Screening and Referrals Learning Collaborative

Summary

In 2017, Minnesota Department of Health (MDH) facilitated a statewide Screening and Referrals Collaborative. The goals of the collaborative were to improve early identification, connection to services, and follow-up for families after a developmental, social-emotional, and/or caregiver depression screening indicated a need for referral. Sixteen teams comprised of local implementing agencies (LIAs) that were implementing evidence-based home visiting models participated. Teams could select a single type or combination of screening, referral and follow-up to focus on. Six teams focused on development screenings, five teams focused on social-emotional screening, and 13 teams focused on caregiver depression screening.

Measures

A review of baseline data from home visiting in Minnesota showed that:

- Among children screened for developmental concerns, 63% of children with an identified developmental concern received a referral.
- Among children screened for social-emotional concerns, 100% of children with an identified social-emotional concern received a referral.
- Among caregivers screened for depression, 59% that screened positive for depression received a referral.
- Of 5,157 eligible infants, 3,014 (58 percent) were screened for potential risk of developmental delay at 4 months of age.

Changes Tested

Teams tested over 60 changes for improving screening, referral and follow-up practices. Of the changes tested, the following are changes that team's felt were most impactful for improvement:

- Update and train staff on how to document screening, referral, and follow-up information in an electronic health record
- Provide training and education to staff on how to use screening tools, how to refer and document screening and referral outcomes.
- Partner with other service agencies in the community to complete warm hand-offs and provide a complete referral (i.e. all required paperwork completed by FHV at time of referral).
- Make a referral in the home immediately after discussing positive screening results with the family. Provide families with a list of mental health resources in the community at time of referral.

- Incorporate screening, referral, and follow-up into organizational procedures.
- Utilize multiple mental health screening tools (PHQ-9 and GAD-7) to identify caregivers with mental health needs.

Conclusions

Without a defined process for documenting referrals, it is difficult to assess follow up. Changes tested that focused on incorporating screening and referral documentation into existing health record systems were most impactful for teams and improved documentation procedures. Building relationships with referral resources in the community was essential to creating a streamlined referral process and providing warm hand offs to services. Making a referral immediately after the screening improved referral completion.

This was the first time that MDH used the Model for Improvement and a Learning Collaborative approach with LIAs, and there were some limitations in data collection and measurement. The measures that were selected were intended to reduce burden of data collection on teams but ultimately the measures ended up being too simple, numbers were very small for some teams, and teams did not find the information collected to be very useful.