

## Assessment and Care Planning

**Assessment:** The systematic process of gathering, verifying, and interpreting information about an individual's health, functional status, and social circumstances. Related terms: screening, needs assessment, baseline assessment. Explanation: Assessment establishes a comprehensive picture that informs care planning, identifies risks, and prioritises interventions. Example: A case manager conducts a biopsychosocial interview, reviews medical records, and uses a standardized functional scale to determine the client's level of independence. Practical application: Data collected guides eligibility determination for services and supports. Challenges: Incomplete records, language barriers, and client reluctance can compromise data accuracy.

**Assessment Tool:** Any instrument, questionnaire, or checklist used to collect specific data during an assessment. Related terms: instrument, scale, questionnaire. Explanation: Tools standardise data collection, enhance reliability, and facilitate comparison across clients. Example: The Mini-Mental State Examination (MMSE) assesses cognitive function in older adults. Practical application: Selecting appropriate tools ensures relevant information is captured for care planning. Challenges: Tool selection must consider cultural relevance, literacy levels, and time constraints.

**Assessment Framework:** A structured model that outlines the steps, domains, and criteria for conducting a comprehensive assessment. Related terms: model, guideline, process map. Explanation: Frameworks provide consistency, guide documentation, and support interdisciplinary collaboration. Example: The WHO International Classification of Functioning, Disability and Health (ICF) framework organizes assessment data into body functions, activities, and participation. Practical application: Using a framework helps case managers align assessment findings with service eligibility criteria. Challenges: Rigid frameworks may limit flexibility for unique client situations.

**Assessment Outcome:** The result or finding derived from the assessment process, indicating the client's current status, needs, and risks. Related terms: finding, result, conclusion. Explanation: Outcomes inform decision-making, goal setting, and prioritisation of interventions. Example: An assessment outcome may reveal that a client has moderate mobility impairment requiring assistive devices. Practical application: Documented outcomes become the basis for care plan objectives. Challenges: Outcomes can be misinterpreted if not clearly linked to assessment data.

**Biopsychosocial Model:** An integrated approach that considers biological, psychological, and social factors influencing health and well-being. Related terms: holistic, multidimensional, integrated care. Explanation: This model guides comprehensive assessments by encouraging exploration of all factors affecting the client. Example: A case manager evaluates a client's chronic disease (biological), coping strategies (psychological), and housing stability (social). Practical application: Enables development of care plans that address root causes, not just symptoms. Challenges: Requires interdisciplinary expertise and sufficient time to explore each domain.

**Case Conference:** A structured meeting of multidisciplinary team members to discuss assessment findings, share perspectives, and coordinate care planning. Related terms: team meeting, multidisciplinary review, care coordination meeting. Explanation: Conferences promote shared decision-making, reduce duplication, and ensure alignment of goals. Example: A nurse, social worker, physiotherapist, and case manager convene to review a client's post-stroke assessment and plan discharge. Practical application: Outcomes of the conference are documented in the care plan and assigned to responsible professionals. Challenges: Scheduling conflicts, differing professional cultures, and confidentiality concerns may hinder effective collaboration.

**Case Management:** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health and social needs. Related terms: care coordination, client advocacy, service navigation. Explanation: Case management integrates assessment data with resource allocation to achieve optimal outcomes. Example: After completing a comprehensive assessment, a case manager arranges home health services, transportation, and financial counseling for a client with multiple chronic conditions. Practical application: Centralises responsibility for the client's journey across health and social care settings. Challenges: High caseloads, limited service availability, and complex eligibility criteria can impede effectiveness.

**Case Planning Cycle:** The iterative sequence of assessment, goal setting, intervention design, implementation, monitoring, and evaluation. Related terms: care planning process, continuous improvement loop, PDCA (Plan-Do-Check-Act). Explanation: The cycle ensures that care plans remain dynamic and responsive to changing client needs. Example: A client's care plan is reviewed quarterly; adjustments are made based on new assessment data indicating improved mobility. Practical application: Provides a roadmap for systematic follow-up and outcome measurement. Challenges: Inadequate documentation and failure to close the loop can lead to outdated or ineffective plans.

**Client-Centred Care:** An approach that respects and responds to the preferences, values, and needs of the individual receiving services. Related terms: person-focused, individualized care, client empowerment. Explanation: Emphasises active client participation in assessment and planning, fostering ownership and adherence. Example: During assessment, the client expresses a desire to remain in their own home; the care plan incorporates home-based support services accordingly. Practical application: Improves satisfaction and health outcomes by aligning interventions with client goals. Challenges: Balancing client wishes with clinical safety and resource constraints.

**Clinical Assessment:** Evaluation performed by a health professional focusing on medical history, physical examination, and diagnostic testing. Related terms: medical assessment, physical exam, diagnostic evaluation. Explanation: Provides essential biomedical data that complement psychosocial information. Example: A physician assesses a client's blood pressure, heart rate, and medication regimen as part of the overall assessment. Practical application: Clinical findings inform medication management, referrals, and risk stratification. Challenges: May be limited by time pressures, incomplete patient histories, or lack of access to diagnostic tools.

**Community Resources:** Services, programs, and supports available within the local environment that address health, social, or economic needs. Related terms: local services, NGOs, public agencies. Explanation:

Identifying community resources expands options for meeting client needs beyond formal health services. Example: A case manager links a client to a neighbourhood food bank to address nutrition insecurity identified during assessment. Practical application: Enhances sustainability of care plans by leveraging existing supports. Challenges: Resource availability varies by geography; up-to-date directories are essential but often lacking.

**Cultural Competence:** The ability to understand, communicate with, and effectively serve individuals from diverse cultural backgrounds. Related terms: cultural sensitivity, cross-cultural communication, cultural humility. Explanation: Informs assessment techniques, language use, and care planning to respect cultural values and beliefs. Example: Using a culturally adapted mental health screening tool when assessing an immigrant client. Practical application: Reduces misinterpretation of symptoms and improves client engagement. Challenges: Requires ongoing training, self-reflection, and access to culturally appropriate resources.

**Data Collection:** The systematic gathering of information from various sources such as interviews, observations, records, and measurement tools. Related terms: information gathering, data acquisition, evidence gathering. Explanation: Accurate data collection underpins reliable assessment outcomes and evidence-based care planning. Example: Recording a client's daily medication adherence using a pill-count method. Practical application: Enables tracking of trends and evaluation of intervention effectiveness. Challenges: Inconsistent data entry, missing data, and privacy concerns can compromise data integrity.

**Eligibility Criteria:** The set of standards or requirements that determine a client's qualification for specific services or programs. Related terms: qualification, admission criteria, service thresholds. Explanation: Assessment results are matched against criteria to decide service allocation. Example: A client must have a documented disability rating of at least 40% to qualify for certain vocational rehabilitation services. Practical application: Guides referral decisions and resource prioritisation. Challenges: Complex or changing criteria can lead to delays or denied services.

**Environmental Assessment:** Evaluation of the physical, social, and economic surroundings that influence a client's health and functioning. Related terms: home assessment, community environment review, contextual analysis. Explanation: Identifies barriers or facilitators in the client's environment that affect care outcomes. Example: Assessing home safety hazards such as loose rugs for a client with balance issues. Practical application: Informs recommendations for home modifications or assistive devices. Challenges: Access to the client's environment may be limited, and clients may under-report hazards.

**Goal Setting:** The process of defining specific, measurable, achievable, relevant, and time-bound (SMART) objectives based on assessment findings. Related terms: objective formulation, target setting, outcome planning. Explanation: Goals translate assessment data into actionable plans and provide benchmarks for progress. Example: "Client will increase walking distance from 50 meters to 200 meters within eight weeks." Practical application: Enables monitoring of client progress and timely plan adjustments. Challenges: Overly ambitious or vague goals reduce motivation and hinder evaluation.

**Health Literacy:** The degree to which individuals can obtain, process, and understand basic health information needed to make appropriate health decisions. Related terms: patient education, communication

skills, health understanding. Explanation: Influences client participation in assessment, adherence to care plans, and self-management. Example: Using plain language and visual aids when explaining medication schedules to a client with limited literacy. Practical application: Improves informed consent and reduces errors. Challenges: Assessing literacy levels without stigmatizing the client can be difficult.

**Interdisciplinary Team:** A group of professionals from varied disciplines who collaborate to provide comprehensive assessment and care planning. Related terms: multidisciplinary team, collaborative team, care team. Explanation: Brings diverse expertise to address complex client needs. Example: A team comprising a physician, nurse, social worker, occupational therapist, and case manager develops a coordinated discharge plan. Practical application: Facilitates holistic assessment and reduces service fragmentation. Challenges: Differing professional languages, role ambiguity, and power dynamics may impede seamless collaboration.

**Individualised Care Plan:** A written document that outlines personalized goals, interventions, responsibilities, timelines, and evaluation criteria for a client. Related terms: personal care plan, client-specific plan, care roadmap. Explanation: Synthesises assessment data and client preferences into a structured plan of action. Example: The plan specifies weekly physiotherapy sessions, monthly social work check-ins, and quarterly medication reviews. Practical application: Serves as a reference for all team members and the client, ensuring coordinated delivery. Challenges: Keeping the plan current, ensuring all stakeholders have access, and avoiding overly complex documentation.

**Informed Consent:** The process by which a client voluntarily agrees to assessment or intervention after receiving clear information about purpose, risks, benefits, and alternatives. Related terms: client agreement, permission, assent. Explanation: Ethical and legal requirement that protects client autonomy. Example: A case manager obtains written consent before conducting a home safety assessment. Practical application: Documents client's willingness and protects the provider from liability. Challenges: Language barriers, cognitive impairment, or limited understanding can compromise true consent.

**Life-Stage Assessment:** Evaluation that considers the client's age-related developmental, social, and health transitions. Related terms: age-specific assessment, developmental review, generational analysis. Explanation: Tailors assessment focus to typical needs of a given life phase. Example: For a young adult transitioning out of foster care, the assessment emphasizes education, employment, and independent living skills. Practical application: Guides the selection of appropriate services and supports. Challenges: Over-generalising life-stage norms may overlook unique circumstances.

**Motivation Assessment:** Exploration of the client's readiness, willingness, and intrinsic drive to engage in planned interventions. Related terms: readiness assessment, engagement evaluation, behavior change readiness. Explanation: Determines the level of support needed to facilitate participation. Example: Using the Stages of Change model to gauge a client's readiness to quit smoking. Practical application: Tailors interventions to match motivational levels, enhancing adherence. Challenges: Motivation can fluctuate; inaccurate assessment may lead to mismatched interventions.

**Multimorbidity Assessment:** Systematic evaluation of multiple co-existing chronic conditions and their combined impact on health and functioning. Related terms: comorbidity assessment, chronic disease

burden, disease interaction review. Explanation: Recognises that multiple conditions interact, influencing treatment priorities and care coordination. Example: Assessing a client with diabetes, chronic obstructive pulmonary disease, and depression to determine overlapping medication side effects. Practical application: Guides integrated care plans that avoid conflicting treatments. Challenges: Complex clinical pictures increase assessment time and require specialised knowledge.

**Needs Assessment:** The process of identifying gaps between a client's current state and desired health or social outcomes. Related terms: gap analysis, requirement identification, service need identification. Explanation: Forms the basis for prioritising interventions and allocating resources. Example: Determining that a client lacks transportation to attend medical appointments, representing a barrier to care continuity. Practical application: Directs referral to community transport services. Challenges: Needs may be hidden, culturally bound, or evolve rapidly.

**Objective:** A specific, measurable statement describing the desired result of an intervention within a care plan. Related terms: target, outcome, performance indicator. Explanation: Objectives operationalise broader goals and facilitate evaluation. Example: "Client will achieve a blood pressure reading below 130/80 mmHg within three months."

Practical application: Allows tracking of clinical indicators and adjustment of treatment strategies. Challenges: Poorly defined objectives can lead to ambiguous outcomes and hinder accountability.

**Outcome Measure:** A tool or indicator used to assess the effectiveness of an intervention against defined objectives. Related terms: performance metric, evaluation indicator, result indicator. Explanation: Provides evidence of progress and informs future planning decisions. Example: Using the Barthel Index to measure improvement in activities of daily living after rehabilitation. Practical application: Data from outcome measures can be reported to funders or used for quality improvement. Challenges: Selecting appropriate measures, ensuring reliability, and avoiding measurement fatigue.

**Patient-Reported Outcome Measure (PROM):** A questionnaire completed by the client that captures their perception of health status, quality of life, or functional ability. Related terms: self-report tool, health questionnaire, client-entered metric. Explanation: Adds the client's voice to assessment data, enriching care planning. Example: The SF-12 health survey completed by a client to assess physical and mental health components. Practical application: Informs goal setting that aligns with client-valued outcomes. Challenges: Literacy, cultural relevance, and response bias can affect validity.

**Personal Protective Equipment (PPE) Assessment:** Evaluation of the need for and appropriate use of protective gear during home visits or community interactions. Related terms: infection control assessment, safety evaluation, risk mitigation. Explanation: Ensures safety of both client and provider, especially during infectious disease outbreaks. Example: Determining whether a case manager should wear a mask and gloves while visiting a client with a respiratory infection. Practical application: Guides procurement and training on proper PPE use. Challenges: Supply shortages, client resistance, and evolving guidelines.

**Plan-Do-Study-Act (PDSA) Cycle:** A quality improvement methodology applied to care planning, consisting of planning an intervention, implementing it, studying results, and acting on findings. Related terms: continuous improvement, iterative testing, quality cycle. Explanation: Enables rapid testing of changes and

refinement of care plans. Example: Testing a new medication reminder app with a small group of clients, evaluating adherence rates, then scaling up if successful. Practical application: Promotes evidence-based adjustments and reduces waste. Challenges: Requires systematic data collection and stakeholder engagement.

**Policy Alignment:** Ensuring that assessment and care planning processes conform to organizational, regional, and national policies governing health and social services. Related terms: regulatory compliance, standards adherence, governance. Explanation: Guarantees that plans are legally defensible and eligible for funding. Example: Aligning care plans with the National Health Service (NHS) commissioning framework. Practical application: Facilitates audit readiness and funding approval. Challenges: Frequent policy changes and differing interpretations can cause confusion.

**Priority Setting:** The act of ranking identified needs or goals based on urgency, impact, client preference, and resource availability. Related terms: triage, ranking, resource allocation. Explanation: Directs limited resources toward the most critical issues first. Example: Prioritising safe housing over recreational activities for a client experiencing homelessness. Practical application: Guides scheduling of interventions and referrals. Challenges: Balancing client desires with clinical necessity may create tension.

**Problem Identification:** The process of pinpointing specific health or social issues that require intervention, derived from assessment data. Related terms: issue detection, concern identification, need recognition. Explanation: Forms the foundation for goal formulation and care planning. Example: Recognising medication non-adherence as a problem after reviewing pharmacy refill records. Practical application: Directs targeted strategies such as medication counseling. Challenges: Overlooking subtle problems or misattributing causes can lead to ineffective plans.

**Professional Boundaries:** The ethical limits that define the relationship between a case manager and a client, ensuring a therapeutic, respectful, and non-exploitative interaction. Related terms: ethical limits, role clarity, confidentiality. Explanation: Maintains trust and protects both parties from conflict of interest. Example: A case manager refrains from providing personal financial advice beyond the scope of service. Practical application: Guides documentation, communication, and referral practices. Challenges: Emotional involvement, cultural expectations, or ambiguous role definitions can blur boundaries.

**Progress Monitoring:** Ongoing review of client status and intervention effectiveness against established objectives and outcomes. Related terms: follow-up, tracking, performance review. Explanation: Detects deviations early, allowing timely plan modifications. Example: Weekly check-ins to assess pain levels after initiating a new physiotherapy regimen. Practical application: Supports accountability and continuous quality improvement. Challenges: Inconsistent data collection, client non-attendance, and limited staff time.

**Quality Assurance (QA):** Systematic activities designed to ensure that assessment and care planning meet predefined standards of excellence. Related terms: quality control, audit, compliance. Explanation: QA processes validate the reliability, accuracy, and effectiveness of care plans. Example: Conducting random chart audits to verify that all assessments include required domains. Practical application: Identifies gaps for training or process redesign. Challenges: Resource intensive and may encounter resistance from staff.

**Risk Assessment:** Identification and analysis of potential hazards that could adversely affect a client's health, safety, or wellbeing. Related terms: hazard analysis, threat evaluation, safety appraisal. Explanation: Informs mitigation strategies within the care plan. Example: Assessing fall risk for an elderly client using a standardized fall-risk tool. Practical application: Leads to interventions such as grab-bar installation or balance training. Challenges: Under-reporting of risks, dynamic nature of risk factors, and balancing autonomy with safety.

**Safety Planning:** Development of strategies to protect a client from identified risks, often involving emergency contacts, crisis protocols, and environmental modifications. Related terms: contingency plan, emergency protocol, protective strategy. Explanation: Translates risk assessment findings into actionable steps. Example: Creating a suicide safety plan with a client experiencing severe depression. Practical application: Provides a clear roadmap for clients and caregivers during crises. Challenges: Ensuring client understanding, updating plans as circumstances evolve, and coordinating with external services.

**Self-Management Support:** Assistance provided to clients to develop skills, confidence, and resources for managing their own health conditions. Related terms: patient empowerment, health coaching, self-care facilitation. Explanation: Enhances adherence, reduces reliance on services, and improves outcomes. Example: Teaching a client with diabetes how to monitor blood glucose and adjust diet accordingly. Practical application: Integrated into care plans as specific educational goals. Challenges: Varying levels of health literacy, motivation, and access to tools.

**Service Mapping:** The process of charting available health and social services, eligibility pathways, and referral processes within a geographic area. Related terms: resource inventory, service directory, network analysis. Explanation: Enables case managers to identify and navigate appropriate resources efficiently. Example: Creating a visual map of local mental health crisis teams, shelters, and employment services. Practical application: Streamlines referral and reduces duplication. Challenges: Keeping the map current, accounting for service variability, and integrating private sector options.

**Shared Decision-Making (SDM):** Collaborative process where clinicians and clients jointly discuss options, preferences, and values to reach a mutually agreeable care plan. Related terms: collaborative planning, patient partnership, joint decision making. Explanation: Promotes client autonomy and improves satisfaction. Example: Discussing medication side-effects with a client and choosing between two equally effective treatments based on lifestyle considerations. Practical application: Documented in care plans as agreed-upon choices. Challenges: Time constraints, power imbalances, and limited client knowledge may impede true partnership.

**Social Determinants of Health (SDOH) Assessment:** Examination of non-clinical factors such as income, education, housing, and social support that influence health outcomes. Related terms: upstream factors, equity assessment, contextual analysis. Explanation: Highlights systemic barriers that must be addressed in care planning. Example: Identifying food insecurity as a determinant affecting a client's diabetes control. Practical application: Leads to referrals for nutrition assistance programs. Challenges: Data may be sensitive, and addressing SDOH often requires cross-sector collaboration.

**Standardised Assessment:** Use of validated, uniform tools that allow consistent data collection across clients

and settings. Related terms: uniform instrument, validated scale, protocol assessment. Explanation: Facilitates comparison, benchmarking, and research. Example: Applying the Geriatric Depression Scale (GDS) to all older adult clients. Practical application: Enables aggregation of data for service evaluation. Challenges: May not capture unique cultural nuances or individualized concerns.

**Strengths-Based Assessment:** An approach that identifies and builds upon the client's existing abilities, resources, and coping strategies. Related terms: asset-focused, empowerment assessment, positive appraisal. Explanation: Shifts focus from deficits to capacities, fostering resilience. Example: Recognising a client's strong family support as a resource for post-hospital recovery. Practical application: Incorporates strengths into goal setting and intervention design. Challenges: Balancing strengths with realistic appraisal of limitations.

**Substance Use Assessment:** Evaluation of the client's consumption of alcohol, illicit drugs, or prescription medications that may affect health and social functioning. Related terms: addiction screening, dependency evaluation, substance misuse review. Explanation: Identifies risk factors and informs appropriate referral pathways. Example: Using the AUDIT (Alcohol Use Disorders Identification Test) to screen for hazardous drinking. Practical application: Connects clients to counseling, detox programs, or harm-reduction services. Challenges: Stigma, denial, and legal concerns may hinder honest disclosure.

**Systemic Review:** A comprehensive, organized examination of the literature and evidence related to specific assessment or care planning practices. Related terms: literature review, evidence synthesis, research appraisal. Explanation: Informs best-practice guidelines and tool selection. Example: Reviewing recent studies on telehealth assessments for remote clients. Practical application: Guides policy updates and staff training. Challenges: Time-intensive, requires critical appraisal skills, and may be limited by publication bias.

**Therapeutic Relationship:** The collaborative, trust-based connection established between case manager and client, facilitating open communication and shared goals. Related terms: rapport, alliance, client-provider bond. Explanation: Underpins successful assessment and care planning. Example: A case manager actively listens, validates concerns, and demonstrates empathy during intake. Practical application: Enhances client disclosure, adherence, and satisfaction. Challenges: Boundaries, cultural differences, and client trauma histories can complicate relationship building.

**Transition Planning:** Structured preparation for a client's movement between care settings, such as hospital to home, ensuring continuity and safety. Related terms: discharge planning, handover, care transition. Explanation: Addresses gaps that often occur during changes in service level. Example: Coordinating a home-care nurse visit within 24 hours of hospital discharge. Practical application: Reduces readmission rates and improves patient outcomes. Challenges: Communication failures, fragmented records, and differing organizational policies.

**Trauma-Informed Assessment:** An approach that recognises the prevalence of trauma and its impact, ensuring the assessment process is safe, respectful, and empowering. Related terms: trauma-sensitive, safety-first, empowerment assessment. Explanation: Minimises re-traumatisation and builds trust. Example: Offering the client control over interview location and pacing when discussing past abuse. Practical application: Leads to more accurate data and better engagement. Challenges: Requires staff training,

awareness of triggers, and flexible protocols.

**Validity:** The extent to which an assessment tool measures what it is intended to measure. Related terms: accuracy, construct validity, criterion validity. Explanation: Determines the credibility of assessment findings. Example: A depression scale that correlates well with clinical diagnosis demonstrates strong validity. Practical application: Valid tools are preferred for evidence-based planning. Challenges: Validity may differ across populations, requiring cultural adaptation.

**Vulnerability Assessment:** Identification of factors that increase a client's susceptibility to harm, neglect, or exploitation. Related terms: risk appraisal, susceptibility analysis, protective factors review. Explanation: Highlights the need for safeguarding measures within care plans. Example: Recognising an elderly client living alone with limited family contact as vulnerable. Practical application: Triggers referrals to adult protective services or community volunteer programs. Challenges: Balancing autonomy with protection and navigating mandatory reporting obligations.

**Vision Assessment:** Evaluation of visual acuity, field of vision, and ocular health as part of a comprehensive health assessment. Related terms: eye exam, visual screening, ocular evaluation. Explanation: Visual impairments can affect mobility, medication management, and overall safety. Example: Using a Snellen chart to assess distance vision in a client with diabetes. Practical application: Leads to prescription of glasses or referral to ophthalmology. Challenges: Access to equipment, client cooperation, and interpreting results in the context of other impairments.

**Weight Management Assessment:** Review of a client's body weight, nutrition habits, and related health indicators to determine risk or need for intervention. Related terms: BMI assessment, nutritional evaluation, obesity screening. Explanation: Provides baseline data for diet-related goals and health risk reduction. Example: Calculating Body Mass Index (BMI) and reviewing dietary intake logs. Practical application: Informs referral to dietitians, exercise programs, or bariatric services. Challenges: Sensitivity around weight, cultural attitudes, and co-existing medical conditions.

**Work-Related Assessment:** Examination of a client's employment status, job demands, functional capacity, and barriers to work. Related terms: occupational evaluation, vocational assessment, employment readiness review. Explanation: Supports return-to-work planning or career transition services. Example: Using the Work Ability Index to assess a client's capacity to perform current job tasks. Practical application: Guides employer accommodations, rehabilitation, or retraining referrals. Challenges: Employer cooperation, confidentiality, and fluctuating health status.

**Wrap-Around Services:** Coordinated, comprehensive supports that surround the client, integrating health, social, educational, and community resources. Related terms: integrated services, holistic support, community integration. Explanation: Addresses complex, multifactorial needs through a single, unified plan. Example: A child with special needs receives medical care, educational support, family counseling, and respite services as part of a wrap-around package. Practical application: Reduces fragmentation and improves continuity. Challenges: Requires robust collaboration, clear communication channels, and shared accountability.

**Yield Analysis:** Examination of the outcomes achieved relative to resources invested in a particular intervention or care plan component. Related terms: cost-effectiveness, outcome-to-cost ratio, efficiency evaluation. Explanation: Informs decision-making about resource allocation and program sustainability. Example: Comparing the reduction in hospital readmissions achieved by a home-visit program against its operational costs. Practical application: Supports funding applications and policy advocacy. Challenges: Quantifying intangible benefits and capturing long-term outcomes can be difficult.