Referral, Community Linkages, and Feedback

Relationships & Communication
Aggregate Record Review Data
Developmental Screening results
Autism screening results
Medical Home Challenges for the Primary Care Practice

- Treating the “whole” child: in the context of the family, the school, the community
- **Adopting an Office Systems approach**
- Operationalizing family feedback as part of the practice system
- Enhanced processes for CSHCN: registries, scheduling tailored for longer visits, **linkages to community resources, assistance with referrals**
Challenges for the Primary Care Practice

- “Knowing the system” of public and private providers locally
- Networking with community partners effectively
- Maintaining continuity and communication with specialists, child care, school, ... (Wraparound)
Systemic Challenges

- Integration of Family-Centered Principles: e.g. continuity, comprehensiveness, coordination, cultural sensitivity.

- Facilitation of networking between community resources that have historically been in “silos.”

- Paucity of mental health services, especially for 0 – 5 year olds.
Systemic Challenges (cont.)

- Additional risks for children living in poverty or in foster care (continuity especially important)
- Lack of reimbursement for care coordination
- Uninsured and underinsured
  - Many insurance/HMO plans have inadequate or deny coverage for services for CSHCN
Sustaining Change

New kind of communication with community

- Relationship with key partners
- Networking to facilitate process beyond practice
- Agreements on how to exchange information, e.g. standardized referral process/form
Establishing Relationships

- Invite community resource representative(s) to the practice for lunch & learn re processes for communication and referrals.
- Have periodic meetings with partners who provide “wraparound” services for patients and families.
- Have evening “mixer” for primary providers and community resources to establish contacts.
- Compile contact information and identify staff to be the liaison for the practice.
Partner with Parents to Do Screening & Surveillance

Important linkages for Medical Home:
- Head Start, Early Head Start, Child Care, Preschools, Schools
- Part C, Part B
- Childcare/school nurses
- Home visiting nurses
- Nurse-Family Partnership
- Family support
- Community mental health providers
Family Contributions

- Gather reviews from families regarding referral experiences
- Engage families in providing information about family resources they recommend
- Become familiar with family support program(s)
Does Screening Mean Becoming an Expert in Evaluating a Child’s Development? **NO**…

Screening is looking at the whole population to **identify those at risk**. Identified children are referred for assessment. Assessment determines the existence of delay or disability which generates a decision regarding intervention.

*Screening is optimized by Surveillance……periodic screening gives a longitudinal perspective of a child’s developmental progress.*
Remember Pearls

- Primary surveillance and screening is routine, with every child/adolescent and family.
- Surveillance and screening include risks and strengths.
- Screening provides a template for conversation, and occurs in the context of a longitudinal relationship between the family and primary care clinician.
- Discussion with family occurs whether screen is positive or negative.
- When surveillance or screening indicate risk, next steps can include more specific secondary screening, a “warm hand-off” to an integrated mental health professional and/or referral and co-management.
When the Screening is Positive: Talking to Families

- Best to first highlight child’s strengths
- Always discuss results of the screening
- Bring up your/parent’s concerns
- Let family know you may not be “expert”, but you can help refer & identify resources
- Positive screen indicates potential of developmental delay/disorder
- Partner with family to decide on next steps & maintain contact throughout process
- Assure family you will follow-up with call, visit
Pathways for Follow-up

Borderline Screen
- Timely follow-up before next routine visit (e.g. ASQ-3 recommendation)

Positive screens
- Internal follow-up (interim visit, f/u with integrated LCSW)
- Referral: Part C, parent support, Head Start, ...
- Referral: D&B Pediatrician, Psychologist, Geneticist, specific therapies
When the MCHAT or Autism Surveillance is Positive

AAP Recommendation is for simultaneous referral for:

- Evaluation and diagnosis
- Early Intervention services
- Audiologic evaluation
Referrals to consider when there are concerns on a screening tool:

- General developmental concerns related to speech, fine or gross motor
  - Occupational therapy
  - Speech therapy
  - Physical therapy
  - Infant Toddler or Preschool EI

- Social-emotional concerns (including concerns about maternal depression)
  - Mental health for the infant and mother dyad [i.e., Child Parent Psychotherapy (0-5 yrs), Parent Child Interaction Therapy (3-7 yrs)]
  - With known abuse/neglect [i.e., above plus also consider Attachment Biobehavioral Catch Up (0-36 months), TF-CBT (3-18 yrs)]
Referrals (cont.)

- Concerns based on not passing the M-CHAT R/F
  - Audiology
  - Early Intervention
  - If concerns about genetic or neurological condition or syndrome also consider referral to developmental/behavioral pediatrician, neurologist or geneticist

- Simultaneous referrals to:
  - Evidence-based parenting programs (i.e., Incredible Years, Strengthening Families, Triple P)
  - Evidence-based home visiting programs (i.e., Healthy Families America)
Referral Steps to Early Intervention (Part C and Part B)

- Complete the referral form and note the PCC and parent concerns

- Complete a 2-way ROI (Release of Information)

- Fax (secure email?) with the screening scoresheet(s) to the Early Intervention agency
Tracking Referrals

- Tickler system: manual or electronic?
- Whose role?
- Reminders to families
- Standardized communication and feedback with Part C, specialists
- Communication processes with mental health providers
- ROI specifics for Part C and schools
Office Workflow Considerations

Key Components

- How does the parent access the screening tool in order to complete it? (FOA gives to parent at check-in/nurse gives during vitals/in EHR portal.....)

- When? and Where? does the parent complete it? (waiting room/exam room...)

- How does the PCC get the completed tool to score and review before seeing the patient and parent? (placed in exam door by nurse/staff brings to PCC...)

- How does the PCC start the referral process if indicated? (referral form in exam room/PCC indicates concerns and sends as task to nurse or check-out in EHR)
Office Workflow Considerations

(-Key Components Cont’d)

- Who completes the referral process? (office referral coordinator/nurse...)

- Where does the parent sign the ROI? Who gives the ROI to the parent? (at checkout/with referral coordinator)

- Materials for parents re: referral & services, general developmental info. Who shares/discusses with parent? (PCC/nurse/referral coordinator)
PDSA (Plan, Do, Study, Act)

Using small tests of change to improve workflow
Sample PDSA:

Practice has many completed screens, but discovers that many parents have left before the PCC sees the screening tool, eliminating the opportunity for discussion with the family.
Discussion