you with any of the following needs?
   - Medical For example, help finding or understanding medical information; help finding health care for yourself or your family.
   - Social For example, having someone to talk to when you need to; getting support at home; finding supports for the rest of your family.
   - Educational For example, explaining your child's needs to teachers; help reading or understanding medical information.
   - Financial For example, understanding insurance or finding help paying for needs that insurance does not cover – such as medications, formulas, or equipment.
   - Legal For example, discussing laws and legal rights about your child's health care or their school needs.
   - General Please let us know what else you need help with (if we don't know, we will work with you to find the answer).

Notes:

Developed by Joanna McAllister, RN, MS, ACHA and the National Center for Medical Home Implementation

Note: Another version of this tool also including the following question (after #2 above):
"When it comes to your child, what matters most to you right now? {GOALS}"
Parent Completed Screening Tool

1) Do you need assistance with or information about any of the following areas?

- Keeping yourself healthy: □ Yes □ No
- Understanding your child’s health condition or treatment plan □ Yes □ No
- Managing special health problems such as: Feeding □, nutrition □, constipation □, bowel continence □, bladder continence □, skin breakdown □, pain □ or others □□□□□□□□□□
- Improving your child’s function or self-care skills □ Yes □ No
- Getting equipment & supplies needed by your child □ Yes □ No
- Finding resources or services needed by your child □ Yes □ No
- Paying for your child’s health care & related needs □ Yes □ No
- Managing your child’s behavior or meeting your child’s emotional needs □ Yes □ No
- Working with your child’s school □ Yes □ No
- Planning for your child’s future □ Yes □ No

2) Do you need to see your Care Coordinator today? □ Yes □ No

3) Your questions/concerns today:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Staff Comments Only: ___________________________________________________________________________________

________________________________________________________________________

Addressograph

Shriners Hospitals for Children

2/3/04

NOTE: A similar version for the youth to complete is also available
Source: Health and Ready To Work (HRTW) National Resource Center (www.syntiro.org/hrtw/tools)
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Referral Perspective/Reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>Parent(s)/Guardian:</td>
<td></td>
</tr>
<tr>
<td>Patient ID:</td>
<td></td>
</tr>
<tr>
<td>Clinic:</td>
<td></td>
</tr>
<tr>
<td>Diagnosis:</td>
<td></td>
</tr>
</tbody>
</table>

**QUESTIONS**

**General Needs:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Financial Needs:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Behavioral Patterns:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Social Issues:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**POSSIBLE RESOURCES**

(Circle One)

- ADRS:  
- Educational Tools:  
- Easter Seals  
- Other:  

- CRS  
- Family Guidance  
- Medicaid/Patient 1st  
- Other:

- Children's Hospital  
- State Dept. of Edu.  
- Other Ins./Financial

*Source: Melissa Boswell, Care Coordinator, Greenville Pediatrics, Greenville, Alabama (12/2013) (A separate page for NOTES is also included)*
Care Coordination Needs Assessment -- Family Interview
(Provided by Cambridge Pediatrics -- Cambridge Health Alliance)

1. Income and health insurance
   - Who works in your family?
   - If someone has a job, does the employer provide health insurance?
   - If not, do you and the child have health insurance?
   - Is anyone unemployed? If so, is your health insurance through COBRA?
   - Do you have concerns about paying for needs that your insurance does not cover, such as medication, formula or equipment?
   - If no income, do you have concerns about applying for public benefits?
   - Are you receiving benefits such as DTA, Social Security or Disability, Food Stamps, child care subsidy or housing subsidy?
   - Do you ever feel you do not have enough food for your family?

2. Housing and utilities
   - Do you own or rent or are you in alternative housing such as a shelter?
   - If you rent, is it your own apartment or do you share with other people?
   - Are you concerned about losing your housing—served eviction notice, or court involvement?
   - Are you having trouble paying your rent or utilities?
   - Do you have utility shut-off protection?
   - Do you have low income utility discounts? Or fuel assistance? Do you need information about these programs?

3. Education
   - Are you concerned about your child’s learning, behavior or performance in school?
   - If so, have you requested testing or is there an IEP or Health Plan (504) in place? If so, are you satisfied with the services or accommodations?
   - If not, do you need help requesting that?
• Have you worked with an educational advocate or lawyer? Have you considered using one?
• Do you know about the services available through the Federation with Special Health Care Needs.

4. Legal
• Do you have concerns of a legal nature? Guardianship? Disputes with landlords? Unhealthy conditions in your housing? Legal rights for education?

5. Social supports
• Most families have others who support the parents in caring for the children, such as supportive family or friends, religious or community connections. Who is that for you?
• Do you feel you have enough support with the stress of raising your child (children)?
• Could we assist you in finding supports in your community or online, such as parenting support groups?
• Does your child have recreational programs, for instance?

I have asked a lot of questions. Now it is your turn to tell me anything I missed.
Pre-Visit Contact Form: Chapel Hill Pediatrics and Adolescents (North Carolina)

After contact, staff to check with scheduling to ensure visit is for adequate amt of time!!!

Date of Contact__________________ Date of Appointment__________________

Patient:________________________ Date of Birth________ Chart#_______

Number where reached:________________________

In order to be prepared for your child’s upcoming visit, we’d like to know:

1. Has your child been to the Emergency Room since their last PE @ CHP? □ YES □ NO

   If yes, where?________________________
   For what reason?________________________
   Records of visit?________________________
   Outcome/Recommendation?________________________

2. Has your child been hospitalized since their last PE @ CHP? □ YES □ NO

   If yes, where?________________________
   For what reason?________________________
   Records of hospital stay?________________________
   Outcome/Recommendation?________________________

3. Has your child seen any specialists or therapists (including mental health providers) since their last PE @ CHP? □ YES □ NO

   Who?________________________
   Where?________________________
   Specialist note is in chart? □ YES □ NO

4. Has your child had any lab data obtained or x-rays performed since their last PE @ CHP? □ YES □ NO

   What?________________________
   Where?________________________
   Result on chart? □ YES □ NO

5. Has your child had any evaluations or services at the Children’s Development Services Agency or school since their last PE @ CHP? □ YES □ NO

6. Are there any forms or letters you’ll need completed during this visit? □ YES □ NO

7. Do you anticipate your child needing lab work at your upcoming visit □ YES □ NO
   If so, arrange Lab Forms and Elmla/Elamax.

8. Are there any major areas of concern or topics you need addressed at this visit?
   1.________________________
   2.________________________
   3.________________________

Source: Pre-Visit Contact form, Chapel Hill Pediatrics, provided by Jennifer Lail, MD
Checklist for Identifying Needs and Service Options

1. General Information
   • Child's Name: ____________________________
   • DOB: ____________________________
   • Parent's Name: ____________________________
   • Telephone: ____________________________
   • Email: ____________________________ Add to newsletter: Y □ N □
     Date Completed: ________

2. Requested Supports/Services:

3. Service options to be considered:
   o Health Insurance* (MH, KM, Private, MSCPA)
   o Home Care (HHA, PCA, PDN, CCM*, AFC*)
   o Incidental Medical Supplies (Diapers, etc.)
   o Adaptive Equipment (PassitOn, GetATStuff)
   o Assistive Technology (MassMatch, Easter Seals AT loan)
   o Prior Approval Process Assistance
   o Home Modifications (KofC, HMLP, CICRF*)
   o Vehicle Modifications/Transportation (KofC, CICRF*, PT-1)
   o In home Respite
   o Out of home Respite (MRT*, PNH/NF*, SRS*-Taunton)
   o Educational Advocacy (FCSN, SpedWatch.org, concordspedpac)
   o Day Programs* (nursing support, transportation, community)
   o Social Security*
   o Social/Recreational Opportunities
   o Parent/Sibling Support (Sibshops)
   o Parent/Sibling Training (MFOFC)
   o Legal Assistance-Guardianship* (VLP, DLC, GBLS, CLC)
   o Residential Benefits (CAP, LIHEAP, Sec8, E911)
   o Financial Benefits & Planning (DTA, Child Support*, SSI*)
   o Flexible Funding
   o DDS Adult Eligibility application process

*denotes transition age considerations

Cklist.doc
Provided by CHQC member Jeanne Clapper, HMEA, Franklin, MA

HMEA's Home First program serves children and young adult with developmental disabilities and complex medical issues with specialized case management services enabling them to live at home.
WE CARE SURVEY

Our goal at the Harriet Lane Clinic is to provide the best possible care for your child and family. We would like to make sure that you know all the resources that are available to you for your problems. Many of these resources are free of charge.

Please answer each question with an "X" and hand it in to your child’s doctor at the beginning of the visit. Thank You!

1. Do you have a high school degree?
   YES
   NO
   If NO, would you like help to get a GED?

2. Do you have a job?
   YES
   NO
   If NO, would you like help with finding employment?

3. Do you smoke cigarettes?
   YES
   NO
   If YES, would you like help to quit?

4. Do you or does anyone else in your home use drugs?
   YES
   NO
   If YES, would you like help with it?

5. Do you or does anyone else in your home have a problem with alcohol?
   YES
   NO
   If YES, would you like help with it?

6. Are you feeling sad or hopeless a lot of the time?
   YES
   NO
   If YES, would you like help with it?
7. Does your partner hit or verbally abuse you?
   YES
   NO
   If YES, would you like help?
   YES
   NO
   MAYBE LATER

8. Do you need daycare for your child?
   YES
   NO
   If YES, would you like help finding it?
   YES
   NO
   MAYBE LATER

9. Do you think you are at risk of becoming homeless?
   YES
   NO
   If YES, would you like help with this?
   YES
   NO
   MAYBE LATER

10. Do you need help in getting food by the end of the month?
    YES
    NO
    If YES, would you like help with this?
    YES
    NO
    MAYBE LATER

In case your child’s doctor cannot address all these issues at this visit, please rank the 3 items that you wish to talk about in order of importance.

1.

2. Most important

3. Least important
FIGURE 3: Nashaway Pediatrics Pre-Visit Survey*

This survey is to be used as a tool to help you organize your thoughts concerning your child(ren) and family. Completing it will enable our practice to assist you with any needs or concerns. Completion of the form is voluntary and you may decide if you wish to have it placed in your child’s record, or you may take it with you.

Child’s Name: ____________________________ Date of Birth: ____________________________

1. During the past 6 months, how much of the time did you worry about your child’s health?
   - □ none of the time
   - □ a little of the time
   - □ most of the time
   - □ all of the time

2. Do you have any concerns about the following issues for your child?
   - □ development differing peers
   - □ ability to learn
   - □ falling behind in school
   - □ sleeping
   - □ loneliness
   - □ behavior
   - □ substance use or abuse
   - □ other(s)  □ being independent
   - □ self-care issues
   - □ the future
   - □ making/keeping friends
   - □ participation in activities
   - □ self-esteem
   - □ eating or diet concerns
   - □ sibling issues

3. Of the above concerns, which are the two most on your mind today?
   a. ____________________________
   b. ____________________________

4. What are your family’s greatest strengths?
   - □ communication
   - □ art
   - □ fun/play/sports
   - □ other

5. What are your child’s greatest strengths?
   - □ communication
   - □ art
   - □ fun/play/sports
   - □ other

6. Do you need help coordinating any aspects of your child’s care? □ YES □ NO
   If so, with what do you feel you need assistance?
   - □ healthcare
   - □ childcare
   - □ insurance
   - □ mental health
   - □ education
   - □ other
   - □ lay-off/unemployment
   - □ lack of insurance
   - □ other

7. Are any of the following issues troubling your family at this time?
   - □ divorce/separation
   - □ substance abuse
   - □ sexual abuse
   - □ domestic abuse: □ physical □ verbal
   - □ other
   - □ death in the family
   - □ sickness in the family
   - □ lay-off/unemployment
   - □ lack of insurance

8. Would you like this to be part of your child’s record? □ YES □ NO

Initial here: ____________________________

*The Nashaway Pediatrics parent Advisory group (PAG) developed this survey. The PAG is a group of parent volunteers who serve as advisors to the staff of Nashaway Pediatrics. If you would like to become a member of our PAG, please speak with your pediatrician.

Downloaded from http://www.medicalhomeinfo.org/tools/assess.html 7/15/05
NASHAWAY PEDIATRICS – CHILDREN’S PRE-VISIT SURVEY*

As you wait to see the pediatrician or nurse practitioner today, you may fill out this paper. You may also choose to share it with us. The grown-up who came with you today can help you answer the questions.

Name: ________________________________  Birth Date: ____________

What I like about myself

( ) How I look                  ( ) My School Work
( ) My Family                   ( ) My Body’s Height
( ) My Friends                  ( ) My Body’s Weight

Other things I am good at ____________________________

Things I might worry about

( ) How I look                  ( ) My School Work
( ) My Family                   ( ) My Body’s Height
( ) My Friends                  ( ) My Body’s Weight

Other things I might worry about ____________________________

I wish I were better at ____________________________

If you would like, please use the back of this paper to draw a picture of yourself doing anything you choose.

* Developed by Nashaway Pediatrics, Parent Advisory Group  Revised 02/03

NOTE: This pre-visit survey for the child to complete complements the parent form on the preceding page

Source: Presentation by Cathy Polewarczyk, Parent Partner, and Kathleen Cleary, MD, Nashaway Pediatrics at NE Serve/Massachusetts Consortium for Children with Special Health Care Needs June 3, 2004
Getting to Know My Child

child's name

parent/guardian

email

Daytime Telephone:

My Child's Strengths Are

My Child's Interests / Activities Are

My Child's Challenges Are

Hints for Working with my Child

The information on this page is written to help you work with and enjoy our child. Thank you for taking the time to read this. It can make all the difference for him/her.

Source: Developed by a parent to help families create a 'picture' of their child to use when sharing information with their child's providers and/or school. Reprinted from Communication Matters, CHQC's guide for sharing information on a child's care (www.masschildhealthquality.org/work/communication-and-confidentiality-task-force/).
**FIGURE 2: Medical Home Assessment Information**

Name: ___________________________  Medical Record Number: ___________________________

Date of Birth: _______________________  Sex: ___________________  Telephone Number: ___________________________

Parent/Caregiver Name: ___________________________  Relationship: ___________________________

Primary Diagnosis: ___________________________  Secondary Diagnosis: ___________________________

Primary Care Physician: ___________________________

Dentist: ___________________________

Specialist(s): ___________________________

Insurance: ___________________________

☐ HMO  ☐ PPO  ☐ CCS  ☐ Medi-Cal  ☐ Healthy Families  ☐ Share of cost?  ☐ Other ___________________________

Insurance ID/Group Number: ___________________________

Health History: ___________________________

_________________________________________________________________________

**QUESTIONS:**

1. Services received by client/family (check and complete any that apply):

   ☐ DCFS: ___________________________  ☐ Special Education: ___________________________

   ☐ Food Stamps: ___________________________  ☐ Special Care Center: ___________________________

   ☐ WIC: ___________________________  ☐ SSI: ___________________________

   ☐ TANF (AFDC): ___________________________  ☐ Mental Health: ___________________________

   ☐ CCS: ___________________________  ☐ MTU: ___________________________

   ☐ Head Start: ___________________________  ☐ Other: ___________________________

2. Other services requested by parent/caregiver (check and complete any that apply):

   ☐ Child/Dependent Care: ___________________________  ☐ Shelter/Energy: ___________________________

   ☐ Education: ___________________________  ☐ Support/Counseling: ___________________________

   ☐ Food/Nutrition: ___________________________  ☐ Training: ___________________________

   ☐ Health/Medical: ___________________________  ☐ Transportation: ___________________________

   ☐ Income Assistance: ___________________________  ☐ Dental Care: ___________________________

   ☐ Mental Health: ___________________________  ☐ Other: ___________________________

3. What are your concerns about your child's health/medical care? Explain.

   ___________________________________________________________

   ___________________________________________________________

   ___________________________________________________________

   ___________________________________________________________

   ___________________________________________________________

   ___________________________________________________________

   ___________________________________________________________
### FIGURE 2: Medical Home Assessment Information Continued

3. What are your concerns about your child’s health/medical care? Explain.

   

4. Do you feel you are able to get all the care you need for your child? Explain.

   

5. Do you have any concerns about your child’s behavior or development? Explain.

   

6. Are there any family problems/concerns that might affect your child? Explain.

   

Plan:  

☐ Rx referral completed.  
☐ Other  

Signature of person completing form: ___________________________ Date: ___________________________

Adapted from: Los Angeles County Department of Health Services, California Children Services Caregiver Contact Triage Form.  
Funded by the Department of Health Services Maternal Child Health Bureau Grant No. MCJ-061502-01-0  
Downloaded from http://www.medicalhomeinfo.org/tools/assess.html 7/15/05
### Youth Name:

### Date of Birth:

### Caregiver Name:

### Date of Enrollment:

### Date Completed:

### Family Partner:

### Goals

*(Goals for parent or caregiver as written in youth Action or Treatment Plan by Hub Provider)*

### Family Strengths

*(Strengths, Accomplishments, Patterns of Resiliency)*
### Life Domains

<table>
<thead>
<tr>
<th>Family Living Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Housing concerns, who lives in the home, how is the space shared, is the family satisfied with their living space?)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social/Fun/Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(What does the family do for fun? Community involvement? Who are their friends? Supports? Social skills?)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supports for your Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(List all potential supports identified by the family.)</em></td>
</tr>
<tr>
<td>Strengths, Needs, and Culture Discovery</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Emotional Behavior</strong></td>
</tr>
<tr>
<td><em>(How does the family handle feelings? Describe mood and behavior when doing well and when having a hard time.)</em></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>School/Work</strong></td>
</tr>
<tr>
<td><em>(Describe school attendance, participation, academic standing, vocational strengths and interests, employment needs.)</em></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Legal</strong></td>
</tr>
<tr>
<td><em>(Involvement with courts, law enforcement, probations, CHINS, etc.)</em></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Source: MA Family Support and Training (FS&T), MassHealth CBHI Services*
### Cultural/Spiritual

*(Traditions, hobbies, activities, spiritual choices. Family rules, expected behaviors, historical patterns of resilience, how decisions are made. How the family deals with stress, etc.)*

### Medical/Current Medications

*(Medical diagnoses and concerns, psychiatric medications, satisfaction with physician or prescriber, etc.)*

### Crisis/Safety

*(What are the events, people, places that come before difficult times/crisis? What has the family tried to distract, calm or prevent crisis? How does the family reach out for support during crisis?)*

*Source: MA Family Support and Training (FS&T), MassHealth CBHI Services*
<table>
<thead>
<tr>
<th>Family Signature and Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Family Partner Signature and Date:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Family Partner Supervisor Signature and Date:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Source: Strengths, Needs, and Culture Discovery form from MA Family Support and Training (FS&T), CBHI services

(Provided by Darcy Rubino, MFV, forms dated March 2014)
# COVER SHEET

**INDIVIDUAL CARE PLAN (ICP) -- MA ICC Services**

<table>
<thead>
<tr>
<th>Youth's name:</th>
<th>Date of this plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Date of Next Meeting:</td>
</tr>
<tr>
<td>CSA name: Cape Ann/Salem</td>
<td>Intensive Care Coordinator:</td>
</tr>
<tr>
<td>Primary care provider:</td>
<td>Family Partner:</td>
</tr>
<tr>
<td>Contact information:</td>
<td>Date of Well-Child Care Visit:</td>
</tr>
<tr>
<td>Date ICP sent to primary care provider:</td>
<td>Date of Risk Management/Safety Plan Review:</td>
</tr>
</tbody>
</table>

## Ongoing Supports and Services that are expected to Continue after Wraparound

*These ongoing supports and services (formal and natural) will become the sustainability plan for the family.*

<table>
<thead>
<tr>
<th>Date Identified</th>
<th>Support name/type</th>
<th>Relationship to Child</th>
<th>Frequency of contact</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

## Current Medications for Target Youth

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Name and contact information of prescriber</th>
<th>Target symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Ground Rules: (including confidentiality and how the team will make decisions)

Vision:

Team Mission:

Needs to be **Addressed** (Priority needs that will be addressed first are in bold)

### Care Planning Team (CPT) Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Strengths</th>
<th>Date On</th>
<th>Date Off</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Signatures:

<table>
<thead>
<tr>
<th>Intensive Care Coordinator:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Partner:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Member(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Note: By signing this document, I acknowledge that I was fully included in the development of the ICP and agree with its contents.*
Child:
Life Domain
Need(s) (Specific statement related to CANS items and Medical Necessity):

Goal:

Strengths for this Need

Culture for this Need

Brainstormed Options

Short Term Objective

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Objective(s)</th>
<th>Measurement Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Responsible Person</th>
<th>Target Start Date</th>
<th>Target End Date</th>
<th>Task Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
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</tr>
</tbody>
</table>

Date of Meeting

<table>
<thead>
<tr>
<th>Progress (Check one.)</th>
<th>Accomplishments / Progress and Barriers (narrative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Partially Met</td>
<td></td>
</tr>
<tr>
<td>Not Met</td>
<td></td>
</tr>
</tbody>
</table>

Insert extra sheets for each goal
Care Coordination Needs Assessment: Initial Care Meeting Planning
Drawn from National Wraparound Initiative resources

Typical Process for an Initial Care Planning Meeting

- Introducing Everyone (strengths) / Reviewing Progress
- Ground Rules
- Share the Family's Vision
- Team Develops Its Mission
- What are the "Big Worries"?
- What are the 2-3 Needs and Goals that we will start with?
  - Select a Goal, and determine the first few Objectives (first steps)
  - What will be the measurement strategy to know if the Plan is working?
  - Strengths and Culture are reviewed / expanded / and discussed
  - Options are "brainstormed" to achieve the Objective
  - Specific Tasks or Action Steps are agreed upon and assigned to meet the Objective. Tasks are written concretely— who will specifically do what by when.
- What is the Implementation Plan? When to meet as a Team again? How to stay in touch between meetings?
- Who was missing today from our planning? Who should we work to involve in this work?
- Risk Management / Safety Planning Review (if needed)
- Follow Up Meeting is scheduled (if necessary)

Implementation (Ongoing) Care Planning Meetings

- Introduction of any new participants (strengths)
- Ground Rules (reminders if needed)
- Review of the exiting Care Plan
  - For each Goal:
    - Has the Need / Goal / Objective been met? If yes, CELEBRATE! move to next Objective or Goal. If not:
      - Did Tasks get done? completed, in process, not completed?
      - What is our tracking or measurement data telling us? On the right track?
      - Brainstorm new options and select new Tasks
- Determine if any new Concerns /Needs have arisen
  - Select a Goal, and determine the first few Objectives (first steps)
  - Determine a measurement strategy to track if the plan is working
  - Strengths and Culture are reviewed / expanded / and discussed
  - Options are "brainstormed" to achieve the Objective
  - Specific Tasks or Action Steps are agreed upon and assigned to meet the Objective. Tasks are written concretely— who will specifically do what by when.
- Review Risk Management / Safety Planning Review (if needed)
- Check in around Implementation Plan (how we will work together in between meetings?)
- Next Meeting is scheduled

Source: Unpublished training materials used by the Community Healthlink Community Service Agency (CSA) Provided by J. Anthony Irsfeld, Ph.D., Director, Families and Communities Together Program (2013).
Care Coordination Information/INTAKE

Name of the Patient: ____________________________
Date of Birth: ____________________________
Parent/Legal Guardian: ____________________________
Phone: ____________________________
Address: ____________________________
Email: ____________________________
Primary Language: ____________________________
Race: ____________________________
Country of Birth: ____________________________

MRN: ____________________________
LAUNCH ID: ____________________________

Project LAUNCH Checklist: Check If has Notes:

Health Insurance: □

Income (SSI, Employment, Cash Assistant, SNAP, WIC) □

Housing: □

School, Early Intervention: □
- Name of School/Day Care/ El
- Grade
- Special Education Services

Family Strengths, Activities Family enjoy together: 

__________________________________________
__________________________________________
__________________________________________

What do you enjoy about your child? 

__________________________________________
__________________________________________
__________________________________________

Notes: 

__________________________________________
__________________________________________
__________________________________________

Concerns:

Family Support/Community:

__________________________________________
__________________________________________
__________________________________________
### Care Coordination Information/INTAKE

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver's Name 1</td>
<td></td>
</tr>
<tr>
<td>Caregiver's Country of Birth</td>
<td></td>
</tr>
<tr>
<td>Caregiver's Primary Language</td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
</tr>
<tr>
<td>Caregiver's Race</td>
<td></td>
</tr>
<tr>
<td><strong>DOB:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Zip code:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver's Name 2</td>
<td></td>
</tr>
<tr>
<td>Caregiver's Country of Birth</td>
<td></td>
</tr>
<tr>
<td>Caregiver's Primary Language</td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
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<tr>
<td>Employment Status</td>
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<tr>
<td>Caregiver's Race</td>
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<tr>
<td><strong>DOB:</strong></td>
<td></td>
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<tr>
<td><strong>Zip code:</strong></td>
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</tbody>
</table>

### SAMHSA:

1. Does someone in family/household have a mental illness?
2. Does Someone in Family/household have substance abuse problem?
3. Has a child (0-8) in the family/household been a victim of violence/trauma?
4. Open abuse or neglect investigation/case?
5. Known substantiated abuse or neglect case?
6. Have any household children (0-8) been homeless in the last 12 months?
7. Children (0-8) have been removed from a childcare/preschool program or expelled from elementary school?
8. Currently incarcerated biological parent?
9. Household member currently deployed by a branch of the U.S military?

---

This template was developed by Yokaira Landron, Family Partner, Project LAUNCH, Martha Eliot Health Center
Adapted 6/30/2014
Date of IFIND Visit __/__/___

CEDARR Family Work Plan
(Required for Initial Visit)

Date Plan Developed: ___4__/__4__/2011 Child’s Name: ___Joseph Jumpup___

Parent(s)/Guardian(s) Name: Mrs. Rita Jumpup

Presenting Issue(s):
1. _Joey is acting out at day care and may be expelled_

2. _Joey is a frequently needs after hours medical care_

3. ________________________________

Actions:

<table>
<thead>
<tr>
<th>Steps/Resources Needed to Provide Requested Assistance</th>
<th>Person(s) Responsible</th>
<th>Time Frame</th>
<th>Completed (Y/N), Date Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine eligibility for Kids Connect and Refer for service</td>
<td>CEDARR Team</td>
<td>1 week</td>
<td></td>
</tr>
<tr>
<td>Determine cause of UR issues and possible interventions</td>
<td>CEDARR Team, Specialist</td>
<td>1 month</td>
<td></td>
</tr>
<tr>
<td>Investigate other needs of the child and family</td>
<td>CEDARR Team</td>
<td>1 month</td>
<td></td>
</tr>
</tbody>
</table>

CEDARR Services (check all that apply)

_time frame_ ___Rita___

_Jumpup_ 4/21/11_

Health Needs Coordination
Therapeutic Counseling
Group Intervention

CEDARR FWP 02/2009
Date of IFIND Visit ___/___/____
CEDARR Direct Service
Close Case
Date of Next Visit/Review ___/___/____

MR/ID# ______________________

______________________________
FSC Signature Date

Source:
CEDARR Family Work Plan: IFIND (Initial Family Intake and Needs Assessment) Tool
Example form completed for hypothetical patient, provided by:
Paul A Choquette, M.A.
Rhode Island EOHHS/Xerox State Healthcare Center for Child and Family Health (12/18/13)
Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation (CEDARR) Initiative
Rhode Island Health Home initiative
CEDARR Family Centers

See also CEDARR JumpUpFamilyCarePlan (6 page example Care Plan)

CEDARR FWP 02/2009
Transition Screening Tool

Do you need assistance with or information about any of the following?

Health
☐ Finding a primary care doctor to address my adult health care needs
☐ Finding a specialty care doctor upon discharge from Shriner's Hospital
☐ Paying for adult health care
☐ Getting treatments, therapies, equipment, supplies or medication after discharge from Shriner's Hospital
☐ Connecting with agencies that can provide me with more information on my disability or special health care need (UCP, OI Foundation, MDA).

Employment
☐ Career planning/job training
☐ Finding a job with supports & accommodations
☐ Services provided through Vocational Rehabilitation
☐ Keeping SSI while working & going to school

Legal Rights
☐ Advocacy
☐ Selective Services Registration
☐ American with Disabilities Act
☐ Education rights/personal rights
☐ Guardianship Information
☐ Wills & Trust
☐ Advanced Directives

Education
☐ Accommodations at school/college for students with disabilities (IEP/504/ADA)
☐ Transition planning in high school
☐ Post secondary education
☐ Paying for school/college

Independent Living
☐ Accessible, affordable housing
☐ Supervised living programs
☐ Independent living supports
☐ Personal care attendant

Transportation
☐ Drivers education/license
☐ Adaptive driving equipment
☐ Public transportation

Psychosocial
☐ Family/support networks
☐ Support Groups
☐ Sexuality
☐ Depression/loneliness
☐ Stress management
☐ Anger/Violence at school or home
☐ Bullying
☐ Risk Taking Behavior (drugs, alcohol, smoking, unprotected sex)

Community Resources
☐ Social Security Benefits
☐ Health Insurance/Medicaid
☐ Division of Services for People with Disabilities (DSPD)
☐ Respite Care
☐ Mental Health Services
☐ Assistive Technology
☐ Recreation/Sports
☐ Assistance programs (food stamps, TANF, housing)

Do you have other questions or concerns about your future?

________________________________________________________

________________________________________________________

________________________________________________________

Would you like to meet with a Care Coordinator today in clinic or be contacted by telephone?

☐ In clinic
☐ Telephone: ________________________________ (phone number)

________________________________________________________ (contact person)

☐ No, thank you

Transition Screening Tool – Shriner's Hospitals for Children
(Resources from the Healthy and Ready to Work (HRTW) National Resource Center)
www.syntiro.org/hrtw/tools/pdfs/S7SHICPlanning_for_future2.pdf

30
Transition Worksheet -- Shriners St. Louis

Name: __________________________
Initial Transition Visit: ________________
DOB: __________________________
Initial Visit Date: __________________________

☐ Living Arrangement
With Family __________________________
Adult Foster Care __________________________
Shelter Care/Group Home __________________________
Semi-independent (supervised) __________________________
Shared Living (roommate) __________________________
Independently (house/apartment) __________________________
Are skills/resources present for above indicated arrangements? ___ Yes ___ No
Referrals made: __________________________

☐ Transportation
Independent (bike, own car) __________________________
Public Transportation __________________________
Specialized Transportation __________________________
Are skills/resources present for above indicated arrangements? ___ Yes ___ No
Referrals made: __________________________

☐ Medical (Name of Medical Staff)
Prosthetic/Orthopedics __________________________
General __________________________
Orthopedic __________________________
Physical Therapist __________________________
Occupational Therapist __________________________
Referrals made: __________________________

☐ Insurance
SSI/SSDI __________________________
Medical __________________________
Referrals made: __________________________

☐ Employment
Competitive employment __________________________
Full Time Part Time __________________________
Supported employment __________________________
Volunteer Work __________________________
Workshops __________________________
Are skills/resources present for above indicated arrangements? ___ Yes ___ No
Referrals made: __________________________

☐ Leisure & Community Participation
Recreation Council __________________________
Agencies __________________________
Life Skills Foundation __________________________
Drivers License/ID Card __________________________
Voting Registration __________________________
Banking __________________________
Assitive Technology __________________________
Referrals made: __________________________

☐ Education
College __________________________
Work Training __________________________
Technical School __________________________
Are skills/resources present for above indicated arrangements? ___ Yes ___ No
Referrals made: __________________________

☐ Advocacy/Legal
MPACT __________________________
Independent Living Center __________________________
Adult organizations __________________________
Information seeking __________________________
Guardianship __________________________
Wills/Trusts __________________________
Are skills/resources present for above indicated arrangements? ___ Yes ___ No
Referrals made: __________________________

☐ Other: __________________________

Source: Transition Worksheet -- Shriners St. Louis
(Resources from the Healthy and Ready to Work (HIRTW) National Resource Center)
## Comprehensive Needs Assessment (General Population, Peds, ABD, and DD Caregiver)

<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>What is your name (member)?</td>
</tr>
<tr>
<td>2</td>
<td>What is your primary telephone number?</td>
</tr>
<tr>
<td>3</td>
<td>What is a secondary telephone number we could use?</td>
</tr>
<tr>
<td>4</td>
<td>In case of an emergency, what is the name and telephone number of a person we can contact?</td>
</tr>
<tr>
<td>5</td>
<td>What is the primary language spoken in the home?</td>
</tr>
<tr>
<td>6</td>
<td>What is your current address?</td>
</tr>
<tr>
<td>7</td>
<td>Who is providing the information to complete the assessment (include name and relationship to member)?</td>
</tr>
<tr>
<td>8</td>
<td>Is there a guardian involved?</td>
</tr>
<tr>
<td><strong>History</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Who is your current primary care provider or family doctor? (Provide name and telephone number)</td>
</tr>
<tr>
<td></td>
<td>What was the date of last appointment?</td>
</tr>
<tr>
<td>2</td>
<td>Do you see any specialists? (Provide names and telephone numbers)</td>
</tr>
<tr>
<td></td>
<td>What was the date of last appointment?</td>
</tr>
<tr>
<td>3</td>
<td>Do you see a dentist? (Provide name and telephone number)</td>
</tr>
<tr>
<td></td>
<td>What was the date of last appointment?</td>
</tr>
<tr>
<td>4</td>
<td>Which of the following medical conditions do you have/have you had? (Select: Asthma, Chronic Obstructive Pulmonary Disease, Tuberculosis, Seizures, Memory Problems, Depression, Schizophrenia, Congestive Heart Failure, Heart Disease, Hepatitis, Diabetes, Kidney Failure, On Organ Transplant List, Paralysis, Multiple Sclerosis, HIV/AIDS, Stroke, Lead Poisoning, Sickle Cell disease, Cancer w/treatment, Hemophilia, Other)</td>
</tr>
<tr>
<td>5</td>
<td>On a scale of 1 to 5, with 1 being &quot;poor health&quot;; 2 being &quot;fair health&quot;; 3 being &quot;good health&quot;; 4 being &quot;very good health&quot;; and 5 being &quot;excellent health&quot;, how would you rate your overall health during the past three months?</td>
</tr>
<tr>
<td>6</td>
<td>Which medications are you taking, including over-the-counter medications and supplements?</td>
</tr>
<tr>
<td></td>
<td>Do you need any help taking your medications?</td>
</tr>
<tr>
<td></td>
<td>Which pharmacy do you use? (Provide name)</td>
</tr>
<tr>
<td>7</td>
<td>Do you have vision problems not corrected with lenses?</td>
</tr>
<tr>
<td></td>
<td>If yes, explain.</td>
</tr>
<tr>
<td>8</td>
<td>Do you have hearing problems not corrected with assistive aids?</td>
</tr>
<tr>
<td></td>
<td>If yes, explain.</td>
</tr>
<tr>
<td>9</td>
<td>What is your current height?</td>
</tr>
<tr>
<td>10</td>
<td>What is your current weight?</td>
</tr>
<tr>
<td></td>
<td>Have you lost weight in the past 6 months without trying?</td>
</tr>
<tr>
<td></td>
<td>How much have you lost?</td>
</tr>
<tr>
<td></td>
<td>Have you gained weight in the last 6 months without trying?</td>
</tr>
<tr>
<td></td>
<td>How much have you gained?</td>
</tr>
<tr>
<td>11</td>
<td>Are your immunizations up-to-date?</td>
</tr>
<tr>
<td>12</td>
<td>Are your preventive screenings up-to-date?</td>
</tr>
<tr>
<td><strong>Functionality</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Do you have a problem with any of these? (Select: Independent as age appropriate; dependant as age appropriate; requires assistance; completely dependant)</td>
</tr>
<tr>
<td></td>
<td>Ambulation/Walking</td>
</tr>
<tr>
<td></td>
<td>Bathing with sponge, bath, shower</td>
</tr>
<tr>
<td></td>
<td>Dressing</td>
</tr>
<tr>
<td></td>
<td>Toilet Use</td>
</tr>
<tr>
<td></td>
<td>Transferring (in and out of bed or chair)</td>
</tr>
<tr>
<td></td>
<td>Eating</td>
</tr>
<tr>
<td></td>
<td>Continence (controls bowel and bladder by self)</td>
</tr>
<tr>
<td></td>
<td>Shopping</td>
</tr>
<tr>
<td></td>
<td>Cooking</td>
</tr>
</tbody>
</table>
Using the telephone  
Housework  
Doing laundry  
Driving  
Managing finances  

2 Do you have a family member or other caregiver assisting you?  
   How often is assistance provided? (Select: daily, weekly, weekends, all of the time)  
   Do you feel you need additional help?  

3 Do you currently use home health services?  
   List home health services used, agency name, hours, and frequency.  

4 Do you currently use any medical equipment and/or supplies?  
   List medical equipment and supplies used and DME company.  

5 Do you need transportation to and from medical appointments?  

6 Do you have an emergency plan? (Drop down menu to include: Do you know what to do in case the electricity goes off? Who would you call if you need medical help? What would you do if there was a fire in your apartment, etc?)  

NUTRITION  

1 Do you follow any special diet? If yes, please describe.  

2 How is your appetite?  

3 Do you have any feeding or eating issues? [Drop down menu to include: excessive fussiness, splitting up, projectile vomiting, colic, difficulty swallowing, difficulty sucking, receives special formula, receives GT feeds, GI disturbances (constipation, distension, diarrhea), food allergy, lactose intolerance, other]  

4 Do you have any difficulty obtaining food or formula?  

5 Do you make use of WIC, food bank, food stamps, or other resources to obtain food?  

DEVELOPMENTAL CONCERNS  (Note: DDD members must be asked these questions)  

1 Do you attend school/day program?  
   If yes, what is the name of the school/day program?  

2 In what grade/type of day program are you currently enrolled?  

3 Do you receive special services/ therapies at school/day program? (IEP, occupational therapy, physical therapy, speech therapy, other)  

4 Have you informed the school/day program about your medical condition(s) or medications?  

5 Question for parent/caregiver: Is there any activity that your child can't do that other children his/her age can do?  

6 Question for parent/caregiver: Do you have any concerns about your child's behavior?  

SUPPORT/ COMMUNITY RESOURCES  

1 Do you participate in community support programs?  
   What community support services do you currently have or need?  

2 Do you currently have a case/care manager through another agency or program (i.e., DDD, DCP&P, SChS, waiver)?  
   What is the case/care manager's name and contact information?  

3 What type of living arrangement do you have? (Select: house, apartment, assisted living, boarding home, nursing home, other)  
   Is current residence suitable for home care? (Only to be asked if applicable)  

4 Who do you live with? (Select: alone, friend, other family member, paid help, spouse or significant other, other)  

5 Do you have any friends or family that are willing to provide emotional support?  

6 Do you have any barriers to care (i.e. difficulty getting appointments, transportation, don't like doctor)?  

PSYCHOSOCIAL HISTORY  (Note: These questions are only to be asked of members who are 10 years old and older)  

1 Do you drink alcohol?  
   On a typical day, how many drinks do you have? (open-ended)  
   On average, how many days per week do you drink alcohol? (open-ended)  

2 Do you smoke or use tobacco?  
   How much do you smoke a day? (Select: less than one pack a day, 1-2 packs a day, 2 or more packs a day)  
   Do you want to quit smoking?  

3 Do you use recreational or street drugs?  

Source: NJ Dept of Human Services: Comprehensive Needs Assessment (CNA) p. 2 of 3  
Care Management Workbook (p. 15-17) -- Revised January 2014  
www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>On a typical day, how much do you use? (open-ended)</td>
<td></td>
</tr>
<tr>
<td>How many times a week do you use recreational or street drugs?</td>
<td></td>
</tr>
<tr>
<td>4 Have you had any recent behavioral health and/or substance abuse treatment? If yes, please describe.</td>
<td></td>
</tr>
<tr>
<td>5 Depression screen (PHQ-2): Over the last 2 weeks, how often have you been bothered by any of the following problems? (Select: not at all, several days, more than half the days, or nearly every day)</td>
<td></td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td></td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless</td>
<td></td>
</tr>
<tr>
<td>6 Are you (or the person you are caring for) thinking of doing anything that may be harmful to yourself (themselves) or someone else?</td>
<td></td>
</tr>
<tr>
<td>7 Do you ever feel unsafe at home?</td>
<td></td>
</tr>
<tr>
<td>8 Is there something else you need me to know? Please provide any additional relevant information.</td>
<td></td>
</tr>
<tr>
<td>Supplemental Questions for DD Beneficiaries (Note: Care Managers should tailor questions to either the caregiver or member, as appropriate)</td>
<td></td>
</tr>
<tr>
<td>1 Are you disruptive or aggressive towards yourself or others?</td>
<td></td>
</tr>
<tr>
<td>2 Is member prevented from participating in any activities due to mental health or behavioral issues?</td>
<td></td>
</tr>
<tr>
<td>3 Is member currently receiving mental health and/or substance abuse services?</td>
<td></td>
</tr>
<tr>
<td>4 As the member’s caregiver, describe the member’s cognitive status.</td>
<td></td>
</tr>
<tr>
<td>5 Has the member’s behavior changed in the last 6 months? If so, what is the impact?</td>
<td></td>
</tr>
<tr>
<td>6 Please describe how you care for the member (i.e., what kinds of task do you do for the member? Do you care for the member full time, etc.?)</td>
<td></td>
</tr>
<tr>
<td>7 Do you feel that the member you care for is getting enough help?</td>
<td></td>
</tr>
<tr>
<td>8 Is there any help that you would like?</td>
<td></td>
</tr>
<tr>
<td>9 Do you want information about benefits/services available?</td>
<td></td>
</tr>
<tr>
<td>10 Do you have a DDD case manager? If yes, do you know how to reach him/her?</td>
<td></td>
</tr>
<tr>
<td>11 When was the last time you were in contact with your DDD case manager?</td>
<td></td>
</tr>
<tr>
<td>Questions for MCO Care Manager</td>
<td></td>
</tr>
<tr>
<td>1 Cognitive Function</td>
<td></td>
</tr>
<tr>
<td>In the care manager’s opinion, what is the member’s cognitive functioning level? (Select: alert/disoriented, easily distracted, requires considerable assistance, requires total assistance)</td>
<td></td>
</tr>
<tr>
<td>2 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>While completing this assessment did the member sound depressed or overly anxious or did caregiver state same?</td>
<td></td>
</tr>
<tr>
<td>In the care manager’s opinion, are there behavioral health issues pertaining to the member or caregiver?</td>
<td></td>
</tr>
<tr>
<td>3 Risk Factors</td>
<td></td>
</tr>
<tr>
<td>What are the member’s risk factors? (Select: none, smoking, alcohol/drug dependency, obesity, nutritional, special needs, other)</td>
<td></td>
</tr>
<tr>
<td>In the care manager’s opinion, does the member have a risk of violence and/or abuse?</td>
<td></td>
</tr>
<tr>
<td>4 Health literacy</td>
<td></td>
</tr>
<tr>
<td>In the care manager’s opinion, does the member (or caregiver) understand his/her health needs?</td>
<td></td>
</tr>
<tr>
<td>Is the member (or caregiver) able to communicate his/her health care needs?</td>
<td></td>
</tr>
<tr>
<td>5 Long-term/Ongoing Care Service Needs</td>
<td></td>
</tr>
<tr>
<td>Does the care manager identify any long-term care and/or ongoing service needs for this member?</td>
<td></td>
</tr>
<tr>
<td>6 DDD Members</td>
<td></td>
</tr>
<tr>
<td>Based on the member’s responses to ALL CNA questions, assess the member’s functionality, social supports, and clinical needs. Select from the following to assess support needed: low, medium, or high.</td>
<td></td>
</tr>
<tr>
<td>7 Overall Impression</td>
<td></td>
</tr>
<tr>
<td>Based on the member’s responses to the CNA, what are the key pieces of information that must be in this particular member’s care plan?</td>
<td></td>
</tr>
</tbody>
</table>
Acknowledgements

We are truly grateful to the many, many dedicated professionals who have willingly shared their resources to support this work. Their spirit of cooperation has truly promoted the quality of care coordination services being delivered to children.

Members of the Massachusetts Child Health Quality Coalition’s Care Coordination Task Force and the special Care Coordination Needs Assessment Working Group the task force convened generously contributed their time and expertise in developing recommendations for a structured care coordination needs assessment process and elements for a standardized tool to use as part of that process. Members of the working group provided great insights on the process, generously shared their own tools, and also identified other tools for reference. Special thanks to Debbie Allen, Jeanne Clapper, Yokaira Landron, Beth Pond, and Bonnie Thompson for the resources they provided. Full lists of the members of each of the two groups can be found on CHQC’s website: www.masschildhealthquality.org/

Several other sets of resources were particularly helpful in this work, including:

- Resource links provided by the National Center for Medical Home Implementation (NCMHI), maintained under an agreement between the Maternal and Child Health Bureau (MCHB) and the American Academy of Pediatrics (AAP), the National Institute for Children’s Healthcare Quality (NICHQ), and earlier sources such as those in Enhancing Collaboration Between Primary and Subspecialty Care Providers for Children and Youth with Special Health Care Needs (Antonelli RC, Stille C); Freeman LC; 2005) were particularly useful.

- A compilation of resources is included in the recently-released Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs implementation guide by Jeanne W. McAllister, BSN, MS, MHA (Lucile Packard Foundation for Children’s Health, April 25, 2014)

- Readiness checklists developed as part of work focused on the transition to adult care also offer important insights to support the needs assessment process. These include the ADAPT (ADolescent Assessment of Preparation for Transition) and the earlier TRAC (Transition Readiness Assessment Questionnaire) surveys developed by Boston Children’s Hospital and resources available from GotTransition/Center for Health Care Transition. An extensive set of resources from the 14 state demonstration grant programs of the MCHB-funded Healthy and Ready to Work (HRTW) program were also very useful.