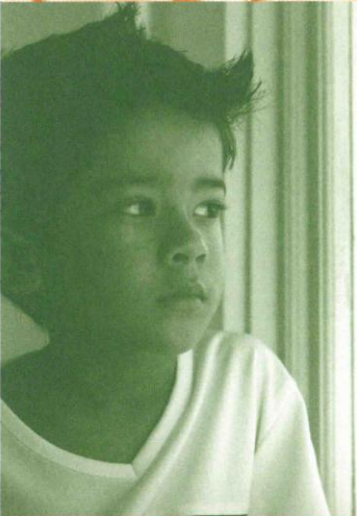**Wilder Research**

ABCD III: Key findings from interviews with clinic care coordinators and clinic administrators

An evaluation of knowledge and practice of the key components of the ABCD III initiative at baseline

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Prepared by:
Rachel Hardeman

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

Contents

Figures

Acknowledgments

Project background

The Assuring Better Child Health and Development (ABCD) III initiative is supported through a three-year grant from the National Academy for State Health Policy, administering the grant for The Commonwealth Fund, to the Minnesota Department of Human Services (DHS), awarded in 2009. 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 ages birth to 5 years. The goal is to support five pilot sites (in Anoka, Olmsted, Ramsey, and Saint Louis Counties) in developing a system that assures efficient linkages between primary care, other medical providers, and child and family service providers. A variety of strategies will be used to enhance care coordination, such as creating processes to systematically screen and assess young children and 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 increased rates of screening and referral, timely access to services for children with potential developmental and/or social-emotional concerns, and positive treatment experiences for families.

Wilder Research has been contracted to evaluate the initiative. This report summarizes the results of a series of key informant interviews conducted with clinic care coordinators and clinic administrators. These key informant interviews will be repeated two more times before the end of the initiative, to identify changes in referral patterns, communication, and coordination that result from this initiative.

Research methods

Semi-structured key informant interviews were conducted with both care coordinators and clinic administrators from each pilot site. These individuals were identified by Department of Human Services (DHS) staff leading the ABCD III Initiative. The interviews were conducted between December 2010 and February 2011.

A total of five care coordinators (one from each participating clinic) were interviewed. Of the five participating clinics, administrators from four of the clinics were interviewed. One of the care coordinators interviewed is also the clinic administrator for the clinic and therefore was interviewed in both capacities. The fifth clinic administrator was contacted multiple times by email and phone with a request for an interview, but interviewers were unable to receive a response from this individual.

Clinic administrators were asked interview questions based on a modified version of the key informant protocol developed for the care coordinators.

Research questions

This report summarizes key findings from the first series of interviews with the goal of describing clinic activities at the beginning of the initiative. Key informant interviews with the care coordinators and clinic administrators will be conducted three times to assess changes in practice over time.

The information collected will help to answer the following research questions:

Impact on Care Coordination/Service quality/Relationships

■ To what extent does each clinic have a close working relationship with local child and family service providers?

■ To what extent do clinics and community programs work together to coordinate care for the child/family?

■ To what extent to children and families receive an appropriate and timely array of assessments and services?

■ What changes did clinics make in terms of staffing in support of coordinated care?

■ Why were services not offered or received following referrals (i.e., inappropriate referrals, ineligibility for services, and lack of available services in the geographic area)?

■ How many of the children referred qualified for services? What kind of services did they receive?

Impact on referrals/information sharing

■ To what extent do providers feel comfortable knowing when to refer children based on screening results and to whom they should be referred?

■ Do primary care providers receive feedback from community providers?

■ Are early intervention agencies receiving increased referrals of children?

■ If primary care providers do not feel comfortable making referrals, what are the reasons?

■ Are children who are screened subsequently referred for services?

- Where are children referred?

- Were children who did not qualify for services referred for other assistance or education?

Impact on knowledge and practice

- To what extent do participating clinics implement a screening instrument and referral protocol?

- To what extent do participating clinics develop a protocol to track referrals made and follow-up services provided to patients?

- To what extent are fax/back referral forms and other methods of communicating between clinic and community agencies in place and regular use?

- Have participating clinics developed and/or shared resource listings for community-based services?

- Have participating clinics increased knowledge about available services and community agencies?

- To what extent are participating clinics making efforts to engage families and cover developmental and anticipatory guidance measures?

- What strategies/protocols are used for networking and collaboration?

- What challenges do participating clinics experience in developing systems/protocols?

- How often are the developed procedures/protocols followed?

Satisfaction with technical assistance

- How do clinic staff/primary care providers/community partners rate the quality and quantity of training/technical assistance that they received through this initiative?

- Are there activities that clinic staff/providers found particularly helpful or not helpful?

This report will address these research questions by summarizing key informant interview findings on the respective topics for both clinic administrators and care coordinators. The findings will be reported in aggregate so as to not single out any particular clinic or individual.

Key informant interview findings

Interview questions aimed to better understand a clinic's processes for coordinating care, communicating with community agencies, creating care plans, and referring to Help Me Grow as well as their satisfaction with the ABCD III Initiative. Because these data were collected as a baseline survey during the early stages of the initiative, it is not expected that clinics will be successful in implementing all tasks related to the initiative.

Impact on care coordination

One of the main objectives of Minnesota's ABCD III project is to improve care coordination in the participating clinics and with Help Me Grow and other child and family service providers. A series of questions were asked to gain an understanding of what participating clinics are doing at baseline around care coordination.

Care coordination is loosely defined as: a patient-centered approach to integrating health care and social support services in which patient and family needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator.

Key informant interviews revealed the following baseline information about the impact of the ABCD III Initiative on care coordination:

■ **Clinic's processes for care coordination vary, but all clinics have some sort of process for coordinating care in place.** Each respondent described a different process for coordinating care within their clinic. For three of the five clinics, this process involves the use of electronic medical records (EMR). The point at which care coordination services are initiated varies by clinic. For example, at some clinics the care coordinator becomes involved at the request of the physician, after the physician has seen the patient. For others, a mailed questionnaire or elevated screen conducted online will trigger the need for care coordination services and thus the coordinator will initiate services well before a patient is seen in the clinic.

■ **Nearly all care coordinators also serve in another position at their clinic.** In addition to acting as care coordinator, most have other titles or positions ranging from clinic manager to office coordinator to nurse. Not having enough time for care coordination duties due to multiple job responsibilities was often mentioned as a barrier to success with the ABCD III Initiative.

■ **The amount of time spent on care coordination in each clinic varies.** Care coordinators reported ranges from 1.5 hours per week up to 32 hours per week spent

on care coordination. The clinic administrators mostly reported that they do *not* spend time on care coordination duties.

■ **The amount of time that is *needed* for care coordination differs from the amount of time that is *spent* on care coordination.** All care coordinators and half of the clinic administrators agree that more time is needed to carry out care coordination duties.

■ **Some clinics have made changes in staffing to support care coordination.** All care coordinators agreed that the duties of coordinating care are time consuming and that changes either have been made or will be made in the future to support care coordination. Changes included hiring a part-time person to help with care coordination and an increase in hours that the designated care coordinator spends on these duties. For those clinics that have made changes, respondents report that the changes have been "received well" by other clinic staff.

■ **Care coordinators are not using care plans for the ABCD III Initiative.** Of the five care coordinators interviewed; none reported that care plans are being used specifically for the ABCD III Initiative. However, clinics that currently participate in Health Care Home reported that they are using care plans for those patients.

■ **Care coordinators are using a tracking system to track screened and referred patients.** While it appears that all clinics have a tracking system in place, it is clear that these systems vary immensely. Some systems are more technologically sophisticated than others. Systems described range from paper files and note cards to an Excel or an Access database DHS has developed for the project. Several care coordinators reported that due to time constraints, they are unable to transition to the Access database from DHS immediately; the learning curve and time it takes to transition from one data base to another is significant and finding the time to incorporate it into their practice is a challenge.

■ **Reasons for not using a care plan vary among clinics.** Several respondents reported that they had not thought to use care plans for the ABCD III Initiative. One was unsure of how well it would work. Several others expressed concern with the time that it takes to receive updates from Help Me Grow, indicating that this would cause a significant delay in their ability to update a care plan appropriately. When asked if there are future plans to incorporate care plans into the ABCD III Initiative, two of five clinics report that they will consider doing so once the referral database is more familiar and being used regularly.

■ **Clinic administrators are working to integrate care coordination into a variety of aspects of the clinic and office procedures**. Clinic administrators were asked if they "always," "sometimes," "rarely" or "never" considered care coordination in

office procedures such as clinic flow, electronic medical records, health information technology and decisions around changes and purchasing for the clinic. Clinic administrators for two clinics reported that they "always" take care coordination into account, while the other two administrators "sometimes" do so.

■ **The amount of involvement of clinic administrators in the processes for coordinating care varies by clinic.** One clinic administrator also acts as the care coordinator for her clinic, and therefore is highly involved in the processes due to her roles. Another clinic administrator reported that as clinic manager she does not play a role in care coordination for her clinic. The final two clinic administrators reported that their roles and responsibilities in coordinating care vary; while they are in the early stages of the ABCD III Initiative, they have more of a role but don't expect to continue with the same level of involvement in the future.

Care coordinators were asked to report the frequency with which they carry out a series of care coordination duties related to screening and tracking, making referrals and communicating with community agencies and following up with families after referrals are made.

Figure 1 indicates that there is some variety in the frequency with which these things are being done. It is clear that clinics are excelling at tracking whether a child referred to Early Intervention or Help Me Grow qualified for the program as well as in using health information technology to do so. Most clinics report that they "Never" or "Sometimes" are referring families to other community services if they do not qualify for Early Intervention/Help Me Grow.

1. Frequency of care coordination duties

N=5 care coordinators	Never	Sometimes	Usually	Always
A. Screening and tracking				
Track screenings completed with an elevated score or concern	1	-	2	2
Use health information technology (i.e. registry or tracking system).	1	-	-	4
Track whether a child referred to Early Intervention/Help Me Grow qualified for the program.	-	1	-	4
B. Referrals and communication				
Make a direct referral to Early Intervention/Help Me Grow when a child has an elevated screening score or there is a concern	-	2	-	3
Establish person-to-person contact with community providers and resource staff (e.g. Head Start, ECFE, Follow Along).	1	1	3	-
Refer families to other community services if they didn't qualify for Early Intervention/Help Me Grow	2	2	-	1

1. Frequency of care coordination duties (continued)

N=5	Never	Sometimes	Usually	Always
C. Follow up				
Follow-up on information the clinic has not received from referrals made	2	2	1	-
Update care plans when care changes*	-	-	-	-
Obtain consent and forward the family's contact information to the agency they're being referred to	1	2	-	2
Assist families in scheduling appointments when a referral is made	1	2	1	1
Contact families to ensure that they understand what services they are supposed to receive or ask how care is going	-	3	2	-
Act as an advocate for families	-	1	4	-

[a]   *Clinics are not using care plans.*

Impact on referrals and information sharing

It is the goal of the ABCD III Initiative to ensure that clinics improve their practices around making referrals to Early Intervention (EI)/Help Me Grow services and community agencies. Additionally, clinics are working to increase linkages between Help Me Grow and other community agencies focused on child development.

In order to assess if at baseline, clinics have processes in place to refer and share information with these agencies, a series of questions were asked of care coordinators and clinic administrators. The findings are as follows:

■ **The strength of the relationships between participating clinics and local Help Me Grow staff are varied.** For two clinics, relationships were in place prior to participation in the ABCD III Initiative. Both clinic administrators and care coordinators from these clinics report that the relationship has been strengthened since participation in the ABCD III Initiative. The three remaining clinics report that they are working to build relationships with Help Me Grow. Most care coordinators report that monthly meetings have facilitated greater communication with Help Me Grow staff and that they are working to make their relationship stronger.

■ **Clinics are building knowledge about and relationships with community agencies.** All but one clinic reported that they have identified and currently utilize a community resource listing for needed referrals. Most clinics do not have a staff person that regularly updates this listing.

- **Clinics are making active referrals to community agencies.** Three care coordinators reported that their clinics make active referrals to: Early Childhood Family Education (ECFE), Follow Along, Head Start, Home Visiting Program, WIC, County Human Services and the Food Shelf. An active referral means that the care coordinator or other clinic staff make contact with the referred agency for the patient and family. Two of the five clinics reported that active referrals are happening but with fewer agencies (ECFE and Head Start).

- **Clinics vary in their policies around making direct referrals to medical specialists.** Two clinics reported that when making referrals, clinic staff contact the medical specialist directly and set up an appointment for the patient and family. One clinic solely provides families with the contact information and expects them to make an appointment with a specialist. The other two care coordinators reported that whether or not a direct referral is made is dependent upon the family and their needs.

- **Referrals to Help Me Grow are happening but the mechanism for making the referral differs among clinics.** Two of the five clinics are making referrals to Help Me Grow via the online system; of these, one is also referring to the local program at the same time. A third clinic is making referrals to Help Me Grow via telephone while the final two are faxing their referrals to their local Help Me Grow. Additionally, all but one clinic reported that they make direct referrals and do not expect the family to make contact on their own.

- **At baseline, clinics had not received information back from Help Me Grow after a referral had been made.** Four of the five clinics reported that they are unsure of what types of information they will receive from Help Me Grow after their referred patient is assessed. One clinic care coordinator was able to speak from previous experience prior to participation in ABCD III, and explained that typically a report detailing the initial contact with Help Me Grow along with the outcome and any care decisions and next steps or a plan will be shared with the clinic.

Impact on knowledge and practice

An objective of the ABCD III Initiative is to improve participating clinic's knowledge and practices around screening, making referrals to Help Me Grow and other community agencies and the overall coordination of care. Working towards sustainability, clinics should ultimately have a documented protocol that outlines the procedures for these processes. Clinic managers and care coordinators were both asked to describe the systematic processes that they currently have in place for screening, referring and managing services for patients and their families. The findings related to these topics are as follows:

■ **Clinics are using informal rather than formal internal processes for reviewing feedback from referrals.** Clinics have not yet developed an internal clinic process for reviewing feedback from referrals and integrating the information they receive. Care coordinators and clinic administrators agree that developing a process is important to success beyond the ABCD III Initiative. Most mentioned an informal system and feel that it has been adequate, but agree that developing a procedure and putting it in writing is important for sustainability. Additionally, clinics do not currently have a routinized method for tracking the referrals for which they are awaiting feedback. Most care coordinators and clinic administrators explained that this is dealt with on a case-by-case basis.

■ **Clinics are unsure of what to do when a child who is referred to EI/Help Me Grow does not qualify for the program.** Respondents were provided with five scenarios or possibilities of what they might do if this were to occur. Most could not answer because this situation has not yet happened in their clinic. Several care coordinators suggested that hypothetically, they would contact the family to discuss results and perhaps find a better fit for the family's needs.

■ **Half of the participating clinics have a documented protocol for referring children with developmental or mental health concerns.** Care coordinators from all participating clinics reported that they have a protocol; for half it is in writing and for the others it is informal. Regardless of the format of the protocol, all clinics say that the protocol is either "always" or "often" followed.

■ **Most clinics are using a standard referral form to <u>send</u> information to community agencies.** Three of the five clinics have a form that is used. They report that it is a general referral form. Care coordinators for the two clinics that do not have a form both mentioned that this is something they are working towards and hope to have in place very soon.

■ **Most clinics have a standard referral form to <u>request</u> information from community agencies.** Three of five clinics have a form to request information. For the two clinics that do not have a standard referral form to request information, one reported that they previously used a fax form but experienced challenges in receiving responses from the community agencies. The other suggested that a barrier to requesting information might be because the clinic does not have a strong relationship with the community agencies.

■ **Over half of clinics at baseline, report not using a tracking system to follow up on referrals to community agencies.** These care coordinators explained that this doesn't mean it doesn't happen, simply that a tracking system is not in place to do so.

Satisfaction with the ABCD III Initiative

Overall, care coordinators and clinic administrators are satisfied with both the quality and quantity of technical assistance they have received. They have found the assistance provided around the Access Database and the Webinars sponsored by DHS to be particularly useful. Respondents agree that the ABCD III Initiative is a "good" initiative; they feel that it has brought important questions and issues around their clinic practice to the forefront and allowed them to begin to consider better and more efficient ways to serve their patient populations.

Respondents did have some suggestions for how they could see the initiative being improved. These suggestions are as follows:

- **Greater clarity regarding the roles of those on the DHS team.** Several care coordinators expressed some confusion over the roles of each person that they are contact with at DHS. This has made it somewhat challenging for participants to know who to go to for various questions and issues.

- **Increased information regarding how the information provided applies directly to the care coordinator role and duties.** Several care coordinators expressed a desire to receive more direct information regarding their role in the initiative and how the information they receive during Webinars or Learning Collaboratives relates to their role.

- **Increased opportunities for follow up when a care coordinator or clinic administrator is unable to attend a webinar or meeting.** Due to their busy schedules, care coordinators at times are unable to attend or participate in all of the learning opportunities offered. Several coordinators suggested that creating a more formal procedure for disseminating information presented in meetings and/or webinars would be beneficial for those that were unable to participate.

- **Creation of more opportunities to interact with other ABCD III Initiative clinics.** Several respondents mentioned that they would value opportunities to network with their peers in the initiative and learn what's working and not working for them.

Barriers and challenges

Care coordinators and clinic administrators were asked if they have experienced any barriers or challenges related to their work in the ABCD III Initiative. All respondents mentioned time management and/or lack of time to carry out ABCD III Initiative duties as extremely challenging. Most also related this to the difficulties of juggling two positions within the clinic (e.g., care coordinator and clinic manager). Care coordinators in particular agree that the time commitment to the initiative is significant. They are finding that there is an overwhelming amount of responsibilities in the clinic, both for the ABCD III Initiative and other responsibilities, which makes it difficult to complete tasks in a timely manner.

Recommendations

Based on the information gathered through this baseline set of key informant interviews with care coordinators and clinic administrators, Wilder Research developed the following recommendations for DHS to consider as they continue their ongoing work with each primary care clinic throughout the initiative:

- **Explore ways to mitigate the challenges around time for care coordinators.** All care coordinators and most clinic administrators reported that time is a significant barrier to carrying out the principles of the ABCD III Initiative. While this is a difficult issue to solve, keeping time constraints in mind and working towards efficiency will be important to the success of the primary care clinics.

- **Provide a webinar or learning collaborative session on care plans.** Participating primary clinics are not using care plans with patients for the ABCD III Initiative and some were unsure of how it would work in this situation. Providing care coordinators with technical assistance and support around care planning might provide them with more insight on this topic.

- **Continue to provide support and technical assistance to primary care clinics around their database and tracking system needs.** Additionally, explore ways to make the process of tracking as streamlined as possible, as time appears to be a significant barrier to using a tracking system.

- **Create opportunities for clinics to have more face-to-face interactions with the Help Me Grow staff.** Several participating clinics are still working on building relationships with their local Help Me Grow. The facilitation of more interaction may foster these relationships.

- **Continue to work with clinic administrators and care coordinators to put clinic process for screening, referrals and reviewing feedback in writing.** While most clinics have processes in place, the processes have not been formalized and clinics lack a written formal protocol or procedure. In order to work towards sustainability, this should be made a priority.

Appendix

Interview

Interview

Client ID#: _____

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

NAME OF CLINICS: Fridley Children's, Mayo Pediatrics, Rochester, Health Partners Pediatrics, White Bear Lake, North Metro Pediatrics, and Saint Luke's Pediatric Associates, Duluth,

May I speak to __[R]___?

IF R IS NOT AVAILABLE: When would be the best time to reach __[R]___? MAKE NOTES ON FACESHEET

IF R IS AVAILABLE, PROCEED.

This is __[Interviewer]__ calling from Wilder Research. We are working with the Minnesota Department of Human Services on the evaluation of the ABCD III Initiative. I would like to ask you some questions about what you and your clinic have been doing around Care Coordination. Your responses will be kept confidential. Only Wilder Research staff will have access to your individual responses. Your identity will not be connected to any information that is reported.
This interview will last approximately **45** minutes.

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

1. What is your position at this clinic? _____

2. How long have you been in this position? _____

3. Can you please describe your position within the ABCD III Initiative? [Probe: are you a clinician, care coordinator, clinic administrator, etc.?]

     _____
     _____
     _____

4. Do you foresee any barriers or challenges in your participation in the initiative? How do you plan to overcome these barriers?

     _____
     _____
     _____

5. What are your impressions of the ABCD III Initiative at this point in time?

     _____
     _____
     _____

6. What type/s of background information/education did you receive about care coordination for developmental and mental health screening before beginning this project?

     _____
     _____
     _____

The next set of questions relate to your duties as a Care Coordinator

1. Please describe your clinic's processes for coordinating care?

   _____
   _____
   _____

2. Are you currently using a tracking system to track screened and referred patients?
   - ❐ Received well,
   - ❐ Received poorly

3. Please describe your relationship with the local Early Intervention (EI)/ Help Me Grow?

   _____
   _____
   _____

4. What changes did your clinic make in terms of staffing to support coordinated care?

   _____
   _____
   _____

5. How do you think that these changes in practice have been received by your coworkers?
   - ❐ Received well,
   - ❐ Received poorly
   - ❐ Received with indifference

6. How many hours per week approximately do you and others in your clinic spend on care coordination duties/activities?
   - ❐ less than 10 hours/week
   - ❐ between 10 and 25 hours/week
   - ❐ between 25 and 40 hours/week
   - ❐ more than 40 hours/week

7. Now I'm going to mention a number of tasks related to care coordination. In your role as a care coordinator please tell me how often (never, sometimes, usually, always) you do the following:

Screening and tracking	Never	Sometimes	Usually	Always	Comments
a. Track screenings completed with an elevated score or concern	☐1	☐2	☐3	☐4	
b. Use health information technology (i.e. registry or tracking system)	☐1	☐2	☐3	☐4	
c. Track whether a child referred to Early Intervention/Help Me Grow qualified for the program	☐1	☐2	☐3	☐4	
Referrals and communication	**Never**	**Sometimes**	**Usually**	**Always**	**Comments**
d. Make a direct referral to Early Intervention/Help Me Grow when a child has an elevated screening score or there is a concern	☐1	☐2	☐3	☐4	
e. Establish person-to-person contact with community providers and resource staff (e.g. Head Start, ECFE, Follow Along).	☐1	☐2	☐3	☐4	
f. Refer families to other community services if they didn't qualify for Early Intervention/Help Me Grow	☐1	☐2	☐3	☐4	
Follow up	**Never**	**Sometimes**	**Usually**	**Always**	**Comments**
g. Follow-up on information the clinic has not received from referrals made	☐1	☐2	☐3	☐4	
h. Update care plans when care changes	☐1	☐2	☐3	☐4	
Family support	**Never**	**Sometimes**	**Usually**	**Always**	**Comments**
i. Obtain consent and forward the family's contact information to the agency they're being referred to	☐1	☐2	☐3	☐4	
j. Assist families in scheduling appointments when a referral is made	☐1	☐2	☐3	☐4	

Family support	Never	Sometimes	Usually	Always	Comments
k. Contact families to ensure that they understand what services they are supposed to receive or ask how care is going	☐1	☐2	☐3	☐4	
l. Act as an advocate for families	☐1	☐2	☐3	☐4	

8. Has your clinic developed an internal clinic process for reviewing feedback from referrals and integrating the information received?

       ☐ Yes
       ☐ No (Go to Next section)

9. Is it in writing?
       ☐ Yes
       ☐ No

10. Do you have a routinized method of tracking those referrals for which you are awaiting feedback?
       ☐ Yes
       ☐ No

11. Do you make contact to follow up on the referrals?
       ☐ Yes
       ☐ No

*We are interested in learning more about your clinic's levels of **communication with Community Agencies** and the kinds of community agencies that your clinic makes referrals to.*

1. Have you or someone else at your clinic identified local child and family service providers?
       ❐ Yes
       ❐ No

2. Does your clinic **<u>actively</u>** 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

3. When a child is assessed by Early Intervention/Help Me Grow and does not qualify for the program, do you [check all that apply]:

      ❐ Await instructions from the primary care provider about whether they would like anything special to be done based on their review of the information received.

      ❐ Automatically contact family to schedule a follow-up visit for 2-6 months from their last visit for monitoring.

      ❐ Contact the family to discuss the results.

      ❐ Contact the family and refer them to other community services that may benefit their child's development and mental health such as ECFE, Head Start, and the Follow Along Program.

      ❐ Nothing more, if the child is not in need of services, they will be seen at their next scheduled visit and screened at that time

The next sets of questions are about 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.

1. Is your clinic currently using Care plans?
    ☐¹ Yes (Go to Q.4)
    ☐² No

2. Why not?

_____
_____
_____

3. Do you have plans to use them in the future? <mark>(Go to Next Section)</mark>

_____

_____

_____

4. Please tell us how much you agree with the following statements regarding Care Plans.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a. A Care Plan is written for patients when appropriate	☐¹	☐²	☐³	☐⁴
b. The Care Plan helps me communicate with other medical specialists	☐¹	☐²	☐³	☐⁴
c. The Care Plan helps me communicate with community agencies	☐¹	☐²	☐³	☐⁴
d. Once results/feedback are received, I or clinic staff review the information and the Care Plan is updated	☐¹	☐²	☐³	☐⁴
e. When a care plan is updated, the family is notified of the change and/or provided a new copy	☐¹	☐²	☐³	☐⁴

5. How do you decide when to develop a care plan?

_____

_____

_____

6. I (or clinic staff) update a patients' Care Plan in the following instances (check all that apply):

❒ To reflect a parental concern
❒ To reflect an elevated screen
❒ To reflect a change in medications
❒ To reflect a change in care (service frequency changes, service ends, etc.)
❒ To reflect the referral(s) made for the patient to EI/Help Me Grow
❒ To reflect the referral(s) made for the patient to a Medical Specialist
❒ Annual review of care plan to update or significant milestones to reflect information received <u>from</u> EI/Help Me Grow
❒ To reflect information received <u>from</u> a medical specialist

The next set of questions are about the referral process for your clinic
1. Would you say that your clinic has a protocol for referring children with developmental or mental health concerns?
   ❒[1] Yes
   ❒[2] No (Go to Q.4)

2. Is the protocol written down?
   ❒[1] Yes
   ❒[2] No

3. How often are these procedures/protocol followed?
   ❒[1] Never
   ❒[2] Rarely
   ❒[2] Often
   ❒[2] Always

4. Please describe your methods of communicating with other clinics and community agencies during the referral process.

_____

_____

_____

5. Have you or someone else in your clinic created/adapted a standard referral form to *send* information to community agencies?
    ☐[1] Yes
    ☐[2] No

6. Have you or someone else in your clinic created created/adapted a standard referral form to *request* information from community agencies?
    ☐[1] Yes
    ☐[2] No

7. Do you or someone else in your clinic utilize a tracking system to follow up on referrals to community agencies?
    ☐[1] Yes
    ☐[2] No

8. Does your clinic refer patients to EI/"Help Me Grow" online or to the statewide phone number?
    ☐[1] Yes (Go to 8a)
    ☐[2] No (Go to 8b)

      8a. If yes, are you also referring patients to the local program?
          ☐[1] Yes
          ☐[2] No
      8b. If No, are you referring to the local program only?
          ☐[1] Yes
          ☐[2] No

9. Does your clinic refer to BOTH a medical specialist and to EI/"Help Me Grow" in <u>*most*</u> situations?
    ☐[1] Yes
    ☐[2] No

10. When making referrals do you or someone else in your clinic contact Early Intervention (EI)/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?
    ☐[1] Contact EI/Help Mw Grow directly
    ☐[2] Provide families with the contact information

11. Please provide us with a brief description of the types of information you are receiving back from **Early Intervention (EI)/Help Me Grow** once the referral and assessment have been completed.

_____

_____

_____

12. When making referrals do you or someone else in your clinic contact **medical specialists** **directly** or do you provide families with the contact information with the expectation that they will make contact on their own?

    ❑¹ Contact medical specialists directly
    ❑² Provide families with the contact information

13. Please provide us with a brief description of the types of information you are receiving back from **medical specialists** once the referral and assessment have been completed.

_____

_____

_____

I would now like to ask you a few questions about the community agencies you might work with when referring patients with developmental or mental health concerns.

1. Do you or someone else in your clinic do the following:

    1a. Identify and utilize a community resource listing for needed referrals.
        ❑¹ Yes
        ❑² No
    1b. Identify a staff person to regularly update a community resources listing.
        ❑¹ Yes
        ❑² No

2. Do you currently communicate with community agencies (e.g. Head Start, ECFE)
    ❑¹ Yes
    ❑² No (Go to Q.3)

4. What barriers must be addressed in order for you to do this?

_____

_____

_____

The last few questions I have are about your satisfaction with the activities you have participated in for the ABCD III Initiative

1. How would you describe the quality of the TA up to this point [For Example: List examples of TA]

_____
_____
_____

3. What have you found most helpful?

_____
_____
_____

4. Is there anything you would like to see more of?

_____
_____
_____

5. Do you have any suggestions for improving the initiative at this point?

_____
_____
_____

6. Is there anything else you would like to see as you move forward with this initiative?

_____
_____
_____

Thank you for your time