Wilder Research

Improving coordination between clinics and school districts
Lessons learned through Minnesota's Assuring Better Child Development (ABCD III) project

Parents who are concerned about their young child's development often seek advice, services, and support from their child's pediatrician or other medical provider. However, young children (ages 0-5) may also be eligible to receive services and supports from their local school district through Infant and Toddler Intervention Services and Preschool Special Education, two components of Minnesota's early intervention system.

Although children benefit from the broader array of services they can receive across these school child-serving systems, a number of barriers, including data sharing concerns, limited staff time, and unfamiliarity with staff and the services available in other sectors, make it difficult for medical providers and school district staff to communicate and effectively coordinate care. Led by the Minnesota Department of Human Services (DHS), the state had the opportunity to create and test sustainable models of improved referrals, communication, and care coordination through its involvement in the Assuring Better Child Health and Development program (ABCD III). This multi-state program was funded by The Commonwealth Fund and administered by the National Academy of State Health Policy (NASHP).

Minnesota's project supported four pilot sites (in Anoka, Olmsted, Ramsey, and St. Louis Counties) over a 3-year period to enhance care coordination by establishing or strengthening linkages between primary care clinics, school districts, community-based medical specialists, mental health service providers, and other partners. This summary first describes the experiences of the four pilot sites and the impact of their work, and then offers recommendations for other clinics and school districts to consider when implementing similar projects.

About the pilot sites

The four sites selected to participate in the ABCD III project shared common goals of developing stronger cross-sector relationships and improving their referral, communication, and care coordination processes. Each site team included representatives from at least one local primary care clinic and school district, as well as other community stakeholders, such as local public health departments or Head Start.

Although the four sites all had clinic and school district representatives in place when their projects began, some sites had already built strong cross-sector relationships while others were establishing new partnerships. None of the sites had formal processes to streamline referrals or a means to share information between the clinic and early intervention staff. For example, there wasn't a system in place to send early assessment results back to the referring medical provider.

In general, all pilot teams were interested in working towards achieving a set of similar outcomes:

- Establishing consistent screening and referral protocols to identify children who may be eligible for early intervention services
- Developing a shared bi-directional communication process
- Creating a consistent process and form to share the child's assessment results, future service plans, and other relevant information with the medical provider
- Improving the timeliness and appropriateness of referrals made by providers to early intervention services
- Reducing delays in communication between early intervention services and the referring provider

Key outcomes from the pilot sites

Overall, the information collected by the participating pilot sites and from parents of children who receive care from each clinic suggests a number of positive outcomes occurred over the course of the pilot project.

Screening and referral practices

Children were referred to early intervention services in a timely manner. Across the four sites, 180 children (ages 0-5) were referred to early intervention services as a result of an elevated screening score or concerns raised by the parent during a well-child appointment. Twenty percent of these children were also referred to other medical or community based services. Some providers noted that, as a result of their involvement in the project, they were more likely to refer children they considered to be at-risk, rather than just those with a known delay.

Across the four pilot sites, all early intervention staff felt that they were receiving appropriate referrals from clinic providers. At least half (51%) of the children ages 0 to 3 referred for early intervention services were found eligible for services and supports. However, as a result of missing data, this may be a low estimate.

A majority of parents received, and were pleased with, the advice they received from their provider regarding their child's screening results. After a developmental screening, the percentage of parents who received advice or next steps from their provider increased slightly from 65 percent in 2011 to 71 percent in 2012. Overall, fewer parents (51% in 2012 and 56% in 2011) reported they received advice or plans for next steps following an appointment with a mental health screening component.

Parent satisfaction with the screening process was high overall. Eighty-three percent of parents were "very satisfied" with the development screening process used by their child's clinic (similar to the 80% reported in 2011). Satisfaction rates were also high following mental health screening (79% of parents were "very satisfied" with the visit in 2012, compared to 72% in 2011).

Timeliness of communication

The timeliness of communication from early intervention services to the referring provider improved over time. For children under the age of 3, the school district has 45 days to conduct an assessment and develop an educational plan. Under ideal circumstances, communication from early intervention services to the referring clinic would follow a similar timeline. As a result of the relationships formed and processes established between the clinics and school district, the median number of days between the referral and follow up communication ranged from 47 to 58 days by the end of the project, an improvement from the 73 to 116 days that occurred at baseline.

Care coordination practices

More care coordination services may be needed. While the need for care coordination services is relatively low overall, it is an unmet need for some families. While 28 percent of parents whose child was referred to early intervention services wanted care coordination services[1] from their child's clinic, only 17 percent of parents reported that they received that service.

Issues to consider

During the course of the three-year project, the pilot sites made a number of promising changes and felt they were successful in improving the bi-directional communication processes. However, the sites also encountered a number of challenges that may be helpful for clinics and school districts to consider how to address when developing similar initiatives.

---

[1] In the parent survey, a care coordinator was described as a clinic staff member who "coordinates your child's care among different doctors, specialists, or services that your child needs and gathers the information about your child from these sources to plan their care."

Developing relationships

Across all four sites, the projects experienced success in building or enhancing existing relationships between primary care providers, early intervention staff, and other key community based organizations. They found great value in having face-to-face meetings and reported learning new information through both structured presentations and information conversations with their team. However, not all sites experienced the same degree of success. Relationships were not as strong among sites where there was staff turnover or limited staff involvement in team meetings. Time and energy is needed to reach out to key stakeholders whose participation may fade over time.

Developing forms, processes

All sites developed a bi-directional process that improved communication between clinic and early intervention staff. While the processes used by each site varied, all determined which method of referral (e.g., fax, online) worked the best for their local system and developed a form that could be used by early intervention staff to share assessment results and planned services with the referring provider. Knowing that the same screening tools were used by both clinic providers and early intervention staff, some pilot sites have also begun to share the screening results with the school district at the time of referral.

Addressing data sharing concerns

Initially, the teams hoped to develop a single release of information form that parents could sign at the time of their medical appointment that would allow: (a) clinics to release information from the child's medical record to early intervention staff and (b) school districts to release early intervention assessment data to the child's medical provider.

However, more guidance is needed by state agencies in order to develop data sharing practices that comply with both HIPAA and FERPA regulations[2]. The teams were able to work around this barrier by developing processes that help ensure that informed consent is gathered consistently by both the clinic and school district. Pilot sites that obtain parent consent as early as possible and that have a more centralized process to obtain consent have been more successful in sharing information that informs the services provided by both early intervention and clinical staff.

Adapting to change

Some of the sites experienced significant changes in staffing that impacted their project's success. The restructuring of the state's early intervention system in 2011 led to significant changes in the roles of early intervention staff for two of the pilot sites. Temporary leaves or permanent staffing changes also disrupted established referral and communication processes. Strong relationships are needed to adapt to unanticipated barriers and change. In addition, it is essential to formalize the expanded roles of staff at an organizational level in order to avoid major disruption when staff turnover occurs.

Providing care coordination services

Although each clinic had a designated care coordinator, the roles and responsibilities of these staff varied considerably. Often, the care coordinators played multiple roles within the clinic, leading to inconsistent time available for various care coordination activities. While multiple care coordination models can likely be effective, sites that were more successful in implementing streamlined referral, communication, and coordination processes had care coordinators who served as a key point of contact, monitored the status of referrals made, and were proactive in communicating with early intervention staff when follow-up information was not provided.

---

[2] The Health Insurance Portability and Accountability Act (HIPAA) is a federal regulation that clinics and other covered entities must follow to protect patients' health information. FERPA, the Family Educational Rights and Privacy Act, is the federal regulation that protects the privacy of students' education records.

Promoting sustainability and spread

A variety of strategies were used by the pilot sites to sustain their work after the end of the grant period and expand their efforts to other clinics and school districts.

Many team members worked within their own professional networks to engage new clinics and school districts. For example, in three of the clinics, the "provider champion" who regularly participated in team meetings became an advocate for change within their clinics, sharing information with their colleagues and working to encourage other clinics within their health system to more formally adopt changes in practice.

Some type of tracking system is needed to monitor which children were referred to early intervention services and to support other care coordination work. Although none of the clinics had an electronic health records (EHR) system in place that met their needs for this project, one clinic did incorporate some key data fields to track screening results and referrals into their EHR system and others would like to explore similar options.

Buy-in at multiple levels within clinics, school districts, and community agencies is likely needed to sustain these changes in practice over time. The ABCD III project provided each site with a small financial stipend that helped defer the costs of participating in team meetings and time needed for tracking and communication activities outside of a partner's typical scope of work. However, for these changes in practice to be maintained over time, staff must be supported to take time to sustain and expand these efforts. For both the pilot sites and other clinics and districts interested in adopting these practices, buy-in and support among supervisors and administrators is key to ensuring that changes in practices are adopted consistently by staff and that new staff are trained to use these approaches to coordinate care.

Strategies for successful implementation

When communication and coordination between clinics and school districts is improved, young children are more likely to receive the services they need. While there are many barriers to adopting changes that lead to improved communication across sectors, the ABCD III pilot sites demonstrated that these challenges can be addressed in a number of ways. While the processes used by different clinics and districts may vary somewhat, the following strategies are essential elements of successful implementation:

- Use regularly-scheduled face to face meetings with clinic providers and staff, early intervention staff, and community organization representatives to build relationships, develop shared referral and communication processes, and address implementation barriers in a timely way.
- Gather release of information forms from families as early as possible in both clinics and with early intervention staff to reduce barriers to sharing information across systems.
- Use existing tracking tools or develop new systems to monitor the status of referrals made and to prompt consistent follow-up.
- Use proactive care coordination approaches to monitor the status of referrals made to early intervention service and request information.
- Formalize changes in practice by establishing buy-in among both staff and supervisors for the practice change, incorporating new roles and responsibilities into existing job descriptions, reinforcing changes in practice through staff training, and developing written documents that describe new practices.