# ABCD/Healthy Beginnings
# Social/Emotional and Maternal Depression
# Information, Screening, and Referral

## PROGRAM NEEDS ASSESSMENT

Please answer the following questions to the best of your ability so that we can assess the needs of your practice/clinic and tailor the Healthy Beginnings program presentation to fit the needs identified. Please note that your answers will be kept confidential and will only be shared with program staff and faculty for planning and research purposes.

Practice Name ________________________________________________

Lead Physician ________________________________________________

1. Which of the following best describes the setting in which you practice?
   ❑ Solo ❑ Group ❑ Clinic/Hospital ❑ Other ____________________

2. What is your specialty area?
   ❑ Pediatric ❑ Family Medicine ❑ Med-Peds ❑ Other_____________

3. How many of the following does your practice employ?
   Physicians ____ Physician Assistants ____ Nurse Practitioners ____Nurses___

4. Approximately how many children under three years old were seen in your practice in the last week? _______________ Month? _____________________

5. What percent of your patients speak English _____%
   Spanish _____%
   Other languages _____%

6. Do you use code 96110 when billing for developmental screening? ❑ yes ❑ no

7. Does your practice currently have a written or unwritten/verbal policy* for the following:
   (*An "unwritten/verbal" policy is a mutually agreed upon practice within the office.)

| | Written | Unwritten/Verbal | None |
|---|---|---|---|
| screening every child for developmental delay | ❑ | ❑ | ❑ |
| screening every child for social/emotional delays | ❑ | ❑ | ❑ |
| screening every mother of children under one year of age for depression | ❑ | ❑ | ❑ |

8. Does your office use any of the following screening tools:

| | Yes | No |
|---|---|---|
| Ages and Stages (ASQ) | ❑ | ❑ |
| ASQ: Social/Emotional (ASQ: SE) | ❑ | ❑ |
| Parents' Evaluation of Developmental Status (PEDS) | ❑ | ❑ |

| | Yes | No |
|---|---|---|
| Checklist for Autism in Toddlers (CHAT) | ❑ | ❑ |
| Edinburgh Postnatal Depression Scale | ❑ | ❑ |
| Beck Depression Inventory (BDI) | ❑ | ❑ |
| Primary Care Evaluation of Mental Disorders | ❑ | ❑ |
| Patient Health Questionnaire (PRIME-MD/PHQ) | ❑ | ❑ |
| Other (please attach, if available) _______________ | ❑ | ❑ |

___________________________________________

9. Who communicates the results of the screening to parents? (check all that apply)
❑ Physician ❑ Registered Nurse ❑ Nurse Practitioner ❑ Other_____________

Who provides general parent/patient education on developmental issues? (check all that apply)
❑ Physician ❑ Registered Nurse ❑ Nurse Practitioner ❑ Other_____________

10. Approximately how many children (under 3) in your practice in the last month do you estimate have been referred for further evaluation due to a suspicion of developmental delays? ______

Among the children you refer for further evaluation of developmental delays, please estimate the percentage who were referred due to social/emotional issues. ________%

11. Where do you refer a child 0-35 months with social/emotional or developmental delay, or disability, for further evaluation? (Please check all that apply.)
❑ Child & Family Connections (CFC- entry point for Statewide Early Intervention system)
❑ Medical/Hospital Program ❑ Private Provider ❑ Do not refer
❑ Other (Specify) ____________________________

12. How does your office typically make a referral for additional services/evaluations?
❑ Physician makes call/referral
❑ Nurse makes call/referral
❑ Secretarial staff makes call/referral
❑ Give referral information to family to contact themselves
❑ Other (Specify) ____________________________

13. Do you experience any difficulties when you screen, refer, or talk to families with a child 0-3 years old about child development issues? ❑ yes ❑ no
If yes, please explain __________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

14. Where do you refer a parent for further evaluation/treatment if maternal depression is suspected?
    ❑ Medical/Hospital Program ❑ Private Provider ❑ Her primary care physician
    ❑ Do not refer ❑ This has not been a concern ❑ This office/clinic treats the mother
    ❑ Other (Specify) ________________

15. Please rate how prepared your practice clinicians and staff are about talking to families:

| | Not Prepared | | | | Very Prepared |
|---|---|---|---|---|---|
| a. regarding social and emotional concerns? | 1 | 2 | 3 | 4 | 5 |
| b. about maternal depression issues? | 1 | 2 | 3 | 4 | 5 |

16. Are any patient education materials regarding development or maternal depression routinely provided to parents? ❑ yes ❑ no
    If yes, which materials are most routinely provided? Please list, and attach, if available.
    ________________________________________________

17. Does your office have Internet access? ❑ yes ❑ no If yes, Who? (check all that apply)
    __ Office manager __ Other administrative staff __ Physicians __ Other healthcare staff

18. Have members of your practice participated in any general and/or social/emotional developmental screening and referral education programs in the past 12 months? ❑ yes ❑ no

19. What barriers and challenges does your practice encounter related to developmental screening and referrals? (Please check all that apply and **circle** the biggest barrier. Also, feel free to add other barriers in the space provided.)
    __ Inadequate reimbursement
    __ Lack of staff to conduct screening
    __ Lack of sufficient training on conducting screening and referrals
    __ Lack of time
    __ Lack of parent acceptance of delay
    __Other:________________________________________

20. What are the top 3 concerns mentioned by parents in your practice about their child's development?
    1. ____________________________________________
    2. ____________________________________________
    3. ____________________________________________

21. List the top 3 developmental screening/Early Intervention resources that you have in your office (for staff use).
    1. ______________________________________________________________
    2. ______________________________________________________________
    3. ______________________________________________________________

**Thank you!**

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