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Pediatric Needs Assessment

Member Name: **Responder's Name:** **Relationship to Member:** **Member Healthcare ID:** **DOB:** **State:**	**Cell Phone: ( )** **Other: ( )** **DATE: / /**	

	QUESTION	RESPONSE	Talking Points
1	*Date Of HRA:	Date Field	*Based on member's individualized needs and preferences, MCP trained staff will use the following talking points to assess member's safety, medical, behavioral health, cognitive and functional needs.* *Healthcare Services Staff are asked to use their expertise to explore where appropriate when questions warrant further probing. Talking points serve as a guide to meet the member where they are at and identify the needs and preferences. All talking point outcomes that contain* ***pertinent positives*** *should be recorded in section 20.*
2	Assessment method:	**Drop Down**: Telephonic/ Mailed /In-person/ Portal/ Other	
3	Assessment Type:	**Drop Down**: Initial Assessment/ Reassessment/ Change in health status	
4	Do you or your child have a language need other than English? If other, describe:	☐Arabic ☐Creole ☐French ☐Mandarin ☐Russian ☐Somali ☐Spanish ☐Vietnamese ☐Other ☐Sign language	**Probe on needs related to language:** • Example- Written vs Spoken needs • Document whether there is a family member or proxy to translate or member request to use language line • If not reflected in systems, update per protocol.

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5	DOES YOUR CHILD need assistance with any of the following areas that you feel they should be able to do themselves at this age? If other, please list/describe	☐ Bathing ☐ Grooming ☐ Dressing ☐ Oral Care ☐ Feeding ☐ Toileting ☐ Continence ☐ Transferring ☐ Hearing or communication device ☐ None ☐ Other	Probe if child **needs** assistance: • with any of the areas listed. • DME/Home Care • Financial and socioeconomic needs • Transferring is anything to do with movement (ie Ambulation)
6	Does your child or family have any special preferences that we should be aware of? If other, describe.	☐ Cultural preference ☐ Fear of strangers ☐ Religion/Spiritual needs or preferences ☐ Time Constraints ☐ None ☐ Other	• **Probe on Cultural, Physical, Spiritual and Literacy needs and preferences:** How is member is able to navigate their needs in the Physical, BH and LTSS domains to ensure needs are met and understood? • What are their strengths in these areas • Any unmet needs that need to be addressed that will impact ability to get medications, medical tx, BH care or LTSS? • Document all findings in section 20.
7	What is your child's main health concern right now? What is your main concern for your child right now? What worries you the most as a parent/guardian?		**Probe on health or safety concerns**: • Any recent falls, injury or Trauma? • Document findings and address needs in care plan and with member.

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8	Does your child have any of these diagnoses/conditions?	☐ ADHD ☐ Asthma ☐ Autism ☐ Behavioral Health Conditions ☐ Bipolar Disorder ☐ Depression ☐ Psychotic Disorders (Schizophrenia) ☐ Substance Use Disorders ☐ Cancer including past history ☐ Respiratory with oxygen ☐ Type I Diabetes ☐ ESRD ☐ Heart Failure ☐ HIV/AIDS ☐ Intellectual/ Developmental Disabilities ☐ Liver Disease ☐ Teen Pregnancy ☐ Pain – does child identify any pain issues on their body or a toy/doll ☐ Add the following: ☐ Sickle cell disease ☐ Cerebral palsy ☐ Cystic fibrosis ☐ Eating disorder ☐ NICU graduate ☐ Spina bifida/neural tube defect ☐ Other ☐ None	**Probe on physical and Behavioral Health conditions and related special needs member may have:** • Use clinical guideposts as appropriate-inquire about connection to services, medication and other areas of clinical criteria (BH, CHF, COPD, DM, HIV/ AIDS) • Describe conditions and typical tx to help members understand question where needed • SUD- give an example such as smoking, alcohol or use of controlled medications not prescribed by a physician. Inquire whether member would like to quit?
9	Does you child have any special dietary needs?	☐ Yes ☐ No If yes, describe:	Are there concerns about your child's weight? Do you have concerns about feeding, chewing and/or swallowing?

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10	Compared to other children your child's age, would you say his/her health is…..?	☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor	If **fair** or **poor**: • Inquire on Caregiver or informal supports • Quality of life Chronic Conditions –introduce Discussion around possible pain/ palliative care needs as warranted by member needs and preferences
11	Is there any activity that your child is unable to do that other children his/her age can do?	☐Free Text	
New	What type of school does your child attend?	☐ Does not yet attend school ☐Public ☐Public school with Special Needs Classroom ☐County DD School ☐Charter ☐Home school ☐Community School ☐Preschool/Head Start ☐Special Needs Preschool ☐Attends daycare ☐Other: _____	
12	Do you worry about your child's progress in school? Is your child on an Individualized Education Plan?	☐ Yes ☐ No ☐ N/A ☐Free Text IEP ☐ Yes	If yes: • System for tracking med? • Caregiver/ or informal supports? • MD appointment , school supports • Probe IEP functioning well for the child • Probe if problems in reading level, difficulties with learning, hearing, vision, etc.

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		☐ No ☐ N/A ☐ Free Text	
13	Has your child visited the Emergency Room in the past 6 months? If yes, how many visits? Reason for visit: Has your child visited an urgent care in the past 6 month? If yes, how many visits? Reason for visit?	☐ Yes ☐ No ☐ Free Text	If yes: • Probe on whether member was admitted • Determine if urgent care center information is available to member and warm transfer to member services as needed.
14	Has your child stayed overnight in the hospital in the past 6 months? If yes, how many visits? Reason for visit:	☐ Yes ☐ No ☐ Free Text	If yes: • Probe on admission dx • Determine whether member understands S/S red flags (use clinical guideposts as appropriate) • Verify that member is seeking ongoing ambulatory care with most important provider(s)
15	Do you have a list of all of your child's medications? Do you know why your child is taking them?	☐ Yes ☐ No ☐ N/A ✔ If no, recommmend "Brown Bag" medication intervention with PCP	If no: • • Ask and coach on where the meds are kept and are they safely out of reach of the child? • Coach on putting all medications in a bag and have them take to PCP office. Ask them to have PCP/ nurse in PCP office to review each medication and why they are taking. • Make sure that physician appointment is in place.

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16	What is your child's current living situation? Do you feel safe in your home?	☐ Homeless ☐ DELETED LIVES ALONE ☐ Lives in a group home ☐ Lives in a shelter ☐ Lives with other family ☐ Lives with others unrelated ☐ Lives in a Foster care situation ☐ Lives in out of state facility ☐ In a Nursing Facility ☐ None of the above ☐ Child's Room- has own room ☐ Child's Room- shares a room ☐ Other ☐ Free Text	If unstable environment is identified, probe on safety and immediate needs. Opportunity to identify caregiver status/ and/or informal supports as appropriate. Daycare- Probe safe supervision/ child's safety at daycare, injuries, etc.
New	Do you and/or your child have a child welfare agency caseworker? If yes, what is the reason you have a caseworker?	☐ None ☐ Legal ☐ Children Services ☐ Community Safety Issues ☐ Domestic Violence ☐ Mental Health (parents/caregivers) ☐ Drugs/Alcohol abuse in the home ☐ Other: _____	If child welfare agency caseworker is identified, inquire about environmental and safety concerns
17	Over the last 2 weeks, how often has your child had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day	Validate tool- 3 or greater requirement for Phq9 in level 1 Probe school experiences- any grade changes, school changes that could affect mood or mental status
18	Over the last 2 weeks, how often has your child been feeling down, depressed or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day	Validate tool- 3 or greater requirement for Phq9 in level 1 Probe school experiences- any grade changes, school changes that could affect mood or mental status Probe about child's "mood" problem or if depressed or anxious, difficulty sleeping, difficulty concentrating

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19	In the past, has your child ever thought about harming him/herself? Does your child currently have any thoughts about harming his/herself? Have they talked about a plan?	☐ Yes ☐ No ☐ Yes ☐ No ✔ 1. Keep the member SAFE by keeping them on the phone 2. Verbalize your desire to assist the member 3. Signal to co-worker for help without going on hold 4. Employ immediate assistance from a first responder (911 etc.) 5. Follow the Crisis Policy	
20	Any other areas of concern related to your child's health? Is there anything that I did not ask you that you would like me to know?	Free Text Field	This question allows for CM willingness to change and impactability as well as self-determination.
21		Free Text Field **(Open Field for CM staff person)**	
22		Free Text Field **(Open Field for CM staff person)**	
23	Do you receive help at home caring for your child because of his/her health problems? Are you receiving the help that you need? Does your child receive SSI?	☐ Yes ☐ No SSI ☐ Yes	

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		☐ No	
24	Does your child see the Doctor regularly for things like Well Child Exams? Immunizations up-to-date? Flu shot?Hearing and vision tests? Dental exam? When was your child's last visit?	☐ Yes ☐ No ☐ Free Text	• A "yes" indicates compliant with all listed areas • Free text box to be used to note areas of non-compliance
25	Are you using any community resources?	☐ Meals on Wheels ☐ Food Bank ☐ Food Stamps ☐ WIC ☐ Free Clothing Store ☐ SSI ☐ Disability ☐ Legal Services ☐ Support Groups ☐ Transportation ☐ Counseling Services ☐ Housing ☐ Utility Services ☐ None ☐ Other: _____	Do you need information on additional community resources?
26	Would you be willing to work with me on the needs that you have identified today?	☐ Yes ☐ No	Working on the identified needs Action statement for the member to be involved in the plan.

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	Would you be willing for me to share this information with other members of care team? (Case Manager, doctors, providers, etc)	☐ Yes ☐ No	When would if be convenient for me to call you next. Confirm your PCP/Pediatrician Confirm their demographics – remind to update