

Appendix 9

Iowa ABCD II Focus Groups: Selected Participant Comments

ABOUT INITIAL RESPONSE TO THE PROJECT

- “Initially I thought, ‘How much time and work will this be? It’s going to throw us off kilter.’ Then after hearing about it I thought it made sense.” (pediatrician)
- “More work. Something else to do.” (family physician)
- “I see four to five children per day. Can I get this done in my time slots? (family physician)
- “Practicality was the main concern at first. –TIME is always a concern.” (pediatrician)
- It is a nice form that the medical students can use. It asks good questions (family physician)

What has been your actual experience with the ABCD II processes?

- “Social emotional was what we were lacking in the past – it was uncomfortable asking those questions at first.” (pediatrician)
- “The child health exam takes about 20 minutes now although one of our physicians in the practice has always taken about 45 min and still does.” (family physician)
- “The biggest area changed was screening for family stressors and mother’s mental health, that takes more time.” (family physician)
- “It is more structured than before, a more organized approach.” (family physician)
- “It takes a little more time, not much.” (family physician)
- “I still dictate after the visit. I could get away from dictating if I write more on the form.” (family physician).
- “I already did an extensive exam. Assessed gait, ask shapes, numbers, ask to count etc.” (family physician)

REGARDING SPECIFIC ASPECTS OF THE CHANGE IN SCREENING PRACTICES

Is 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.” (pediatrician)
- “I added talking with fathers about post-partum blues.”(family physician)
- “Many times you didn’t think about those things until a child wasn’t doing them. Now we are being more attentive to those types of problems.” (family physician)

Are you going to continue using the screening format?

- “Yes, we will continue using the format. ...The forms were good in identifying risk history and concerns from parents. Parents were glad to hear that providers were asking those [stress and maternal depression] kinds of questions and felt they were ‘cared about’.” (pediatrician)
- “I still dictate, if I don’t continue (dictation) we will need to add more information to the form about physical needs. Need more room to write.” (family physician).
- “A lot of parents expressed that, ‘No one has ever asked me about that before’.” (pediatrician)

- “Need to decide as a group if we are switching over. We may want to tweak the form a little.” (family physician)
- “I recommend keeping it because I am used to it now.”(family physician)
- “Working on the electronic medical record. There are no templates for well child exams. “ (family physician)
- For children under age two, I would use my old process. My old system had triggers for anticipatory guidance; the ABCD form is not as useful for that. I need those cues because I do not have children of my own (family physician).

How comfortable/uncomfortable are you asking risk history questions?

- “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.” (pediatrician)
- “[We told parents] ‘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.” (registered nurse, pediatrics)
- “The more questions that were asked during a visit and at subsequent visits, the more comfortable we became.” (pediatrician)
- “I [nurse 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 ... questions ... less intrusive.” (registered nurse, pediatrics)
- There were some [families] that were surprised the first time we asked the question. People would think it was the baby’s exam, not theirs, but they got comfortable with it. I was able to do follow-up on questions.(family physician)
- “I started skipping stress questions, just asked the first one. It is obvious if you watch how they work with their children if there is family stress. If mom has “mom skills” won’t go into stress questions.”
- The physical development (red flags) didn’t change. That is straight forward. It was the emotional support that was new. .(family physician)
- “Using the forms, I was more inclined to be uniform. I may have missed less social emotional problems, The forms force you to ask the questions.”(family physician)
- “Only asked [stress and Maternal depression] questions up to 4 months. Started skipping those questions because they asked the same thing over and over.” .(family physician)
- The patients I see are MY patients. It is obvious if I need to worry about the family stressors. I can tell by looking at them if there is a problem.” .(family physician)

What is your comfort level with the issue of maternal depression? Is the sequence suggested on the screening tool helpful?

- “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.” (pediatrician)

- “We can’t fix everything, but asking these questions is a start to getting the mother down the right path.” (pediatrician)
- Never had a problem with it. I do family care. I ask a lot of questions. Postpartum teaching – I talk about postpartum blues. So it was already being addressed. (family physician).
- “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.” (pediatrician)
- “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.” (pediatrician)
- This is a small enough community to remember when mom comes in that in 2 weeks I will be seeing the father. (For instance) I asked mom this week if the husband snored because I knew he was coming next week for an exam (family physician).
- Never had a problem with it. I do family care. I ask a lot of questions. Postpartum teaching – I talk about postpartum blues. So it was already being addressed (family physician).
- There were some that were surprised the 1st time. People would think it was the baby’s exam, not theirs, but got comfortable with it. Was able to do follow-up on questions (family physician).
- “I look back at previous visit questions to see what happened at past visit and follow up and proceed from there.” (family physician)

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.” (pediatrician)
- “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.” (pediatrician)
- “Some families don’t want to use local referral sources and will opt to wait a long time to go to Iowa City [1.5 hours away] for follow up.” (pediatrician)
- “It has been really confusing on who takes control of the referral. Went back and forth on where to go or who to go. Who we could refer to wasn’t clear.” (family practice, registered nurse).
- “[The time they had a question] if they would have just called the Care Coordinator -she would have figured it out. (family practice registered nurse)

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.” (pediatrician)
- “Many times you didn’t think about those things until a child isn’t doing them. Now we are being more attentive to those types of problems.”(family physician)
- “The physical development (red flags) didn’t change. That is straight forward. It was the emotional support that was new.” (family physician)

How did you do a follow-up for a Level 2 screening?

- “May have caught things earlier and watched for a couple of months, then would refer to [the] developmental clinic.” (family physician)
- “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.” (pediatrician)
- “About 95-98% of resources are provided within the pediatric unit for Level 2; many outside resources are not needed. May do some Level 3 depending on reason. Or do a DDST before referring on. Speech is an immediate referral to the AEA.” (pediatrician)

What are your suggestions for the screening form?

- “More room needed 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...’.” (pediatrician)
- “Make the forms age specific. Remove ‘don’t drink soda’ from the newborn form. Is obvious. (family physician)
- (counterpoint to drink soda) “I had one once” (family physician)
- “We were not using the Ages and Stages SE [before], but were using the [basic ASQ.] If this form takes care of that process, that would be good.” (family physician).

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

- “To make this successful there must be a community resource where I can send people TODAY.” (pediatrician)
- “The project has been very helpful - especially with a good team of providers in the clinic and in the community where everyone knows their role.” (pediatrician)
- “The project is very doable and is more successful when everyone can come to the table and support each other.” (pediatrician)
- “Luncheon Learning with the community partners helps bring resources together.” (pediatrician)
- “It might help to make a booklet of well child exam or keep together in chart to make them easier to find (an internal comment to each other).” (family physician)

Should we take this project forward?

- “The project should definitely be continued - it was great at opening dialogue with caregivers and therefore led to better care of patients.” (pediatrician)
- “Good process, shows genuine care and concern to the family - take it forward.” (pediatrician)
- “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.” (pediatrician)
- “Is a good process, shows genuine care and concern for the family.” (pediatrician)
- “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.” (pediatrician)
- “We heard positive remarks from families about the new approach and felt as though their needs were being taken care of also.” (pediatrician)

- “The well-child visit is a “happy” time to build rapport. It really strengthens the connection to the family.” (pediatrician)
- “Would consider using (the form)” (family physician).
- “Like the nutritional part of the form.” (family physician)
- “Need to decide as a group if we are switching over. We may want to tweak the form a little.” (family physician)
- “I recommend keeping it because I am used to it now.” (family physician)
- “We had medical students using the forms. It helped them know what to ask at each age.” (family physician)
- “[Process] feels solid – really connected to the family.” (pediatrician)
- “It’s critical that the link with local service providers exists. Have to know the service providers to whom you refer.” (pediatrician)
- “Better be incorporating this into medical training. This is a solid framework.” (pediatrician)