Vermont Health Care Innovation Project

Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 3

"Shared Plans of Care and Care Conferences"

Index

Third In-Person Learning Session: Faculty Biographies

Jeanne McAllister, BSN, MS, MHA

Jeanne McAllister is an Associate Research Professor of Pediatrics with Children's Health Services Research at Indiana University School of Medicine where her focus is on care coordination as a pathway to family-centered care. Jeanne's areas of interest span improvement science applications to pediatric health care reform with an emphasis upon children and families with special health care needs and the health care teams who work collaboratively to care for and with them. Jeanne joined CHSR to focus on the development of a statewide system for screening, evaluation and continuous coordinated care for children and families with neurodevelopmental disabilities. She has 30+ years of experience blending skills in health systems improvement with maternal and child health nursing, health science education and health care management.

Jeanne served as director and co-founder of the Center for Medical Home Improvement from 1997-2013. Her work with CMHI focused upon the development and sustainability of community-based primary care medical homes and interdisciplinary professional education for its staff. She has also served as Principal Investigator with the Lucile Packard Foundation for a Children's Health board grant, "Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs"; as Principal Investigator for HRSA MCHB system grants from 1997-2013; and as lead researcher for an AHRQ R18 medical home transformation study resulting in 2 peer-reviewed articles.

Jeanne received a Bachelor of Science in Nursing from the University of Vermont, a Master of Science in Health Professions Education from the University of Pennsylvania, and a Masters in Health Management and Policy from the University of New Hampshire

Jill S. Rinehart, MD FAAP

As the oldest sibling of two children with special health care needs, Dr. Rinehart grew up in Minnesota, with the intimacies of a family in need of the support a Medical Home provides. After receiving her undergraduate degree in English from Dartmouth College, Dr. Rinehart attended the University of Minnesota Medical School, where she participated in research on resiliency in siblings of children with disabilities. After completing pediatric residency at the University of Vermont School of Medicine she joined Dr. Hagan in full time private practice and quickly became a national leader in Medical Home issues, including participation in the Project Advisory Committee to the original AAP Medical Home Policy statement and her recent involvement in the development of the Lucille Packard Foundation for Children's Health "Achieving a Shared Plan of Care" paper and guide. Dr. Rinehart is currently concluding her first year leading a Pediatric Care Coordination Learning Collaborative

with VCHIP/CHIPRA designed to improve the capabilities of Vermont pediatric medical homes to provide effective care coordination to their families with complex needs. Her practice is featured in the AAP "Best Practice in Medical Homes" monograph. Dr. Rinehart currently serves as the American Academy of Pediatrics Vermont State Chapter Vice President and was the recipient of the 2012 "Green Mountain Pediatrician" award for her efforts to work collaboratively across all silos of our community to improve systems of care for children in Vermont.

Kristy Trask, RN, CLC

Kristy graduated from UVM in 1991 and 1993 with degrees in Health Education and Nursing respectively. She worked at UVM Medical Center for 7 years before joining Hagan, Rinehart and Connolly Pediatricians in 2000. During her time at HRCP, Kristy's role has evolved into a care coordinator position, working with children, families and community agencies to provide compassionate and coordinated care. Kristy is a Certified Lactation Counselor and enjoys working with mothers and infants around breastfeeding. Additionally in 2012, she was a graduate of the VT ILEHP (Interdisciplinary Leadership and Education for Health Professional) program at UVM.

Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 3
"Shared Plans of Care and Care Conferences"
March 16, 2016 (Sheraton Inn, Burlington, VT)
March 17, 2016 (Lake Morey Resort, Fairlee, VT)

AGENDA

8:30 AM - 9:00 AM	**Registration and Light Refreshments**
9:00 AM - 9:15 AM	**Welcome and Opening Remarks**
9:15 AM - 10:45 AM	**Creating and Implementing Shared Plans of Care** Jeanne McAllister, BSN, MS, MHA, Indiana University School of Medicine **Examples of Person-Directed Shared Plans of Care** Jill Rinehart, MD, FAAP, Hagan, Rinehart and Connolly Pediatricians
10:45 AM - 11:00 AM	**Mid-Morning Break**
11:00 AM - 12:00 PM	**Community Team Breakouts** Team Time to Develop or Refine Shared Plans of Care
12:00 PM - 1:00 PM	**Networking Lunch**
1:00 PM - 2:00 PM	**Conducting Effective Care Conferences** Jill Rinehart, MD, FAAP, Hagan, Rinehart and Connolly Pediatricians Kristy Trask, RN, CLC, Hagan, Rinehart and Connolly Pediatricians Shelly Waterman, Parent Partner
2:00 PM – 3:15 PM	**Community Team Breakouts** Practice care conferences with UVM Standardized Patients and Faculty
3:15 PM – 3:30 PM	**Mid-Afternoon Break**
3:30 PM – 4:15 PM	**Community Team Reports on Progress and Next Steps**
4:15 PM – 4:30 PM	**Closing Remarks and Celebration**

Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 3:
"Shared Plans of Care and Care Conferences"
March 16, 2016 (Sheraton Inn, Burlington, VT)
March 17, 2016 (Lake Morey Resort, Fairlee, VT)

Morning Community Team Breakout Session Discussion Guide
Team Time to Develop or Refine Shared Plans of Care

If your Community Team has already begun development of a Shared Plan of Care, consider how to refine it and share it.

If your Community Team has not yet begun development of a Shared Plan of Care, consider how to design it and share it.

Potential Content Areas:

- Person-Centered Information (e.g., About Me, Demographics)
- Insurance/Benefits Information
- Family/Support System (e.g., About My Family, Preferred or Emergency Contacts)
- Clinical/Health (e.g., Driving Diagnoses, Rx/Treatment, Utilization, Functional, DME)
- Social Issues (e.g. Financial/Legal, Housing, Transportation, Employment)
- Mental Health/Substance Abuse Information
- Care Team Information (e.g., Professionals and Services)
- Care Conference Information (e.g. Attendees, Outcome/Summary, Next Scheduled)
- Negotiated Goals (with strategies, timeline, responsibilities and accountabilities)
- Planned Follow-up and Duration
- Upcoming visits/appointments/events

Sharing the Care Plan:

- Ideal: assemble into e-health record, with prompts, person/family access through portal, and ability to message to other providers.
- Workarounds (more likely): Electronic, paper, scanned, cloud, jump drive, SharePoint, whatever it takes!
- Encourage person and family to advocate for use of care plan across organizations and systems.

- Establish frequency of follow-up (e.g., care coordinator contacts, assessment and monitoring of progress toward goals, planned check-ins, clear contacts for person/family/support person).
- Identify when the team will meet again if everything goes as planned.
- Identify and document triggers, such as transitions in care or acute episodes, that would bring the team together between planned care team meeting.
- Identify how the team will communicate.

Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 3: "Shared Plans of Care and Care Conferences"
March 16, 2016 (Sheraton Inn, Burlington, VT)
March 17, 2016 (Lake Morey Resort, Fairlee, VT)

Afternoon Community Team Breakout Session Discussion Guide
Standardized Patient Role Play

1. Identify a time keeper.
2. During first 5-10 minutes, read these instructions and the case study to learn about the activity and the person. Identify who from your community you would involve in the person's care team (including services already listed and those you feel would assist in her care). Match care team roles to people from your community who are attending today's session today so that the participants in the activity are playing themselves. Identify who will act as the team facilitator or lead care coordinator.
   Assemble the care team for a care conference with the patient and any family or friends she would like to bring to the meeting. Each team member should have a draft copy of the shared care plan template (either yours or the sample) and should be aware of the modifications to the template discussed during the morning breakout session.
3. Take 20 minutes to role play the care conference. At the end of the role play you should be able to complete your shared care plan template with:
   - Near-term goals and priorities of the person and the team
   - Action items with specific team members assigned
   - How the team will communicate between meetings
   - How the plan will be distributed and maintained
   - When the team will convene again
   - Acute events, such as emergency room visits, hospitalizations, loss of housing, that would trigger the team to convene sooner
   - Any other missing information the team needs to complete the shared care plan

   IMPORTANT: If the group gets stuck or strategies are not working during the role play, anyone can call a pause. The group can quickly brainstorm a solution, including swapping in or out one of the people participating in the role play and/or rewinding. The team should then resume. After 20 minutes the time keeper should stop the role play for reflection.
4. Take 10 minutes to reflect.
   - What went well?
   - How could it have gone better?
   - Who is missing on the care team?
   - Determine if you were able to identify all the necessary components of the shared care plan.
   - Based on your reflection identify clear strategies you will use to improve the care conference.
5. Take 20 minutes to repeat the role play from the beginning, integrating what you learned from the first attempt.
6. Take 10 minutes to reflect.
   - How did it go the second time around – better or worse?
   - What went well, and what still needs to be improved?
   - Based on your reflection, identify strategies you will use to improve care conferences.

Case Study

54-year-old woman who is unemployed and lives in her boyfriend's house with her adult son and sister. Active health issues include poorly controlled diabetes (fasting glucose is 580, HbA1c is 11), diabetic neuropathy in her feet, anxiety, depression, and cognitive delays.

Services

- Primary care, including care coordinator
- Diabetes educator
- Mental health counselor
- VCCI care coordinator
- Transportation
- SASH
- Designated Mental Health Agency – CRT and CSP

Strengths

- Works well with team
- Strong desire to improve health
- Compassionate and caring

Challenges

- Recently moved to Vermont at request of now-deceased husband
- Very few supports
- Unstable housing; recently homeless; now living with boyfriend
- Unemployed
- Lacks consistently reliable transportation
- Upon purchase of car, does not have money for food or utilities
- No refrigerator for insulin
- Threat of violence from sister who lives with her (not sleeping due to threat of violence)

Person's Priorities

- Stable housing
- Transportation

Overdue Care

- Eye exam
- Dental care

Systems Issues

- Incompatible health records delaying communication among care team
- Mental health agency unable to share care notes and not participating in care team meetings

Sample Shared Plan of Care #1

Shared Care Plan

Patient Information

Patient's Name:			Mobile Phone Number:	
Birthdate:	Age:	Sex:	Home Phone Number:	Email Address:
Address:			Preferred Method of communication: ☐ Phone ☐ Email ☐ Text ☐ Other:	

Insurance Information

Primary Insurance:		ID Number:
Policy Holder:	Policy Holder birthdate:	Employer:
Secondary Insurance:		ID Number:
Policy Holder:	Policy Holder birthdate:	Employer:

Emergency Contact Information

Name:	Relationship:
Home Phone Number:	Work Phone Number:
Legal Decision Maker Information:	

ED Plan

About Me

Insert picture here	Preferred activities:
	How I learn:
	Interaction tips:
	Communication style:
	Tips to avoid triggers/behaviors:
	Mobility:

My Care Plan

My Care Team			
Lead Care Coordinator:		Phone:	
Organization:		Email:	
Primary Care Physician:		Phone:	
Organization:		Email:	
Name	Organization & Role	Email	Phone Number

My Strengths

My Goals			
Personal Goals	Steps needed to achieve the goal	Person Responsible	Date Completed
1.			
2.			
3.			
4.			
5.			

Medical Goals	Steps needed to achieve the goal	Person Responsible	Date Completed
1.			
2.			
3.			
4.			
5.			

Possible challenges with meeting a goal	Plans for how to handle these challenges

Future Goals

Participant's signature _____ Date:_____

Lead Care Coordinator's signature _____ Date:_____

Sample Shared Plan of Care #2

Last review and update:

Shared Plan of Care (Medical Summary & Negotiated Actions)

SEE EMERGENCY CARE INFORMATION ON PAGE 2

PATIENT INFORMATION

First Name:	Last Name:	Middle:	Sex:	Birthdate:	Age:	MRN/System:

ABOUT ME

[INSERT PICTURE]

Strengths & preferred activities:	
How I learn:	
Interaction tips:	
Communication style:	
Tips to avoid triggers/behaviors:	
Mobility:	

DEMOGRAPHIC INFORMATION

Primary contact last name:	First:	Relationship to patient:

Street Address:	City:	County:	State:	Zip:

Mailing Address:	City:	State:	Zip:

Email (Preferred? ☐Y ☐N):	Phone (Preferred? ☐Y ☐N):	Secondary Phone (Preferred? ☐Y ☐N):

Legal Decision Maker Information:

Emergency Contact Information:

Insurance Information

Primary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	
Secondary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	
Waiver	Type:		☐ Waiting List	Date applied:	
Medicaid redetermination date:					

Who are the people living in your home(s)? (Include you, and any other children or adults living with you.)

Primary Household			Secondary Household		
First and last names	Age	Relationship to your child	First and last names	Age	Relationship to your child
Self		**Self**			

Last review and update:

ALERTS

EMERGENCY/ADVANCED CARE INFORMATION:

**If needed, please see attached emergency or advanced care plan.*

MEDICATION ALLERGIES:

VITAL SIGNS

Height:		Weight (date):	
Baseline BP/HR:		Baseline RR:	

BMI:		Percentile:		Z-score:	

CONDITIONS & MEDICAL HISTORY LIST

DIAGNOSIS		DATE OF DIAGNOSIS	DIAGNOSIS		DATE OF DIAGNOSIS
Birth/Genetic:			Cardiovascular:		
Dental:			Endocrine:		
Ears, Nose, and Throat:			Gastrointestinal:		
Genitourinary:			Hematology:		
Infectious Disease:			Musculoskeletal:		
Neurologic:			Ophthalmology:		
Psychiatric/Psychological:			Renal:		
Respiratory:			Skin:		
Neurodevelopmental:			Behavioral:		

MEDICATIONS & TREATMENTS

Medication name	Form	Dose	Time of day	Reason	Route (by mouth unless noted). Other comments:

Last reconciled:	
Special medication instructions:	
Treatment Plan:	
Medication History:	
Allergies:	
Diet:	
Current Equipment:	
Equipment Needs:	

PROFESSIONALS & SERVICES

Primary care clinician:		Phone:		Fax:	
Non-clinician contact:		Phone:		Email:	

Last visit:				
Street Address:	City:	State:	Zip:	Practice:

Preferred pharmacy:		Phone:		Fax:	
Preferred hospital:		Phone:		Fax:	

Last review and update:

OTHER PROVIDERS	NAME/TYPE/LOCATION	LAST VISIT	REASON FOR SERVICE	CONTACT INFORMATION
Specialist 1:				
Specialist 2:				
Specialist 3:				
Specialist 4:				
Psych / Behavior:				
Dentist:				
Vision:				
Therapy (OT/PT/etc.):				
Hearing:				
Home Care:				
Community agency:				
Government services:				
Waiver/Other case manager:				
Equipment/Vendor:				

IMMUNIZATIONS

DTaP/DTP/TD								
OPV/IPV					HPV			
MMR			Varicella			Hep A		
Hep B				Meningococcus				
PPD				Pneumovax				
Flu								
HIB				Rotovirus		Tdap		

FAMILY MEDICAL HISTORY

Condition	Who?	Condition	Who?	Condition	Who?
Coronary Artery Disease:		Hypertension:		Diabetes:	
Mental Health:		Cancer Type:		Genetic:	
Neurodevelopmental:		Lipids:		Other:	

NOTES:

HOSPITALIZATIONS (date, reason, location if known)

SURGERIES (date, reason, location if known)

PROCEDURES (labs, imaging, etc.)

DIAGNOSIS SPECIFIC MONITORING

Last review and update:

ABOUT MY FAMILY

Race/Ethnicity:	
Unique family attributes:	
Family description of health condition:	
Family's support "system"	
Family life stressors:	
Housing:	☐ Own ☐ Rent
Emergency exit plan (fire, tornado, etc.):	
Transportation access/safety:	
Caregivers' occupations:	
Family financial concerns:	

SCHOOL

Current setting:	First Steps:	Head Start:	Preschool:
	K-12; Grade:	Homeschooled:	Other:

Current school name:		Current School District:	
Primary Contact:	☐ Classroom teacher	☐ Teacher of Record	☐ Other:
Contact name:		Contact Email:	Contact Phone:

Previous setting:	First Steps:	Head Start:	Preschool:
	K-12; Grade:	Homeschooled:	Other:

Previous school name:		Previous School District:	

Services:
☐ Has a 504 Plan ☐ Has an individualized education plan (IEP/IFSP) ☐ Behavioral Intervention Plan ☐ Response to intervention (RTI)
☐ Gifted services ☐ Physical therapy (PT) ☐ Occupational therapy (OT) ☐ Speech
☐ Other:

Educational History:

CHILDCARE

Childcare type:	☐ Full-time	☐ Part-time	☐ In-home	☐ Center-based	☐ Voucher supported	☐ Respite only
Primary contact:	☐ Classroom teacher	☐ Director	☐ Other**:**			

Contact name:		Contact Email:		Contact Phone:	

NOTES/OTHER

Last review and update:

Plan of Care: Negotiated Actions

Prioritized Goals	Action Items/strategies (To reach short term goals)	Person responsible	Resolved (Date)
Family Personal Goals & Priorities			
			☐Completed ☐In progress ☐On Hold ☐Dropped
			☐Completed ☐In progress ☐On Hold ☐Dropped
			☐Completed ☐In progress ☐On Hold ☐Dropped
Collaboration with/request from primary care and community			☐Completed ☐In progress ☐On Hold ☐Dropped
Clinical Goals & Priorities			
			☐Completed ☐In progress ☐On Hold ☐Dropped
			☐Completed ☐In progress ☐On Hold ☐Dropped
			☐Completed ☐In progress ☐On Hold ☐Dropped
Collaboration with/request from primary care and community			☐Completed ☐In progress ☐On Hold ☐Dropped
Parking Lot/Future Goals			

Family Signature: **Clinician Signature:** **Care Coordinator Signature:**

Date: **Date:** **Date:**

Care Coordinator:
Phone:
Email:

Sample Shared Plan of Care #3

Vermont Agency of Education and
Agency of Human Services
Interagency Agreement

Section 1:
Coordinated Service Plan (CSP) Forms

Version: April 9, 2009

For a CSP	➔	Complete Section 1
For referrals to LIT or SIT	➔	Complete Sections 1 & 2
For referrals to CRC	➔	Complete Sections 1, 2, & 3

1. Coordinated Service Plan Overview

"A ***Coordinated Services Plan*** is a written addendum to each service plan developed by an individual agency for a child or adolescent with severe emotional disturbance which shall be developed when the eligible child has needs that require services from more than one agency. It shall be designed to meet the needs of the child within his or her family or in an out-of-home placement, and in the school and the community." (Act 264, revised, 1989)

In 2005, an additional ***Interagency Agreement*** was developed in which "eligible children and youth are entitled to receive a coordinated services plan developed by a service coordination team including representatives of education, the appropriate departments of the Agency of Human Services, the parents or guardians, and natural supports connected to the family. The coordinated services plan includes the Individual Education Plans (IEP) as well as human services treatment plans or individual plans of support, and is organized to assure that all components are working toward compatible goals, progress is monitored, and resources are being used effectively to achieve the desired result for the child and family. Funding for each element of the plan is identified." (Interagency Agreement, 2005)

PLEASE NOTE: Coordination of services *provides coordination of planning* ***but not*** *entitlement for specific services. Approval for specific services and/or placements is the responsibility of the appropriately involved agency or agencies. Established approval processes must be followed in implementing components of this plan.*

Factors to Consider in Developing a Coordinated Services Plan

1. **Are the parents, guardians, and /or educational surrogate parents, on the team?**
   - Other family members or friends on the team? Can the child/youth participate?
   - Are there representatives from the appropriate agencies such as community mental health, local education agency, and Agency of Human Services Divisions and Programs?
2. **What are the goals of the plan?**
   - What are the child/youth, family, and other treatment team members' goals?
   - Do the recommended supports and services help to achieve those goals? *Goals should not be a list of services*, rather what is hoped to be attained with supports and services.
   - Is the CSP team (including the family) in agreement?
3. **What are the strengths of the child and family?**
   - How is the child successful? What are the child's interests?
   - What natural supports and resources are available to the child?
   - What are the strengths of the family?
4. **What are the needs of the child and family?**
   - What are the areas of concern and need? (What are the clinical concerns?)
   - What other stressors are impacting the child and the family?
5. **Are there current written assessments? What was the purpose of the assessments?**
   - Does the assessment include the family?
   - Does the assessment include strengths of the individual and the family?
   - Were the evaluators familiar with local resources?
   - Have past evaluations been reviewed and recommendations implemented?
   - What level of risk exists?
   - Is the child on an IEP?
   - Has medication been considered and for what purpose?
6. **What local services have been tried?**
   - For how long, and what were the results?
   - Did community-based services actively involve the parents?
   - If the results were not positive at that time, what do CSP team members believe were the reasons? Can these reasons be reduced/eliminated sufficiently to significantly improve the prospect for success?
   - Who has participated in supports, and in treatment or services?
   - What less restrictive interventions have been tried? If less restrictive interventions have been ruled out, explain why. (*It is important to note that our system of care supports serving the child in the least restrictive manner appropriate to the child/youth's well-being.*)
7. **What is the local CSP team recommending?**
   - What are the CSP team recommendations? Is the team in agreement?
   - What will constitute a successful outcome? How are the recommendations related to the stated need?
8. **How will the team be accountable?**
   - When will the team next meet to determine if the plan has been implemented?
   - Since a change for the better is expected, how will the team determine if it is happening?
   - What indicators will measure progress?

2. Consent for Eligibility Determination & Coordinated Services Planning

Child/Youth's Name	Lead Agency

A Coordinated Services Plan (CSP) is a process that follows a series of steps to help children and youth realize their hopes and goals. People from the child or youth's life work as a team to develop a plan that brings together the services and supports needed. I understand that as a parent I am a member of the CSP team.

I give my consent to the lead agency to start the process of determining if my child is eligible for a CSP. Often eligibility is part of the initial CSP meeting when information is gathered and reviewed about how particular agencies or departments are involved with the child/youth.

If my child is eligible, I give consent for the CSP team to develop a coordinated services plan.

I understand that:

- I must also sign a *Consent for Release of Information* form (page 3). The *Consent for Release of Information* will let the lead agency share my child's information with the CSP team. The CSP team members are listed on page 4.
- The lead agency will let me know within 30 days of when it gets this signed form and the signed *Consent for Release of Information* whether or not my child is eligible.
- Records that the lead agency has gathered throughout the coordinated services planning process are confidential. The lead agency will not share these records with others without first getting my consent in writing unless the law says they must be shared.
- I can look at or get a copy of these records by writing a letter to the lead agency.
- I will be given a copy of this consent form after I sign it.
- If I do not give my consent the lead agency cannot determine if my child is eligible for a CSP and a CSP cannot be developed.
- My child's current benefits and services will not be affected if I do not give my consent.

If my child is found eligible, I want to speak with my Local Interagency Team's parent representative before the *Coordinated Services Plan* meeting.	☐ Yes ☐ No

	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (*if applicable*)			

3. Consent for Release of Information

Child/Youth's Name	Lead Agency

I consent to the sharing of information about my child to the Coordinated Services Planning Team (CSP team). The CSP team members are listed on page 4. I understand that as a parent I am a member of the CSP team.

I understand that:

- My child's information includes records of educational, psychological, social history, ~~medical evaluations,~~ health history and services given to my child.
- My child's information will be shared with the CSP team and primary care provider so that the team can determine if my child is eligible for a CSP and if so, develop and implement a CSP for my child.
- I can look at or get a copy of the information about my child that is shared with CSP team and primary care provider by writing a letter to the lead agency.
- The CSP team and primary care provider knows that my child's information is confidential. The team will not share information about my child with others without first getting my consent in writing unless the law says it must be shared.
- This consent form expires one year from the date that I sign it.
- I can take away my consent at any time by writing a letter to the lead agency, except for when the CSP team has already used the information.
- If I do not give my consent, the CSP team and primary care provider cannot determine if my child is eligible for a CSP and my child will not get a CSP.
- My child's current benefits and services will not be affected if I do not give my consent.
- I will be given a copy of this consent form after I sign it.
- General information about the usefulness of the coordinated services planning process is gathered by the State Interagency Team. Information from my child's CSP may be used in this effort, but information on my child and family will not be identified.

I want to speak with my Local Interagency Team's parent representative.	☐ Yes ☐ No

	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (*if applicable*)			

4. Lead Agency

Lead Agency & Representative:	Date:
Lead Agency Address:	Phone:
Person completing form:	Phone:

5. Background Information

Child/Youth's Name:	Gender:
Date of Birth:	Age:
Name of parent (1): Phone:	Physical Address: Mailing Address:
Name of parent (2): Phone:	Physical Address: Mailing Address:
Guardian (*if applicable*):	Address: Phone:
Educational surrogate parent (*if applicable*):	Address: Phone:
Legal Custody: ☐ Both parents ☐ Mother ☐ Father ☐ Department for Children & Families ☐ Other (*please describe*):	
Name of current caretaker (*if not parent*):	Address: Phone:

6. CSP Team Participants

Name (*Please Print*)	Relationship to child/youth

7. Elements of a Coordinated Services Plan

A. What are the hopes and goals for this child or youth?
(Family voice and choice is an important value of the coordinated services planning process. Please make sure that the child or youth and family members have an opportunity to speak first.)

B. What are the family and child/youth's strengths, resources, and natural supports that can help realize those hopes and goals?
(Natural supports include family members' networks of relationships and community resources.)

C. What are the needs, challenges, concerns, and priorities that must be considered?
(*Use existing plans and assessments as well as current experience to identify these.*)

7. Elements of a Coordinated Services Plan (cont.)

D. What are the current supports and services that help realize those hopes and goals?

Support / service	Responsible party	Current status & funding

E. What is the proposed plan of supports and services?
(*Consider how these address the needs in 7C.)*

Support / service	Responsible party	Date to begin	Current status & funding

Date of CSP review (*no more than one year from date of current plan*):

8. Elements of a Proactive Crisis Plan

***Use this section only if needed* and/or attach existing agreed upon behavior plans or support documents that address this need across environments.**

Teams are strongly encouraged to develop a proactive crisis plan if the child or youth is medically fragile, at risk for, or has ever been hospitalized in a psychiatric setting, or demonstrates risky and unsafe behaviors.

Situation (triggers/stressors)
Coping strategies (Describe skills, strategies, to prevent, reduce or de-escalate crisis)
What is needed to feel safe in crisis?
Key support people to contact – include names, relationship and contact information.
What to do to manage the crisis?
What NOT to do
Conditions for emergency room, police, hospital

PLEASE NOTE: *There may be special or unusual circumstances that will require the responsible adults to modify the plan.*

9. Appeal Process

Most Coordinated Services Planning Teams are able to write and successfully implement a child or youth's Coordinated Service Plan. At times, **a team** may need to turn to its Local Interagency Team (LIT) for technical assistance, consultation or dispute resolution. Occasionally, a **LIT** may need to turn to the State Interagency Team (SIT) for technical assistance, consultation or dispute resolution. **Parents**, as members of a Coordinated Services Planning Team, may turn to the LIT or SIT for dispute resolution.

PLEASE NOTE: *If a parent has a dispute regarding* ***service delivery*** *rather than* ***service coordination*** *s/he must use the appropriate dispute resolution mechanism(s) in the section C. below.*)

A. Act 264 Appeal Process Regarding Coordination of Services

A local agency, a service provider or a parent on the team may request an appeal concerning coordination among the agencies under Act 264 and related provisions of the Interagency Agreement.

An appeal is available if the State Interagency Team is unable to resolve the dispute. The SIT shall inform the local agency, service provider(s) and parent(s)of their right to an appeal and provide the name and address for submitting the appeal.

The appeal process shall consist of a hearing pursuant to Chapter 25 of Title 33. The hearing shall be conducted by a hearing officer appointed by the Secretary of the Agency of Human Services and the Commissioner of Education. Based on evidence presented at the hearing, the hearing officer shall issue written findings and proposals for decision to the Secretary and the Commissioner. The Secretary and the Commissioner may affirm, reverse, or modify the proposals for decision. All parties shall receive a written final decision of the Secretary and the Commissioner.

B. Appeal Process Regarding Issues of Payment and Reimbursement between Agencies

When a non-education agency fails to provide or pay for services for which they are responsible and which are also considered special education and related services, the school district (or state agency responsible for developing the child's Individualized Education Plan [IEP]) shall provide or pay for these services to the child in a timely manner. The school district (or state agency responsible as the education agency) may then claim reimbursement for the services from the non-education agency that was responsible and failed to provide or pay for these services. The procedures outlined in the Interagency Agreement of June 2005 shall be used for reimbursement claims between agencies.

C. Other Grievance Procedures Available to Parents.

In addition to the opportunity to file an appeal regarding coordination of services under Act 264, the parent has the right to other grievance procedures depending on the nature of the service and complaint. Those grievance procedures may include but are not limited to:

1) Parent's complaints regarding the provision of a free appropriate public education and other rights under the Individuals with Disabilities in Education Act: contact the Agency of Education at (802) 479-1255.
2) Managed Care Organization grievance related to Medicaid Coverage: contact the Green Mountain Care Board 1-800-250-8427.
3) Grievances related to Medicaid Eligibility: contact the Green Mountain Care Board 1-800-250-8427.
4) Complaints or grievances regarding staff performance or quality of programs: contact the supervising provider responsible for service delivery.

Below is a script for opening dialogue with a person and/or their family during the planned care visit

Opening of the Visit

We are pleased to be able to meet with you (and your child today).

More than anything else, our intention is to:

- *Hear from you about what matters the most (regarding your child)*
  <u>And</u>
- *Learn how we can help you to get what you need (to support your child and family)*

{Introduce clinician and then make typical visit disclaimers….}

End of the Visit:

- *We hear you saying what matters most to you is . . . (share Negotiated Actions/ draft)*
- *Together we have 3 months to work with you around these important goals.*
- *What will happen next is…x, y, z.*

Planned Coordinated Care: Care Coordination Intake

Please use the following to think through your top concerns and priorities. We will discuss these on the phone and/or at your visit. Thank You.

Person's Name_____Date_____
Family Name _____

1) What would you like us to know about you?
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? (Some examples below)

- ❑ Doing things for themselves
- ❑ Learning
- ❑ Sleeping
- ❑ Self-care
- ❑ Making and keeping friends
- ☐ Trouble at work
- ☐ Communication
- ☐ Behavior
- ☐ The future
- ☐ Other

4) Have there been any important changes recently, such as a:

- ❑ Child leaving home?
- ❑ Move to a new town?
- ❑ Sickness or death of a loved one?
- ☐ New job or job change?
- ☐ Separation or divorce?
- ☐ Other (fill in below)?

5) Can we help you with any of the following needs? **(Adapt to the domains in your Camden Card)**

- ○ **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/Work** (For example, keeping a job; help reading or understanding medical information)?
- ○ **Legal** (For example, discussing laws and legal rights about your health care)?
- ○ **Financial** (For example, understanding insurance or finding help paying for needs that insurance does not cover - such as medications, formulas, or equipment)?
- ○ **Environmental** (For example help finding clean rugs, air filters or safety items for your home)
- ○ **General.** Please let us know what else you need help with (if we don't know, we will work with you to help find the answer)?

➢ Place for your thoughts and/or notes:

Planned Coordinated Care: Pediatric Care Coordination Intake

Families, please use the following to think through your top concerns and priorities for your child. We will discuss these on the phone and/or at your visit. Thank You.

Child/Youth Name_____Date_____
Family Name _____

1) What would you like us to know about your child?
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? (Some examples below)

- ❑ Their growth/development
- ❑ Learning
- ❑ Sleeping
- ❑ Self-care
- ❑ Making and keeping friends
- ❑ Communication
- ☐ Doing things for themselves
- ☐ Falling behind in school
- ☐ Behavior
- ☐ The future
- ☐ Playing with friends
- ☐ Other

4) Have there been any important changes recently, such as a:

- ❑ Brother of sister leaving home?
- ❑ Move to a new town?
- ❑ Sickness or death of a loved one?
- ☐ New job or job change?
- ☐ Separation or divorce?
- ☐ Other (fill in below)?

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)?
- ○ **Legal** (For example, discussing laws and legal rights about your child's health care or their school needs)?
- ○ **Financial** (For example, understanding insurance or finding help paying for needs that insurance does not cover - such as medications, formulas, or equipment)?
- ○ Environmental (For example help finding clean rugs, air filters or safety items for your home)
- ○ **General.** Please let us know what else you need help with (if we don't know, we will work with you to help find the answer)?

➢ Place for your thoughts and/or notes: