
One Plan

Directions and Guidelines
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Children's Integrated Services

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One Plan: Directions and Guidelines

Introduction:

The One Plan is a vehicle for developing a comprehensive and individualized child and/or family plan with the goal of supporting family's competence and competency. Towards that end, the One Plan reflects the work of all team members in order to scaffold and reinforce the family's capacity for achieving their goals. This ultimate goal of empowering families to build their capacity is met by a single integrated plan, regardless of how many disciplines are involved or how many family members are receiving services. Building a single integrated service plan acknowledges that families have limited resources. By identifying family priorities through the One Plan, families experience and continue to build on their success.

The One Plan is both a process and a product. It is a process that begins with the referral and initial family contacts, and ends when the family transitions from CIS services. At each stage of this process, the family should be an integral member of the team. During the One Plan process, team members help the family identify their resources, gather information that is pertinent to the family's identified concerns, and integrate family information into a summary that will lend itself to the development of a plan that is both responsive and practical.

The actual plan is really a component of the One Plan process (Section III). It is comprised of a prioritized list of family concerns, measurable outcomes and strategies addressing family's concerns and a grid that specifies the 'who, what and where' of services. A Plan Review examines the family/team's progress toward outcomes so that outcome strategies can be modified to insure family success.

There are several questionnaires and interview forms in the One Plan (e.g., Adult and Child Health forms, Developmental Interview). Although they appear as a structured interview or as a form to be filled in by family members, these forms are meant to be used as a guideline for an informal discussion with families. Additional questions may be asked depending on the referring concern, and for clarification or follow-up.

In gathering information, it is expected that the various disciplines will need to collect additional data. For example, mental health will need to conduct a mental health status, subsidized child care will need to complete the Family Support plan, Early Intervention will need a developmental evaluation, etc. These additional evaluations are not only a requirement of the respective agencies but an important tool in discovering family strengths and areas of need that will ultimately help families realize their goals. Tools that generate confidential information should be kept separate from a family's One Plan file and at the primary provider's agency.

The following pages list each section of the One Plan process with their accompanying components, including descriptions and guidelines for completing the One Plan. Under each stage there is a section labeled Toolbox – this section refers the reader to supportive documents for the One Plan. As feedback comes in, this document will be changed to reflect our growing understanding of what is meant by an integrated service plan that is responsive to and successful for families.

I. Identification:

Referral and Intake

Referral: see Form CIS-01

Intake: see Form CIS-02

Insurance Information: Form CIS-02 supplemental

Authorization: see form CIS-03

II. Information Gathering & Summary:

Screening, Assessment and Eligibility Determination

Purpose/Function:

- To gain a thorough understanding of the family's concerns.
- To begin relationship-building with the family and engage family members as partners in the information gathering process.
- To identify a family's resources, including sources of emotional and material supports.
- To gather and organize health information (including medical, physical, and social) from parents, health care providers and other sources, and to consider the impact of these factors on family functioning
- To gather and organize data from previous screenings and assessments.
- To conduct family interviews, child screenings and assessments as indicated
- To integrate all pertinent data into a summary

Notes:

1. The 'Consent for Evaluation' needs to be signed during the first home visit.
2. Typing the name and date into the footnote on the first page should copy to following pages. Use name that works for your agency (e.g., client's last, first name, child/family/pregnant mother's name, etc)

Family Resources and Supports

Completion: Although this form needs to be completed prior to the summary, it does not need to occur prior to the health information forms.

1. **Information provided by:** Enter the name of the family member who is giving information regarding the family's social network and the date the form was completed.
2. **People who are important or helpful to me/my family (including extended family members, family friends and neighbors, people from place of worship, school, child care, medical facilities, ...).** Use Ecomap (see toolbox for directions) or another strategy (e.g. – systems map) to identify sources of support and stresses in a family's day-to-day life with their social network. The Ecomap or similar tool will help the team gain an understanding of the family's ecology or the constellation of the people in a family's life and their role in supporting (or potential stressors to) family functioning.

Adult Health Information

Purpose/Function:

- To gather information about the health of the postpartum or adult client that has relevance to the adult and family functioning and referring concerns

Completion: This form is only to be used when the client is an adult (e.g., expectant mothers, postpartum families, young parents, parents with developmental disabilities). Not all information needs to be completed during the first meeting but should be completed prior to writing the One Plan Summary. Some topics may be too sensitive for some families to talk about during the initial interview and before trust is established. Note these topics on the form so that you remember to return to them.

A. Pregnancy, Birth and Medical History

Note: Complete this section of the form **only** if the client is a pregnant or postpartum mom.

1. **Describe any notable prenatal, birth or family health history:** List those prenatal/birth events and family health issues that may impact mother's or child's health.
2. **Dates of first pregnancy medical appointment and date of next appointment:** Enter dates of prenatal/postpartum mom's first medical appointment for her current/most recent pregnancy and the next scheduled appointment.
3. **Weight goals during pregnancy, 3 months post-natal, ongoing:** Enter weight goals
4. **Cultural/Family beliefs and activities that are important to me about my pregnancy, child birth and/or parenting**
5. **Actual date of delivery and Obstetrician/Midwife:** Enter postpartum mom's actual delivery date. Enter the Obstetrician's or Midwife's name for both prenatal and postpartum moms.

B. Your Health (only Adult clients)

Note: The second section is for prenatal/postpartum moms and adults who are clients. Adults may be clients when there are parenting concerns of a child from birth through five years, young parents, parents with developmental disabilities, etc.

Child Health Information

Purpose/Function:

- To gather information about the child's health, development and history that has relevance to the child's development and referring concerns
- To gather information about the family that has relevance to the child's development and referring concerns.

Completion: Complete this form if client is a child. Not all information needs to be completed during the first meeting but should be completed prior to writing the Summary. Some topics may be too

sensitive for some families to talk about during the initial interview and before trust is established. Note these topics on the form so that you remember to return to them.

Note: These questions are meant to be incorporated into a discussion with parent(s)/guardian(s) about their child, rather than conducted as a structured interview. Additional questions may be asked depending on the referring concern, and for clarification or as follow-up.

A. My Child's Information and History

- 1. Describe your child's strengths and interests.** Families may need help with this question but it is important to stress to families that we see their child as a whole person – more than just their concerns. To address this item, it might help families to ask what their child is good at, what they like best about their child, to describe the child's personality, whether they like to be inside or outside best, what they enjoy doing with siblings or playmates or the kinds of activities they seem to enjoy the most or if left to select would choose to do. Enter a list of child's favorite activities and favorable characteristics.
- 2. When did your concerns first develop and has your child received any services/treatment?** Responses to this question may have occurred when families were asked to describe their concerns during the intake. Otherwise, possible issues to explore include reviewing concerns the family has given in intake, check when the family's concerns first developed, identify any services and treatments the family has pursued, and what approaches have worked/not worked.
- 3. Describe your child's early development or behavior. Did you have any concerns?** It is helpful to get a picture of the child as an infant and the parent's comfort with the child as an infant – questions could address when the child first smiled, recognized the parent; whether the child liked to be held as a baby; how was the family able to settle the child when upset; whether the infant cried more than other babies as well as typical developmental milestones.
- 4. Please describe any notable prenatal, birth or health history:** The key to this question is to identify issues that may be related to present concerns. General questions about the prenatal period and birth (e.g., describe your pregnancy, how was the delivery), enable the family to identify events that they feel might have impacted their child's development. Also, identify family health issues that might impact child's own health or development.
- 5. Has your child been diagnosed with a physical, intellectual or psychological condition?** Discuss with families any previous diagnoses that were given to child. Enter diagnosis the child has received or NA
- 6. Are there any early life events that could affect your child's development or well-being?** Some topics that may impact a child's development may include the child's childcare history and whether there has been consistency in care, periods of separation from primary caretaker, trauma, or family illness and stress.

B. General Health

- 1. Does your child take any medications on a regular basis, including herbal preparations, over-the-counter drugs, or nutritional supplements?**
- 2. Is your child generally healthy? If your child is sick a lot, please explain your concerns. Date and reason of any hospitalizations.** Include information regarding well-child visits and availability of a medical and dental home.
- 3. Vision and Hearing screenings and age.** Check box to indicate whether a child's hearing and vision were screened or evaluated and indicate the age of the child at testing.

4. **What does your child like to eat? Is there a special diet? Breastfeeding?** Check to see if there is variety in the child's diet and whether the child eats well. What are mealtimes/feeding like?
5. **How does your child nap or sleep at night?** Amount of sleep for child/does child sleep through the night and what are nap/bedtime routines like. For families of infants, are they aware of putting their infant on 'Back to Sleep'?
6. **Are immunizations up to date?**
7. **Is your child exposed/or has your child ever been exposed to alcohol, tobacco, lead or other substances that could affect your child's development or well-being?**
8. **Any concerns about your child's safety?** Concerns about safety may stem from the physical space/set up of the home/child care, the neighborhood, or someone who has close contact with the child.

Summary

Completion: The Summary report is a compilation and integration of all relevant data gathered about the client and the client's family. This report is completed after data has been gathered from primary sources and within 45 days of receiving the referral. Remember to use 'family-friendly' language as this is a summary for families as well as providers.

Note: Comprehensive assessment reports generated by programs that follow a different format may be substituted for the Summary as long as they contain all the required information.

Sources of Information: List names, dates and purposes of assessments/evaluations, observations and interviews; name of providers conducting evaluations; identify reports, including medical reports.

Reason for Referral: (Eligibility/Diagnosis if applicable). This section will be populated by information on the intake form when the data management system is operational. After interviewing families, this section may need to be updated.

Enter all referral concerns given by referring agency and parent(s)/guardian(s), if they were not the referral source. Also, enter any diagnosis the client has received.

History (Health, Family, Social and Developmental)

Describe history (including medical, health, family, social, and developmental) that is relevant to the family's concerns.

Current Status: Includes current Health status –medical, physical and behavioral health, current medications, neurological status, vision and hearing, etc. as is relevant to the family's concerns.

Include family/child strengths and interests.

Observations and Results (Developmental and Behavioral or Health):

This section summarizes the results of data gathered through interviews (e.g. – pregnant/postpartum moms, parents, and other primary caregivers), reports from physicians and other providers, child observations, screenings and assessments.

When children are the primary client include the following sections:

Understanding and Communication (communication skills)

Playing, Thinking and Exploring (cognitive/learning skills)

Expressing and Responding to Feelings, and Interacting with Others (Social and emotional skills)
Using Hands and Moving Body (physical/motor skills)
Eating, Sleeping, Toileting and Dressing (adaptive and self-help skills)

When a pregnant or postpartum woman or parent is the primary client, include the following sections:

Physical and oral health - prenatal/birth/postpartum experiences, childbirth education, work environment

Social-emotional status - postpartum mood reactions, trauma/domestic violence, specialized learning needs, family supports

Nutrition and physical activity - food security and resources, weight gain, level of activity/exercise

Safety, injury prevention, environmental exposures - travel, housing, exposure to chemicals/toxins, substance use, illness

Preparation for parenting - self care, infant care and feeding, adequate resources, cultural/family ways

Summary (ECFMH - Interpretive Summary):

The summary should integrate the relevant results/findings presented throughout the report rather than restate the findings, identifying how the various factors in the client's life might contribute to the findings or are related to one another.

Recommendations:

Signatures: All practitioners who participated in the assessment/evaluation process should sign, give their credentials and date.

Toolbox – Supplemental Forms

Note: Providers from the various CIS programs are expected to complete additional child screenings/assessments and family interviews during the Information Gathering process (Section II) that are related to presenting concerns.

Ecomap Process

Guide for Child Development Interview

Guide to parent interview questions that address child's current development and functioning in 5 developmental domains.

Family Support Applications

Note: This application is only available as hard copy.

The Family Support Application should be used when subsidized child care is identified as a need upon referral. Currently, this form can take the place of the Information Gathering section (Section II) of the One Plan. If a family is found eligible and is in need of additional services then the team will need to complete a plan for the family, consisting of the Section III documents, including the Family Resources, Concerns and Priorities, Family Outcome pages and the Service Grid.

Diagnosis and Eligibility Determination

These forms are specific to CIS: EI and CIS: ECFMH

One Plan Cover Page

Home Visit Notes

Our Family and Child's Transition Plan for CIS: EI

Development of Plan:

Individualized Goals and Outcomes

Purpose/Functions:

- Develop an integrated service plan for the child's and/or family's services, based on family identified concerns and the team's assessment results as expressed in the Summary.
- Engage the family in reviewing their strengths and resources, major concerns and priorities.
- Engage the family as an active partner in the development of a plan that addresses their priorities.

Family Resources, Concerns and Priorities

Completion: This form should be the first form completed in the 'Development of Plan' section.

1. **Family Resources.** Identify the child and/or family's resources as gleaned from family interviews, the ECOMAP and observations. Resources can include specifics about their support system (e.g., good relationship with primary physician, supportive extended family nearby, grandparent is available to care for children), specific abilities (e.g., Dad enjoys carpentry) or resources (e.g., reliable transportation, backyard, library nearby) or family/individual strengths (e.g., parents gave up smoking while pregnant, family enjoys camping together). This section could be populated from previous sections and elaborated on if necessary.
2. **Reason for Referral.** This section will be populated with info from the referral/intake forms when data system is in place. For now, enter reasons for referral (including a diagnosis) identified by the referral source and family. Also, enter diagnosis or reasons for eligibility identified through the assessment process.
3. **Family/Child Concerns and Priority.** List concerns and needs that the family has identified during the intake and information-gathering process, using the family's language. Check with the family to insure that all the concerns have been accounted for (including those that have come up in the course of the assessment) and check to make sure the concerns are accurately stated. Prioritize concerns according to family wishes.

For families who are in crisis: families may want to incorporate a goal into the plan about what to do if an emergency/crisis occurs.

Family Outcomes

Completion: Complete a Family Outcomes form for each outcome. This needs to be completed after the Family Resources, Concerns and Priorities form, and prior to the service grid.

1. **Date of Plan.** Enter the date that the outcomes were written.
2. **Outcome #.** Enter the priority number that the family has given to this outcome. The team, including the family, will want to decide how many outcomes they will address during the period before the scheduled review.
3. **Child, Family, Expectant Family.** Check whether this specific outcome is for the child, the family or the expectant mother.
4. **Plan.** Check the appropriate box for the type of plan the outcome was written for:
 - interim (occurs occasionally for CIS:EI families only),
 - initial (the first plan developed for the child/family at entry into services),
 - review (check if this outcome was written as a result of a required periodic review, every 6 months or more often as needed by family, or a plan change as needed by family/child.)
 - annual review (check if this is an annual review – required for EI), and
 - transition (check if this is an outcome identified during the transition process).
5. **We want:** Identify what the family wants to have happen – their goal, written in the family’s own words.
6. **So that:** identify what will happen as a result of attaining this goal/outcome, or the purpose of this goal/outcome.
7. **Activities and Strategies and Who, When and Where:** List the activities or strategies that the family and team will implement to reach the family’s goal. Remember to utilize family resources wherever possible rather than just relying on provider services. Identify who will implement the strategy, when and where the activity or strategy will occur. Examples:
 - 1) Family wants their child to talk more and say the names of farm animals since the family owns a farm:
 - Activity - sing songs with child, related to animals and sounds
 - Who – Dad and service provider (give names of service provider &/or title) will identify songs Dad and child can sing together
 - When & Where – Dad and child will sing songs together every night during bath time and during weekly truck ride to grandpa’s farm
 - 2) Family wants to make sure their toddler has healthy teeth
 - Activity – Helping toddler care for his/her teeth
 - Who – parent or other caregiver and service provider will identify ways (e.g., songs, games, tools) so toddler can help take care of their teeth
 - Where and when – parent and toddler will brush teeth together using identified strategies right after bath during bedtime routine
8. **How will we know we are successful?** Describe what the outcome will look like when it is accomplished, including the criteria (How will the team measure progress towards this outcome? What does the team need to observe to be satisfied that the outcome is accomplished?)
9. **Review Date:** Enter the date when progress towards the outcome will be reviewed.
10. **Date Reviewed:** Enter the actual date when the outcome is reviewed
11. **Outcome Review:** Describe the progress made towards the criteria established for a successful outcome.
12. **Status:** Check whether the outcome has been achieved (if criteria reached), continued (if the team, including family, determines the outcome needs more time/work to be fully realized – in this event, strategies should be reviewed and modified as needed) or change outcome/activities* (the team has decided that the outcome itself needs to be modified – in this event complete a new outcome form).

Services Grid

Completion: The Service Grid follows outcome development and is completed along with the ‘Consent for Initiation of Services’ prior to beginning services.

First Grid: This grid shows details about the services that the family will receive. Many of these items will have a drop-down list in the data management system.

- 1. Supports and Services:** Identify the type of service, e.g., nursing, family supports, developmental education, physical therapy, mental health) that address each outcome.
- 2. Outcome:** Identify the priority number of the outcome(s).
- 3. Qualified Provider’s Title**
- 4. Location:** (e.g., home, child care, clinic, school, hospital, etc).
- 5. Natural Environment:** A natural environment is one in which children and families usually spend their days or are part of their typical activities and routines. Write ‘Y’ if the service is provided in a natural environment (home, child care), ‘N’ if it is not (clinic). Note: CIS: EI needs to have a justification if services are not provided in the natural environment.
- 6. How Often?** Enter how many visits/contacts will occur per month.
- 7. How long?** Enter how long each visit/contact will be each month.
- 8. Planned Start Date:** Enter when services/supports are planned to begin.
- 9. Actual Start Date:** Enter when the service/support actually begins

Second Grid: This grid will identify the family’s immediate team members as well as those who will provide consultation.

1. Have all team members who have helped with the assessment and development of the plan sign and date this form.
2. **Physician’s Signature:** Physician’s signature as appropriate.

Consents

Purpose/Function:

- To ensure families are informed participants during each stage of the Integrated One Plan process
- To support family participation and decision-making throughout the One Plan process

Notice and Consent for Evaluation: This should be signed during the first visit with the family.

1. Identify any specific screenings, assessments or evaluations that you and the family have identified, as well as their purpose.
2. Family will check whether they approve and sign and date the form.
3. This form can be used again at initiation of services.

Consent for Initiation/Change/Continuation of Services: This form should be signed at the meeting when the family’s Plan (Outcomes and Service Grid) is developed.

1. Add names and contact information for the family’s service coordinator and intake coordinator prior to the meeting.

2. CIS: EI families will need to check the first box to demonstrate they have received and understand their rights. Point out parental rights and safeguards specific to this stage in the One Plan process.
3. Families can check more than one of the following boxes
4. Families should have a copy of their consent forms. This consent is particularly important for them to have as it identifies and give contact info for their service coordinator and intake coordinator. Families should be informed that they can call either of these persons if they have a concern about services or a complaint.

Toolbox – Supplementary Forms

Cover page (sample)

Service Delivery

Plan Review

Completion: Each agency has its own requirements for when a Family’s plan should be reviewed. Please follow that review schedule. Revised Priorities (when applicable), Family Outcome form(s) and the service grid need to be completed. This form is a brief version of the Summary report.

1. **Reason for Review:** Check whether this is a planned review (regularly scheduled periodic review), annual review (regularly scheduled annual review), or Change in Services/Update/Referral (requests for additional services within CIS or another agency, team review or consultation to address additional family issues, or lack of progress on current outcomes).
2. **Date:** Enter date of the review
3. **Sources of Information:** Identify sources of information that have occurred since the most recent Summary report.
4. **Current Status:** List current services, important sources of support, changes in family living situation and health status.
5. **Results of Screening/Evaluation/Observations:** Organize and describe the important changes since the last report, including both areas of success, and areas that are emerging or are concerns.
6. **Summary:** Briefly integrate findings from the previous sections.
7. **Recommendations:** Identify those areas that as a result of the team’s review are in need of continued or additional services.
8. **Signatures** of the providers who participated in the One Plan evaluation and review.
9. Complete new/revised Family Outcomes pages, Service grid and Family consent for change in services.

Toolbox - Supplemental Forms:

Home Visit Notes

Providers can use their own format that should at least include the following:

- ✓ Date
- ✓ Type of activity – phone call, team meeting, consultation, home visit
- ✓ Participants
- ✓ Brief description of activity
- ✓ Next steps as appropriate

III. Transition/Exit

Purpose/Function:

- to identify next steps for a family when services are changing
- provide the family with necessary services, resources and supports for their transition
- facilitate sharing of information between sending and receiving agency/service provider
- engage the family in the transition planning process and address any concerns about the transition.

Completion: Planning for transitions should be initiated during program entry and reviewed at regular intervals. This allows the family and team to periodically reframe expectations and prepare for programming changes while working on current goals. When possible, a Transition Plan should be begun at least 3 months in advance of the transition date. Transitions occur for children/moms/families that are leaving CIS services, or CIS: EI families when the child turns 3 (although other CIS services may continue). During the Transition phase, the Plan Review (update of child/mom/family status), and Family Outcome(s) need to be completed. The Transition grid will take the place of the Service Grid.

Note: CIS: EI is responsible for completing the Part C Transition plan as required by Federal law. We are currently working on consolidating these forms.

Transition Plan

1. **Date of Plan/Actual Transition Date:** Enter the date the transition plan was begun and date of transition from services.
2. **Reason for Transition:** Check
 - a. child turn 3 (CIS:EI only) and identify EEE contact, if applicable at bottom of box
 - b. child turns 6 (when CIS child services end),
 - c. no longer needs services (child/mom/family has reached goals),
 - d. change of primary service provider (primary service provider change within CIS or to an agency outside CIS),
 - e. family withdrawal from services (other than moving or no longer in need of services - give reason for withdrawal),
 - f. move out of state/region (give place of relocation),
 - g. unable to contact family/client (document attempts),
 - h. other
3. **Outcomes and Priorities:**
 - a. Identify family Resources and Strengths
 - b. Identify family Hopes and Current Concerns and Prioritize
4. **Transition Plan**
 - a. Steps and Supports needed, Persons Responsible/Date to be completed/Outcome
5. Attach an updated summary of recent assessments

Toolbox - Supplemental Forms:

Our Family and Child's Transition Plan for CIS: EI n