Objectives for today

• Review nursing process used with initial assessment of cyshn

• Review screening and assessment tools

• Use of the tier tool

• Development of a care plan

• Discuss CaCoon outcomes

• Review CaCoon Family Outcomes

• Review ORCHIDS and TCM Documentation
Figure 1. Development of worker ability

Novice-to-Expert scale (1)

<table>
<thead>
<tr>
<th>Level</th>
<th>Stage</th>
<th>Characteristics</th>
<th>How knowledge etc is treated</th>
<th>Recognition of relevance</th>
<th>How context is assessed</th>
<th>Decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Novice</td>
<td>Rigid adherence to taught rules or plans</td>
<td>Without reference to context</td>
<td>None</td>
<td>Rational</td>
<td>Rational</td>
</tr>
<tr>
<td>2</td>
<td>Advanced beginner</td>
<td>Guidelines for action based on attributes or aspects (aspects are global characteristics of situations recognisable only after some prior experience) Situational perception still limited All attributes and aspects are treated separately and given equal importance</td>
<td>None</td>
<td>Present</td>
<td>Holistically</td>
<td>Holistically</td>
</tr>
<tr>
<td>3</td>
<td>Competent</td>
<td>Rigid adherence to taught rules or plans</td>
<td></td>
<td>Present</td>
<td>Holistically</td>
<td>Holistically</td>
</tr>
<tr>
<td>4</td>
<td>Proficient</td>
<td>Rigid adherence to taught rules or plans</td>
<td></td>
<td>Present</td>
<td>Holistically</td>
<td>Holistically</td>
</tr>
<tr>
<td>5</td>
<td>Expert</td>
<td>Rigid adherence to taught rules or plans</td>
<td></td>
<td>Present</td>
<td>Holistically</td>
<td>Holistically</td>
</tr>
</tbody>
</table>

CaCoon Outcome
Identify vulnerable population

- Children who have, or are at increased risk for, a **chronic physical, developmental, behavioral, or emotional condition** and who also require health and related services of a type or amount beyond that required by children generally*

- For example, *more doctor visits, specialized treatments, prescription drugs, and mental health services and special education.*
CaCoon Practice

Care with compassion
Holistic and relationship-centered
Activities based on professional assessment
Sensitive to vulnerabilities
Effective and Efficient
Autonomous practice
Goal of CaCoon Activities

- Connect vulnerable population to needed services while supporting family autonomy and growth
<table>
<thead>
<tr>
<th>Home Visiting Components</th>
<th>Nursing Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation Phase</strong></td>
<td><strong>Assessment and Diagnosis</strong></td>
</tr>
<tr>
<td>• Introduction</td>
<td>• Individual and family assessment</td>
</tr>
<tr>
<td>• Determine purpose of visit and visit activities with client</td>
<td>• Strengths-based assessment—protective factors identified</td>
</tr>
<tr>
<td>• Engage in social conversation</td>
<td>• Resources identified</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Health risks and active health problems identified</td>
</tr>
<tr>
<td>• Identify and state client’s problems</td>
<td>• Unmet health needs identified</td>
</tr>
<tr>
<td><strong>Working Phase: Identification</strong></td>
<td><strong>Planning and Implementation</strong></td>
</tr>
<tr>
<td>• Client asks questions and identifies nurse as someone who can help</td>
<td>• Mutual planning, priority setting, goal-setting</td>
</tr>
<tr>
<td>• Client identifies problems</td>
<td>• Primary interventions used are health teaching, counseling, referral and follow-up, and advocacy</td>
</tr>
<tr>
<td>• Nurse provides health teaching, support and counseling, follow-up assessment, referral, and advocacy</td>
<td><strong>Implementation</strong></td>
</tr>
<tr>
<td>• Client uses nurse as resource and accesses community resources</td>
<td>• Primary interventions used are case management, health teaching, counseling, collaboration, and consultation</td>
</tr>
<tr>
<td>• Nurse engages client in mutual problem-solving</td>
<td><strong>Evaluation</strong></td>
</tr>
<tr>
<td><strong>Resolution and Termination</strong></td>
<td>• Evaluation of outcomes: outcomes met, partially met, or not met</td>
</tr>
<tr>
<td>• Problems solved or ongoing but stable</td>
<td>• Replan—change in goals, outcomes, and/or interventions</td>
</tr>
<tr>
<td>• Client becomes independent of nurse or continues to need support</td>
<td>• New priorities or emerging problems identified and nursing process continues</td>
</tr>
<tr>
<td>• Relationship ends when client no longer needs nurse or no longer participates in plan (moves or refuses participation in plan or visits)</td>
<td><strong>Used with permission. ©The Honor Society of Nursing, Sigma Theta Tau International</strong></td>
</tr>
</tbody>
</table>

Source: Adapted from McNaughton, 2005
CaCoon outcome
Comprehensive Nurse Assessments to determine needs

- Every child will have a screening and assessment for exceptional health needs
- The Tier Tool is required
- Standardized tools are used
- *Children’s visit frequency will be related to the needs and goals identified*
- *If working with PHN extender, frequency of case conferencing will correlate with complexity of child’s condition/parent needs*
## Eligibility Criteria – CaCoon B Codes

### Diagnosis
- B1. Heart Disease
- B2. Chronic Orthopedic Disorders
- B3. Neuromotor disorders including cerebral palsy and brachial palsy
- B4. Cleft lip and palate and other congenital defects of the head, face
- B5. Genetic disorders, e.g. cystic fibrosis, neurofibromatosis
- B6. Multiple minor anomalies
- B7. Metabolic disorders, e.g. PKU
- B8. Spina Bifida
- B9. Hydrocephalus or persistent ventriculomegaly
- B10. Microcephaly and other congenital or acquired defects of the CNS
- B11. Organic speech disorders, e.g. dysarthria/dyspraxia
- B12. Hearing Loss
- B23. Traumatic Brain Injury
- B24. Fetal Alcohol Spectrum Disorder
- B25. Autism, autism spectrum disorder, e.g. PDD, Asperger’s
- B26. Behavioral or mental health disorder with developmental delay
- B28. Chromosomal disorders, e.g. Down syndrome
- B29. Positive Newborn Blood Screen
- B30. HIV, seropositive conversion
- B31. Visual Impairment

### Very High Risk Medical Factors
- B16. Intraventricular hemorrhage (grade III or IV) or periventricular leukomalacia (PVL) or chronic subdurs
- B17. Perinatal asphyxia accompanied by seizures
- B18. Seizure disorder
- B19. Oral-motor dysfunction requiring specialized feeding program e.g. Failure to Grow, Organic-Non-organic (medical diagnosis), gastrostomy, nasogastric
- B20. Chronic lung disorder, e.g. tracheostomies, ventilator
- B21. Suspect neuromuscular disorder, e.g. abnormal Neuromotor exam at NICU Discharge

### Developmental Risk Factors
- B22. Developmental Delay

### Other
- B90. Other chronic conditions not listed
Use standard tools to inform the nurse plan
Assessment

- History
- Review of systems- *region X cards*
- Focused assessments/screeners
  - Nutrition
  - ASQ
  - Pain
- Family assessment
- Tier Assessment
## CaCoon Annual Nursing Assessment

### Identifying Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Language:</th>
<th>Interpreter at visit:</th>
</tr>
</thead>
</table>

**Referral source:**
- [ ] Babies First!
- [ ] Specialty Clinic
- [ ] Healthy Start
- [ ] Hospital
- [ ] OMC
- [ ] MCM
- [ ] PH other
- [ ] El/ECSE
- [ ] School
- [ ] Parent
- [ ] Other:

### Family Information

**Child Lives With**
- [ ] Mother
- [ ] Father
- [ ] Sibling
- [ ] Grandparent
- [ ] Foster Parent
- [ ] Other:

**Child Care Provided by:**
- [ ] Parents
- [ ] Family/Friend/Neighbor
- [ ] Day Care Center

**Insurance Plan**
- [ ] OHP
- [ ] Private
- [ ] IHS
- [ ] None
- [ ] Other:

**Family Support System**
- [ ] Family Members
- [ ] E.I.
- [ ] School District
- [ ] Friends
- [ ] None
- [ ] Other:

**Need Help Finding?**
- [ ] Housing
- [ ] Utilities
- [ ] Food
- [ ] Child Care
- [ ] Exceptional need r/t diagnosis
- [ ] Family Needs Survey
- [ ] Other:

**Other Agencies Involved**
- [ ] WIC
- [ ] E.I.
- [ ] School District
- [ ] Healthy Start
- [ ] TANF
- [ ] Mental Health
- [ ] Child Welfare
- [ ] Developmental Disabilities
- [ ] Other:

### Mode of Transportation
- [ ] Own car
- [ ] Friend(s)
- [ ] Relative
- [ ] Bus
- [ ] Other:

---

*Image of a child laughing.*
## CaCoon Program Visit Tool

**Visit date:** __________________________  **Location:** __________________________

### Subjective:

#### Area
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Objective</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well child care</strong></td>
<td>□ Adequate health maintenance/Medical home</td>
<td>□ PCP:</td>
</tr>
<tr>
<td>□ Potential/actual alteration in health maintenance</td>
<td>□ Next well child check up:</td>
<td>□ Referral</td>
</tr>
<tr>
<td></td>
<td>□ Immunizations up to date</td>
<td>□ Case management</td>
</tr>
<tr>
<td></td>
<td>□ Needs immunizations</td>
<td>□ Illness prevention</td>
</tr>
<tr>
<td></td>
<td>□ Adequate insurance</td>
<td>□ Individual teaching</td>
</tr>
<tr>
<td></td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
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<tr>
<td><strong>Specialty care</strong></td>
<td></td>
<td></td>
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<tr>
<td>□ Dr.: __________________________</td>
<td>□ Next appt: __________________________</td>
<td>□ Referral</td>
</tr>
<tr>
<td>□ Dr.: __________________________</td>
<td>□ Next appt: __________________________</td>
<td>□ Case management</td>
</tr>
<tr>
<td></td>
<td>□ Surgery date: _________________</td>
<td>□ Illness prevention</td>
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<tr>
<td></td>
<td>□ Has transportation</td>
<td>□ Individual teaching</td>
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<td></td>
<td>□ Yes</td>
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<td>□ No</td>
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<td></td>
<td>□ Adequate insurance</td>
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<td>□ Yes</td>
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<tr>
<td></td>
<td>□ No</td>
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<tr>
<td><strong>Nutrition/growth</strong></td>
<td>□ Meets body requirements</td>
<td>□ Nutrition screen</td>
</tr>
<tr>
<td>□ &lt; body requirements</td>
<td>□ 0-6 mos. Nutrition Screen</td>
<td>□ Referral to WIC</td>
</tr>
<tr>
<td>□ &gt; body requirements</td>
<td>□ Wt:</td>
<td>□ Referral to Feeding</td>
</tr>
<tr>
<td>□ Alt. in oral motor skills</td>
<td>□ Ht:</td>
<td>□ Referral to nutrition</td>
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<tr>
<td>CODE</td>
<td>Intervention</td>
<td></td>
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<tr>
<td>I</td>
<td>Intervention</td>
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<td>R</td>
<td>Referral</td>
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<tr>
<td>A</td>
<td>Abnormal</td>
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<td>Q</td>
<td>Questionable</td>
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<th>Date</th>
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<th>Head Circumference</th>
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<th>Oral Health</th>
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<tr>
<th>Safety Check List</th>
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<tr>
<th>Vision</th>
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<th>Hearing</th>
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<thead>
<tr>
<th>H.O.M.E.</th>
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<thead>
<tr>
<th>Infant Reflexes</th>
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<thead>
<tr>
<th>M-CHAT</th>
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<thead>
<tr>
<th>CAT/CLAMS</th>
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<table>
<thead>
<tr>
<th>Nutrition screening</th>
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<table>
<thead>
<tr>
<th>0-6 mos. Nutrition care plan</th>
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</tbody>
</table>
Nutrition and Growth examples of tools

• Birth- 6 Months Actual/Potential Alteration in Growth/Nutrition

• Nutrition Screening- A Look at Diet and Health

• Complete Growth grid including head circumference and ht/wt assessment

• Use appropriate growth grid for condition
Screening tools examples

- Vision
- Hearing
- EHDI Protocol
- Development
  - ASQ Screener, not standardized for CSHN
  - MCHAT
  - CAT/CLAMS
  - RDSI
- Pain – CaCoon Pain Card
PAIN ASSESSMENT (1 OF 2)

Outcomes:
1. Child (all ages) will have an assessment of their pain status at the time of the initial nursing assessment and a reassessment at appropriate intervals.
2. Child will have access to a medical evaluation of their pain.
3. Child and family will be offered effective pain relief strategies.
4. Child will experience relief of pain.

Observations: Does the child exhibit verbal or nonverbal pain cues? ♦ Are parents and other caregivers aware of child's pain cues? ♦ Does child's environment contribute to decreased or increased pain-positioning, adaptive equipment, environmental temperature, adequate food and fluids available?

Behavioral cues in Infants: grimacing, brow bulge, deepened nasolabial furrows, quivering chin, open or pursed lips, reflexive limb withdrawal, body posturing (squeaming, kicking, trunk arching, whimpering to high pitched cry.)

Physiological cues: skin color changes, palmar sweating, decreased O₂ saturation, increased heart rate, blood pressure

Inquire about parent and child/adolescent concerns
For Infants/Toddlers assess:
- Whether underlying condition is being well managed.
- Parental understanding of importance of preventive health care, ability to advocate for child in health system.
- Parental knowledge of emergency and illness care (signs/symptoms of pain) emergency numbers available.
- Parent's awareness of pain cues.
- Use appropriate pain scale to assess pain - FACES, FLACC.
- Observe for nonverbal pain cues - does child have a condition where communication of pain is limited.

- Location, frequency, triggers of pain.
- Degree to which pain interferes with daily activities, quality of life and sleep patterns.
- Presence of acute or chronic condition or injury that could contribute to pain.
- Presence of environmental hazards that may contribute to pain and knowledge to modify environment for infant safety; appropriate car seat.
- Adequacy of pain relief from medication or other strategies.
- Cultural and family beliefs about pain and methods of pain control.
## FLACC Scale

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant quivering chin, clenched jaw</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uncozy, retolrno, toenoe</td>
<td>Kiokking, or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arched, rigid or jerking</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans or whimpers; occasional complaint</td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging or being talked to, distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.

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Family Data

- Family Needs Survey
- Interview
- Family knowledge of condition
- Health literacy
- Culture and language
# CACOON Program Care Coordination

## Tier Level Assessment
*(To be assigned AFTER initial assessment)*

### Client Information
- Client Name: ______________________  BD: ________  Date: ____________
- Diagnosis/Risk Codes: ______________________  Initials: ________

**A score of 2 or 3 in any category with an asterisk may indicate the family should be assigned the higher tier level regardless of their total score.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
<th>Minimal Need (1 pt)</th>
<th>Moderate Need (2 pts)</th>
<th>High Need (3 pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Needs</strong></td>
<td></td>
<td>• Medical diagnosis with limited effects on health and/or</td>
<td>• Medical diagnosis has complex or long-term effects on health</td>
<td>Medical diagnosis/condition is severe enough to impair major body systems (may require technological support) and/or health status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Condition is stable and the course and treatment predictable</td>
<td>• Condition usually stable, however illness or crisis exacerbates condition</td>
<td>• Condition frequently becomes unstable or has an unpredictable course</td>
</tr>
<tr>
<td><strong>Medical Management</strong></td>
<td></td>
<td>• Routine preventative care with PCP</td>
<td>• Regular physician visits</td>
<td>• Condition requires medical management from one or more specialists to maintain health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• May see specialist annually for consultation</td>
<td>• Periodic consultation with or treatment from one or more specialists</td>
<td>• Frequent hospitalizations or visits to ER</td>
</tr>
<tr>
<td><strong>Development</strong></td>
<td></td>
<td>• Child meets developmental benchmarks in all areas or</td>
<td>• Child does not meet developmental benchmarks in one or more domains</td>
<td>• Frequent consultations with or treatments from one or more specialists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Has questionable development in one domain</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td>• Does not need EI/ECSE services</td>
<td>• Has IFSP, IEP or 504 plan</td>
<td>• Attends specialty classroom or requires full-time aide for most of the day</td>
</tr>
<tr>
<td>(including EI/ECSE)</td>
<td></td>
<td>• Attends regular classroom with minimal support</td>
<td>• Attends regular classroom with one special health consideration/protocol at school</td>
<td>• Requires health related protocols and/or delegated procedures in order to attend school</td>
</tr>
<tr>
<td><strong>Parent/Child</strong></td>
<td></td>
<td>• Child’s health condition has potential to interfere with attachment and/or</td>
<td>• Child’s health condition and/or parent behavior interferes with the development of bonding and/or positive parent/child interaction</td>
<td></td>
</tr>
<tr>
<td>Interaction</td>
<td></td>
<td>parent/child interaction</td>
<td></td>
<td>• Child’s health condition and/or parent behavior presents significant barrier to achieving bonding and/or positive parent/child interaction</td>
</tr>
<tr>
<td><strong>Health Teaching and</strong></td>
<td></td>
<td>• Minimal information and health teaching needs</td>
<td>• Needs periodic interpretation of information</td>
<td>• Needs significant interpretation/reiteration of information</td>
</tr>
<tr>
<td>Information Needs</td>
<td></td>
<td></td>
<td>• Needs health teaching around specialty care and/or treatments</td>
<td>• Needs health teaching and monitoring around specialty care and/or treatments</td>
</tr>
</tbody>
</table>

### Tier Level Assignment
- Tier Level I = 13 - 18 points
- Tier Level II = 19 - 28 points
- Tier Level III = 29 - 36 points
<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
<th>Minimal Need (1 pt)</th>
<th>Moderate Need (2 pts)</th>
<th>High Need (3 pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td></td>
<td>• No adaptation required to home or community environment in order to accomplish ADL/access community environment</td>
<td>• Condition will require some adaptation in order to accomplish ADL/access community environment</td>
<td>• Condition will require use of multiple adaptive devices and/or specialized services to accomplish ADL/access community environment</td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td>• Housing and neighborhood is safe and not overcrowded</td>
<td>• Housing substandard and/or frequent moves</td>
<td>• Family history of being evicted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family owns home or tenancy will be long-term</td>
<td>• Neighborhood suggests possible presence of delinquency or gangs</td>
<td>• Has been or currently homeless</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No safety hazards present</td>
<td>• Safety hazards present</td>
<td>• Neighborhood has high crime rate and poorly kept</td>
</tr>
<tr>
<td>Resource</td>
<td></td>
<td>• Specialty resources available locally</td>
<td>• Specialty resources available; not all locally</td>
<td>• Specialty resources available; none are local</td>
</tr>
<tr>
<td>Utilization**</td>
<td></td>
<td>• Knowledge of resources</td>
<td>• Some awareness of available resources</td>
<td>• No knowledge of available resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No assistance needed to access</td>
<td>• Limited means to access resources</td>
<td>• No means to access resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family comfortable asking for help when needed</td>
<td>• Needs coaching or support to access and utilize resources</td>
<td>• Needs direct assistance to access and utilize resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Family not always comfortable asking for help when needed</td>
<td>• Family resists accepting help when needed</td>
</tr>
<tr>
<td>Finances**</td>
<td></td>
<td>• Income sufficient to meet basic family needs and emergencies</td>
<td>• Income sufficient to meet basic needs; may need to borrow to cover emergencies</td>
<td>• Income insufficient to meet basic needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family has a budget</td>
<td>• Family does not budget; spending pattern sometimes inappropriate and spontaneous</td>
<td>• Lacks budgeting skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pays bills on time</td>
<td>• Family has unpaid bills</td>
<td>• Family has overwhelming debt</td>
</tr>
<tr>
<td>Coping**</td>
<td></td>
<td>• Good problem solving skills</td>
<td>• Does not anticipate problems; uses resources to deal with crises</td>
<td>• Poor problem-solving skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Appropriate coping strategies</td>
<td>• One or more family members using inappropriate coping strategies (e.g., substance abuse)</td>
<td>• One or more persons unable to function or creating an unsafe condition for self/child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Generally happy family where members support each other</td>
<td>• Limited communication/support between family members; relationships strained</td>
<td>• Relationship patterns tend to be destructive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Has strong, supportive network</td>
<td>• Inadequate support network; needs assistance from social services</td>
<td>• Support system absent; relies heavily on assistance from social services</td>
</tr>
<tr>
<td>Culture</td>
<td></td>
<td>• Cultural beliefs do not create a barrier to care</td>
<td>• Differences in cultural beliefs exist; not creating barriers to care</td>
<td>• Significant differences in cultural beliefs creating barriers to care</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td>• Family reads and speaks English</td>
<td>• Family members have minimal English speaking and reading skills; would benefit from use of an interpreter</td>
<td>• Family members do not understand, read or speak English and require use of an interpreter</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td>Tier Level I = 13 - 18 points</td>
<td>Tier Level II = 19-28 points</td>
<td>Tier Level III = 29-36 points</td>
</tr>
</tbody>
</table>
Tier Tool Shapes Care Plan

• Properly informed tier will show strengths and opportunities

• Tier looks at 13 domains-comprehensive

• Tier provides language about the child which can accurately inform a plan of care

• Tier can demonstrate if you have made a difference if you use it consistently.
Developing the Plan of Care

• Use the score from the tier and assessment findings to form tentative nursing conclusions

• Partner with the parents about the strengths and opportunities identified

• Share mutual goals identified and how you will work together to achieve those goals
Nursing Care Planning

- Based on the plan identify steps/interventions, learning needs, tasks needed to achieve the resolution of the problem/s

- Identify a time frame in which to achieve the goals

- Document the plan, share with family and essential partners

- Reassess for barriers, alter plan as needed
Plan of Care

- Urgent medical needs and safety issues for the child will be highest priority
- Use nursing language
- Use client centered language
- Mutual goals shape the care plan
Care Plan

- Keep the initial plan short!
- Keep the plan general rather than specific
- Use dates to identify active/inactive or met/unmet status of plan
Example of Plan of Care…

Actual/Potential Alteration in Growth/Nutrition
<table>
<thead>
<tr>
<th><strong>Subjective:</strong></th>
<th><strong>Objective:</strong></th>
<th><strong>Assessment:</strong></th>
<th><strong>Plan/Intervention:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Reports:</td>
<td>PCP: _________</td>
<td>Intake: □ Adequate calories □ Inadequate calories</td>
<td>Instructed on:</td>
</tr>
<tr>
<td>Healthy/stable/other _________</td>
<td>Other Agencies Involved: □ WIC □ AFS □ SCF □ EI □ CDRC □ Feeding Clinic □ Other _________</td>
<td>Feeding Dynamic: □ Efficient □ Inefficient</td>
<td>□ Formula preparation</td>
</tr>
<tr>
<td>Appetite _________</td>
<td></td>
<td>Nursing Diagnosis: □ Potential/alteration: growth and development r/t _________</td>
<td>□ How to increase Br. Milk supply</td>
</tr>
<tr>
<td>Hunger cues _________</td>
<td>Head Circumference: _________</td>
<td>□ Dysfunctional suck/swallow/breathe r/t _________</td>
<td>□ How to express milk</td>
</tr>
<tr>
<td>Feeding Skills _________</td>
<td>Gain/Loss since last wt.ok. _________</td>
<td>□ Fatigue/limited endurance r/t _________</td>
<td>□ Cues</td>
</tr>
<tr>
<td>Length of feedings _________</td>
<td>Oz/day gain _________</td>
<td>□ Potential/alteration: nutrition r/t _________</td>
<td>□ Sleep □ Cry</td>
</tr>
<tr>
<td>Breast Feeding □ Yes □ No</td>
<td>Suck/swallow ratio _________</td>
<td>□ Increased caloric need r/t _________</td>
<td>□ Hunger □ Fullness</td>
</tr>
<tr>
<td>How often</td>
<td>Length of time observed _________</td>
<td>□ Decreased caloric need r/t _________</td>
<td>□ Other _________</td>
</tr>
<tr>
<td>Supplements/Herbs _________</td>
<td>State stability _________</td>
<td>□ Potential/alteration: parenting r/t _________</td>
<td>□ Feeding method</td>
</tr>
<tr>
<td>Formula Feeding _________</td>
<td>Gastrointestinal concerns: □ Reflux (dx) □ Diarrhea □ Constipation □ Vomiting □ Retching</td>
<td>□ Potential/alteration: safety r/t _________</td>
<td>□ Normal suck/swallow</td>
</tr>
<tr>
<td>Formula type _________</td>
<td>Screening Tools: □ Feeding Assessment □ NCAST Feeding □ Growth Grid □ Breastfeeding Screen (Wk 1) □ Feeding Diary □ S/Sx of stress □ Sleep Activity Record</td>
<td></td>
<td>□ Length of feedings</td>
</tr>
<tr>
<td>Concentration: Cal/oz _________</td>
<td></td>
<td></td>
<td>□ Formula preparation</td>
</tr>
<tr>
<td>Nipple type _________</td>
<td></td>
<td></td>
<td>□ Normal suck/swallow</td>
</tr>
<tr>
<td>Feedings at night _________</td>
<td></td>
<td></td>
<td>□ Length of feedings</td>
</tr>
<tr>
<td>Spitting up _________</td>
<td></td>
<td></td>
<td>□ Delay of solids</td>
</tr>
<tr>
<td>On vitamins or fluoride _________</td>
<td></td>
<td></td>
<td>□ Growth and development</td>
</tr>
<tr>
<td>Juice _________ oz/day</td>
<td></td>
<td></td>
<td>□ Community resources</td>
</tr>
<tr>
<td>Solids _________</td>
<td></td>
<td></td>
<td>□ Telephone _________</td>
</tr>
<tr>
<td>□ Cereal □ Fruit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Vegetable □ Eggs/meat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Dairy/Milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stool: Number of BM diapers/day _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voids: Number of wet diapers/day _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep pattern _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment: □ Calm □ Stressed □ Chaotic □ Other _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mom’s physical state: Mother reports: □ Exhausted □ Coping Well □ In pain/healing □ Depressed □ Other _________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Plan/Intervention:**

- Instructed on:
  - □ Formula preparation
  - □ How to increase Br. Milk supply
  - □ How to express milk
  - □ Cues:
    - □ Sleep
    - □ Cry
    - □ Hunger
    - □ Fullness
  - □ Other _________
  - □ Feeding method
  - □ Normal suck/swallow
  - □ Length of feedings
  - □ Formula preparation
  - □ Bottle/ nipple changes
  - □ Delay of solids
  - □ Growth and development
  - □ Community resources
  - □ Telephone _________

**Referrals to:**

- □ PCP □ Respite
- □ WIC □ Nutritionist
- □ OHP □ Mental health
- □ EI □ Food stamps
- □ Lactation consultant
- □ Cacoon nurse

**Handouts provided:**

- □ Feeding brochure
- □ Info related to diagnosis
- □ Other _________

**Follow up Plan, Monitoring & Advocacy:**

- □ Telephone _________
- □ Revisit _________
- □ Faxed report to _________ on date _________
# Birth - 6 Months

## Actual/Potential Alteration in Growth/Nutrition

<table>
<thead>
<tr>
<th>Subjective:</th>
<th>Objective:</th>
<th>Assessment:</th>
<th>Plan/Intervention:</th>
</tr>
</thead>
</table>
| Parent Reports: | PCP: | Intake: □ Adequate calories  
□ Inadequate calories  

Feeding Dynamic:  
□ Efficient  
□ Inefficient  

Nursing Diagnosis:  
□ Potential/alteration: growth and development r/t  
□ Dysfunctional suck/swallow/breathe r/t  
□ Fatigue/limited endurance r/t  
□ Potential/alteration: nutrition r/t  
□ Increased caloric need r/t  
□ Decreased caloric need r/t  
□ Potential/alteration: parenting r/t  
□ Potential/alteration: safety r/t  
□ Other ________ |
| Healthy/stable/other_________ | Other Agencies Involved:  
□ WIC  
□ AFSC  
□ SCF  
□ EI  
□ CDRC  
□ Feeding Clinic  
□ Other ________  

Release of Info Signed: Y / N  
Insurance:  
Age today ________  
Today’s weight ________ lbs  
Length: ________ in  
Head Circumference: ________ in  
Gain/Loss since last wt. ok. ________  
Oz/day gain ________ |
| Appetite ________ | | Suck/swallow ratio  
Length of time observed ________  
State instability ________  
Gastrointestinal concerns:  
□ Reflux (dx)  
□ Diarrhea  
□ Constipation  
□ Vomiting  
□ Retching  

Screening Tools:  
□ Feeding Assessment  
□ NCFAST Feeding  
□ Growth Grid  
□ Breastfeeding Screen (Wk 1)  
□ Feeding Diary  
□ S/Sx of stress  
□ Sleep Activity Record  

Appointments Scheduled:  
PCP  
Specialist  
WIC appointment ________ |
| Hunger cues ________ | | Goals: (date)  
□ Will gain ½ - 1 oz/day by ________  
□ Will gain ____ oz/week by ________  
□ Other ________  

□ Growth curve will improve by ________  
□ Coordination of care with:  
□ Nutritionist  
□ EI  
□ PCP  
□ WIC  
□ Other ________  

Plan: (date)  
□ Supplement with breast milk  
□ Supplement with formula  
□ Br feed q 1-3 hrs, minimum of 8 X’s in 24hrs.  
□ Add one more formula feed/day  
□ Mom to keep feeding diary for: ________ days  
□ Decrease supplements  
□ Mom to get Elec Breast pump from WIC  
□ Other ________ |
| Hunger cues ________ | | Instructed on:  
□ Formula preparation  
□ How to increase Br. Milk supply  
□ How to express milk  
□ Cues  
□ Sleep  
□ Cry  
□ Hunger  
□ Fullness  
□ Other ________  

□ Feeding method  
□ Normal suck/swallow  
□ Length of feedings  
□ Formula preparation  
□ Bottle/ nipple changes  
□ Delay of solids  
□ Growth and development  
□ Community resources  
□ Telephone ________  

Referrals to:  
□ PCP  
□ Respite  
□ WIC  
□ Nutritionist  
□ OHP  
□ Mental health  
□ EI  
□ Food stamps  
□ Lactation consultant  
□ Cacoon nurse  

Handouts provided:  
□ Feeding brochure  
□ Info related to diagnosis  
□ Other ________  

Follow up Plan, Monitoring & Advocacy:  
□ Telephone ________  
□ Revisit ________  
□ Faxed report to ________ on date ________ |
FTT Nursing Care Plan Components

Subjective

1. consistent
   interview is predictable/logical

2. clear
   for your thinking for your client for your plan

3. focused
   to the problem

Subjective:

Parent Reports:

Healthy/stable/other________
Appetite _________________
Hunger cues _______________
   Feeding Skills___________
Length of feedings __________
Breast Feeding □ Yes □ No
How often _________________
Supplements/Herbs___________
Formula Feeding_____________
Formula type _______________
Concentration: Cal/oz________
Nipple type_________________
Feedings at night____________
Spitting up _________________
On vitamins or fluoride_______
Juice___________________oz/day
Solids_____________________
 □ Cereal □ Fruit
 □ Vegetable □ Eggs/meat
 □ Dairy/Milk

Stool: Number of BM diapers/day ______________
Comment_____________________

Voils: Number of wet diapers/day ______________
Comment_____________________
Sleep pattern_________________
Environment: □ Calm
 □ Stressed □ Chaotic
 □ Other
Mom’s physical state: Mother reports:
 □ Exhausted
 □ Coping Well
 □ In pain/healing
 □ Depressed
 □ Other ____________________
FTT Nursing Care Plan Components

**Objective**

1. consistent
2. clear
3. focused

| Objective: | PCP: ____________________________ |
| Other Agencies Involved: | WIC □ AFS □ SCF |
| □ EI □ CDRC |
| □ Feeding Clinic □ Other ____ |
| Release of Info Signed: Y / N |
| Insurance ___________________ |
| Age today ___________________ |
| Today’s weight______________lbs |
| Length:_______________________in |
| Head Circumference:__________in |
| Gain/Loss since last wt.ck. ___ |
| Oz/day gain __________________ |

Suck/swallow ratio___________
Length of time observed ____
State instability ______________
Gastrointestinal concerns:
□ Reflux (dx) □ Diarrhea
□ Constipation □ Vomiting
□ Retching

Screening Tools:
□ Feeding Assessment
□ NCAST Feeding
□ Growth Grid
□ Breastfeeding Screen (Wk 1)
□ Feeding Diary
□ S/Sx of stress
□ Sleep Activity Record

Appointments Scheduled:
PCP__________________________
Specialist____________________
WIC appointment______________
Examples of Care Plans

- Template of care plan
- Nutrition 0-6 months care plan
- Standardized guidelines for specific conditions with usual interventions
- TCM guide is example of TCM care plan
- You need a Nurse Care Plan, too
Nursing Care Plan

- Allows you to stay on track
- Helps you communicate to your client and colleagues in an organized manner
- Provides documentation of your professional nursing practice
- Allows monitoring the effectiveness of the plan
- Assure compliance with programs
Minimum requirements as established by:

- Oregon Nurse Practice Act
- Oregon Health Authority
- Your employer’s policies
- TCM regulations
- Need to chart discrete care coordination activities (CaCoon expectation)
- Identify outcomes
Documentation

• Legible
• Timely
• An auditor, supervisor, others should be able to see a progression of interventions, evaluations and necessary adaptations to the original plan.
• Most recent form available at the ORCHIDS training documents website:
http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/ORCHIDS/Pages/orchids_train.aspx
TCM Billable Activities

• Rule 410-138-0007
  – Assessment and periodic reassessment
  – Development of TCM Care Plan
  – Referral and related activities
  – Monitoring
Targeted Case Management

TCM Policy Documents

http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HealthScreening/BabiesFirst/Pages/index.aspx
http://www.dhs.state.or.us/policy/healthplan/guides/tcmngmt/138%20RB%202020%20-0711.pdf
Webinar Sept
Billing TCM

What are your concerns about TCM billing?

Questions? Clarifications? Examples?
QUESTIONS about developing a care plan?

- Examples from your practices
  - Issues of concern
  - Getting help
Children with special needs are a vulnerable population.

Randomized studies at Level 1 are absent for CYSHN.

Level 2, 3, 4 and 5 research informed CaCoon program development and continues to provide the basis for ongoing quality improvements.

CaCoon has been recognized as a Promising Practice by the American Association of Maternal Child Health Programs (AMCHP) and is actively pursuing Best Practice status.
CaCoon Outcome
Care Coordination to meet needs

Care Coordination: CaCoon Chart Review Tool

1. Child has source of well child care-WCC is up to date.
2. Family’s financial situation has been assessed: income, insurance and transportation needs
3. Family’s coping skills, strengths and needs have been documented.
4. Documentation of referrals made to other providers and outcome of referrals. Copies of screening results, growth charts and referral forms are present in chart.
5. Documentation of teaching that facilitated family’s coping and self advocacy skills.
   Teaching can be direct teaching of skills to parent or child, information about a child’s diagnosis, teaching a young parent how to communicate with providers so that parent gets what she needs for her child
6. Evidence of phn/family collaboration in planning interventions with family. Family’s input has been considered in developing a plan.
7. Documentation of transition planning for adolescents (14 years or older)
8. Tier level has been assigned and the level is used to inform phn interventions.

CaCoon Care Coordination… outcome targets

• Care Coordination to meet health needs of client in efficient, effective manner

• Promote the normalization of the family related to the experience of having a child with special health needs

• Increase family confidence and competence in self management of the child and needs related to the chronic condition

• Improved health outcomes for child and greater resiliency for family
Care Coordination to meet health needs of client

Child has source of well child care-WCC is up to date

Specialty Care needs assessed and accessed as needed

Documentation of referrals made to other providers and outcome of referrals.

Copies of screening results, growth charts and referral forms are present in chart.

Tier level has been assigned and the level is used to inform phn interventions.
Family Outcome:

Effective self management and autonomy which supports successful transition to a meaningful, healthy life in adulthood for the person with special health needs.
Family Engagement

Parent goal is to minimize their perceived vulnerability

- Overcoming fear
- Building trust—mutual trust grows over time
- Seeking mutuality—shared power, dropping the ‘expert’ nurse role
- Partnership
Supports which increase effective self management and autonomy

Families with CYSHN benefit from partnerships with knowledgeable health care professionals who:

- Identify family strengths
- Recognize family needs
- Encourage and value family autonomy and self-determination
As a parent of a child with special needs, the most important part of care coordination is establishing trust between my family and our care coordinator.

I just want to know that the Coordinator believes in the strengths of my family as we face all the barriers in the health care system.

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Family supports which increase effective self management and autonomy

...activities which identify family strengths are especially powerful cognitive interventions that help family members form a more positive view of themselves and their ability to address health-related issues.

Family supports which increase effective self management and autonomy

Normalization Promotion for Families with CYSHN

1. Acknowledge the condition and its potential to threaten lifestyle

2. Adopt a ‘normalcy’ lens for defining the child and the family

3. Engage in parenting behaviors and family routines that are consistent with normalcy lens

4. Develop a treatment regime that is consistent with the normalcy lens

5. Interact with others based on a view of the child and family as normal

From: Primary Care of the Child with a Chronic Condition 5th Edition; Allen, Vessey and Schapiro; Chapter 5 pg 79
Building Resiliency increases effective self management and autonomy

Resilience is the dynamic process of positive adaptation in the context of significant stress.

Resiliency is constructive behavior patterns and functional competencies that families demonstrate under difficult circumstances.

Family to family connection greatly promotes resiliency!
Recognize and manage stress

• Distress emerges with unsuccessful attempts to cope with stress.

• Stressors for families with CYSHN are considerable and on-going.

• Therapeutic partnerships acknowledge, authenticate and reduce stress.

• Sharing with other families with CYSHN reduces stress through commonality
Characteristics of Family Stress

Sudden Onset
Instability in course of condition
Functional limitations
Visibility of condition*

This is why we have a requirement that the CaCoon family be contacted within 10 days of referral
Measures of Value for CaCoon

- Family value for the service
- Effective Professional Collaborations
  - Nurse confidence and competence
- Documentation which supports the work
- Youth with special needs who transition successfully to community life
Measuring Outcomes

Why do we need nurses?

• How OCCYSHN uses CaCoon data

• Every few years OCCSYHN surveys families about CaCoon

• What you put in ORCHIDS matters

• Demonstrating CaCoon nurse effectiveness for children with special health needs.
% of Clients Assessed

- Injury: 71%
- Oral Health: 72%
- Smoking: 70%
- Well Child Care: 75%
- Parenting: 79%
- Chronic Condition: 86%
- Community Resources: 88%
- Nutrition: 89%
- Access to Care: 90%
- Basic Needs: 89%
- Child Development: 91%
- Medical Home: 91%
- Total assessed: 96%
CaCoon Data – Client Interventions

<table>
<thead>
<tr>
<th>Interventions for Clients with an Identified Need</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>95%</td>
</tr>
<tr>
<td>Oral Health</td>
<td>90%</td>
</tr>
<tr>
<td>Smoking</td>
<td>61%</td>
</tr>
<tr>
<td>Parenting</td>
<td>96%</td>
</tr>
<tr>
<td>Chronic Condition</td>
<td>93%</td>
</tr>
<tr>
<td>Community Resources</td>
<td>97%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>95%</td>
</tr>
<tr>
<td>Access to Care</td>
<td>96%</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>99%</td>
</tr>
<tr>
<td>Child Development</td>
<td>93%</td>
</tr>
<tr>
<td>Medical Home</td>
<td>80%</td>
</tr>
<tr>
<td>Total intrv</td>
<td>98%</td>
</tr>
</tbody>
</table>
Nutrition

Assessment:

- Does the child meet body requirements relative to the child’s condition?*
- What are the outcomes of your intervention(s)?
- How has this changed overtime?

Intervention:

- Individual Teaching
- Nutrition Care Plan
- Breastfeeding Assistance
- Case Management
- Infant Cues
- Nutritional Monitoring
- Feeding Interventions
Assessment:

- Does the child demonstrate physical and emotional progress towards age-appropriate and milestones relative to the child’s condition?
- What are the outcomes of your intervention(s)?

Interventions:

- Individual Teaching
- Case Management
- Screening
Family Knowledge of Chronic Condition

Assessment:
- Is the family knowledgeable of their child’s condition?
- Have your interventions helped the family to better understand their child’s condition or better care for their child?

Interventions:
- Case Management
- Individual Teaching
- Teaching: Disease Process
- Normalization Promotion
- Child Health Assessment
- Family Assessment
- Parenting Promotion
Access to Medical Care

Assessment:
- Does the family have access to treatment appropriate for their child’s condition?
- Have your intervention(s) helped this issue?
- Has access over time?

Intervention:
- Individual Teaching
- Case Management
- Health Systems Guidance
Assessment:

- Is the child up-to-date on well-child care?
- What impact(s) has your intervention had since the last visit?

Interventions:

- Individual Teaching
- Case Management
## ORCHIDS Reporting - Quality Improvement

### Client Assessments (New clients with 3+ visits)

<table>
<thead>
<tr>
<th></th>
<th>Current %</th>
<th>Target % FY 2013</th>
<th>Target % FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>89%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Child Development</td>
<td>91%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Home</td>
<td>91%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Well Child Care</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Access to Medical Home</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Parent Knowledge of Chronic Condition</td>
<td>86%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 3.1 How the Nursing Process Occurs in Home Visits

<table>
<thead>
<tr>
<th>Home Visiting Components</th>
<th>Nursing Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation Phase</strong></td>
<td>Assessment and Diagnosis</td>
</tr>
<tr>
<td>- Introduction</td>
<td>- Individual and family assessment</td>
</tr>
<tr>
<td>- Determine purpose of visit and visit activities with client</td>
<td>- Strengths-based assessment—protective factors identified</td>
</tr>
<tr>
<td>- Engage in social conversation</td>
<td>- Resources identified</td>
</tr>
<tr>
<td>- Assessment</td>
<td>- Health risks and active health problems identified</td>
</tr>
<tr>
<td>- Identify and state client’s problems</td>
<td>- Unmet health needs identified</td>
</tr>
<tr>
<td><strong>Working Phase: Identification</strong></td>
<td>Planning and Implementation</td>
</tr>
<tr>
<td>- Client asks questions and identifies nurse as someone who can help</td>
<td>- Mutual planning, priority setting, goal-setting</td>
</tr>
<tr>
<td>- Client identifies problems</td>
<td>- Primary interventions used are health teaching, counseling, referral and follow-up, and advocacy</td>
</tr>
<tr>
<td>- Nurse provides health teaching, support and counseling, follow-up assessment, referral, and advocacy</td>
<td><strong>Implementation</strong></td>
</tr>
<tr>
<td><strong>Working Phase: Mutual Relationship</strong></td>
<td>- Primary interventions used are case management, health teaching, counseling, collaboration, and consultation</td>
</tr>
<tr>
<td>- Client uses nurse as resource and accesses community resources</td>
<td><strong>Evaluation</strong></td>
</tr>
<tr>
<td>- Nurse engages client in mutual problem-solving</td>
<td>- Evaluation of outcomes: outcomes met, partially met, or not met</td>
</tr>
<tr>
<td><strong>Resolution and Termination</strong></td>
<td>- Replan—change in goals, outcomes, and/or interventions</td>
</tr>
<tr>
<td>- Problems solved or ongoing but stable</td>
<td>- New priorities or emerging problems identified and nursing process continues</td>
</tr>
<tr>
<td>- Client becomes independent of nurse or continues to need support</td>
<td></td>
</tr>
<tr>
<td>- Relationship ends when client no longer needs nurse or no longer participates in plan (moves or refuses participation in plan or visits)</td>
<td></td>
</tr>
</tbody>
</table>

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Source: Adapted from McNaughton, 2005
Next Steps:

• What do you need to provide CaCoon services?

• What further supports do you want?

• Have your CaCoon coordinator send those needs to Matt @ gonzam@ohsu.edu
Questions and Answers

• Do you have questions?

• Comments?

• Share your county’s standard nursing care plans
OCCYSHN Staff

OCCYSHN Director:
• Marilyn Hartzell M.Ed

CaCoon Consultant:
• Candace Artemenko RN, BSN

Administrative Assistant:
• Matthew Gonzalez, B.A.