

**Assessment**

1. Match each description with the appropriate domain.
	1. Screening, Identification, and Assessment. Description #:\_\_\_\_
	2. Shared Plan of Care. Description #:\_\_\_\_
	3. Team-Based Communication. Description #:\_\_\_\_
	4. Child and Family Empowerment and Skills Development. Description #:\_\_\_\_
	5. Care Coordination Workforce. Description #:\_\_\_\_
	6. Care Transitions. Description #:\_\_\_\_

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| 1. Provides the foundation for effective, high-quality care coordination. Assessment is a continuous process that reflects ongoing conversations with CYSHCN and families about their needs, preferences, and priorities.
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| 1. Refers to the transfer of care between and within medical, behavioral health, social service, education, and justice systems.
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| 1. Communication between members of the care team is timely, efficient, respectful, and culturally sensitive.
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| 1. Care Coordination includes education, coaching, and training for CYSHCN, families, and care teams. This includes providing resources and advocating for and with CYSHCN and their families.
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| 1. Well trained and prepared to serve CYSHCN and their families. All care team members have opportunities to gain the knowledge needed to perform their roles effectively.
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| 1. Provides a roadmap and an accountability system for integrating care based on family needs and priorities identified in the assessment and is used in coordinating a child’s care.
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1. Fill in the blank: The life course perspective or life course theory (LCT) is a multidisciplinary approach to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, which incorporates both life span and life stage concepts that determine the health trajectory.
	1. Learning
	2. Achieving developmental milestones
	3. Care planning
	4. Understanding the mental, physical, and social health of individuals
2. A whole person health approach for CYSHCN and their families is an important aspect of achieving the goal that CYSHCN enjoy a full life from childhood through adulthood and thrive in a system that supports their families and their social, health, and emotional needs, ensuring their dignity, autonomy, independence, and active participation in their communities.
	1. True
	2. False
3. What are strategies to improve access to PDN services. Select all that apply.
	1. Offer coaching and education to families to help them improve their communication skills with home health agencies and nurses.
	2. Connect families to family advocacy and peer organizations that have lived experiences navigating home health agencies and working with nurses in their homes.
	3. Consider alternatives to offer the parent(s)/guardian(s) (e.g., exploring PPECs or new home health agencies).
	4. Encourage families to move to better coverage areas.
4. What are three ways that care coordinators continuously seek to identify the changing and new needs of enrollees and their families? Select three options
	1. Sending handouts in the mail
	2. Frequent interactions
	3. Assessments
	4. Care Plans

Key

* 1. 1
	2. 6
	3. 3
	4. 4
	5. 5
	6. 2
1. d
2. a
3. a, b, c
4. b, c, d