



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

## **REQUEST FOR APPLICATIONS (RFA) (COMPETITIVE)**

**PHPA 4124/BPM059150**

**Issue Date: October 2, 2026**

### ***Statewide Care Coordination Program for Children and Youth with Specific Health Care Needs***

#### **NOTICE**

A Prospective Applicant that has received this document from the Maryland Department of Health, or that has received this document from a source other than the Procurement Officer, and that wishes to assure receipt of any changes or additional materials related to this RFA, should immediately contact the Procurement Officer and provide the Prospective Applicant's name and mailing address so that addenda to the RFA or other communications can be sent to the Prospective Applicant.

**STATE OF MARYLAND  
MARYLAND DEPARTMENT OF HEALTH  
RFA KEY INFORMATION SUMMARY SHEET**

**Request for Applications:**           **Statewide Care Coordination Program for Children and Youth  
with Specific Health Care Needs**

**Solicitation Number:**               **PHPA 4124/BPM059150**

**RFA Issue Date:**                   **October 2, 2026**

**RFA Issuing Office:**               **Maryland Department of Health  
Office of Children & Youth with Specific Health Care Needs**

**Procurement Officer:**           **Nikita Real BS, MPH  
Maryland Department of Health  
201 West Preston Street  
Baltimore, Maryland 21201  
Nikita.Real@maryland.gov**

**Grant Monitor:**                   **Bailey House, MPH  
Title V CYSHCN Program Manager  
Office of Children & Youth with Specific Health Care Needs  
Maryland Department of Health  
201 West Preston Street  
Baltimore, Maryland 21201**

**Pre- Proposal Conference:**       **October 16, 2026 at 12:00PM  
Meeting link available on eMMA**

**Questions due date and time:**   **November 6, 2026, at 2:00 pm EST Local Time**

**Applications are to be sent to:**   **eMaryland Marketplace Advantage (eMMA)  
(<https://emma.maryland.gov/page.aspx/en/usr/login?ReturnUrl=%2fpage.aspx%2fen%2fbuy%2fhomepage>). For  
questions and/or technical assistance, please contact  
[emma.helpdesk@maryland.gov](mailto:emma.helpdesk@maryland.gov). In addition, you may visit  
<https://procurement.maryland.gov> for additional  
information.**

**Closing Date and Time:**           **November 13, 2026, at 2:00pm EST Local Time**

## **SECTION 1 - GENERAL INFORMATION**

### **1.1 Summary Statement**

- 1.1.1 The Maryland Department of Health (MDH or the Department), Office of Children and Youth with Specific Health Care Needs (OCYSHCN), is issuing this Request for Applications (RFA) to fund a single entity to provide consistent statewide care coordination services to ensure equitable access for all Children and Youth with Specific Health Care Needs (CYSHCN) and their families.
- 1.1.2 It is the State's intention to obtain services as specified in this RFA, from an Agreement between the selected Applicant and the State. The anticipated duration of services to be provided under this Agreement is three years with one (1) two-year (2-year) option period. The anticipated dates of services to be provided under this agreement are: July 1, 2027 to June 30, 2030 with an option period from July 1, 2030 to June 30, 2032.
- 1.1.3 The Department intends to make a single award as a result of this RFA.
- 1.1.4 Applicants, either directly or through their subcontractor(s), must be able to provide all services and meet all the requirements requested in this solicitation and the successful Applicant shall remain responsible for performance regardless of subcontractor participation in the work.

### **1.2 Contract Type**

- 1.2.1 The Agreement resulting from this solicitation shall be a cost reimbursement.

### **1.3 Procurement Officer**

- 1.3.1 The sole point of contact in the State for purposes of this solicitation prior to the award of any Agreement is the Procurement Officer at the address listed below:

Nikita Real BS, MPH  
Maryland Department of Health  
201 West Preston Street  
Baltimore, Maryland 21201  
Nikita.Real@maryland.gov

- 1.3.2 The Department may change the Procurement Officer at any time by written notice.

### **1.4 Grant Monitor**

- 1.4.1 The Grant Monitor is:

Bailey House, MPH  
Title V CYSHCN Program Manager  
Office of Children & Youth with Specific Health Care Needs  
Maryland Department of Health

201 West Preston Street  
Baltimore, Maryland 21201

- 1.4.2 The Department may change the Grant Monitor at any time by written notice.

## 1.5 eMaryland Marketplace Advantage

- 1.5.1 Each Applicant is requested to indicate its eMaryland Marketplace Advantage (eMMA) vendor number in the Transmittal Letter (cover letter) submitted at the time of its application submission to this RFA.
- 1.5.2 eMMA is an electronic commerce system administered by the Maryland Department of General Services. The RFA and associated materials, the solicitation and summary of the Pre-Proposal Conference, Applicant questions and the Procurement Officer's responses, addenda, and other solicitation-related information will be provided via eMMA.
- 1.5.3 In order to receive a contract award, a vendor must be registered on eMMA. Registration is free. Go to <https://procurement.maryland.gov/>, click on "Register" to begin the process, and then follow the prompts.

**Note: If you are part of an organization with multiple applicants, please ensure each applicant is registered under its own eMMA number (SUP #). An SUP can only be used once per solicitation. Please reach out to the eMMA Help desk for any additional information. [emma.helpdesk@maryland.gov](mailto:emma.helpdesk@maryland.gov)**

### Pre- Proposal Conference

A pre-Proposal conference (Conference) will be held at the date, time, and location indicated on the Key Information Summary Sheet.

Attendance at the Conference is not mandatory, but all interested parties are encouraged to attend in order to facilitate better preparation of their Proposals. If the solicitation includes an MBE goal, failure to attend the Conference will be taken into consideration as part of the evaluation of an offeror's good faith efforts if there is a waiver request.

It is highly recommended that ALL Prime Contractors bring their intended subcontractors to the Conference/Site Visit to ensure that all parties understand the requirements of the contract and the MBE Goal.

MBE subcontractors are encouraged to attend the Conference to market their participation to potential prime contractors.

Following the Conference, the attendance record and summary of the Conference will be distributed via the same mechanism described for amendments and questions (see Section 1.5.2 eMMA).

## 1.6 Questions

- 1.6.1 Written questions from prospective Applicants will be accepted by the Procurement Officer. Questions to the Procurement Officer shall be submitted via e-mail to the following e-mail address: [Nikita.Real@maryland.gov](mailto:Nikita.Real@maryland.gov)  
Please identify in the subject line the Solicitation Number and Title.

- 1.6.2 Questions are requested to be submitted no later than the due date indicated on the RFA Key Information Summary Sheet. The Procurement Officer, based on the availability of time to research and communicate an answer, shall decide whether an answer can be given before the Application due date.

#### **1.7 Application Due (Closing) Date and Time**

- 1.7.1 Applications, in the number and form set forth in Section 4.2 "Applications" must be received by the Procurement Officer, in eMaryland Marketplace (eMMA) no later than 2:00 pm EST Local Time on November 13, 2026 in order to be considered. If emailing please identify in the subject line the Solicitation Number and Title.
- 1.7.2 Requests for an extension of this time or date will not be granted. Applications received after the due date and time listed in this section will not be considered. Questions regarding this solicitation should be directed (By e-mail only, no phone calls will be accepted) to the PROCUREMENT OFFICER.
- 1.7.3 Applications may be modified or withdrawn by written notice received by the Procurement Officer before the time and date set forth in this section for receipt of Application. Multiple and/or alternate Applications will not be accepted.

#### **1.8 Award Basis**

- 1.8.1 The Grant shall be awarded to responsible Applicants submitting Applications that have been determined to be the most advantageous to the State, considering price and evaluation factors set forth in this RFA, for providing the activities as specified in this RFA. See RFA Section 5 for further award information.

#### **1.9 Revisions to the RFA**

- 1.9.1 If it becomes necessary to revise this RFA before the due date for Applications, the Department shall endeavor to provide addenda to all prospective Applicants that were sent this RFA, or which are otherwise known by the Procurement Officer to have obtained this RFA.
- 1.9.2 Acknowledgment of the receipt of all addenda to this RFA issued before the Application due date shall be included in the Transmittal Letter accompanying the Applicant's Project Narrative. Acknowledgement of the receipt of addenda to the RFA issued after the Application due date shall be in the manner specified in the addendum notice. Failure to acknowledge receipt of an addendum does not relieve the Applicant from complying with the terms, additions, deletions, or corrections set forth in the addendum.

#### **1.10 Cancellations**

- 1.10.1 The State reserves the right to cancel this RFA, accept or reject any and all Applications, in whole or in part, received in response to this RFA, waive or permit the cure of minor irregularities, and conduct discussions with all qualified or potentially qualified applicants in any manner necessary

to serve the best interests of the State. The State reserves the right, in its sole discretion, to award a Grant based upon the written Applications received without discussions or negotiations.

- 1.10.2 In the event a government entity proposes and receives the recommendation for award, the contract, application and solicitation for this RFA may be canceled, and the award processed in accordance with COMAR 21.01.03.01.A(4). If the services that are the subject of the RFA are currently being provided under an interagency agreement with a public institution of higher education and the State determines that the services can be provided more cost effectively by the public institution of higher education, then the RFA may be canceled in accordance with Md. Code Ann., State Finance and Procurement Art., § 3-207(b)(2).

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## **SECTION 2 – MANDATORY REQUIREMENTS**

### **2.1 Applicant Mandatory Requirements**

The Applicant must provide proof with its application that the following Mandatory Requirements have been met:

- 2.1.1 The Applicant shall be a social organization as defined per Section 7-402 of the State Finance and Procurement Article of the Annotated Code of Maryland or a local, state government agency, public college or state university.
- 2.1.2 For social organization Applicants (not local, state government agency, public college, or state university), the Applicant must be a nonprofit organization, classified by the IRS as tax-exempt under section 501(c)(3) of the Internal Revenue Code. Applications must include attachments of the following documentation from the applicant:

**REQUIRED DOCUMENTATION:** Documentation of tax-exempt status of the Applicant or the Applicant's fiscal sponsor (i.e., IRS tax exempt status determination letter)

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## **SECTION 3 – SCOPE OF WORK**

### **3.1 Background and Purpose**

#### **Background:**

The Office of Children and Youth with Specific Health Care Needs' (OCYSHCN) mission is to ensure a comprehensive, coordinated, culturally aware, and family-focused system of care that meets the needs of Maryland's children and youth with specific health care needs and their families. The vision of OCYSHCN is that every child born in Maryland receives comprehensive newborn screening, and those with specific health care needs enjoy a full life from childhood through adulthood, thrive in systems that support their families and their social, health and emotional needs, and experience dignity, autonomy, independence, and active participation in their communities.

There is a clear need for an integrated, family-centered care coordination model that begins early and spans medical and community services and agencies.

Applicants to this Request for Applications may initiate a new program or add to an existing program within the applicant organization providing care coordination services to Children and Youth with Specific Health Care Needs (CYSHCN) and their families.

#### **Purpose:**

The Maryland Department of Health (MDH), Prevention and Health Promotion Administration (PHPA), Maternal and Child Health Bureau (MCHB), Office of Children and Youth with Specific Health Care Needs (OCYSHCN) is issuing this solicitation to fund a single entity to provide consistent statewide care coordination services to ensure equitable access for all Children and Youth with Specific Health Care Needs (CYSHCN) and their families.

#### **Objectives:**

The objectives of this agreement with the Office of Children and Youth with Specific Health Care Needs are to:

1. Provide standardized, comprehensive, culturally aware, and family-focused care coordination service to Maryland families caring for children and youth with specific health care needs (CYSHCN) using tools and protocols provided by the Office of Children and Youth with Specific Health Care Needs.
2. Operationalize a tiered approach to the provision of services, to include assessment of both the caregiver and the child with specific health care needs to determine level of need, assignment to the appropriate tiered level of support, and re-assessment at regular intervals.
3. Provide capacity building training and educational opportunities to caregivers of CYSHCN and to youth with specific health care needs (YSHCN), thereby preparing them to navigate the system more easily, comfortably, and successfully and giving them the ability to manage their child's/their own care in the future.

For purposes of this project, the Office of Children and Youth with Specific Health Care Needs is adopting the definition of Care Coordination from "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework" published by [The Commonwealth Fund](#) and later incorporated into the [Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0](#).

*Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.*

Core principals of the Maryland Statewide Care Navigation Program are that:

1. Services shall be standardized and consistent across the State.
2. Services shall be easily accessible to families with the burden resting with the program to find families, not on families to find the program.
3. Every point of contact with the program requires a response to support access to appropriate medical, behavioral health, educational, and social services.
4. Services shall emphasize self-reliance and family empowerment and be designed and delivered to strengthen the client/client representative's ability to navigate systems independently over time, as appropriate.
5. This "safety net" program shall support clients and client representatives:
  - a. Who do not receive care coordination through other benefits.
  - b. Who already receive coordination services but still have unaddressed needs by providing gap-filling support.
  - c. Who are uninsured or underinsured and require support to access medical care.

## **3.2 Scope of Work - Requirements**

The Applicant shall:

### **3.2.1 General Requirements**

#### **3.2.1.1 Comply with The Americans with Disabilities Act**

- A. The Americans with Disabilities Act (<https://www.ada.gov/>) protects qualified individuals with disabilities from discrimination on the basis of disability in services, programs, and activities. Accessibility and inclusion of diverse populations are essential to reduce health disparities for vulnerable populations. Vendors must comply with all ADA requirements in their work to ensure the needs of persons with disabilities and other vulnerable populations are met. This includes, but is not limited to:
  - a. facilities and any venues used for meetings/conferences are accessible.
  - b. requested accommodations are provided in a timely manner; and
  - c. written and printed materials developed in accessible formats (easy to read, large print, etc.), or providing access to alternative formats.
- B. For grants which include direct patient care or service delivery through a program, the ADA requires entities provide full and equal access for people with disabilities. This includes, but is not limited to:
  - a. Reasonable modifications of policies, practices, and procedures;
  - b. Effective communication; and
- C. Accessible facilities.

#### **3.2.1.2 Comply with Maryland Children and Youth with Specific Health Care Needs Statewide Care Coordination Services Program Implementation Guide**

- A. Through the award of MDH Procurement ID Number, PHPA 3238/ BPM047339, "Planning for a Statewide System of Care Navigation," (issued November 15, 2024)

OCYSHCN is developing a “Program Implementation Guide.” Applicants must agree to comply with the *Maryland Children and Youth with Specific Health Care Needs Statewide Care Coordination Services Program Implementation Guide* (the Guide).

- a. This request for applications will detail certain requirements noted within the Guide. Applicants are expected to explain how requirements will be met. The applicant may expand on known guidelines or policies in their application.
- b. As a result of MDH Procurement ID Number, PHPA 3238/ BPM047339, certain Local Health Departments are currently engaged in a pilot of processes noted within the Guide. Exhibit E contains a Draft Program Implementation Guide. This is for reference only and is not intended to serve as the final *Maryland Children and Youth with Specific Health Care Needs Statewide Care Coordination Services Program Implementation Guide*.
- c. Revisions to the Guide by the selected Applicant are permitted, with the approval of MDH, Office of Children and Youth with Specific Health Care Needs.
- d. Applicant recognizes the right of MDH to revise system policies, procedures, and guidelines, with advanced notification, if possible, during the grant period.

### **3.2.1.3 Comply with State and Federal privacy and reporting requirements**

#### **A. Data security**

- a. Compliance with the Health Information Portability and Accessibility Act (HIPAA) and the Maryland Protection of Information in Government Agencies Act (MD PIGA) by limiting access to clients’ PHI/PII and other sensitive information to the persons or classes of persons within the vendor who need access to the information to carry out their job duties.
- b. Compliance with applicable COMAR regulations for safeguarding and protecting confidentiality of information and data.

#### **B. Record Retention**

- a. Maintain adequate records that fully describe the nature and extent of all services provided to clients, including but not limited to care planning documents, activity records, and medical records as required by Maryland regulations and statutes, as well as applicable HIPPA rules.
- b. See Maryland regulations and statutes at [mgaleg.maryland.gov](http://mgaleg.maryland.gov)

#### **C. Comply with mandated reporter laws and procedures for child abuse or neglect.**

## **3.2.2 Specific Requirements**

### **3.2.2.1 Operational Requirements**

- A. Applications should include descriptions of how operational requirements will be met and who is responsible for the operational requirements.
- B. Beyond compliance with the Americans with Disabilities Act (see Section 3.2.1.1), certain accessibility standards are required or encouraged of the Statewide Care Coordination Services Program (the Program).
  - i. Physical Accessibility
    1. While brick-and-mortar location(s) are not a requirement of this RFA, Applicants planning for a physical location should describe:
      - a. The anticipated location, purpose, and benefit of physical location(s).

- b. Accessibility standards that go beyond the minimum ADA requirements to meet the needs of diverse clients/client representatives.
  - ii. Digital accessibility
    - 1. Digital materials, spaces, and communication should meet the [Web Content Accessibility Guidelines \(WCAG\) 2.2](#) Level AA standards.
  - iii. Written and verbal communications accessibility
    - 1. In accordance with Executive Order 01.01.2024.25, signed on July 23, 2024, and creating a Maryland Plain Language Initiative, written communications for clients/client representatives shall be clear, concise, and well-organized.
    - 2. Beyond the Plain Language Initiative, OCYSCHN requires that written materials pass health literacy assessments prior to publication.
      - a. Applications should include applicant's own health literacy standards for written materials OR may use the MDH standard minimums:
        - i. 4th-6th grade reading level on the SMOG (Simplified Measure of Gobbledegook)
        - ii. 90% score on the CDC Clear Communication Index
        - iii. 80% score on the PEMAT (Patient Education Materials Assessment Tool)
    - 3. Verbal communications shall be in plain language and adapted to each client/client representative needs.
    - 4. Communications with clients/client representatives will be conducted in the client/client representative's preferred language or via certified interpreter.
      - a. Applications should describe how services will be provided in the client/client representative's preferred language.
- C. General Communication
  - i. Establish and maintain multiple modes of communications designed to meet the needs of referring agencies and clients/client representatives. These modalities include in-person, phone (voice), phone (text), and video conferencing.
  - ii. Establish and maintain a clear, secure, HIPAA-compliant, and accessible communication path for enrolled clients, providers and staff to answer questions, resolve problems, and provide information.
  - iii. Establish and maintain a system to house current addresses, phone numbers, and other contact information for clients and their representatives, including a policy to securely share contact information.
  - iv. Establish and maintain a client contact procedure.
- b. Hours of Operation
  - i. Applications should describe how the program will accommodate reasonable day, time, and location preferences for the client/client representatives served under this agreement.
- c. Information System(s)
  - i. Applicants shall use an electronic data system to uniformly document all communication, activities, forms, and notes. This includes communication via text, phone, email, and fax.
  - ii. Applications should name and describe what system(s) will be used to keep records and data, including any licensing and access requirements.

1. System(s) should be selected to:
    - a. Allow for the accurate and timely processing of data for reporting as specified in section 3.2.6.
    - b. Reduce overall burden on families to report similar information multiple times or complete unnecessary or complicated forms.
    - c. Facilitate information sharing among service providers and agencies where possible.
  2. Electronic records are the property of the Maryland Department of Health.
- d. Continuity of Operations
- i. In the event of any disruption in grant funded services, the vendor will provide MDH with a status report of operations by telephone or email by the end of the next business day. Include the scope of the problem and contingency plan to reconvene services in the status report.

### **3.2.3 Planning, Collaboration and Oversight**

#### **A. Planning**

- a. Applicants must submit a detailed master work plan with the grant application.
  - i. Applicants shall submit a detailed master Work Plan (see §4.3.1.4 for sample template).
  - ii. The Work Plan must include objectives, activities, measures of effectiveness, data sources, time frame, and team members responsible for each overarching program goal or activity.
- b. Present an overview of the master work plan to OCYSHCN staff within 10 business days of the project start date at the “kick-off” meeting as described in section 3.2.2.2.B.
- c. Within 15 business days of the project start date, provide an updated master work plan based on discussion at the initial kick-off meeting.

#### **B. Collaboration**

- a. Kick-off Meeting
  - i. Within 10 business days of the project start date, participate in a kick-off meeting with OCYSHCN staff.
  - ii. The purpose of this meeting is to:
    1. Review invoicing procedures.
    2. Review the submitted master work plan to ensure alignment (OCYSHCN and Vendor).
    3. Schedule recurring meetings as discussed in section 3.2.2.2.B.b (OCYSHCN and Vendor).
    4. Establish protocols around shared documents and data as discussed in section 3.2.2.2.B.d. (OCYSHCN and Applicant).
- b. Recurring Meetings
  - i. Meet with OCYSHCN staff on a recurring basis to update on the status of work plan components, get input or clarifications, and collaborate to ensure expectations are aligned throughout the project period.
  - ii. Additional collaboration requirements include:
    1. Provide agendas (when needed) for meetings in advance.
    2. Take meeting notes and provide summaries of action items and assigned staff after each meeting.

3. Provide copies or access to all notes, slides, and materials presented during meetings after each meeting.
  4. Provide an updated copy of the work plan indicating the current status and upcoming activities.
  5. Provide a data summary that provides a snapshot of program growth or maintenance (see section 3.2.6)
- c. Meeting Scheduling
    - i. Meeting frequency, days and times, will be determined together between OCYSHCN staff and the Applicant, but the meetings will be at least monthly during the pre-implementation period.
    - ii. Meetings should be scheduled at grant start or as soon as a need is identified.
  - d. Shared documents
    - i. Applicant shall house program documents within a shared drive provided by MDH in a way that allows collaboration in a timely and efficient manner and ensures that OCYSHCN has the ability to provide feedback on processes and deliverables.
    - ii. OCYSHCN and the Maryland Department of Health reserves the right to maintain and use any surveys, educational materials, or recruitment materials, rubrics, data, or other materials developed as a direct component of this project.
  - e. Responsiveness to communication
    - i. Respond to communications from OCYSHCN within three (3) business days and in a thorough manner.
  - f. Maryland Children and Youth with Specific Health Care Needs Statewide Care Coordination Services Program Implementation Guide and Program Standard Operating Procedures.
    - i. In accordance with Section 3.2.1.2 of this RFA, the provided *Maryland Children and Youth with Specific Health Care Needs Statewide Care Coordination Services Program Implementation Guide* may be revised upon discussion with and approval from OCYSHCN.
    - ii. Standard Operating Procedures not explicitly outlined within the Guide shall be developed by the selected applicant at its discretion and upon reasonable discussion with OCYSHCN.

### 3.2.4 Pre-Implementation Period

- A. OCYSHCN recognizes that the first year of project funding will require a period of program development, which shall be referred to as the pre-implementation period.
- B. Applicants to this Request for Applications may initiate a new program or add to an existing program within the applicant organization providing care coordination services to Children and Youth with Specific Health Care Needs (CYSHCN) and their families.
- C. Submit a detailed master work plan with the grant application.
  - a. The Work Plan must include objectives, activities, measures of effectiveness, data sources, time frame, and team members responsible for each program goal.
  - b. The Work Plan must delineate the pre-implementation period and outline when and how the following components will be implemented:
    - i. Development of Capacity Building Curriculum (see also Section 3.2.5.G.b.vi)

1. A primary objective of this project is to provide capacity building training and educational opportunities to caregivers of CYSHCN and to youth with specific health care needs (YSHCN), thereby preparing them to navigate the system more easily, comfortably, and more successfully and giving them the ability to manage their child's/their own care in the future.
  2. Capacity building is defined as: Activities that increase an individual's skills, confidence, and ability to navigate systems and manage their or their child's care over time.
  3. Applications should include a detailed plan to develop a capacity building curriculum.
    - a. Applicants may adopt existing capacity building curriculums or modules or may develop new content or curriculum or both. (Consider referring to the [National Center for Care Coordination Technical Assistance](#))
    - b. Applications should include a list of baseline topics that would be developed or compiled to support capacity building.
    - c. Health Care Transition shall be included in the capacity building curriculum.
  4. The selected applicant shall continue to develop and expand on the curriculum throughout the funding period as needed to meet client needs.
- ii. Development of policies and procedures
    1. As noted in Section 3.2.2.1, Standard Operating Procedures not explicitly outlined within the Guide shall be developed by the selected applicant at its discretion and upon reasonable discussion with OCYSHCN.
  - iii. Staff hiring, onboarding, and training
    1. Because applicants to this RFA may initiate a new program or add to an existing program within the applicant organization, the submitted Work Plan should describe hiring, onboarding, and training needs and time frames in detail.
    2. While hiring staff with lived expertise is not a requirement of this RFA, the application should note if the intent is for any staff to have experiential understanding.
    3. See also, Section 3.2.7, Staffing and Training
  - iv. Initial program promotion and client recruitment
    - c. Development of program outreach materials and messaging, referral source list and pathways, and overall outreach strategy.
    - d. Outreach plan should be submitted to MDH for review and feedback.
    - e. Other program promotion and recruitment requirements are listed in section 3.2.5.D.

### **3.2.5 Implementation**

- A. Applicants to this Request for Applications may initiate a new program or add to an existing program within the applicant organization providing care coordination services to Children and Youth with Specific Health Care Needs (CYSHCN) and their families.

- B. Applications and the submitted Work Plan shall specify the anticipated implementation date.
- C. A core principle of the program is that services shall be standardized and consistent across the State, however, OCYSHCN recognizes that full statewide implementation may happen incrementally. Applications and the submitted Work Plan shall specify if incremental implementation is planned, and if so, the anticipated date(s) and progression.
- D. **Recruitment and Referral**
  - a. A core principle of the program is that services shall be easily accessible to families with the burden resting with the program to find families, not on families to find the program.
    - i. Recruitment refers to actions the selected applicant will take to “find families.”
    - ii. Referral refers to the actions that OCYSHCN and other external organizations will take to direct clients/client representatives to program services.
    - iii. Self-referral refers to the actions taken by clients/client representatives to enroll in program services of their own volition.
    - iv. Recruitment shall be active and driven by seeking out clients (outreach) where they are. Applications and submitted work plans should describe recruitment and other outreach activities in detail.
      - 1. Outreach activities shall include connections with state agencies and community-based organizations.
      - 2. Outreach activities shall further include development and dissemination of MDH-approved outreach materials.
  - b. Referrals and self-referrals shall originate from OCYSHCN screening programs and/or be the direct result of outreach activities and is a submitted form or a request (written or verbal) for assistance that comes from a client, client representative, or another agency, organization, or provider.
  - c. Guidance regarding referral and self-referral procedures shall be included in the Program Implementation Guide.
  - d. Applications should include information on how referrals will be accepted and steps to be taken upon referral or self-referral.
  - e. Applications must include:
    - i. Target enrollment numbers for each year of implementation.
    - ii. An estimated TOTAL client capacity for when the program is at full implementation.
- E. **Eligibility**
  - a. Clients must:
    - i. Be age 0-22
    - ii. Be a child or young adult with a specific health care need
    - iii. Live in Maryland
  - b. There is no eligibility requirement related to insurance or citizenship status. The program shall be available to all children with specific health care needs living in Maryland, regardless of insurance or citizenship status.
  - c. Client representatives can be any caregiver, parent, legal guardian, or family member of the client who has access to the information needed for the referral or to coordinate care for the child or youth.
    - i. Applications should describe how the program will ascertain legal standing to provide consent, when required.
- F. **Enrollment**

- a. An objective of the program is that enrollment shall include assessment of family/caregiver level of need (client representative) and CYSHCN (the client) level of need, assignment to an appropriate tier of service provision, and re-assessment at regular intervals while the family is enrolled in the program.
  - i. Assessment of level of need
    1. All referrals shall receive a response of some sort.
    2. Once a referral has been received, assessment of level of need and tier determination should begin but does not have to be concluded prior to providing assistance.
  - ii. Assignment to tier of service provision
    1. Tiers are generally used to ensure that clients/client representatives receive the level of service that best meets their unique needs.
    2. Tier determination guidance shall be included in the Guide.
    3. Tier determination is for internal use only for resource allocation and data reporting purposes. The client/client representative does not need to know their tier.
    4. Generally, the tiers are:
      - a. Tier 1 – Provide Information/Referral. For families who need brief information or a one-time connection and have relatively limited needs and/or strong existing supports.
      - b. Tier 2 – Warm Handoff to Partner. For families best served by another existing program, where your primary role is to make a warm handoff and ensure connection.
      - c. Tier 3 – Short Term Enrollment. For families needing shorter-term, focused coordination and skill-building around a limited number of goals.
      - d. Tier 4 – Long Term Enrollment. For families with multi-system, high-complexity needs, high stress, and limited support who would benefit from more intensive, longer-term coordination.
  - iii. Re-assessment at regular intervals
    1. Routine re-assessment of level of need shall take place at regular intervals.
    2. This is a separate process from assessment of program satisfaction.
  - iv. A core principle of the program is that this “safety net” program shall support clients and caregivers who do not receive care coordination through other benefits. If a client already receives system coordination services but still has unaddressed needs, the program can provide gap-filling support.

#### **G. Services while enrolled**

- a. Facilitated Community Connections
  - i. Tiers 1 and 2 are intended to meet gap-filling needs.
  - ii. Service provision for Tier 1 or 2 clients/client representatives shall include a facilitated community connection to applicable resources and/or an alternate service provider
  - iii. Applications should include information on:
    1. Response timeframe

2. How resources will be ascertained and maintained
  3. How connections will be made
  4. Follow-up with client/client representative
- b. Care Coordination
- i. Clients/client representatives assigned to Tier 3 or Tier 4 shall receive comprehensive, culturally aware, and family-focused care coordination services.
  - ii. Care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.
    1. This section represents the core service delivery phase of the program and builds directly on information gathered during referral, assessment of need, intake, and care plan and continues until families are ready to graduate from the program.
    2. Care coordination service delivery guidance shall be included in the Guide.
    3. Applications should include information on how each element of care coordination services will be addressed and who is responsible.
  - iii. Elements of care coordination services include:
    1. Intake and assessment of need
    2. Care Planning
    3. Capacity Building
    4. Ongoing re-assessment of need
    5. Graduation
    6. Case closure
  - iv. Intake and Assessment of Need
    1. The primary purpose of intake and assessment is to gather sufficient information to:
      - a. Finalize or refine client tier to ensure the client has the right level of support
      - b. Develop a shared understanding of the client's needs and build rapport to support meaningful, appropriate care coordination, while minimizing burden on families
      - c. Jointly identify client strengths, challenges, and priority goals
      - d. Initiate shared care planning tools
  - v. Care Planning
    1. Activities essential to care planning include:
      - a. Identification of client needs and creation of a Care Plan
      - b. Addressing client needs by:
        - i. Connecting clients/client representatives to referrals and resources and otherwise helping families problem-solve barriers (example: transportation to appointments)

- ii. Providing education, training, and coaching to client/client representative to build capacity, empowerment, and self-reliance skills
- iii. Conducting joint planning with client/client representatives to prepare the client for success (care mapping, emergency planning, and health care transitions)
- iv. Assisting or supporting clients in finding, scheduling, following up, paying for, addressing insurance issues, preparing for appointments or paperwork, or navigating health care appointments and services
- v. Facilitating communication across systems and providers
- vi. Making warm handoffs whenever possible to minimize client/client representative burden
- vii. Follow-up with families to ensure connections were made

## 2. Creation of a Care Plan

- a. The Care Plan is a written document that allows staff to work alongside the client/client representative to map out the client's specific medical, developmental, or behavioral goals, including interventions delivered by the staff to meet those goals, and outcomes.
- b. Beginning during intake and continuing throughout the care coordination service, complete and update the Care Plan.
- c. Goals should be:
  - i. Client/client representative-driven and centered
  - ii. Mutually agreed upon by client and client representative, where appropriate
  - iii. Realistic
  - iv. Focused on improving access to services, reducing barriers, and including capacity building goals
- d. The care plan should remain flexible and responsive. Coordinators should regularly review and revise the Care Plan with the client/client representative:
  - i. As the client/client representative meets goals within the plan.
  - ii. As responsibilities shift in capacity building or health care transition.
  - iii. When required by the client's change in medical condition.
  - iv. When the client transitions from one setting to another.
- e. Care Mapping
  - i. The Care Map is a visual tool that helps families and care coordinators understand the child's care team, services, and supports across systems.

- ii. Care coordinators will help guide and assist client/client representatives in developing a care map. The process will help find gaps and missing or weak connections that need to be addressed in the Care Plan.
  - iii. The care mapping activity should be completed early in the process and before an initial care plan is solidified but not before the client/client representative's urgent needs are met.
  - iv. Care Plans should incorporate issues identified in the care mapping activity.
- f. Shared Plan of Care (SPOC)
  - i. The Shared Plan of Care is a document that ensures that all providers and support persons involved in the child's care are aligned around their current goals and progress.
  - ii. Care coordinator will prepare the SPOC with the client/client representative collaboration before graduation or within 1 year, whichever is sooner;
  - iii. With family consent, this document can be shared with the child's medical providers, education team, and other social service providers to support coordinated care.
- g. Emergency Preparedness
  - i. The Emergency Preparedness document will ensure that the client/client representative are adequately prepared for medical events, personal emergencies, community emergencies, or other disruptions to care.
  - ii. Care coordinators will assist the client/client representative in completing the Emergency Preparedness document and associated activities before graduation or within 1 year, whichever is sooner;
  - iii. Issues, barriers, or goals that come out of reviewing Emergency Preparedness document should be incorporated into the larger Care Plan.
- h. Health Care Transition (HCT)
  - i. Health Care Transition activities shall be incorporated into services for clients who are age 12 and above.
  - ii. The HCT Plan is an addendum to the overall Care Plan and will ensure that the client/client representative are adequately prepared to move from a child-centered health care system to an adult-centered health care system and have the information, skills, and support needed to manage changes in care.

- iii. Care coordinators will assist the client/client representative in completing an initial HCT Plan before graduation or within 1 year of enrollment or turning 12 if already enrolled, whichever is sooner.
- iv. General goals of HCT planning include:
  - 1. Increasing understanding of adult systems and eligibility criteria
  - 2. Supporting youth participation in decision-making
  - 3. Facilitating continuity of care
  - 4. Ensuring that families know where to turn for support following the transition
- v. Tools used to support the creation of the HCT plan and the furtherance of its goals, include but are not limited to:
  - 1. The Youth Transition Readiness Assessment (or the or Parent/caregiver version) published by Got Transitions in the Six Core Elements of Health Care Transition™
  - 2. Charting the LifeCourse
- vi. Issues, barriers, or goals that come out of reviewing and preparing the client/client representative's HCT plan should be incorporated into the larger Care Plan.
- vii. If the client has an existing HCT plan, a new one should not be developed but any goals should be incorporated in the overall Care Plan.
- viii. Care coordinators should transition from working with the client representative to working with the client to address the Care Plan goals, as appropriate for that client, their condition, and their needs, thus modeling the dynamic change in the larger system.
- vi. Capacity Building
  - 1. The selected applicant shall provide capacity building training and educational opportunities to caregivers of CYSHCN and to youth with specific health care needs (YSHCN), thereby preparing them to navigate the system more easily, comfortably, and more successfully and giving them the ability to manage their child's/their own care in the future.
  - 2. Capacity building is also discussed in Section 3.2.4.C.b.i, Pre-Implementation Period.
  - 3. Applications should include a detailed plan to develop a capacity building curriculum.
  - 4. Applications should also include:
    - a. A clear indication of understanding the purpose of capacity building for clients/client representatives

- b. A statement of goals for the capacity building curriculum
  - c. Proposed activities included in the capacity building curriculum. Activities may include, but are not limited to: group and individual education and skill-building, coaching, and a progressive shift in responsibility
- vii. Ongoing re-assessment of need
  - 1. At least annually, or according to each individualized care plan, reassess the needs of the client/client representative including their physical, mental, cognitive, social, functional and environmental health status, and determine the use of and need for additional resources and supports.
  - 2. Applications should include process descriptions of how re-assessment of need will be addressed and by whom.
- viii. Graduation
  - 1. “Graduation” is an integral part of the capacity building curriculum and the program as a whole, but is not a requirement.
    - a. Graduation should be a purposeful and supportive process and is only for those client/client representatives who have gotten their needs met and/or fulfilled their capacity building goals to a degree they can successfully manage their child’s/their own care in the future.
    - b. Graduation reinforces the program’s emphasis on self-reliance and family empowerment.
    - c. Applications should include:
      - 1. A clear indication of understanding the theory behind graduation from the program
      - 2. A detailed description of pre-requisites for graduation
      - 3. A statement of how clients/client representatives will be supported absent graduation from the program
  - 2. Case Closure
    - a. Case closure may occur through planned graduation, early completion of goals, or other circumstances such as loss of contact, changes in eligibility, family decision to discontinue participation, relocation out of Maryland, or aging out of eligibility.
    - b. In all cases, the reason for closure should be documented clearly in the record and does not preclude future re-enrollment of the client/client representative in the program.

### **3.2.6 Program Assessment and Reporting**

- A. Program assessment shall be two-fold
  - a. Routine assessment shall be conducted to gauge client/client representative satisfaction with program services and supports
  - b. Routine assessment shall be conducted to evaluate the program’s success overall

- B. Client/client representative satisfaction
  - a. Applications should describe how client/client representative satisfaction will be evaluated
  - b. Applications should further describe how assessments indicating a lack of client/client representative satisfaction will be addressed
- C. Program Evaluation
  - a. Applications should describe how referral source satisfaction will be evaluated
  - b. Applications should describe how the program in its entirety shall be evaluated
    - i. Applicants will be expected to incorporate quality improvement (QI) activities into operations to critically review the effectiveness of chosen strategies, policies, or procedures. These QI activities should lead to adjustment or improvement strategies as needed to optimize their effectiveness.
    - ii. Applications should indicate any methodology or process for quality improvement.
- D. Data Collection and Sharing
  - a. Applications should include the establishment of incremental goals for enrollment, “lives touched,” and number of graduated clients/client representatives
  - b. Applicants shall provide a monthly summary report during check-in meetings that include:
    - i. Total number of clients
    - ii. Average number of clients per care coordinator
    - iii. Number of completed forms/activities (e.g. emergency planning, health care transition, care mapping, care plans, capacity building)
    - iv. Care coordination outcomes (e.g. resource/referral, evaluation, and goal data)
    - v. Recruitment/outreach data (e.g. contacts attempted, new enrollments)
    - vi. Revenue from billing
    - vii. Data should be stratified by demographics, status, and tier
- E. Reporting
  - a. Final reportable performance measures shall be determined in collaboration between the Applicant and OCYSHCN.
  - b. Possible performance measures include, but are not limited to:
    - i. # of outreach events in each Maryland county/region
    - ii. # of families referred in each Maryland county/region
    - iii. # of clients/client representatives assessed
    - iv. # of clients/client representatives assigned to given tiers
    - v. # of clients/client representatives re-assessed
    - vi. # of clients/client representatives moved to a different tier
    - vii. # of care plans reviewed and updated
    - viii. # of emergency information forms created
    - ix. # of emergency information forms reviewed and updated
    - x. # of health care transition plans created
    - xi. # of referrals to other organizations (including how many to each organization)
    - xii. # of capacity building training activities provided to individual caregivers of CYSHCN
    - xiii. # of capacity building training activities provided to individual YSHCN

- xiv. # of capacity building training/educational activities provided to a group of caregivers
- xv. # of capacity building training/educational activities provided to a group of YSHCN
- xvi. # of clients/client representatives graduated from the program
- xvii. # of cases closed
- xviii. # of client satisfaction surveys completed
- xix. Narrative explanation of any program changes resulting from client satisfaction surveys
- c. While final performance measures shall be determined post-award, in all cases, reporting shall be:
  - i. Monthly
    - 1. Smaller summary data and information reported during monthly check-in meetings.
  - ii. Quarterly invoicing and reporting submitted to OCYSHCN via online forms
  - iii. Annual final report

### **3.2.7 Staffing and Training**

#### **A. Staffing**

- i. A core principle of the program is that services shall be standardized and consistent across the state. Applications should include a detailed staffing plan that describes:
  - 1. How standardized statewide coverage will be achieved, including experiential knowledge of specific geographic areas
  - 2. Staff categories or titles and anticipated experience providing care coordination services, working with CYSHCN and their families, and working within Maryland systems
  - 3. Roles and responsibilities
  - 4. Goal staffing numbers for each grant year
- ii. Provide a Curriculum Vitae (CV)/Resume for each proposed staff member. The Applicant is required to have experience managing this type of care coordination service provision and this experience should be highlighted on the CV of all relevant team members.
- iii. The Applicant will have a designated Project Director who oversees all project activities and is the main point of contact for the Department.
- iv. The Applicant will have a designated Fiscal contact.
- v. A single individual may fulfill multiple roles. If so, the Applicant should highlight this in their initial work plan.
- vi. The Applicant may employ or subcontract to fulfill the requirements of the grant. If the applicant plans to use subcontracts or sub-vendors, the applicant should clearly outline who the subcontractor is (or what type of vendor, if unknown) and what parts of the scope of work the subcontractor will be responsible for in the workplan.

#### **B. Training**

- i. As noted in Section 3.2.4, Pre-Implementation Period, the submitted Work Plan should describe hiring, onboarding, and training needs and time frames in detail.
- ii. Training and professional development should be provided to staff to support them in their work and ensure the highest quality service is provided to clients
  - 1. This includes topics that are:
    - a. Legally required
    - b. Required to meet each program component or activity
    - c. Would enhance the effectiveness or quality of the services provided
  - 2. Budget submissions may include limited funding for staff professional development or training
- iii. At minimum, Applicant and all project-affiliated staff shall complete Department HIPAA training prior to working with families.

### 3.2.8 Program Reach

- A. There are over one million children in Maryland.
- B. There are approximately 300,000 children and youth with specific health care needs in Maryland.
- C. According to the National Survey of Children's Health (NSCH), a child must experience a specific health consequence that is caused by a medical, behavioral, or other health condition lasting or expected to last 12 months or longer to qualify as a child or youth with a special health care need.
- D. As noted in Section 3.2.2.4, Implementation, referrals and self-referrals shall originate from OCYSHCN screening programs and/or be the direct result of outreach activities and is a submitted form or a request (written or verbal) for assistance that comes from a client, client representative, or another agency, organization, or provider.
- E. There are approximately 150 babies identified by newborn bloodspot screening each year.
- F. Applications should include estimates of how many clients/client representatives can be served annually at each service level tier, keeping in mind that Tier 1 may involve only a one-time connection, while Tier 4 will involve long-term enrollment. The expectation is that, given variations in support levels, approximately 1,000 clients/client representatives can be served annually.

### 3.2.9 Vendor Revenue

- A. The program shall be available to all clients meeting eligibility criteria (see section 3.2.5.E) at **no cost to the client**.
- B. The selected applicant may bill the client's health insurance carrier for care coordination services but **balances** (including co-pays, co-insurance, deductibles, or other balances after insurance payment) **may not be billed to the client or client's family**.
- C. If the selected applicant bills clients' health insurance for some or all care coordination services then the expectation is that the overall grant funding will support more clients or more services per client.

### 3.2.10 Applicant Qualifications

#### A. Required qualifications

- a. Applications should include descriptions detailing how these requirements will be met and provide evidence of experience or capability.
  - i. Availability beyond the termination of this grant for the accountability of any services performed as part of the Contract including, but not limited to, providing documents and witnesses.
  - ii. Applications must demonstrate organizational capacity. This can be demonstrated by evidence of:
    1. Understanding of the Maryland health care system and support services.
    2. At least two (2) years of knowledge and experience with medically complex children and/or adults with disabilities, comorbid conditions, and individuals experiencing poverty. These may include private, public, nonprofit, local, regional, and national entities.
    3. Demonstrated ability to provide services in a time-efficient and cost-effective manner.
    4. Demonstrated communication and/or coordination with other programs and groups serving medically complex children and/or adults with disabilities in community-based services.
    5. Ability to communicate in other languages and/or provide interpreter services for clients' preferred language.
    6. Ability to provide written materials in alternative formats, if requested. Formats include translators, interpreters, large print, and electronic copies.

### **3.3 Invoicing**

#### **3.3.1 General**

(a) All invoices shall include the following information:

- Grantee name;
- Remittance address;
- Federal taxpayer identification number (or if sole proprietorship, the individual's social security number);
- Invoice period;
- Invoice date;
- Invoice number
- State assigned Contract number;
- State assigned (Blanket) Purchase Order number(s);
- Goods or services provided; and
- Amount due.

Invoices submitted without the required information cannot be processed for payment until the Contractor provides the required information.

(b) The Department reserves the right to reduce or withhold Grant payment in the event the Grantee does not provide the Department with all required deliverables within the time frame specified in the Grant or in the event that the Grantee otherwise materially breaches the terms and conditions of the Grant until such time as the Grantee brings itself into full compliance with the Grant.

#### **3.3.2 Invoice Submission Schedule**

The Grantee shall submit invoices in accordance with the following schedule:

Invoices and resulting payment are based on performance for services/goods provided.

| Quarterly Invoice            | Performance Period     | Due Date         |
|------------------------------|------------------------|------------------|
| Q1                           | 7/1/2027 - 9/30/2027   | October 15, 2027 |
| Q2                           | 10/1/2027 - 12/31/2027 | January 15, 2028 |
| Q3                           | 1/1/2028 - 3/31/2028   | April 15, 2028   |
| Q4                           | 4/1/2028 - 6/30/2028   | July 15, 2028    |
| Final Financial Report (440) | 7/1/2027 - 6/30/2028   | August 30, 2028  |

3.3.3 Insurance Requirements - The recommended awardee must provide current certificate(s) of insurance with the prescribed coverages, limits and requirements set forth in this section within five (5) Business Days from notice of recommended award. During the period of performance for multi-year contracts, the Grantee shall provide certificates of insurance annually, or as otherwise directed by the Contract Monitor. Any insurance furnished as a condition of the Contract shall be issued by a company authorized to do business in the State of Maryland.

- 3.3.3.1 Subcontractor Insurance - The Grantee shall require any subcontractors to obtain and maintain comparable levels of coverage and shall provide the Contract Monitor with the same documentation as is required of the Contractor.
- 3.3.3.2 The following type(s) of insurance and minimum amount(s) of coverage are required:
- A. Commercial General Liability - of \$1,000,000 combined single limit per occurrence for bodily injury, property damage, and personal and advertising injury and \$3,000,000 annual aggregate. The minimum limits required herein may be satisfied through any combination of primary and umbrella/excess liability policies.

## **SECTION 4 – APPLICATION FORMAT**

### **4.1 Two-Part Submission**

- 4.1.1 Applicants shall submit applications in separate volumes:
- Volume I – Project Narrative
  - Volume II – Budget Justification/Narrative

### **4.2 Applications**

- 4.2.1 Applications must be submitted to eMaryland Marketplace Advantage (eMMA), or the RFA email address [RFA.PHPA@maryland.gov](mailto:RFA.PHPA@maryland.gov). The Procurement Officer will not accept submission after the date and exact time stated in the Key Information Summary Sheet.

4.2.1.1 The submission subject line shall state the RFA Title and PHPA number and either Project Narrative or Budget Narrative.

- 4.2.1.2 Two Part Submission:
- A. Project Narrative (See Section 4.3)
  - B. Budget Narrative (See Section 4.4)

- 4.2.2 Applications will be shown only to State employees, members of the Evaluation Committee, or other persons deemed by the Department to have a legitimate interest in them.

**\*All information submitted as part of this proposal is subject to release under the Public Information Act (PIA). If you would like the Maryland Department of Health (MDH) to consider redactions in the event that your proposal is subject to a PIA request, submit a proposed PIA copy including justifications for each redaction and under what statute that justification is qualified for redaction.**

### **4.3 Volume I – Project Narrative**

**Note: No pricing information is to be included in the Project Narrative (Volume 1). Pricing information is to be included only in the Budget Justification/Narrative (Volume II).**

- 4.3.1 The Project Narrative shall include the following documents and information in the order specified as follows:

#### **4.3.1.1 Transmittal Letter:**

- Applicant;
- Solicitation Title and Solicitation Number that the Proposal is in response to;
- Signature, typed name, and title of an individual authorized to commit the Applicant to its Proposal;
- Federal Employer Identification Number (FEIN) of the Applicant, or if a single individual, that individual's Social Security Number (SSN);
- Applicant's eMMA number;

- Applicant's MBE certification number (if applicable);
- Applicant's SBR number (if applicable) – please contact eMMA at 410-767-1492 if you don't know your number.

**4.3.1.2 Scope of Work/Work Plan** shall include the Scope of Work, including the Work Plan (as described in Section 3.2).

**4.3.1.3 Mandatory Requirements Documentation**

**4.3.1.4 Applicant Technical Response to RFA Requirements and Proposed Work Plan:**  
(A work plan template is provided as Exhibit E)

- The Applicant shall address each Scope of Work requirement (Section 3.2) in its Project Narrative and describe how its proposed services, including the services of any proposed subcontractor(s), will meet or exceed the requirement(s). If the State is seeking Applicant agreement to any requirement(s), the Applicant shall state its agreement or disagreement. Any paragraph in the Project Narrative that responds to a Scope of Work (Section 3.2) requirement shall include an explanation of how the work will be done. Any exception to a requirement, term, or condition may result in having the Application classified as not reasonably susceptible of being selected for award or the Applicant deemed non-responsive.
- Applicant shall acknowledge they have read the American with Disabilities Act Statement in Section 3.2 and will meet all requirements.

**4.3.1.5 Signed W-9 with Contact Person Names and Phone Number**

**4.3.1.6 SDAT Status- Maryland State Department of Assessments & Taxation (SDAT).**  
[Visit https://sdat.dat.maryland.gov/RealProperty/Pages/default.aspx](https://sdat.dat.maryland.gov/RealProperty/Pages/default.aspx) for additional information.

- The applicant shall take the necessary steps to ensure good standing with the Maryland State Department of Assessments & Taxation.
- The applicant must be in good standing at the time the award is made.

|                                         |
|-----------------------------------------|
| <b>4.4 Volume II – Budget Narrative</b> |
|-----------------------------------------|

**4.4.1** Under a separate folder from the Project Narrative and clearly identified in the format identified in Section 4.2 “Applications,” the Applicant shall submit a copy of the Budget Narrative. The Budget Narrative shall contain all price information in the format specified in **Exhibit C**. The Applicant shall complete the Budget Narrative Form only as provided in the Budget Narrative Form.

**4.4.2** The Applicant shall attach to the Budget Form **Exhibit B** document that details the total cost of the proposed activities. The budget categories may include: Personnel (salary and fringe), Consultants; Travel; Contractual; Supplies; Operating Costs; and Other project-related costs.

## **SECTION 5 – EVALUATION COMMITTEE, EVALUATION CRITERIA, AND SELECTION PROCEDURE**

### **5.1 Evaluation Committee**

- 5.1.1 Evaluation of Applications will be performed by a committee established for that purpose and based on the evaluation criteria set forth below. The Evaluation Committee will review Applications, participate in Applicant oral presentations and discussions, and provide input to the Procurement Officer. The Department reserves the right to utilize the services of individuals outside of the established Evaluation Committee for advice and assistance, as deemed appropriate.

### **5.2 Project Narrative Evaluation Criteria**

The criteria to be used to evaluate each Project Narrative within the Scope of Work: Requirements are listed below in descending order of importance.

- 5.2.1 General Requirements as described in Section 3.2.1
- 5.2.2 Specific Requirements as described in Section 3.2.2
- 5.2.3 Planning, Collaboration and Oversight as described in Section 3.2.3
- 5.2.4 Pre-Implementation Period as described in Section 3.2.4
- 5.2.5 Implementation as described in Section 3.2.5
- 5.2.6 Program Assessment Reporting as described in Section 3.2.6
- 5.2.7 Staffing and Training as described in Section 3.2.7
- 5.2.8 Program Reach as described in Section 3.2.8
- 5.2.9 Vendor Revenue as described in Section 3.2.9
- 5.2.10 Qualifications as described in Section 3.2.10

### **5.3 Budget Narrative Evaluation Criteria**

All Qualified Applicants will be ranked from the lowest (most advantageous) to the highest (least advantageous) based on the rating of the Project Narratives. The Budget Narrative (including the Budget Form and Budget Narrative), will be evaluated based on reasonable cost given the time and effort described in the Project Narrative. The budget line items must be within the stated guidelines set forth in this RFA and as submitted on **Exhibit C – Budget Narrative**.

## **5.4 Selection Procedures**

### **5.4.1 General**

The Grant will be awarded in accordance with the Standard Grant Agreement method outlined in the Announcement. The State may determine an Applicant to be non-responsive and/or an Applicant's Application to be not reasonably susceptible of being selected for award at any time after the initial closing date for receipt of Applications and prior to Grant award.

If the State finds an Applicant to be not responsive and/or an Applicant's Project Narrative to be not reasonably susceptible of being selected for award, that Applicant's Budget Narrative will be returned if the Budget Narrative is unopened at the time of the determination.

### **5.4.2 Award Determination**

Upon completion of the Project Narrative and Budget Narrative evaluations and rankings, each Applicant will receive an overall ranking. The Procurement Officer will recommend award of the Grant to the responsible Applicant that submitted the Application determined to be the most advantageous to the State. In making this most advantageous Application determination, technical factors and financial factors will be weighted equally.

## **RFA ATTACHMENTS**

### **EXHIBIT A – Budget Form**

This must be completed and submitted with the Project Narrative in a separate envelope.

### **EXHIBIT B- Budget Narrative**

This form must be completed and submitted with the Budget Form in a separate envelope from the Project Narrative.

### **EXHIBIT C- Standard Grant Agreement “Sample”**

This is the sample grant agreement used by the Department. **It is provided with the RFA for informational purposes and is not required to be submitted an Application submission time.** Upon notification of recommendation for award, a completed standard grant agreement will be sent to the recommended awardee for signature. The recommended awardee must return to the Procurement Officer one (1) executed copies of the Standard Grant Agreement within five (5) Business Days after receipt. Upon award, a fully executed copy will be sent to the Grantee.

**ATTACHMENT A-** Conditions of Award

**ATTACHMENT B-** Federal Funds

**ATTACHMENT C-** Debarment Affirmation

**ATTACHMENT D -** Certification Regarding Tobacco Smoke

**ATTACHMENT E -** Certification Regarding Lobby

**ATTACHMENT F-** Additional Information required for Prevention and Health Promotion Administration Grants

### **EXHIBIT D – RFA Document Checklist**

Use this checklist to ensure that the required documents for the Project Narrative and Budget Narrative are completed.

**EXHIBIT E - DRAFT** *Maryland Children and Youth with Specific Health Care Needs (CYSHCN) System of Care Coordination Pilot Implementation Guide for Local Health Departments (LHDs)*

### **EXHIBIT F - Work Plan Template**

**THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.**

## EXHIBIT A – BUDGET FORM

### BUDGET FORM

The Budget Narrative shall contain all price information in the format specified on these pages. Complete the Budget Form only as provided in the Budget Form format. Do not amend, alter or leave blank any items on the Budget Form. Failure to adhere to any of these instructions may result in the Budget Narrative being determined non-responsive and rejected by the Department.

Submitted By:

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

Location(s) from which services will be performed (City/State): \_\_\_\_\_

FEIN: \_\_\_\_\_

eMMA #: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_ -- \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_ -- \_\_\_\_\_

E-mail: \_\_\_\_\_

### Budget Summary

| Line Item       | Qty | Unit Cost | Total Cost |
|-----------------|-----|-----------|------------|
| Salary          |     |           |            |
| Fringe          |     |           |            |
| Contractual     |     |           |            |
| Travel          |     |           |            |
| Operating Costs |     |           |            |
| Supplies        |     |           |            |
| Other           |     |           |            |
| Other           |     |           |            |
| Other           |     |           |            |
| Other           |     |           |            |
| <b>TOTAL</b>    |     |           |            |

IDC 10 % CAP

## EXHIBIT B – BUDGET NARRATIVE

### BUDGET NARRATIVE TEMPLATE

(Please submit a separate Narrative for each Budget Period)

#### Sample Line-Item Justification

**Personnel (Preventionist):** \$15,600

**Justification:** The Preventionist will be responsible for: conducting project-related relationship-building activities with new and existing partners; developing informational materials for community leaders and the public, including fact sheets and social media posts related to the project topic; coordinating and facilitating monthly project meetings with partners; conducting awareness-building activities within key demographic areas in the community to engage the project target audience; developing and providing professional training at targeted local governmental agencies and private businesses; attending community events relevant to the project and the project's partners. The Project Coordinator will also attend RISEMD meetings, collect data, conduct evaluation activities, prepare reports, and act as a liaison with the MDH Grant Monitor.

\$30/hr. x 520 hours = \$15,600

## EXHIBIT C – Standard Grant Agreement “Sample”

### ORGANIZATIONS RECEIVING APPROPRIATIONS FROM THE STATE STANDARD GRANT AGREEMENT

This Agreement, which is executed in compliance with Section 7-402 of the State Finance and Procurement Article of the Annotated Code of Maryland, is made this <enter day> day of <month, year>, between the State of Maryland (the “State”), acting through the Maryland Department of Health, (the “Department”), located at <enter MDH Address> and the <grantee name> (the “Grantee”), located at <grantee address> in <county / city> County, <state, zip>, a Maryland Limited Liability Company / Corporation. .

1. Effective on the date of execution of this Agreement, the State is extending to the Grantee a grant in the amount of <amount in words> Dollars (\$ xx,xxx.xx) (the “Grant”), which the Grantee shall use only for the following purposes: <grant purpose>

2. Any expenditure of Grant funds that is not consistent with the purposes stated in paragraph 1 may, at the sole discretion of the Department, be disallowed. Should any expenditure be disallowed, or should the Grantee violate any of the terms of this Agreement, the State may require repayment to the State Treasury, an offset from any State Grant to the Grantee in the current or succeeding fiscal year, or other appropriate action. The Grantee shall repay to the State any part of the Grant that is not used for the purposes stated in paragraph 1 within 3 months after the date of this Agreement.

3. The Grantee may not sell, lease, exchange, give away, or otherwise transfer or dispose of real or personal property, or any part of or interest in real or personal property, acquired with Grant funds without the prior written consent of the Department. This includes transfer or disposition to a successor on the merger, dissolution, or other termination of the existence of the Grantee. The Grantee shall give the Department written notice at least 30 calendar days before any proposed transfer or disposition. Any proceeds from a permitted transfer or disposition shall be applied to repay to the State a percentage of that portion of the Grant allocable to the particular real or personal property transferred or disposed of, unless the Department and the Grantee agree to other terms and conditions. The percentage shall be equal to the percentage of the unadjusted basis of the property that would remain if the property had been recovery property placed in service after December 31, 1980, and if all allowable deductions had been taken up to the time of disposition under the Accelerated Cost Recovery System (ACRS) specified in the United States Internal Revenue Code, Section 168(b)(1).

4. For any item of real or personal property that is acquired with Grant funds and has an original fair market value of Five Thousand Dollars (\$5,000) or more, the Grantee shall, at its own expense, and for the reasonable useful life of that item or for 5 years, whichever is less, obtain and maintain insurance. The insurance shall provide full protection for the Grantee and the State against loss, damage, or destruction of or to the real or personal property. The Grantee shall, on request, provide the Department with satisfactory evidence of its compliance with this requirement. Proceeds of insurance required by this paragraph shall be applied toward replacement of the real or personal property or toward the partial or total repayment of the State of the Grant, in the sole discretion of the Department.

5. The Grantee may not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, or any other characteristic forbidden as a basis for

discrimination by applicable laws and certifies that its Constitution or by-laws contains a non-discrimination clause consistent with the Governor's Code of Fair practices.

6. The person executing this Agreement on behalf of the Grantee certifies, to the best of that person's knowledge and belief, that:

- A.) Neither the Grantee, nor any of its officers or directors, nor any employee of the Grantee involved in obtaining contracts with or grants from the State or any subdivision of the State, has engaged in collusion with respect to the Grantee's application for the Grant or this Agreement, or the performance of this Agreement, or has been convicted of bribery, attempted bribery, or conspiracy to bribe under the laws of any state or of the United States.
- B.) The Grantee has not employed or retained any person, partnership, corporation, or other entity, other than a bona fide employee or agent working for the Grantee, to solicit or secure the Grant or this Agreement, and the Grantee has not paid or agreed to pay any such entity any fee or other consideration contingent on the making of the Grant or this Agreement; the grantee understands and complies with the Conflicts of Interest provision of the Public Ethics Law, Maryland Code Annotated, General Provisions, Title 5, Subtitle 5 and as otherwise set forth under Maryland law..
- C.) The Grantee, if incorporated, is registered or qualified in accordance with the Corporations and Associations Article of the Annotated Code of Maryland, is in good standing, has filed all required annual reports and filing fees with the Department of Assessments and Taxation and all required tax returns and reports with the Comptroller of the Treasury, the Department of Assessments and Taxation, and the Department of Labor, Licensing and Regulation, and has paid or arranged for the payment of all taxes due to the State; and
- D.) No money has been paid to or promised to be paid to any legislative agent, attorney, or lobbyist for any services rendered in securing the passage of legislation establishing or appropriating funds for the Grant.
- E.) Neither the Grantee, nor any of its officers or directors, nor any person substantially involved in the contracting or fund raising. activities of the Grantee, is currently suspended or debarred from contracting with the State or any other public entity or subject to debarment under the Code of Maryland Regulations, COMAR 21.08.04.04.

7. Within 60 calendar days after the close of any grant period in which the Grantee receives funds under this Agreement, the Grantee shall provide to the Department an itemized statement of expenditures, showing how the funds were expended for that grant period. In addition, a copy of the statement shall be mailed to the Director, General Accounting Division, Office of the Comptroller of the Treasury, Room 200, Louis L. Goldstein Treasury Building, Annapolis, Maryland 21401. The Grantee shall retain bills of sale or other satisfactory evidence of the acquisition of any real or personal property for at least 3 years after the date of this Agreement. The Department, the Department of Budget and Management, the State Comptroller, and the Legislative Auditor, or any of them, may examine and audit this evidence, on request, at any reasonable time within the retention period.

8. The Grantee shall comply with Section 7-221, 7-402, and 7-403 of the State Finance and Procurement Article of the Annotated Code of Maryland, as applicable.

9. The laws of Maryland shall govern the interpretation and enforcement of this Agreement.
10. This Agreement shall bind the respective successors and assigns of the parties.
11. The Grantee may not sell, transfer, or otherwise assign any of its obligations under this Agreement, or its rights, title, or interest in this Agreement, without the prior written consent of the Department.
12. No amendment to this Agreement is binding unless it is in writing and signed by both parties.
13. The following items are incorporated by referenced and made a part of this Agreement\_.  
Appendix A & B, Attachment A, B, C, D, E.&F.
14. The Grantor can terminate this agreement, in whole or in part, for convenience, without a breach or default of the Grantee, with thirty days notice to the Grantee.
15. Grantee agrees to indemnify, defend and hold harmless the State of Maryland from any claims, demands, losses, or suits arising from or out of their performance of this Agreement.

IN TESTIMONY WHEREOF, WITNESS the hands and seals of the parties.

GRANTEE

DEPARTMENT

\_\_\_\_\_  
(Name of Corporation or Association)

By:

\_\_\_\_\_  
SEAL

Name: \_\_\_\_\_.

Title:

\_\_\_\_\_  
\_\_\_\_\_.

Date:

\_\_\_\_\_

\_\_\_\_\_  
Maryland Department of Health.  
(Name of Corporation or Association)

By:

\_\_\_\_\_  
SEAL

Name: \_\_\_\_\_.

Title:

\_\_\_\_\_

Date:

\_\_\_\_\_

## **APPENDIX A**

The Department's Grant Monitor is:

<Name and Title of MDH grant monitor>  
agency, address,  
<Office>  
Maryland Department of Health  
201 W. Preston Street  
Baltimore, Maryland 21201  
Phone:  
Email:

The Grantee's Grant Monitor is:

<enter name, title, office, grantee  
phone number and email >

### **I. BACKGROUND INFORMATION OF AGREEMENT**

<Enter background information of the agreement>

### **II. DUTIES OF THE GRANTEE**

#### **SCOPE OF WORK:**

<Enter all duties and scopes of work for the grant agreement>

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**APPENDIX B (insert revised budget)**

**Cost Estimate for:**

**<Name of Project>**

---

**PERIOD OF PERFORMANCE - <Date of Project>**

**<Enter Budget>**

## II. DUTIES OF THE DEPARTMENT

Other than awarding the funds to the <grantee/sub-recipient/sub-awardee> for this project <MDH awarding agency> will:

Provide necessary technical support and monitoring to <grantee/sub-recipient/sub-awardee> to ensure state and federal grant compliance.

This includes but is not limited to:

- Completion of the MDH Office of the Inspector General Risk Assessment. Visit <https://health.maryland.gov/oig/Pages/DHMH%20OIG.aspx> for more information.
- Completion of the Standard Grant Agreement Checklist.
- Determination of Good Standing with the Maryland State Department of Assessments & Taxation (SDAT). Visit <https://sdat.dat.maryland.gov/RealProperty/Pages/default.aspx> for additional information.
- Review for Debarment, Suspension, or any Exclusion from doing business with Maryland. Visit <https://bpw.maryland.gov/pages/debarments.aspx> for additional information.
- Determination regarding No Conflicts of Interest.
- Review of Single Audits

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#### SECTION IV. INCORPORATION BY REFERENCE

Both parties hereby agree that the documents described below, if any, are hereby incorporated into and made an integral part of this Agreement: (Type "None", if none)

| Exact Title of Document(s)                                                                                          | Number of Pages |
|---------------------------------------------------------------------------------------------------------------------|-----------------|
| <u>Conditions of Award- Attachment A</u>                                                                            | <u>2</u>        |
| <u>Federal Funds- Attachment B</u>                                                                                  | <u>2</u>        |
| <u>Debarment Affirmation- Attachment C</u>                                                                          | <u>2</u>        |
| <u>Certification Regarding Tobacco Smoke- Attachment D</u>                                                          | <u>1</u>        |
| <u>Certification Regarding Lobby- Attachment E</u>                                                                  | <u>5</u>        |
| <u>Additional Information required for Prevention and Health Promotion<br/>Administration Grants – Attachment F</u> | <u>2</u>        |

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**CONDITIONS OF AWARD**

**Maryland Department of Health (MDH)**

<Enter Department Here>

<Enter Federal Awarding Agency Here>

<Enter Name of Federal Award and Grant Number Here>

**Period of Performance:** <Enter from and To Dates Here>

**Important Dates:**

<Enter Date Here>: Quarterly progress report  
<Enter Date Here>: All funds obligated  
<Enter Date Here>: All funds must be spent  
<Enter Date Here>: Final progress and fiscal report due to MDH

The grantee/sub-grantee/sub-recipient (**circle one**), shall comply with these conditions. Consequences for failure to comply with these conditions may include: a point reduction in score for future competitive and non-competitive applications, a reduction of overall award, audit exceptions and/or reduction in future awards.

**Program Requirements:**

1. The grantee/sub-grantee/sub-recipient, <Enter Grantee Name Here> > agrees to comply with MDH guidelines and initiatives with regards to their expenditures/purchases.
2. When procuring equipment, the recipient must comply with the procurement standards at 45 CFR Part 92.36 and 45 CFR 74.40 through 74.48, including 74.45, which requires the performance and documentation of some form of cost or price analysis with every procurement action.
3. The grantee/sub-grantee/sub-recipient, will perform activities that coordinate, integrate, prioritize and sustain improvements in public health emergency preparedness.
4. The grantee/sub-grantee/sub-recipient, shall cite <Enter Name of Federal Award> and the MDH <Enter Department Here> as a funding source when publishing or presenting data or programs partially or fully funded by MDH grants.
5. The grantee/sub-grantee/sub-recipient, should inform the MDH <Enter Department Here> as a courtesy when a presentation or publication is made public that involves programs or data partially or fully funded by MDH, and any federal grants. All reports, data, software, or presentations generated from federal funded projects must be made available to MDH for review and comment prior to release or distribution.

**Fiscal Requirements:**

1. The grantee/sub-grantee/sub-recipient, shall **not** use <Enter Name of Federal Award> to:
  - a. Support the costs of operating clinical trials of investigational agents, equipment or treatments;
  - b. Make payments directly to recipients of services, except for reimbursement of reasonable and allowable out-of-pocket expenses associated with consumer participation in State or consortia activities;
  - c. Support legal services;
  - d. Provide direct maintenance expenses of privately owned vehicles or any other costs associated with a vehicle, such as lease or loan payments, vehicle insurance, or license registration fees;
  - e. Purchase or improve land, or to purchase, construct, or make permanent improvements to any building, except for minor remodeling;

- f. Pay property taxes;
  - g. Fund capital improvement projects;
  - h. Supplant personnel costs and/or other activities.
  - i. Prepare, distribute, or use of any material (publicity/propaganda) or to pay the salary or expenses of grants, contract recipients, or agents that aim to support or defeat the enactment of legislation, regulation, administrative action, or executive order proposed or pending before a legislative body.
2. The grantee/sub-grantee/sub-recipient will comply with all MDH and federal fiscal requirements for timely submission of detailed budgets and budget modifications, including monthly invoice requirements.
  3. The grantee/sub-grantee/sub-recipient will return any unspent and unobligated funds to MDH and provide the necessary supporting documentation.

#### **Audits:**

The grantee/sub-grantee/sub-recipient shall submit audits in accordance with Federal OMB 2 CFR 200, Subpart F - Audit Requirements. An electronic copy of all audits (2 CFR 200 Subpart F, as well as independent auditors) performed against federal funding should be forwarded to the Department for review.

#### **Site Visits and Surveys:**

1. As requested, the grantee/sub-grantee/sub-recipient shall participate fully in the MDH [<Enter Department Here>](#) Quality Improvement and Technical Assistance activities, which may include, but are not limited to:
  - a. Comprehensive site visits at the Department's request within the project period;
  - b. Interviews of staff, review of fiscal and program records, **monitoring, risk assessment**, review of inventory purchased against federal funding, interviews with administrators, and observation of program activities/facility.

#### **Equipment Inventory Requirements:**

Equipment purchased with federal funds may be recalled or requested to support local, regional and/or statewide emergency response efforts and must be cataloged for future reference and review. Cataloging of equipment should be updated and maintained throughout the project period.

#### **Risk Assessment:**

The grantee/sub-grantee/sub-recipient shall be required to participate in an MDH Risk Assessment in accordance with Federal OMB 2 CFR §200.205 (b) through (d), §200.207, and §200.331 (b) thru (h). As part of this requirement, sub- recipients will be monitored based on a risk level of High, Medium or Low. Each risk level imposes certain monitoring requirements set by the MDH Office of the Inspector General in accordance with the above federal guidelines.

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**FEDERAL FUNDS**

A Summary of Certain Federal Fund Requirements and Restrictions  
[Details of particular laws, which may levy a penalty for noncompliance,  
are available from the Maryland Department of Health.]

1. Form and rule enclosed: 18 U.S.C. 1913 and section 1352 of P.L. 101-121 require that all *prospective* and present subgrantees (this includes all levels of funding) who receive more than \$100,000 in federal funds must submit the form "Certification Against Lobbying". It assures, generally, that recipients will not lobby federal entities with federal funds, and that, as is required, they will disclose other lobbying on form SF- LLL.
2. Form and instructions enclosed: "Form LLL, Disclosure of Lobbying Activities" must be submitted by those receiving more than \$100,000 in federal funds, to disclose any lobbying of federal entities (a) with profits from federal contracts or (b) funded with nonfederal funds.
3. Form and summary of Act enclosed: Sub-recipients of federal funds on any level must complete a "Certification Regarding Environmental Tobacco Smoke," required by Public Law 103-227, the Pro-Children Act of 1994. Such law prohibits smoking in any portion of any indoor facility owned or leased or contracted for regular provision of health, day care, early childhood development, and education or library services for children under the age of 18. Such language must be included in the conditions of award (they are included in the certification, which may be part of such conditions.) This does not apply to those solely receiving Medicaid or Medicare, or facilities where WIC coupons are redeemed.
4. In addition, federal law requires that:
  - a) OMB 2 CFR 200, Subpart F, Audit Requirements requires that grantees (both recipients and subrecipients) which expend a total of \$750,000 or more in federal assistance shall have a single or program-specific audit conducted for that year in accordance with the provisions of the Single Audit Act of 1984, P.L. 98-502, and the Single Audit Act Amendments of 1996, P.L. 104-156. and the Office of Management and Budget (OMB) 2 CFR 200, Subpart F.
  - b) All sub-recipients of federal funds comply with Sections 503 and 504 of the Rehabilitation Act of 1973, the conditions of which are summarized in item (C).
  - c) Recipients of \$10,000 or more (on any level) must include in their contract language the requirements of Sections 503 (language specified) and 504 referenced in item (B).

Section 503 of the Rehabilitation Act of 1973, as amended, requires recipients to take affirmative action to employ and advance in employment qualified disabled people. An affirmative action program must be prepared and maintained by all contractors with 50 or more employees and one or more federal contracts of \$50,000 or more.

This clause must appear in subcontracts of \$10,000 or more:

- i. The contractor will not discriminate against any employee or applicant for employment because of physical or mental handicap in regard to any position for which the employee or applicant for employment is qualified. The contractor agrees to take affirmative action to employ, advance in employment and otherwise treat qualified handicapped individuals without discrimination based upon their physical or mental handicap in all upgrading, demotion or transfer, recruitment, advertising, layoff

or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

- ii. The contractor agrees to comply with the rules, regulations, and relevant orders of the secretary of labor issued pursuant to the act.
- iii. In the event of the contractor's non-compliance with the requirements of this clause, actions for non-compliance may be taken in accordance with the rules, regulations and relevant orders of the secretary of labor issued pursuant to the act.
- iv. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices in a form to be prescribed by the director, provided by or through the contracting office. Such notices shall state the contractor's obligation under the law to take affirmative action to employ and advance in employment qualified handicapped employees and applicants for employment, and the rights of applicants and employees.
- v. The contractor will notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the contractor is bound by the terms of Section 503 of the Rehabilitation Act of 1973, and is committed to take affirmative action to employ and advance in employment physically and mentally handicapped individuals.
- vi. The contractor will include the provisions of this clause in every subcontract or purchase order of \$10,000 or more unless exempted by rules, regulations, or orders of the [federal] secretary issued pursuant to section 503 of the Act, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontract or purchase order as the director of the Office of Federal Contract Compliance Programs may direct to enforce such provisions, including action for non-compliance.

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sec. 791 et seq.) prohibits discrimination on the basis of handicap in all federally assisted programs and activities. It requires the analysis and making of any changes needed in three general areas of operation-programs, activities, and facilities and employment. It states, among other things, that:

*Grantees that provide health...services should undertake tasks such as ensuring emergency treatment for the hearing impaired and making certain that persons with impaired sensory or speaking skills are not denied effective notice with regard to benefits, services, and waivers of rights or consents to treatments.*

- D) All sub-recipients comply with Title VI of the Civil Rights Act of 1964 that they must not discriminate in participation by race, color, or national origin.
- E) All sub-recipients of federal funds from SAMHSA (Substance Abuse and Mental Health Services Administration), NIH (National Institute of Health), CDC (Center for Disease Control and Prevention), and HHS (Health and Human Services) are prohibited from paying any direct salary at a rate of Executive Level II or more than \$189,600 per year. (This includes, but is not limited to, sub-recipients of the Substance Abuse Prevention and Treatment and the Community Mental Health Block Grants and NIH research grants, Public Health and Emergency Preparedness and Hospital Preparedness Program Cooperative Agreements.)
- F) There may be no discrimination on the basis of age, according to the requirements of the Age Discrimination Act of 1975.
- G) For any education program, as required by Title IX of the Education Amendments of 1972, there may be no discrimination on the basis of sex.

- H) For research projects, a form for Protection of Human Subjects (Assurance/Certification/Declaration) should be completed by each level funded, assuring that either: (1) there are no human subjects involved, or that (2) an Institutional Review Board (IRB) has given its formal approval before human subjects are involved in research. [This is normally done during the application process rather than after the award is made, as with other assurances and certifications.]
- I) In addition, there are conditions, requirements, and restrictions which apply only to specific sources of federal funding. These should be included in your grant/contract documents when applicable.

**DEBARMENT AFFIRMATIONS**

In accordance with the requirements of United States Office of Management and Budget's Grants and Cooperative Agreements with State and Local Governments OMB 2 CFR 200.213, Suspension and debarment:

**A. AUTHORIZED REPRESENTATIVE**

I HEREBY AFFIRM THAT:

I am the \_\_\_\_\_  
(Title)

and the duly authorized representative of

\_\_\_\_\_  
(Name of Grantee/sub-recipient/sub-awardee)

and that I possess the legal authority to make this Affidavit on behalf of myself and the entity for which I am acting.

**B. AFFIRMATION REGARDING DEBARMENT**

I HEREBY AFFIRM THAT:

Neither I, nor to the best of my knowledge, information, and belief, the above entities, or any of its officers, directors, partners, or any of its employees directly involved in obtaining or performing contracts with public bodies, has ever been suspended or debarred (including being issued a limited denial of participation) by any public entity, except as follows [list each debarment or suspension providing the dates of the suspension or debarment, the name of the public entity and the status of the proceedings, the name(s) of the person(s) involved and their current positions and responsibilities with the entity, the grounds for the debarment or suspension, and the details of each person's involvement in any activity that formed the grounds for the debarment or suspension]:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. AFFIRMATION REGARDING DEBARMENT OF RELATED ENTITIES**

I FURTHER AFFIRM THAT:

1. The entity was not established and it does not operate in a manner designed to evade the application of or defeat the purpose of debarment pursuant to Sections 16-101, et seq., of the State Finance and Procurement Article of the Annotated Code of Maryland; and
2. The entity is not a successor, assignee, subsidiary, or affiliate of a suspended or debarred entity, except as follows [indicate the reason(s) why the affirmations cannot be given without qualification]:

\_\_\_\_\_  
\_\_\_\_\_

**D. SUB-CONTRACT AFFIRMATION**

I FURTHER AFFIRM THAT:

Neither I, nor to the best of my knowledge, information, and belief, the above entity, has knowingly entered into a contract with a public body under which a person debarred or suspended under Title 16 of the State Finance and Procurement Article of the Annotated Code of Maryland will provide, directly or indirectly, supplies, services, architectural services, construction related services, leases of real property, or construction.

I DO SOLEMNLY DECLARE AND AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE CONTENTS OF THIS AFFIDAVIT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF.

Date:   X  \_\_\_\_\_

By:   X  \_\_\_\_\_  
(Authorized Representative and Affiant)

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**DEPARTMENT OF HEALTH & HUMAN SERVICES**

---

Public Health Services  
Health Resources and  
Service Administration  
Rockville, MD

**CERTIFICATION REGARDING ENVIRONMENT TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned, or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences, portions of facilities used for impatiens drug or alcohol treatment, service providers whose sole sources of applicable Federal funds are Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply will result with the monetary penalty of up to \$1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offer or/contractor (for acquisitions) or applicant/grantee (for grants) certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

X

Signature of Authorized Certifying Official

4/2004

**Certification Regarding Lobbying**

The undersigned certifies to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement and the extension continuation, renewal amendment or modification of any Federal contract, grant loan or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract grant loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-contract, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered unto. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352 title U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 for each such failure.

|                                                                                                   |                                                                          |
|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Award No.                                                                                         | Organizational Entry                                                     |
| Name and Time of Official signing for Organizational Entry<br><input checked="" type="checkbox"/> | Telephone No. of Signing Official<br><input checked="" type="checkbox"/> |
| Signature of Above Official<br><input checked="" type="checkbox"/>                                | Date Signed<br><input checked="" type="checkbox"/>                       |

## INSTRUCTIONS FOR COMPLETION OF SF-LLL DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether sub-awardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A continuation sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

- a. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
- b. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
16. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District if known.  
Check the appropriate classification of the reporting entity that designates if it is, or expects to be a prime or sub-award recipient. Identify the tier of the sub-awardee, e.g. the first sub-awardee of the prime is the 1<sup>st</sup> tier. Sub-awards  
Include but are not limited to subcontracts, sub-grants and contract awards under grants.
17. If the organization filing the report in item 4 checks "Sub-awardee", then enter the full name, address, city, state, and zip code of the prime Federal recipient. Include Congressional District if known.
18. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational Level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
19. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
20. Enter the most appropriate Federal Identifying number available for the Federal action identified in item 1 (e.g. Request for Proposal (RFP) number, Invitation for BID (IFB) number, grant announcement number, the contract, grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g. "RFP-DE-90-001".
21. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
22. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name First Name, and Middle initial (MI).
23. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
24. Check the appropriate box (es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

25. Check the appropriate box (es). Check all boxes that apply. If other, specify nature.
26. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal Official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
27. Check whether or not a SF-FFF-A Continuation Sheet(s) is attached.
28. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D.C. 20503.

**The Remainder of This Page is Left Blank**

Complete this form to disclose lobbying activities pursuant to 31 U.S. C 1352 (See reverse for public burden disclosure.)

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Continuation Sheet

Reporting Entity: \_\_\_\_\_ Page \_\_\_\_ of \_\_\_\_

Authorized for Local Reproduction Standard Form-LLL-A

**ATTACHMENT F**

**ADDITIONAL INFORMATION REQUIRED FOR PREVENTION AND HEALTH PROMOTION  
ADMINISTRATION GRANTS**

- The grant period or term is:

\_\_\_\_\_ (insert start and end dates) \_\_\_\_\_

- There (☒ X are / \_\_\_\_\_ are not) programmatic conditions that apply to this grant, regardless of the type of funding. If applicable, these conditions are contained in Appendix D.
- Within 60 calendar days after the close of any grant period, the Grantee shall provide to the MDH Department of Program Cost and Accounting and the PHPA grantor an itemized statement of expenditures showing how the funds were expended for the grant period.
- Interim fiscal reporting requirements for this grant are listed below. All interim fiscal reports must be sent to the grant monitor within 30 days of the listed dates. Failure to submit the interim reports as described may delay further disbursement of grant funds.

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- All expenditure reports must be signed by the Chief Executive Officer or the Chief Financial Officer of the grantee's organization.
- Before any grant funds are distributed, the Grantee shall provide a budget detailing how the grant funds are to be expended.
- PHPA may call for annual independent financial audits of past and future grants to verify the propriety of reported expenditures.
- Whenever funds must be distributed prior to the beginning of the grant period, subsequent payments to the Grantee will be made only after the Grantor verifies, through detailed expenditure reports, that the initial funds have been spent.

- Federal Funding Acknowledgement ( if applicable)

a. This grant ( \_\_\_\_\_ does/ \_\_\_\_\_ ) does not contain federal funds.

b. The total amount of federal funds allocated for the

\_\_\_\_\_ is \$ \_\_\_\_\_ in

Maryland State fiscal year \_\_\_\_\_. This represents \_\_\_\_\_ % of all funds budgeted for unit in that fiscal year. This does not necessarily represent the amount of funding available.

c. If contained, the source of these federal funds is:

\_\_\_\_\_.

d. The CFDA number is \_\_\_\_\_. The conditions that apply to all federal funds awarded by the Prevention and Health Promotion Administration are contained in Appendix B. Any additional conditions that apply to this federally funded grant are contained in Appendix D

10. This grant ( \_\_\_\_\_ does/ \_\_\_\_\_ ) does not contract with subproviders on a cost reimbursement basis.

|                                           |
|-------------------------------------------|
| <b>EXHIBIT D – RFA Document Checklist</b> |
|-------------------------------------------|

**Project Narrative Checklist:**

- ☐ Transmittal Letter
- ☐ Project Narrative including Scope of Work (*See Section 3.2 Scope of Work – Requirements*)
- ☐ Work Plan

**Budget Narrative Checklist:**

- ☐ Budget Form (*See Exhibit A – Budget Form*)
- ☐ Budget Narrative (*See Exhibit B – Budget Narrative*)

**EXHIBIT E – *DRAFT* Program Implementation Guide**

See attached *Maryland Children and Youth with Specific Health Care Needs (CYSHCN) System of Care Coordination Pilot Implementation Guide for Local Health Departments (LHDs)*

## EXHIBIT F – Work Plan Template

**Title:**

**Applicant name:** \_\_\_\_\_

**Project Period:**

| <b>Overarching Goal: [Example]</b> To provide business consultation services including analyzing PHPA’s existing operational processes, recommending automated solutions accessible to the State, and implementing new processes helping PHPA meet efficiency and quality assurance goals. |                                                                 |                         | <b>Measures of Effectiveness:</b><br>(Add measures as needed)<br>1.<br>2.<br>3. |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------|----------------------------------------------|
| Objectives                                                                                                                                                                                                                                                                                 | Activities Planned To Achieve This Objective<br>(Add as needed) | Data<br>(Add as needed) | Time frame for Assessing Progress                                               | Team Members Responsible & Partners Required |
| 1.                                                                                                                                                                                                                                                                                         | 1a.<br>1b.<br>1c.                                               | 1a.<br>1b.<br>1c.       |                                                                                 |                                              |
| 2.                                                                                                                                                                                                                                                                                         | 2a.<br>2b.<br>2c.                                               | 2.a<br>2b.<br>2c.       |                                                                                 |                                              |
| 3.                                                                                                                                                                                                                                                                                         | 3a.<br>3b.<br>3c.                                               | 3a.<br>3b.<br>3c.       |                                                                                 |                                              |



# Maryland Children and Youth with Specific Health Care Needs (CYSHCN) System of Care Coordination Pilot

Implementation Guide For Local Health Departments (LHDs)

DRAFT

# DEFINITIONS & KEY CONCEPTS

# DEFINITIONS AND KEY CONCEPTS

The table below presents key terms and concepts used throughout this guide:

| Key Terms/Concepts                                                | Definition                                                                                                                                                                            |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Care Coordination</b>                                          | Short-term, family-centered support that helps families understand options, connect to services, and organize care across health, education, and community systems.                   |
| <b>Care Map</b>                                                   | A visual diagram, created with the family, showing the child's providers, services, and supports and how they connect to the family.                                                  |
| <b>Care Plan</b>                                                  | A working document that translates family goals into clear action steps, timelines, and responsibilities for the family and care coordinator.                                         |
| <b>Children and Youth with Special Health Care Needs (CYSHCN)</b> | Children and youth who have, or are at increased risk for, ongoing physical, developmental, behavioral, or emotional health needs and require services beyond those of most children. |
| <b>Durable Medical Equipment (DME)</b>                            | Medical equipment used at home over time (for example, wheelchairs, oxygen equipment).                                                                                                |
| <b>Emergency Preparedness Document</b>                            | A tool families use to record key information and plans for what to do, and who to contact, in a medical or other emergency.                                                          |
| <b>Enrollment vs. Non-Enrollment</b>                              | Only Tier 2B and Tier 3 families are formally enrolled in the pilot; Tier 1 and Tier 2A families receive information or a warm handoff but are not enrolled.                          |
| <b>Family Capacity Building</b>                                   | Activities that increase the family's skills, confidence, and ability to navigate systems and manage their child's care over time.                                                    |

| Key Terms/Concepts                                       | Definition                                                                                                                                              |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Family-Centered Care</b>                              | A partnership approach to health care decision-making between the family and health care provider.                                                      |
| <b>Family Experiences with Coordination of Care</b>      | Survey tool used to understand families' experiences with care coordination.                                                                            |
| <b>Full Care Coordination (Tier 3)</b>                   | Higher-intensity, longer-term coordination for families with complex, multi-system needs and fewer existing supports.                                   |
| <b>Health Care Transition (HCT)</b>                      | Planned process of preparing youth and families to move from pediatric to adult health care and other adult services.                                   |
| <b>Health Coverage Assistance Team (HCAT)</b>            | Maryland program that helps families understand and enroll in health coverage and related benefits.                                                     |
| <b>Individualized Education Program (IEP) / 504 Plan</b> | School plans that describe special education services (IEP) or accommodations (504 Plan) for students with disabilities or health needs.                |
| <b>Intake</b>                                            | A structured but conversational meeting where staff and families review needs, services, and priorities and confirm enrollment in the appropriate tier. |
| <b>Learning Pilot</b>                                    | A “test and refine” approach in which LHDs implement the model, document experiences, and use data and feedback to improve tools and workflows.         |
| <b>Local Health Department (LHD)</b>                     | County or local public health agency implementing the CYSHCN coordination pilot.                                                                        |

| Key Terms/Concepts                                                            | Definition                                                                                                                                    |
|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Managed Care Organization (MCO)</b>                                        | Health plan responsible for arranging and paying for services for enrolled members.                                                           |
| <b>Maryland Department of Health (MDH)</b>                                    | State health agency that houses OCYSHCN and oversees the CYSHCN System of Care Coordination Pilot.                                            |
| <b>Office for Children and Youth with Special Health Care Needs (OCYSHCN)</b> | Title V office within MDH that leads and coordinates the CYSHCN coordination pilot.                                                           |
| <b>Physical, Occupational, and Speech Therapy (PT / OT / Speech)</b>          | Therapy services that support movement, daily living skills, and communication.                                                               |
| <b>Plan-Do-Study-Act (PDSA)</b>                                               | A simple quality-improvement cycle used to plan a change, try it, study what happened, and adjust.                                            |
| <b>Shared Plan of Care (SPOC)</b>                                             | A single, shared document summarizing the child's history, goals, needs, and key services so the family and team can work from the same plan. |
| <b>Short-Term Care Coordination (Tier 2B)</b>                                 | Time-limited care coordination focused on a few priority goals and skills so families can manage more independently after the pilot.          |
| <b>Tier 1 – Information &amp; Referral</b>                                    | Not enrolled in the pilot; families receive information, resources, or referrals and the case is then closed.                                 |
| <b>Tier 2A – Warm Handoff</b>                                                 | Not enrolled in the pilot; families are actively connected to another program or provider and the case closes after the handoff.              |

| Key Terms/Concepts                                       | Definition                                                                                                                                   |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 2B – Short-Term Care Coordination Enrollment</b> | Enrolled; families receive short-term coordination and coaching to address several related needs and build coordination skills.              |
| <b>Tier 3 – Full Care Coordination Enrollment</b>        | Enrolled; families receive more intensive, ongoing coordination for complex needs across systems.                                            |
| <b>Warm Handoff</b>                                      | A live, supported connection to another program or provider (for example, a three-way call or shared email), not just giving a phone number. |
| <b>Women, Infants, and Children (WIC)</b>                | A nutrition program that provides food and support to eligible pregnant people, infants, and young children.                                 |

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# INTRODUCTION

# INTRODUCTION

## Purpose of This Guide

This Implementation Guide is intended to support Local Health Departments (LHDs) in implementing the Maryland Children and Youth with Specific Health Care Needs (CYSHCN) System of Care Coordination Pilot in a consistent and effective manner.

The guide provides practical guidance for delivering care coordination services that are family centered, equitable, and aligned with the pilot's goals and design. The guide outlines the core components and phases of the pilot, from referral and tier determination through intake, care planning and care coordination, family capacity building, transition planning, and closure. It describes expected workflows, staff responsibilities, and use of tools to support consistent implementation across pilot sites while allowing flexibility to respond to local context and individual family needs.

This guide is designed to support day-to-day implementation. It clarifies expectations for how families move through the pilot, how services are delivered at different tiers, and how information is documented for learning and evaluation purposes. The guide reflects the pilot's emphasis on time limited navigation, skill building, and preparation for family independence beyond program involvement.

As a pilot, the CYSHCN System of Care Coordination model is expected to evolve, adopting best practices. This guide establishes shared expectations for implementation while supporting reflection, documentation of challenges, and identification of opportunities for improvement. Lessons learned during implementation will inform future refinement of the model, tools, and processes.

It includes:

- How children, youth, and families move through the pilot program
- Pilot site staff responsibilities at each step
- Documentation and reporting expectations
- Required family-facing tools
- Recommended tools and resources
- Tier-based service levels
- Strategies for supporting self-reliance and family empowerment

## How to Use This Guide

This guide is intended to be used as a reference throughout the pilot. Care coordinators, supervisors, and program managers should refer to relevant sections as families move through the cascade of care.

Staff should use this guide to:

- Understand required workflows and decision points at each phase of the pilot
- Clarify roles and responsibilities for care coordinators and other staff
- Identify which tools to use with families and when
- Support consistent documentation and tracking of activities
- Guide conversations with families about what to expect from the pilot

The guide should be used alongside professional judgment and in partnership with families. While core workflows and tools are required, staff may adapt their approach based on family preferences, needs, and local context. Any adaptations or challenges should be documented to support pilot learning and continuous improvement.

This guide establishes shared expectations for implementation but is not intended to replace professional judgment or supervisory guidance. When questions arise that are not addressed here, LHD staff should consult with supervisors and MDH staff as appropriate to support with decision making.

## **Overview of the Maryland CYSHCN System of Care Coordination Pilot**

The Maryland CYSHCN System of Care Coordination Pilot is a time-limited initiative designed to test and refine a family-centered, equitable approach to care coordination for children and youth with special health care needs and their families. The pilot responds to longstanding challenges identified through statewide assessment and stakeholder engagement, including fragmented systems, inconsistent access to care coordination, and significant burden placed on families to navigate health, education, behavioral health, and community-based services independently.

In partnership with the Maryland Department of Health (MDH) Office for Children and Youth with Specific Health Care Needs (OCYSHCN), Cardea Services conducted a landscape analysis to inform the development of the CYSHCN System of Care Coordination Pilot. The analysis included a comprehensive review of national literature and state models to identify evidence-informed care coordination frameworks, tools, and best practices, as well as an assessment of Maryland's existing CYSHCN programs, policies, and initiatives. State-level findings were supplemented with perspectives from key state and local programs to identify strengths, gaps, and implementation considerations, with particular attention to equity, feasibility, and scalability. Across Maryland, families of CYSHCN often interact with multiple systems that operate in parallel rather than in coordination, use different eligibility criteria, and lack shared tools or communication pathways. The landscape analysis identified strong local efforts and committed partners, while highlighting gaps in coordination, duplication of services, and variability in navigator roles, tools, and capacity across jurisdictions. Program leads shared that families consistently expressed the need for

a single, trusted point of contact who can help them understand options, coordinate across systems, and build the skills needed to navigate services over time.

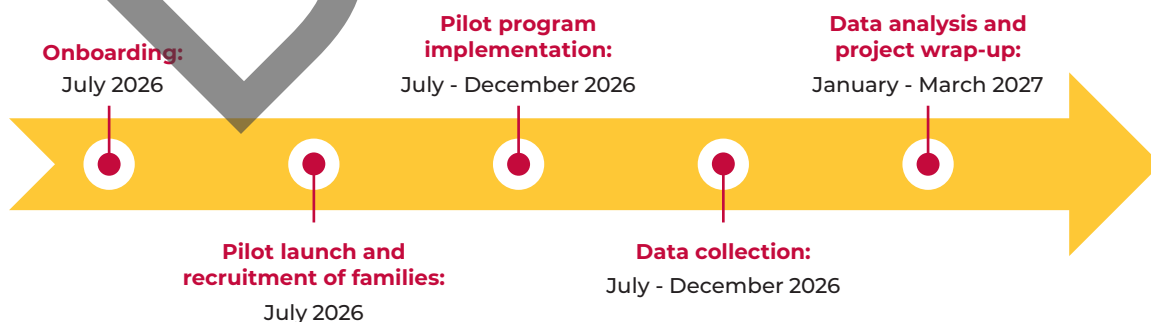
The pilot is designed to address these barriers and gaps by testing a structured coordination model implemented through LHDs, with oversight from OCYSHCN. The pilot is intended to complement and strengthen existing local and state resources by clarifying roles, standardizing core tools and workflows, and emphasizing the vital role of cross-system collaboration.

Key features of the pilot include a tiered coordination approach that aligns the level of support with family needs; the use of shared care planning tools, such as the Care Plan, a Care Map and Shared Plan of Care; and a short-term, skills-building component that prioritizes family empowerment and self-reliance. The model is intentionally flexible to accommodate local context while maintaining consistent expectations for family-centered care approach, equity, and consistent documentation to better support care coordination.

The pilot enrollment period is limited, with families participating for up to four months. This duration allows for meaningful engagement and coordination while reinforcing the pilot's focus on building family capacity rather than providing indefinite case management. Throughout the pilot period, LHD staff will document experiences, challenges, and adaptations as part of a continuous learning process.

The Maryland CYSHCN System of Care Coordination Pilot is structured as a learning pilot. Findings from implementation, including staff feedback, family experience, and process data, will be used to refine the coordination model, tools, and workflows in preparation for a future statewide system of care. The pilot period provides an opportunity to assess feasibility, identify capacity and readiness considerations, and ensure that the model is responsive to families across diverse communities before broader rollout.

The pilot period is up to 4 months in length for enrolled families, with enrollment starting in March 2026 and concluding in June 2026.



## Guiding Principles

The pilot is grounded in:

- ❖ Family-Centered Care Approach

Families are key partners in the coordination of care for their children. Care coordinators should value and respect family priorities, build on family strengths, and actively involve families in shared decision making as it relates to their child's care.

- ❖ Equity and Accessibility

Services are delivered in ways that respond to differences in language, culture, geography, income, and access to resources. Staff work to reduce barriers and support fair access to services.

- ❖ Strengths-Based Empowerment

Care coordination builds on family strengths and existing skills while supporting growth in confidence and independence. The goal is to help families gain the knowledge and tools they need to manage care more independently over time.

- ❖ Cross-System Collaboration

Care coordination supports connection across health, behavioral health, education, and community systems. Staff work to strengthen relationships across systems and reduce disruption and duplication for families.

- ❖ Learning and Improvement

The pilot is designed as a learning effort. Staff will document experiences, challenges, and successes to support reflection and continuous improvement.

## Using a Plan–Do–Study–Act (PDSA) Framework in the CYSHCN System of Care Coordination Pilot

### Purpose of the PDSA Framework

The Maryland CYSHCN System of Care Coordination Pilot is intentionally designed as a learning pilot. The goal of the pilot is not only to deliver Care Coordination services, but also to test, refine, and strengthen a model that can be scaled statewide. To support this goal, the pilot will be implemented using a Plan–Do–Study–Act (PDSA) framework.

The PDSA framework provides a structured yet flexible approach to continuous improvement. It allows LHDs to implement core components of the pilot, learn from real-world experience, and make thoughtful adjustments over time. This approach recognizes that families' needs, local contexts, and system constraints vary, and that learning from implementation is essential to building an effective and sustainable system of care.

Importantly, the use of PDSA is not a performance evaluation of individual staff or pilot sites. Rather, it is a tool for strengthening workflows, tools, and partnerships, and for ensuring that the coordination model remains family-centered, feasible, and responsive.

### What PDSA Means for LHDs

For LHDs, using a PDSA framework means that staff are expected to:

- Implement the pilot using the core workflows, tools, and principles described in this Implementation Guide
- Document experiences, challenges, and adaptations encountered during implementation
- Reflect regularly on what is working well and what may need adjustment
- Make small, manageable changes to improve service delivery during the pilot period

LHDs should feel supported in identifying opportunities for improvement and raising questions about how the model functions in practice. Adaptations made during the pilot should be intentional, documented, and shared as part of ongoing learning and technical assistance.

### The PDSA Cycle in Practice

The PDSA framework consists of four interconnected steps that repeat over time:

#### **Plan**

During the planning step, LHDs implement pilot activities as outlined in this Implementation Plan. This includes preparing staff, using the required forms and tools, and following established workflows for referral, intake, care coordination, and closure.

Planning also involves identifying what is being tested during the pilot, such as:

- Referral and tiering workflows
- Intake and assessment processes
- Use of care planning tools
- Family engagement strategies

### **Do**

During the “Do” step, LHD staff carry out pilot activities in real-world settings. This includes working directly with families, coordinating services, and documenting care coordination activities.

The “Do” step is where staff may notice patterns, challenges, or unexpected outcomes. Examples may include intake appointments taking longer than expected, families needing additional explanation of tools, or referral pathways not functioning as intended.

### **Study**

The “Study” step involves reflecting on implementation experiences and reviewing available information. This may include:

- Staff observations and reflections
- Feedback from families
- Data from intake forms, engagement tracking, or surveys
- Discussion during team meetings or check-ins

The purpose of this step is to understand why something is or is not working, rather than assigning blame.

### **Act**

Based on what is learned, LHDs may make small adjustments to improve implementation. These adjustments might include:

- Refining scripts or explanations provided to families
- Adjusting the timing or pacing of certain activities
- Clarifying roles or hand-offs between partners
- Modifying internal workflows to reduce burden

These changes are then incorporated into practice, and the cycle begins again.

### **How PDSA Applies Across All Phases of the Pilot**

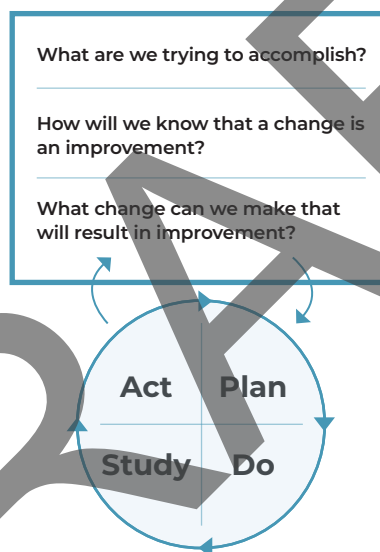
Rather than treating PDSA as a separate activity within each phase, the framework should be viewed as a continuous lens applied across the entire care coordination journey. Each phase of the pilot—Referral and Tier Determination, Intake and Assessment, Care Planning and Coordination, Family Capacity Building, Transition, and Closure—offers opportunities for learning and refinement.

For example:

- In early phases, PDSA may focus on referral flow and tiering decisions
- In middle phases, it may focus on care planning tools and coordination strategies
- In later phases, it may focus on graduation readiness and transition supports

LHDs are not expected to formally document every PDSA cycle. Instead, they should use PDSA as a mindset that encourages reflection, communication, and improvement throughout the pilot. However, if an LHD would find it helpful to formally document one or more PDSA cycles, the Institute for Healthcare Improvement's [PDSA Worksheet](#) is a recommended tool.

### **Visual Concept: PDSA as a Continuous Cycle**



Source: <https://www.ihl.org/library/model-for-improvement>

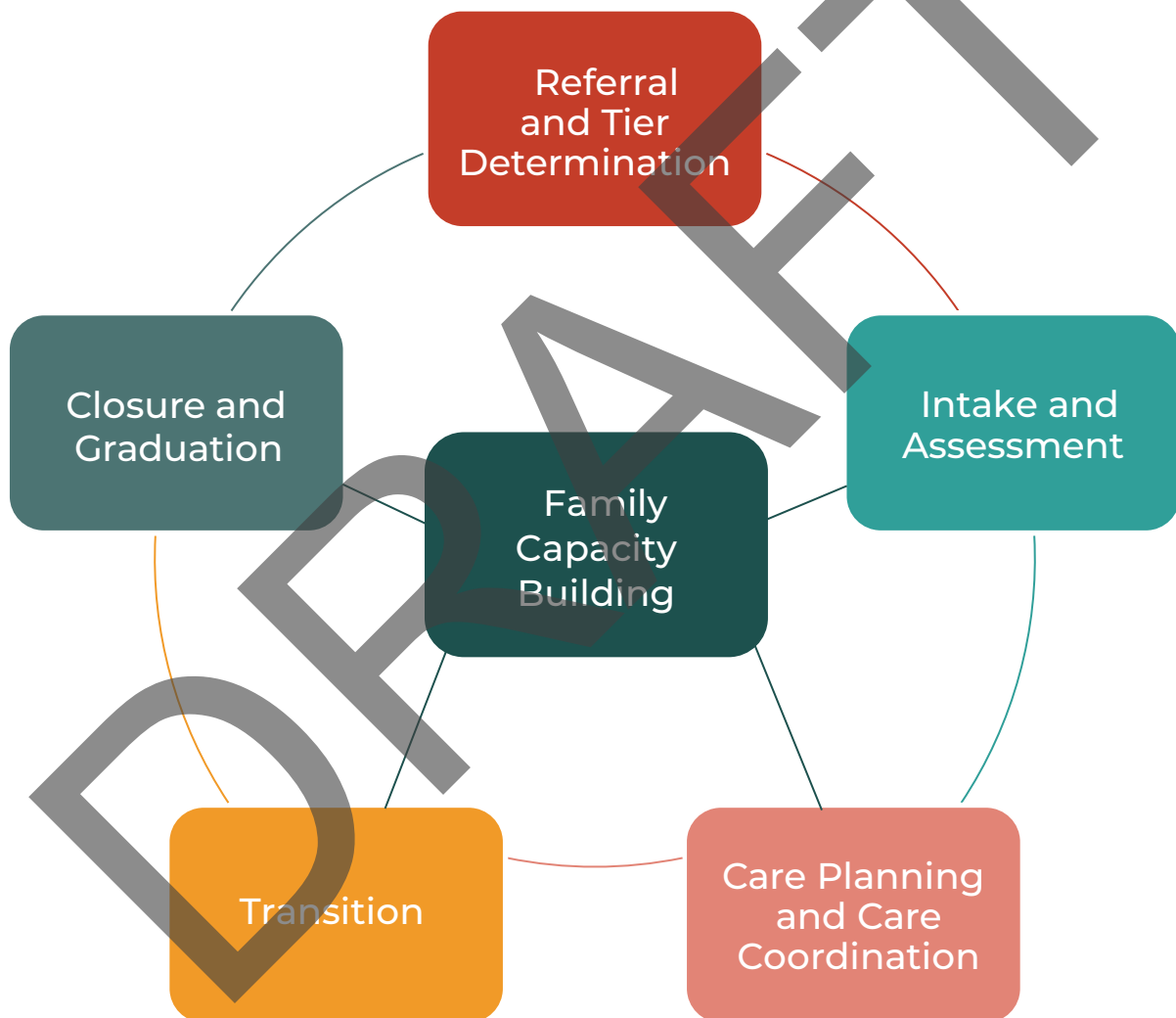
This visual reinforces that PDSA is ongoing and cyclical, not linear or one-time.

### **Key Takeaways for LHD Staff**

- PDSA is a learning and improvement tool, not an evaluation tool
- Small adjustments during the pilot are expected and encouraged
- Reflection and documentation support stronger implementation and future scale-up
- The goal is to build a system of Care Coordination that works well for families and for local implementation

## Program Implementation

The Maryland CYSHCN System of Care Coordination Pilot follows a structured, phase-based model that guides families from referral through closure. Each phase builds on the one before it, with clear steps, tools, and staff responsibilities to support consistent implementation across pilot sites. The model is designed to be time limited, skills focused, and family centered, with intensity of coordination varying by tier. The flow below shows how families move through the pilot and how care coordination, capacity building, and transition activities connect across phases.



DRAFT

**PHASE 1:**

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**Referral & Tier Determination**

# PHASE 1

## Referral and Tier Determination

Phase 1 serves as the entry point into the Maryland CYSHCN System of Care Coordination Pilot and includes two processes: 1) Referral, and 2) Tier Determination.

### Reviewing the CYSHCN Care Coordination Referral Form

Purpose: Connecting families/caregivers to the pilot and assessing whether they meet minimum eligibility requirements.

**Your goals** when reviewing the form are to:

1. Make sure you have enough information to reach the family.
2. Understand why they are being referred and what they need help with.
3. Confirm whether the child is likely eligible (Age 21 and younger and Maryland resident).
4. Decide whether to move forward to Tier Determination (Phase 1 activity) or close out.

Below are **step-by-step instructions** for receiving and reviewing the referral form.

#### Step 1. Receive and Log the Referral

1. Identify how the referral came in (e.g., email, fax, online form, in-person).
2. Log the referral in the Care Coordination Program Data Collection template. Refer to the [Evaluation & Reporting section](#) for more details. As needed, save and log the referral following your site's tracking process (e.g., spreadsheet, registry, EHR), noting at minimum:
  - a. Child/young adult name.
  - b. Date referral was received.
  - c. Referral source (family/self vs provider/organization).
  - d. LHD region selected (if relevant).
3. If the referral clearly belongs to a different region/LHD based on county or zip, follow your local handoff protocol to route it to the appropriate LHD or partner.

**Note:** While timing may vary based on referral volume and local capacity, pilot sites should aim to initiate outreach to families within a reasonable timeframe after receiving a referral, typically within 3–5 business days.

## Step 2. Confirm Who Completed the Form

1. Look at the top of the form to see who filled it out:
  - a. If self-referral/family/caregiver referral, only Section 1 will be complete.
  - b. If provider/organization referral, Sections 2, 4, and 5 of the form will be complete.

This tells you:

- Whose perspective you are reading (family vs provider).
- Which sections to focus on in the next step.

## Step 3. Check for Basic Eligibility & Contact Information

Using the demographic and contact fields (family or provider section, depending on who completed it):

1. Maryland connection
  - a. Confirm the child is a Maryland resident, and the referral is within your LHD's jurisdiction (county/zip).
  - b. If residency is clearly "No" or outside your area, follow local guidance (e.g., redirect, consult supervisor).
2. Contact information
  - a. Make sure there is at least one reachable phone number and/or email for the parent/caregiver or youth.
  - b. If contact info is missing or clearly incorrect, plan to use any alternate contact (e.g., referring provider) to obtain correct information before proceeding.
3. Preferred contact method and language
  - a. Note the preferred contact method (phone, email, text) if indicated.
  - b. Note whether interpretation services are requested and in which language.

This sets you up to contact the family in a way that respects their preferences and language needs.

## Step 4. Review Referral Details (Family OR Provider Version)

Now read the main "story" of the referral. What you look at depends on who completed the form, but you'll always do only one of the following:

### 4A. If the Referral Was Completed by a Family/Caregiver (or Self-Referral)

Focus on the family section of the form:

1. Find the "What Can We Help You With?" / "Description of need" area.

2. Read the family's description in full and, if helpful, note key phrases in your own tracking (e.g., "needs help with IEP," "looking for specialists," "lost insurance").
3. Scan for any signals of urgency or distress (e.g., "running out of medications," "school will remove services," "no doctor and child is very sick").
4. Keep their wording in mind; you can echo it back when you call them ("I see you wrote that you need help with..."), which helps build trust and avoids making them repeat information unnecessarily.

#### **4B. If the Referral Was Completed by a Provider/Organization**

Focus on the provider/organization sections:

1. Provider & contact information
  - a. Note the name, organization, phone, and email of the referring provider/organization for possible clarification or coordination.
2. Care Coordination needs (provider perspective)
  - a. Review the checked categories (e.g., medical/health care, social/behavioral, supportive services, youth transition, insurance).
  - b. Read the provider's "Description of need" to understand the concern from their perspective (e.g., frequent ED use, gaps in therapy, school challenges).
3. Health & medical care needs
  - a. Review of the provider's responses about:
    - o Diagnosed or suspected conditions.
    - o Duration of condition.
    - o Current treatments/therapies.
    - o Current services (PT, OT, speech, behavioral, nursing, early intervention, IEP/504, etc.).
    - o Any specialized medical equipment noted.
  - b. Use this to form an initial picture of medical complexity and how many systems are already involved.

### **Step 5. Identify Red Flags / Urgent Issues**

While reviewing the referral details (family or provider):

1. Look for red flags such as:
  - a. Immediate health/safety risk (e.g., "can't get life-sustaining meds," "child is unsafe at home").
  - b. Imminent loss of critical services (e.g., losing housing, expiring benefits).
  - c. Serious school issues with potential harm (e.g., repeated suspensions for disability-related behavior).

2. If your LHD has crisis or escalation guidelines:
  - a. Follow the local escalation protocol (e.g., alert supervisor, connect to crisis services, follow mandated reporting requirements).
3. If red flag policy is not fully defined:
  - a. Make a brief note of the concern.
  - b. Discuss immediately with your supervisor to decide whether to prioritize outreach and what safety steps are needed.

## **Step 6. Decide Initial Next Step & Update Case Status**

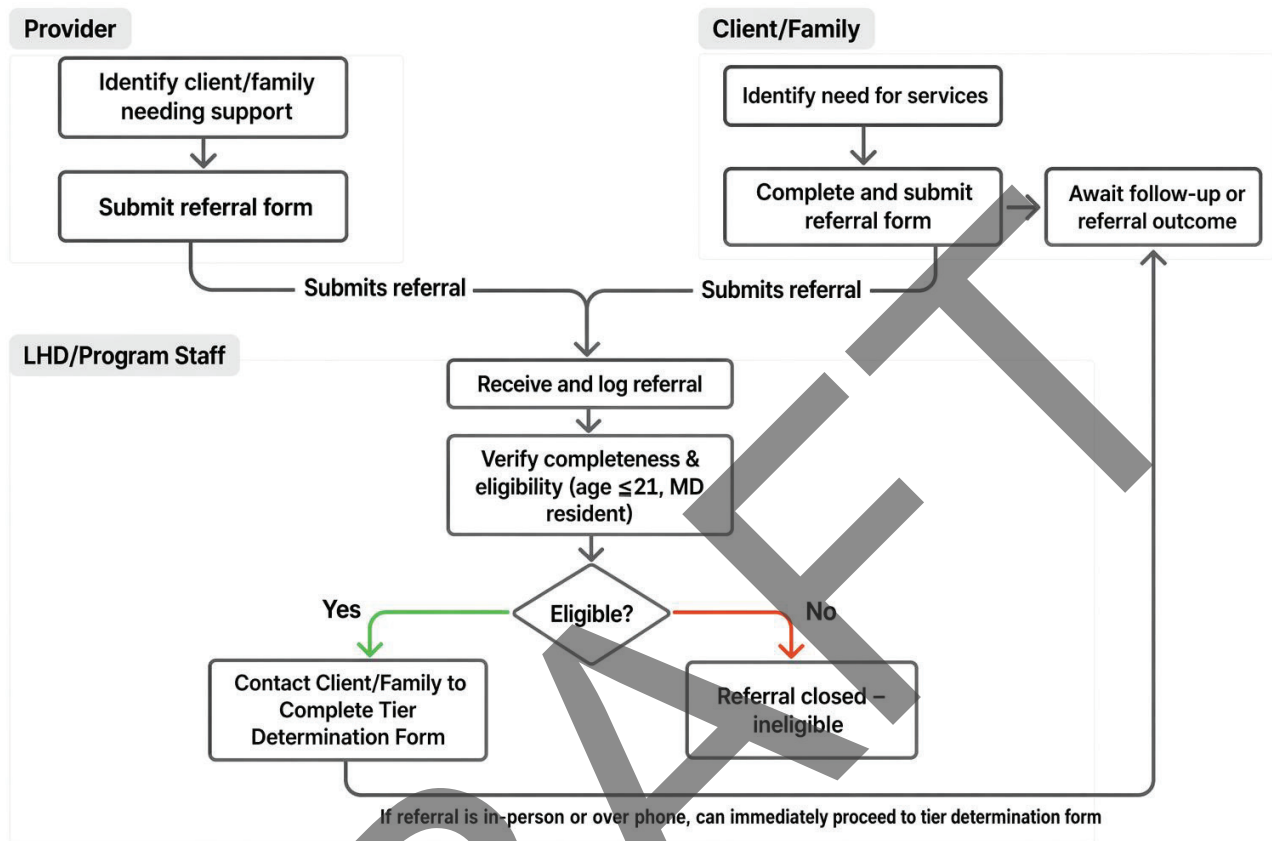
After reviewing eligibility, contact info, and referral details:

1. Decide whether the case should move forward to a Tier Determination conversation (Phase 1 Tier Determination Form), or whether another action is more appropriate (e.g., refer out, not eligible).
2. In the Case Status / internal section of the referral, update:
  - a. Enrollment/Case Status, selecting one, such as:
    - o Pending Tier Determination – Use when the family appears appropriate for the pilot and you plan to contact them for a Tier Determination interview.
    - o Referred Out – Use when another program is clearly a better fit and your role is limited to a warm handoff.
    - o Not Eligible – Use when basic criteria are clearly not met (e.g., not Maryland-based, not CYSHCN focus).
  - b. Staff Name – your name.
  - c. Date – date you recorded this status.
  - d. Assign the individual a Person Case ID in this format: MM-DD-YYYY-0001. The date should be the date of the referral, and the four digits will be based on the number of individuals.
    - o For example, if two referrals were received on the same day, the first referral would be 07012026-0001 and the second referral would be 07012026-0002.
3. Complete applicable fields on the Person\_Case\_Master and Referral\_Tracker tabs in the Care Coordination Program Data Collection Template.

## **Tools Needed:**

- [Referral Form](#)
- Care Coordination Program Data Collection Template

**Figure 1. Referral Workflow**



## Tier Determination Process

*Purpose:* Understand the family's current needs, existing support, prior experience in accessing services, and confidence navigating systems to select the appropriate tier.

The Tier Determination Form should be completed with the family, not independently by staff after the conversation. Final tier assignment should be determined using professional judgment. Health care providers and supporting staff should use discretion, recognizing that each family of a child or youth with specific health care needs is unique, and individual circumstances may not fit neatly into a single tier.

The conversation should feel respectful, collaborative, and conversational, even though specific information must be documented. Staff should:

- Use clear, jargon-free language.
- Normalize questions (e.g., "We ask everyone this because it helps us understand how best to support you.").
- Remain attentive to signs of stress or fatigue and offer breaks or a follow-up call as needed.

## Before You Begin

- Review the referral form and any prior documentation in the record. Populate any information from the referral into the Tier Determination form.
- Skim the Tier Determination form so you know what topics you'll cover (child info, medical info, current support, needs, stress, and preferences).
- Allow sufficient time for the Tier Determination conversation (this may occur in one or more contacts).
- Ensure language access or accommodation (e.g., interpreter, video relay, trusted support person) are available if requested.
- Explain to the family that this form helps determine the best "tier" of support and that they can skip or return to questions as needed.

Below are **step-by-step instructions** for completing the Tier Determination Form.

### Step 1. Complete Header Information

1. Record the date of completion in the "Date of Completion" field.
2. Enter your name in "LHD Staff Completing Form."
3. Enter the individual Person Case ID assigned on the referral form (format: MM-DD-YYYY-0001).
4. If the Tier Determination will occur over more than one contact, make a note in your case notes (e.g., "Tier Determination started on [date], completed on [date]").

*Purpose:* Clearly identifies who completed the form and when and allows the team to see how recent the tier decision is.

### Step 2. Verify Child and Parent/Caregiver Information (Section 1)

1. With the family on the phone or in person, review the child's information:
  - Name
  - Date of Birth
  - County of Residence
  - Residence Address and/or Zip Code
2. Review Parent/Caregiver Information:
  - Main parent/caregiver name
  - Relationship to the child
  - Phone number and email address
3. If this information was pre-populated from the referral form, read it back to the family and ask if anything has changed:
  - Correct spelling of names
  - Updated address or phone number
  - Preferred contact method or email

4. Use this section to confirm who should be contacted for ongoing care coordination (for example, which caregiver is the primary contact).

*Purpose:* Ensures accurate identification and contact information so the right caregiver is engaged, and communication is reliable throughout the pilot.

### Step 3. Review of Medical Information (Section 2)

Use Section 2 to gain a baseline understanding of the child's health conditions, insurance, and providers.

1. Diagnoses / Conditions
  - Ask: "What are your child's diagnoses or suspected health conditions?"
  - Write the conditions in the "Diagnoses" field, using the family's words when possible.
  - Ask: "How long has your child had this condition (or these conditions)?" and record the duration.
2. Insurance Information
  - Ask: "What kind of health insurance does your child currently have?"
  - In "Child's Type of Health Insurance," **check all that apply** (e.g., Medical Assistance, MCHP, private insurance, none, unsure, other).
  - If the family knows the plan name, complete: *"If insurance is known, name of health plan:"*
  - Ask: *"What support, if any, do you receive from your child's health plan?"* (e.g., case manager, help scheduling, no support). Document their response.
3. Medical Providers
  - Ask: "How many medical or service providers does your child currently see?" and use the form's categories (None, 1-2, 3+).
  - If the child has more than one provider, ask: *"What types of specialists does your child see?"* and list them (e.g., neurologist, developmental pediatrician).
  - Ask: *"What support services, if any, do your child's medical providers offer?"* (e.g., help with appointments, follow-up calls, help with forms) and document their response.

*Purpose:* Establishes a snapshot of medical complexity, health insurance context, and existing provider support that will help inform the tier assignment.

### Step 4. Explore Interest, Existing Services, and Scope of Need (Section 3)

Section 3 asks about interest/readiness, overlap with other services, and what the family needs help with.

#### **4A. Interest / Readiness for Support**

1. Ask: "Would you like ongoing support from our program, or would you prefer a one-time connection to other services?"
2. Capture their response in the space provided, using their own language when possible.

*Purpose:* Clarifies whether the family is seeking ongoing coordination (more consistent with Tier 2b or 3) or a one-time linkage (more consistent with Tier 1 or 2a).

#### **4B. Overlap With Other Services and Programs**

Go through each question and document "Yes / No / Not sure" per the form.

1. Ask: "Have you applied for or been denied Medicaid in the past 12 months?"
2. Ask: "Are you already receiving help from another program or service, like H-CAT, WIC, or another case manager?"
3. Ask: "Do you already have a case manager, care coordinator, or someone whose job it is to help you manage your child's care?"

If Yes to any, briefly note the program or person, if the family knows it (e.g., "H-CAT care coordinator," "MCO case manager").

*Purpose:* Identifies when this pilot is supplementing, collaborating with, or potentially duplicating other care coordination, which is critical when choosing tiers (especially Tier 2a warm handoff).

#### **4C. Scope of Need**

1. Start with an open-ended question: "What do you need help with when it comes to supporting your child's health care needs?"
2. Give the family time to answer. Use follow-up prompts if needed (e.g., "Are there challenges with appointments, school, insurance, daily care?").
3. In "What do you need help with..." and "Description of need," summarize the family's needs in their own words and include multiple needs if they share them.
4. Under the "INTERNAL USE ONLY" checklist, based on the family's description, check all categories that apply:
  - Medical/Health Care
  - Social/Behavioral
  - Access (transportation, internet, phone)
  - Supportive services (housing, food, education)
  - Youth care transition
  - Financial/Insurance
  - Advocacy/Legal

*Purpose:* Clarifies the breadth and type of needs (single vs multiple domains), which is key to determining the appropriate tier and planning next steps.

### Step 5. Assess Caregiver Capacity (Section 3 – Caregiver Capacity)

The Caregiver Capacity questions help you understand how the family is managing day-to-day demands.

1. Ask: “On a scale from 1 to 5, how confident do you feel managing your child’s health needs right now, where 1 is ‘not confident at all’ and 5 is ‘very confident’?”
  - Record the number (1–5) in the space provided.
2. Ask: “About how many hours a month do you spend coordinating care for your child?”
  - Encourage an estimate if they’re unsure (e.g., “Would you say more like 5 hours, 10 hours, 20 hours?”).
  - Document the approximate number or range.

*Purpose:* Helps determine how stretched the caregiver is and whether they may need more intensive support (e.g., Tier 3) versus lighter, time-limited coordination.

### Step 6. Discuss Stress and Resource Preferences (Section 3 – Stress and Support, Resource Preferences)

#### 6A. Stress and Support

1. Ask: “How often do you feel stressed or overwhelmed by your child’s care needs?”
  - Use the response options on the form (Rarely / Sometimes / Often / Always) and circle or record the one that best fits their answer.
2. Stay attentive to emotional cues (sighing, long pauses, tearfulness); if needed, slow down, validate their feelings, and offer to take a break.

#### 6B. Resource Preferences

1. Ask: “What type of support do you find most helpful—for example, education, reminders, direct assistance, or something else?”
2. In the “Resource Preferences” space, summarize their preferences (e.g., “prefers written step-by-step instructions,” “needs someone to help make calls,” “likes reminders by text”).

*Purpose:* Provides insight into stress burden and how the family wants support delivered, which will shape both the tier and how you tailor coordination within that tier.

### Step 7. Close the Tier Determination Conversation (With the Family)

At this stage, do not feel pressured to choose or name the tier while on the call. The focus is on summarizing and setting expectations about next steps.

1. Summarize what you heard, using the family's language where possible:
  - “It sounds like you’re mainly needing help with [X, Y, Z]...”
2. Explain what happens next, in plain language, without naming a specific tier:
  - For example:
    - » “I’m going to review everything you shared with our team and use it to decide the best way we can support you.”
    - » “Sometimes that means we work with families for a longer period, other times it’s more short-term or connecting you with another program.”
3. Let them know when they can expect to hear back:
  - “You’ll hear from me (or a team member) by [timeframe your program uses] about the next step.”
4. Confirm the family’s preferred method and timing of follow-up contact (phone, text, email; mornings vs afternoons, etc.).
5. Thank the family for their time and participation and acknowledge the effort it takes to share this information.

*Purpose:* Closes the conversation respectfully, sets realistic expectations, and leaves space for staff to thoughtfully determine the tier *after* the interaction.

### **Step 8. Determine and Document the Patient Coordination Tier (Section 4 – Internal Step After the Call)**

After the conversation (and not in front of the family in real time):

1. Review the full Tier Determination Form and your notes, including:
  - Diagnoses and clinical complexity.
  - Insurance and support from the health plan.
  - Number and types of providers.
  - Scope of needs (how many domains were checked).
  - Existing case management/care coordination.
  - Caregiver confidence and estimated hours spent coordinating care.
  - Frequency of stress/overwhelm.
  - Family's stated preference for ongoing vs one-time support.
2. In Section 4: Patient Coordination Tier, select one option:
  - Tier 1 – Provide Information/Referral
    - » For families who need brief information or a one-time connection and have relatively limited needs and/or strong existing supports.
  - Tier 2a – Warm Handoff to Partner
    - » For families best served by another existing program, where your primary role is to make a warm handoff and ensure connection.
  - Tier 2b – Short Term Enrollment (Move to Intake)

- » For families needing shorter-term, focused coordination and skill-building around a limited number of goals.
- Tier 3 – Long Term Enrollment (Move to Intake)
  - » For families with multi-system, high-complexity needs, high stress, and limited support who would benefit from more intensive, longer-term coordination.
- 3. If you are unsure between two tiers:
  - It is acceptable to start with a more supportive tier and step down later if appropriate.
- 4. Document the rationale for your tier selection in your case notes (e.g., “Multiple systems + 20+ hours/month coordinating care + Often overwhelmed + no other case manager → Tier 3; plan to revisit in 3 months”).
- 5. Update the applicable fields on the Person\_Case\_Master and Tier\_Determination\_Tracker tabs in the Care Coordination Program Data Collection Template.

*Purpose:* Finalizes the tier assignment outside the family conversation, giving staff time to integrate all information and, when needed, consult with supervisors.

**Note:** Tier assignment decisions are made by the LHD care coordination team, informed by information shared by the family, and documented during the Tier Determination process. When needed, care coordinators should consult with a supervisor prior to finalizing a tier assignment. Final tier decisions should be clearly documented in case notes, including the rationale for the decision.

#### Important Practice Notes for LHD Staff (Tier Determination)

- The Tier Determination conversation may span more than one contact; prioritize family comfort over “finishing the form” in one sitting.
- Not all questions will apply to every family; use professional judgment while ensuring you have enough information to make a reasonable tier decision.
- Use trauma-informed, family-centered, and culturally responsive approaches throughout.
- The tier can be revisited and changed later if needs grow, lessen, or new information emerges.

#### Tools Needed:

- [Tier Determination Form](#)
- Care Coordination Program Data Collection Template

## Tier Pathways and Outcomes

Based on the Tier Determination interview, families are routed to one of four pathways as outlined in Table 1.

**Table 1. Tier Overview At-A-Glance**

| Tier           | Pilot Enrollment Eligibility | Primary Purpose                                                                                                                                                                                                                                                                                                                                        |
|----------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 1</b>  | Not Eligible                 | Information and referral only (families and CYSHCN require minimal support and have uncomplicated medical care, no follow-up needed)                                                                                                                                                                                                                   |
| <b>Tier 2A</b> | Not Eligible                 | Connection facilitated “warm handoff” to another program or provider (families and CYSHCN require minimal support and have uncomplicated medical care, single referral, or linkage)                                                                                                                                                                    |
| <b>Tier 2B</b> | Eligible                     | Short-term care coordination (family and CYSHCN with 2-4 identified concerns, requiring a partner in developing a care plan and assistance with service connection, care coordination needs expected to be met within 3–6 months.                                                                                                                      |
| <b>Tier 3</b>  | Eligible                     | Long-term and/or ongoing, complex coordination (families and CYSHCN with 5+ identified concerns requiring coordination or multiple services/systems, more comprehensive care plan and more frequent follow up, family support and training, involving multiple providers and systems) care coordination needs expected to be met beyond 6 months mark. |

## Tier Determination Assignment Overview

Table 2 provides more detail about each tier's primary purpose, including practical guidance and real-world examples to help determine the most appropriate tier for families contacting or referred to the pilot. Final tier assignment should be determined using professional judgment. Health care providers and supporting staff should use discretion, recognizing that each family of a child or youth with specific health care needs is unique, and individual circumstances may not fit neatly into a single tier.

**Table 2. Tier Determination Assignment Overview**

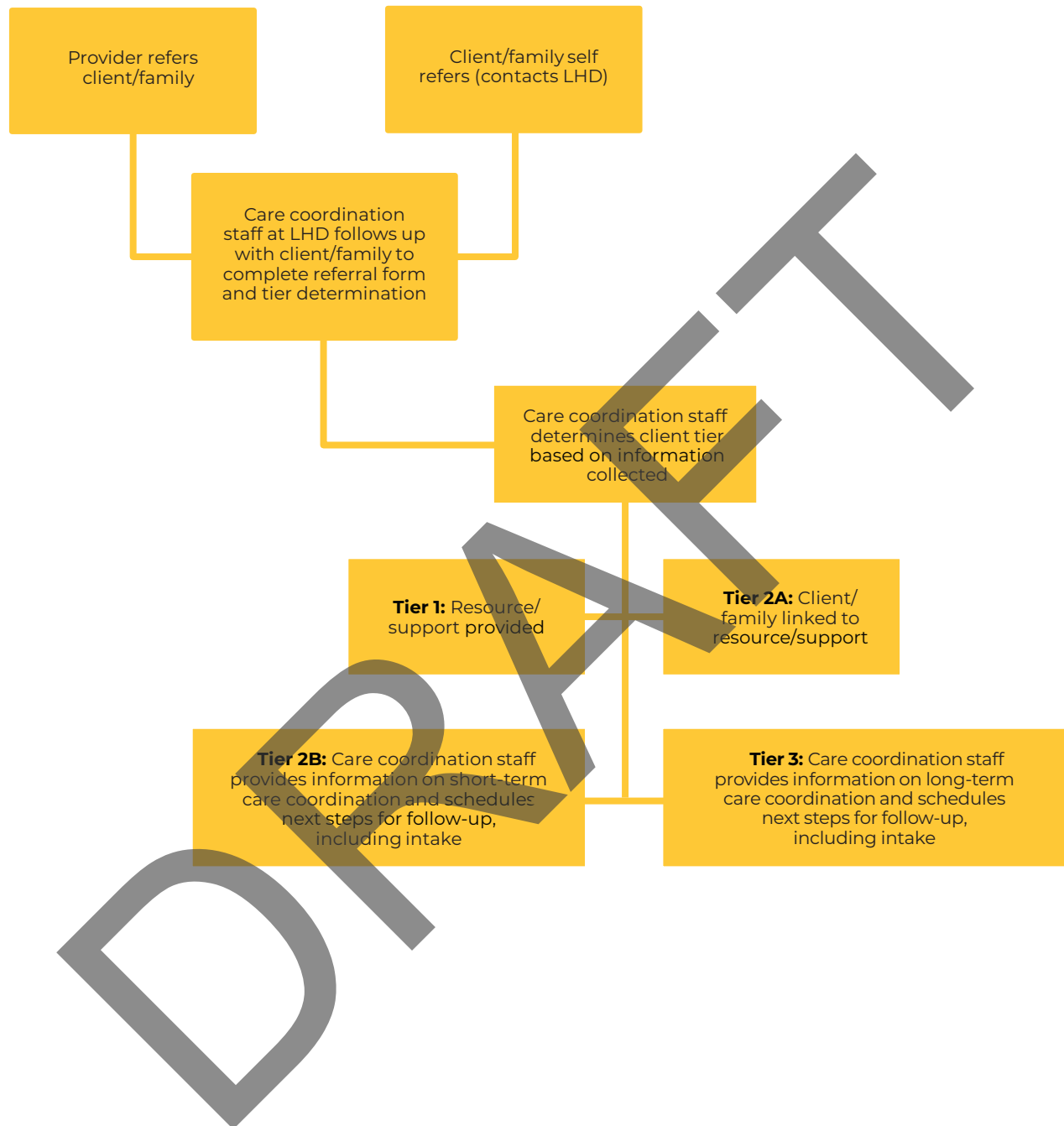
| Tier      | Pilot Enrollment Eligibility | Primary Purpose                                                                                                                                                                     | Examples                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1</b>  | Not Eligible                 | Information and referral only (families and CYSHCN require minimal support and have uncomplicated medical care, no follow-up needed)                                                | <ul style="list-style-type: none"> <li>A parent of a child with asthma requests information on where to apply for Medicaid and feels comfortable completing the application independently.</li> <li>A social worker calls looking for a resource for a family with an infant with developmental concerns asks for the phone number for the Infants and Toddlers Program and does not request additional assistance.</li> <li>A pre-school teacher working with a family of a child with specific health care needs requests a list of food pantries or diaper banks to provide to the family.</li> </ul> |
| <b>2A</b> | Not Eligible                 | Connection facilitated "warm handoff" to another program or provider (families and CYSHCN require minimal support and have uncomplicated medical care, single referral, or linkage) | <ul style="list-style-type: none"> <li>A family of a child who is hard of hearing needs to connect with their Managed Care Organization (MCO) care coordinator but is unsure how to initiate contact. Care coordination staff at the local health department facilitates the connection. Family declines follow up or connection to other services.</li> </ul>                                                                                                                                                                                                                                           |

*Continued on following page.*

| Tier      | Pilot Enrollment Eligibility | Primary Purpose                                                                                                                                                                                                                   | Examples                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>2A</b> | Not Eligible                 | Connection facilitated “warm handoff” to another program or provider (families and CYSHCN require minimal support and have uncomplicated medical care, single referral, or linkage)                                               | <ul style="list-style-type: none"> <li>• A child with a suspected developmental delay requires early intervention. Care coordination staff assists with submitting the referral and confirming intake scheduling. Parents are uninterested in enrollment in care coordination.</li> <li>• A caregiver of a youth with emerging behavioral health needs requires connection to a provider and brief assistance to identify an appropriate provider and understanding the referral requirements. Declines connection to care coordination at this time but may follow back up in future.</li> </ul>                                                                                                                                      |
| <b>2B</b> | Eligible                     | Short-term care coordination (family and CYSHCN with 2-4 identified concerns, requiring a partner in developing a care plan and assistance with service connection, care coordination needs expected to be met within 3-6 months. | <ul style="list-style-type: none"> <li>• A family of a child with ADHD needs help coordinating behavioral health services and school support (e.g., IEP or 504 plan), care coordinator connects family with school support for further assistance.</li> <li>• A caregiver of a child with a chronic condition (e.g., diabetes or asthma) has insurance but is overwhelmed by referrals, waitlists, and authorization requirements and needs short-term support to help with coordinating and accessing services.</li> <li>• A youth with specific health care needs is transitioning between pediatric and adolescent services and needs support to understand next steps, eligibility changes, and how to access services.</li> </ul> |

| Tier | Pilot Enrollment Eligibility | Primary Purpose                                                                                                                                                                                                                                                                                                                                         | Examples                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3    | Eligible                     | Long-term and/or ongoing, complex coordination (families and CYSHCN with 5+ identified concerns requiring coordination or multiple services/ systems, more comprehensive care plan and more frequent follow up, family support and training, involving multiple providers and systems) care coordination needs expected to be met beyond 6 months mark. | <ul style="list-style-type: none"> <li>• A child with complex medical needs (e.g., technology dependence, multiple chronic conditions) sees multiple specialists, receives school-based services, and requires coordinated care across providers.</li> <li>• A family struggles to understand insurance coverage for their child's ongoing health care needs, faces barriers to accessing specialty and community services, and lacks a consistent point of coordination.</li> <li>• A youth with significant behavioral health needs is involved with multiple systems (e.g., healthcare, education, or child welfare) and experiences frequent service disruptions, requiring ongoing coordination and advocacy.</li> </ul> |

**Figure 2. Tier Determination Workflow**



DRAFT

**PHASE 2:**

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**Intake & Assessment**

# PHASE 2

## Intake and Assessment

Phase 2 of the Maryland CYSHCN System of Care Coordination Pilot focuses on conducting a comprehensive, family-centered intake and assessment for families who are enrolled in care coordination. This phase applies to families assigned to Tier 2B (Short-Term Care Coordination) and Tier 3 (Full Care Coordination). The intake and assessment process establishes a shared understanding of the child's needs, the family's priorities, and the supports currently in place, and it lays the foundation for effective care planning and coordination.

Phase 2 should be approached as a relationship-building process rather than a purely administrative task. Although specific forms and tools are required, the intake process is intended to be conversational, supportive, and responsive to family circumstances. LHD staff should take time to explain the purpose of each step, how information will be used, and what families can expect as they move forward in the pilot.

### Purpose and Goals of the Intake Process

The primary purpose of intake and assessment is to gather sufficient information to support meaningful, appropriate care coordination while minimizing burden on families. Intake allows LHD staff and families to jointly identify strengths, challenges, and priorities, and to confirm that enrollment in care coordination is the right level of support.

The goals of Phase 2 include building rapport and trust with the family, confirming or refining the tier assignment, identifying priority goals for coordination, and initiating shared care planning tools that will be used throughout the pilot.

### Role of the Care Coordinator

During Phase 2, LHD staff complete the Intake Form in partnership with the family. The Intake Process is a core component of Phase 2 for families enrolled in Tier 2B (Short-Term Care Coordination) and Tier 3 (Full Care Coordination). The purpose of intake is to develop a shared understanding of the child's needs, the family's priorities, and the systems involved in care, while beginning care planning in a family-centered and supportive manner. The intake will cover key areas including the child's medical history, behavioral health needs, educational supports, social determinants of health, existing providers and services, and family strengths.

**The Intake Form should be completed with the family, not independently by staff, after the conversation.** Intake should feel conversational and respectful, even though specific information must be documented. Staff should remain attentive to signs of stress, lack of understanding or fatigue and adjust pacing as needed.

## Before You Begin

- Review the referral and Tier Determination information prior to contacting the family.
- Allow sufficient time for the intake conversation (often 60–90 minutes, which may occur over more than one interaction if needed).
- Ensure language access or accommodations are available, if required.
- Explain to the family that the intake helps guide care coordination and that they may skip or return to questions as needed.

## Tools Used:

- [Intake Form](#)
- Data Collection Template
  - [Baltimore County](#)
  - [Talbot County](#)

## Intake Process Workflow

### Step 1. Complete Header Information

1. Record the date of completion.
2. Enter the name of the staff member completing the form.
3. Enter the individual Person Case ID assigned on the referral form and used on the tier determination form (format: MM-DD-YYYY-0001).
4. Confirm whether this intake is being completed in a single session or across multiple contacts.

### Step 2. Verify Child and Parent/Caregiver Information (Section 1)

1. Review the child's name, date of birth, county of residence, and address or zip code.
2. Confirm parent/caregiver name, relationship to the child, and preferred contact information.
3. If information was populated from the referral, verify accuracy with the family and correct as needed.
4. Use this section to confirm who should be contacted for ongoing care coordination.

*Purpose:* Ensures accurate identification and communication throughout the pilot.

### Step 3. Review of Medical Information (Section 2)

1. Confirm medical diagnoses from the referral and how long the child has had the condition(s).
2. Ask whether the child is currently receiving treatment or therapy.
3. Mark all applicable services (e.g., PT, OT, Speech, Behavioral Health, Early Intervention, IEP/504).

4. Ask about use of specialized medical equipment and document details.
5. Discuss any prior screenings or testing, including:
  - a. Reason for testing
  - b. Provider or system that conducted testing
  - c. Known outcomes or recommendations
6. Document information in the family's own words when possible.

*Purpose:* Establishes a baseline understanding of current and past medical and developmental services.

#### **Step 4. Explore Family and Social Systems (Section 3)**

1. Ask about household members, including names, ages, and relationships.
2. Review available support systems (extended family, community, faith-based supports, friends).
3. Note gaps in support or areas where the family feels isolated.

*Purpose:* Identifies natural supports and contextual factors that influence care coordination.

#### **Step 5. Identify Care Coordination Needs (Section 4)**

1. Ask who currently coordinates the child's care (parent, PCP, care coordinator, case manager).
2. Review unmet medical needs, including:
  - a. Needed Durable Medical Equipment (DME)
  - b. Medications not currently accessible
  - c. Difficulty accessing specialists
  - d. Missed or delayed immunizations
3. For each "Yes" or "Unknown" response, ask follow-up questions and document details.
4. Discuss educational and developmental service needs across the listed domains.
5. Review social support needs (transportation, housing, food, childcare, insurance, legal/advocacy).
6. Capture both immediate needs and emerging concerns.

*Purpose:* Clarifies where care coordination can add the most value.

#### **Step 6. Assess Parent/Caregiver Knowledge and Capacity (Section 5)**

1. Ask what information or education would be most helpful to the parent/caregiver.
2. Discuss challenges navigating systems such as insurance, education, or specialty care.
3. Ask about backup caregiving or respite needs.
4. Identify the family's biggest concerns in their own words.
5. Ask whether an emergency preparedness plan exists and document status.

*Purpose:* Informs goal setting and family capacity-building activities.

### **Step 7. Address Transition Planning (Section 6 – Ages 12–21 Only)**

1. If the child is age 12 or older, introduce transition planning in age-appropriate language.
2. Ask what steps the family has already taken toward adult care.
3. Discuss goals related to health, independence, and adulthood.
4. Document needs related to adult providers, insurance/benefits, and independent living.

*Purpose:* Ensures transition planning begins early and aligns with family priorities.

### **Step 8. Complete Internal Case Status and Tier Confirmation**

1. Indicate whether the intake has been completed.
2. Enter staff name and date.
3. Confirm the appropriate coordination tier (Tier 2B or Tier 3).
4. If tier assignment changes from initial determination, document rationale in case notes.

*Purpose:* Finalizes enrollment status and guides next steps in care planning.

### **Step 9. Close the Intake Conversation**

5. Summarize key needs and priorities identified during intake.
6. Explain next steps, including care planning, Care Map development, and follow-up timing.
7. Confirm preferred method and timing of future contact.
8. Thank the family for their time and participation.

### **Step 10. Update the Care Coordination Program Data Collection Template**

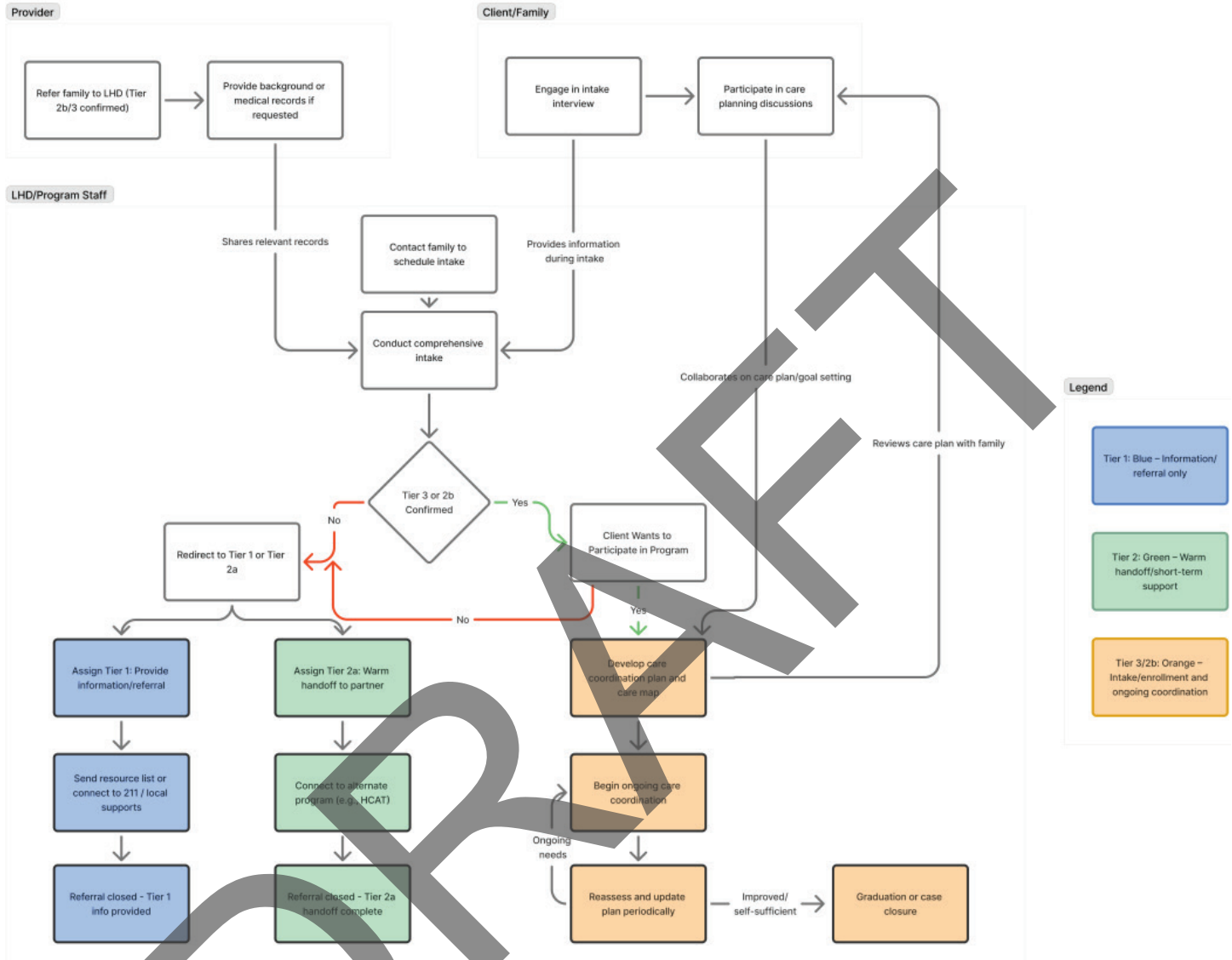
1. After the Intake is completed, update the applicable fields on the “Person\_Case\_Master” and “Intake Tracker” tabs in the Care Coordination Program Data Collection Template.

#### **Important Practice Notes for LHD Staff**

- Intake may require more than one conversation; do not rush completion.
- Not all questions will apply to every family.
- Use professional judgment and trauma-informed practices.
- Intake information should directly inform goals, care planning, and coordination activities.

Based on information gathered during intake, LHD staff confirm the family’s tier assignment. In some cases, intake findings may indicate that a different tier is more appropriate than initially assigned. Decisions to adjust a tier are made by the LHD care coordination team, with supervisor consultation as needed, and should be documented clearly in case notes.

**Figure 3. Intake Workflow**



## Introducing the Care Map and Shared Planning

A key component of Phase 2 is the introduction of the Care Plan and the Care Map. The Care Plan is a written document that allows staff to work alongside the parent/caregiver to map out a child's specific medical, developmental, or behavioral goals, including interventions delivered by the staff to meet those goals, and outcomes. The Care Map is a visual tool that helps families and care coordinators understand the child's care team, services, and supports across systems. During intake, staff should introduce and begin developing the Care Plan and the Care Map collaboratively, as they are able, explaining that these are living documents that will be updated over time. Further directions and details on co-creating the Care Plan and the Care Map with families can be found in the [Care Planning and Care Coordination](#) section of [this guide](#).

As staff work to complete the Care Plan, they can begin conversations about care coordination goals during this phase. Goals should be family-driven, realistic, and focused on improving access to services, reducing barriers, and building family capacity.

### **Consistency Across Tiers with Differing Intensity**

The intake and assessment process is intentionally consistent across Tier 2B and Tier 3 to promote equity and clarity. All enrolled families complete the same core intake steps and are introduced to the same planning tools. The primary difference lies in the depth and duration of coordination that follows intake, not in the intake process itself.

By maintaining a consistent intake approach, LHDs ensure that all families receive a thorough and respectful assessment while allowing flexibility in how coordination is delivered based on tier.

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**PHASE 3:**

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**Care Planning & Care Coordination**

# PHASE 3

## Care Planning and Care Coordination

Phase 3 represents the core service delivery phase of the Maryland CYSHCN System of Care Coordination Pilot. During this phase, LHD staff actively partner with enrolled families to engage in care planning and care coordination. This includes coordinating services across systems, supporting access to care, and working toward family-identified goals.

Phase 3 builds directly on information gathered during referral, intake, and assessment and continues until families are ready to transition or graduate from the pilot.

### Purpose and Goals of Care Coordination

- Supporting client access to appropriate medical, behavioral health, educational, and social services
- Improving communication and alignment across systems
- Reducing fragmentation and duplication of care
- Strengthening the family's own ability to navigate systems independently over time

### Role of the Care Coordinator

Care coordinators will serve as:

- A single, consistent point of contact for the family/guardian
- A facilitator of communication across providers, agencies, and systems
- A coach and advocate for families
- A partner in planning

Care coordination intensity and frequency vary by Tier, but the overall workflow will be consistent across Tier 2B and Tier 3.

### Care Coordination Workflow

#### Step 1: Review Referral, Intake, and Tier Determination Information

Reviewing the referral and intake information ensures that the care coordinator begins Phase 3 with a clear understanding of the child and family's needs and priorities. It also allows them to understand the families assigned Tier and expected level of engagement with the program.

Care coordinator will review:

- Referral form (if completed) and reason for referral
- Intake assessment results

- Assigned Tier level
- Identified priority needs, risks, strengths, and existing supports

Tools reviewed:

- Referral form
- Intake form
- Tier Determination form

## Step 2: Initial Care Coordination Meeting

The care coordinator will hold an initial meeting via phone, video, or in-person (based on the family's preference) to introduce themselves, build rapport, and confirm the family's priorities. They will also introduce and potentially begin the Care Plan, either during the initial meeting, or subsequent meeting.

Timing:

- Tier 2B: Within 2 weeks of intake
- Tier 3: Within 1 week of intake

Coordinator Responsibilities:

1. Give overview of care coordination support and what to expect.
  - Share: "Care coordination means working together to help you manage and connect the pieces of your child's care. My role as a care coordination is to help you navigate different systems, like health care, school, and community services. I want to help so things feel more organized and less overwhelming."
  - Share: "You can expect me to be a regular point of contact for you while you're in the program. We can touch base regularly and adjust the plan if your goals change."
2. Describe expected frequency of contact (based on Tier and family's level of need).
  - Share: "We can decide how often we connect based on what your needs are."
  - Using your professional judgment: "Based on what we know so far, I expect we'll connect about [X times a month] but we can adjust if your needs change. If something urgent comes up, you can reach out between scheduled check-ins."
3. Introduce tools that may be used over time together.
  - **Care Map:** "The Care Map is a visual map that shares how everyone is involved in your child's care. It helps us see how providers connect, if there's any overlap, or what services may be missing."
  - **Care Plan:** "The Care Plan is going to be a plan we create together that breaks down what your goals are for your child, into clear next steps. We can write down what I'll be helping with."

- **Shared Plan of Care:** “This is an optional document we may create later together. It’s a document you’d share with your child’s providers that helps outline what your child’s goals are, and what each provider’s responsibilities are in helping them meet those goals. It helps providers see and understand how everyone works together with your child.”
  - **Emergency Preparedness Document:** “This is a tool we can work on together that helps us prepare for any emergencies or disruptions in care. It will include information like who to contact, what equipment and medications your child needs, and what and who to go to in emergencies.”
4. Confirm preferred communication methods and best times to connect.
    - Ask: “What’s the best way to reach you – phone, text, email, or something else?”
    - “Are there certain days and times that work better for you?”
  5. Review and complete Care Map.
  6. Describe purpose of Care Plan and begin to complete/fully complete Care Plan in initial meeting, if able.

## Completion of Care Map

The Care Map is a visual tool that can support families and care coordinators with understanding the child’s care team, services, systems, and supports. The Map is completed with the family and care coordinator. The Care Map should have been introduced during the Intake meeting.

Tiers:

- Both Tier 2B and Tier 3 can benefit from the development and maintenance of a Care Map.

## Tools Used:

- Care Map

Coordinator responsibilities:

1. Review how the map can be used.
  - Describe: “As we reviewed previously, we can create a Care Map together to map out who’s currently involved in your child’s care. This can include doctors, therapists, school staff, other community-based services, or even informal supports (like involved, supportive family members or friends.) This helps us see what’s already in place, where things are working well, and where there may be gaps or places that feel confusing or overwhelming.
2. Develop Care Map collaboratively with the family.
  - Ask:
    - » “Who are the main medical providers involved in your child’s care

right now?”

- » “Are there any specialists, therapists, or clinics you interact with regularly?”
- » “Is your child receiving any behavioral health, therapy, or developmental services?”
- » “Is your child connected to school-based services, early intervention, or special education supports?”
- » “Who do you usually communicate with at school?”
- » “Are there community programs or agencies involved?”
- » “Are there family members or friends who play a big role?”

o Understand Gaps:

- » “Are there providers you’re waiting to hear back from or hoping to connect with?”
- » “Are there services you’ve tried to access but haven’t been able to yet?”
- » “Are there providers involved in your child’s care whose roles feel unclear?”

o Reviewing Map:

- » “Are there areas where you feel support is missing?”
- » “Are there places where you’re getting the same information from multiple providers, or communication feels disconnected?”

### **Step 3: Completion of Care Plan (during initial or subsequent care coordination meeting)**

The Care Plan translates the family goals into concrete, actionable steps. This Plan can be used as a guide throughout care coordination and returned to. The Care Plan identifies: the specific services and support needed by the family, referrals that may need to be made, follow-up steps, and who is responsible for next steps (including what the family may be responsible for as well as the care coordinator.)

Timing:

- o Completed during initial care coordination meeting, or in subsequent meeting after

### **Tools Used:**

- [Care Plan and Service Tracker](#)
- Care Coordination Program Data Collection Template

Coordinator Responsibilities:

1. Introduce Care Plan and describe purpose of document.
  - o Share: “The Care Plan is a tool we use to plan what work we’ll be doing together and helps us keep track of goals. We can keep track of who’s doing what and what’s coming next.”

- » “The plan is meant to support you, not add more work. We can go at a pace that feels manageable.”
- 2. Walk through Care Plan document and complete collaboratively with the family.
  - Tier 2b: Typically focus on 2-3 priority goals
  - Tier 3: Focus on multiple goals across systems
    - o Review:
      - » “Based on what you’ve shared with us so far, what feels like the most important thing to focus on?”
      - » “What goals would make the biggest difference for your child right now?”
      - » “What do you think needs to happen to move towards these goals?”
      - » “Are there services and supports you’ve been trying to access?”
      - » “Are there information or paperwork that has been getting in the way?”
- 3. Ensure plan reflects family priorities and is realistic and achievable.
  - o Clarify roles and responsibilities:
    - » Ask: “For this next step, would it be helpful if I handled this, or if we worked on it together?”
    - » “What feels manageable for you to take on right now?”
  - o Set realistic timelines:
    - » “Does this timeline feel realistic for you?”
    - » “Would it help to break this larger goal into smaller steps?”
- 4. Review next steps.
  - o “Before we wrap up, let’s review what we decided today.”
  - o “Before our next meeting, I’ll work on \_\_\_ and you’ll be working on \_\_\_\_.”
  - o “We can check back in on this at our next meeting and adjust as needed.”
- 5. Complete Service Tracker portion of Care Plan.
  - o Log the date of the visit/meeting with client.
  - o Log the visit type (identifying whether it was in-person, a phone call, a virtual visit, or another type of visit).
- 6. Update the Care Coordination Program Data Collection Template.
  - o As the care plan and service tracker are updated, complete the “Care\_Plan\_Service\_Tracker” tab in the Care Coordination Program Data Collection Template.

#### **Step 4: Ongoing Care Coordination Activities**

Care planning and active coordination are intentionally iterative. Family needs, circumstances, and priorities may evolve over time, and care coordination activities should remain flexible and responsive.

Common care coordination activities include:

- Making referrals and warm handoffs
- Scheduling or supporting appointment scheduling
- Following up with providers and agencies
- Supporting completion of paperwork (e.g., Medicaid, CMS-related forms, other applications)
- Facilitating communication across systems and providers
- Helping families problem-solve barriers, such as transportation
- Revisiting the Care Plan to update interventions/steps that care coordination and client are taking towards goals, outcomes, and any referrals or specific resources provided to client
- Revisiting the Care Plan to add new goals that the client identifies

Although Phase 4 focuses explicitly on family capacity building, opportunities to strengthen family skills and confidence should be incorporated throughout Phase 3.

Tiers:

**Tier 2B:** Includes lower frequency of contact with the family (short-term coordinator)

**Tier 3:** Includes higher frequency of contact with the family (longer-term coordination)

### Tools Used:

- Care Plan and Service Tracker
- Shared Plan of Care
- Care Map
- Emergency Preparedness Document

Coordinator responsibilities:

1. Maintain ongoing communication and check-ins with family
  - a. Ongoing communication should be proactive, intentional, and align with family needs.
  - b. Check-ins can include Scheduled phone or video calls, brief check-ins by text or email, follow-up calls after appointments or referrals.
  - c. Prompts:
    - i. “How did your child’s appointment go?”
    - ii. “Were you able to connect with that provider like we discussed?”
    - iii. “Did anything come up that changed what you need support with?”

2. Track progress towards identified priorities and goals utilizing the Care Plan and Service Tracker tool.
  - a. Ensure consistent document of care coordination interventions (activities) to support pilot evaluation.
  - b. The Care Plan and Service Tracker is a tool to be used by the care coordinator and completed after each point of contact and care coordination activity.
    - i. Use service tracker to:
      1. Monitor frequency of coordination
      2. Support continuity across staff if case transferred between providers
      3. Inform evaluation
3. Support completion of paperwork.
  - a. Reduce administrative burden that delays access to services.
  - b. Examples:
    - i. Medicaid applications or renewals
    - ii. CMS
    - iii. Program applications or authorizations
4. Identify and connect families to referrals and resources.
  - a. Identify appropriate referrals based on Care Plan goals.
    - i. Use existing LHD, health department, or partner organization resource directories and confirm that resources are current and appropriate for the family's location and needs
    - ii. Search by ZIP code, service category, and eligibility criteria and review program descriptions and eligibility requirements with families to support families in identifying options that align with their priorities
    - iii. Utilize resource platforms including:
      1. [Findhelp](#)
      2. [2-1-1 Maryland](#)
      3. [Maryland Children's Medical Services \(CMS\)](#)
      4. [Maryland Infants and Toddlers Program \(Early Intervention\)](#)
  - b. Make warm handoffs when possible.
  - c. Confirm referral receipt and next steps.
  - d. Follow up with families to ensure connections were made.
  - e. Prompts:
    - i. "Were you able to connect with the referral?"
    - ii. "What happened when you reached out?"

5. Support coordination and communication across systems and providers.
  - a. Reduce fragmentation and burden on families.
  - b. Clarifying roles between providers, supporting information-sharing (with consent), helping families prepare questions or talking points for appointments.
6. Involve families in care coordination activities when appropriate.
  - a. Encourage families to practice skills, including preparing for appointments, making follow-up calls, tracking next steps.
  - b. Reinforce learning and highlight progress to support independence.
  - c. Prompts:
    - i. “Would you like to try making this call together?”
    - ii. How did it feel to follow up on that?”
7. Update the Care Map as new services are added and responsibilities shift
  - a. Add new providers and services.
  - b. Remove services no longer in use.
  - c. Update roles and responsibilities.

## Additional Steps Occurring Concurrently During Phase 3

### Completion and utilization of Shared Plan of Care (SPOC)

The Shared Plan of Care ensures that all providers and stakeholders involved in the child's care are aligned around their current goals and progress. With family consent, this document can be shared with the child's medical providers, education team, and other social service providers to support coordinated care.

Tiers:

**Tier 2B:** Use of SPOC is optional. Coordinators may opt not to complete formal SPOC if family needs are limited or short-term. Instead, care planning conversations can be clearly documented in the Engagement Tracking Tool to ensure alignment with family priorities.

**Tier 3:** SPOC can be used as a central coordination tool and actively maintained.

### Tools Used:

- [Shared Plan of Care](#)

Care Coordinator responsibilities:

1. Introduce how Shared Plan of Care can be used.
  - o “The Shared Plan of Care is a way to keep everyone on the same page about what's most important to your family and how different providers are supporting your child. With your permission, this

is something we can share with doctors, school staff, and other providers, so you don't have to explain everything again."

- "You can decide who has access to this document."

2. Complete with family.

- Review of family-identified goals from the Care Plan.
- Identify key providers and systems involved (with help from Care Map).
  - » Complete section: "Please list all people living in your home and other people that support you"
- Complete remaining components:
  - » "My insurance"
  - » "My Diagnoses"
  - » "I want the person working with me to know:"
  - » "My Emergency Plan"
  - » "My Food Allergies/Intolerances"
  - » "My Drug Allergies/Intolerances"
  - » "My Pharmacy"
  - » "My Prescription Medications"
  - » "My Over-the-Counter Medications"
  - » Providers:
    - "My Primary Care Provider"
    - "Other Provider"
    - "My Home Care"
  - » "Durable Medical Equipment"
  - » "Orthotic and/or a Prosthetic"
  - » "My Dentist"
  - » "My Eye Doctor"
  - » "My Audiologist"
  - » "My Transportation Information"
  - » "My Education"
  - » "My Transition to Adulthood"
  - » "My Hospitalizations, Emergency Room Visits, and Other Procedures"
  - » To keep updated as it is helpful:
    - "My Follow-up Appointments"
    - Additional Information
- "What do you want providers to understand first about your child."
- "Which goals feel most important for everyone to be aligned on?"

3. Encourage families to keep document accessible and updated.
  - » Normalize that updates are to be expected
  - » Reinforce that the document is meant to be used and not filed away
4. Encourage families to share document with child's medical providers, education team, other social service providers.
  - o "Would it be helpful to share this with your child's doctor or school team?"
  - o "Would you like support sharing this, or do you prefer to do it yourself?"

### **Development of Emergency Preparedness Document**

The Emergency Preparedness Document will support families and their child's readiness for emergencies and care disruptions.

Tiers: Both Tier 2B and Tier 3 can benefit from the development and maintenance of an Emergency Preparedness Document.

### **Tools Used:**

- [Emergency Preparedness Document](#)

Coordinator responsibilities:

1. Introduce and explain how Emergency Preparedness Document can be used.
  - a. "This document helps make sure important information is easy to access if there's an emergency or unexpected situation."
  - b. "The goal of this document is to make things a little easier during stressful moments and minimize disruptions in your child's care."
2. Complete the document with the family.
  - a. Review of emergency contacts.
  - b. Document:
    - i. Primary care providers and specialists
    - ii. Diagnoses and past procedures
    - iii. Common presenting problems
    - iv. Medications
    - v. Equipment or other supplies
  - c. Identify:
    - i. Backup caregivers
    - ii. Disasters most likely to affect client
    - iii. Emergency plans
  - d. "If something unexpected happened, who would need this information right away?"
  - e. "Are there medications or equipment that emergency providers should know about?"

3. Encourage families to keep document accessible and updated.
  - a. “This is most helpful when it’s easy to find. Some families may keep it on their phone or with other medical records.”
  - b. “We can revisit this anytime something changes.”
4. Encourage families to share document with child’s medical providers, education team, other social service providers.
  - a. “Would you like your child’s school or medical team to have a copy?”
  - b. “Are there family members or other trusted caregivers who should also have this information?”

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**PHASE 4:**

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**Family Capacity Building**

# PHASE 4

## Family Capacity Building

### Purpose and Goals of Family Capacity Building

Phase 4 of the Maryland CYSHCN System of Care Coordination Pilot focuses on strengthening family capacity, confidence, and self-reliance. While capacity building is reinforced throughout the pilot, Phase 4 emphasizes intentional skill development to support families in managing their child's care more independently over time. Phase 4 typically overlaps with Phase 3 and continues until families are ready to transition or graduate from the pilot.

Phase 4 does not represent a separate or sequential period of service. Instead, family capacity building is an intentional emphasis within ongoing care coordination activities. While skill-building and coaching occur throughout Phase 3, Phase 4 highlights strategies for progressively shifting responsibility to families as they prepare for transition and graduation from the pilot program.

Goals for family capacity building include:

- Increasing family understanding of health, behavioral health, educational, and social service systems
- Strengthening communication, organization, and follow-through skills
- Reducing reliance on coordination support over time
- Preparing families to manage care coordination tasks independently

### Role of the Care Coordinator

During Phase 4, care coordinators:

- Coach and guide families rather than completing tasks on their behalf
- Partner with families to practice coordination skills
- Reinforce learning and confidence
- Support use of tools families can continue using beyond the pilot

Care coordinators can use the Family Voices resource [Assessing Family Engagement in Systems of Care](#) to guide engagement conversations and ensure practices reflect family priorities and perspectives. This resource can be used to support reflection on engagement practices, build rapport, and guide how coordinators partner with families:

Care coordinators may also use the state [Family Voices Family-to-Family Health Information Center](#) as a resource for families. Family-to-Family programs provide family-run, peer support and information to help families navigate systems, understand options, and build confidence.

## How to Use These Resources

### During Initial and Ongoing Engagement

- Use concepts from the Family Voices engagement framework to guide early conversations about family priorities, communication preferences, and expectations.
- Reflect on engagement practices over time, including whether families feel heard, respected, and involved in decision-making.

### When Families Need Peer Support or System Navigation Help

- Share information about the Family-to-Family Health Information Center as an option for peer support and system Coordination guidance.
- Explain that Family-to-Family programs are staffed by families who have lived experience navigating care systems.
- Support families in contacting their local Family-to-Family program if they are interested.

## Tools Used:

- Care Map
- Care Plan and Service Tracker
- Shared Plan of Care
- Emergency Preparedness Document

## Family Capacity Building Workflow

### Step 1: Identify Capacity-Building Priorities

Care coordinators review information from intake, care planning, and ongoing coordination to identify areas where families would benefit from skill-building.

*Purpose:* To focus capacity-building efforts on areas that support long-term independence.

#### Coordinator Responsibilities:

1. Review the Care Plan and Engagement Tracking Tool
2. Identify tasks the coordinator is frequently completing for the family
3. Identify areas where the family has expressed uncertainty or difficulty

#### Prompts:

- a. “Which parts of navigating services feel hardest right now?”
- b. “Are there steps you’d like to feel more confident handling?”

### Step 2: Practice Coordination Skills During Active Coordination

Care coordinators intentionally involve families in care coordination activities and gradually shift responsibility as appropriate.

*Purpose:* To reinforce learning through practice and reduce reliance on coordination support.

Coordinator Responsibilities:

1. Invite families to participate in calls, appointments, and follow-ups
2. Model communication and problem-solving strategies
3. Provide coaching and support during shared activities

Prompts:

- a. “Would you like to try making this call together?”
- b. “What questions do you want to ask during this appointment?”
- c. “What support do you need to follow up on what you learned?”

### **Step 3: Reinforce Skills and Reflect on Progress**

Care coordinators pause to reflect with families on progress and skill development.

*Purpose:* To help families recognize growth and build confidence. To normalize challenges and problem-solving

Coordinator Responsibilities:

1. Highlight skills the family has practiced
2. Acknowledge effort and progress

Prompts:

- a. “What felt easier this time compared to before?”
- b. “What do you feel more confident doing now?”

### **Step 4: Support Independent Use of Planning Tools**

Care coordinators reinforce how families can use planning tools independently.

*Purpose:* To ensure families can maintain tools and find resources independently.

Coordinator Responsibilities:

1. Review Care Map, Care Plan, Shared Plan of Care, and Emergency Preparedness Document
2. Encourage families to update tools as services or needs change
3. Reinforce that tools are meant to be used actively

Prompts:

- a. “Which of these tools has been most helpful?”
- b. “How do you see yourself using this moving forward?”
- c. “How can we support you with using these tools on your own?”

## Step 5: Prepare for Transition and Graduation

As families approach closure, care coordinators shift focus toward readiness for independence.

*Purpose:* To support a smooth transition out of the program.

Coordinator Responsibilities:

- Review skills gained during the pilot
- Identify any remaining support needs
- Ensure families know where to seek help after the pilot

Prompts:

- a. “What do you feel ready to handle on your own?”
- b. “Who would you reach out to if questions come up after the pilot?”

Integration with Other Phases

Family capacity building is reinforced throughout Phase 3 and directly supports readiness for Phase 6: Closure & Graduation.

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PHASE 5:

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Transition

# PHASE 5

## Transition

Phase 5 of the Maryland CYSHCN System of Care Coordination Pilot focuses on supporting youth and families as they prepare for transitions in care. Transitions may include movement from pediatric to adult health care systems, changes in service eligibility, shifts in educational or vocational supports, or changes in providers or programs. While transition planning is most associated with youth approaching adulthood, it may also be relevant for younger children and families experiencing significant changes in their service landscape.

Transition planning is intended to promote continuity of care and reduce disruptions that can occur when youth age out of programs or move between systems. This phase builds on the work completed in earlier phases by helping families anticipate upcoming changes, understand new expectations, and prepare to navigate adult-oriented systems with greater independence.

### Purpose and Goals of Transition Planning

The purpose of Phase 5 is to ensure that youth and families are adequately prepared for transitions and have the information, skills, and support needed to manage changes in care. Effective transition planning helps reduce gaps in services, supports youth autonomy, and reinforces family confidence.

The goals of this phase include increasing understanding of adult systems and eligibility criteria, supporting youth participation in decision-making, facilitating continuity of care, and ensuring that families know where to turn for support following the transition.

### When to Initiate Transition Planning

Transition planning should begin early and proactively, rather than waiting until a youth is close to aging out of pediatric systems or services. Early planning allows families and youth to anticipate changes, build skills gradually, and reduce stress associated with transitions.

Local Health Department staff should initiate transition planning when any of the following conditions are present:

- The youth is approximately 12 years of age or older, regardless of current readiness
- A significant transition in health care, insurance, education, or services is anticipated
- A family or youth expresses concern about future eligibility, providers, or independence
- A provider, school, or partner identifies upcoming changes that may affect care continuity

Initiating transition planning does not mean that all transition-related tasks must be completed immediately. Instead, it allows staff to begin age-appropriate conversations, assess readiness, and introduce tools and concepts over time. Transition planning should progress at a pace that reflects the youth's developmental level, family preferences, and overall care coordination needs.

For some families, transition planning may occur over several months or alongside other care coordination activities. For others, particularly those enrolled in Tier 2B, transition planning may be more focused and time-limited. Regardless of tier, early initiation helps ensure that transition planning feels supportive rather than rushed.

### Tools Used:

- Care Map
- Care Plan and Service Tracker
- Shared Plan of Care
- Emergency Preparedness Document

### Transition Planning Workflow

During Phase 5, LHD staff engage families and youth in a range of activities designed to prepare them for upcoming transitions in care. These activities may occur over time and alongside other care coordination efforts, depending on the youth's age, readiness, and tier of support. Staff should introduce transition planning early enough to allow families time to prepare, while remaining sensitive to readiness and family preferences.

Key activities during this phase may include administering transition readiness assessments, providing education on differences between pediatric and adult systems, and helping families identify adult health care providers, behavioral health supports, or community resources. Staff may also support youth in developing skills related to self-advocacy, appointment management, and understanding their own health needs.

When appropriate, LHD staff assist with the preparation of transfer-of-care documentation, ensuring that important medical, educational, and service information is organized and available to new providers or programs. The Care Map should be updated to reflect anticipated changes and new connections.

#### Step 1. Introduce the Concept of Transition

1. Explain to the youth and family that transition planning is about preparing for future changes in care.
2. Normalize that transition can feel overwhelming and that planning early can help reduce stress later.
3. Clarify that transition planning is flexible and will move at a pace that feels comfortable for the family.

*Purpose:* Sets expectations and builds buy-in without creating urgency or pressure.

## **Step 2. Assess Transition Readiness**

1. Determine whether the youth is developmentally and emotionally ready to engage in transition planning discussions.
2. Administer an appropriate transition readiness assessment for:
  - a. Parents/caregivers, and/or
  - b. Youth or young adults
3. Review assessment results together, highlighting strengths as well as areas where additional support may be helpful.

*Purpose:* Establishes a baseline understanding of readiness and guides next steps.

## **Step 3. Review Health Care Transition Timelines**

1. Share Health Care Transition (HCT) timelines with the youth and/or caregivers.
2. Review the timeline together, focusing on:
  - a. What typically changes during adolescence and young adulthood
  - b. What skills youth may need to develop over time
  - c. When certain decisions or actions are commonly needed
3. Emphasize that the timeline is a guide, not a checklist or deadline.

## **Step 4. Support Skill Development and Youth Engagement**

1. Encourage youth participation in conversations about their care, to the extent appropriate.
2. Discuss topics such as:
  - a. Understanding their health conditions
  - b. Communicating with providers
  - c. Managing appointments and medications
  - d. Knowing when and how to ask for help
3. Use provider question prompts to help youth practice asking questions and engaging in visits.

*Purpose:* Builds youth self-advocacy and independence gradually.

## **Step 5. Identify Adult Providers and Services**

1. Discuss which services will need to transition to adult systems (e.g., primary care, specialists, behavioral health).
2. Support families in identifying potential adult providers, when appropriate.
3. Discuss changes in insurance coverage, benefits, or eligibility that may occur.
4. Update the Care Map to reflect anticipated transitions and new providers.

*Purpose:* Promotes continuity of care and reduces gaps during system changes.

## **Step 6. Prepare Transfer-of-Care Documentation**

1. Work with the family to gather key information needed for transition, such as:
  - a. Medical history and diagnoses

- b. Current medications and equipment
  - c. Providers and services
  - d. Emergency information
2. Complete or begin a Transfer of Care document that can be shared with new providers.
3. Review the document with the family and explain how and when it may be used.

*Purpose:* Ensures accurate information follows the youth into adult systems.

### **Step 7. Review and Update the Transition Plan**

1. Revisit transition readiness, goals, and timelines periodically.
2. Adjust plans based on:
  - a. Youth development and confidence
  - b. Family preferences
  - c. Changes in services or eligibility
3. Document progress and next steps in case notes and care planning tools.

*Purpose:* Keeps transition planning aligned with real-world changes.

### **Step 8. Integrate Transition Planning into Closure or Ongoing Coordination**

1. For families nearing graduation, ensure transition-related steps are included in closure planning.
2. For families continuing in coordination, identify which transition activities remain ongoing.
3. Reinforce skills and resources families can continue using after pilot involvement ends.

*Purpose:* Links transition planning with long-term self-reliance.

- Transition planning should be individualized, unique to the health care needs; not all steps will apply to every family.
- Youth should play an active role in transition planning as transition readiness increases.
- Transition readiness conversations should be ongoing as the child nears transition to adult health care.
- Documentation should focus on readiness, planning, and progress rather than completion of tasks.

The intensity of transition planning activities varies by tier. For families enrolled in Tier 2B, transition support is typically brief and focused on immediate next steps, such as identifying an adult provider or understanding changes in eligibility.

For families enrolled in Tier 3, transition planning may be more complex and require coordination across multiple health systems. These families could benefit from additional preparation, ongoing discussion, and more tailored support to ensure continuity of care.

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PHASE 6:

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Closure & Graduation

# PHASE 6

## Closure & Graduation

Phase 6 marks the conclusion of a family's involvement in the Maryland CYSHCN System of Care Coordination Pilot program. This phase is designed to ensure that at the conclusion of this pilot, families leave with increased confidence, clear next steps, and appropriate supports in place for themselves and their child with special health care needs. Closure may occur through planned graduation, early completion of goals, or other circumstances such as loss of contact or changes in eligibility.

Closure should be approached as a purposeful and supportive process rather than an abrupt disruption to services. LHD staff should play a critical role in helping families reflect on progress made, reinforce skills gained during the pilot, and prepare for managing care more independently without the direct involvement of the pilot program.

### Purpose and Goals of Closure and Graduation

The primary purpose of Phase 6 is to consolidate meaningful gains achieved during care coordination and to support families in sustaining progress beyond the pilot period. Graduation reinforces the pilot's emphasis on self-reliance and family empowerment.

The goals of Phase 6 are to:

- Confirm progress toward identified goals
- Support families in sustaining gains made during care coordination
- Reinforce skills and knowledge that promote self-reliance
- Ensure continuity of care and service connections
- Gather family feedback to inform pilot learning and improvement

### Graduation Criteria

#### Step 1: Review Progress Toward Goals

LHD staff review the family's goals, progress notes, and care coordination activities to determine whether goals have been met, or substantial progress has been made.

#### Step 2: Assess Readiness Indicators

Families may be considered ready for graduation when one or more of the following are present:

1. Priority goals have been achieved or are on a stable path forward
2. Connections to needed services and providers are in place
3. The family demonstrates increased confidence navigating systems

4. The level of coordination support needed has decreased

### **Step 3: Discuss Graduation with the Family**

Graduation decisions should be discussed collaboratively with the family. Staff should explain the rationale, confirm readiness, and address any concerns or remaining questions.

- Tier 2B families may graduate earlier once short-term goals are met.
- Tier 3 families may require a longer coordination period before reaching readiness.
- Graduation decisions must be documented clearly in case notes.

While decisions are made collaboratively, final determination rests with the LHD care coordination team based on documented progress, readiness indicators, and program parameters. Any concerns or disagreements should be discussed with a supervisor and documented in the family's record.

## **Closure Activities**

Once readiness for closure is confirmed, LHD staff complete the following steps.

### **Step 1. Review Accomplishments with the Family**

Discuss progress made during the pilot, highlight key accomplishments, and reinforce strategies the family can continue using independently.

### **Step 2. Update Shared Tools**

Update the Care Map to reflect current providers, services, and supports. Ensure information is accurate and usable for the family moving forward.

### **Step 3. Complete the Graduation Summary**

Document outcomes, services in place, remaining needs (if any), and recommendations for next steps.

### **Step 4. Administer the Post-Engagement Survey**

Administer the Post-Engagement Survey to capture the family's experience with the pilot. This should be completed whenever feasible, regardless of the reason for closure.

### **Step 5. Provide Transition Information**

Share relevant resources, contact information, and guidance on next steps. Confirm that the family knows who to contact if questions arise after closure.

### **Optional Step: Follow-Up Check-In**

When appropriate, LHDs may offer an optional follow-up check-in approximately 30-60 days after closure to confirm services remain in place and address any outstanding questions.

## Types of Closure

Closure may occur under the following circumstances:

1. Planned Graduation: Goals are met and the family is prepared to continue independently.
2. Early Graduation: Typically for Tier 2B families once shortterm goals are achieved.
3. Other Closure: Closure due to loss of contact, family decision to discontinue participation, relocation out of Maryland, or aging out of eligibility.

In all cases, the reason for closure should be documented clearly in the family's record.

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# EVALUATION & REPORTING

# EVALUATION & REPORTING

This section outlines how documentation, evaluation, and reporting activities are integrated throughout the pilot to support care coordination, assess family experience and outcomes, and inform program improvement and expansion. Data collection will intentionally be embedded into the pilot workflow to minimize burden on families and staff, while stipends will be provided to families who participate in surveys and interviews to thank them for their time.

## Purpose and Goals of Evaluation & Reporting

Evaluation and reporting activities are designed to:

- Track implementation of core pilot workflows across participating LHDs.
- Understand family needs, care coordination activities, referrals, and outcomes.
- Assess family experience, caregiver confidence, and changes over time.
- Identify facilitators, barriers, capacity needs, and workflow considerations that affect implementation.
- Support Plan-Do-Study-Act (PDSA) learning and continuous quality improvement during the pilot period.
- Inform MDH decisions about program refinement, sustainability, and potential statewide expansion.

Findings will be used for:

- Continuous quality improvement and real-time learning across pilot sites.
- Reporting to MDH and other project partners in aggregate or de-identified form.
- Refining tools, workflows, training, and technical assistance supports.
- Understanding readiness and considerations for future implementation or expansion.

Evaluation findings are intended to strengthen the model and are not intended to evaluate individual staff performance. Data should be interpreted in context, including referral volume, staffing capacity, community resources, family needs, and local workflow differences.

## Role of Care Coordinator and LHD Staff

To support documentation, evaluation, and reporting, care coordinators and designated LHD staff serve as:

- Guides for families, explaining evaluation activities in clear, family-centered language.
- A bridge between family experience and the evaluation process, helping ensure that family voices and priorities are reflected.

- Primary documentation partners who enter accurate and timely information in the data tracker and local records.
- Stewards of privacy and confidentiality, using the Person\_Case\_ID consistently and limiting unnecessary identifying information.
- Collaborators who use data and family feedback to reflect on implementation, identify challenges, and strengthen pilot workflows.

## Tools Used:

The following tools support evaluation and reporting during the pilot:

- Care Coordination Program Data Collection Template (Excel data tracker), which collects key elements from the following forms:
  - [Referral Form](#)
  - [Tier Determination Form](#)
  - [Intake Form](#)
  - [Care Plan and Service Tracker](#)
- [Statewide Care Navigation Family Experience Survey](#)
- [End-of-pilot family interview guide.](#)
- [Pilot site staff interview guide.](#)
- Local documentation systems, case notes, or records used by the LHD.

## Data Sharing and Confidentiality

All documentation and evaluation activities must comply with applicable privacy, confidentiality, and data security requirements. Families should be informed about evaluation activities, and participation in surveys or interviews should be described as voluntary. Verbal consent should be obtained before any interview participation or before sharing family contact information with the evaluation team for interview scheduling.

- Use the assigned Person\_Case\_ID across the tracker rather than names.
- Do not enter child, youth, or caregiver names; full addresses; phone numbers; email addresses; or other unnecessary direct identifiers in the tracker.
- Keep free-text notes brief, high-level, and related to service coordination or reporting needs.
- Store the workbook in an approved secure location with access limited to staff who need it for implementation, supervision, evaluation, or reporting.
- Share data with MDH, Cardea, or other evaluation partners only through approved secure transfer methods and only in the format requested.
- Report findings in aggregate whenever possible to protect family privacy.

## Care Coordination Program Data Collection Template

The Care Coordination Program Data Collection Template is the primary data tracker for the pilot. It is organized around a single Person\_Case\_ID for each child or young adult. The same Person\_Case\_ID should be used across all tracker tabs so information from the referral, tier determination, intake, care planning, and service tracking processes can be linked without relying on names.

The Person\_Case\_ID should be created when the referral is first received. LHDs should follow the agreed upon ID convention, which is the referral date plus a four-digit sequential number, such as 07012026-0001. Once assigned, the Person\_Case\_ID should not be changed unless a duplicate or error is identified and corrected consistently across all tabs.

Timing:

Frequency of sharing the completed data collection template will be determined in collaboration with the LHDs and MDH/Cardea.

### Tools Used:

- Care Coordination Program Data Collection Template

Coordinator Responsibilities:

1. Enter and complete data collection template as new clients and subsequent forms are completed in alignment with the data entry expectations and workflow outlined on the following page.

## Workbook Structure

| Worksheet                  | Purpose                                                                                                                        | When to Use                                                                                      | Key Notes                                                                                                                                                                     |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Instructions               | Provides guidance on the workbook structure, Person_Case_ID, duplicate data reduction, progress tracking, and data entry tips. | Review before entering data and when orienting new staff to the tracker.                         | Follow the guidance to use one ID across tabs and to add rows within Excel tables so formatting and dropdowns continue.                                                       |
| Person_Case_Master         | Serves as the single source of truth for each child or young adult.                                                            | Create one row when a referral is first received and update as the case moves through the pilot. | Core demographics are entered here once. Some columns auto-flag whether referral, tier determination, and intake records exist on other tabs. Do not overwrite formula cells. |
| Referral_Tracker           | Captures information from each referral form submission.                                                                       | Complete after referral review and update when referral status changes.                          | One row per referral form submission. Record referral source, contact preferences, needs, staff review, and enrollment status.                                                |
| Tier_Determination_Tracker | Captures information from each completed tier determination.                                                                   | Complete after the tier determination conversation or review is completed.                       | One row per completed tier determination. Record recommended tier and whether the family should move to intake.                                                               |

*Form continued on page 73.*

## Workbook Structure Cont.

| Worksheet                 | Purpose                                                                                                  | When to Use                                                                                                                                   | Key Notes                                                                                                                          |
|---------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| Intake_Tracker            | Captures information from the intake process for families moving into active care coordination.          | Complete for Tier 2B and Tier 3 families, or as directed, when the family agrees to participate and intake is completed.                      | Record current services, unmet needs, emergency preparedness, transition needs for ages 12-21, intake completion, and intake tier. |
| Care_Plan_Service_Tracker | Summarizes care plan goals, interventions, outcomes, referrals, visit count, and common mode of contact. | Initiate once the care plan/service tracker is being used and update as goals, interventions, outcomes, or closure information are available. | Use for high-level reporting. It does not replace detailed case notes or the family-facing Care Plan.                              |

## General Data Entry Expectations

- Enter or update tracker information as soon as possible after each activity, using the completed referral, tier determination, intake, care plan, service tracker, or local documentation as the source.
- Use one Person\_Case\_ID consistently across every applicable tab.
- Use dropdown values when available to support consistent reporting. Use free-text fields only where the tracker is designed for narrative or notes.
- Use Unknown, Not sure, or N/A consistently when information is not available or not applicable, depending on the dropdown options in the field.
- Add new entries within the existing Excel tables so formatting, formulas, and drop downs continue correctly.
- Do not change worksheet names, column names, formulas, or table structure.
- Keep notes concise and high-level. Do not include detailed clinical narratives, unnecessary protected health information, or contact information in notes fields.

## Data Tracker Workflow

The following workflow should be used alongside the phase-specific instructions in this guide.

1. **Create the Person\_Case\_ID and Master Record.** When a referral is received, create a Person\_Case\_ID and enter one row in the Person\_Case\_Master tab.
  - Enter the Open\_Date using the date the referral was received.
  - Enter assigned staff, staff type, date of birth, Maryland residency, county of residence, and primary language, as available.
  - Use Current\_Workflow\_Status to reflect where the family is in the process, such as Referred, Tier Determination Pending, Intake Needed, Intake Complete, or Closed.
  - If a case is closed, referred out, or found ineligible, update status and Closed\_Date when applicable.
2. **Enter Referral Information.** After reviewing the referral form, enter one row in the Referral\_Tracker tab with the same Person\_Case\_Master ID created in Step 1 for a new client.
  - Record referral date, referral source, preferred contact method, interpretation needs, preferred language, immediate assistance needs, current care coordination support, and whether the family wants care coordination.
  - Record the need categories identified on the referral, such as medical/health care, social/behavioral, supportive services, youth transition, and insurance.
  - Update Enrollment\_Status and enter the staff name and form completion or review date.
3. **Enter Tier Determination Information.** After the tier determination conversation is completed, enter one row in the Tier\_Determination\_Tracker tab with the same Person\_Case\_Master ID created in Step 1 for a new client.
  - Record the tier determination completion date, staff name, relevant condition and insurance information, provider count, current supports, and support preferences.
  - Record identified need domains, caregiver confidence, stress level, recommended tier, and whether the family should move to intake.
  - Use Move\_to\_Intake? to indicate whether the family should proceed to intake based on the recommended tier and family agreement to participate.
  - Update the "Current\_Workflow\_Status" on the Person\_Case\_Master tab so the workflow status reflects the next step.
4. **Enter Intake Information.** For Tier 2B and Tier 3 families who agree to participate, complete Intake\_Tracker after intake is completed. Enter one row in Intake\_Tracker with the same Person\_Case\_Master ID created in Step 1 for a new client.
  - Record intake date, staff name, current treatment or therapy, specialized medical equipment, unmet needs, emergency preparedness information, and transition-related needs for youth ages 12-21.
  - Complete Intake\_Completed and Intake\_Tier fields.
  - Use Notes only for concise context that supports reporting or handoff.

- Update the “Current\_Workflow\_Status” on the Person\_Case\_Master tab so the workflow status reflects the next step.
5. **Enter Care Plan and Service Tracking Summary** Once the family has moved into active care coordination and a care plan/service tracker is being used, complete or update Care\_Plan\_Service\_Tracker. Enter one row in the Care\_Plan\_Service\_Tracker tab with the same Person\_Case\_Master ID created in Step 1 for a new client.
- Record high-level care coordination goals, interventions, and outcomes. The tracker allows space for up to three goals; additional goals can be summarized in Notes.
  - Record referrals made, approximate number of visits or contacts, and most common mode of visits or contacts.
  - Update outcomes and notes as goals are completed, changed, or closed.
  - Continue to maintain detailed case notes and the family-facing Care Plan outside of the tracker according to local procedures.
6. **Update Closure and Graduation Information.** At planned graduation, early graduation, or other closure, update the tracker to reflect the final case status.
- Enter Closed\_Date in Person\_Case\_Master.
  - Update Current\_Workflow\_Status to Closed or the appropriate closure status.
  - Confirm that care plan outcomes and service tracking summary fields are updated.
  - Document closure reason in a concise note when needed.
  - Offer the post-program family assessment and the opportunity to participate in a family interview, when appropriate.
7. **Review Data Quality Before Reporting.** Before submitting data or using the tracker for reporting, designated staff should review the workbook for completeness and consistency.
- Check that every row has a Person\_Case\_ID and that the same ID is used consistently across tabs.
  - Check for duplicate IDs or duplicate records that need to be reconciled.
  - Confirm that dates, statuses, recommended tiers, Move\_to\_Intake, intake completion, and closure fields are complete when applicable.
  - Confirm that no names, contact information, or unnecessary identifying information have been entered in notes fields.
  - Confirm that formula fields in Person\_Case\_Master have not been overwritten.

## Evaluation Activities with Families

### Statewide Care Navigation Family Experience Survey

The family experience survey, distributed to families at the close of the pilot period of the program will assess reflections of family experiences in the pilot, improvements

made in resource connection, changes in confidence and understanding in navigating their child's care, and recommendations for program improvement.

Goals of the family experience survey include understanding:

- The family/caregiver's existing (if any) experience with care coordination
- The initial needs of the family/caregiver and child at the beginning of the pilot, and whether needs were met
- How confident and supported the family/caregiver felt BEFORE and AFTER navigating providers and connecting their child to resources prior to and at the completion of the pilot program
- Family satisfaction with the pilot care coordination program
- Components of the program that were most helpful to them/their child
- Barriers or what made it challenging to follow up on resources
- Recommendations for program improvement
- Experience with care coordinator (including connection to services, advocacy, and ease of communication)
- How easy or difficult it is to manage appointments and their child's care BEFORE and AFTER the program
- What tools they use to organize their child's care AFTER the program
- What resources they have been connected to through care coordination

Timing:

- Distributed near or at the conclusion of the pilot program period

### Tools Used:

- [Statewide Care Navigation Family Experience Survey](#)

Coordinator Responsibilities:

1. Introduce the assessment and explain its purpose

- *Based on whether family is nearing completion of program or end of pilot:*  
"As we near the end of the pilot period/the end of your participation in the program, we want to make sure we center your voices and hear about your experience with the program."
- "This survey will help us understand what worked well for your family, areas where we can improve, and how confident you feel now managing your child's care."
- "Your honest feedback is really important, which is why we have made these anonymous. Your responses will help us make the program better for families like yours in the future."
- "The survey takes about 15 minutes to complete."

## 2. Share the survey

“This survey is electronic and can be completed on a computer or your phone. It can be accessed by this link: <https://survey.alchemer.com/s3/8743131/Statewide-Care-Navigation-Family-Experience-Survey> or by scanning this QR code



## 3. Support completion as needed

- “Remember, there are no right or wrong answers. Just your honest experience.”
- “Feel free to skip any questions you’re not comfortable answering.”

### End-of-Pilot Family Interview Guide

The end-of-pilot family interview is another opportunity to capture family reflections on their experience in the pilot, with the opportunity for deeper, richer context and qualitative feedback on their recommendations for program improvement.

Goals of the family interviews include:

- Understanding family experiences with the pilot program, including what components were most helpful and barriers to program engagement
- Reflections from families on referral and intake process, and ease of working with coordinator
- Reflections from families on care coordination activities, including process of resource connection, appropriateness of referrals, and communication with care coordinator

Timing:

- Families can be engaged if interested at the conclusion of the pilot program period

### Tools Used:

- [Family/Caregiver Interview Guide](#)

### Coordinator responsibilities:

1. Inform families about the opportunity to participate
  - “As we wrap up your time in the pilot/in the program, there’s also an opportunity (in addition to the anonymous survey) to share more detailed feedback through a short interview with the evaluation team.”
  - “This is completely optional but would give you the chance to talk more openly about what you think worked well and what could be improved.”
  - “There is a stipend for families that participate in interviews. The interview would be approximately 60 minutes long and virtual (over Zoom) or over the phone, whichever you prefer.”
2. Explain the purpose of the interview and voluntary nature
  - “The interview helps the project team understand families’ experiences more in depth.”
  - “Choosing not to participate doesn’t affect the services and supports you receive or may receive in the future.”
  - “Your feedback would be combined with the feedback from other families and used to strengthen the program.”
3. Gauge interest and confirm consent to share contact information
  - “Would you be interested in participating in an interview like this?”
  - “If you are, I can share your contact information with our evaluation team so they can reach out directly to coordinate scheduling. They can also answer any questions you might have.”
4. Support coordination and scheduling as needed
  - If family agrees, notify evaluation staff and share their contact information

### Pilot Site Staff Interviews

The pilot site staff interviews are an opportunity for care coordinators and other implementation staff at pilot sites to support evaluation by providing their experiences with implementation of the programming, offer reflections on feasibility, challenges or barriers to implementation, and recommendations on program expansion and scale-up.

Goals of the pilot site staff interviews include:

- Understanding care coordinator staff experiences implementing the pilot program, including facilitators and barriers to program implementation
- Reflections from pilot site staff on the onboarding process and ease and understanding using suggested programmatic tools
- Reflections from pilot site staff on the care coordination process, from referral processing, to intake, to care planning, to ongoing care coordination activities including resource connection
- Existing capacity and needed support or resources to make their role more effective

- Recommendations for program improvement and expansion to a statewide coordination program

Timing:

- At conclusion of pilot program period

### **Tools Used:**

- [Pilot site staff interview guide](#)

Coordinator responsibilities:

1. Participate in interviews as able
  - Respond to interview invitation from evaluation team and coordinate participation based on availability
2. Share implementation insights and lessons learned
  - Prepare to reflect on individual experiences implementing pilot, including following care coordination processes, and utilizing suggested tools, family capacity building (skill building and coaching of families), documentation, and reporting.
3. Reflect on evaluation findings as part of continuous improvement
  - Engage in discussions with evaluation team about how evaluation findings can inform overall program improvement, including sharing lessons learned.

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# SUPPORT & TECHNICAL ASSISTANCE

# SUPPORT & TECHNICAL ASSISTANCE

## Meetings

LHD staff will participate in monthly meetings with the Maryland Department of Health and Cardea Services to support implementation of the CYSHCN System of Care Coordination Pilot.

Meetings will be used to:

- Share updates on pilot implementation
- Discuss challenges and problem-solve barriers
- Review workflows, tools, and expectations
- Support alignment across pilot sites
- Share lessons learned and promising practices

Attendance by designated LHD staff involved in the pilot is expected. Staff should come prepared to share updates, questions, and examples from implementation.

## Technical Assistance Support

Technical assistance will be provided throughout the pilot to support effective and consistent implementation. Support may include:

- Regular office hours or check-ins with MDH and Cardea staff
- Ad hoc consultation related to workflow challenges, tiering decisions, or complex cases
- Support with tool use, documentation, and data collection
- Opportunities to share lessons learned and implementation feedback across pilot sites

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# APPENDIX & FORMS

# APPENDIX

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## Care Coordination Referral Form

### Section 1: Referral Source

*Referral Source (check one):*

- ☐ I am a young adult (18+ years old) with specific health care needs referring myself.
- ☐ I am a parent or caregiver referring a child or youth with specific health care needs.
- ☐ I am a provider or community partner making a referral for a child or youth with specific health care needs. (skip to section 2)

☐ Other \_\_\_\_\_

Today's date: \_\_\_\_\_

### **Child or Young Adult Information**

- ☐ I am referring myself (I am over 18 years old)
- ☐ I am a parent/caregiver referring my child

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Maryland Resident: Yes ☐ No ☐

Do you have a stable/secure home? Yes ☐ No ☐

County of Residence: \_\_\_\_\_

Residence Address and/or Zip Code: \_\_\_\_\_

Is this your permanent residence? Yes ☐ No ☐

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### *Parent/caregiver Information*

Main Parent/Caregiver Name: \_\_\_\_\_

Relationship to Child: ☐ Parent ☐ Legal Guardian ☐ Other; please explain:

\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

What is your preferred method of contact?

- ☐ Email
- ☐ Phone Call
- ☐ Text Message

Additional Caregiver Name: \_\_\_\_\_

Please contact me using an interpretation service. Yes / no. I would like to be contacted using the following language: \_\_\_\_\_

Do you need immediate assistance with your care support needs?

☐ Yes ☐ No ☐ Not sure

Do you currently have anyone helping coordinate your child's care?

☐ Yes ☐ No ☐ Not sure

Would you like assistance from a care coordinator?

☐ Yes ☐ No ☐ Not sure

*What Can We Help You With?*

Description of need:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Care Coordination Staff Completing Form: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

**\*If you are a self-referral or family/caregiver referral, stop here\***

## **Section 2: Provider/organization referrals**

Referring Person/Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### *Child or Young Adult Information*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Maryland Resident: Yes ☐ No ☐

County of Residence: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Family/caregiver Information

Caregiver Name: \_\_\_\_\_

Relationship to Child: ☐ Parent ☐ Legal Guardian ☐ Other Relative ☐ Other

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Additional Caregiver Name: \_\_\_\_\_

Does the caregiver need to be contacted with an interpretation service? Yes ☐ No ☐  
If yes, what language? \_\_\_\_\_

### Section 4: Care Navigation Needs (from the Provider perspective)

☐ Medical/Health Care

☐ Social/Behavioral

☐ Supportive services (housing, transportation, food, education)

☐ Youth care transition

☐ Insurance

Description of need: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Section 5: Health & Medical Care Needs (Provider responses)

Does the child have a diagnosed or suspected health condition or issue? Yes ☐ No ☐  
If yes, please list: \_\_\_\_\_

How long has the child had this condition? \_\_\_\_\_

Is the child currently receiving treatment or therapy? Yes ☐ No ☐ If yes, describe: \_\_\_\_\_

Current therapies/services (check all that apply):

☐ Physical Therapy

☐ Occupational Therapy

- ☐ Speech
- ☐ Behavioral
- ☐ Nursing
- ☐ Early Intervention
- ☐ IEP/504
- ☐ Other: \_\_\_\_\_

Does the child use any specialized medical equipment? Yes ☐ No ☐

### **Section 7: Case Status (Internal Use Only)**

Enrollment Status:

- ☐ Accepted
- ☐ Pending Tier Determination
- ☐ Referred Out
- ☐ Not Eligible

Intake Completed: Yes ☐ No ☐

Person Case ID Assigned (Format: MM-DD-YYYY-0001; e.g., 07012026-0001): \_\_\_\_\_

Staff Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Care Coordination Tier Determination Form

Date of Completion: \_\_\_\_\_

LHD Staff Completing Form: \_\_\_\_\_

### Section 1: Information on Child and Parent/Caregiver

INTERNAL NOTE: This information is meant to sync from the referral form. However, LHD staff can verify information if calling family/caregiver back from a self-referral or outreaching to family/caregiver based on a provider referral.

#### *Child or Young Adult Information*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

County of Residence: \_\_\_\_\_

Residence Address and/or Zip Code: \_\_\_\_\_

#### *Parent/Caregiver Information*

Main Parent/Caregiver Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Section 2: Medical Information

#### *Diagnoses*

What are the child's diagnoses/suspected health conditions?

How long has the child had this condition(s)?

#### *Insurance Information*

Child's Type of Health Insurance:

☐ Medical Assistance (Medicaid)

☐ Maryland Children's Health Program (CHIP)

☐ Private (e.g., Employer, Marketplace)

☐ None

☐ Unsure

☐ Other \_\_\_\_\_

If insurance is known, name of health plan:

---

What support, if any, do you receive from your child's health plan?

---

#### *Medical Providers*

How many medical or service providers does your child currently see? (None, 1–2, 3+)

---

If parent/caregiver indicates their child has more than one provider, ask the following question:

What types of specialists does your child see?

---

What support services, if any, do your child's medical providers offer (e.g., helping with scheduling appointments, helping your child connect with a specialist, follow up after appointments to see how your child is doing)?

---

### **Section 3: Tier Determination**

#### *Interest/readiness*

- Would you like ongoing support from our program, or would you prefer a one-time connection to other services?

---

#### *Overlap with other services and programs*

- Have you applied for or been denied Medicaid in the past 12 months?  
Yes ☐ No ☐ Not Sure ☐

- Are you already receiving help from another program or service (e.g., H-CAT, WIC, case manager)?  
Yes ☐ No ☐ Not Sure ☐
- Do you already have a case manager, care coordinator, or other person helping you manage your child's care?  
Yes ☐ No ☐ Not Sure ☐

#### *Scope of Need*

**Internal Note:** Synced information from referral form if documented

What do you need help with when it comes to supporting your child's health care needs?

Description of need:

---

---

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---

*INTERNAL USE ONLY:* Based on the description of need, LHD staff should select all applicable categories where the child needs support.

- ☐ Medical/Health Care
- ☐ Social/Behavioral
- ☐ Access (transportation, internet, phone)
- ☐ Supportive services (housing, food, education)
- ☐ Youth care transition
- ☐ Financial/Insurance
- ☐ Advocacy/Legal

#### *Caregiver Capacity*

- How confident do you feel managing your child's health needs right now?  
(Scale 1-5) \_\_\_\_\_
- Approximately how many hours a month does the parent/caregiver spend coordinating care for the child?  
\_\_\_\_\_

#### *Stress and Support*

- How often do you feel stressed or overwhelmed by your child's care needs?  
Rarely ☐ Sometimes ☐ Often ☐ Always ☐

### Resource Preferences

- What type of support do you find most helpful (e.g., education, reminders, direct assistance)?
- 

### Section 4: Patient Navigation Tier

*INTERNAL USE ONLY:* Based on answers to the questions above, LHD staff should select the appropriate tier based on the scope/level of need.

- ☐ Tier 1 - Short-Term Support
- ☐ Tier 2 - Intermediate Term Enrollment
- ☐ Tier 3 - Long-Term Enrollment

DRAFT

## Care Coordination Intake Form

Date of Completion: \_\_\_\_\_

Staff Completing Form: \_\_\_\_\_

### Section 1: Information on Child and Parent/Caregiver

INTERNAL NOTE: This information is meant to sync from the referral form. However, LHD staff can verify information if calling family/caregiver back from a self-referral or outreaching to family/caregiver based on a provider referral.

#### *Child or Young Adult Information*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

County of Residence: \_\_\_\_\_

Residence Address and/or Zip Code: \_\_\_\_\_

#### *Parent/Caregiver Information*

Main Parent/Caregiver Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Section 2: Medical Information

#### *Screenings and Treatments*

Is the child currently receiving treatment or therapy? Yes ☐ No ☐

If yes, please select all that apply: PT ☐ OT ☐ Speech ☐ Behavioral ☐ Nursing ☐

Early Intervention ☐ IEP/504 ☐

Other (or additional detail): \_\_\_\_\_

Does the child use any specialized medical equipment? Yes ☐ No ☐

Has the child received any previous screenings or testing? (through school, psychologists, neurologists, or other specialties). Please describe a.) what the testing was for, b.) who led the testing, and c.) any outcomes of the testing.

---

### Section 3: Family & Social Systems

*Household members (names/ages/relationships):*

Support systems:

Extended Family ☐ Community ☐ Faith-Based ☐ Friends ☐ None ☐

### Section 4: Care Navigation Needs

Who is the primary coordinator of this child's care? (Parent/caregiver, PCP, Care Coordinator, Other Specialist, Case Manager/Social Worker)

---

*Medical*

Are there any **medical devices or durable medical equipment (DME)** that the child needs but does not currently have? Yes ☐ No ☐ Unknown ☐

If Yes:

---

Are there any **medications** that the child needs but does not currently have access to? Yes ☐ No ☐ Unknown ☐

If Yes:

---

Are there **specialists** you'd like to connect your child to/tried to connect your child to but haven't been able to? Yes ☐ No ☐ Unknown ☐

If Yes:

---

Are there any **immunizations** your child has been unable to receive?

Yes ☐ No ☐ Unknown ☐

If Yes:

---

Are there any other unmet medical needs the child has?

---

*Educational/Developmental Services*

Does the child need connection to **services related to:**

1. **General Development** (Learning new skills, meeting developmental milestones):  
Yes ☐ No ☐ Unknown ☐
2. **Speech and Language skills** (Using words or sounds to communicate, understanding others, being understood)  
Yes ☐ No ☐ Unknown ☐
3. **Motor Skills** (Walking, running, climbing, using hands and fingers (feeding self, drawing, playing)  
Yes ☐ No ☐ Unknown ☐
4. **Feeding/Eating** (Difficulties with self-feeding, diet, or appetite):  
Yes ☐ No ☐ Unknown ☐
5. **Sleeping** (Falling asleep, staying asleep, restless sleep, snoring)  
Yes ☐ No ☐ Unknown ☐
6. **Cognitive/Thinking Skills** (Paying attention, learning new concepts, early learning skills (letters, numbers), reading and writing)  
Yes ☐ No ☐ Unknown ☐
7. **Social/Behavioral Skills** (Interacting/playing with other children, communicating needs, managing big feelings, calming down):  
Yes ☐ No ☐ Unknown ☐

*Social Supports and Resources*

Does the child need assistance transitioning to...

**Transportation** for medical appointments?

Yes ☐ No ☐ Unknown ☐

Additional details:

---

**Stable housing?**

Yes ☐ No ☐ Unknown ☐

Additional details:

---

**Resources for food?** (including connection to WIC, SNAP, or other food resources.)

Yes ☐ No ☐ Unknown ☐

Additional details:

---

**Childcare/daycare?**

Yes ☐ No ☐ Unknown ☐

Additional details:

---

**Financial/Insurance?**

Yes ☐ No ☐ Unknown ☐

Additional details:

---

**Advocacy/Legal/Judicial?**

Yes ☐ No ☐ Unknown ☐

Additional details:

---

### **Section 5: Parent/Caregiver Knowledge and Capacity**

What additional information or education would help the parent/caregiver? (e.g., more information about child's diagnosis, how to navigate working with child's insurance company)

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---

Does the parent/caregiver need support determining a backup caregiver/respite care plan?

---

What are the biggest challenges/concerns the parent/caregiver has?

Does the child have an emergency preparedness plan? Yes ☐ No ☐ Unknown ☐

Additional details:

---

## **Section 6 (For Children Age 12-21): Transition Planning**

What steps have you (or your family) taken so far to prepare for the transition to adult care?

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---

What goals or priorities do you (or your family) have for your health or independence as you move into adult care?

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Does the child need assistance transitioning to...

### **Adult healthcare providers?**

Yes ☐ No ☐ Unknown ☐

Additional details:

---

### **Adult insurance and benefits?**

Yes ☐ No ☐ Unknown ☐

Additional details:

---

### **Independent living?**

Yes ☐ No ☐ Unknown ☐

Additional details:

---

### Section 6: Case Status (Internal Use Only)

Intake Completed: Yes ☐ No ☐

Staff Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Section 7: Patient Navigation Tier

- ☐ Tier 1 - Short-Term
- ☐ Tier 2 - Intermediate Term Enrollment
- ☐ Tier 3 - Long-Term Enrollment

DRAFT

## Care Plan and Service Tracker

This care plan and service tracker is designed to identify and develop goals in collaboration with families and track when goals are set and completed.

Child or Young Adult Name: \_\_\_\_\_

Person Case ID Assigned (should be the same ID assigned on the referral and tier determination forms): \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Child/Young Adult's Diagnoses:

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Parent/Caregiver Name: \_\_\_\_\_

Care Coordination Staff Working with Child/Family:

---

## Service Tracker

| Date of Visit (MM/DD/YYYY) | Visit Type (in-person, phone call, virtual/Zoom) |
|----------------------------|--------------------------------------------------|
| Ex. 05/13/2026             | Ex. Zoom meeting                                 |
|                            |                                                  |
|                            |                                                  |
|                            |                                                  |
|                            |                                                  |
|                            |                                                  |
|                            |                                                  |
|                            |                                                  |
|                            |                                                  |

## Care Plan

| Date                                                                                                                                                 | Goal                                        | Target Date                           | Goal Met |
|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------|----------|
| Goal Created                                                                                                                                         | What goal or need is the family expressing? | For Meeting Goal                      | (Y/N)    |
|                                                                                                                                                      |                                             |                                       |          |
| <b>Outcome</b>                                                                                                                                       |                                             | <b>Referrals/Resources</b>            |          |
| E.g., family connected with housing voucher/housing program, family given food pantry information, found primary care provider for child/young adult |                                             | Specific Referrals/Resources Provided |          |
|                                                                                                                                                      |                                             |                                       |          |
| Date                                                                                                                                                 | Goal                                        | Target Date                           | Goal Met |
|                                                                                                                                                      |                                             |                                       |          |
| <b>Outcome</b>                                                                                                                                       |                                             | <b>Referrals/Resources</b>            |          |
|                                                                                                                                                      |                                             |                                       |          |

## Care Plan Cont.

| Date    | Goal | Target Date         | Goal Met |
|---------|------|---------------------|----------|
|         |      |                     |          |
| Outcome |      | Referrals/Resources |          |
|         |      |                     |          |
| Date    | Goal | Target Date         | Goal Met |
|         |      |                     |          |
| Outcome |      | Referrals/Resources |          |
|         |      |                     |          |
| Date    | Goal | Target Date         | Goal Met |
|         |      |                     |          |
| Outcome |      | Referrals/Resources |          |
|         |      |                     |          |

### Example Care Goals or Needs

- Medical Home or Primary Care Provider
- Clinical or Medical Management related to \_\_\_\_\_ (including education about medical or behavioral condition)
- Educational/Developmental Services (Early Intervention Services, Developmental Specialist, Speech/Language Therapy, Occupational Therapy, Physical Therapy, Behavioral Therapy, IEP)
- Referral and Appointment Management Across Child's Provider Teams
- Social Services (housing, food, transportation)
- Financial/Insurance
- Advocacy/Legal/Judicial
- Emergency Preparedness Plan
- Health Care Transition to Adult Care/Providers

### Example Interventions

- Care coordination staff will make referrals to community organizations
- Care coordination staff will make referrals to medical homes; family will follow up with providers
- Family will provide care coordination staff with list of current providers and specialists
- Will utilize Shared Plan of Care document to map out child's current providers
- Will work on Emergency Preparedness Document Together
- Will provide Got Transition "Family Toolkit"

### Example Outcomes

- Family connected with housing voucher/housing program
- Family given food pantry information
- Child/young adult connected to primary care provider
- Family has an individualized Emergency Preparedness Plan

## My Shared Plan of Care

### 1. What is "My Shared Plan of Care"?

"My Shared Plan of Care" is a self-management tool that can help you keep track of what is going on with your health. Take this information with you when you visit your providers. It may help you be an active partner in your care. Keep your plan in a safe place. It has confidential information.

### 2. What is "Self-Management"?

Self-management means that you play a key role in managing your care. You are part of a team, along with your Special Child Health Services case manager, care coordinator, doctors, nurses, pharmacists, and others, working together to manage your health.

### 3. How can I make the most of "My Shared Plan of Care"?

- Fill in the parts you know in "My Shared Plan of Care".
- If there are things you don't know, work with your care team members (e.g., case manager, care coordinator, doctors, nurses, therapists, pharmacists, etc.) to complete "My Shared Plan of Care". If there are parts that do not apply to you, then you do not need to fill them in.
- Take "My Shared Plan of Care" with you to all your health care appointments.
- With your consent, your care team can review "My Shared Plan of Care" for a current picture of your health and to help you keep the information accurate, up-to-date, and complete. You can also work together to define problems, set priorities and goals, create treatment plans, and solve problems.

My Care Coordinator is: \_\_\_\_\_

|                                |  |                                                                  |               |
|--------------------------------|--|------------------------------------------------------------------|---------------|
| My name (child's name):        |  | Date of birth:                                                   | Gender:       |
| This form was completed by:    |  |                                                                  | Relationship: |
| Parent/Guardian's name:        |  |                                                                  |               |
| My address (child's):          |  |                                                                  |               |
| Street/Apt. # (if needed):     |  |                                                                  |               |
| City/State/Zip code:           |  |                                                                  |               |
| My phone:                      |  |                                                                  |               |
| My email:                      |  |                                                                  |               |
| Parent A/Guardian A's address: |  | Parent B/Guardian B's address: (Complete this section if needed) |               |
| Street/Apt. # (if needed):     |  | Street/Apt. # (if needed):                                       |               |
| City/State/Zip code:           |  | City/State/Zip code:                                             |               |
| Parent A/Guardian A's phone:   |  | Parent B/Guardian B's phone:                                     |               |
| Parent A/Guardian A's email:   |  | Parent B/Guardian B's email:                                     |               |

My Shared Plan of Care was Changed On:

| Date | Who changed it? | What changed? | Page # | Date | Who changed it? | What changed? | Page # |
|------|-----------------|---------------|--------|------|-----------------|---------------|--------|
|      |                 |               |        |      |                 |               |        |
|      |                 |               |        |      |                 |               |        |
|      |                 |               |        |      |                 |               |        |
|      |                 |               |        |      |                 |               |        |
|      |                 |               |        |      |                 |               |        |
|      |                 |               |        |      |                 |               |        |
|      |                 |               |        |      |                 |               |        |

Please list all the people living in your home and other people that support you:

| Name | Relationship | Do they live in your home? Y/N |
|------|--------------|--------------------------------|
|      |              |                                |
|      |              |                                |
|      |              |                                |
|      |              |                                |
|      |              |                                |

My Insurance

| Primary Insurance Name |  | Secondary Insurance Name |  |
|------------------------|--|--------------------------|--|
|                        |  |                          |  |
|                        |  |                          |  |
| Dental Insurance Name  |  | Vision Insurance Name:   |  |
|                        |  |                          |  |
|                        |  |                          |  |

My Diagnoses

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

### I want the person working with me to know:

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| I need help with (check all that apply): <input type="checkbox"/> Transportation <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> English as a Second Language<br><input type="checkbox"/> Social <input type="checkbox"/> Behavior <input type="checkbox"/> Communication <input type="checkbox"/> Feeding <input type="checkbox"/> Learning <input type="checkbox"/> Diet <input type="checkbox"/> Education<br><input type="checkbox"/> <b>Other (please specify)</b> _____ <b>Comments:</b> |                                                                                                                |
| My Religion/Spirituality impacts my healthcare: <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Comments:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |
| I learn best by: <input type="checkbox"/> Reading <input type="checkbox"/> Being talked to <input type="checkbox"/> Being shown how <input type="checkbox"/> Seeing pictures or videos<br><input type="checkbox"/> <b>Other (please specify)</b> _____ <b>Comments:</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                |
| I have access to the Internet: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | I have a Health Care Proxy: <input type="checkbox"/> Yes (if yes, attach document) <input type="checkbox"/> No |
| I have a service animal: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | I have a therapy animal: <input type="checkbox"/> Yes <input type="checkbox"/> No                              |

### My Emergency Plan

|                                                                                                |          |               |
|------------------------------------------------------------------------------------------------|----------|---------------|
| Emergency Contact Name:                                                                        | Phone #: | Relationship: |
| Back-up Emergency Contact Name:                                                                | Phone #: | Relationship: |
| <b>Call my Emergency Contact</b> if the following symptoms are present:                        |          |               |
| <b>Call 9-1-1</b> if the following symptoms are present, (and call my Emergency Contact, too): |          |               |
| <b>Take these steps</b> while waiting for my Emergency Contact or medical help to arrive:      |          |               |

### My Food Allergies/Intolerances

| Food | Reaction | Date Occurred | Comments |
|------|----------|---------------|----------|
|      |          |               |          |
|      |          |               |          |
|      |          |               |          |
|      |          |               |          |
|      |          |               |          |

### My Drug Allergies/Intolerances

| Drug Name | Reaction | Date Occurred | Comments |
|-----------|----------|---------------|----------|
|           |          |               |          |
|           |          |               |          |
|           |          |               |          |
|           |          |               |          |
|           |          |               |          |

Other Allergies/Comments:

## My Pharmacy

|                |          |
|----------------|----------|
| Pharmacy Name: | Phone #: |
| Pharmacy Name: | Phone #: |

## My Prescription Medications

| Start Date                  | Prescribed by | Drug Name | Directions | Stop Date<br>(if no longer taking med.): |
|-----------------------------|---------------|-----------|------------|------------------------------------------|
|                             |               |           |            |                                          |
| Why I take this medication: |               |           |            |                                          |
| Comments:                   |               |           |            |                                          |

| Start Date                  | Prescribed by | Drug Name | Directions | Stop Date<br>(if no longer taking med.): |
|-----------------------------|---------------|-----------|------------|------------------------------------------|
|                             |               |           |            |                                          |
| Why I take this medication: |               |           |            |                                          |
| Comments:                   |               |           |            |                                          |

## My Prescription Medications

| Start Date                  | Prescribed by | Drug Name | Directions | Stop Date<br>(if no longer taking med.): |
|-----------------------------|---------------|-----------|------------|------------------------------------------|
|                             |               |           |            |                                          |
| Why I take this medication: |               |           |            |                                          |
| Comments:                   |               |           |            |                                          |

| Start Date                  | Prescribed by | Drug Name | Directions | Stop Date<br>(if no longer taking med.): |
|-----------------------------|---------------|-----------|------------|------------------------------------------|
|                             |               |           |            |                                          |
| Why I take this medication: |               |           |            |                                          |
| Comments:                   |               |           |            |                                          |

| Start Date                  | Prescribed by | Drug Name | Directions | Stop Date<br>(if no longer taking med.): |
|-----------------------------|---------------|-----------|------------|------------------------------------------|
|                             |               |           |            |                                          |
| Why I take this medication: |               |           |            |                                          |
| Comments:                   |               |           |            |                                          |

## My Over-the-Counter Medications

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

## My Over-the-Counter Medications

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

| Drug Name                   | Directions |
|-----------------------------|------------|
|                             |            |
| Why I take this medication: |            |
| Comments:                   |            |

**My Primary Care Provider**

|                               |                          |
|-------------------------------|--------------------------|
| Primary Care Provider's Name: | Care Coordinator's Name: |
| Office Phone #:               | Email:                   |

|                                                                |                                                                                                                                                               |
|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Treatment Plan (Including labs, radiology, diagnostic testing) |                                                                                                                                                               |
|                                                                |                                                                                                                                                               |
|                                                                |                                                                                                                                                               |
|                                                                |                                                                                                                                                               |
|                                                                |                                                                                                                                                               |
|                                                                |                                                                                                                                                               |
|                                                                |                                                                                                                                                               |
|                                                                |                                                                                                                                                               |
| Hospital Privileges:                                           | Immunizations up to date:<br><input type="checkbox"/> Yes (if yes, attach immunization record or fill out immunizations table)<br><input type="checkbox"/> No |

**Other Provider (This includes medical, mental health, others)**

|                                                                       |                                                                                                                                                               |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Type of Provider:                                                     | Provider's Name:                                                                                                                                              |
| Office Phone #:                                                       | Email:                                                                                                                                                        |
| <b>Treatment Plan (Including labs, radiology, diagnostic testing)</b> |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
| Hospital Privileges:                                                  | Immunizations up to date:<br><input type="checkbox"/> Yes (if yes, attach immunization record or fill out immunizations table)<br><input type="checkbox"/> No |

**Other Provider (This includes medical, mental health, others)**

|                                                                       |                                                                                                                                                               |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Type of Provider:                                                     | Provider's Name:                                                                                                                                              |
| Office Phone #:                                                       | Email:                                                                                                                                                        |
| <b>Treatment Plan (Including labs, radiology, diagnostic testing)</b> |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
| Hospital Privileges:                                                  | Immunizations up to date:<br><input type="checkbox"/> Yes (if yes, attach immunization record or fill out immunizations table)<br><input type="checkbox"/> No |

**Other Provider (This includes medical, mental health, others)**

|                                                                       |                                                                                                                                                               |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Type of Provider:                                                     | Provider's Name:                                                                                                                                              |
| Office Phone #:                                                       | Email:                                                                                                                                                        |
| <b>Treatment Plan (Including labs, radiology, diagnostic testing)</b> |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
| Hospital Privileges:                                                  | Immunizations up to date:<br><input type="checkbox"/> Yes (if yes, attach immunization record or fill out immunizations table)<br><input type="checkbox"/> No |

**Other Provider (This includes medical, mental health, others)**

|                                                                       |                                                                                                                                                               |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Type of Provider:                                                     | Provider's Name:                                                                                                                                              |
| Office Phone #:                                                       | Email:                                                                                                                                                        |
| <b>Treatment Plan (Including labs, radiology, diagnostic testing)</b> |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
|                                                                       |                                                                                                                                                               |
| Hospital Privileges:                                                  | Immunizations up to date:<br><input type="checkbox"/> Yes (if yes, attach immunization record or fill out immunizations table)<br><input type="checkbox"/> No |

My Home Care

|                                                                                                                                                                                                                                                                                                              |                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| I have a <b>private duty</b> (check all that apply):<br><input type="checkbox"/> Nurse/Aid <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Social Worker <input type="checkbox"/> RespiteCare |                      |
| Home Health Care Agency's Name:                                                                                                                                                                                                                                                                              | Case Manager's Name: |
| Office Phone #:                                                                                                                                                                                                                                                                                              | Office Fax #:        |
| Ordered by:                                                                                                                                                                                                                                                                                                  | Ordered by:          |
| Email:                                                                                                                                                                                                                                                                                                       | Email:               |
| Treatment Plan (Including labs, radiology, diagnostic testing)                                                                                                                                                                                                                                               |                      |
|                                                                                                                                                                                                                                                                                                              |                      |
|                                                                                                                                                                                                                                                                                                              |                      |
|                                                                                                                                                                                                                                                                                                              |                      |
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|                                                                                                                                                                                                                                                                                                              |                      |
|                                                                                                                                                                                                                                                                                                              |                      |
|                                                                                                                                                                                                                                                                                                              |                      |

### Home Care Infusion

|                                                                                                                                                                            |                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| I have a <b>home care infusion</b> (e.g., nutrition, IV therapy). If YES, list: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure |                      |
| Home Care Infusion Agency's Name:                                                                                                                                          | Case Manager's Name: |
| Office Phone #:                                                                                                                                                            | Office Fax #:        |
| Ordered by:                                                                                                                                                                | Email:               |

### Durable Medical Equipment

|                                                                                                                                                                                             |                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| I use a <b>durable medical equipment</b> (e.g., wheelchair, walker, hospital bed). If YES, list: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure |                      |
| Durable Medical Equipment Agency's Name:                                                                                                                                                    | Case Manager's Name: |
| Office Phone #:                                                                                                                                                                             | Office Fax #:        |
| Ordered by:                                                                                                                                                                                 | Email:               |

### Orthotic and/or a Prosthetic

|                                                                                                                                                                                    |                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| I use an orthotic and/or a prosthetic (e.g., leg brace, prosthetic limb). If YES, list: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure |                      |
| Orthotic/Prosthetic Agency's Name:                                                                                                                                                 | Case Manager's Name: |
| Office Phone #:                                                                                                                                                                    | Office Fax #:        |
| Ordered by:                                                                                                                                                                        | Email:               |

**My Dentist**

|                       |                 |
|-----------------------|-----------------|
| Dentist's Name:       | Office Phone #: |
| Email:                |                 |
| <b>Treatment Plan</b> |                 |
|                       |                 |
|                       |                 |
|                       |                 |
|                       |                 |

**My Eye Doctor**

|                                                                           |                 |
|---------------------------------------------------------------------------|-----------------|
| Eye Doctor's Name:                                                        | Office Phone #: |
| Email:                                                                    |                 |
| <b>Treatment Plan</b>                                                     |                 |
|                                                                           |                 |
|                                                                           |                 |
|                                                                           |                 |
|                                                                           |                 |
| I wear glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No  |                 |
| I wear contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |

## My Audiologist

|                                                                                                                                       |                 |
|---------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Audiologist's Name:                                                                                                                   | Office Phone #: |
| Email:                                                                                                                                |                 |
| <b>Treatment Plan</b>                                                                                                                 |                 |
|                                                                                                                                       |                 |
|                                                                                                                                       |                 |
|                                                                                                                                       |                 |
| I wear hearing aids: <input type="checkbox"/> Yes (if YES, Type of Hearing Aid _____, Date Changed _____) <input type="checkbox"/> No |                 |

## My Transportation Information

|                                                                                                                                |                        |          |
|--------------------------------------------------------------------------------------------------------------------------------|------------------------|----------|
| I have my own form of transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO, complete section below) |                        |          |
| Transportation Agency's Name:                                                                                                  | Contact Person's Name: | Phone #: |
| Transportation Agency's Name:                                                                                                  | Contact Person's Name: | Phone #: |
| Transportation Agency's Name:                                                                                                  | Contact Person's Name: | Phone #: |

## My Education

|                                                                                                                                                                   |                                               |                 |              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------|--------------|
| School Name:                                                                                                                                                      |                                               | School Address: |              |
| School District:                                                                                                                                                  |                                               | Classroom Type: |              |
| <b>Contact Person's Name</b>                                                                                                                                      | <b>Role (e.g., nurse, teacher, principal)</b> | <b>Phone #</b>  | <b>Email</b> |
|                                                                                                                                                                   |                                               |                 |              |
|                                                                                                                                                                   |                                               |                 |              |
|                                                                                                                                                                   |                                               |                 |              |
| I have an <b>IEP/IFSP</b> : <input type="checkbox"/> <b>Yes</b> (if YES, Date of last IEP/IFSP):_____ <b>(attach IEP/IFSP)</b> <input type="checkbox"/> <b>No</b> |                                               |                 |              |
| I have an <b>504 Plan</b> : <input type="checkbox"/> <b>Yes</b> (if YES, Date of last IEP/IFSP):_____ <b>(attach 504 Plan)</b> <input type="checkbox"/> <b>No</b> |                                               |                 |              |
| <b>Attendance:</b> <input type="checkbox"/> <b>GOOD</b> <input type="checkbox"/> <b>POOR</b> (if POOR, explain my attendance and how it affects my education):    |                                               |                 |              |
| <b>Behavior:</b> <input type="checkbox"/> <b>GOOD</b> <input type="checkbox"/> <b>POOR</b> (if POOR, explain my attendance and how it affects my education):      |                                               |                 |              |

My Transition to Adulthood

I have started a Transition to Adulthood Plan with members of my care team:

☐ **Yes** (if YES, provide details of your plan below, e.g., school, job, relationships, housing)    ☐ **No**    ☐ **N/A** (if less than 12 years old)

Handwriting practice area with horizontal lines and a large diagonal 'DRAFT' watermark.

I have found an adult Primary Care Provider: ☐ **Yes**    ☐ **No**    ☐ **N/A**

## My Hospitalizations, Emergency Room Visits, and Other Procedures

[illegible]

My Hospitalizations, Emergency Room Visits, and Other Procedures

| Date(s) | Hospital/Facility Name | Reason for Admission | Treatment/Procedure(s) |
|---------|------------------------|----------------------|------------------------|
|         |                        |                      |                        |
|         |                        |                      |                        |
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|         |                        |                      |                        |
|         |                        |                      |                        |

My Name (child's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*if you need more space, use extra pages

My Follow-Up Appointments

| Date(s) | Things to Remember for My Appointment | Provider Name | Type of Provider | Treatment Provided |
|---------|---------------------------------------|---------------|------------------|--------------------|
|         |                                       |               |                  |                    |
|         |                                       |               |                  |                    |
|         |                                       |               |                  |                    |
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|         |                                       |               |                  |                    |

My Name (child's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*if you need more space, use extra pages

My Follow-Up Appointments

| Date(s) | Things to Remember for My Appointment | Provider Name | Type of Provider | Treatment Provided |
|---------|---------------------------------------|---------------|------------------|--------------------|
|         |                                       |               |                  |                    |
|         |                                       |               |                  |                    |
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|         |                                       |               |                  |                    |
|         |                                       |               |                  |                    |

My Name (child's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*if you need more space, use extra pages

My Additional Information

This section is to be completed by you in partnership with your care team members. This information may include concerns about your medical condition(s), barriers, or goals. This information should also include observations, actions, and solutions.

| Date(s) | Information |
|---------|-------------|
|         |             |
|         |             |
|         |             |
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|         |             |

My Name (child's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*if you need more space, use extra pages

My Additional Information

This section is to be completed by you in partnership with your care team members. This information may include concerns about your medical condition(s), barriers, or goals. This information should also include observations, actions, and solutions.

| Date(s) | Information |
|---------|-------------|
|         |             |
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|         |             |

My Name (child's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*if you need more space, use extra pages

I have actively participated in the development of My Shared Plan of Care. I understand and agree with the information in this plan. I know that I can work with my providers at any time to make changes to my Shared Plan of Care.

Name (Printed):

Signature:

Date:

Parent/Guardian's Name(Printed):

Signature:

Date:

Primary Care Provider's Name(Printed):

Signature:

Date:

Care Coordinator's Name(Printed):

Signature:

Date:

### Informed Consent

I authorize that my care team members listed in my Shared Plan of Care have access to my entire Shared Plan of Care: ☐ Yes ☐ No

Name (Printed):

Signature:

Date:

Parent/Guardian's Name(Printed):

Signature:

Date:

I (or my authorized legal guardian) am providing consent for the following additional people to have full access to my Shared Plan of Care.

Name of Person/Relationship:

Signature:

Date:

Name of Person/Relationship:

Signature:

Date:

## Care Mapping

### Care Mapping: A How-To Guide for Patients and Families

Richard C. Antonelli, MD, MS, Medical Director of Integrated Care, Boston Children's Hospital, Assistant Professor of Pediatrics, Harvard Medical School

Cristin Lind, BA, Family Leader

Families raising children with special needs have long acted as the primary care coordinators for their children, connecting the dots between home, health care, school, and the community. Acting as “air traffic control” between health care providers, home care workers, child and respite care, teachers, specialists, and community agencies can add considerable stress and time to parenting, cause families to miss work or work less, strain relationships or cause needs to go unmet.

Professionals can help relieve some of this stress and help families be more effective by partnering with them to coordinate and plan care. We have developed a tool, the care map, to assist families and the professionals they partner with. Although it was initially created for families raising children with special needs, it can also be used for anyone of any age or level of needs to make partnering with professionals more effective.

### What is care mapping?

Care mapping is a process which guides and supports the ability of families and care professionals to work together to achieve the best possible health outcomes. In its most developed form, care mapping is a family-driven, person-centered process which highlights a family's strengths and communicates both the big picture and the small details of all the resources needed to support a child and their family. It provides a comprehensive snapshot of a family's needs and enables the care team to appreciate how each of these aspects relate to each other.

### How do I make my care map for my child or family member?

Here are some step-by-step instructions for creating your own care map:

1. Starting with a blank piece of paper and a pencil, draw a circle in the middle of the paper which represents your child and a ring around him/her depicting your family.
2. Coming out from the center, begin depicting the individuals or organizations that are part of your child's team, grouping them into broad categories and subcategories in a way that makes sense to you and to the people you will want to share the map with. Some examples of categories might include Medical, school, recreation/community/social, legal/financial, social services, advocacy, and information, spiritual, transition, work, housing, transportation, and caregiver support. It may take several attempts before it feels complete. Don't worry about getting it 100% right.
3. You may need or want to re-write it using different colors, symbols, and line shapes to communicate additional data such as barriers, support, or unmet needs. It's best to keep your process simple. You can use a photo of your child or family in the center.

4. Include your child/youth in the care mapping process. They may even be able to make their own. It will likely look quite different from the one you make, but that can be informative.
5. Lastly, make copies of your care map and/or scan it. Having an electronic version will allow you to share it by email with care team members if you need to.

### **How do I use my care map?**

You can use your care maps to:

- Reflect on your own experience and journey. Many families who have created their own care map express a feeling of satisfaction and pride at the support they are managing for their child when they can see them all at once.
- Assess the Big Picture. Is there anything on the care map that surprises you? How do you feel when you look at it? Is there anything missing?
- Communicate with care team members, family, and friends. Share it with trusted members of your child's care team, including family, caregivers, healthcare or education providers, or anyone who you think could benefit from the big picture or who you partner with to make decisions about care.

### **What else should I think about when making or using a care map?**

One common pitfall in making a care map is to make it so complex and detailed that it becomes difficult for someone other than you to read or understand. Keep it simple or create different versions depending on the need. It can be tempting to include details about other important responsibilities to drive home the message that you are juggling a lot of responsibilities, but adding things unrelated to your child's care can dilute the care map's impact.

Another common pitfall is using mind-mapping software or some other technological tool that isn't flexible enough to create an expressive care map. While software can add many additional features to your care map, use it only if you are extremely proficient. We advise that you at least begin on paper. Many people have expressed that the handwritten aspect of the care map serves an important reminder that it is created by families.

### **How can I learn more about care mapping?**

Further training materials are being developed to support families who have children with special needs to develop the skills to create and use their own care maps. We are also beginning to work with primary care providers, subspecialty providers, and community care providers to learn how to effectively engage families in a discussion of care coordination utilizing this tool as a focal point.

In addition, we are in the process of developing tools to measure the experience of families and professionals engaged in care mapping.

For the latest information on care mapping, please visit [[Care Mapping](#)].

# REFERENCES

Antonelli R, McAllister J, Popp J. "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework." The Commonwealth Fund. May, 2009.

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Antonelli R and Lind C. (2012, October) Care Mapping: An Innovative Tool and Process to Support Family-Centered, Comprehensive Care Coordination. Poster session presented at the annual Primary Care Innovation Conference of the Harvard Medical School Primary Care Center, Boston, MA.

Turchi RM, Berhane Z, Bethell C, Pomponio A, Antonelli R, Minkovitz CS. (2009). Care Coordination for CSHCN: Associations with Family-Provider Relations and Family/Child Outcomes. Pediatrics.Dec;124 Suppl 4:S428-34

DRAFT

# EMERGENCY PREPAREDNESS

## Emergency Information Form for Children With Special Health Care Needs

The American College of Emergency Physicians and the [American Academy of Pediatrics](#) are pleased to present the Emergency Information Form (EIF), which can be downloaded from the menu at the bottom of this page.

This important document will ensure prompt and appropriate care for Children with Special Health Care Needs (CSHCN). Now, when these patients present to emergency departments or health care professionals with an acute illness or injury, physicians, parents, EMS professionals, and nurses will be able to use the EIF as a tool to transfer critical information.

The EIF will ensure that a child's complicated medical history is concisely summarized and available when it is needed most - when the child presents with an acute health problem at a time when neither parent nor pediatrician is immediately available.

AAP and ACEP believe the EIF is an important tool that will help facilitate the transfer of relevant information for Children with Special Health Care Needs.

### *EIF Documents*

- [Download the EIF](#)
- [Download a sample, completed EIF](#)
- [Blank Interactive Emergency Information Form](#)
- [ACEP Policy Statement - Emergency Information Form for Children With Special Health Care Needs](#)
- [AAP Policy Statement - Emergency Preparedness for Children With Special Health Care Needs](#)

## Statewide Care Navigation Family Experience Survey

### Thank you for participating in the Statewide Care Navigation Pilot Program!

As you know, the Maryland Department of Health Office of Children and Youth with Specific Health Care Needs (CYSHCN) has worked with Cardea to create and design a care coordination program for families like yours.

While you may still receive services through your local health department, the pilot program is ending soon, which means we'd like to hear about your experience with the care you and your child received over the last few months. The following survey will take about 15-20 minutes, and will ask about:

- Your experience with the care coordination services from your local health department
- What you liked about the services and resources you were connected to
- Any changes in how you manage and organize your child's care
- Suggestions for improving care coordination for future families

Your feedback will help us improve programs for families across the Maryland.

This survey is voluntary. You can stop at any time or skip questions. It is also confidential; we won't ask for your personal information, and we won't know who you are or link your answers to your name. Cardea staff will combine your response with responses from other families or caregivers. All data for this project will be kept on a secure, password-protected computer. Only approved staff at Cardea will be able to see the data.

If you have any questions, you can contact Pegah Maleki anytime at [pmaleki@cardeaservices.org](mailto:pmaleki@cardeaservices.org).

If you have questions about your rights as a participant, please contact Maryland Department of Health's IRB Administrator:

### Demographic Information and Program Interest

The following questions are to help us understand the backgrounds of participants enrolled in our pilot program, and your initial motivation to join the program.

1. Which county in Maryland do you live in?

- ☐ Allegany
- ☐ Anne Arundel
- ☐ Baltimore County
- ☐ Baltimore City
- ☐ Calvert
- ☐ Caroline
- ☐ Carroll
- ☐ Cecil

- ☐ Charles
- ☐ Dorchester
- ☐ Frederick
- ☐ Garrett
- ☐ Harford
- ☐ Howard
- ☐ Kent
- ☐ Montgomery
- ☐ Prince George's
- ☐ Queen Anne's
- ☐ St. Mary's
- ☐ Somerset
- ☐ Talbot
- ☐ Washington
- ☐ Wicomico
- ☐ Worcester

2. Does your child have any of the following diagnoses?

Please check all that apply.

- ☐ **Autism**
- ☐ **Ambulatory difficulty**—Having serious difficulty walking or climbing stairs
- ☐ **Cognitive difficulty**—Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions
- ☐ **Developmental disability**—Conditions causing impairment in physical, learning, language, or behavior areas
- ☐ **Emotional challenges/disabilities**—anxiety disorders, bipolar disorders, conduct disorders)
- ☐ **Hearing difficulty**—Deaf or having serious difficulty hearing
- ☐ **Independent living difficulty**—Because of a physical, mental, or emotional problem, having difficulty doing errands alone.
- ☐ **Learning disability**—Differences in how child processes information
- ☐ **Orthopedic Impairment**—Impairment affecting child's muscles, bones, and/or joints
- ☐ **Self-care difficulty**— Having difficulty bathing or dressing
- ☐ **Speech/language impairment**—Impairment that affects child's ability to produce speech sounds, use language correctly, or understand language
- ☐ **Traumatic brain injury**—Sudden injury to the brain

- ☐ **Vision difficulty**—Blind or having serious difficulty seeing, even when wearing glasses
- ☐ Another disability not listed: \_\_\_\_\_
3. What is your child's current insurance status? Please check all that apply.
- ☐ Uninsured (does not currently have insurance)
- ☐ Medicaid
- ☐ CHIP (Children's Health Insurance Program)
- ☐ Parent's employer-based plan
- ☐ Private plan through Maryland Marketplace (Maryland Health Connection)
- ☐ Other - Write In: \_\_\_\_\_
4. Why did you choose to enroll in this care navigation program?

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### Overall Experience with Program

The following questions will ask you to share about you and your child's overall experience with the care coordination services you received through the pilot program at your local health department.

5. Before you joined this program, did you ever work with a care coordinator (or navigator) to help with your child's care?
- This may be someone from your insurance, local health department, or a community organization who helps manage your child's appointments and connecting you with resources.
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Other - Write In: \_\_\_\_\_
6. Overall, how satisfied are you with your experience in this program?
- ☐ Very dissatisfied
- ☐ Dissatisfied

☐ Satisfied

☐ Very satisfied

7. How likely are you to recommend this program to a friend or family member?

☐ Not very likely

☐ Somewhat likely

☐ Likely

☐ Very Likely

8. What part of the program has been most helpful for you and your child?

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9. How did you find out about the care coordination program?

☐ I signed up myself online or over the phone

☐ A healthcare provider or other service referred me

☐ Other - Write In: \_\_\_\_\_

10. Please rate your experience with your current care coordinator you're connected to through this pilot program.

Use the scale on the following page to rate how much you agree with each statement.

Rate your experience with your current care coordinator below:

| Statement                                                                             | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---------------------------------------------------------------------------------------|-------------------|----------|---------|-------|----------------|
| My child and I have been in contact with a care coordinator within the last 3 months. |                   |          |         |       |                |
| My care coordinator is easy to reach when I need help.                                |                   |          |         |       |                |
| My care coordinator understands my child's medical and non-medical needs.             |                   |          |         |       |                |
| My care coordinator provides emotional support to me and my family.                   |                   |          |         |       |                |
| My care coordinator connects us to resources and services we need.                    |                   |          |         |       |                |
| My care coordinator advocates for my child's needs.                                   |                   |          |         |       |                |
| My overall experience with our care coordinator has been positive.                    |                   |          |         |       |                |

11. Did your care coordinator help connect you to a primary care provider/doctor or medical home?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Other - Write In: \_\_\_\_\_
12. How often do you meet or talk with your current care coordinator through this pilot program?
- ☐ Once a week
- ☐ Once every 2-3 weeks
- ☐ Once a month
- ☐ Spoke/met just once or twice
- ☐ Other - Write In: \_\_\_\_\_
13. What parts of the program have you and your child been connected to? Please check all that apply.
- ☐ Initial intake meeting to plan goals with your care coordinator
- ☐ Care Plan made with care coordinator for goals and next steps
- ☐ Shared Plan of Care document that helps communication between your family and members of your child's care team
- ☐ Emergency Readiness Plan that includes your child's medication, medical needs, and emergency contacts
- ☐ Transition plan that outlines your child's goals for moving to adulthood
14. Since joining the program, **what medical resources or which providers has your care coordinator connected you and your child to?** Please check all that apply.
- ☐ Medications
- ☐ Dentist
- ☐ Therapy services (like physical therapy, occupational therapy, or speech therapy)
- ☐ Medical equipment
- ☐ Mental or behavioral health provider (like therapists or psychiatrists)

- ☐ Nutritionist
- ☐ Primary care provider or doctor
- ☐ Specialists (e.g., cardiologist, neurologist, endocrinologist, hearing specialist)
- ☐ Vaccines
- ☐ Eye doctor (optometrist, ophthalmologist)
- ☐ Other - Write In: \_\_\_\_\_

15. Since joining the program, **what non-medical resources or which providers has your care coordinator connected you and your child to?** Please check all that apply.

- ☐ Childcare resources
- ☐ School supports (like IEP or 504 Plan)
- ☐ Family support/parental support groups
- ☐ Financial assistance programs (SSI, Medicaid waivers)
- ☐ Food support (SNAP, WIC)
- ☐ Housing support or home modifications
- ☐ Legal help
- ☐ Recreational programs
- ☐ Early Intervention services for children under 3
- ☐ Respite care (help for parents)
- ☐ Transportation help
- ☐ Other - Write In: \_\_\_\_\_

16. Are there any resources or support that **you and your child needed** but you **didn't get connected to?**

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17. Has anything **made it hard for you to follow-up** on resources and referrals shared by your care coordinator?
- 

### Reflections on Changes in Managing Your Child's Care

The following questions will ask you to share reflections on any changes to how you now manage your child's care and services after participating in the care coordination program.

18. After joining the program, how aware are you of available community resources for your child?
- ☐ Not aware
- ☐ Somewhat aware
- ☐ Aware
- ☐ Very aware
19. Please rate how easy or hard it is to do the following activities for your child, BEFORE and AFTER joining the program.
- Use a scale from 1-4, from Very Easy (1) to Very Difficult (4).

| Statement                                              | BEFORE joining the program | AFTER joining the program |
|--------------------------------------------------------|----------------------------|---------------------------|
| Schedule appointments and reach your child's providers |                            |                           |
| Get information about your child's medical care        |                            |                           |
| Receive referrals to needed specialists or services    |                            |                           |
| Coordinate between medical and non-medical providers   |                            |                           |

20. Please rate how much you agree with the statements below about managing your child's care BEFORE and AFTER joining the program.

Use a scale from 1-4, from Strongly Disagree (1) to Strongly Agree (4).

| Statement                                                                                                                                   | BEFORE joining the program | AFTER joining the program |
|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|
| I have the time to find the resources and providers my child needs.                                                                         |                            |                           |
| I am confident I can connect my child to the right healthcare providers if they have new needs.                                             |                            |                           |
| I feel overwhelmed by my responsibilities trying to coordinate my child's care.                                                             |                            |                           |
| I know how to navigate the healthcare system for my child.                                                                                  |                            |                           |
| I feel supported by the people involved in my child's care, like doctors, teachers, behavioral health professionals, and/or social workers. |                            |                           |
| I am not sure where to find the services and support my child needs.                                                                        |                            |                           |
| I feel confident communicating with my child's providers.                                                                                   |                            |                           |
| It is hard for me to coordinate my child's care (appointments, insurance, communication with providers, etc.)                               |                            |                           |

## Recommendations for Program Improvement

21. Is there anything else you would like to share?

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22. Are there any parts of this program you would change to make it more helpful?

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## You have reached the end of the survey!

Thank you for completing the Statewide Care Navigation Family Experience Survey!

As a reminder, your answers will help us improve future programs for families of children with specific health care needs in Maryland.

If you have any questions or concerns, feel free to contact Vimbai at [vmadzura@cardeaservices.org](mailto:vmadzura@cardeaservices.org).

## System of Care Coordination Pilot Program Family/Caregiver Interview Guide

|              |       |
|--------------|-------|
| Facilitator: | Date: |
| Note-taker:  |       |

### Introduction & Consent

Hi, my name is \_\_\_\_\_, and this is my colleague \_\_\_\_\_, who will be taking notes. We work for Cardea, a national nonprofit. We help health and human service programs learn what is working with their programs, and what can be improved.

The Maryland Department of Health (MDH), with support from Cardea, wants to learn about families' experiences with the care coordination pilot program for Children and Youth with Specific Health Care Needs (CYSHCN.) This program tries to make it easier for families across the state to get the medical, social, and community services they need.

We are talking with families who joined this pilot program to understand:

- What services or supports you were connected to through your care coordinator
- How easy or hard it was to get the services your child needed
- How well the care coordinator worked with you and other providers
- What worked well and what could be better for families receiving care coordination in the future

What you share today will be combined with the information other families share, and your feedback will help MDH and Cardea understand how the program works. It will also help us understand how we can improve care coordination for families in the future.

Participating in this interview is your choice, and the information you share today will not be directly shared back with your care coordinator or MDH tied back to your name. We will take themes from conversations with families and write up a written report to share with MDH and pilot sites about family experiences with the program.

You can skip any question, ask us to go back to a question, or stop today's interview at any time. The interview will take about one hour. We may use short quotes in the final report, but we will not use your name or details that could identify you. MDH will not get personal information about you.

With your permission, we would like to audio record our conversation so we can capture your words correctly. Only the Cardea team will listen to the recording, and we will delete it after we review our notes and the transcription (the conversation written out.) If you do not want to be recorded, we will take detailed notes instead.

All information will be stored safely on Cardea's secure, password-protected system.

Taking part in this interview may not benefit you personally, but what you share can help improve care coordination programs for families like yours across Maryland.

|                                                                                                                      | Yes | No |
|----------------------------------------------------------------------------------------------------------------------|-----|----|
| Do you have any questions about why we are talking today?                                                            |     |    |
| Do you want to continue with today's discussion?                                                                     |     |    |
| Do I have your permission to record the discussion?                                                                  |     |    |
| Do I have your permission to use quotes without your name summaries or reports?<br>We will not identify you by name. |     |    |

## Interview Questions

### Background and Enrollment

1. Please share your name, pronouns (if you want), and anything else about yourself that feels important.
2. What is your connection to the care coordination program?
3. How did you first come into contact with the care coordination program? (e.g., did you call, did you fill out a referral form, did a provider complete the referral form on your behalf?)

If you referred yourself:

- What made you decide to reach out?
- Did you call or fill out a form online?
- If you filled out a form online:
  - What was easy to understand?
  - What was confusing?
- During your first call, did a care coordinator ask you questions to help join the program?
  - What made enrollment easy?
  - What made it hard to get started in the program?

### Care Coordination Process and Planning

4. After you joined the program, what was the first meeting (intake) like? This was likely your first meeting with the care coordinator. They asked questions about your family's needs and goals.

- PROBE: What was it like to share your family's needs and concerns with the care coordinator?
  - PROBE: Did they ask about the kinds of support and services you needed?
  - PROBE: How well did the care coordinator understand your family's situation?
5. How involved did you feel when setting goals and making a care plan?
    - PROBE: Did you feel listened to and included in decisions?
  6. After the intake meeting, what was communication like with the care coordinator while you were in the program?
    - PROBE: How often did you talk or meet with the care coordinator?  
PROBE: Did they follow up with you in a timely way?
    - PROBE: How easy or hard was it to reach the care coordinator when you needed to?

### **Resources and Service Connection**

7. How did the care coordinator help connect you and your family to the resources you needed?
  - PROBE: Did the coordinator connect you directly, make referrals for you, or give you information so you could reach out yourself?
  - PROBE: Did the connection process feel easy or challenging?
8. How well did the services and resources suggested by the care coordinator match your child's and family's needs?
  - PROBE: In what ways were the suggestions helpful?
  - PROBE: In what ways were they not helpful?
  - PROBE: Did the resources fit your family's situation (like location, culture, language, or your child's specific needs/diagnoses)?
9. Were there any supports or services that were still hard to get, even with help from the care coordinator?

### **Impact**

10. How much did this program help you and your family meet your child's care goals?
11. How did being in the program change your experience managing your child's care?
  - PROBE: Did anything change in how well you could find or get care and services for your child?

### **Program Improvement and Recommendations for Future Programming**

12. What parts of this program would you want to see in future care coordination programs for families?
  - PROBE: What kinds of support would help families/caregivers manage their child's care and find community resources?

13. What would you change about the program? What would make it easier for families to take part in the future?

### Closing

14. Is there anything else you'd like to share about your experience in the program?

Thank you for your time today! Everything you've shared will be extremely helpful as we learn more about families' experiences with this pilot care coordination program for children and youth with special health care needs. I wanted to remind you that what you shared today is private, and your name will not appear in any notes or reports. We will combine what you shared with feedback from other families to write a report about overall experiences in the program. What we learn will help improve future care coordination programs for families across Maryland.

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## System of Care Coordination Pilot Program Site Staff Interview Guide

|              |       |
|--------------|-------|
| Facilitator: | Date: |
| Note-taker:  |       |

### Introduction & Consent

Hi, my name is \_\_\_\_\_, and this is my colleague \_\_\_\_\_, who will be taking notes. We work for Cardea, a national nonprofit organization that provides research and evaluation services to health and human service organizations across the U.S.

The Maryland Department of Health (MDH), with support from Cardea, is evaluating the care coordination pilot program for Children and Youth with Specific Health Care Needs (CYSHCN.) This pilot program aims to implement and assess how a pilot care coordination program can improve access and coordinate medical, social, and community-based services that families need.

As part of this evaluation, we are speaking with care coordinators and other pilot site staff involved in the pilot, to better understand

- How the care coordination model is being implemented at your site
- How care coordination staff are connecting families to care
- What processes and tools are working well
- What challenges and barriers exist and any suggestions for improvement
- Recommendations for scaling-up a statewide care coordination system

Participation in today's conversation is voluntary and confidential. You can skip any question or end the interview at any time. This interview will take no more than 1 hour. Though we may include quotes from interviews in the final report, your name, role, and site will not be shared in any notes or reports, and this will not affect your current or future employment. The Maryland Department of Health will not receive any identifying participant information at any point during this project, or transcripts of our conversations.

With your permission, we would like to ask to audio record this conversation to ensure accuracy in our notes. Only the Cardea evaluation team will have access to the recordings, which will be deleted at the end of this project. If you prefer not to be recorded, we will instead take detailed written notes.

We will store all data securely on Cardea's encrypted, password-protected server.

Your participation will help improve care coordination services for families of children and youth with special health care needs across Maryland.

|                                                                                                                      | Yes | No |
|----------------------------------------------------------------------------------------------------------------------|-----|----|
| Do you have any questions about the purpose of today's discussion?                                                   |     |    |
| Do you want to continue with today's discussion?                                                                     |     |    |
| Do I have your permission to record the discussion?                                                                  |     |    |
| Do I have your permission to use quotes without your name summaries or reports?<br>We will not identify you by name. |     |    |

## Interview Questions

### Introduction

1. Please share your name, pronouns, or any identities that feel important to you, what your role/title is related to care coordination and serving CYSHCN families, and how long you've been participating in the pilot program?

### Onboarding Process

2. What was your experience with the onboarding process for how to deliver this program?
  - PROBE: After onboarding, how prepared did you feel delivering care coordination services?
  - PROBE: Were the materials clear and easy to use?

### Care Coordination Process

3. How was the process for gathering information at intake?
  - PROBE: What was it like to use the intake form to conduct the intake session?
  - PROBE: Was there information you felt was missing or not collected?
4. How was the process of completing the Tier Determination tool and assigning families to tiers?
5. Please share about the process you use for care planning and engaging families in goal setting.
  - PROBE: What makes the process of care planning and goal-setting easier?

- PROBE: What makes the process of care planning and goal-setting more challenging?
6. How was the process of using service tracking tools during follow-up conversations with families?
    - PROBE: Did this tool feel effective in capturing services delivered and referrals made?
    - PROBE: Is there anything missing from the tracking tools that you collect somewhere else? (ex: external notes, excel spreadsheets, etc.)
  7. How do you communicate/coordinate with partners from other systems (e.g., healthcare providers, schools, community-based services)?
    - PROBE: What makes this coordination easier?
    - PROBE: What makes this coordination more challenging?

### **Capacity and Supports**

8. How would you describe your capacity and workload working with families in this pilot program?
9. What additional supports, training, or resources would make this role easier or more effective?
  - PROBE: What additional training topics would be helpful for care coordination staff as the program expands?

### **Family Experience**

10. From your perspective, how have families responded to this pilot?
11. How well has this pilot program supported families' coordination of care for their child?
  - PROBE: Can you share an example of a positive outcome or success story?
  - PROBE: Can you share an example of where this program could have better met a family's needs?
12. In your role, do you support youth/families during transitions (e.g., from pediatric to adult systems)?
  - PROBE: If so, what does this support look like?

### **Reflections and Recommendations**

13. Are there any additional aspects of this pilot program that worked well that we have not discussed so far?
  - PROBE: For staff?
  - PROBE: For families?

14. What aspects could be improved?
15. From your experience, what lessons learned from the pilot could help inform the development of a statewide care coordination program?
  - PROBE: What do you think is needed for care coordinator staff/sites implementing care coordination to make a program like this sustainable?

## Closing

16. Is there anything else you'd like to share about your experience delivering care coordination services through this pilot program?

Thank you so much for taking the time to speak with us and share your insights today. Your perspective is incredibly valuable as we learn about how this pilot care coordination program works to support children and youth with special health care needs and their families in the state. I want to remind you that everything we discussed will be kept confidential, and your name and any identifying information will not appear in notes or reports. The information you shared will be combined with input from other care coordination staff and families to help describe overall experiences with the pilot program and identify ways to strengthen and improve future care coordination efforts across Maryland.



DRAFT



**Maryland**

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