

Focus Group I-Physicians, Nurse Practitioners
Urban Pediatric Practice
April 6, 2006

Attendance;

3 Physicians

Clinic Manager RN (clarified as necessary)

Nurse Manager RN (clarified as necessary)

Some providers were unable to attend because of a funeral for a 19 month old patient

C iv How were you informed of the project? How was the staff informed? Did you have enough information at the beginning?

Information was provided at the meetings about the project. Those who were unable to attend were provided information at department meetings or given a sheet with the project overview. If people did not attend meeting, they were probably very confused about the purpose and procedure of the screening. The clinic manager dispersed handouts about the project at a Department. meetings.

“No one indicated that it was too much work. Everyone was interested.”

A. WHAT WAS YOUR INITIAL REACTION WHEN YOU FIRST HEARD ABOUT THE PROJECT? WHAT WAS YOUR FIRST FLASH WHEN YOU HEARD ABOUT IT?

The screening would be more than we were doing currently. We were concerned about the time it would take. “It makes sense to link mother/family wellness to healthy development of children.”

Providers were concerned that the whole project was “doable” during well baby checks; social-emotional issues related to parent stress and Maternal Depression were lacking in past office practice. There was no active negativity among staff. No one was against it.

(B)” Initially thought how much time and work will this be?” “Its going to throw us off kilter
Then after heard about it thought it made sense. Once I heard it was a 'simple questionnaire’

“Practicality was the main concern at first. –TIME always a concern”

“ Social emotional was what we were lacking in the past – it was uncomfortable asking those questions at first”

Repeatedly “Time” as main concern.

C - SPECIFIC ASPECTS OF THE PROJECT:

C –i Was the screening you were asked to do appropriate to child health? Did the tasks fit into or were they outside of your scope of practice?

“Yes, this is within the scope of child health. It fits in.” Initial concern about the project related to sufficient time to complete the form required for the project. The providers did not use the whole form at the end of the project period-many times because it was subsequent visit for the child; many of the questions or issues were covered in previous visits. The doctors/nurse practitioners felt that much of the time would be added to the nurse workload versus their own.

C -i. How useful were the forms provided for the screening?

It may have been more work to actually chart things in two places (the form and EMAC*). On the forms provided, it was hard to elaborate or explain more than space allowed for; the boxes that could be checked were good reminders of topics and reasons but did not allow for explanation. The developmental milestones were very helpful, especially in raising red flags for certain children. “Disregarded the referral section – was too wordy.” The referral section was not well utilized; many services families are referred to are used frequently and information on referral sources is found elsewhere in the office. Some of the boxes (milestones) were confusing-one interpretation by a nurse may have been a very different interpretation from the doctor or nurse practitioner.

Example: walking

* Note: One physician uses an electronic charting tool and does not write on the patient hard copy chart.

B , C –iiAre you going to continue using the screening format? Would time defer you from continuing the project?

“Yes, we will continue using the format. Social emotional component drew out concerns from parents. The forms were good in identifying risk history and concerns from parents. Parents were glad to hear that providers were asking those kinds of questions and felt they were ‘cared about.’” Everyone agreed that they would like to continue with the project. The social history questions drew out good conversation from parents. A lot of parents expressed that, “No one has ever asked me about that before.”

D. , E How comfortable/uncomfortable are you asking risk history questions? (note the nurses complete the HMF and then the physician/PNP completed the exam and followed up with concerns identified).

Providers were uncomfortable asking risk history questions at first but as a rapport grew with the clients and their comfort level increased. Some parents questioned why they were being asked about their social history but understood as it was explained to them. “At first the nurses had a hard time asking questions because they seemed to be “intrusive.” There was not one report of a parent to who simply said “no” and would not talk about the answers to the questions. Parents did hesitate on some questions but when the purpose behind the screening was explained ,then they answered many of the questions. Were told “ if we are taking care of our parents it is good for the children” and that there are other resources in the community that can help.” The more questions that were asked during a visit and at subsequent visits, the more comfortable we became.

The clinic manager worked with the nurses one-on-one to help them understand why they were asking these questions. Knowing that kids being in stable homes is important to their health and safety, helped them (the nurses) feel more comfortable and that questions were less intrusive.

C- ii What are your suggestions for the screening form? Does the order make sense?

In order to not repeat some of the information at every visit, it was suggested that there be a subsequent visit box that would contain previous visit and next visit information. It could contain a section of “things to review at next visit.” The order did make sense and in many cases, actually streamlined the whole visit.

Some questions were considered redundant and providers skipped them. It was very helpful for the providers to look back at the old charts to bring up any issues from the previous visit. The providers felt it gave them credibility with the families and making them feel those providers really cared about their patients and their patient’s families. It is harder to look back on previous visits when some charting is done in electronic form-but free forms are always available.

More room need for writing notes.

“Notes make staff feel more credible to parents. Example, Last time you were here, you mentioned your mother had just died and you were under stress...”

Under stress questions instead of “other” put reason and then a blank and they can fill in reason instead of having multiple reasons to check. Give more space to write.

Like the check list just don’t get too many boxes.

D Should there be a free form for “reasons” to explain stress? (This was in follow up to one persons comment to get a feel for other participants responses).

Some of the “reasons for stress” boxes were used more frequently than others. Many of the reasons parents gave for stressors did not fit in any one box and the “other” box was the most commonly checked for those situations. Day-to-day stressors were cited quite commonly and if there was more room to explain the cause of stress, and, if needed, a more appropriate referral could be made. Many providers felt some areas on the form were too busy and contained too much information. It was suggested that fewer boxes were easier to use. One provider actually read off the boxes to the family and it created dialogue about specific concerns or situations.

What does the childcare box mean?

The interpretation of childcare box was interpreted in many different ways. One took the meaning as problems encountered with daycare and babysitters; one took it to mean problems or availability with daycare providers; one thought childcare meant respite care for those who stay home with children all the time or cannot get a break. Childcare also was interpreted to mean the amount of children in the home and childcare outside of the home.

D What is your comfort level with the issue of maternal depression? Is it a childcare responsibility?

“Maternal depression is an easy question to avoid because it deals with the mother or caretaker but it is an important issue that affects children. The screening is a great way to begin a dialogue with parents. It is a start; doing something is better than doing nothing.”

If the form was not completed in this section - providers took it to mean that either the nurses did not fill out the form or the nurse did not ask those questions to patient caretakers. “

If the nurses didn’t complete it I didn’t either”

Responsibility for asking questions is not clearly defined and varies among practitioners.

We can’t fix everything, but asking these questions is a start to getting the mother down the right path.

If looked back at previous visits and it was asked two or three times already then didn’t ask again.

If we noticed from past visits that she wasn’t depressed, we didn’t ask it again.

If the nurses thought mom looked happy, maybe they didn’t ask it.

If it was a busy day I didn’t ask it. Never skip it at 3 weeks.

D As you are involved with patients/clinic flow is busier, do you have time to ask questions?

Corners are cut when the clinic is busy or the caregiver was asked the questions at previous visits.

D Did nurses skip questions/steps?

If the nurses did skip any questions, many of the doctors/NP's also skipped the questions. The providers counted on the nurses to ask the questions. Some providers skipped questions because they were busy or felt like some of the questions were redundant. It was important to ask the questions of new moms, those with a risk history of depression and any that were on medications for depression.

Don't move the maternal depression questions up on the form because you have to warm up to the mom before you can ask it.

When asked if the order of the questions was a factor – if moving the Maternal depression question up on the form would help the consensus was NO.

Need to develop rapport first before asking those questions. First need to talk about the things the parent wants to talk about and that is the baby.

Like the current flow.

How was this issue to deal with?

Many providers believe this is an important issue, but a relationship must be established and strong rapport with clients before they could give the necessary information. Many providers wanted to take care of what the caregivers came in for before they tried to add any evaluations. If the caregivers felt taken care of, they were much more likely to provide information about social risk history and depression.

C – iii, F Were you able to determine child and family need for services and resources appropriate for the family?

Many providers had a system for referrals already, their referral process did not differ much from when the project started. The referral box had some reminders of services, but not all the referrals needed were listed on the form. It was suggested that every form be customized to the specific provider's area. Towards the end of the project, many providers were not using the referral form but instead making notes of referrals in dictations and charts.

Too many boxes on the form for referrals – too cumbersome.

Boxes are helpful, but I never looked at them

F. Have you had a need and there were no services available? Did you get what you wanted?

I didn't drop (referral) just because there was not a service available-I want to get people the help they need, I'll work with several different places to get services the clients needed.

There was not a case of never having a service available but knowing what clients needed and asking will they go, what are the barriers?

If I had any Medicaid questions, I just emailed the Care Coordinator - always got a positive response. Never dropped a referral need because referral was difficult.

Some families don't want to use local referral sources and will opt to wait a long time to go to Iowa City for follow up. (1 1/2 hours away)

Insurance coverage is a broader problem.

Boxes under referral are too general needs to be specific.

How do you deal with this issue? Should it be something that is passed off to physicians?

Advocating for children is the main responsibility of the providers-but families affect the care of these children and providers want do whatever is necessary to provide services to families who need them. Many nurses may tell caregivers information but it is much more powerful coming from a physician. The providers do believe that their patients listen to them as well as caregivers-sometimes they do need convincing about certain topics.

What other services are provided? How are clients from other areas handled?

The pediatric unit sees children from the tri-state area: Iowa, Illinois and Wisconsin. The problem is referrals services are state-specific and residents of Illinois and Wisconsin do not qualify in Iowa. The form needs to be specific to the area so that providers can made appropriate referrals to services that clients qualify for.

G Are the screening standards appropriate? Are they comfortable for you to use?

The levels of screening concept are great-it is similar to the EPSDT process. The comfort level eases as the project was continued.

How did you do a follow up for ages and stages? From the Denver screen?

Most of the ages & stages/Denver screen referrals are done in-office. If there is a problem, a more formal exam is done and then re-checked at the next visit. If the provider feels it is necessary, an extensive work-up can be done.

About 95-98% of resources are provided within the pediatric unit for level two, many outside resources are not needed. May do some level three depending on reason. Or do a DDST before referring on. Speech is an immediate referral to the AEA.

What is the difference between the process and the outcome for this project?

There has been a shift to outcome versus the process of the project. The process is documented the whole way-in charts, dictations, eMAC, etc. It is important to note that the outcome of the whole process is the definition of success of the project.

H Have you ever used the website?

Many providers were not aware of the website; most had not had the time to look at it. The nurse-manager announced the website but many still did not visit it. They used websites they were familiar with from American Academy of Pediatrics and the Centers for Disease Control.

I. If you had a problem, where would you go to find answers?

Many of the providers varied on resources, depending on the problem. Those with "common" problems usually referred to a textbook. If the problem was a little more in-depth, many utilized websites from AAP, information from the Health Department, Medline Searches and the Google Search Engine.

CLOSURE:

Providers felt the key to success of the project was to have a community resource base that would be accessible to everyone with current, up-to-date resources that served clients in the immediate communities. “To make this successful there must be a community resource where I can send people TODAY.”

What is your perception about what you have done for the project? What else made this successful?

“The project has been very helpful-especially with a good team of providers in the clinic and in community where everyone knows their role”.

Most felt that everyone knew their role and established strong links to provide good care.

“The project is very doable and is more successful when everyone can come to the table and support each other.”

The providers felt they were doing a better job for their clients-not as worried about overstepping boundaries of care.

“Luncheon Learning with the community partners helps bring resources together.”

C- iv If you joined a practice in another community, what would you suggest to the new practice? What did you really learn from this experience?

“The project should definitely be continued-it was great at opening dialogue with caregivers and therefore led to better care of patients.”

“Good Process, shows genuine care and concern to the family. -take it forward.”

It was important to not assess a situation with a family unless there was adequate time to really learn about the family’s needs and their history. When an assessment is done without involving the family, many people felt like something may be left out.

“Is a good process, shows genuine care and concern for the family.”

“It was much easier to build a relationship with parents at a well child visit when the child is not ill, when the parent or child is not upset and more time is given to assess the family situation.”

We heard positive remarks from families about the new approach and felt as though their needs were being taken care of also.”

“The well child visit is a “happy” time to build rapport. It really strengthens the connection to the family. “Feels solid – really connected to the family.”

It’s critical that the link with local service providers exist. Have to know the service providers to whom you refer.

Would you take format to a new practice if you moved? If so how would you implement it:

It takes a while when a new person comes in. You can’t start right away to make changes.

“Better be incorporating this into medical training. This is a solid framework”.