CDS REACH EI Referral Study

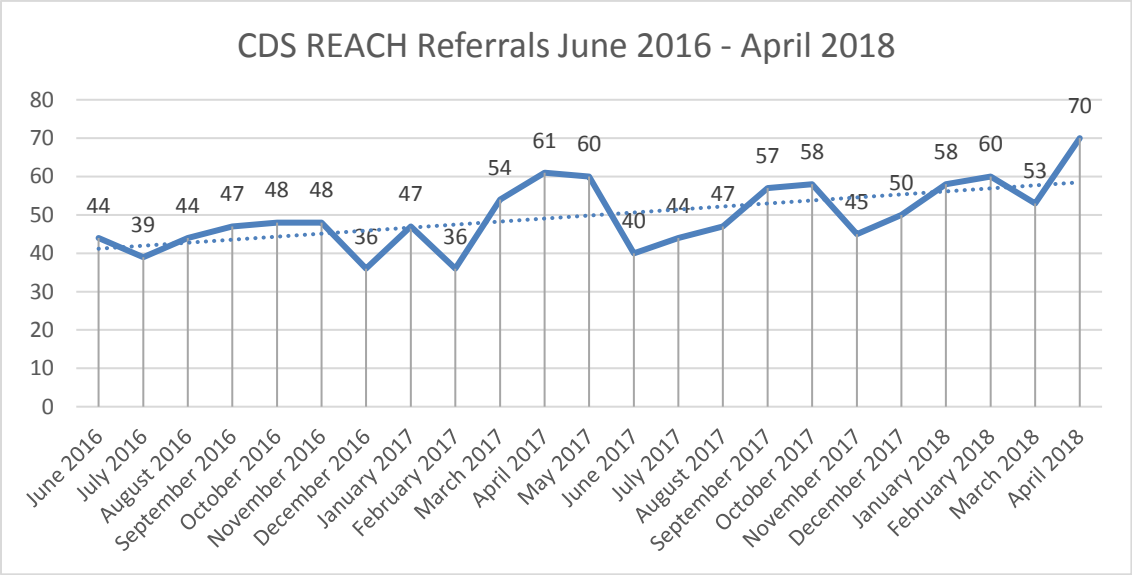
REACH EIPMs, JULY 2018

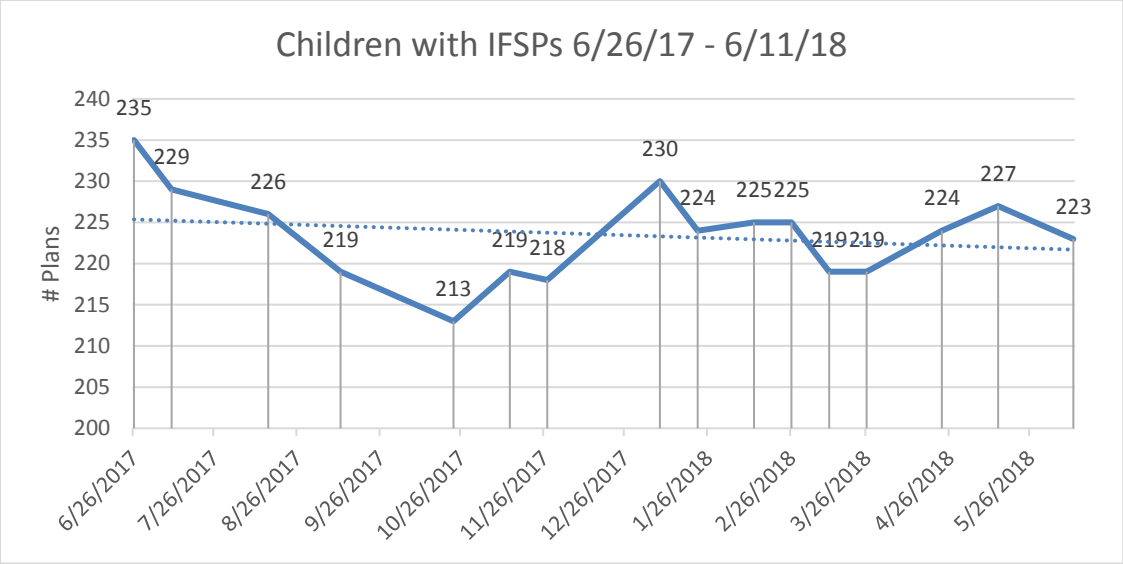
Abstract

CDS REACH part C has been experiencing a steady increase in referral numbers, but no change in the number of active plans. After reviewing the outcomes of over 1,100 referrals to REACH across the past 23 months and analyzing trends, we conclude that physician referrals are primarily responsible for the increase in referral numbers. Within this category, we see an increasing trend in parent withdrawals prior to evaluation and a decreasing trend in the number of children found eligible amongst those that receive an eligibility determination. We consider these the main reasons for the unchanging number of active plans despite the higher referral number. We recommend interfacing with our most common physician group referrals to explore these trends. The DHHS CAPTA referral program has resulted in only 5% of children referred to REACH being identified eligible. 85% did not receive an eligibility determination. We do not view the CAPTA program as an effective use of CDS REACH resources and recommend state leadership consider whether this program is currently meeting its objectives.

Background

CDS REACH has experienced an increasing number of referrals over the past several years. In an environment of limited budgets and stagnant salaries, we have had to absorb these referrals with existing staff, putting our indicators and employee satisfaction at risk. Despite the increasing number of referrals, the number of children with IFSPs over the past year has been comparatively flat and unchanging. Clearly, more referrals is not resulting in more children identified.





Study Question

CDS REACH is receiving more referrals, but these referrals do not seem to be resulting in a greater number of children with IFSPs. Why?

Working Hypothesis

If REACH is receiving more referrals, but the number of children with IFSPs is unchanging, then there are two likely possibilities:

1) The additional referrals contain disproportionately more ineligible children and/or;
2) An increasing number of referrals are being lost to no contact or being withdrawn by parents.

Methods

REACH referrals from the period spanning June 2016 – April 2018 were downloaded from CINC for analysis on June 28th, 2018, resulting in a sample of 1,146 referrals. The following data was captured for each referral:

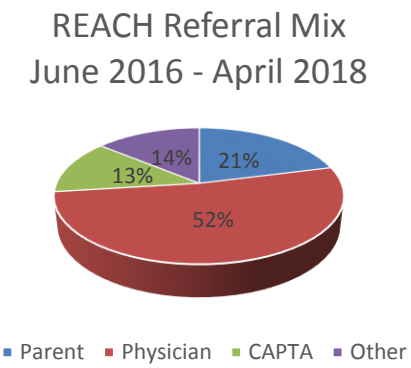
- Referral source
- Eligibility determination
- Closing reason

Referral data was analyzed for trends.

Results

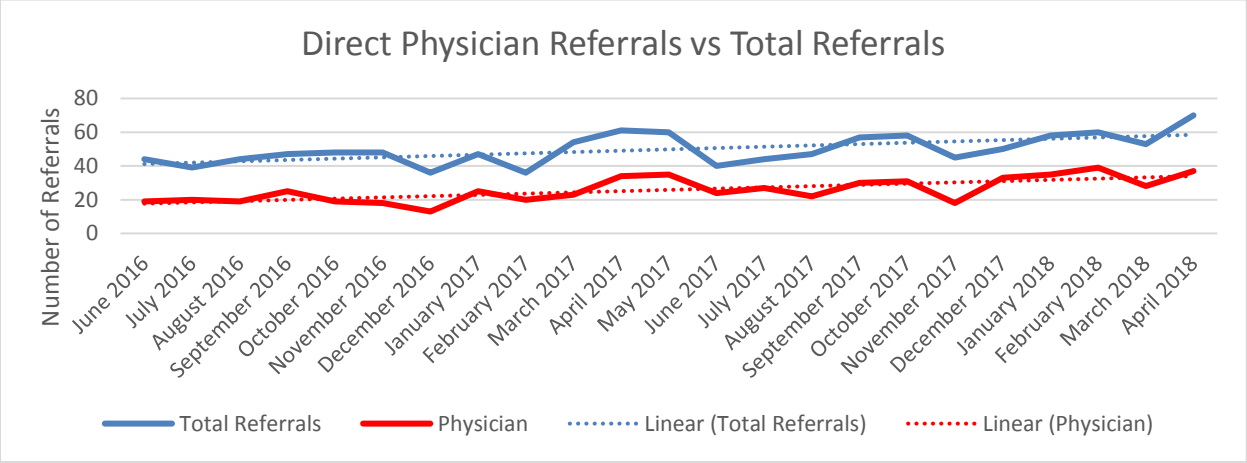
Referral Mix

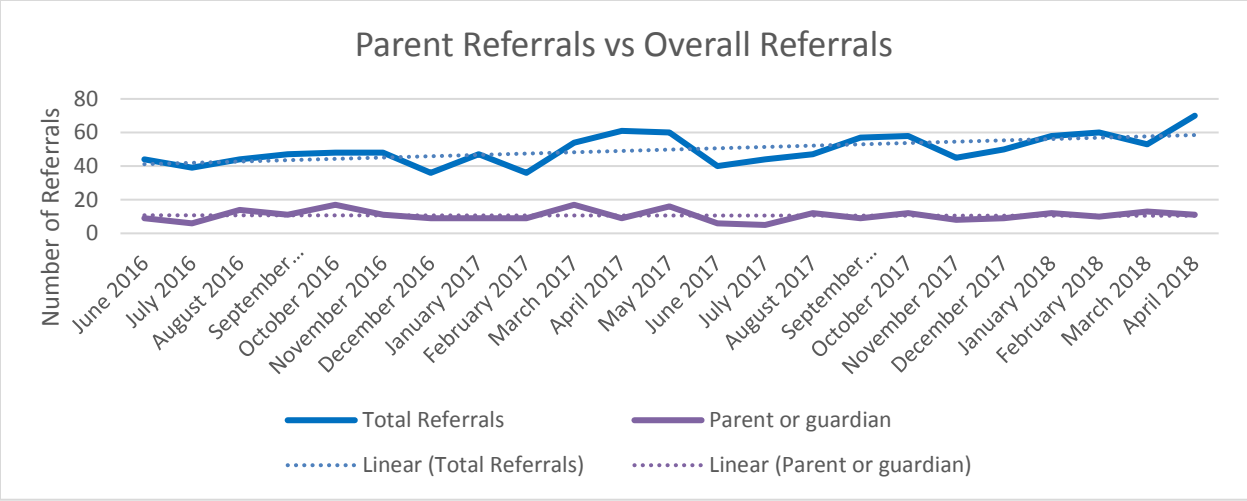
Physicians, a category that is predominantly composed of pediatricians, but also includes audiologists, were the number one source of direct referrals to REACH. Out of 1,146 referrals in the study period, 594 (52%) came directly from physicians. Rounding out the top three, REACH received 244 (21%) referrals from parents and 151 (14%) referrals from DHHS' Child Abuse Protection and Treatment Act Program, also known as CAPTA. All other referral sources accounted for 159 (14%) of referrals. Notable from this "other" category were 68 (5%) referrals from child care or early head start (EHS). This study will focus on physician and CAPTA referrals.

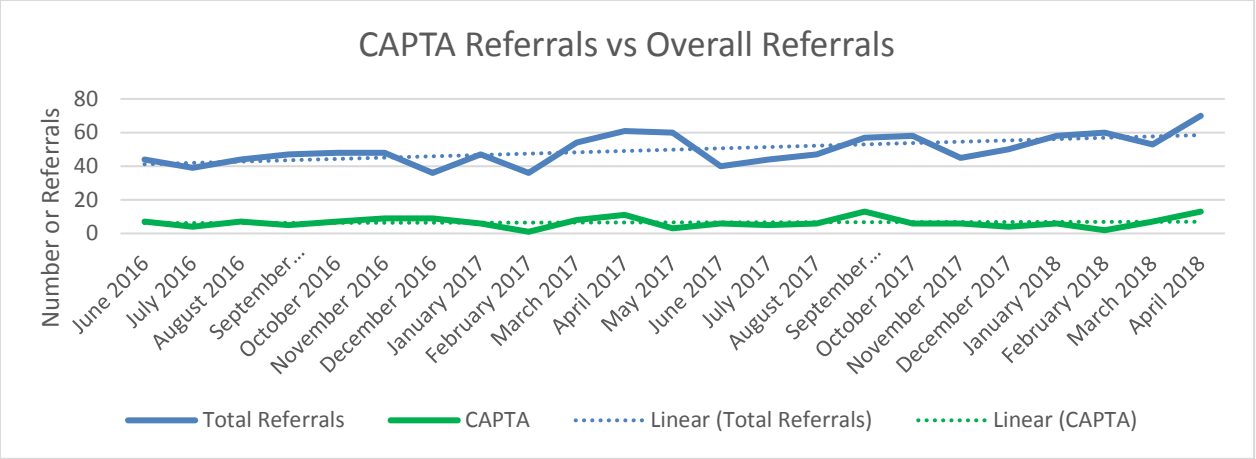


Physician Referrals

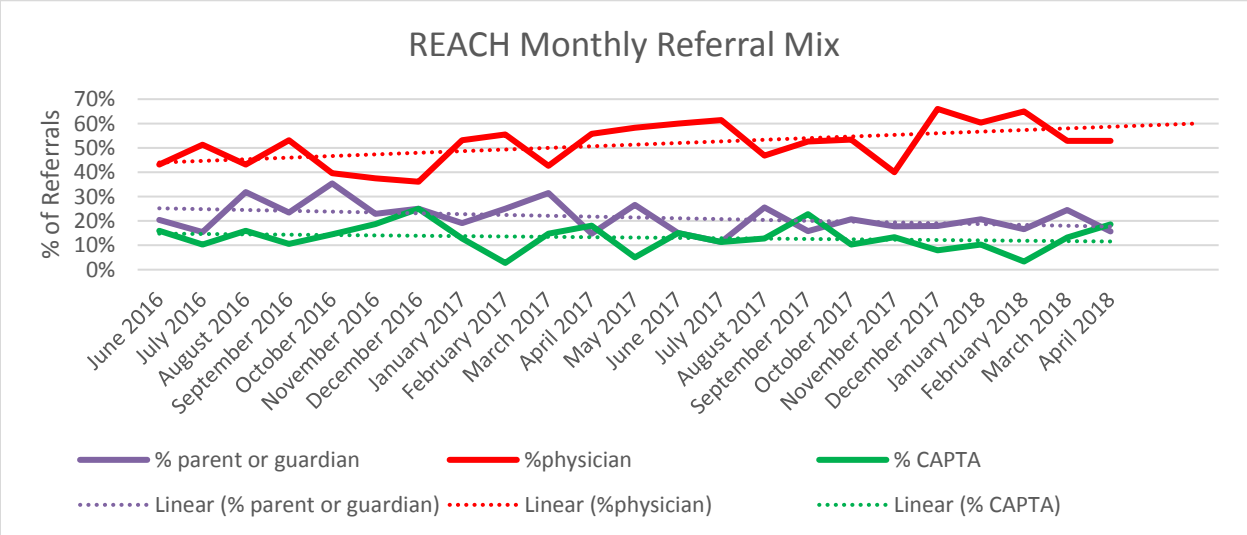
The data indicate that physicians are responsible for the recent increasing trend in the number of referrals to REACH. Physicians not only account for the significant majority of referrals overall, but also trends in physician referrals closely match the trend in overall referral numbers for REACH. In comparison, referrals from other sources have been unchanged over the study period and have not fluctuated significantly with overall referrals.



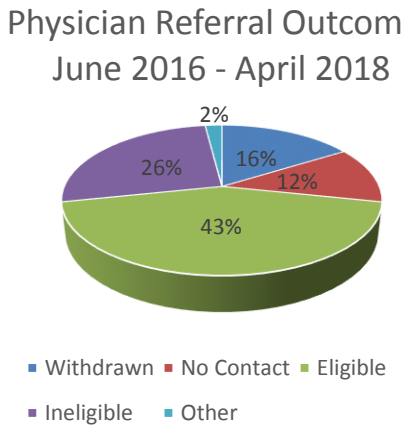




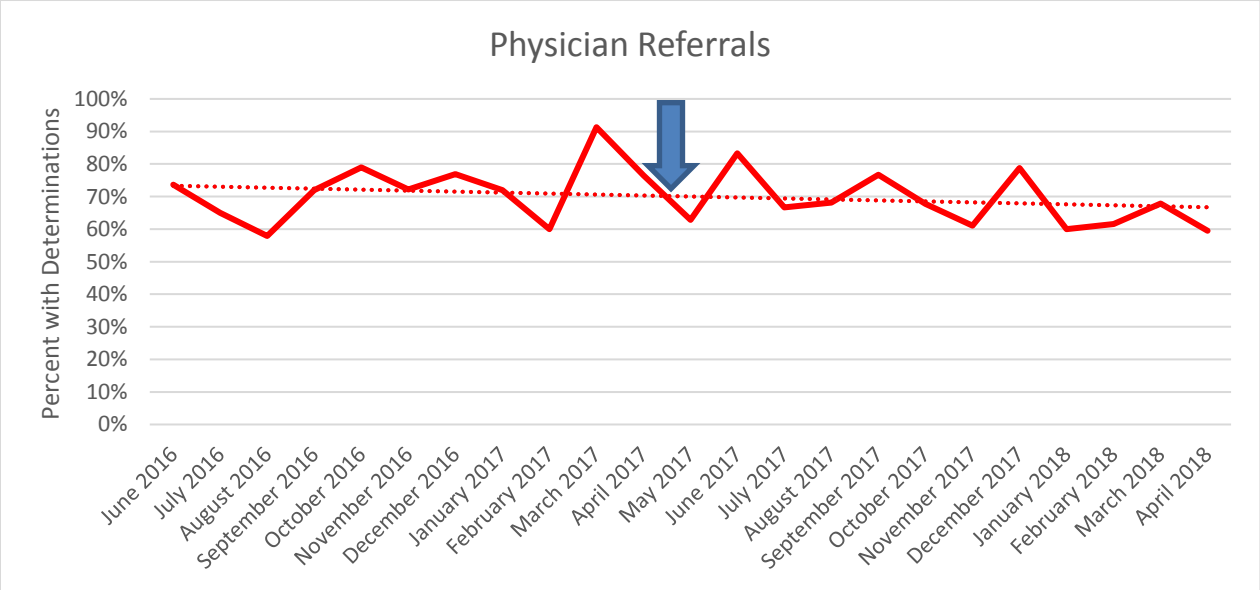
Looking at the data differently, but drawing the same conclusion, physicians are making up an increasing percentage of the REACH referral mix each month, while CAPTA and parent referrals are trending toward being a smaller part of each set of monthly referrals.



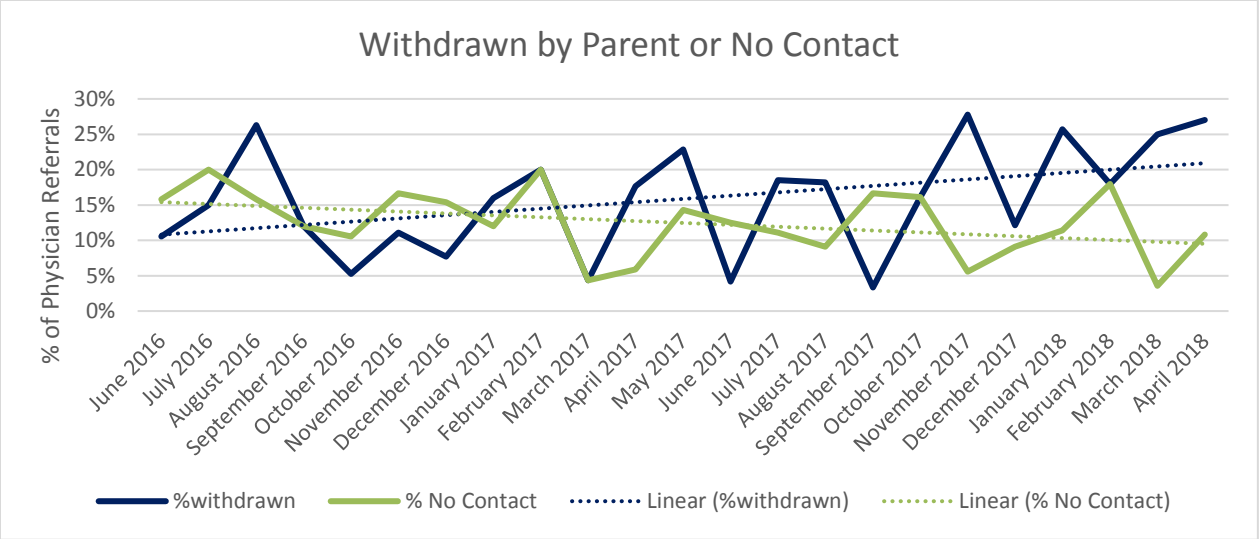
To find out why we have an unchanging number of children with IFSPs relative to our referral trends, it makes sense to focus on the outcomes of physician referrals. Out of the 594 children referred by physicians across the study period, 258 children (43%) were identified as eligible and 155 children (26%) were found ineligible, putting the total number of children that received an eligibility determination at 413 (70%). Of the 30% that did not receive an eligibility determination, 98 (16%) were withdrawn by their parents, 73 (12%) were lost to no contact, and 9 (2%) were either screened out or moved out of state.



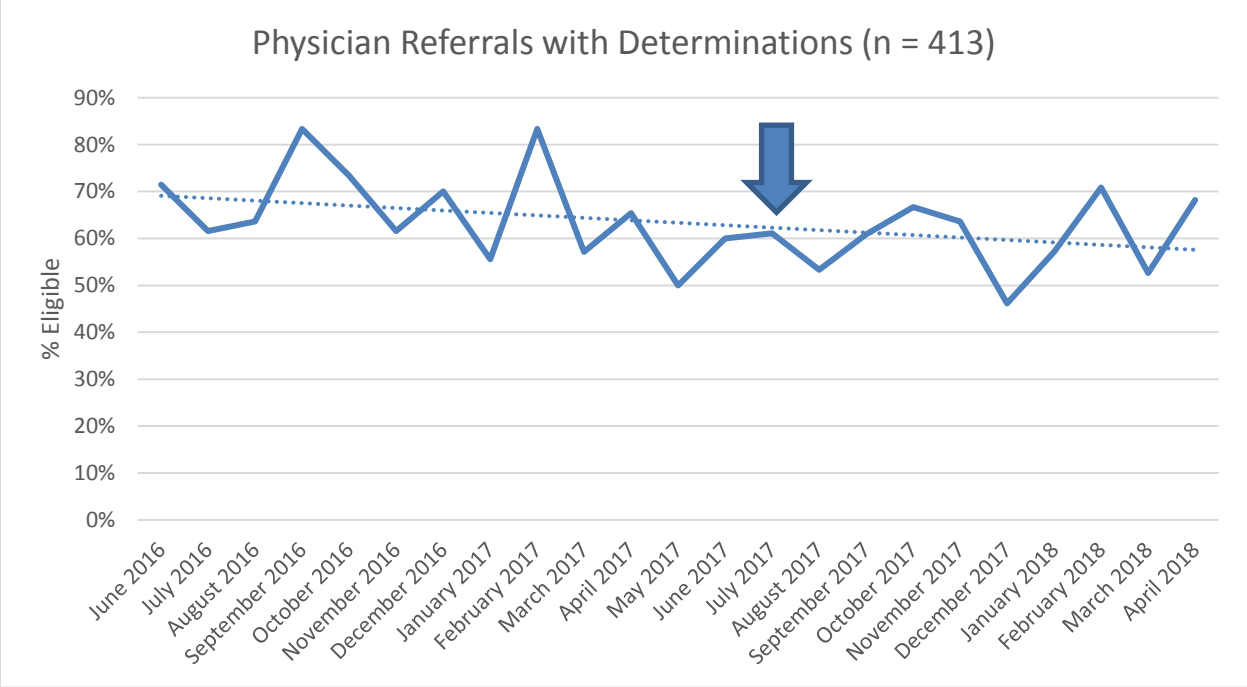
Although in the total sample, 70% of physician referrals received an eligibility determination, this is a number that has been trending downward over the past year. The trendline suggests that we crossed below our 70% average around May 2017.



This indicates that REACH is losing an increasing number of children due to either no contact or parents withdrawing their chidren prior to receiving an eligibility determination. The data suggests that it is the latter category, parent withdrawals, that is the main culprit. In fact, CDS seems to be losing fewer children due to no contact, which is a positive development.

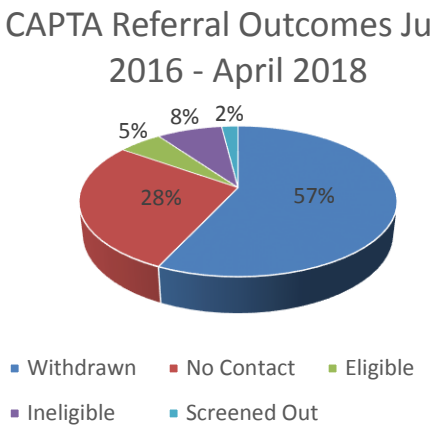


An increase in parent withdrawals isn't the only trend evident in the physician data. The data also indicate that physicians are referring fewer eligible children. Over the study period, of the 413 children who received an eligibility determination, 258 were found eligible and 155 were found ineligible. This equals a finding rate of 62% or 5 out of every 8 children who made it to eligibility and received an eligible determination. The data suggest that we crossed below this 62% overall average figure in July 2017 and have been trending downward.



CAPTA Referrals

The data indicate that the number of CAPTA referrals has been unchanging over the past several years. We therefore conclude that CAPTA referrals are unlikely to be contributing to the increasing trend in overall referrals. What is striking about CAPTA referrals, however, is the exceptionally small number of them that result in an eligibility determination. Compared to 70% of physician referrals that received a determination across the study period, only 13% of CAPTA referrals received a determination. Where 43% of all physician referrals resulted in finding an eligible child, only 5% of CAPTA referrals did so. By far, the most common outcome (85%) for a CAPTA referral was the child either being withdrawn by parents or lost to no contact. In raw numbers, of the 151 children referred to REACH through the CAPTA program, only 20 received a determination and only 8 children were eventually identified eligible.



Summary

Physicians are responsible for the increasing number of referrals at CDS REACH. While a solid majority of these referrals (70%) made it to an eligibility determination across the study period, we are seeing a downward trend in the number of referrals getting to this stage, most likely due to an increasing number of parent withdrawals. Also, of the physician referrals that do make it to eligibility, we also see a downward trend in the number children found eligible. Both trends should be viewed as the main reasons why the number of children with IFSPs has remained flat over the past two despite the increasing referral trend. Most (85%) CAPTA referrals do not receive an eligibility determination. Notwithstanding the good intentions of the CAPTA referral program, the extremely poor results of the program indicate that its primary outcome has been time lost to paperwork, phone calls, and other administrative tasks.

Recommendations

While administrative inefficiency was not the named focus of this study, the study does point to where efficiencies can be found. In the short term, the most straightforward way to decrease unnecessary workload on staff, especially service coordination staff, would be to eliminate or drastically modify the CAPTA referral program. Over the years, CDS service coordination staff has identified a number of problems with this program. Firstly, the program is highly automated with little active involvement of its case workers. Children are automatically referred to CDS though the DHHS system regardless of whether child abuse has been substantiated and, in many instances, the DHHS case worker listed on the referral is unaware of the referral. Secondly, because the referrals may reflect actions taken by DHHS a month or more in the past, these referrals often contain erroneous parent or guardian information. CDS service coordinators have reported contacting listed parents who are no longer in legal custody of the

child and, when we are able to make contact with the parent or guardians who *are* in legal custody of the child, we often find that these parents or guardians are unaware that a referral to CDS has been made. What usually follows is an uncomfortable conversation with parent where we explain that their child was referred to us automatically by DHHS (even if DHHS closed the case), that we are not DHHS, and that we are available to evaluate their child to see if he or she has developmental delay or disability. It's no surprise that so few children referred through the CAPTA program make it to eligibility. Whenever parents or guardians are unaware and/or uninvolved in the referral process, the chances of following through with intake are slim, let alone carrying out a successful program of early intervention. Compounding the problem is the fact that, in the case of CAPTA, the referral source itself is minimally involved. On the other hand, we have found that when a DHHS case worker is directly involved in the referral of a child, we have more success with getting though intake. Unfortunately, the number of "CPS" referrals across the study period was very small, accounting for only 15 (1%) of the 1,146 total referrals. Thus, we do not have large enough numbers to substantiate this latter claim.

In the long term, leadership staff at REACH would do well to communicate the results of this study directly to physicians, perhaps concentrating first on the largest clinics before moving to the smaller ones. The data from physician referrals lead to two primary recommendations for physicians:

First, regarding the increasing trend of parent withdrawals; when physicians refer families to CDS they should ensure that they have the full support and participation of parents. Although the data does not exactly implicate physicians as the cause of the increasing parent withdrawal trend, the intake protocol at REACH has not changed significantly. Service coordinators still follow the same intake phone call script as they always have, with only occasional small modifications from time to time (ex: removing the reference to FAPE). It is therefore unlikely that increasing withdrawals are the result of issues with the CDS intake process. Second, regarding the declining trend of children who make it to eligibility and are found eligible; REACH should focus some effort on educating physicians about early intervention eligibility standards. Physicians should refer children to CDS only when, after evaluating or screening a child, they strongly suspect that a child has a *significant* developmental delay or diagnosed disability. Children who might have a mild delay or are referred to CDS as a part of a conservative "wait and see" approach may not be an effective use of limited CDS resources and parent time and/or expense.

Further Study

Parent and child care referrals were not examined in this study, primarily due to time limitations and the fact that these referral numbers have not changed substantially over the past several years. However, results of a small pilot study suggested that when parents refer, they do a good job following through with the entire intake process. However, when parents refer on their own, meaning that a physician is not listed in the "how did you hear about CDS" portion of the intake paperwork, fewer children are found eligible than when a physician is involved in the referral. Screening may be the best course of action for these "solo parent referrals" if this result is found to hold up over a larger sample size.

Of the small number of child care referrals from the pilot (6), only 2 made it to eligibility. If this ratio holds up over a larger sample size, it might be worthwhile for leadership to reach out to frequent child care referral sources to ensure that when they make referrals, they have accurate parent information and parents are on board with referrals.