CFCS
Communication Function Classification System

Establishing Consistent Use of the Communication Function Classification System (CFCS)

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- These materials are intended to increase your understanding of how the CFCS should be used and why consistent use of the tool is important.
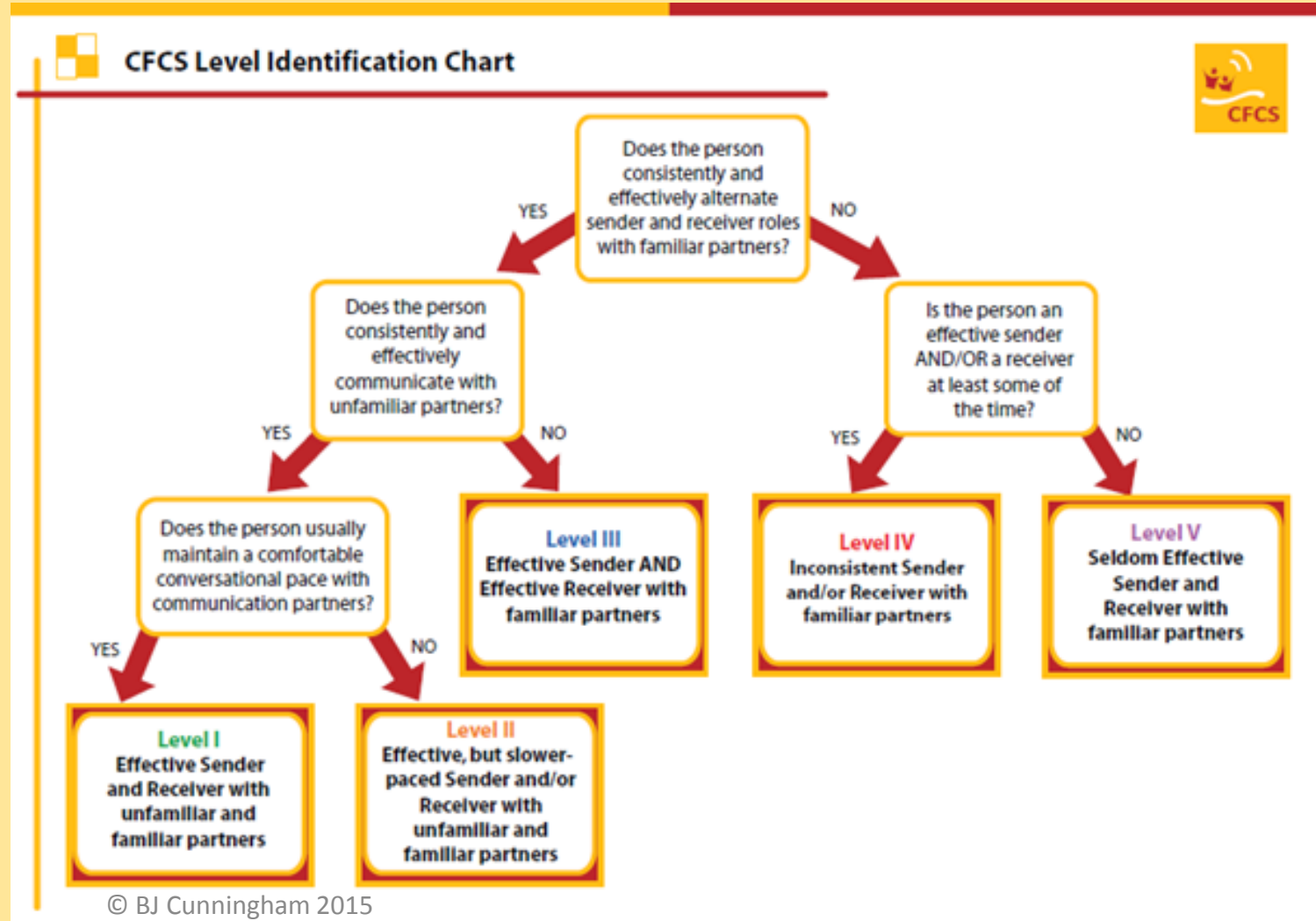
- Please review the information.

What is it?

- A valid and reliable tool that can be used to classify children's everyday communication abilities into five levels of function.

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Who is using it?

- This innovative tool has already been adopted by many clinical groups internationally and is being used in current research in our field.

- Due to demand, the tool has already been translated into 14 different languages!

Why do people like it?

- Teams have reported that the CFCS helps them focus on the client's ability to communicate with familiar and unfamiliar people, regardless of communication methods.

- It allows therapists to focus on participation instead of the traditional speech-language functions.

- It gives parents and professionals a common language for describing and understanding children's abilities.

What is this about?

- There is still some confusion among SLPs as to how and with whom the CFCS should be used.

- We hope this presentation will help therapists establish consistent use of the CFCS and understand why consistent use of the tool is important.

What do I need to know?

- The first step is to read the 4 pages of the CFCS. If you have not already done so, you can use this link to review some introductory information. http://cfcs.us/wp-content/uploads/2014/02/CFCS_universal_2012_06_06.pdf

- Additionally, there are two things therapists should know about the CFCS.

    1) It should be completed **in collaboration with families** whenever possible.

    2) Children's communication skills should be classified **based on current level of function**. Chronological age should <u>not</u> be considered.

Why should I <u>complete the CFCS with families</u>?

• Parents and clinicians may classify children's abilities differently (parents may place their child at higher levels of function). Consistently including parents in classifications will improve the professional's ability to compare outcomes for various interventions.

• Parents spend the most time with their child, observing him or her in numerous environments and are therefore best positioned to provide an estimate of their child's "everyday communication abilities".

• Clinicians should complete the tool independently <u>only when</u> parents are unavailable.

Why should I complete the CFCS <u>based only on level of function</u>?

- Consistent classification by level of function allows us to collect valid and reliable information about therapeutic outcomes for the children we see. With this data we can lobby administrators and government using evidence-based information about the effectiveness and importance of our services to secure funding for speech-language therapies.

- As a profession, we can establish a shared and consistent terminology about levels of communicative function and communicate with each other more effectively. Currently we use "mild", "moderate" and "severe" to describe how a child functions, but what one clinician calls mild, another might call moderate.

What do I need to do?

- If you consistently complete the tool in collaboration with families and classify children's abilities by level of function alone, then no change is required.

- If you are not completing the CFCS in collaboration with families, or if you classify considering chronological age, then a slight shift in how the tool is used is needed.

- Establishing consistent use of the CFCS will move our profession forward.

- Next, some brief clinical scenarios of preschoolers we might typically see are provided for those who would like an opportunity to practice making classifications **by level of function**.

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SCENARIO 1

48-month-old (4 years) with age appropriate communication skills.

Answer: CFCS Level I –By the age of 4 a typically-developing child would be able to effectively send and receive messages independently.

Communication Function Classification System (CFCS)

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II. Effective but slower paced Sender and/or Receiver with unfamiliar and/or familiar partners. The person independently **alternates between sender and receiver** roles with most people in most environments, but the **conversational pace is slow** and may make the communication interaction more difficult. The person may need extra time to understand messages, compose messages, and/or repair misunderstandings. Communication misunderstanding are often repaired and do not interfere with the eventual effectiveness of the person's communication with both **unfamiliar and familiar partners**.

III. Effective Sender and Receiver with familiar partners. The person **alternates between sender and receiver roles with familiar** (but not unfamiliar) conversational partners in most environments. Communication is **not consistently effective** with most **unfamiliar partners**, but is **usually effective** with **familiar partners**.

IV. Inconsistent Sender and/or Receiver with familiar partners. The person does **not** consistently alternate **sender** and **receiver** roles. This type of inconsistency might be seen in different types of communicators including: a) an occasionally effective sender and receiver; b) an effective sender but limited receiver; c) a limited sender but effective receiver. Communication is **sometimes effective** with **familiar partners**.

V. Seldom Effective Sender and Receiver even with familiar partners. The person is limited as both a **sender and a receiver**. The person's communication is difficult for most people to understand. The person appears to have limited understanding of messages from most people. Communication is **seldom effective** even with **familiar partners**.

SCENARIO 2

60-month-old (5 years) with motor speech disorder. Requests and comments using sentences with Picture Exchange (PECS) with family members. Unable to communicate at school.

Answer: CFCS Level III - This child is able to communicate effectively with family members, but not others. This places him/her at CFCS level 3.

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SCENARIO 3

24-month-old (2 years) with receptive language delay. Follows familiar one-step directions, answers "who" and "what" for familiar things.

Answer: CFCS Level IV –Due to the receptive language delay, this child is unable to effectively receive messages from familiar communication partners (and is also likely inconsistent or seldom effective sending messages).

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SCENARIO 4

36-month-old (3 years) child with autism and expressive/ receptive / pragmatic language delays. Limited interaction with family. Does not respond to questions or directions.

Answer: CFCS Level V – This child rarely sends messages to family members and does not respond to messages that are relayed to him/her.

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SCENARIO 5

72-month-old (6 years) non-verbal child with Cerebral Palsy. No language delays. Communicates independently using an AAC system.

Answer: CFCS Level II –This child is able to convey and understand messages, but because of the AAC system used to communicate, he/she needs more time to send messages.

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SCENARIO 6

18-month-old with age appropriate communication skills

Answer: CFCS Level IV–A typically developing 18-month-old does not consistently understand our messages or consistently convey their messages so that we can understand them.

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- Thank you for taking the time to review these materials. We hope you have found them helpful for your clinical practice.
- We appreciate any and all feedback!

- For more detailed information on development of the CFCS see Hidecker et al. (2011). Developing and validating the Communication Function Classification System (CFCS) for individuals with cerebral palsy. *Dev Med Child Neurol, 53(8), 704-710.* http://onlinelibrary.wiley.com/doi/10.1111/j.1469-8749.2011.03996.x/pdf

- If you are interested in how classification systems such as CFCS are useful, see Rosenbaum et al. (2014). Classification in childhood disability: focusing on function in the 21st century. *Journal of Child Neurology, 29(8) 1036-1045.* DOI: 10.1177/0883073814533008. http://jcn.sagepub.com/content/29/8/1036