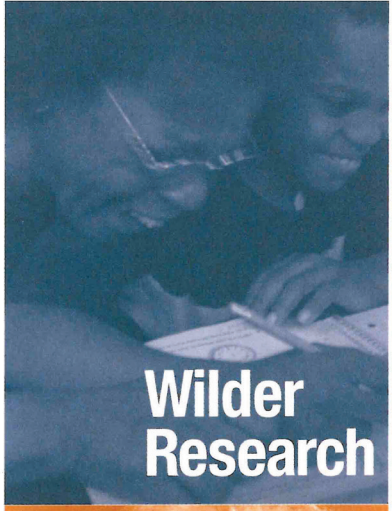
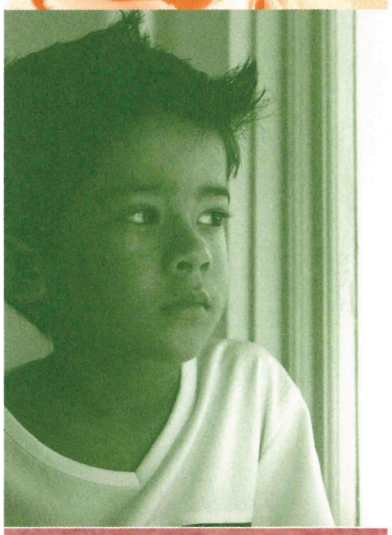
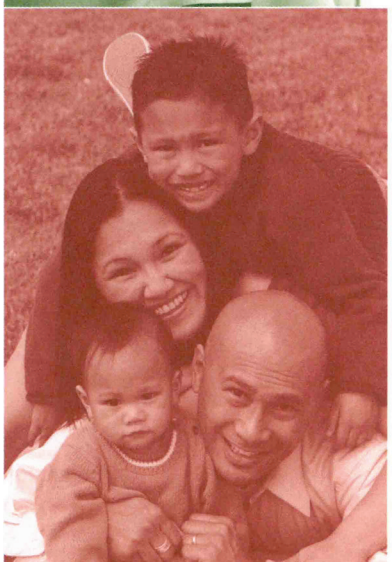






ABCD III: Lessons learned through Year 2

Implementation efforts and plans for sustainability among four pilot sites

FEBRUARY 2012

ABCD III: Lessons learned through Year 2

Implementation efforts and plans for sustainability among four pilot sites

Supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health and social issues. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

February 2012

Prepared by:
Melanie Ferris, Darcie Thomsen

Wilder Research
451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700
www.wilderresearch.org

Contents

Executive summary 1
Project background 7
Year 2 evaluation activities 7
Summary of highlights from the first evaluation report 9
Minnesota's Help Me Grow early intervention system 11
Early intervention eligibility and services 11
Changes to the early intervention system 12
Description of pilot site activities 14
Screening and referral summary 14
Common accomplishments, challenges 18
Site- specific summaries 19
Olmsted County 22
St. Louis County 25
Sustainability and spread 33
Current spread and sustainability efforts among pilot sites 33
Issues to consider when promoting statewide spread 35
Lessons learned 37
Recommendations 40
Suggested enhancements for pilot partners 40
Suggested enhancements for state-level stakeholders 41
Suggestions for Year 3 evaluation activities 43
Appendix 44
Summary of changes to Minnesota's early intervention system 45
Areas to monitor 50
Map of IEIC regions (as of July 1, 2011) 51
Summary of key reporting measures 52
Care coordinator interview protocol 62
Provider champion interview protocol 66
Early intervention staff interview protocol 69
MDE staff interview protocol 72

Figures

1. Clinic screening summary through June 2011 15

2. Referrals made to early intervention and medical/community providers through June 2011 16

3. Frequencies of follow-up communication and eligibility for Part B/C services 17

4. Referral and feedback communication flowchart – Anoka County..... 20

5. Referral and feedback communication flowchart – Olmsted County..... 24

6. Referral and feedback communication flowchart – St. Louis County..... 27

7. Referral and feedback communication flowchart – Ramsey County 30

Acknowledgments

Appreciation is extended to the local early intervention and clinic representatives from each ABCD III pilot site and Minnesota Department of Education (MDE) staff for participating in key informant interviews. We also thank the Department of Human Services (DHS) staff who helped shape the interview questions: Susan Castellano, Ruth Danielzuk, Glenace Edwall, Meredith Martinez, and Catherine Wright.

Wilder Research contributors to this report include:

Jennifer Bohlke
Marilyn Conrad
Michelle Gerrard
Rachel Hardeman
Cheryl Holm-Hansen

Executive summary

The Assuring Better Child Health and Development (ABCD) III initiative is supported through a three-year grant from the Board of The Commonwealth Fund to the Minnesota Department of Human Services (DHS). The purpose of the initiative is to develop and test sustainable models for improving care coordination, referrals, and screenings between pediatric primary care, other medical providers, and child and family service providers offering developmental and mental health services to children age birth through 5 years. The project supports four pilot sites (in Anoka, Olmsted, Ramsey, and St. Louis Counties).

A mixed-method evaluation approach, involving 25 semi-structured key informant interviews with local- and state-level stakeholders and a review of screening and referral data tracked by clinic and local early intervention staff, was implemented to: (1) describe the implementation efforts of the four pilot sites, including their accomplishments and challenges; (2) report the impact of these efforts, including changes in the number of youth screened and referred to early intervention services, and the timeliness of communication back to the clinic; (3) identify steps the pilot sites are taking to sustain and spread their efforts; and (4) provide recommendations to local partners for enhancing their efforts and to the Department of Human Services for supporting improved linkages between primary care and early intervention services across the state.

Key findings: Description of pilot site activities and their impacts

Baseline summary

When the ABCD III initiative began in late 2009, the pilot sites were at very different places in terms of planning and implementing ways to enhance their referral and coordination practices. There were initial differences between sites in their screening protocols, time available by care coordinators to facilitate referrals, and existing communication and coordination with early identification staff. None of the sites had processes for clinics to refer families to Help Me Grow or for early intervention staff to communicate information back to the clinic following a referral.

Recent activities

During the past two years, the pilot sites have worked to establish referral and communication processes that can be operationalized into daily practice and sustained over time. Key findings based on data collected through June 2011 include:

- While referrals to early intervention services were often triggered by elevated developmental screening results, less than one-third of the children referred to early intervention services (31%) received a simultaneous referral to a medical provider

- Clinic partners had received information back from early intervention staff for about half of the children they had referred, suggesting communication processes were in place but could be improved

- Clinic staff received confirmation from early intervention staff that one-third of the children referred to early intervention services through Help Me Grow were determined eligible for Part B/C services, though this percentage is likely to increase as follow-up communication is available for children referred

Detailed descriptions of the efforts made by each of the four pilot sites to establish more consistent communication protocols between the pediatric clinic and local school district staff are included in the full report. While this report focuses on the experiences of the partners involved with each pilot site team, it is important to note that in July 2011, the Minnesota Department of Education (MDE) restructured the early intervention system to refocus the IEICs' roles and responsibilities to those mandated in statute and to create a more consistent early intervention system. The restructuring, which reduced the total number of IEICs from 96 to 11, had a significant and immediate impact on the activities of the pilot sites located in the Twin Cities metro region, but had a negligible impact in greater Minnesota. Although this system-level change did not have a consistent impact across all pilot sites, the sites did experience a number of common implementation challenges and accomplishments:

- Across all pilot sites, teams with consistent member participation in project meetings noted relationships between partners had improved. This has led to greater understanding of the services available through different child-serving systems and more frequent communication following referrals.

- Although the specific steps taken by each pilot site to screen and refer children to early intervention services vary, all sites have developed referral forms that are being used regularly. The forms used by the pilot sites are based on a shared referral and communication form developed by DHS (which includes a brief section completed by the clinic describing the needs of the child and reason for referral as well as sections completed by local early intervention staff summarizing the assessment results and planned future services).

- While appropriate informed consent procedures have been incorporated into the referral and communication processes, it has not always been feasible to consolidate forms used to communicate information across systems. The pilot clinics have

developed processes to receive assessment results from local school district staff when direct referrals are made, but would also like to have similar processes in place that support communication when referrals are made through the online Help Me Grow system. Ideally, pilot clinics were interested in receiving referral confirmation through the online system, contact information for the local school district staff who will be following up with the family when referrals are made through the online system, and a summary of the child's assessment results from local school district staff.

- Overall, early intervention agencies without a centralized point of communication to coordinate feedback to the clinic have been less successful ensuring information is consistently sent back to the referral source from early intervention services and school districts following a referral. Two main barriers were identified as reasons these changes in practice have been difficult to operationalize: (1) challenges developing a single informed consent form and consistent referral and communication process at the system-level that can be adopted by local early intervention agencies and clinics; and (2) limited time among care coordinators to monitor referral status and follow-up with local early intervention and school district staff.

- The consistency of feedback from local school district staff varies considerably across pilot sites, with more effective communication occurring among pilots sites with both clinic care coordinator and early intervention staff time allocated for proactive coordination and referral monitoring.

Sustainability and spread

All pilot sites have already begun to take steps to expand their efforts to include multiple providers at the partner clinic, and some pilot sites have begun to consider ways to expand these efforts to other departments, clinics, or school districts. Representatives from all pilot sites felt that, as a result of shared paperwork and stronger cross-disciplinary relationships, elements of their improved screening, referral, and communication processes could be sustained over time. However, all sites were still working to fully integrate the processes into practice. Two common challenges identified by the pilot sites were: (1) limited clinic care coordination hours, making it difficult to follow up on referrals made to early intervention staff, and (2) ensuring all school district partners, including some that were not involved with the initiative prior to the restructuring in July 2011, were aware of and invested in implementing the new communication protocols.

While the pilot sites have considered expansion and sustainability primarily at a local level, the lessons learned from their work to date can also inform the efforts of state agencies to encourage and support changes in state policy and practice that lead to

improved communication and care coordination. DHS staff are encouraged to consider the following key findings when considering strategies to promote statewide spread:

- Spread can, and will likely need to, be supported at both a local level and state level.
- Standardized documents are likely needed to maintain efficiency in the referral and communication processes used by clinic and school district staff.
- Additional discussion is needed to determine ways the state Help Me Grow referral system can assist referring providers to connect to the appropriate school district while still protecting student privacy.
- Pilot partners felt face-to-face meetings were essential to building interdisciplinary relationships.

Recommendations

Based on the information gathered through this baseline set of key informant interviews with Help Me Grow representatives, Wilder Research developed the following recommendations for the pilot sites and DHS to consider as they continue their ongoing work with each partner throughout the initiative.

Suggested enhancements for pilot partners

- **Work collaboratively to identify reasons for delays in follow up information being sent to the clinic.** It may be helpful for the teams to focus future quality improvement cycles (the PDSA – Plan, Do, Study, Act – cycles) on reviewing the status of referrals where follow up information has not been received to determine why communication has not been received and develop strategies to address these barriers.

- **Identify and establish relationships with early childhood staff from local school districts not currently involved in the initiative.** ABCD III clinic partners may need to take additional steps to gather contact information for the specific person(s) from each district who receives referrals through the online Help Me Grow system, such as requesting lists of school district representatives from the Department of Education or working to develop contact lists through the regional IEICs as they are established.

- **Consider ways to integrate ABCD III initiative activities into the job descriptions of involved staff and allocate time and resources to support care coordination and communication activities.** Staff time and other resource allocations (e.g., modifications to existing tracking systems to monitor the status of referrals) may also be changed in order for these efforts to be sustained over time. Partners may need to do more work within their clinic, school district, or agency to create buy-in for these changes at multiple administrative levels.

Suggested enhancements for state-level stakeholders

- **Consider policies or guidelines to encourage and incentivize care coordination efforts among clinic and school district staff.** Clear definitions of care coordination tasks would help standardize these key roles, as would some type of reimbursement for these services.

- **Implement enhancements to the online Help Me Grow system that help facilitate communication between clinic providers and school district staff.** The pilot site teams have suggested a number of enhancements to the Help Me Grow referral system that would help them better monitor the status of referrals they make to early intervention services: an option to attach documents to allow for sharing of screening results, referral

forms, and other medical information; and a system confirmation email that assures the provider the referral has been received and includes the contact information for the school district staff members who they can contact for additional information.

- **Establish a standard informed consent process that can be used to ensure clinic providers gather basic information from school district staff following a referral.** Rather than continuing to pursue standard release of information and communication forms that allow both the clinic and school district to share information, an alternative approach could involve developing a common release of information form to be used by clinics that asks parents for their permission to a far more limited set of information from the school district. Though not a fully streamlined process, this approach would help medical providers request standard types of information from school districts in a consistent manner while still allowing school districts to develop their own informed consent form for sharing additional information with clinics, as needed.

- **Train and encourage school district staff to routinely ask families to share information with the child's medical provider during the assessment process.** Early intervention staff can take a more proactive role to communicate with clinics by routinely asking parents for their permission to share assessment results and referral recommendations with the child's medical provider as part of the assessment process. Standardizing this practice would ensure all families have the option of choosing whether to allow greater communication between their child's school and clinic.

Suggestions for Year 3 evaluation activities

- **Offer individual technical assistance to each pilot site team to review clinic screening and referral data.** Some pilot sites may be interested in additional time with Wilder Research staff to review the results from their clinic's Access database, identify situations where patient information was not communicated in a timely manner, and consider strategies to improve their team's processes.

- **Integrate questions into the final provider champion interviews to assess how follow-up information is being used by pediatricians and providers.** At this stage in the evaluation, it was too early to have a good sense of which providers follow up with patients using the information they receive. However, this information will be helpful to capture in the final evaluation report so that school district and early intervention staff better understand how their work to communicate information improves patient care.

Project background

Awarded in 2009, the Assuring Better Child Health and Development (ABCD) III initiative is supported through a three-year grant from the Board of The Commonwealth Fund to the Minnesota Department of Human Services (DHS). The purpose of the initiative is to develop and test sustainable models for improving care coordination, referrals, and screenings between pediatric primary care, other medical providers, and child and family service providers offering developmental and mental health services to children age birth through 3 years, though Minnesota chose to include children up to age 5. The project supports four pilot sites (in Anoka, Olmsted, Ramsey, and St. Louis Counties). A variety of strategies are being used to enhance care coordination by establishing or strengthening linkages between primary care clinics and community-based medical specialists and mental health service providers. If successful, the initiative will result in benefits such as timely access to services for children with potential developmental and/or social-emotional concerns and improved care coordination.

This report is the second of three planned reports designed to: 1) describe the implementation efforts of the four pilot sites, including their accomplishments and challenges; 2) report the impact of these efforts, including changes in the number of youth screened and referred to early intervention services, and the timeliness of communication back to the clinic; 3) identify steps the pilot sites are taking to sustain and spread their efforts; and 4) provide recommendations to local partners for enhancing their efforts and to the Department of Human Services for supporting improved linkages between primary care and early intervention services across the state. Because a major restructuring of the early childhood system occurred in 2011, this report also briefly summarizes the impact of changes to the state's early intervention system on project activities.

Year 2 evaluation activities

Semi-structured key informant interviews were conducted with representatives from each project site, as identified by Department of Human Services (DHS) staff. Interviews were conducted with provider "champions," care coordinators, and local and regional Help Me Grow staff to better understand how care is currently coordinated and how the initiative has impacted screening, referral, and communication processes among pilot partners. In addition, partners were asked to describe any challenges or barriers to implementation, as well as planned strategies for sustaining and spreading their efforts. Interviews with the following partner groups were conducted August - October 2011:

- **Care coordinators:** A total of nine care coordinator representatives were identified as key informants by the Department of Human Services (DHS) staff. Seven interviews

were completed, representing all pilot sites. One identified key informant was on leave during the data collection period, and one did not feel they had enough involvement with the initiative to participate in the interview.

- **Provider champions:** At each pilot clinic, one provider – highly interested in improving current screening, referral, and communication processes and willing to contribute time to develop and implement changes to current protocols – has been identified as the "provider champion." Interviews were completed with three of the five provider champions identified as key informants by DHS. Two provider champions did not respond to multiple attempts to schedule an interview.

- **Help Me Grow and local school district staff:** A total of nine early intervention and local school district staff were identified as key informants by DHS, and seven interviews were completed, representing all pilot sites. Two of the identified representatives did not respond to multiple attempts to schedule an interview.

- **Minnesota Department of Education (MDE) staff:** Key informant interviews were conducted with four MDE staff members who have been involved with restructuring the early intervention system and developing the state's Help Me Grow referral system. This data collection activity was added specifically for this Year 2 report, as some information about the restructuring was needed to provide greater context to the implementation efforts described by some of the pilot sites.

In addition, each clinic site maintained an Access database developed by DHS to track screening results and outcomes, referrals to Help Me Grow, and follow up communication received from local school districts and early intervention staff. The tracking system allows Wilder Research to gather quantitative data demonstrating the length of time between referral and assessment, consistency of communication with the clinic, and the percentage of youth referred and determined eligible for Help Me Grow services.

All early intervention partners were also asked to maintain an Excel tracking sheet to monitor the referrals made to them through the initiative and the outcomes of these referrals, including referrals for children who were not determined eligible for Part B/C services. Depending on the structure of the referral and communication process for each site, the tracking sheet was maintained by local school district staff or a central intake office representative. Three of six partners submitted a spreadsheet for youth referred through June 30, 2011. The relatively low response rate was likely due, in part, to the restructuring changes that were also being finalized at this time. Early intervention staff also noted challenges tracking referral information only for children enrolled in Medicaid, as they do not typically have different paperwork requirements for children based on insurance status.

This report summarizes key findings from the series of interviews, describing pilot team activities during the second year of the initiative. During the interviews, team representatives were asked to describe changes to their referral, communication, and coordination practices since they began the initiative. Many also discussed their early work to sustain and spread their efforts. Key themes common across all pilot sites are highlighted.

Summary of highlights from the first evaluation report

In 2010, a series of baseline reports were prepared to summarize the screening, referral, and communication processes used and anticipated challenges to improved communication and coordination from the perspectives of medical providers, clinic care coordinators, and early intervention staff. Across all stakeholder groups and within each pilot site, partners noted a need to improve communication and coordination between medical providers and early intervention and hoped their involvement would help them develop better relationships and processes that could be sustained over time. The baseline interviews identified a number of ways in which referral and communication processes could be improved.

- **In general, clinic providers were less familiar with early intervention services and less likely to make referrals to these services than to specialty medical providers.** Prior to the initiative, providers from the participating clinics reported they often offered anticipatory guidance to parents about their child's development; asked parents if they have any concerns about their child's development; and used validated, standardized instruments to assess for potential developmental and mental health concerns. However, they were less likely to refer children to Help Me Grow (Minnesota's early intervention referral system) or community services as a result of an elevated screening score or other developmental/mental health concern. In addition, providers tended to be more comfortable referring children to medical specialists than to community services, and they were more familiar with the developmental referral options available to them in their practice than with mental health referral options. Few providers "strongly agreed" that they had a strong understanding of the services available to children through Help Me Grow or had a strong working relationship with local early intervention staff.

- **Prior to the initiative, there were no consistent processes to streamline referrals, share medical information with early intervention staff, or ensure feedback was given to the referring provider by school district staff.** As a result, all sites focused some of their early work on developing common referral and informed consent forms. They stressed the need for forms that could be completed efficiently, while still providing enough detail to be useful to early intervention staff and the providers. It should be noted that the level of coordination between staff from each clinic and local early

intervention services staff varied considerably at baseline. We anticipated this would lead to some sites being better positioned to make changes in their referral, communication, and coordination processes.

- **Across the four pilot sites, there was wide variability in care coordinator roles and responsibilities.** Clinic care coordinators usually had other primary roles within the clinic (e.g., clinic administrator, RN), and spent only a portion of their time on care coordination activities. Although the amount of time spent on care coordination activities at each clinic varied, all coordinators felt the amount of time needed to provide these services was less than the amount of time available. At baseline and through the first year of the initiative, the care coordinators had systems in place to track referrals, but these varied widely – from queries built into their electronic health records system to notecards or other paper forms.

- **While team meetings were difficult for some partners to attend regularly, teams who had begun their implementation efforts noted the importance of face-to-face meetings in building relationships and sharing information between partners.** A few representatives felt some providers had already learned about criteria that could lead to early intervention referrals (e.g., low birth weight). In addition, a number of partners felt the meetings helped them better understand the services available to children through Help Me Grow, as well as the types of information that were needed by partners in other child-serving systems.

- **All teams were concerned about anticipated changes to Minnesota's early intervention system, which were being planned by the Minnesota Department of Education (MDE).** The partners knew the restructuring plan would lead to a regional, rather than local, system and changes to the roles and responsibilities of local early intervention staff. However, specific details were unknown when the first series of interviews were completed. These changes went into effect on July 1, 2011 and will be described in this report.

Minnesota's Help Me Grow early intervention system

Under Minnesota Statute, Interagency Early Intervention Committees (IEICs) are responsible for creating a local infrastructure to support the complex needs of young children age birth to five and their families, by ensuring processes are in place to identify, screen, assess, and refer these children to appropriate services. This network of IEICs and the services provided by the school districts - collectively called Help Me Grow - is Minnesota's early intervention system for Infant and Toddler Intervention Services (IDEA Part C services for children age 0-2) and Preschool Special Education (IDEA Part B services for children age 3-5). The Minnesota Department of Education (MDE) is the lead state agency receiving federal funds for the purposes of providing early intervention services. MDE works closely with other agencies, including the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS), to provide families with coordinated, comprehensive and multidisciplinary early intervention services.

Early intervention eligibility and services

Part B/C eligibility is based on: certain diagnosed physical or mental conditions or disorders; demonstrated delays as measured by assessment and evaluation procedures in cognitive, physical, communication, social or emotional, and adaptive development areas; and/or a high probability of a delay resulting from a physical or mental condition, regardless of whether the child is currently demonstrating a need or delay. Once referred to Help Me Grow, a family will be contacted by staff from their local school district or other early intervention system to get more information regarding the concerns. Trained early childhood specialists will arrange for a developmental screening or schedule a comprehensive evaluation to determine eligibility for Help Me Grow: Infant and Toddler Intervention Services or Preschool Special Education Services.

An Individualized Family Services Plan (IFSP) for age 0-2 or an Individualized Education Program (IEP) for age 3-5 is created for children who meet the program requirements. This written plan provides a clear outline of priorities, services, and outcomes for early intervention services and preschool special education services. A service coordinator is assigned to help families of children age 0-2 access services and resources, convene IFSP meetings and periodic reviews, and change the service plan as needed. Children age 3-5 receiving services through an IEP are assigned an IEP Case Manager.

Current referral activities

In general, the pilot sites fax referral forms directly to their local early intervention (EI) partner or used the online Help Me Grow system to refer, but also sent a simultaneous fax or email to the EI partner to alert them to the referral and to send the partner the referral form and any relevant information (e.g. screening forms, medical records). Representatives from the pilot site clinics felt it would be helpful for the online referral system to: 1) provide confirmation that the clinic referral had been received; 2) notify the clinic of which district the referral was sent to and who can be contacted at the school district for more information; and 3) allow the clinic to attach informed consent forms or other documents that would be helpful to EI staff and allow follow-up communication to occur.

Changes to the early intervention system

A series of interviews were conducted with MDE staff and questions were added to the key informant interviews with pilot site clinic and early intervention staff to explore the potential impact of these changes. A more detailed summary, including the reasons for the restructuring, anticipated benefits and challenges, and the impact of these changes, as perceived by pilot site stakeholders, is included in the appendix.

Briefly, when the ABCD III initiative began, there were 95 IEICs across the state, each comprised of individuals representing school districts, social service agencies, early childhood organizations, and parents. These IEICs were often organized at a county-level, though in more populated areas of the state, IEICs were centralized around individual school districts or school cooperatives. On July 1, 2011, the Minnesota Department of Education (MDE) restructured the early intervention system to a regional IEIC model. At the most basic level, the restructuring led to three significant and interrelated changes to the state's early intervention system: 1) a reduction in the total number of IEICs; 2) a shift in funding allocation from the IEICs to local school districts; and 3) clarification of the roles and responsibilities of the IEICs to a more limited set of activities (as defined through state statute and federal requirements).

Early experiences of pilot site partners

At the time of the key informant interviews, the regional IEICs were still being established and there was uncertainty as to how the restructuring may change the referral and communication protocols established by the four pilot sites. However, the pilot site representatives were able to provide some initial feedback about their perception of the restructuring's impact on their work. While partners with the Olmsted County and St. Louis County pilot sites did not feel the restructuring had led to changes in their work, the restructuring had led to significant changes with the two Twin Cities metro locations

(Anoka and Ramsey Counties). Prior to the restructuring, both metro counties had a central office that took referrals through a specific intake line, conducted intake interviews with the families referred to Help Me Grow, had consent forms signed and facilitated a referral to the appropriate school district for further evaluation for Part B/C services. In this model, the central office served as a communication hub for referring providers and school district staff and helped ensure follow up information was sent back to the clinic. While some features of the central office remained in both counties following the restructuring, their scope of work has narrowed.

Description of pilot site activities

When the ABCD III initiative began in late 2009, the pilot sites were at very different places in terms of planning and implementing ways to enhance their referral and coordination practices. There were initial differences between sites in their screening protocols, time available by care coordinators to facilitate referrals, and existing communication and coordination with early identification staff. However, none of the sites had processes to refer families to Help Me Grow or to communicate information back to the clinic following a referral. During the past two years, the pilot sites have worked to establish, referral, and communication processes that can be operationalized into daily practice and sustained over time. Although all pilot sites have the necessary forms in place, it has proven difficult for all partners to fully integrate these changes into their practice.

Screening and referral summary

Each clinic participating in the ABCD III initiative is using an Access database (developed by the Minnesota Department of Human Services) to monitor screening results, referrals made through Help Me Grow and to other community services/medical providers, and the timeliness of communication with early intervention staff. The data presented in this report include all information gathered by the clinic partners from the date their project implementation began (on or before January 1, 2011) through June 30, 2011. Although some of the participating clinics are using the database to track and monitor all children (age 0-5) referred to early intervention and other medical services, the evaluation for this initiative focuses only on children who are enrolled in Minnesota's Medicaid program. At the time these data were submitted by clinic partners, North Metro Pediatrics had not yet screened or referred a child enrolled in the Spring Lake Park school district (a subgroup of MA-enrolled youth, and the target population for the Anoka pilot). As a result, the Anoka totals in the following tables (Figures 1-3) include only data submitted by Fridley Child & Teen Clinic. Additional evaluation measures of interest to the funder are reported in the appendix.

In each database submitted, there were some missing data, particularly the date of the child's screening or clinic appointment and the date of communication received from the school district and/or early intervention services partner. These data issues have been shared with the clinics' care coordinators, and are expected to be resolved before the next reporting period. Because of the relatively small numbers of youth served by each pilot site, and some of the missing data concerns, these data should be considered preliminary.

Across the four pilot sites, screening and referral data were gathered for a total of 93 children. Across the four pilot sites, clinics screen children for developmental or social-emotional concerns at key intervals using the Ages and Stages Questionnaire – developmental and social-emotional versions (ASQ and ASQ:SE) – or Ireton Development Screening Inventory. For evaluation purposes, the clinics are entering screening and referral data for children age 0-5 who have an elevated screening score or who are referred for early intervention services. The percentage of children with elevated screening scores ranged from 0 percent (Anoka) through 83 percent (Olmsted) (Figure 1). Because children with non-elevated screening scores are not entered into the database, the percentages of youth screened with elevated scores at each pilot site are not generalizable estimates of the prevalence of developmental concerns across the clinic's patient population.

1. Clinic screening summary through June 2011

	Anoka County	Olmsted County	Ramsey County	St. Louis County
Total number of children entered into database with screening scores reported	9	35	18	31
Percentage of children screened with elevated scores	0%	83%	61%	65%

Note: *The total number includes only children in the site's target population (children age 0-5, MA-enrolled) who have elevated screening scores or who are referred to early intervention services. In Anoka County, the target population is restricted further to only include children enrolled in the Spring Lake Park school district. One clinic (North Metro Pediatrics in Anoka County) has not yet served any children in the project's target population.*

Through June 2011, a total of 83 children were referred to early intervention services through Help Me Grow. In three of the pilot sites (Olmsted, Ramsey, and St. Louis Counties), roughly three-quarters of youth with elevated screens (72%-82%) were referred to Help Me Grow. Fewer children with elevated screening scores were referred to other services (e.g., community providers, case management, medical specialists) (8% in Olmsted County, to 45% and 47% in Ramsey and St. Louis Counties, respectively). Although DHS has encouraged simultaneous referrals to both medical providers and early intervention services, this does not occur frequently. There is concern among providers from at least one pilot site that concurrent referrals may result in unnecessary duplication of services, but this issue was not explored in detail during the key informant interviews. Overall, only 26 children were referred to both Help Me Grow and other types of services at the time of the pediatric appointment (Figure 2).

2. Referrals made to early intervention and medical/community providers through June 2011

	Anoka County	Olmsted County	Ramsey County	St. Louis County
Number of referrals made to Help Me Grow	9	36	17	22
Percentage of youth referred to Help Me Grow with elevated screening scores	0%	72%	82%	74%
Percentage of youth with elevated screening scores referred to other services	0%	8%	45%	47%
Number of children referred to both HMG and other agencies	3	4	11	8

Note: *Not all children referred to early intervention or specialty medical services had elevated screening scores.*

Through the end of June, clinic partners had received information back from early intervention staff for roughly half of the children they referred. For some children it may have been too soon after the referral (within 45 days or before the evaluation was complete) to expect to receive feedback from early intervention services. However, a more detailed review of the data submitted by the clinics confirmed that information was missing for children referred earlier in the initiative, including children under 3 years of age who are required to receive an evaluation from the school district within 45 days of the referral. Delays in entering information into the Access database may also contribute to, but not fully explain, why follow-up information was received by the clinic for approximately half of all children referred to early intervention services.

Data submitted by three of the clinics confirmed approximately one-third of the children referred to early intervention services through Help Me Grow were determined eligible for Part B/C services. However, because information for this field was not consistently entered in each clinic database, this total likely underestimates the percentage of children determined to be eligible for early intervention services under Part B/C. These missing data issues have been shared with partners from each pilot site (Figure 3).

3. Frequencies of follow-up communication and eligibility for Part B/C services

	Anoka County (N=9)	Olmsted County (N=36)	Ramsey County (N=19)	St. Louis County (N=22)
Number of children for whom the clinic received information following a referral to EI services (% of youth referred)	4 (44%)	17 (47%)	10 (53%)	13 (59%)
Percentage of children determined eligible for Part B/C services among all referred [a]	-	36%	30%	33%

[a] *This total includes all children referred through Help Me Grow, including those for whom the clinic has not received follow-up information.*

Comparisons of data tracked by the clinic and early intervention staff suggest greater communication is needed to monitor referral status and clarify which children should be identified as ABCD III participants. An Excel tracking sheet was developed for early intervention staff to track referrals made by the clinic and the outcomes of these referrals. These tracking sheets were completed and submitted by only Ramsey County (completed by the Ramsey County central office), Duluth Public Schools District, and the Spring Lake Park School District. Although the tracking files maintained by the clinic and early intervention partners for each pilot should contain information for the same children in the initiative's target population, there were differences in the lists submitted by each site. Although this may simply reflect data entry delays, it suggests there may be weak links in the referral and communication processes established by each pilot site. In addition, for at least one pilot site, there has been some confusion about which children to monitor for evaluation purposes. While the project partners may have the long-term goal of monitoring referrals made to early intervention services by other system partners, the evaluation is focused on tracking information for children who were referred directly by the clinic, not including children referred by other agencies who happen to be patients at the pilot clinic.

Common accomplishments, challenges

Relationships between partners have improved. Across all pilot sites, those who have participated in project meetings noted relationships between partners had improved. This has led to greater understanding of the services available through different child-serving systems and more frequent communication following referrals. In addition, a number of partners noted more willingness among partners to continue working on larger system-level barriers to interdisciplinary referrals and communication.

> There are things we're fine tuning, but the doors are open for communication.
> —Early intervention staff

Although the specific steps taken by each pilot site to screen and refer children to early intervention services vary, all sites have developed referral forms that are being used regularly. The forms used by the pilot sites are based on a common referral and communication form developed by the Minnesota Department of Human Services as part of the technical assistance they provide to the pilot partners. Although the forms developed by each pilot site vary somewhat in terms of the level of detail, all forms have a brief section completed by clinic that summarizes the needs of the child and reason for referral, and sections to be completed by local early intervention staff that summarize the result of the referral and planned services.

Appropriate informed consent procedures have been incorporated into the referral and communication processes, but it has not always been feasible to consolidate forms used to communicate across systems. When the initiative began, the pilot sites were interested in developing shared informed consent forms that can be used by both clinic and early intervention staff to allow for bi-directional sharing of information. However, it has been difficult to develop a single form that all system partners feel is adequate. A common concern among pilot sites is the difficulty of developing an informed consent process that allows them to refer through the state Help Me Grow system and receive information about which district will be following up with the child and family, as well as the final evaluation results from local school district staff.

Overall, the pilot sites without an early intervention point person responsible for coordinating feedback to the clinic have been less successful ensuring information is consistently sent back to the referral source from early intervention services and school districts following a referral. Two main barriers were identified as reasons these changes in practice have been difficult to operationalize: 1) challenges developing a single informed consent form and process that works across systems, and 2) limited time among care coordinators to monitor referral status and follow-up with local early intervention and school district staff. However, improved relationships between partners

have allowed some sites to follow up on referrals, when time is available. For example, in Ramsey County, communication (described in more detail in the site-specific summaries) for the suburban school districts in Ramsey County is streamlined through a central office, but needs to be established separately with staff from Saint Paul Public Schools. Similarly, the Child Find coordinator for 12 school districts in St. Louis County (not including Duluth Public Schools) plays a key role as the point person to facilitate communication between the clinic care coordinator and local school district staff.

Proactive coordination and communication strategies are needed to develop and sustain effective communication loops. The consistency of feedback from local school district staff varies considerably across pilot sites. The data submitted by the pilot site partners indicated there were delays in getting information from school district staff following the referral or in entering this follow up information into the tracking sheets after it is received by the clinic. Each pilot site has different processes in place and use different combinations of staff roles and responsibilities to relay information between the clinic and school district. However, pilot sites with staff time allocated for proactive coordination and referral monitoring roles seemed to have more effective communication feedback.

Site- specific summaries

Anoka

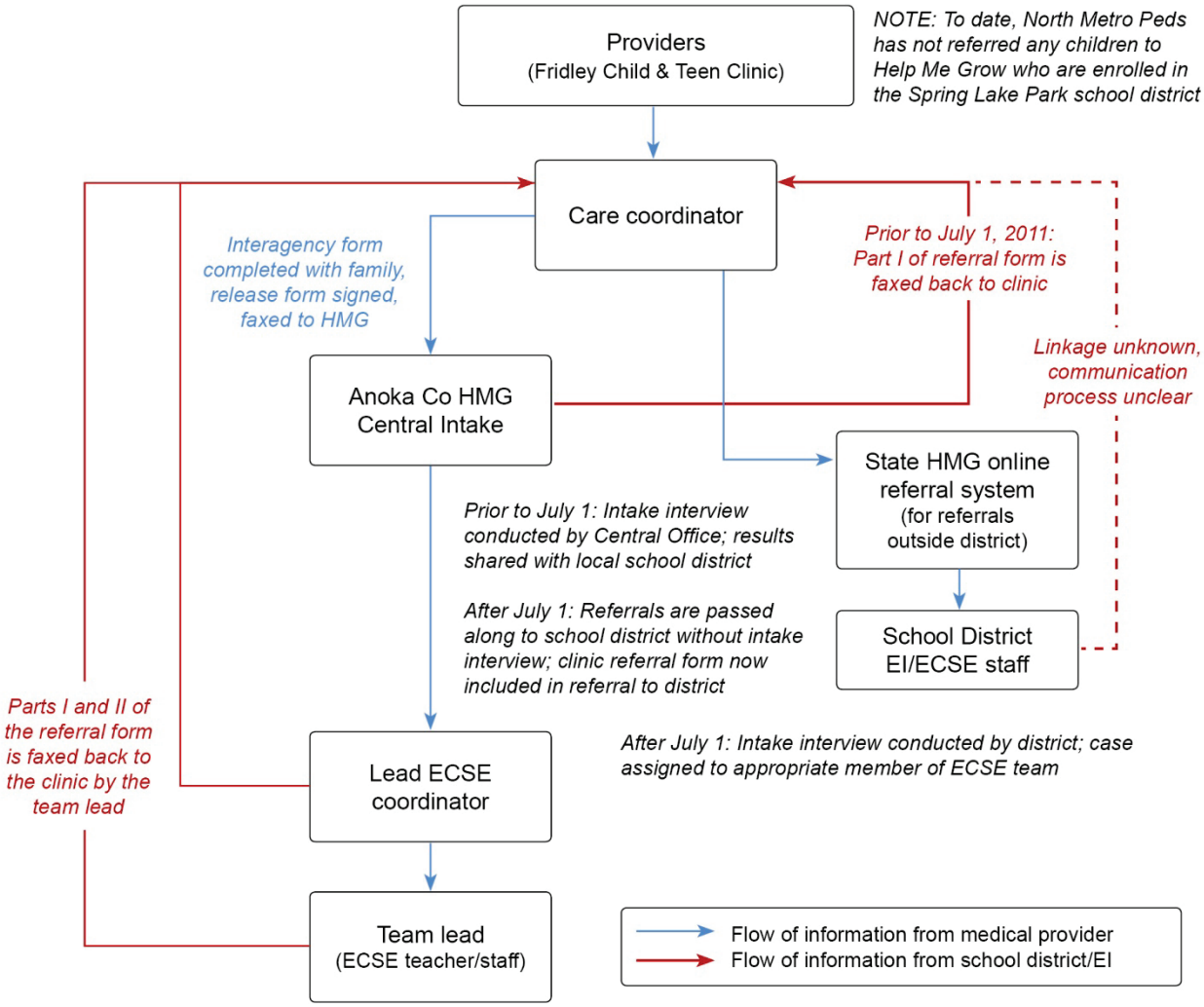
The Anoka County pilot team includes two clinics, Fridley Child & Teen Clinic and North Metro Pediatrics, who are focusing their efforts on developing screening, referral, and communication procedures with one school district in the county, Spring Lake Park. There are strong existing partnerships in the county between a number of early childhood agencies and programs in the county, including Head Start and the Anoka County Public Health Department. However, there were not strong relationships between the clinics and these early intervention partners. Prior to the restructuring, Anoka County Help Me Grow central office staff played a key role in facilitating referrals, collecting data for the evaluation, and ensuring follow-up. Changes in central office staffing and the scope of activities supported by the central office did lead to major disruptions in the clinic's referral and communication processes. In addition, some partners have not participated consistently in team meetings. Despite these challenges, the team does have a referral and communication plan in place that they are working to implement with greater consistency.

Current referral practices

Informed consent and referral forms have been created and implemented by both partner clinics. At both clinic sites, providers make referrals to Help Me Grow following

an elevated screening score or other concerns about the child's development. At Fridley Child & Teen Clinic, the medical assistant completes an informed consent form with the family when the provider makes a referral to Help Me Grow for children enrolled in the Spring Lake Park school district and faxes this document and the referral form directly to the Anoka County central office. All other referrals are made through the online Help Me Grow system. The care coordinator at North Metro Pediatrics is responsible for faxing their informed consent and referral forms to the central office for all children in Anoka/ Hennepin and Spring Lake Park school districts and uses the online system for all other referrals. Thus far in the initiative, North Metro Pediatric clinic has not referred any children in the Spring Lake Park school district to Help Me Grow.

4. Referral and feedback communication flowchart – Anoka County



The early intervention system restructuring disrupted the pilot site's feedback process, but these issues are being addressed. Prior to the restructuring, when the central office received a referral, they contacted the family and conducted a brief 30-minute intake interview. The referral form was then faxed back to the clinic to share the results of the referral (e.g., plans for future appointments, service referrals, confirmation the parent gave consent for additional evaluation activities). According to Fridley Child & Teen staff, they typically received this follow-up information within 48 hours of the referral. The form was then forwarded to the school district so that information could be added summarizing results from the child's evaluation and referrals made for additional services.

When the restructuring occurred, the Anoka County central office no longer had a role in conducting intake interviews, and the central office was replaced with a single staff person who is now responsible for simply forwarding referrals on to the district. However, when the staff change occurred, the form from the clinic used to trigger follow-up communication was no longer being forwarded to the school district. This disruption in the referral process has been resolved, but the pilot partners continue to refine their processes. At the district level, a new part-time staff person has been hired to take on some of the responsibilities associated with conducting the intake interviews. This person may also assist with some of the data collection and reporting tasks for ABCD III in the future.

Unique implementation elements

The two clinic partners use different approaches to refer children to mental health services. At Fridley Child & Teen Clinic, referrals for mental health concerns are made directly through Help Me Grow. The clinic care coordinator noted that there are a limited number of providers in the area, but that it is difficult for the clinic to know whether providers are taking new patients and to update the types of insurance accepted by each agency. They feel families may become frustrated when they receive a list of potential providers from the clinic, only to learn they cannot actually schedule an appointment with many of them. In contrast, North Metro Pediatrics makes most of their mental health referrals to a provider who accepts sliding-fee payments, but may not make concurrent referrals through Help Me Grow.

Accomplishments, challenges

The representative from the school district felt all referrals from the clinic were appropriate. However, there were situations where a child who received care from the clinic was referred by another agency (e.g., WIC). This suggests there may be patients that clinic providers could refer earlier for early intervention services. At the time of the interviews, the partners had not discussed a protocol for sharing information for children who receive care from a clinic provider but were referred by a different agency.

Because the target population for this initiative is narrowed to only children enrolled in the Spring Lake Park school district, the effectiveness of the referral and feedback processes used by North Metro Pediatrics cannot be adequately measured. According to the care coordinator at North Metro Pediatrics, the clinic serves very few children who are in the Spring Lake Park school district. Expanding the initiative to another district would offer more opportunities to examine how well the feedback communication process works for this clinic location.

Planned Year 3 activities

The two clinics have established screening and referral processes that they plan to continue to refine in the final year of the initiative. However, at the time the interviews were conducted, it did not seem all partners had a shared vision to create and sustain a more consistent and efficient feedback loop between local school districts and clinics.

Olmsted County

The Olmsted County pilot team includes the Mayo Clinic, which is focusing on improving its screening, referral, and communication processes with the Rochester and Zumbro School Districts. The Mayo Clinic serves children and families from Rochester and surrounding communities.

According to the local Help Me Grow representatives interviewed, communication and coordination with the Mayo Clinic has improved as a result of the initiative. For example, one representative felt that they were receiving earlier referrals, and that clinicians had a better understanding of the available community resources. Enhancements to the referral process have been made, but additional work is needed to refine communication processes that meet the requirements of all partners.

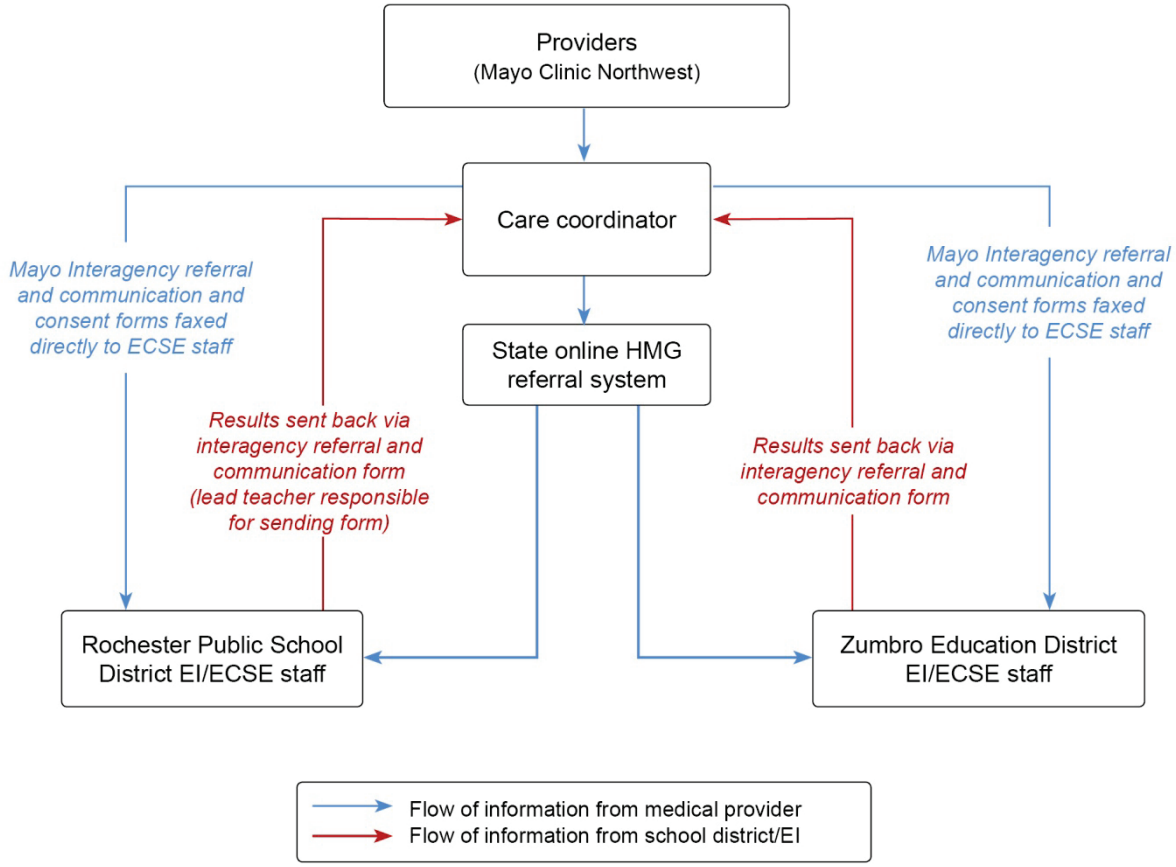
Current referral practices

Through the initiative, referral and communication processes between the Help Me Grow offices and clinic staff have been established and implemented. The Mayo Clinic administers the Ireton to screen children for potential developmental concerns. The Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) and the Modified Checklist for Autism in Toddlers (M-CHAT) are mailed to parents near the child's 18-month birthday to further identify children who may benefit from more thorough social-emotional, developmental, or autism evaluations. The developmental screening coordinator tracks and integrates all assessment results into the electronic medical record (EMR). When a child has an elevated screening score or has concerns that suggest a need for early intervention services, the clinician places an order for referral through the EMR system. Next, the

developmental screening coordinator completes an informed consent form and the Interagency Referral & Communication Form with the family, enters the referral into the state online Help Me Grow referral system, and faxes the completed forms directly to the Rochester or Zumbro Help Me Grow offices. After referrals are received, the intake staff at each local school district is responsible for contacting the developmental screening coordinator to confirm that the referral was received. Next, the Help Me Grow office staff contact the family for an intake interview. After the intake interview is completed, evaluations are conducted for those children whose screening interviews indicate a need for further assessment. For those children whose intake interviews do not indicate a need for further evaluation, a summary of results is sent to the referring clinician. Similarly, when an evaluation is completed, a summary is sent to the referring provider. Intake and assessment staff may also refer the family to resources in the community to address other specific needs throughout the intake and evaluation process.

The use of the state online Help Me Grow referral system is increasing. The Rochester Help Me Grow representative noted that all referrals from the partner clinic were now coming through the state online referral system. When making referrals to the state online referral system, the clinic simultaneously faxes a consent form that allows the provider to release additional information to Help Me Grow staff and alerts them that a referral has been made. One Help Me Grow representative stated they sometimes follow-up directly with the clinic before contacting the child's caregiver, but noted that it is more common to contact the child's parent if further information is needed prior to completing an intake interview. Overall, the information received from the clinic was considered adequate; however, representatives from the clinic felt that communication after a referral is received could be improved.

5. Referral and feedback communication flowchart – Olmsted County



Unique implementation issues

To reduce a perceived duplication of services, dual referrals are not commonly pursued by the pilot site. When asked how often the clinic refers patients to both a medical specialist and Help Me Grow, clinic representatives reported concern that dual referrals would result in duplication of services. Site representatives also felt that many of their patients prefer to pursue referrals within the Mayo Health System before those at other community agencies.

Accomplishments, challenges

Through the initiative, the pilot team has increased collaboration with community providers in order to reduce the number of families who complete duplicate screenings. Prior to participating in the initiative, there was little communication between the Rochester School District's early screening program and the clinic. As a result, many families were being asked to complete the same screening tool multiple times (from the clinic and as part of the district's early childhood screening). To minimize paperwork burden for families, the Rochester School District now sends all early childhood screening results for Mayo Clinic patients to the developmental screening coordinator at Mayo, where results are

documented in the child's medical record. Additionally, clinicians now receive prompts through the clinic's EMR system to refer children who are approaching their third birthday to their local school district for early childhood screening.

The pilot site is no longer pursuing a common consent form. During the first two years of the initiative, the team discussed sharing a common consent form to minimize paperwork burden for families. However, at the time of the interviews, the pilot team members felt that without further guidance and oversight from state agencies (particularly DHS and MDE), the legal complexity of sharing information among multiple systems will preclude them from developing a common consent form.

Planned Year 3 Activities

During the final year of the initiative, the project partners were interested in refining their communication processes, expanding the referral and communication processes to more Mayo Health Systems providers, and exploring options for providers to make more active referrals to Head Start.

St. Louis County

The St. Louis County pilot team includes the St. Luke's Pediatrics, Duluth Help Me Grow, and the St. Louis County Help Me Grow Collaborative. St. Luke's Pediatrics serves children and families from Duluth and surrounding communities.

According to the pilot team members interviewed, communication and coordination between the clinic site and local Help Me Grow offices has improved as a result of the initiative. For example, one representative reported the referrals from doctors have doubled over the past two years, and that they receive earlier and more frequent communication from primary care providers since the initiative began. Enhancements to the referral process have been made, but additional work is needed to refine communication processes used by all local school district partners.

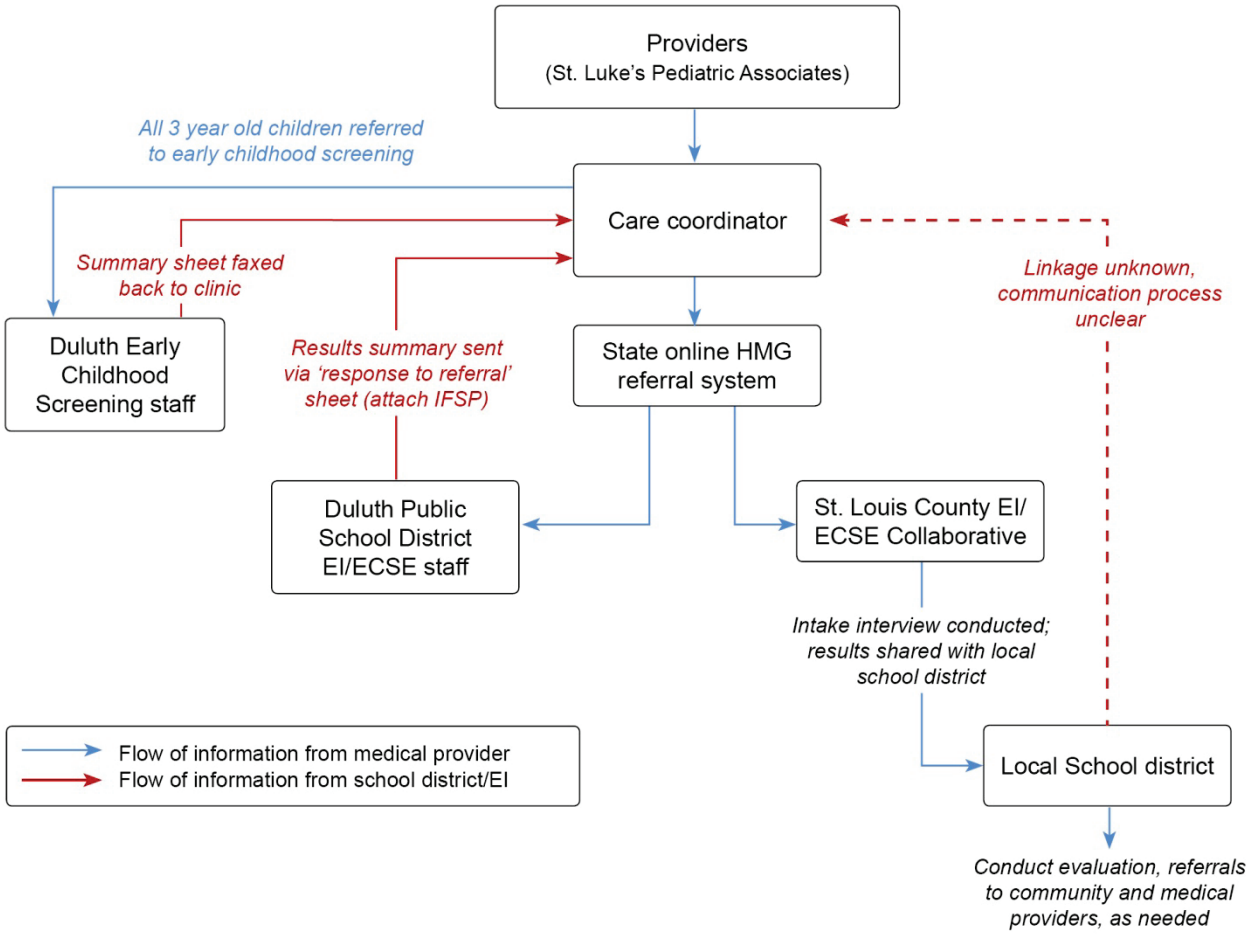
Current referral practices

Through the initiative, referral and communication processes between the Help Me Grow offices and clinic staff have been established and are beginning to be implemented. St. Luke's Pediatrics administers the Ages and Stages Questionnaire (ASQ) to screen children for potential developmental concerns during all Well Child visits. When a child has an elevated screening score or has concerns that suggest a need for early intervention services, the clinician places an order for referral through the EMR system. Next, the care coordinator completes an informed consent form with the family, and enters

the referral into the state online Help Me Grow referral system. The local Help Me Grow staff often calls the care coordinator to confirm that the referral was received. The Help Me Grow office staff then contacts the family for an intake interview. Both Duluth and the County Help Me Grow Collaborative have intake coordinators who complete initial intake interviews with families. In Duluth, intake staff also conducts evaluations for those children whose screening interviews indicate a need for further assessment. When the county Help Me Grow collaborative central office staff completes the intake interview, a summary is then sent to the appropriate school district to provide them with additional background information before they contact the family to schedule an evaluation. Local school district teachers who conduct evaluations are then responsible for sending a summary of evaluation results back to St. Luke's Pediatrics.

The use of the state online Help Me Grow referral system is increasing. Both Help Me Grow representatives noted that all referrals from the partner clinic were now coming through the state online referral system. Overall, the information received from the clinic was considered adequate. However, the Help Me Grow collaborative representative felt that communication between the local school districts in the collaborative and the clinic could continue to be improved.

6. Referral and feedback communication flowchart – St. Louis County



Unique implementation efforts

Through the initiative, the pilot team has begun collaborating with community providers to increase the number of children completing universal early childhood screenings. Prior to participating in the initiative, there was little communication between the Duluth Public School's early childhood screening program and St. Luke's Pediatrics. As a result of the initiative, Duluth Public School's early childhood screening program now has a communication form it uses to send early childhood screening results to the partner clinic. Though not an intentional outcome of the ABCD III initiative, St. Luke's clinicians now receive alerts through their Electronic Medical Records (EMR) system, and make active referrals to Duluth Public Schools for children who are due to receive early childhood screening assessments.

Accomplishments, challenges

Through the initiative, local school districts have begun communicating assessment results back to referral sources. Prior to participating in the initiative, there was little communication between local early intervention staff and the clinic. As a result, clinicians were concerned that their referrals to Help Me Grow were not perceived as critical. As a result of the initiative, the pilot site has developed communication forms that succinctly summarize the results of each referral. School districts send these forms back to the clinic, and the care coordinator documents screening and assessment results in the child's medical record.

Planned Year 3 Activities

During the final year of the initiative, the project partners were interested in refining their communication processes, expanding the referral and communication processes to more local clinics, and exploring options for providers to make more active referrals to Head Start and other community resources.

Ramsey County Help Me Grow

During the first two years of the initiative, the Ramsey County team has experienced significant changes. In summer 2010, the White Bear Lake Health Partners Clinic replaced the East Side Family Clinic as the primary care partner on the team. Although this change delayed some implementation activities, the new clinic partner is also a Health Care Home, which means that many of the referral and care coordination activities were already established. More recently, the early intervention system restructuring resulted in reductions in staffing at the Ramsey County Help Me Grow central office and new difficulties in closing the communication loop with all school districts in the county. Although a relatively small number of children have been referred to early intervention services through the initiative to date, the team has developed referral and communication processes that they feel can be spread to other providers and sustained over time.

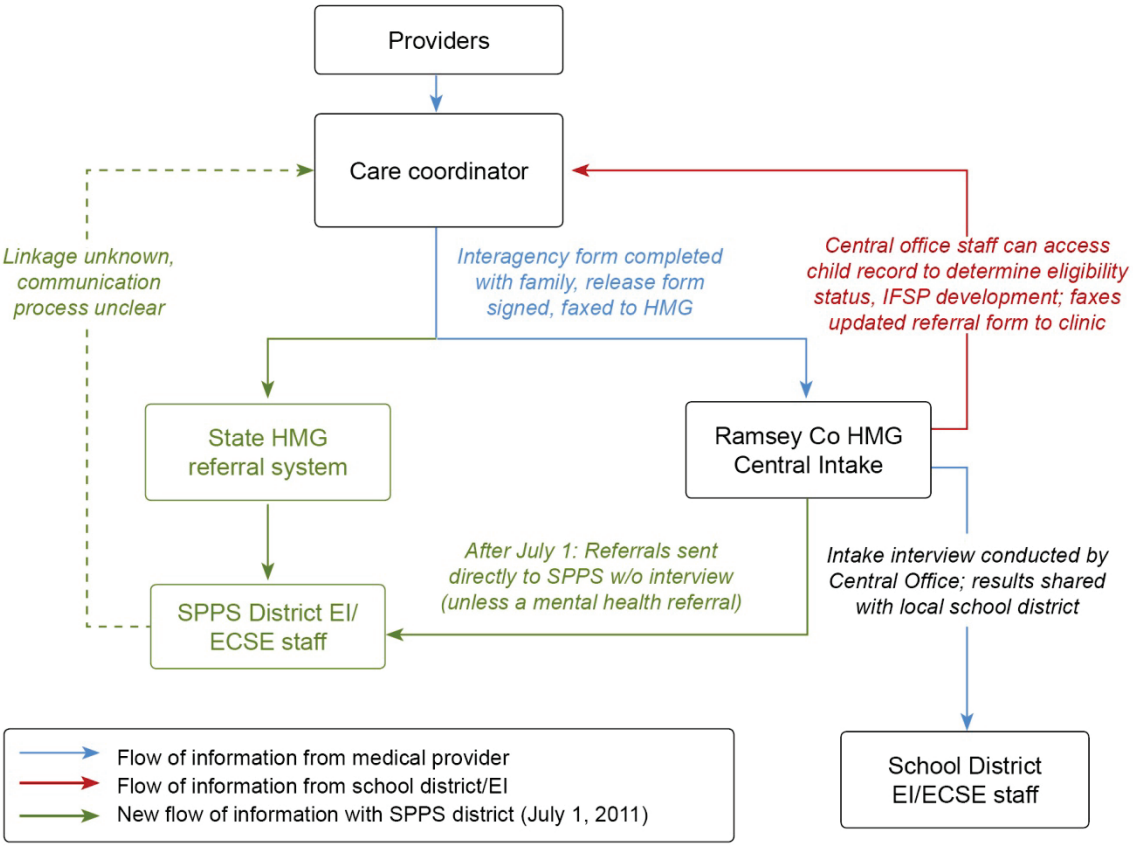
Current referral practices

The Ramsey County Help Me Grow central office has been the central point of contact in the county when there is a concern about a young child's development. Prior to the initiative, a majority of referrals that came to the local Help Me Grow office were made by parents who may have seen information in preschools or Early Childhood Family Education (ECFE) classes. Other common referral sources included preschools, clinics, hospitals, and public health nurses.

Through the initiative, referral and communication processes between the central office and clinic staff have been established and implemented. The White Bear Lake Health Partners Clinic administers the Ireton to screen children for potential developmental concerns and uses the ASQ:SE less frequently to identify potential social-emotional development concerns. When a child has an elevated screening score or concerns that suggest a need for early intervention services, the clinic care coordinator completes an informed consent form and Interagency Referral & Communication Form with the family and faxes the completed form directly to the Ramsey County Help Me Grow office. The central office staff person typically calls the clinic care coordinator to confirm the referral was received and contacts the family for an intake interview. The intake interview is intended to ask the parents a number of questions about their child's development in key developmental domain areas, the child's medical history, and the types of services the family is currently receiving. When the intake interview is completed, a summary is sent to the appropriate school district to provide additional background information before they contact the family to schedule an evaluation. Central office staff can begin to work with the family to help them identify resources in the communities to address specific needs (e.g., applying for insurance, housing support) before the assessment is completed by the school district.

The Ramsey County Help Me Grow central office provides a key linkage to facilitate communication between the school district and clinic. Because of the arrangement set up by the school districts in Ramsey County, the central office staff has access to the student plans and can retrieve completed IFSP/IEP materials directly. As a result, the Central Office is responsible for completing the final portion of the team's referral and communication form which includes a summary of the evaluation results, determination of Part B/C eligibility, and list of referrals made.

7. Referral and feedback communication flowchart – Ramsey County



The IEIC restructuring has resulted in some significant changes to the team's referral and communication procedures. Prior to July 1, 2011, central office staff provided the same initial intake and service coordination services for all school districts in Ramsey County and had access to district data (e.g., completed IFSP plans, determination of Part B/C eligibility). With the restructuring, Saint Paul Public Schools (SPPS) decided to take on all intake, service coordination, and communication responsibilities. The central office may still receive referrals for children enrolled in SPPS, but simply pass these referrals on to district staff when referrals are received. Program partners stated they have invited representatives from SPPS to attend their project meetings, but the district has not yet been involved with the initiative. Thus far, the clinic has not received information from SPPS following a referral, because the district has neither a process to communicate evaluation results and service recommendations back to the referring provider nor a protocol in place to obtain consent from parents allowing district staff to share the information with the child's primary care provider.

Unique implementation elements

Ongoing informal communication and strong interagency relationships have resulted in strong connections between the central office and clinic. A strong relationship, which allows for and is strengthened by ongoing information communication, has developed between the clinic's care coordinator and the Ramsey County central office. Because the Ramsey County central office can directly access information from the district to monitor the status of referrals and view completed service plans, the office plays a unique role in facilitating information sharing between the suburban districts and pilot clinic. This strategy has worked very well for this pilot site; the clinic care coordinator described the process as "seamless." However, because the school districts have not been directly involved with the clinic, the line of communication between the school and clinic was severed when Saint Paul Public Schools (SPPS) modified their contract with the central office. The pilot site team does plan to reach out to SPPS in the upcoming year to discuss the initiative and identify potential communication strategies.

Central office staff makes extra efforts to ensure parents understand what information will be shared with their child's medical provider. Informed consent forms have been created and are regularly used by clinic staff to ask parents for authorization to receive information from early intervention services and the school district. These signed consent forms are faxed to the central office with the Interagency Referral and Communication Form. Prior to submitting information back to the clinic, central intake office staff review the informed consent form with the parent(s) and describe exactly what types of information will be sent to the clinic to ensure parents are aware of what information will be shared and have an opportunity to decline their consent. Central office staff noted that it is extremely rare for parents to choose not to have information sent back to their child's medical provider.

Accomplishments, challenges

Ongoing informal communication and strong interagency relationships help ensure the initial screening and referral processes occur smoothly. The clinic's care coordinator has taken a proactive approach to work collaboratively with the Ramsey County central office to refer children for services and monitor the status of these referrals. However, this work does necessitate considerable time. In addition, it is not known whether some of the communication and coordination activities through the Ramsey County central office will need to be further scaled back to align with the IEIC restructuring goals.

More work is needed to involve school districts in the process and ensure the feedback loop is completed. While information sharing and tracking is well-established between the clinic and Ramsey County central office, there is not a process to coordinate with SPPS staff and encourage the district to provide information to the clinic following a district child evaluation. At this phase in the project, it is not known how centralized these referral and communication processes may be within SPPS.

Planned Year 3 activities

During the final year of the initiative, the project partners were interested in fine-tuning their communication processes, expanding their screening and referral protocols, and exploring options for providers to make more active referrals to Head Start and other early childhood programs.

Sustainability and spread

All pilot sites have already begun to take steps to expand their efforts to include multiple providers at the partner clinic, and some pilot sites have begun to consider ways to expand these efforts to other departments, clinics, or school districts. Across the pilot sites, there was greater confidence among partners in their ability to sustain and expand their screening and referral practices than the feedback communication loops, which are still being fine-tuned. While changes are being made, there are ongoing challenges to sustainable system change to improve communication and coordination between medical providers and schools. While the pilot sites have considered expansion and sustainability primarily at a local level, the lessons learned from their work to date can also inform the efforts of state agencies to encourage and support changes in state policy and practice that lead to improved communication and care coordination.

Current spread and sustainability efforts among pilot sites

At each of the five participating clinics, the consistent use of screening tools and new informed consent and referral forms has spread. At each clinic, the initiative began with the involvement of a single provider champion who was interested in and willing to pilot new strategies to establish or enhance screening, referral, and communication processes. This work has spread to multiple providers within each clinic, and some pilot sites are also discussing other strategies to incorporate these forms and procedures into practice across other physician disciplines (e.g., family medicine), clinics within their health care system, or other clinics in the region. The strategies used by the pilot clinics to encourage spread have varied, from peer-to-peer sharing among providers to administrative decisions to establish new practice standards that providers are expected to follow. This suggests there is no single way to encourage spread among providers in a single practice or clinic system, but that the strategy selected must align with the clinic's work culture.

All pilot sites felt that, as a result of shared paperwork and stronger cross-disciplinary relationships, elements of their improved screening, referral, and communication processes could be sustained over time. At the clinic level, providers involved in the initiative have created consistent screening and referral processes and developed standard informed consent and referral forms that aid the referral and communication processes. Two of the clinics also have strong partnerships in place with their local Follow Along program or other early childhood screening program to help ensure all children receive developmental screening prior to entering school. All clinic pilot partners felt the improved consistency of screening and use of new referral forms could be sustained over time and likely spread into other areas of the clinic.

For some clinics, the Access database developed for the initiative was a useful care coordination tool that they may continue to use over time. However, other clinics have other systems in place (e.g., electronic health records, Excel spreadsheets) they use to monitor child referrals and felt the Access database, which is required to gather evaluation data, duplicated some existing functions. The database or other internal tracking system to monitor the status of referrals is key to sustaining any ongoing care coordination role.

Overall, there was less confidence in the current effectiveness and long-term sustainability of the feedback loop from the school district to clinic. Across all pilot sites, the consistency of feedback from school district staff is not as strong as the screening and referral processes in place at the clinic. This is likely due to a number of reasons. First, and likely most importantly, while communicating evaluation results and referral outcomes back to the referring source is good practice, it is not mandated by statute nor part of the job description of individual staff and teachers. Second, while there may be one person at the district coordinating intake interviews and assigning referrals to appropriate district staff and teachers, the individual staff members responsible for completing the team's referral and communication form and sending that information back to the clinic are less connected to the initiative and may not know why that information is important to the child's medical provider. In addition, they may not be aware of efforts made by medical providers to be more proactive in their sharing of screening results and medical information with the district, and therefore, not see the partnerships as a reciprocal relationship. Finally, sustainability is threatened when there is staff turnover at any communication point: among medical providers, clinic care coordinators, central office staff (if a central office exists to take in referrals from Help Me Grow), district early childhood special education coordinators, or teachers and school staff who conduct assessments and develop treatment plans. DHS has tried to address this issue by encouraging the pilot sites to formalize their processes with written protocols that can be referred to if there are changes in staffing at any level. However, for sustainable system change to occur, additional steps are needed to identify these best practice activities as expectations that are part of, not in addition to, the responsibilities of all early intervention staff.

Care coordination activities must be supported at multiple levels of the clinic and school district. Across the pilot sites, there is wide variation in the roles clinic coordinators play in the initiative. Care coordinators who have more time available for these tasks are able to regularly follow up on the status of referrals and be more proactive in their communication with the region's central intake office and/or school district staff. Time limitations at clinics do not allow care coordinators to check the status of referral and seek out information as frequently as they would ideally like, though care coordination efforts may be enhanced as more clinics become certified as medical homes. Care coordination among school staff is also challenged by time limitations and a lack of buy-

in at higher administrative levels of the school or district. For example, a representative of one school district stated that she can choose to follow up with the clinic when she is the service coordinator for an individual student, but - without buy-in at higher levels - can only encourage her colleagues to do the same. Limited time was also a barrier to services coordination at the school level, particularly for districts that are now taking on the responsibilities for intake interviews (done by their local IEIC office before the restructuring).

> It does take persistence and it does take a care coordinator. I think that's the piece where there is a big gap in how many hours you get [for care coordination] and how many it truly requires.
> —Care coordinator
>
> I'm really not coordinating care – I'm facilitating a referral and being a key contact so that the provider can receive information back. It's a small piece of my actual clinic position.
> —Care coordinator

Issues to consider when promoting statewide spread

Spread can, and will likely need to, be supported at both a local level and state level. Across the state, there are nearly 500 school districts, most with their own early childhood staff member(s) responsible for conducting assessments and developing individual treatment plans. However, communicating assessment results and other information back to the referring clinics has not been part of their job responsibilities. In order for spread of these enhanced communication and coordination practices to occur in school districts throughout the state, strategic communication efforts are needed. Pilot partners felt peer sharing is important to encouraging buy-in and responding to real and perceived barriers to changing current practices and protocols. However, state agencies play a key role in supporting changes in practice through the training and other guidance they offer to school districts, regional IEICs, and medical providers, as well as the ways they incentivize and encourage screening, referral, care coordination, and communication activities through changes in reimbursement and future grant opportunities. The potential role professional groups may have in promoting changes in practice or creating forums to allow for peer sharing of best practices were not discussed by the pilot partners, but may be helpful to consider.

Standardized documents are likely needed to maintain efficiency in the referral and communication processes used by clinic and school district staff. Within each clinic and school district, there may be unique screening, tracking, and other processes that align with existing recordkeeping systems and roles of staff. However, if there are efforts to increase communication and coordination across systems, some consistency in paperwork and procedures will likely be needed to minimize paperwork burden and maximize efficiency. DHS has begun to work on common referral and communication

forms that can be used to share information between clinics and school districts. While it may not be possible to develop a single form that can be used statewide, use of common forms among clinics and school districts within IEIC regions would help streamline paperwork in many situations.

Additional discussion is needed to determine ways the state Help Me Grow referral system can assist referring providers to connect to the appropriate school district while still protecting student privacy. According to clinic staff, they do not receive any information confirming their referral was received or notifying them of where the referral will be directed (e.g., the name and contact information for key staff from the appropriate school district) when they refer directly through the state Help Me Grow system. For medical providers who are accustomed to receiving follow-up information whenever a referral to a health care provider is made, this lack of feedback is a deterrent to referring through Help Me Grow.

> When we do the online referral, which is nice and easy, you still have no clue where it's going. Who do we contact when we don't know?
> —Clinic care coordinator
>
> Providers have soured on making referrals because they don't think they will hear anything back.
> —Early intervention staff

Pilot partners felt face-to-face meetings were essential to building interdisciplinary relationships. The regular team meetings of partners from each pilot site have been used to develop forms, clarify processes, identify and resolve barriers, and discuss ways to enhance their screening, referral, and communication processes. The pilot partners also identified a number of indirect benefits to these meetings, such as: greater understanding of the service options available through the district and clinic; more timely referrals as providers learn more about Part B/C eligibility criteria (e.g., low birth weight); and increased informal communication. The face-to-face meetings have been difficult for some partners to attend, but have been seen as very beneficial to those who have been active participants. Based on information gathered through the key informant interviews, there are differences in the level of coordination among partners, based on level of involvement in team meetings. The use of larger regional meetings or other types of strategies may be needed to create opportunities for relationship-building if the initiative is expanded significantly.

> I think now we have players that recognize what they want to do and are trying to work around the barriers and challenges that are in place. Many times [when players are not on the same page] we don't even try to have the conversation because we don't think a solution can be found.
> —Early intervention staff

Lessons learned

This report describes the experiences to date of the four ABCD III pilot sites and their efforts to enhance and expand screening, referral, care coordination, and communication practices. While there is variation in the processes each ABCD III team are working to implement, the level of buy-in and amount of time available by partners to work on this initiative, and the perceived sustainability of their efforts, there are some key lessons learned that are common across all pilot sites.

Pilot partners describe the benefits of their involvement in the initiative as both enhancements to their individual practice strategies and system-level improvements. At this point in the initiative, all pilot sites have improved their current screening, referral, and communication processes and have started to identify how these changes have improved their work individually and as a partner in their regional child-serving system.

> When the system works well, your patients are satisfied. You're in the loop more.
> —Clinic provider

In general, early intervention staff felt they were getting appropriate referrals from their partner clinic(s). All intervention partners interviewed felt they were receiving appropriate referrals from the pilot clinics (meaning the referral was timely and that it was appropriate for the provider to refer for the type(s) of concerns identified through screening and/or by the caregiver). Some of the improvement in referral appropriateness was attributed to increased knowledge among providers of early intervention services and when to refer. It is more difficult to assess whether the referral was timely. While early intervention staff generally felt children were being referred at a young age when concerns were identified, one partner noted some children who are patients of the partner clinic had been referred by another community resource, suggesting a potential referral was "missed" by the clinic provider.

Care coordinators and other key points of contact play key roles in tracking the status of referrals and facilitating communication across systems. The referral and communication processes established by each pilot site are effective when all partners are involved and things are running smoothly. However, processes also need to be in place to monitor referral status and identify disruptions in the flow of information between partners. Although it may be difficult to determine when follow-up information should be received by the clinic for early intervention services for children age 0-3 who do not need to meet the 45-day evaluation timeline, some process is likely needed to regularly follow up with school district staff to discuss the status of specific referrals.

> With the passive referrals, some children were falling through the cracks. I am finding the active process we are using to be more efficient.
> —Clinic provider
>
> You need to have checks and balances in place to make sure communication is happening.
> —School district staff

Although participating providers are often using the Help Me Grow system to refer children to early intervention services for developmental delays, different approaches may be used to refer children when there are mental health/social-emotional development concerns. Although some clinics refer directly through Help Me Grow for mental health concerns, two clinics have mental health providers identified in their clinic or region that they tend to refer to directly.

> I don't refer all children with mental health concerns; sometimes a primary care provider can manage simple concerns. I know the times when I need extra help and where to look for those services.
> —Clinic provider

The protocols established by each pilot site focus on streamlining communication at the time of referral, but do not address how service updates are relayed to the clinic after the child's evaluation is completed. A few pilot partners noted that the school district often makes additional service referrals after the evaluation is completed, but that there is not a formal process in place to receive updates. One clinic did report that they typically do a 6-month follow up after making a referral, as part of their health care home efforts. In addition, two sites have considered incorporating a 6-month follow up to their procedures, initiated either by the district or by the clinic's care coordinator.

Some of the initiative's current tracking and data collection requirements may be more difficult for pilot partners to complete because it is only being done for a small sub-population of children. Because the ABCD III initiative is funded through DHS, the target population for the evaluation of this pilot project is limited to children enrolled in Medicaid programs. While this distinction is meaningful to DHS staff, clinic and school district staff do not typically differentiate children based on insurance status. This makes it more difficult for staff to follow children screened and referred specifically through this initiative. While expanding the efforts of the ABCD III initiative to include additional clinics will require more time for follow-up communication activities, these efforts may be more efficiently streamlined and integrated into the work of school district and early intervention staff in the future when processes are applied to all patients, rather than a subset of children based on insurance status and/or referral source.

> One of my frustrations with the project is that it is so specific to a single referral source. From my perspective, it makes things very fuzzy to put so much emphasis on improving referrals and communication for some kids, just based on who referred them.
> —Early intervention staff

Recommendations

Based on the information gathered through this baseline set of key informant interviews with Help Me Grow representatives, Wilder Research developed the following recommendations for the pilot sites and DHS to consider as they continue their ongoing work with each partner throughout the initiative.

Suggested enhancements for pilot partners

- **Work collaboratively to identify reasons for delays in follow up information being sent to the clinic.** The data submitted by the clinics suggests feedback is not consistently received from early intervention partners involved in ABCD III. A more systematic and proactive process of monitoring referrals may result in fewer children "falling through the cracks" and earlier identification of breakdowns in the flow of information between system partners. It may be helpful for the teams to focus future quality improvement cycles (the PDSA – Plan, Do, Study, Act – cycles) on reviewing the status of referrals where follow up information has not been received to determine why communication has not been received and develop strategies to address these barriers.

- **Identify and establish relationships with early childhood staff from local school districts not currently involved in the initiative.** Clinic representatives expressed frustration that they have not received follow-up communication (e.g., acknowledgement of the referral, confirmation of eligibility, summary of referral information) for referrals made through the state Help Me Grow system. Ideally, the online system could be modified to confirm a referral has been received and identify the school district staff members who will receive the referral. However, given that there are no immediate plans to make this change, current ABCD III partners may need to do more work to gather contact information for the specific person(s) from each district who receives referrals through the Help Me Grow system. Options for gathering this information could include requesting lists of school district representatives from the Department of Education or working to develop contact lists through the regional IEICs as they are established. While this action would not completely address the issue, to the extent families know and are willing to share what school district they live in, it would at least ensure the clinic care coordinators can contact the correct person from each local school district after a referral is made.

- **Consider ways to integrate ABCD III initiative activities into the job descriptions of involved staff and allocate time and resources to support care coordination and communication activities.** Although staff from most pilot sites felt at least some of their changes in practice could be sustained after the initiative ends, some steps are

likely needed to formalize these changes. In addition to continuing their work to create written documents describing their processes, responsibilities may need to be added to current job descriptions to help ensure the work can be sustained through changes in staffing. Staff time and other resource allocations (e.g., modifications to existing tracking systems to monitor the status of referrals) may also be changed in order for these efforts to be sustained over time. Partners may need to do more work within their clinic, school district, or agency to create buy-in for these changes at multiple administrative levels.

Suggested enhancements for state-level stakeholders

- **Consider policies or guidelines to encourage and incentivize care coordination efforts among clinic and school district staff.** The work of the pilot sites has demonstrated the importance of some type of consistent care coordination or referral monitoring function to be in place at both the clinic and at the school district/regional level. However, these tasks fall outside of the scope of reimbursable and required services for clinics that are not certified health care homes. Clear definitions of care coordination tasks would help standardize these key roles, as would some type of reimbursement for these services.

- **Implement enhancements to the online Help Me Grow system that help facilitate communication between clinic providers and school district staff.** The pilot site teams have suggested a number of enhancements to the Help Me Grow referral system that would help them better monitor the status of referrals they make to early intervention services: an option to attach documents to allow for sharing of screening results, referral forms, and other medical information; and a system confirmation email that assures the provider the referral has been received and includes the contact information for the school district staff members who they can contact for additional information.

- **Establish a standard informed consent process that can be used to ensure clinic providers gather basic information from school district staff following a referral.** The pilot sites involved in this initiative have successfully developed shared release of information and communication forms that allow clinic and school district staff to share a considerable amount of information with one another at the time of referral and throughout the assessment process. While some standardization of paperwork and data sharing protocols is likely needed in order for new referral and communication processes to be manageable for both clinic and school district staff, there are barriers that need to be addressed before these forms and processes can be standardized and adopted in districts across the state. Some school districts, particularly those without existing relationships with referral clinics, may not feel comfortable sharing information

back to the clinic using a form signed by parents at the clinic. Rather than continuing to pursue standard release of information and communication forms that allow both the clinic and school district to share information, an alternative approach could involve developing a common release of information form to be used by clinics that asks parents for their permission to a far more limited set of information from the school district: confirmation of the child's school district and name of the key early intervention service contact at the district; confirmation that the referral was received by local school district staff; the status of the referral (e.g., did an intake interview or evaluation take place?); and determination of Part B/C eligibility. Ideally, this standard, scope-limited release of information form could be vetted and approved by MDE and/or legal representation from a number of local school districts to ensure it addresses any confidentiality concerns. Local school districts would then maintain primary responsibility for asking parents if they are interested in sharing the child's completed IFSP with the clinic provider using a form developed and approved by the school district. Though not a fully streamlined process, this approach would help medical providers request standard types of information in a consistent manner while still allowing school districts to gather their own informed consent form, as needed.

- **Train and encourage school district staff to routinely ask families to share information with the child's medical provider during the assessment process.** Early intervention staff can take a more proactive role to communicate with clinics by routinely asking parents for their permission to share assessment results and referral recommendations with the child's medical provider as part of the assessment process. Standardizing this practice would ensure all families have the option of choosing whether to allow greater communication between their child's school and clinic.

Suggestions for Year 3 evaluation activities

- **Offer individual technical assistance to each pilot site team to review clinic screening and referral data.** Some pilot sites may be interested in additional time with Wilder Research staff to review the results from their clinic's Access database, identify situations where patient information was not communicated in a timely manner, and consider strategies to improve their team's processes. Depending on the strategies used, Wilder may be able to help the teams use the Access database to better assess whether changes in practice lead to more timely and consistent follow up, a greater percentage of youth referred who are determined eligible for Part B/C services, or other outcomes of interest.

- **Integrate questions into the final provider champion interviews to assess how follow-up information is being used by pediatricians and providers.** When clinic care coordinators receive information from school district or early intervention staff, they pass that information to the provider by entering a note into the child's record, scanning the document in to the child's record, or passing along a copy of the faxed referral form directly to the provider. At this stage in the evaluation, it was too early to have a good sense of which providers follow up with patients using the information they receive. However, this information will be helpful to capture in the final evaluation report so that school district and early intervention staff better understand how their work to communicate information improves patient care.

Appendix

Summary of changes to Minnesota's early intervention system

Map of IEIC regions (as of July 1, 2011)

Summary of key reporting measures

Data collection tools

Care coordinator interview protocol

Provider champion interview protocol

Early intervention staff interview protocol

MDE staff interview protocol

Summary of changes to Minnesota's early intervention system

When the ABCD III initiative began, there were 95 IEICs across the state, each comprised of individuals representing school districts, social service agencies, early childhood organizations, and parents. These IEICs were often organized at a county-level, though in more populated areas of the state, IEICs were centralized around individual school districts or school cooperatives. On July 1, 2011, the Minnesota Department of Education (MDE) restructured the early intervention system to a regional IEIC model. The restructuring was intended to refocus the IEICs' roles and responsibilities to those mandated in statute and to create a more consistent early intervention system.

To better understand the reasons for the restructuring and the anticipated challenges and improvements expected to occur as a result of this change, key informant interviews were conducted with four MDE staff members. In addition, materials developed by MDE explaining the restructuring process and clarifying the roles and responsibilities were reviewed. These data collection activities were outside of the primary scope of the evaluation, but were pursued to ensure changes in practice among the pilot sites were understood within the context of larger system-level changes, when appropriate.

Reasons for the restructuring

The early intervention system was restructured in response to a number of concerns. According to MDE staff, questions had been raised about the number of local IEICs, and Minnesota had been encouraged by the federal Office of Special Education Programs to consider reducing the number of IEICs. Questions had also been raised regarding the timeliness of response by early intervention staff after a referral was made. While some local IEICs had effective identification, assessment, and referral systems in place, Minnesota had failed to achieve compliance in some areas, particularly in meeting the 45-day timeline under the Part C federal mandates. While not a direct reason for the restructuring, MDE staff noted they had little information available about the services provided by the local IEICs. The changes to the state's early intervention system are intended to lead to more timely responses to referrals, greater consistency in the services provided by the IEICs, and improved coordination across each region.

Summary of the restructuring changes

At the most basic level, the restructuring led to three significant and interrelated changes to the state's early intervention system: 1) a reduction in the total number of IEICs; 2) a shift in funding allocation from the IEICs to local school districts; and 3) clarification of the roles and responsibilities of the IEICs to a more limited set of activities (as defined through state statute and federal requirements).

Reduction in the number of IEICs

As of July 1, there are 11 IEICs in the state, a reduction from the 95 IEICs in place prior to the restructuring. This change was particularly noticeable in the Twin Cities 7-county metro region, which serves approximately half of the children currently eligible for Part B/C services. A single regional IEIC now takes the place of 12 local IEICs. A map of all IEIC regions can be found in the appendix.

Changes in funding allocations

In 2010, prior to the restructuring, Minnesota received just over $7 million in federal Individuals with Disabilities Education Act (IDEA) Education Part C funds. Eighty percent of that funding was allocated to the 95 IEICs, and 20 percent of the funding was retained by the department for various staff and interagency initiatives, professional development, and implementation of Help Me Grow, the statewide public awareness initiative. As of July 1, 2011, 20 percent of federal Part C funds will continue to be retained by MDE, and an additional 10 percent will be used for professional development activities. Most of the remaining funding (60% of the full Part C allocation) is allocated to Special Education Administrative Units (SEAUs) – the school districts, cooperatives, or educational districts responsible for funding and delivering early intervention and special education services – while 10 percent is allocated directly to the regional IEICs.

Clarification of IEIC roles and responsibilities

Under Minnesota statute, the IEICs are responsible for nine key areas, including: implementing interagency child-find systems; increasing public awareness around early intervention; assuring the development of individual family service plans for all eligible infants and toddlers; establishing and evaluating systems of identification, referrals, and assessments; and identifying current services and funding within the community for children with disabilities under age five. Under the restructuring, the regional IEICs have been asked to focus their activities primarily on public awareness, coordination of Child Find activities, and other outreach. Care coordination activities, which had been a significant portion of work done by some local IEICs, falls under the responsibility of the SEAUs, though some SEAUs may choose to use their funding to create or maintain a central regional intake and referral office.

Anticipated improvements

At the time interviews were conducted with MDE staff, regional IEICs were in the process of defining their membership and creating draft work plans that would describe their planned efforts to focus on public awareness and Child Find activities in their region.

MDE staff were hopeful that the restructuring would allow regions to do more strategic public awareness, improve their ability to identify eligible youth from key populations (e.g., homeless families) through Child Find, and improve the timeliness of response for children age 0-3.

Under the previous early intervention system structure, the 95 IEICs each had their own way of receiving referrals and coordinating with the referral source and local school districts. MDE staff hopes that the restructuring will lead to greater consistency in the scope of services provided through the regional IEIC and how they are provided. According to one MDE staff, some IEICs will need to reconsider how they provide outreach to families, as some of the family support services they used to offer (e.g., family picnics) should not be paid for using Part C funds.

Anticipated challenges

From the perspective of MDE staff, fear of, and resistance to, change were the most significant challenges to overcome during the restructuring process. They acknowledged that, in some regions, the restructuring would significantly change the scope of IEIC activities and the processes used to respond to early intervention service referrals, but those changes will refocus the IEICs on the activities mandated in statute. While staff noted new relationships may need to be formed between the clinic and local school district staff, they didn't feel the process itself would be any different. They noted the state Help Me Grow referral line can provide a back-up for any referring providers who have not established relationships with local early intervention staff.

Maintaining a consistent feedback loop between referral sources and school districts is an ongoing challenge to the state's early intervention system. However, MDE staff felt that the responsibility for providing feedback to the primary care provider fell to the local school district staff who conducted the child evaluations and made referrals for services. MDE staff acknowledged parents are not consistently asked by school district staff whether they would like to share evaluation results with their child's medical provider. MDE staff did not feel the restructuring would directly impact any communication between local school districts and referral sources.

It should also be noted that the restructuring was implemented just as the state's government shutdown began. Some direct impacts to the system occurred as a result of the shutdown; MDE staff encouraged local IEICs and school districts to inform referral sources that the state's online Help Me Grow system would not be available until the state budget issue was resolved. Although these direct impacts were short lived, they may have led to greater anxiety and concern among early intervention staff and referral sources who were not clear who they should contact if referrals needed to be made in the interim.

Planned next steps

During the next year, MDE plans to recommend effective public awareness, early identification, and referral processes for local school districts and regional IEICs to consider. MDE also plans to provide a service coordination module through their Centers of Excellence training programs in each region. Although MDE has heard that local school district and early intervention staff are interested in more state guidance and referral protocols, processes to identify children in need of early intervention services, respond to referrals in a timely way, and ensure service coordination, are ultimately locally-driven. MDE can suggest best practices, but feel they cannot mandate local staff to conduct activities that fall outside of the parameters of state mandates and federal Part C regulations.

MDE also plans to assess the impact of the restructuring on referral rates and response timeliness and to identify promising public awareness, early identification, timely response, and service coordination activities. MDE will also encourage the new regional IEICs to share challenges and promising practices with one another.

Coordination with ABCD III

The MDE staff interviewed all felt the goals of the ABCD III initiative – to strengthen linkages between providers – aligned with what they hoped to achieve through the restructuring. However, their primary interests focus on ensuring children are connected with the early intervention services they need and less so on encouraging communication between the school district and referral source. Although MDE has not previously offered specific guidance to the IEICs or school districts regarding strategies to streamline the referral and communication processes between schools and medical providers, they are looking to the initiative to help them identify promising practices that can be shared with early childhood intervention and special education staff across the state. In addition, one staff member noted that the regional IEIC model may allow opportunities to streamline the referral process with major regional hospitals or child-serving clinics.

Early experiences of pilot site partners

At the time of the key informant interviews, the regional IEICs were still being established and there was uncertainty as to how the restructuring may change the referral and communication protocols established by the four pilot sites. However, the pilot site representatives were able to provide some initial feedback about their perception of the restructuring's impact on their work. While partners with the Olmsted County and St. Louis County pilot sites did not feel the restructuring had led to changes in their work, the restructuring had led to significant changes with the two Twin Cities metro locations (Anoka and Ramsey Counties). Prior to the restructuring, both counties had a central

office that took referrals through a specific intake line, conducted intake interviews with the families referred to Help Me Grow, had consent forms signed and facilitated a referral to the appropriate school district for further evaluation for Part B/C services. In this model, the central office served as a communication hub for referring providers and school district staff and helped ensure follow up information was sent back to the clinic.

Although both Ramsey and Anoka Counties maintained a central intake line after the restructuring, there were reductions in both the number and responsibilities of central office staff. In Anoka County, the central office staff person passes the referral along to staff at each school district, but no longer responds directly to the clinic to confirm the referral and no longer conducts intake interviews when a family is initially referred to Help Me Grow. Due to staffing changes in the central office, the referral form developed through the ABCD III initiative was not being passed along to school district staff and did not trigger staff to share evaluation results and a plan summary with the clinic provider. School district staff also noted they have needed to hire more staff to conduct intake interviews.

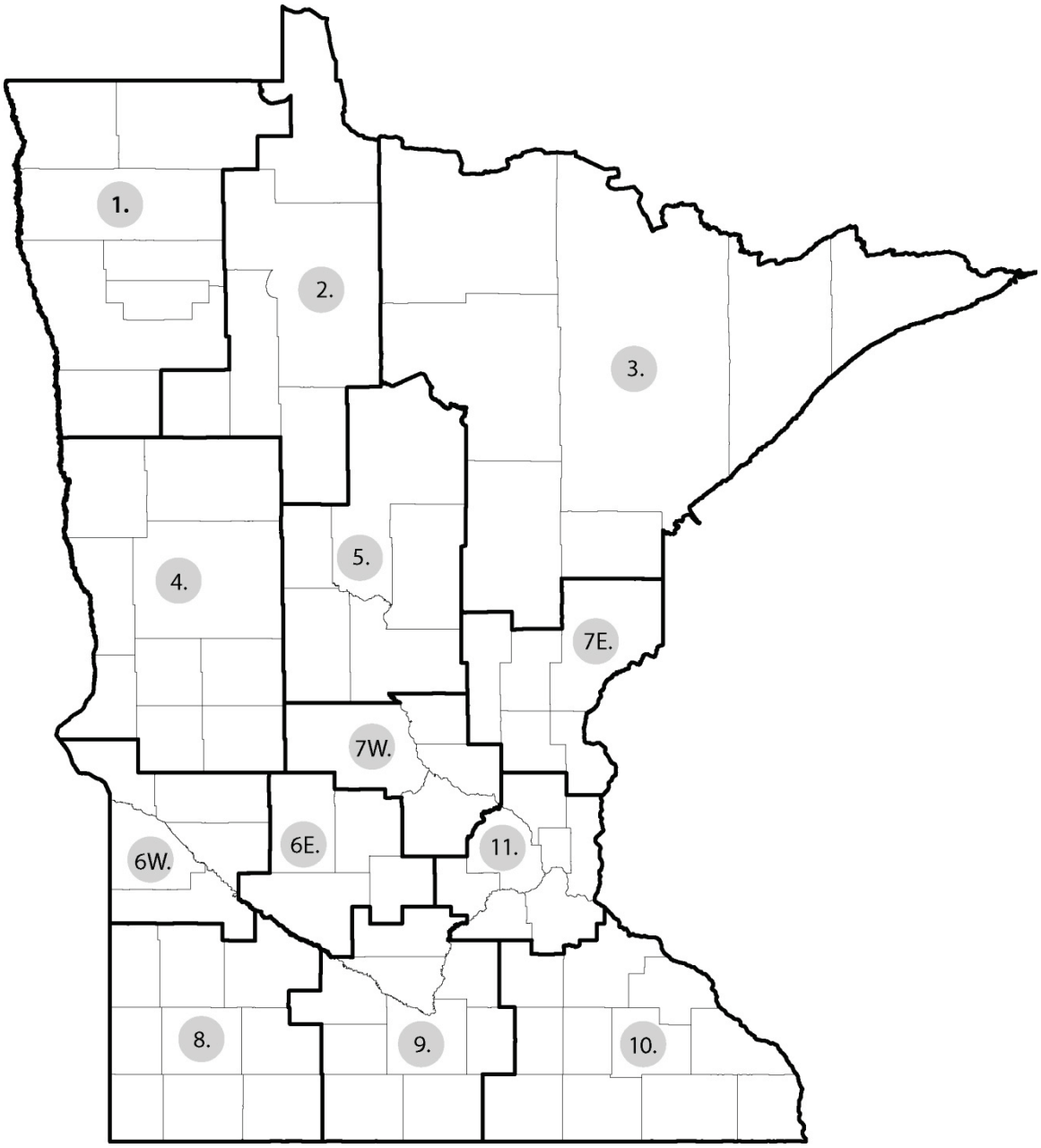
In Ramsey County, the suburban school districts chose to reallocate some of their funds to support the central office, allowing central office staff to continue conducting interviews and having access to the child's district records to provide information to the clinic summarizing the outcome of the referral. The Saint Paul Public Schools District (SPPS), the largest district in the county, has chosen to use their funding allocation to take on the responsibility of conducting the intake interviews. To date, SPPS has not been involved with the ABCD III initiative, and it is not clear whether or how they plan to communicate assessment results and information from the child's service plan to the referring provider.

In general, the pilot sites faxed referral forms directly to their local early intervention (EI) partner or used the online Help Me Grow system to refer, but also sent a simultaneous fax or email to the EI partner to alert them to the referral and to send the partner the referral form and any relevant information (e.g. screening forms, medical records). Representatives from the pilot sites felt it would be helpful for the online referral system to: 1) provide confirmation that the clinic referral had been received; 2) notify the clinic of which district the referral was sent to and who can be contacted at the school district for more information; and 3) allow the clinic to attach informed consent forms or other documents that would be helpful to EI staff and allow follow-up communication to occur.

Areas to monitor

Overall, changes to the early intervention system had varied impacts on the pilot sites. The restructuring did have an immediate and significant impact on the referral and communication processes used by the two metro pilot sites, but went largely unnoticed by the other two sites in greater Minnesota. As the roles and responsibilities of the IEICs and school district staff are refined, the pilot sites may notice improved timeliness of the responses to referrals or changes in parents' receptiveness to early intervention services following public awareness campaigns. Pilot site representatives are not only interested in continuing to build relationships with local early intervention and school district staff, but also in advocating for modifications to the state Help Me Grow referral system that would allow them, with appropriate informed consent forms in place, to better monitor the outcomes of their referrals.

Map of IEIC regions (as of July 1, 2011)



Summary of key reporting measures

Minnesota's ABCD III Initiative: Communities Coordinating for Healthy Development
Project objectives and evaluation measures tracked by pilot clinics
September 19, 2011

Minnesota ABCD III Objectives and Draft Evaluation Measures

Overview

The measures presented in this brief summary were calculated using data collected by each clinic partner through the first year of implementation, ending June 30, 2011. Across the five clinic sites, staff used an Access database as a tool to collect and track child screening, referral, and coordination information. A copy of each clinic database was submitted to Wilder Research for analysis and reporting of data for youth, ages 0-5, enrolled in Medicaid. (Two clinics, Fridley Child & Teen and North Metro Pediatrics, have further focused their target population to include only youth who are enrolled in the Spring Lake Park School District.)

About the data

In this summary, each evaluation measure is described and reported at clinic- and aggregate-levels whenever possible. The following considerations should be kept in mind when reviewing these data:

- The Access databases used by clinic staff were used as the data source for all but one outcome measure. Based on conversations with early intervention (EI) and clinic partners at each site, we understand processes are in place allowing EI staff to communicate eligibility status, assessment results, and other information with the partner clinic and this information is intended to then be entered by clinic staff into their database. However, inconsistent communication between EI and clinic staff or delays in data entry may lead to underreporting of these evaluation measures.
- Some items (i.e., eligibility for Part B/C services) were marked as "unknown" by clinic staff. It is unknown whether this reflects a service-delivery/referral system issue, poor communication, or delays in data entry by clinic staff. This will be explored further in future interviews with partners from each pilot site.
- There were a total of 5 youth without birthdates and/or screening/referral dates in the databases submitted. Data for these youth were included in the reported totals for all children ages 0-5.

<u>Objective 1</u>: Early intervention services in the pilot communities will receive increased referrals of children (closer to the expected rate) and the referrals will be earlier (based on child's age) than had previously occurred.

Measure 1.1 – Percentage of children referred to EI from participating clinics (tracked by clinic staff)

Numerator:	The number of children who were referred to EI from participating clinic(s) *(generated by the clinic tracking system)*
Denominator:	The number of children screened by the participating clinic(s) *(generated by the clinic billing office)*

Measure 1.1 Children age 0-3: Percentage of children referred to EI from participating clinics

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Assn.	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred by clinic to IEIC	8	0	20	29	10	67
Total number of youth screened at clinic	Not reported	24	118	Not reported	Not reported	-
Percent	-	0%	17%	-	-	-

Measure 1.1 Children age 0-5: Percentage of children referred to EI from participating clinics

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asn.	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred by clinic to IEIC	9	0	20	35	13	77
Total number of youth screened at clinic	Not reported	24	155	272	Not reported	-
Percent	-	0%	17%	13%	-	-

NOTE: *Some clinics have experienced difficulty being able to use billing data to report the total number of youth screened. Steps have been taken to assist the clinics in gathering this information moving forward. The totals reported for the clinics are for screenings completed January-June 2011. The estimate provided by the Mayo Clinic included the number of ASQ tools administered during this 6-month time frame and assumed 23% of those screened are enrolled in a public insurance plan (this estimate is based on clinic data from 2009-2011).*

Measure 1.2 – Rate of referrals by participating clinics (tracked by IEIC staff)

Numerator:	The number of children who were referred to EI from participating clinic(s) *(generated by EI tracking spreadsheet)*
Denominator:	The number of children screened by the participating clinic(s) *(generated by the clinic billing office)*

Measure 1.2 Children age 0-3: Rate of referrals from participating clinics to EI

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Assn.	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred by clinic to IEIC	1	0	12	Not reported	6	-
Total number of youth screened at clinic	Not reported	24	118	Not reported	Not reported	-
Percent	-	0%	10%	-	-	-

Measure 1.2 Children age 0-5: Rate of referrals from participating clinics to EI

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Assn.	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred by clinic to IEIC	1	0	12	Not reported	6	-
Total number of youth screened at clinic	Not reported	24	155	272	Not reported	-
Percent	-	0%	8%	-	-	-

NOTE: *Potential reasons for different counts of youth referred reported by clinic and EI staff (measures 1.1 and 1.2) may include families referred to EI by clinic staff refusing or discontinuing EI services, or different timeframes being used by clinic and EI staff to collect and report data.*

Measure 1.3 – Rate of EI assessment completion

Numerator:	The number of children with a completed EI assessment *(generated by the clinic tracking system)*
Denominator:	The number of children referred to EI from participating clinics *(generated by the clinic tracking system)*

Measure 1.3 Children age 0-3: Rate of EI assessment completion

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Assn.	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children with a completed EI assessment	5	0	10	4	2	21
Number of youth referred to EI from clinic	8	0	20	29	10	67
Percent	63%	0%	50%	14%	20%	31%

Measure 1.3 Children age 0-5: Rate of EI assessment completion

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Assn.	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children with a completed EI assessment	5	0	10	5	3	23
Number of youth referred to EI from clinic	9	0	20	35	13	77
Percent	56%	0%	50%	14%	23%	30%

Measure 1.4 – Timeliness of EI assessment

Numerator:	Date of referral to EI from clinic *(generated by the clinic tracking system)*
Denominator:	Date EI assessment completed *(generated by the clinic tracking system)*

Measure 1.4 Children age 0-3: Timeliness of EI assessment

	Anoka Child & Teen (N=4)	North Metro Pediatrics (N=0)	St. Luke's Pediatric Asso (N=10)	Mayo Pediatric (N=4)	White Bear Lake Health Partners (N=1)
Average number of days between referral to EI and assessment completion	86 days	-	34 days	40 days	17 days
Range	10-292	-	12-54	28-45	N/A

Measure 1.4 Children age 0-5: Timeliness of EI assessment

	Anoka Child & Teen (N=4)	North Metro Pediatrics (N=0)	St. Luke's Pediatric Asso (N=10)	Mayo Pediatric (N=5)	White Bear Lake Health Partners (N=2)
Average number of days between referral to EI and assessment completion	86 days	-	34 days	48 days	52 days
Range	10-292	-	12-54	28-82	17-85

Measure 1.5 – Percentage of children who qualify for Part B/C services

Numerator:	The number of children referred to EI from the participating clinics who qualified for services under Part B/C *(generated by the clinic tracking system)*
Denominator:	The number of children referred to EI from the participating clinics *(generated by the clinic tracking system)*

Measure 1.5 Children age 0-3: Percentage of children who qualify for Part B/C services

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred to EI who qualified for Part B/C services	0	0	6	12	3	21
Number of children referred to EI from the participating clinic	8	0	20	29	10	67
Percent	0%	0%	30%	41%	30%	31%

Measure 1.5 Children age 0-5: Percentage of children who qualify for Part B/C services

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred to EI who qualified for Part B/C services	0	0	6	14	3	23
Number of children referred to EI from the participating clinic	9	0	20	35	13	77
Percent	0%	0%	30%	40%	23%	30%

Measure 1.6 – Percentage of children referred by clinic to EI and/or other services

Numerator:	The number of children who received any referral (to EI or other agency/service) from the participating clinic *(generated by the clinic tracking system)*
Denominator:	The number of children screened by the participating clinic *(generated by the clinic billing department)*

Measure 1.6 Children age 0-3: Percentage of children referred by clinic to EI and/or other services

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children who received referral to EI and/or other agency service	3	0	47	29	10	89
Number of children screened by clinic	Not reported	24	118	Not reported	Not reported	-
Percent	-	0%	40%	-	-	-

Measure 1.6 Children age 0-5: Percentage of children referred by clinic to EI and/or other services

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children who received referral to EI and/or other agency service	3	0	63	35	13	114
Number of children screened by clinic	Not reported	24	155	272	Not reported	-
Percent	-	0%	41%	13%	-	-

Measure 1.7 – Percentage of children who did not quality for Part B/C referred to other services

Numerator:	The number of children who did not quality for Part B/C services but were referred to other services *(generated by the clinic tracking system)*
Denominator:	The number of children who did not quality for Part B/C services *(generated by the clinic tracking system)*

Measure 1.7 Children age 0-3: Percentage of children who did not quality for Part B/C services who received other referrals

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred to other services/programs	3	0	1	0	5	9
Number of children who did not qualify for services under Part B/C	8	0	3	6	7	24
Percent	38%	0%	33%	0%	71%	38%

NOTE: *Referrals were made by providers to the following services/programs for each clinic: Anoka Child & Teen (2 – Follow Along Program; 1-ECFE); St. Luke's Pediatric Association (1-audiologist); White Bear Lake Health Partners (2- audiologist, 1- pulmonologist, 1-mental health; 1-neurology*

Measure 1.7 Children age 0-5: Percentage of children who did not quality for Part B/C services who received other referrals

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children referred to other services/programs	3	0	1	0	7	11
Number of children who did not qualify for services under Part B/C	8	0	3	6	9	26
Percent	38%	0%	33%	0%	78%	42%

NOTE: *Referrals were made by providers to the following services/programs for each clinic: Anoka Child & Teen (2 – Follow Along Program; 1-ECFE); St. Luke's Pediatric Association (1-audiologist); White Bear Lake Health Partners (2- audiologist, 1- pulmonologist, 2-mental health; 1-neurology; 1-vision)*

<u>Objective 2</u>: Clinics will know when to refer children based on screening results and to whom children should be referred. Each community agency and clinic will have a good working relationship with the other. Necessary information will flow well between primary care providers and community agencies and service providers. Providers will feel more comfortable with referrals made and know what happened as a result.

Measure 2.1 – Frequency of feedback from agencies following clinic referrals

Numerator:	The number of children with documentation that information was received back from the referral agency and placed in the child's medical record *(generated by the clinic tracking system)*
Denominator:	The number of children referred for EI services *(generated by the clinic tracking system)*

NOTE: *The frequency of feedback measures how often the clinic receives information regarding assessment results, referrals made, or other information from EI staff. In some cases, the clinic may not have received information from EI staff because the assessment has not yet been completed. The protocols used by each clinic to communicate this information to the provider and document information received from EI staff in the child's medical record varies. None of the clinics have developed consistent protocols or changes in practice to integrate information regarding EI services into a new or existing care plan.*

Measure 2.1 Children age 0-3: Percentage of children whose clinic/medical provider received feedback from the referral agency

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children whose medical provider received feedback from the EI agency	6	0	13	18	6	43
Number of children referred for EI services	8	0	20	29	10	67
Percent	75%	0%	65%	62%	60%	64%

Measure 2.1 Children age 0-5: Percentage of children whose clinic/medical provider received feedback from the referral agency

	Anoka Child & Teen	North Metro Pediatrics	St. Luke's Pediatric Asso	Mayo Pediatric	White Bear Lake Health Partners	Total
Number of children whose medical provider received feedback from the EI agency	7	0	13	20	9	49
Number of children referred for EI services	9	0	20	35	13	77
Percent	78%	0%	65%	57%	69%	64%

Care coordinator interview protocol

ABCD-III (Assuring Better Child Development)
Care Coordinator Interview

First, I would like to ask you a few questions about your work as a care coordinator and your role in the ABCD III Initiative:

1. How long have you been the Care Coordinator at [Name of Clinic]?
2. Can you describe your role as Care Coordinator? [*Probe: what are your tasks and responsibilities?*]
3. What is your role specifically with the ABCD III initiative?
4. How many hours per week approximately do you and others in your clinic spend on care coordination duties/activities [e.g. less than 10 hours/week; between 10 and 20; more?]
5. Could you please describe for me, your clinic's processes for coordinating care?

TRACKING: As part of your work with the ABCD III Initiative, you have been asked to track information about screenings and referrals. I would like to ask you a few questions about tracking, more specifically about what kind of information you track and how you do so.

6. Are you currently using a tracking system to track screened and referred patients? *[Note: answer to this should be YES]*
7. Are you using the Access Database created by DHS to do this or another method? *[Note: answer to this should be YES but if they say NO, find out what they are using and why they are not using the Access Database created by DHS]*
8. Are you using any other systems to track screened and referred patients <u>in addition</u> to the Access Database? [What are they, please describe?]

Now I would like to ask you a few specific questions about what you are tracking in your Access Database:

9. What patients do you track in the Access Database *[e.g. only ABCD III patients (Medicaid only or private pay referred children as well), all patients, ABCD III patients and Health Care Home patients, etc?]*
10. Are you using the Access Database to track information outside of the scope of the ABCD III initiative? [If YES, what kinds of information are you tracking?]
11. How do you decide who to track in the database?

THE REFERRAL PROCESS. I'd like to shift gears to talk specifically about the process you use to make referrals to Help Me Grow, community agencies, mental health providers and medical specialists. I'd like you think primarily about the steps that now occur when a patient at your clinic needs a referral.

Referrals to Help Me Grow:

12. When making referrals to Help Me Grow do you or someone else in your clinic contact Help Me Grow <u>directly</u> or do you provide families with the contact information with the expectation that they will make contact on their own?
13. Does your clinic refer patients to Help Me Grow online or using the statewide phone number or both? What about a referral to the local Help Me grow by fax or phone?

14. Do you make contact with Help Me Grow to follow up on the referrals made to Help Me Grow? If no, why not?
15. What are you doing to follow up? Is there a procedure/protocol for follow up? [If Yes, ask for a copy of the protocol]
16. Does your clinic refer to BOTH a medical specialist and to EI/"Help Me Grow" in *most* situations? What types of situations would you refer to both and when wouldn't you make this dual referral?
17. Please provide us with a brief description of the types of information you are receiving back from **Help Me Grow** once the referral and assessment have been completed.
18. When a child is assessed by Help Me Grow and does not qualify for the program, what do you do?

Referrals to Mental Health:

19. When making referrals to mental health do you or someone else in your clinic contact the provider directly or do you provide families with the contact information with the expectation that they will make contact on their own?

20. Would you say that your clinic has a protocol for referring children with mental health concerns?
21. Is the protocol written down? [What is it?, Please briefly describe. **Request copy of written protocol, if available. (NOTE: DHS is interested in comparing these to the first documents they received from each clinic.]**

Referrals to community agencies:

22. Does your clinic **actively** [an active referral means that someone at the clinic is making the referral for the family/patient rather than giving them the information to make their own referral (passive)] refer to any of the following community agencies? [check all that apply]

    ❒ECFE
    ❒Public Health: Follow along
    ❒Head Start
    ❒Public Health: Home Visiting Program
    ❒WIC
    ❒County human services
    ❒Food shelf
    ❒Others:

23. Please describe your methods of communicating with other clinics and community agencies during the referral process.
24. Have you or someone else in your clinic created/adapted a standard referral form to ***send*** information to community agencies?
25. Have you or someone else in your clinic created created/adapted a standard referral form to ***request*** information from community agencies?
26. Do you Refer families to other community services if they didn't qualify for Help Me Grow? [If yes, how do you do this?]
27. Have you or someone else in your clinic identified and utilized a community resource listing for needed referrals?

General process for making referrals:

28. Has your clinic developed an internal clinic process for reviewing feedback from referrals and integrating the information received?
29. Is it in writing?
30. How often are these procedures/protocol followed?
    - ❒[1] Never
    - ❒[2] Rarely
    - ❒[2] Often
    - ❒[2] Always

FAMILY SUPPORT. We are also interested in the kinds of family support that is provided to patients and their families during their clinic visits and the referral process. Can you please tell me if you or someone else in your clinic does the following:

31. Assist families in scheduling appointments when a referral is made?
32. Obtain consent and forward the family's contact information to the agency they're being referred to?
33. Contact families to ensure that they understand what services they are supposed to receive or ask how care is going?

COMMUNICATION. We are interested in learning more about your clinic's levels of communication with Help Me Grow?

34. Please describe your relationship with the local Help Me Grow agency. **(NOTE: Prompt with names, specific agency titles from Help Me Grow contact sheet). [Probe to understand communication patterns between clinic and Help Me Grow.]**
35. What barriers make it difficult to communicate effectively with Help Me Grow*? What have you already done to address these challenges? Are there other ways you plan to address these barriers?*
36. What steps have you and/or clinic staff taken to improve communication between Help Me Grow and your clinic? [Ask for copies of any forms that have been developed.]
37. Are you communicating directly with the school district? **[Probe: If so – can you describe the information shared with the district? If not – what information would you like to receive from the district? What are the barriers to communication?]**

CARE PLANS. The care plan is a written summary document combining the needs, concerns and desired outcomes of the patient, family and care team in addition to the medical treatment plan. The care plan also outlines the services that will be provided to the family to meet their identified needs. The care plan is detailed to allow for follow-up and tracking by care coordinators.

38. Is your clinic currently using Care plans? [*If no, why not? Plans to use in future?]*
39. If yes, for whom are the care plans used? *[e.g. ABCD III patients only? Everyone in the clinic? Health Care Home patients only? Etc]*
    If using Care Plans, do you also use them for ABCD III patients?

OVERALL. I'm also interested in hearing your overall thoughts about your involvement in this initiative.

40. Do you feel that implementing ABCD III has been beneficial to your clinic as a whole?
41. Do you think that ABCD III has been beneficial to your patients?
42. How do you see spread [e.g. how do you see the principles of ABCD III being adopted by others in your clinic?] of these activities happening in your clinic? (currently or ideas for how it will happen in the future?) If so, what will the barriers or challenges be?
43. What advice would you give to other clinics/practices like yours who are interested in improving their communication/coordination practices with Help Me Grow, mental health and other community agencies?
44. Have you shared what you have learned about the ABCD III Initiative with your colleagues?
45. Do you feel that other primary care providers in your clinic are interested in implementing practices from the ABCD III Initiative? Which practices?
46. What are the most important things you've learned thus far through this initiative? *[Probes: What do you see as your major accomplishments/barriers?]*
47. What challenges or issues would you like to be able to address in the next year of this initiative?

SUSTAINABILITY *[NOTE: May need to skip section if informant is new to the initiative and unable to answer questions about changes made/sustainability plans.]*

48. Do you plan to sustain all or some of the practice changes you've made after the initiative ends? If not, why not
49. What pieces of this initiative are not currently sustainable? What do you see as the most important challenges to sustainability?

Provider champion interview protocol

ABCD-III (Assuring Better Child Development)
Clinic Champion Interview

First, we would like to ask you a few questions about who you are and the work that you do at Fridley Children's and Teen's Medical Clinic:

1. How long have you been a provider at Fridley Children's and Teen's Medical Clinic?

2. What is your role specifically with the ABCD III initiative?

3. What (if any) changes did your clinic make in terms of staffing to support the work being done for the ABCD III project?

4. Does your clinic/practice have a care coordinator on staff? *(If not, who fulfills the tasks of the care coordinator?)*

5. We are interested in understanding more about your current practices around **anticipatory guidance**, **screening** and the **referral process**. Please check the appropriate box if you *rarely, sometimes, usually or always* do the following:

	I rarely do this	**I sometimes do this, it depends on the child**	**I usually do this with most children**	**I always do this with all children**
a. Conduct anticipatory guidance and parental education about development and behavior issues	☐[1]	☐[2]	☐[3]	☐[4]
b. Ask parents whether they have any concerns about the child's learning or development	☐[1]	☐[2]	☐[3]	☐[4]
c. Ask parents whether they have any concerns about the child's mental health	☐[1]	☐[2]	☐[3]	☐[4]
d. Conduct **universal** periodic screening of the child's risk for **developmental delays** or problems using a standardized, validated tool	☐[1]	☐[2]	☐[3]	☐[4]
e. Conduct **universal** periodic screening of the child's risk for **mental health concerns** using a standardized, validated tool	☐[1]	☐[2]	☐[3]	☐[4]
f. Refer patients with elevated screening scores to Early Intervention (EI)/Help Me Grow	☐[1]	☐[2]	☐[3]	☐[4]
g. Refer children seen in practice to community agencies (e.g. Head Start, Early Childhood Family Education (ECFE))	☐[1]	☐[2]	☐[3]	☐[4]

6. We are also interested in understanding your current ***comfort*** and ***satisfaction*** with respect to current practices around anticipatory guidance, screening and the referral process. Please tell us how much you agree with the following:

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a. I have a strong understanding of the developmental health referral options available for children I see in practice	☐1	☐2	☐3	☐4
b. I have a strong understanding of the mental health referral options available for children I see in practice	☐1	☐2	☐3	☐4
c. I feel comfortable knowing when to refer children I see in practice to other Early Intervention (EI)/ Help Me Grow	☐1	☐2	☐3	☐4
d. I know what kinds of services children can receive at Early Intervention (EI)/Help Me Grow	☐1	☐2	☐3	☐4
e. I (or my clinic) have a strong working relationship with the people I refer to at Early Intervention (EI)/Help Me Grow	☐1	☐2	☐3	☐4
f. At the end of an appointment, I feel confident I made the most appropriate referral (or non-referral)	☐1	☐2	☐3	☐4

REFERRALS

We'd like to learn specifically about the process you use to make referrals to Help Me Grow, community agencies, mental health providers and medical specialists.

7. Do you ever make dual referrals [e.g. to both Help Me Grow and another medical provider such as a specialist]?

8. Please briefly describe the types of information you are receiving back from Help Me Grow once the referral and assessment have been completed?

9. What types of information are you receiving from local schools or school districts?

10. Does your clinic actively [an active referral means that someone at the clinic is making the referral for the family/patient rather than giving them the information to make their own referral (passive] refer to any of the following community agencies? [check all that apply]
    - ☐ ECFE
    - ☐ Public Health: Follow along
    - ☐ Head Start/Early Head Start
    - ☐ Public Health: Home Visiting Program
    - ☐ WIC
    - ☐ County Human Services
    - ☐ Food shelf
    - ☐ Mental Health Providers
    - ☐ Others:

CARE PLANS
The care plan is a written summary document combining the needs, concerns and desired outcomes of the patient, family and care team in addition to the medical treatment plan. The care plan also outlines the services that will be provided to the family to meet their identified needs. And the care plan is detailed to allow for follow-up and tracking by care coordinators.

11. Are you currently using Care plans? [If no, why not? Plans to use in future?]

12. If yes, for whom are the care plans used? [e.g. ABCD III patients only? Everyone in the clinic? Health Care Home patients only? Etc]

OVERALL
We are also interested in your overall thoughts about your involvement in this initiative.

13. Do you feel that implementing ABCD III has been beneficial to your clinic as a whole? (If so, how? If not, why not?)

14. Do you currently see spread of these activities happening in your clinic? [If NO, do you have any ideas for how it will happen in the future?] What will the barriers or challenges be?

15. What advice would you give to other clinics/practices like yours who are interested in improving their communication/coordination practices with Help Me Grow, mental health and other community agencies?

16. Have you shared what you have learned about the ABCD III Initiative with your colleagues?

17. Do you feel that other primary care providers in your clinic are interested in implementing practices from the ABCD III Initiative? Which practices?

18. What are the most important things you've learned thus far through this initiative? (e.g. What do you see as your major accomplishments? Major barriers?)

19. What challenges or issues would you like to be able to address in the next year of this initiative?

SUSTAINABILITY

20. Do you plan to sustain all or some of the practice changes you've made after the initiative ends? If not, why not?

21. What pieces of this initiative are not currently sustainable? What do you see as the most important challenges to sustainability?

Thank you!

Please return this document to Darcie Thomsen at Wilder Research (darcie.thomsen@wilder.org).

Early intervention staff interview protocol

ABCD III – Help Me Grow Key Informant Interview Questions
Finalized August 2011

First, I would like to ask you a couple questions about your background and your role in the ABCD III Initiative.

50. Can you describe your role with Help Me Grow? What is your specific role with the ABCD III initiative? How are you involved with the clinic partner? How long have you been involved with Help Me Grow and the initiative?
51. Does anyone else from your local Help Me Grow or the local school district have a role in the ABCD III initiative? Please describe who they are and the roles they have.
52. How often do you attend meetings with clinic staff and other local ABCD III partners as part of the ABCD III initiative?

CHANGES IN HELP ME GROW STRUCTURE

I know that significant changes were made to the Help Me Grow statewide infrastructure starting in July.

4. How has this change from a local to regional model changed your work?
5. [If the person was involved with initiative before July 1st] How has it impacted the relationship you have with each clinic? In what other ways has this change impacted your work?
6. Are there any other issues that came from this change that you are currently working to address?

REFERRAL PROCESS

I'd like to shift gears to talk specifically about the process now used when a referral comes to Help Me Grow. I'd like you to think primarily about the steps that now occur when you receive a referral from [name of clinic]. However, if the process used with the clinic is significantly different than how you handle referrals from other sources, I'd like to know more about that, as well.

7. To begin, I'd like to walk through the intake, assessment, and referral process you would use for a referral that came to you today.
    a. How do referrals come to you from the clinic? What types of information is sent by the clinic? How is that similar or different than other referrals you receive?
    b. Do all children referred to Help Me Grow receive an assessment? If not, what steps do you take to gather information about the child and determine whether an assessment is needed? Is there any communication with the clinic during that process? *[Prompt for additional details to understand full process.]*
    c. Who conducts the assessment? *[Is it done by a single staff person, or by any member of a team?]*
    d. How are these results shared with the family? *[If not offered in response to the initial question: How and when to you obtain consent/a release of information form from the family? What happens when a family refuses to sign a release of information form?]* What other communication do you have with the family during the intake and assessment process?
    e. How do you share the results with the clinic? Do you have similar procedures in place to communicate results back to other referral sources?
    f. Are there any other steps or key activities occur after a referral is received by your office that are unique to, or were started because of, this project? *[If so, please describe.]*

8. What are the barriers you face in making sure that these steps occur in a timely manner? How have you, or how do you plan to address these barriers?

9. Since becoming involved with this initiative, are there any other changes you've made to improve the intake, assessment, referral, feedback and communication processes you just described? What other changes, if any, are you currently working on or planning to make?

10. Overall, do you feel like you are currently receiving appropriate referrals from the clinic? *[Probes: Are children being referred as early as they should be? Are you receiving the number of referrals that you would expect for children birth to five? Do you have thoughts about reasons clinics may not be referring children?]* Are there any steps you have taken to work with clinics to ensure you receive appropriate referrals? *[If so, please describe.]*

COMMUNICATION AND COORDINATION WITH CLINIC

Now I'd like to ask you a few questions about communication and coordination between your agency and the clinic. I'd like you to think about both the information you receive, the ways you communicate with the clinic, and the ways you work in partnership with the clinic to coordinate services.

11. What barriers make it difficult to communicate effectively with clinic providers? *[NOTE: This includes communication to and from HMG] [Prompts: What have you already done to address these challenges? Are there other ways you plan to address these barriers?]*

12. What steps have you and/or clinic staff taken to improve communication between Help Me Grow and the clinic? Have you developed a process/protocol for providing feedback or communicating with the clinic? *[Ask for copies of any forms that have been developed/copies of protocols.]*

13. In addition to the steps you've taken to improve communication with the clinic, are there steps you've taken to improve service coordination with the clinic? *[If so, please describe.] [Prompts: How do you involve youth and families in service coordination and communication with the clinic? How do you see your care coordination role as similar to or different than the role clinic care coordinators play when working with children and families?]*

OVERALL

I'm also interested in hearing your overall thoughts about your involvement in this initiative.

14. What are the most important things you've learned thus far through this initiative? [Probes: What do you see as your major accomplishments/barriers?]

15. What is the advantage, from your program perspective, of having providers and schools sharing information about a child's assessment results, services planned, or other information?

16. What advice would you give to other Help Me Grow regions interested in improving their communication/coordination practices with medical providers?

SUSTAINABILITY

[NOTE: May need to skip section if informant is new to the initiative and unable to answer questions about changes made/sustainability plans. Clarify whether changes/sustainability activities are district- or school-level efforts.]

17. What changes in practice do you think are most important for you to sustain after the ABCD IIII project ends? Have you already begun to consider how to sustain the changes you've made to improve communication and coordination with the clinic after the initiative ends? *[If so, please describe your plans to continue this work after the initiative ends. What support is needed from the school, district, and/or State to help you sustain this work?]*

18. Have you considered any steps to expand the changes you've made to your work with other clinics? *[If so, please describe changes. If not – why?]* What pieces of this initiative are not currently sustainable? What do you see has the most important challenges to sustainability? *[Probe to understand specific activities that are perceived as difficult to sustain and why.]*

MDE staff interview protocol

ABCD III Initiative
Key informant interviews with MDE staff – FINAL
August 16, 2011

INTRO

BACKGROUND

1. To begin, can you give me an overview of the changes that were made to the IEIC system earlier this summer? *[Probe to find out how roles of local HMG, IEIC staff have changed]*

VISION FOR NEW HMG SYSTEM

2. What program improvements does MDE hope to encourage by changing the IEIC system from a local to regional model, and shifting some work and funding to the local level? *[Optional probe: What do you see as the strengths or enhancements that will be made to the early identification and referral system in Minnesota as a result of this change to a regional model?]*

3. What barriers/challenges do you anticipate the HelpMeGrow offices will face when transitioning to this new model? How has and how will MDE support the regional offices in implementing these changes?

4. How do you see school districts changing their efforts to take on new Help Me Grow (early assessment, intervention, and referral) activities? How will the work of LEAs change? What role, if any, does the State have in supporting schools and districts in expanding their efforts in these areas?

5. I'd like to ask you a few more detailed questions about the work of local Help Me Grow staff. What steps are local Help Me Grow staff <u>required</u> to take when children are referred, but do not qualify for Part B/C services? What steps are IEIC staff <u>required</u> to take when children are referred, but are not eligible for services? *[Probe: With this recent change in the Help Me Grow system, have local Help Me Grow staff received training or information from MDE about how they should handle referrals, conduct assessments, make referrals, or communicate information? (Ask for copies of specific training materials, if any have been developed.)]*

6. What is the advantage, from your program perspective, of having the provider and school sharing information about a child's assessment results, services planned, or other information?

COORDINATION WITH ABCD III

7. As I described earlier, ABCD III focuses on enhancing communication and coordination between pediatric clinics and early childhood intervention services.

   In MDE's work with Help Me Grow staff, has there been specific discussion of how to handle referrals or enhance communication with clinics? *[Probe for details] [Optional probes: Are there specific ways that this change to a regional model may impact how Help Me Grow staff engage clinics in referral and communication activities? What do you expect will happen at the local level to communicate information, such as assessment results and service referrals, to the clinic providers who refer children to Help Me Grow? Which of these changes will be a result of meeting Part B/C requirements and which are changes you hope to see because it is good practice (though not required)?]*

8. Through our interviews with clinic care coordinators involved in the ABCD III initiative, we know they are interested in receiving information back from their referral sources in a timely manner. Do you have any plans in place to monitor the timeliness of communication or screening and referral practices, such as how often referrals come from different sources or how frequently children referred to Help Me Grow meet the eligibility criteria? *[If so, probe to discuss data collection interests, plans]*

9. Do you see any ways in which the goals of the ABCD III project may align with what your agency hopes to achieve through the HMG program or inform your work? Do you see any ways that the goals of the ABCD III project may conflict with your agency's vision for the HMG program?

10. The last phase of the ABCD III project is focused on sustainability and spread. How do you think the work of this project would best be spread from the four pilot sights to other clinics and school districts around the state? What is necessary for school districts to sustain or expand this collaborative work with clinics? What do you see as the role of regional Help Me Grow staff and local education agencies (LEAs) in supporting this initiative (ABCD III) and its spread?