Developmental Delays and Disabilities Screening and Referral Study

2008-2010 RTOI Project
Waisman Center,
University of Wisconsin-Madison
Developmental Delays and Disabilities Screening and Referral Study

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Developmental Delays and Disabilities Screening and Referral Study

Goal:
To promote timely identification and referral of young children with developmental challenges to appropriate supports and services by family physicians through routine use of validated developmental screening tools.
Presentation Outline

- **Background:** *Family Medicine*
- **Context:** *Practice Redesign*
- **Strategy:** *Medical Home*
- **Project Focus:** *Developmental Screening*
- **Intervention:** *Training and Technical Assistance*
- **Participants:** *Baseline Information*
- **Assessment:** *Mid-Point Data*
- **Conclusion:** *Preliminary Observations*
Primary Care Specialties

The Primary Care Physician
Number of Office Visits to Primary Care Physicians vs. Other Specialists

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Primary Care</td>
<td>492</td>
</tr>
<tr>
<td>Other Specialists</td>
<td>398</td>
</tr>
<tr>
<td>Family medicine</td>
<td>215</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>157</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>120</td>
</tr>
</tbody>
</table>

Where do family physicians practice?


PCHPS = Primary Care Health Professional Shortage Area
Why is primary care important?

- longer life spans and fewer deaths due to heart and lung disease
- fewer cases and deaths due to colon and cervical cancer
- better detection of breast cancer
- less ER and hospital use
- better preventive care
- reduced health disparities
What do family physicians do?

Family physicians provide comprehensive and continuous primary care health care to:

- individuals and families
- women and men regardless of age or disease
- infants, children and adolescents regardless of disease
Percentage of Children’s Office Visits by Specialty

Sources:
National Ambulatory Medical Care Surveys, 1992-2002
AAFP Task Force On the Care of Children, 2005
Family physicians provide

- Prevention & management of acute injuries and illnesses
- Health promotion
- Hospital care for acute medical illnesses
- Chronic disease management
- Maternity care
- Well-child care and child development
- Primary mental health care
- Rehabilitation
- Supportive and end of life care
Defining Family Physicians

“Family Physicians are committed to fostering health and integrating health care for the whole person by humanizing medicine and providing science-based high quality care”

Source:
How are family physicians trained?

- 3 year Residency
  - More than 400 family medicine residencies
    - Community-based
    - Medical school-based
    - Military
    - Inner-city
    - Urban
    - Suburban
    - Rural

- Board Certification and Maintenance of Certification requirements
### Family medicine residency clinical curriculum

<table>
<thead>
<tr>
<th>Continuity Patient Care – all 3 years</th>
<th>Life-Long Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult medicine</td>
<td>Critical care medicine</td>
</tr>
<tr>
<td>Maternity care</td>
<td>Gynecologic care</td>
</tr>
<tr>
<td>General surgery</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Care of children</td>
</tr>
<tr>
<td>Skin care</td>
<td>Human behavior</td>
</tr>
<tr>
<td>Women’s health</td>
<td>Newborn care</td>
</tr>
</tbody>
</table>
Laying the Groundwork for Change . . .
Institute of Medicine
Institute of Medicine —

*Crossing the Quality Chasm:*
*A New Health System for the 21st Century*
Patient- and Family-Centered Principles

- People are treated with **respect and dignity**.

- Health care providers communicate and share complete and unbiased **information** with patients and families in ways that are affirming and useful.

- Individuals and families build on their strengths through **participation** in experiences that enhance control and independence.

- **Collaboration** among patients, families, and providers occurs in policy and program development and professional education, as well as in the delivery of care.

- *Institute for Family-Centered Care*

  www.familycenteredcare.org
Patient- and family-centered care is working with patients and families, rather than doing things to or for them.
What Is a Medical Home? (AAP)

- Provision of care through a primary care physician through partnership with other allied health care professionals and the family
- Acts in CYSHCN’s best interest to achieve maximum family potential
- An approach to providing health care services in a high-quality, comprehensive, and cost-effective manner
What Is a Medical Home? (AAFP)

The American Academy of Family Physicians believes that everyone should have a personal medical home that serves as the focal point through which all individuals—regardless of age, sex, race, or socioeconomic status—receive acute, chronic, and preventive medical services. Through an on-going relationship with a family physician in their medical home, patients can be assured of care that is not only accessible but also accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians.
American Academy of Family Physicians (AAFP)  
American Academy of Pediatrics (AAP)  
American College of Physicians (ACP)  
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home  
March 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.
Patient Centered Medical Home

- Personal Physician
- Physician Directed Medical Practice
  - In partnership with patients and families
- Whole Person Orientation
- Coordinated Care
- Quality and Safety
- Enhanced Access
Medical Home Quality Improvement

Pediatricians, family physicians, and families working together to assure that all children have access to family-centered, culturally competent, coordinated, comprehensive primary care (Pediatrics, 2002).

Quality improvement methodology

- Core team: MD, Nurse or Case Manager, and a parent.
- Rapid cycle improvement.
- Developing a system of care, tracking, and monitoring children with special needs.

www.medicalhomeimprovement.org
In this Toolkit, Wisconsin physicians and families share their stories and insights on creating a Medical Home Partnership. They will guide you through the key steps of quality improvement – the small steps that can make big differences for Children and Youth with Special Health Care Needs.

**Five Regional Centers for CYSHCN**
Wisconsin has five Regional Centers dedicated to supporting families with children with special health care needs - and the providers who serve them. Regional Center staff facilitate the work of Medical Home teams around the state. Contact your Center about resources for families or support in strengthening your Medical Home.
Medical Home and Screening

Medical Home is the framework for early identification through early and continuous screening

- Population-based public health screening
  - newborn metabolic/genetic screening
  - newborn hearing screening

- Medical home-based screening
  - preschool vision screening
  - developmental screening

- Sia, Pediatrics, 2004
Developmental Screening by FPs & Pediatricians

- Nearly all...
  - Used list of developmental milestones
  - Prompted parents for concerns

- About one-third...
  - Used a provider administered instrument

- About one-third...
  - Used a validated parent questionnaire

- Sices, *JDBP*, 2003
Both pediatricians and FPs...

- Considered EI services effective
- Thought there was inadequate time to perform screening during well-child care

- Sices, *JDBP*, 2003
In comparison to pediatricians, family physicians were less likely to...

- Feel confident caring for children with delays (47% vs 71%)
- Believe there are sufficient resources in the community to care for children with delays (45% vs 68%)

- Sices, *JDBP*, 2003
Where do family physicians practice?


PCHPS = Primary Care Health Professional Shortage Area
Developmental Screening by FPs & Pediatricians -- Wisconsin

Wisconsin Data on Developmental Screening 2007 Survey
Respondents (n=173) *Fleischfresser and Mathur*
Developmental Screening by FPs & Pediatricians -- Wisconsin

Types of outpatient developmental screening in WI

- Clinical impression (history and physical exam) without the use of a screening instrument/checklist
- Clinical impression guided by a screening tool
- Age appropriate checklist of developmental milestones
- Formal developmental screening tool: Ages and Stages Questionnaire
- Formal developmental screening tool: Ages and Stages Socio-emotional Questionnaire
- Formal developmental screening tool: Parents Evaluation of Developmental Status (PEDS)
- Formal developmental screening tool: Bayley Neurodevelopmental Screen
- Formal developmental screening tool: Denver II Developmental Screen
- Formal developmental screening tool: Other

Always/Almost
Sometimes
Never
Developmental Delays and Disabilities Screening and Referral Study

Goal:
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- 2008-2010 RTOI Project
  Waisman Center,
  University of Wisconsin-Madison
Barriers to Developmental Screening by Family Physicians

- Awareness of screening options
- Knowledge of specific tools
- Practice configuration
  - Time
  - Staff
  - Finances
- Implementation difficulties

- 2008-2010 RTOI Project
  Waisman Center,
  University of Wisconsin-Madison
Strategies to Enhance Developmental Screening by FPs

- Context of quality improvement
- Practice-based training and TA
- Statewide network
- Physician champions

- 2008-2010 RTOI Project
  Waisman Center,
  University of Wisconsin-Madison
Interventions: Core Training

- Promoting Child Development in Primary Care Practice: Developmental Screening
  - 2 hours
  - Physicians encouraged to invite team members
  - Delivered at physicians’ offices
  - Co-presenters:
    - Regional Early Intervention Professionals
    - Regional Children and Youth with Special Health Care Needs Professionals
  - CME credit offered
Interventions: *Optional*

- Technical assistance and additional training around
  - Implementing developmental screening into office work flow
  - Other topics related to child development
    - Typical child development
    - Common developmental disabilities
    - Influence of maternal mental health on child development
Practice-Based Developmental Screening Initiative

Collaborative Initiative

- WI Children and Youth with Special Health Care Needs Program, State and Regional Centers
- WI Birth to 3 Program, State and Local Programs
- Waisman Center, UW-Madison
  - WI Early Intervention Professional Development Project
  - WI Surveillance of Autism and Other Developmental Disabilities
Participants will:

- **Recognize the purpose of developmental screening** and importance of early intervention for children with developmental delays.

- **Identify how to select and utilize tools** to screen for developmental delay and describe the need for use of a valid and reliable screening tool.

- **Identify ways to incorporate developmental screening** into well-child care delivery in primary care practice.

- **List resources and referral options**, in the community, for children with developmental challenges and their families.
Core Training . . .

Surveillance vs. Screening

- Developmental Surveillance:
  recognizing children who may be at risk of developmental delays

- Developmental Screening:
  using standardized tools to identify and refine risk of developmental delays.
Core Training . . .

Screening and Medical Home

To ensure that...

1) children with undiagnosed special health care needs are identified as early as possible so that they and their families can be given appropriate services to address those needs and

2) children with existing special health care needs receive continuous screening and surveillance to identify or prevent secondary conditions that may interfere with their development and well-being.

- Sia, Pediatrics, 2004
Core Training . . .

Algorithm Within a Pediatric Preventative Care Visit

1. Pediatric Patient at Preventive Care Visit
2. Perform Surveillance
3. Does Surveillance Demonstrate Risk? Yes
4. Is This a 9-, 18-, or 30-mo* Visit? Yes
5a. Administer Screening Tool
6a. Schedule Early Return Visit
5b. Administer Screening Tool
6b. Are the Screening Tool Results Positive/Concerning?
7. Make Referrals for: Developmental and Medical Evaluations and Early Developmental Intervention/Early Childhood Services
8. Schedule Next Routine Visit
9. Is a Developmental Disorder Identified?
10. Identify as a Child With Special Health Care Needs

Increasing Developmental Concern
Comparing Validity Across Three Screening Tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASQ</td>
<td>72% (51-90%)</td>
<td>86% (81-</td>
</tr>
<tr>
<td>Denver II</td>
<td>56%-83%</td>
<td>43-80%</td>
</tr>
<tr>
<td>PEDS</td>
<td>75% (74-79%)</td>
<td>74% (70-</td>
</tr>
</tbody>
</table>

Squires, 1999; Glascoe, 2006; Glascoe, Pediatrics, 1992
Core Training . . .

ASQ: Ages & Stages™ Questionnaire

- Parent report tool with 30-35 items / level
- 4-60 months of age
- Covers 5 developmental areas in children
- Choices of responses (yes, sometimes, not yet)
- Requires 15-20 minutes to complete if completed in the waiting room by parents, 5 minutes to score
- Written at a 6th grade level
- Spanish and other language versions available
Core Training . . .

Delivering Difficult News to Parents

- Validate parent concerns
- Present news in a thoughtful and caring manner
- **PROVIDE HOPE AND EMPHASIZE STRENGTHS**
- Use descriptive terms
- Provide information on community resources and services
- Help to establish an action plan
- Offer ongoing support
### CPT Codes for Screening

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96110</td>
<td>Developmental screening</td>
</tr>
<tr>
<td>96111</td>
<td>Second-stage screening or assessment</td>
</tr>
<tr>
<td>99420</td>
<td>Administration and interpretation of health risk assessment (can include family psychosocial screen)</td>
</tr>
<tr>
<td>96114</td>
<td>Neurobehavioral status exam</td>
</tr>
</tbody>
</table>
Core Training . . .

Resource and Referral Process

What do I do with a concerning screen?
Goal:
To promote timely identification and referral of young children with developmental challenges to appropriate supports and services by family physicians through routine use of validated developmental screening tools.

- 2008-2010 RTOI Project
  Waisman Center,
  University of Wisconsin-Madison
Data Collection

The project will compare physicians’:

- Use of CPT code for developmental screening
- Referral rates to early intervention and early childhood special education

- before and after the core training on screening
Sequence of Activities

- Recruitment
- Baseline assessment
- Core training
- Optional training and technical assistance
- Post-intervention assessment
Assessing Intervention--Initial

- Baseline assessment
  - Practice characteristics
  - Perceived benefit of use of screening tools in refining risk of delay
  - Frequency of use of screening tools in children under 5 years
  - Frequency of use of CPT code for developmental screening
  - Referral rates of children to EI/ECSE
Assessing Intervention -- *Ongoing*

- Referral tracking (12 months)
  - Early Intervention
    - birth to 1 y.o.
    - birth to 3 y.o.
  - Early Childhood Special Education: 3-5 y.o.
Assessing Intervention -- Final

- Post-intervention assessment
  - Collect same information as baseline assessment, compare...
    - Perceived benefit of use of screening tools in refining risk of delay
    - Frequency of use of screening tools in children under 5 years
    - Frequency of use of CPT code for developmental screening
    - Referral rates of children to EI/ECSE
Baseline Practice (N=17)

- Average age of physician = 38
- Average # of children under 5 = 146
- 94% rated Dev Scrng “very important”
- 56% performed Dev Scrng very frequently (+75%); 31% with moderate frequency
- 0% using standardized tool
- 12% (2/17) used cpt 96110
- Avg referral to EI/EC = 8 per practice
Participating Practice Sites
Mid-Point Data

- Initial Training March-June 2009
- Current Status:
  - 68% (11/16) using ASQ
    - Screening 9,18,24 months
  - 25% (2/8) using cpt 96110
  - 2/8 with concerns referred to EI/EC (.25/practice)
- 5 out of 12 specifically said they feel they are “doing a better job”
Narrative Themes

- Integration with EMR
- How to track results w/ paper record
- Entire practice groups implemented ASQ
- “Easier to pinpoint area of developmental concern”
- More effective at eliciting parent concerns than open-ended questions
- “Doing a much better job at screening”
- More efficient
Narrative Themes

- Role of EI--Unsure benefit compared to therapy referral
- Coordination and workflow
- Concerned about billing
  - Part of well-child check
  - Family’s insurance coverage
Next Steps

- Convene conference calls focused on themes
- Medical Home Webcast Series
  - Common developmental disabilities
  - Typical child development
  - Family centered communication
  - Sharing concerning results
  - Why refer to Birth-3?
What's New? - Wisconsin Southern Regional Center for Children and Youth with Special Health Care - Windows Internet Explorer

Waisman Center

Children and Youth With Special Health Care Needs

What's New?

Wisconsin Medical Home Webcast Series

The WI Medical Home Webcast Series is an online learning opportunity developed through a partnership between the WI Children and Youth with Special Health Care Needs (Title V) Program and the Waisman Center. Webcasts are archived presentations with associated handouts. Questions can be submitted on an ongoing basis. Questions can be submitted online by clicking on the submit questions online link on the Webcast Series webpage, the chat balloon above the Webcast you are viewing. The training team will respond within 2-3 weeks.

Webcasts currently available:

- Developmental Surveillance and Screening in the Medical Home
  Mala Mathur, MD, MPH
  Pediatrician, Group Health Cooperative of South Central Wisconsin

- Screening for Autism Spectrum Disorders (ASD) using the M-CHAT
  Mala Mathur, MD, MPH
  Pediatrician, Group Health Cooperative of South Central Wisconsin

- Key Community Resources When There is a Developmental Concern
Other Project Features

- Peer-to-Peer Mentors
- Stipend of $300 per physician
- ASQ kit provided
- Assistance in meeting external requirements
  - Maintenance of Certification
  - NCQA PCMH Certification
  - CME credit
Connect work at State level with other UCEDD partners

- State Title V CYSHCN Program
- Professional Societies: AAP, AAFP
- Health, both public and private sector
- Early Childhood: Birth to 3, School 3-5, Child Care and Head Start
Advisory Committee

- Project Advisory Committee functions as a subcommittee of the **Healthy Children Committee of the Wisconsin Early Childhood Collaborating Partners** (WECCP)
- WECCP is a network of state, regional and community public and private entities that are working together to positively impact the lives of young children and their families encompassing the areas of
  - early care and education,
  - health,
  - mental health,
  - parent education and
  - family support.
Advisory Committee

Project Advisory Committee

*Members include:*

- WI Academy of Family Physicians
- WI Chapter, American Academy of Pediatrics
- WI Department of Health Services
  - Title V, Children/Youth with Special Health Care Needs Program
  - Part C Birth to Three Program
- WI Department of Public Instruction
  - Part B, Section 619 Early Childhood
- WI Head Start Collaboration Project
- WI Division of Early Childhood
- WI Alliance for Infant Mental Health
- WI Parents as Teachers
- Family Voices – Wisconsin
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Preliminary Observations

- Electronic Medical Record is a major opportunity and a significant barrier
- Practice structure matters
- Leadership is key
- Look for fit with other initiatives
- Measuring primary care outcomes requires new methodologies
Preliminary Observations

- Electronic Medical Record
  - Template text re: development
  - Integration with validated screening tools
  - Impact on flow of use of paper forms
  - Patient portals
Preliminary Observations

- Practice Structure
  - Engagement of practice support staff
  - Impact on spread
Preliminary Observations

- Leadership is key
  - Organizational buy-in
  - Impact on spread
Preliminary Observations

- Look for fit with other initiatives
  - Practice improvement activities
  - NCQA certification
Preliminary Observations

Measuring Primary Care Outcomes

- Breadth of case mix
- Challenge of low incidence conditions
- Secondary factors may impact proxy indicators
- Consideration of alternative measures
Measuring Primary Care Outcomes

Relationship of Primary Care Physicians’ Patient Caseload With Measurement of Quality and Cost Performance

David J. Nywelt, PhD; William B. Weeks, MD, MPA; Daniel J. Gottlieb, MSJ; Lawrence P. Casaling, MD, PhD; Elliott C. Fisher, MD, MPH


ABSTRACT

Context Sufficient numbers of patients are necessary to generate statistically reliable measurements of physicians’ quality and cost performance.

Objective To determine whether primary care physicians in the same physician practice collectively see enough Medicare patients annually to detect meaningful differences between practices in ambulatory quality and cost measures.

Design, Setting, and Patients Primary care physicians in the United States were linked to their physician practices using the Healthcare Organization Services database maintained by IMS Health. Patients who visited primary care physicians in the 2005 Medicare Part B 20% sample were used to estimate Medicare caseload per practice. Caseloads necessary to detect 10% relative differences in costs and quality were calculated using national mean ambulatory Medicare spending, rates of mammography for women 66 to 69 years, and hemoglobin A1C testing for 66- to 75-year-olds with diabetes, preventable hospitalization rate, and 30-day readmission rate after discharge for congestive heart failure (CHF).

Main Outcome Measures Percentage of primary care physician practices with a sufficient number of eligible patients to detect a 10% relative difference in each performance measure.

Results Primary care physician practices had annual median caseloads of 260 Medicare patients (interquartile range [IQR], 195-500), 25 women eligible for mammography (IQR, 10-50), 35 patients with diabetes eligible for hemoglobin A1C testing (IQR, 15-55), and 0 patients hospitalized for CHF. For ambulatory costs, mammography rate, and hemoglobin A1C testing rate, the percentage of primary care physician practices with sufficient caseloads to detect 10% relative differences in performance ranged from less than 10% of practices with fewer than 11 primary care physicians to 100% of practices with more than 50 primary care physicians. None of the primary care physician practices had sufficient caseloads to detect 10% relative differences in preventable hospitalization or 30-day readmission after discharge for CHF.

Conclusion Relatively few primary care physician practices are large enough to reliably measure 10% relative differences in common measures of quality and cost performance among fee-for-service Medicare patients.

INTRODUCTION

Ample evidence reveals that despite high and rising costs of health care in the United States, quality is lagging.1-3 Moreover, research has repeatedly documented considerable variation in Medicare spending and quality across the country independent of patient illness levels or demographic characteristics.3-4 To stimulate improved quality and lower costs of ambulatory care for its beneficiaries, the Centers for Medicare & Medicaid Services has been overseeing a
Measuring Physicians’ Quality and Performance
Adrift on Lake Wobegon

Donald M. Berwick, MD, MPP

In Garrison Keillor's mythical hometown, Lake Wobegon, all the women are strong, all the men are good-looking, and all the children are above average. That is, of course, impossible, at least when it comes to the children. In any given population for any defined characteristic "everyone above average" is, statistically, nonsense.

Of course, the same is true of health care. Performance on anything called "good" about the care (such as reliability, waiting times, dignity, or survival) in any defined population (such as physicians, hospitals, visits, or health plans) will follow some distribution. The shape of that distribution can be orderly (such as quasi-normal, binomial, or Poisson) or disorderly, but for sure, every member cannot be above average.

That bare fact disturbs the peace, mainly because it invites comparison. For instance, patients who need heart surgery want to know who can do the very best for them. That curiosity also may well stir fear, jealousy, and defensiveness among those who vie to care for those patients. Likewise, how can cardiac surgeons sleep well if they learn that tens of entities—so many of each that hospital leaders complain bitterly of the burden.

But what about physicians? No doubt physicians vary in their clinical skills and outcomes. This is especially interesting now because physicians traditionally have been thought to hold the keys to the health care treasury, that is, the physician's pen (or lately, keyboard), some argue, is at the root of health care profligacy and could be the strongest lever to control health care costs wisely.

The reasons for comparative measurement of performance in health care are many and depend on the actor. Contractors may want to choose among vendors. Patients may want to choose their site of care. Payers may want to attach financial incentives to good performance. And improvers may want to find out what problems they have, and who else may have solved them, so as to learn.

The edgiest use of comparative measurement is probably "pay for performance," financial carrots and sticks attached to measured achievements in care. One of the clearest examples has been in England, where British general practitioners (GPs) engaged with the National Health Service beginning in 2004 under the Quality and Out-
Measuring Primary Care Outcomes: Suggestions from Berwick

- Define broader quality metrics
  - Decrease the focus on narrow conditions
  - Cluster practice groups and organizations

- Combine payer source data
  - Public, private, uninsured

- Ask patients/families more about their experience of care and value that information
  - HCAHPS and beyond

- Follow patient outcomes

*JAMA.* 2009;302(22):2485-2486
Defining the *Minimum Necessary Intervention*

- A work in progress . . . .
  - What tools are needed?
  - How much personal contact?
  - What follow up support resources?
  - How to facilitate connections with community resources?