Early Measures of Effectiveness of a Coordinated Care Pilot Project

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ABSTRACT

Children and adolescents with moderate to severe problems in two or more areas pose significant problems to the Health Care Providers. These problems are exacerbated by a service delivery design which does not encourage or facilitate a formal consultation and collaboration between providers. Tolaini and Dodge (2000) discuss the lack of integration among treatment, prevention and promotion among service providers to children. The results of a National Ambulatory Medical Care Survey (Woo & Woodwell, 2000) document that 25% of the 130 million child visits per year for primary health care (non-mental health and other specialties) have a psychological problem associated with the presenting problem. This lack of consultation and collaboration between providers offers fragmented care which is time consuming, expensive, and frequently ineffective.

Child- and Adolescent Program Enrichment Services (CAPES) provides a dynamic approach designed to establish an area in which innovative consultation and collaboration is facilitated to provide recommendations for children and adolescents. The CAPES panel of experts (Child Psychiatrist, Pediatrician, Family Therapist, Psychologist, Educational Expert, Occupational Therapist, and Speech and Language Therapist) gather in one room and provide an opportunity for parents to present to the panel their history, current status and issues affecting their child, as well as their desired resolution. CAPES then coordinates the dynamic perspective of multiple service providers, school personnel, and families, with the goal of changing the trajectory of care and resolution for the child or adolescent. CAPES has been designed as a new approach to providing care to children and adolescents and the effectiveness of this approach is explored through analyses of pre-test and post-test scores on the Child Behavior Checklist (CBCL). Nonparametric statistics were utilized based upon the sample size and lack of assumptions of the sampling distribution. Examination of the distribution of data around the median was conducted to determine the appropriate nonparametric statistic for dependent data. Based upon the examination, it was found that the sign test is the appropriate nonparametric test for this data.

Participants included 17 parents of children and adolescents participating in the CAPES program. These parents completed the CBCL before entry into the program and again at a time ranging from 6 to 27 months (mean 11.6, standard deviation 6.7) after participating in the program. The CBCL was used to assess parent report of child behavior problems in children and adolescents from 4 to 18 years of age. The CBCL was designed to be a comprehensive, brief measure of behavior problems. The CBCL includes 115 items which are rated on a scale from 1 (not true) to 3 (very true). A higher total score indicates more severe problems. The CBCL has been found to be valid and reliable. The CBCL has been found to be valid and reliable. The CBCL is scored in three parts: Internalizing Problems, Externalizing Problems, and Total Problems. The Total Problems score is the total sum of both the Internalizing and Externalizing Problem scores.

Nonparametric statistics were utilized based upon the sample size and lack of assumptions of the sampling distribution. Examination of the distribution of data around the median was conducted to determine the appropriate nonparametric statistic for dependent data. Based upon the examination, it was found that the sign test is the appropriate nonparametric test for this data. Significant and non-significant differences may be of a function of needs for which children and adolescents were presented to the CAPES program.

METHOD

Sign Test for Dependent Data

<table>
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<tr>
<th>Pair of Variables</th>
<th>No. of Non Ties</th>
<th>Percent v &lt; V</th>
<th>Z</th>
<th>p-value</th>
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<tbody>
<tr>
<td>Affective Pre/Post</td>
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<td>Anxiety Pre/Post</td>
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<tr>
<td>ADH Pre/Post</td>
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<td>2.94</td>
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<tr>
<td>OD Pre/Post</td>
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</table>

CONCLUSIONS

The CAPES program appears to have been effective in addressing issues in children and adolescents who present with moderate to severe problems in two or more areas as well as their desired resolution. The families provide intake information to the CAPES panel. This intake form designed by the CAPES panel allows for members of the panel to effectively share information among experts representing diverse professions.

Step 1: At each of the CAPES meetings the panel is composed of a Child Psychiatrist, Pediatrician, Family Therapist, Psychologist, Educational Expert, Occupational Therapist and Speech and Language Therapist. During the scheduled meeting of the CAPES panel the child/adolescent with the most recent meeting of the CAPES panel is to present and discuss the history, current status and their desired resolution.

Step 2: The CAPES panel members discuss and refine the suggestions and recommendations through a series of consultations between meetings. This approach allows the CAPES panel to develop and refine the care recommendations.

Step 3: The final care recommendations, in hierarchical order, are composed in written format to be presented to the family within two weeks after the initial meeting.

Step 4: Two or more members of the CAPES team meet with the parents on a second time and the recommendations are shared. The proposed recommendations do not refer the child/adolescent to any particular provider; setting forth only the care recommendations, in hierarchical order.

Step 5: The parents proceed with the care recommendations, including contacting the appropriate providers.

Step 6: Six months after the care recommendations are offered to the family, a meeting is scheduled with the CAPES panel of experts and parents for an update on their progress.

REFERENCES

