CIS SEMI ANNUAL REPORTING GUIDANCE FOR CALENDAR YEAR 2020 HALF 2

Reporting on data between July 1, 2020 and December 31, 2020

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Performance Measure Guidance

Introduction: CIS Semi-Annual Data Report Guidance

PURPOSE

This document provides guidance to regional partners for the collection, analysis, and reporting of the data used to generate the Children's Integrated Services (CIS) semi-annual report for Calendar Year 2020 Half 2. The CIS Semi-Annual Report aims to tell the story of CIS by summarizing qualitative (regional narratives) and quantitative (performance measures) data and identifying both themes and trends regionally and statewide. Data submitted to the State should reflect *only* information regarding CIS clients and service providers and exclude data pertaining to other services accessed by families in conjunction with CIS.

IMPORTANT REMINDERS

Technical Assistance

If you have questions after carefully reviewing this guidance, or are experiencing issues with the reporting template, please don't hesitate to contact your state Technical Assistance Liaison for additional support. The State team may also be able to support training for field staff in your region responsible for providing data when needed.

Standard Reporting Template

Please don't change the template! Using the standard reporting template without any adaptations is necessary to streamline data collection across regions and enhance information quality and consistency. This includes adding or removing columns and/or rows, changing the wording of a heading, *or in any way altering the template*. If you need to add any information or footnotes to the data you have provided, please utilize the Notes tab on the data template. The template can be found here: https://cispartners.vermont.gov/sites/cis/files/Tools/Semi-Annual_Performance_Measure_Template.xlsx

Standard Data Across CIS

Please report each measure broken down by service area. This will allow us to look at performance across service areas and will allow us to see population-level data.

Report Submission

The State provides two templates to the field to be completed and submitted for semi-annual reporting. These include:

CIS Semi-Annual Data Template: This is an Excel spreadsheet capturing raw numbers for four performance measures, with guidance for each outlined in this document. Numbers must be entered for all cells highlighted in yellow.

CIS Semi-Annual Narrative Template: This is a Word document with space to answer the following questions:

1. What has worked well in CIS? Why did it work well? Please list each item separately and add as many additional rows to table as needed. Provide at least one family story for this section that illustrates something that worked well.

2. What hasn't worked well in CIS? Why didn't it work well/what were the barriers? Please list each item separately and add as many additional rows to table as needed. Provide at least one family story for this section that illustrates something that didn't work well.

3. Please report any novel, innovative and successful initiatives taken in any arena rather than enumerating outreach activities.

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Performance Measure Definitions- Defining the Client

The table below provides guidelines for determining which clients should be counted in the specified categories.

CIS Client	An eligible child, pregnant person, parent up to 2 months post-partum, or a childcare program receiving supports or services through CIS.
Referrals	All clients for whom a referral was received for any CIS Service on or after the first day of the reporting period. A referral date is defined as the date that it was received by the CIS Coordinator or the CIS staff person/service provider. A referral should be counted when they are for an individual, family, or child care provider who is not receiving any active CIS services at the time of the referral, even if they did previously. Referrals that are made from CIS Programs to other CIS Programs internally by the CIS Team (also known as Intra-agency referrals) are not counted as new referrals for the purpose of this Semi-Annual report. CIS Contracted and MIECHV funded CIS services are considered internal referrals- everyone else is an external referral source. External referrals include FSD, CSHN, Head Start, MCH/WIC, CCFAP, etc..
Initial Contact	All clients for whom a referral was received for any CIS Service on or after July 1, 2020 who were followed up on with the client/family/childcare program to engage services. The purpose of Initial Contact is to explain the CIS services to determine what the family's needs are and why they

	were referred in order to determine which CIS service will be the best fit.
Screening/Evaluation/Assessment	All clients for whom a referral was received for any CIS Service, who were open for service at any time between July 1, 2020 and December 31, 2020. This includes all referrals for early intervention where the evaluation/assessment did not identify a delay (NOPR)
Initial One Plan	All CIS clients who: • were open for service at any time between July 1, 2020 and December 31, 2020, and • have a signed One Plan approved by the client/family/childcare program CIS One Plans are comprised of at least: • CIS 01 Referral Form • CIS 02 Intake/ Family Support Supplemental Form (where applicable) • CIS 03 Authorization • an outcome that references the hopes and aspirations of the family. If the family or child has an existing plan with mental health, their primary care provider, or Family Services, the CIS Primary Coordinator is responsible for strategies that support the child/family to be successful with their existing plan. In cases where there isn't another plan the family is functioning under, then a full CIS One Plan must be completed. • A service grid that identifies the services that CIS is providing. • Parental consent for the services CIS is providing.
Services started no later than 30 days from a signed One Plan	All CIS Clients who: • have a signed One Plan open for service at any time between July 1, 2020 and December 31, 2020, and • the client/family/childcare program have consented to a new service added to the signed One Plan between July 1, 2020 and December 31, 2020,

6 Month Review	All CIS Clients who: • have a signed One Plan open for service at any time between July 1, 2020 and December 31, 2020, and • who are active for 6-months from the date of their last signed One Plan and the anniversary of that 6 months is between July 1, 2020 and December 31, 2020.
Annual Review	All CIS clients who: • have a signed One Plan open for service at any time between July 1, 2020 and December 31, 2020, and • who are active for at least 12 months from the date of their last signed One Plan and the anniversary of that 12 months occurs between July 1, 2020 and December 31, 2020.
Reason for Exiting from CIS Service	All CIS Clients who: • have a signed One Plan open for service at any time between July 1, 2020 and December 31, 2020, and • end services with CIS at any time between July 1, 2020 and December 31, 2020.

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PERFORMANCE MEASURE GUIDANCE

This section offers definitions and instructions for the collection, reporting, and regional use of each performance measure. Please review closely and reach out to your TA Liaison with any questions.

Performance Measure 1: Increase in the percentage of those served by CIS who achieve one or more outcomes (One Plan goals) by annual review or exit from ALL CIS services, whichever is earliest.

What does this Performance Measure tell us?

This measure shows how effective CIS teams are in serving their clients by capturing the number of clients who achieved one or more outcomes (also known and used interchangeably with 'One plan goals' or 'goals') at their annual review or exit from CIS, whichever is earliest in the reporting period. There are three classification options:

1. One or more outcomes met: The team (which includes the family/client/child care provider) has identified one or more outcome(s) as having been achieved by annual review or exit from CIS.
2. No outcomes met**:** The client/family/child care provider has not achieved any outcomes by annual review or exit from CIS
3. Lost to follow-up: Clients who exit CIS by disengaging, moving or otherwise discontinuing service without notice are included in the 'lost to follow-up' column. 'Lost to follow-up' is defined as a minimum of no contact after three diverse attempts, either by phone, mail or in person.

Who is counted in this measure?

Clients who are active and: have had their annual review between July 1, 2020 and December 31, 2020 OR clients who exited from all CIS services between July 1, 2020 and December 31, 2020.

How is this measure counted when a client is served by multiple CIS Services?

The intent of this measure is to look at the whole plan, so whomever is the primary service coordinator should record this under their service. For example, a client is served by both Early Intervention and Strong Families Vermont Sustained Family Support Home Visiting (PAT) and met at least one outcome at their annual review. The primary service coordinator for them is Early Intervention, so they are counted under the Early Intervention row.

What if the services were delivered in three or fewer visits?

They should be counted only if a plan with an outcome was created and that outcome was achieved. CIS One Plans are comprised of at least:

- CIS 01 Referral Form
- CIS 02 Intake/ Family Support Supplemental Form (where applicable)
- CIS 03 Authorization
- an outcome that references the hopes and aspirations of the family. If the family or child has an existing plan with mental health, their primary care provider, or Family Services, the CIS Primary Coordinator is responsible for strategies that support the child/family to be successful with their existing plan. In cases where there isn't another plan the family is functioning under, then a full CIS One Plan must be completed.
- A service grid that identifies the services that CIS is providing;
- Parental consent for the services CIS is providing.

What are some detailed examples of goals for each of the services?

The state will not be prescriptive with goals because every individual client has their own individual wants and needs, unique to them. When developing outcomes, the CIS team and the family should start with the family's hopes- one way to think about it is that the strategies achieve the goal, and the goal achieves a hope. For more support in writing SMART goals, please check out the following recourses:

- https://tfalc.com/blog/setting-smart-goals/
- http://www.intensivefamilypreservation.org/creating-goals-and-objectives-with-families/
- https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/engaging-and-goal-setting-with-families.pdf
- https://ectacenter.org/knowledgepath/ifspoutcomes-iepgoals/ifspoutcomes-iepgoals.asp

Does this count as an 'outcome'?

- **The "We want…so that" and the "How will we know if we are successful?" goal: YES!** When the team with the client/family/child care provider agrees this goal has been demonstrated and is considered achieved, then this counts as 'outcome met'.
- **Steps, Objectives and Strategies: NO!** In order to count under "1 or more outcomes met", an outcome/goal from the One Plan must be met in its entirety. The steps/objectives and strategies beneath each outcome are not counted in this measure.
- **Short term services delivered in three (3) or fewer visits**: **MAYBE!** If a service provider, with the client, creates a plan and completes at least one outcome in less than 3 visits, they should be counted in this cohort. Remember, they will need a service grid with signed consent, even though this documentation is not typically required for these clients.

Remember that outcomes do not need to be complicated and long-term.
Outcomes should be SMART- Specific, Measurable, Achievable, Relevant and Time-bound. This means that sometimes the outcomes with the client will not be years-long efforts, and can be simple, specific, and short term.

Remember, don't duplicate your count!
A client who has both an annual review and an exit between July 1, 2020 and December 31, 2020 should only be counted once, using the data from whichever goal review happened first.

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Performance Measure 2: Increase in the percentage of those served by CIS receiving services within timelines documented in the CIS Appendix 4: Timeline of the current CIS contract

What does this Performance Measure tell us?

This measure tracks timeliness of service delivery by collecting data on six points. While each point has different time standards, they all share four classification options:

1. Yes: The time standard was met.
2. No – due to provider**:** The time standard was not met, through no fault of the client. Provider circumstances are circumstances that are attributable solely to a situation within, or at the express request of, the provider over which the family has no input or control
3. No – due to family**:** The time standard was not met, through no fault of provider(s). Family circumstances are circumstances that are attributable solely to a situation within, or at the express request of, the family over which the provider has no input or control. FSD involvement often falls under family circumstance. State review of case timelines may be needed to determine this designation. Exceptional weather circumstances are allowable when a provider agency is closed due to extreme weather, or travel conditions pose a substantial hazard. This must be well documented in the client's file. All circumstances must have written documentation recorded in the client's file. "Well documented" means at least one full sentence describing the exact circumstances.
4. No – lost to follow-up: Clients who exit CIS by disengaging or otherwise discontinuing service without notice are included in the 'lost to follow-up' column. 'Lost to follow-up' is defined as a minimum of no contact after three diverse attempts, either by phone, mail or in person.

How does the state define availability with regards to Family vs Provider circumstance?

There must be a provider who can offer:

1. at least 3 different dates
2. reflecting a diversity of times and days of the week (not, for example all Tuesdays at 3pm)
3. over the course of the 30 days (not, for example, all within the last week of those 30 days).
    - If the family cannot make any of those 3 dates, then the delay is due to family circumstance because the providers have done their due diligence for availability.
    - If the provider cannot meet these three requirements when offering dates to the family, any delay is caused by provider circumstances.
    - Clear documentation of attempts to schedule, including specific dates, must be recorded in the child's file.

- *State review of case timelines, including specific dates, may be needed to determine this designation.

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Timelines in Depth: Initial Contact

The purpose of Initial Contact is to explain CIS services to the family in order to determine what their needs are and why they were referred to CIS in order to determine which CIS service will be the best fit. This contact should occur within 5 calendar days of receiving the referral. An Initial Contact is defined as "two people talking together" by phone or via face to face.

Who is counted in this measure?

All new referrals or re-referrals received from external sources between July 1, 2020 and December 31, 2020

How is 'lost to follow up' defined for the Initial Contact timeline?

For the purpose of initial contact timelines, 'lost to follow up' up' is defined as a situation where the region has attempted to contact the family/client at least three times and were unsuccessful- meaning no contact with a human was ever made.

What is the difference between internal referrals and external referrals?

CIS Contracted and MIECHV funded CIS services are internal referrals- everyone else is an external referral source. External referrals include FSD, CSHN, Head Start, MCH/WIC, CCFAP, etc..

How do we 'give credit' to Initial Contact?

Whomever makes the first contact/ is the first person to acknowledge the referral gets the credit for the contact. For example, a referral is made to the Specialized Child Care coordinator. They reach out to the family and through their conversation, discover that Early Intervention may be a CIS service that the family is interested in. The Specialized Child Care coordinator would bring this referral to the CIS Referral and Intake team to talk about connecting the family with Early Intervention, but they would still indicate that the initial contact was made on the Specialized Child Care line on the Semi Annual Template worksheet.

How are situations where the referral source gave the wrong contact information on the initial referral classified?

- If the referral source gave the wrong contact information but the region is still able to connect with the family after getting new information from the referral source, this would be a delay in initial contact due to family circumstance.

- If the referral source gave the wrong contact information and the region is NOT able to connect with the family (the referral source doesn't have another number, etc.) then this would be considered 'lost to follow up'.
- If the region has made at least three diverse contact attempts and are unable to reach anyone and the referral source has included an address, many regions will send a letter to the family with their contact information and a close out date. If the date comes and goes with no response, then this is considered a 'lost to follow up' as of that date.
- If the region has made at least three diverse attempts, are unable to reach anyone and don't have an address, then this is considered 'lost to follow up' on the last contact attempt.

What if a referral is received that is clearly not for a CIS service?

If during the initial contact discussion with the family it is determined that none of the CIS programs are a good fit and the referral is forwarded to other community agencies, then this would not be counted within the Semi Annual Template. Regions are welcome to record these numbers on the 'notes' tab.

What if a referral is received that is for a CIS service, but the family declines involvement?

The initial contact conversation would still be recorded on this spreadsheet. The intent of this measure is to ensure that families do not have to wait to receive services that they need from CIS. Even if the family chooses not to engage with CIS, this measure is looking to ensure that the initial contact was timely.

Is texting and/or emailing allowable under Initial Contact?

No. We understand that times are changing, and technology is evolving. However, the intent of the Initial Contact is a conversation to determine which CIS service will be the best fit. The state feels at this time that this cannot be accomplished through text or email.

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Timelines in Depth: Screening and Assessment

Should occur within 45 calendar days of the initial referral date.

Who is counted in this measure?

All new referrals or re-referrals received from external sources between July 1, 2020 and December 31, 2020 who are eligible for CIS.

How is this measure counted when a client is served by multiple CIS Services?

The intent of this measure is to look at the creation of the One Plan, so whomever is the primary service coordinator should record this under their service. For example, a client is served by both Strong Families Vermont Responsive Nurse Home Visiting and Specialized Child Care. The primary service coordinator for them is Strong Families Vermont Responsive Nurse Home Visiting, so they are counted under the Responsive Nurse Home Visiting row.

What counts as screenings and assessments for Specialized Child Care?

- The CIS-02 Intake form is screening tool for clients regarding resources;
- The Family Support Supplemental form is a screening/assessment tool that should be completed for CCFAP cases;
- Observations made in childcare through the onsite review also count.

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Timelines in Depth: Initial One Plan Meeting

Should occur within 45 calendar days of the initial referral date.

Who is counted in this measure?
All new referrals or re-referrals received from external sources between July 1, 2020 and December 31, 2020 who are eligible for CIS and the situation allows for the creation of the One Plan.

How is this measure counted when a client is served by multiple CIS Services?
The intent of this measure is to look at the creation of the One Plan, so whomever is the primary service coordinator should record this under their service. For example, a client is served by both Strong Families Vermont Sustained Nurse Home Visiting (MECSH) and Early Childhood Family and Mental Health (ECFMH). The primary service coordinator for them is MECSH, so they are counted under the MECSH row.

What counts as a One Plan?
CIS One Plans are comprised of at minimum:

- CIS 01 Referral Form
- CIS 02 Intake/ Family Support Supplemental Form (where applicable)
- CIS 03 Authorization
- an outcome that references the hopes and aspirations of the family. If the family or child has an existing plan with mental health, their primary care provider, or Family Services, the CIS Primary Coordinator is responsible for strategies that support the child/family to be successful with their existing plan. In cases where there isn't another plan the family is functioning under, then a full CIS One Plan must be completed.

- A service grid that identifies the services that CIS is providing;
- Parental consent for the services CIS is providing.

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Timelines in Depth: Start of Services

Starting services in a timely manner ensures that every client has the best opportunity to maximize their growth and development while accessing CIS services. Services should begin within 30 calendar days of the date that the family gives their consent. This is also known as the date of signed consent on the One Plan service grid.

Who is counted in this measure?

All clients who are active and have had any services added or changed between July 1, 2020 and December 31, 2020

How is this measure counted when a client is served by multiple CIS Services?

The intent of this measure is to look at the timeliness of individual programs. Any time a service is added, no matter by whom, it should begin within 30 days. For example, a client is served by both Early Intervention and Specialized Child Care. Early Intervention starts Physical Therapy 31 days from the date of signed consent because of a snow storm. The Specialized Child Care Coordinator adds specialized child care to the service grid and begins work with the family that day to find a placement. Early Intervention would have one tally in the 'No- delayed due to family' column and Specialized Child Care would have one tally in the 'Yes' column.

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Timelines in Depth: 6-month Review

A complete One Plan review occurs at least 6 months from the last completed One Plan.

Who is counted in this measure?

Clients who are active and who had either their Initial One Plan created or an Annual Review occur at least 6 months prior to July 1, 2020 and December 31, 2020.

How is this measure counted when a client is served by multiple CIS Services?

The intent of this measure is to look at the whole plan, so whomever is the primary service coordinator should record this under their service. For example, a client is served by both Early Intervention and Strong Families Vermont Sustained Family Support Home Visiting (PAT). The primary service coordinator for them is Early Intervention, so they are counted under the Early Intervention row.

How do we keep families engaged in Specialized Child Care Family Support when they don't have to meet with us at six months anymore?

According to the CIS Contract, CIS providers are required to review One Plans at least every 6 months. CCFAP policies and CIS Contract Requirements are not the same thing. Family Engagement is a requirement under the CIS Contract. CIS providers must engage regularly with families to support their success in meeting their One Plan goals. CCFAP Family Support eligibility determination after one year is dependent upon the families' progress on their One Plan outcomes. Families who do not engage despite our best efforts are not eligible for CCFAP Family Support after one year.

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Timelines in Depth: Annual Review

A complete Annual One Plan review occurs at least 12 months from the date of the completed Initial One Plan. Every subsequent year, the annual review is completed 12 months from the date of the preceding annual review.

Who is counted in this measure?

Clients who are active and have their annual review due between 7/1/2020 and 12/31/2020.

How is this measure counted when a client is served by multiple CIS Services?

The intent of this measure is to look at the whole plan, so whomever is the primary service coordinator should record this under their service. For example, a client is served by both Specialized Child Care and Early Childhood Family and Mental Health (ECFMH). The primary service coordinator for them is ECFMH, so they are counted under the ECFMH row.

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Performance Measure 3: Decrease in the percentage of those served by CIS who exit the program due to lost to follow-up;

What does this Performance Measure tell us?

This measure tracks the reason that a client exited all CIS services between July 1, 2020 and December 31, 2020. There are 5 classifications for this measure:

1. All Goals Met: Clients who exit from CIS with notice and having met all One Plan goals.
2. Aged Out: Clients who exit CIS due to age and have not met all One Plan Goals. If a client has met all One Plan goals at the same time as reaching an age limit, please classify them as 'All Goals Met'.
3. Withdrawn: Clients who exit from CIS before they meet the age limit, with notice and with One Plan goals not met. *We will be exploring different ways to break up the "positive' withdrawals for the next reporting period.
4. Transitioned to Other Community Service: Clients exit from CIS and into other community supports that are better suited to fit their needs.
5. Moved: Clients who have relocated out of region with notice prior to reaching the age limit.
6. Lost to follow-up**:** Clients who exit CIS by disengaging, moving or otherwise discontinuing service without notice are included in the 'lost to follow-up' column. 'Lost to follow-up' is defined as a minimum of no contact after three diverse attempts, either by phone, mail or in person.

What are the age ranges served by each of the CIS Programs?

- Early Childhood and Family Mental Health: birth up to age 6
- Early Intervention: birth up to age 3
- Strong Families Vermont Responsive Family Support Home Visiting: birth up to age 5
- Strong Families Vermont Sustained Family Support Home Visiting (PAT): birth up to age 5
- Strong Families Vermont Responsive Nurse Home Visiting: birth up to age 5
- Strong Families Vermont Sustained Nurse Home Visiting (MECSH): prenatal up to age 2
- Specialized Child Care: children and families with children birth up to age 13 who are receiving Specialized Child Care benefit; child care providers may be served for as long as needed.

How is this measure counted when a client is served by multiple CIS Services?

The intent of this measure is to look at the whole program, so whomever is the primary service coordinator should record this under their service. For example, a client is served by both Specialized Child Care and Strong Families Vermont Responsive Nurse Home Visiting. The primary service coordinator for them is Specialized Child Care, so they are counted under the Specialized Child Care row.

Does this count as an Exit?

- **A child exits out of early intervention but is still receiving other CIS services. NO!** For the semi-annual data report, they are not an exit, but for EI reporting they are!
- **A post-partum client 'ages out' but her child is still a client of CIS. YES!** The post-partum client is counted as an exit, but the child would be considered a new referral.
- **A child leaves CIS early because they need more intensive mental health services. YES!** If there was a signed one plan and 3 or more visits took place, then they do count as an exit.

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Performance Measure 5: Total number of CIS referrals received AND number of CIS referrals received directly by the CIS Coordinator from a primary referral source.

What does this Performance Measure tell us?

The State believes that an increase in the number of referrals made directly to the CIS coordinator supports the idea of growing community awareness that CIS is a comprehensive source for early childhood services. This measure captures two points of data:

1. Total number of referrals received by each CIS Service Area between July 1, 2020 and December 31, 2020.
2. Number of referrals received by CIS Coordinator**:** Reflects the number of referrals the CIS Coordinator received directly from the primary referral source, between July 1, 2020 and December 31, 2020. The referral must be from an external source to count here.

Who is counted in this measure?

All new referrals or re-referrals received from external sources between July 1, 2020 and December 31, 2020.

What is the difference between internal referrals and external referrals?

CIS Contracted and MIECHV funded CIS services are internal referrals- everyone else is an external referral source. External referrals include FSD, CSHN, Head Start, MCH/WIC, CCFAP, etc..

What qualifies as a countable referral for this performance measure?

- A CIS referral must contain a least enough information about a potential need for a CIS services that it is brought to the referral and intake team, and a CIS service provider is assigned to follow up and conduct an intake. Even if an intake is never completed (due to the potential client's failure to keep scheduled appointments, or if they subsequently refuse to accept CIS services) it is still counted as a referral.
- Referrals made directly to a CIS provider organization (Like an HHA) are triaged depending on the client's level of need and subsequently brought to the weekly CIS referral team meetings and would be counted as a CIS referral.

What if a referral is received that is clearly not for a CIS service?

If it is determined that none of the CIS programs are a good fit and the referral is forwarded to other community agencies, then this would not be counted within the Semi Annual Template. Regions are welcome to record these numbers on the 'notes' tab.

What if a referral is received that is for a CIS service, but the family declines involvement?

This still counts as a referral and should be recorded on this spreadsheet. The intent of this measure is to ensure that there is a robust community awareness of CIS, even if the family chooses not to engage with CIS.

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