# Attachment B1:

# Pediatric Mental Health Care Access Program Health Care Provider Survey

**HRSA Evaluation of the Maternal and Child Health Bureau Pediatric Mental Health Care Access and Screening and Treatment for Maternal Depression and Related Behavioral Disorders Programs Project**

April 2020

# HRSA Evaluation of the Maternal and Child Health Bureau Pediatric Mental Health Care Access and Screening and Treatment for Maternal Depression and Related Behavioral Disorders Programs Project

## Pediatric Mental Health Care Access Program
## Health Care Provider Survey

Funding for data collection supported by the
Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services

HRSA funded [insert name of state] to implement a Pediatric Mental Health Care Access (PMHCA) program, [insert program name]. HRSA also funded JBS International, Inc. (JBS) to conduct an outcome and impact evaluation of the MCHB PMHCA program (hereafter referred to as the HRSA MCHB evaluation). JBS is an independent evaluator of the program and is not part of HRSA or any other federal agency.

**Survey Purpose:** As part of the HRSA MCHB evaluation, we are conducting a survey of pediatric health care providers who are participating in [insert name of state]'s HRSA PMHCA program. The survey is designed to collect information on your experiences with the PMHCA program (e.g., assessing and treating behavioral health conditions, accessing behavioral health care services for your patients, capacity to address behavioral health conditions) and assist HRSA in future program implementation.

**Survey Instructions:** This online survey should take less than ten (10) minutes for you to complete. Please answer based on your current practice and understanding, unless otherwise indicated. There are no right or wrong answers to the survey questions. Please note that your responses will remain private and are voluntary. Survey results will be reported to HRSA in the aggregate, and no identifying information will appear in the evaluation reports without your prior approval. No identifiable data will be provided to HRSA.

**About Your State's Program and Helpful Terminology:** Each state's **PMHCA program** includes creating a **Pediatric Mental Health Care Team**; enrolling pediatric health care providers, such as yourself into the program; and providing training on how to consult with the Pediatric Mental Health Care Team in your state and/or to provide behavioral health care in your practice. The questions that follow ask about your experiences obtaining training, clinical behavioral health consultation, referral, and community linkage information from your state's PMHCA program and about your current practices for addressing behavioral health conditions in your pediatric patients.

Please create a Unique Identifier for your survey to maintain the privacy of your responses and allow us to match your future survey responses.

***How to create your Unique Identifier:*** Use the first two letters of your first name, the first two letters of your last name, and the month of your birthday. For example, for John Smith, born in May, the Unique Identifier would be JOSM05.

## BEHAVIORAL HEALTH CAPACITY

1. In the last 12 months, how often have you managed treatment for the following behavioral health conditions?

| | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Depressive Disorder | 0 | 0 | 0 | 0 | 0 |
| Anxiety Disorder | 0 | 0 | 0 | 0 | 0 |
| Attention-Deficit/ Hyperactivity Disorder | 0 | 0 | 0 | 0 | 0 |
| Substance Use Disorder (SUD) | 0 | 0 | 0 | 0 | 0 |
| Concomitant Medical and Behavioral Health Conditions | 0 | 0 | 0 | 0 | 0 |

2. In the last 12 months, how did you receive training from the PMHCA program? *Select all that apply.*
   o In-person training event *(if selected, go to question 3)*
   o Webinar *(if selected, go to question 3)*
   o Self-study with program resources *(if selected, go to question 3)*
   o Video conferencing *(if selected, go to question 3)*
   o Learning collaborative (e.g., Project ECHO, Project REACH) *(if selected, go to question 3)*
   o Other (specify) *(if selected, go to question 3)*

   o Did not participate in trainings *(if selected, go to question 4)*

3. In the last 12 months, in how many PMHCA program trainings did you participate?
   o 1-2 trainings
   o 3-5 trainings
   o 6-7 trainings

   o 8+ trainings

4. In the last 12 months, have you contacted the Pediatric Mental Health Care Team for clinical behavioral health consultation?
   o Yes (if yes, go to question 5)
   o No (if no go to question 11)

5. In the last 12 months, what were the **most common** reasons you contacted the Pediatric Mental Health Care Team? *Select three.*
   o Interpret screening results
   o Determine appropriate assessment steps
   o Assist with diagnosis
   o Immediately manage patient safety
   o Help with referrals
   o Initiate pharmacotherapy
   o Discontinue pharmacotherapy
   o Determine pharmacotherapy effectiveness
   o Adjust pharmacotherapy to improve effectiveness
   o Adjust treatment due to change in status
   o Other (specify)

6. What patient issue(s) prompted you to contact the Pediatric Mental Health Care Team? *Select all that apply*.
   o Comorbid medical conditions
   o Behavioral health conditions
   o Developmental delay
   o School performance
   o Behavioral concerns
   o Child in foster care
   o Adverse childhood events
   o Parent/Caregiver mental health/SUD
   o Social determinants of health/family environment

   o Other (specify)

7. In the last 12 months, how frequently did you interact with the Pediatric Mental Health Care Team using the following methods?

| Method of Interaction | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Email | 0 | 0 | 0 | 0 | 0 |
| Screensharing | 0 | 0 | 0 | 0 | 0 |
| Telephone (terrestrial and/or wireless communications) | 0 | 0 | 0 | 0 | 0 |
| Text messaging | 0 | 0 | 0 | 0 | 0 |
| Video conferencing | 0 | 0 | 0 | 0 | 0 |
| Face-to-Face | 0 | 0 | 0 | 0 | 0 |
| Other (specify) | 0 | 0 | 0 | 0 | 0 |

8. I prefer to interact with the Pediatric Mental Health Care Team via: *Select one.*
   - o Email
   - o Screensharing
   - o Telephone (terrestrial and/or wireless communications)
   - o Text messaging
   - o Video conferencing
   - o Face-to-Face

   - o Other (specify)

9. I can readily obtain input from the Pediatric Mental Health Care Team when I have questions about how to assess or treat pediatric patients with behavioral health conditions.
   - o Strongly Disagree
   - o Disagree
   - o Neither Agree or Disagree
   - o Agree

   - o Strongly Agree

10. In the last 12 months, my interaction with the Pediatric Mental Health Care Team informed my:

| | Strongly Disagree | Disagree | Neither Agree or Disagree | Agree | Strongly Agree | N/A |
|---|---|---|---|---|---|---|
| Assessments of pediatric patients | 0 | 0 | 0 | 0 | 0 | 0 |
| Formulations of diagnoses | 0 | 0 | 0 | 0 | 0 | 0 |
| Use of pharmacotherapy | 0 | 0 | 0 | 0 | 0 | 0 |
| Referrals to social services | 0 | 0 | 0 | 0 | 0 | 0 |
| Referrals to counseling services | 0 | 0 | 0 | 0 | 0 | 0 |

11. In the last 12 months, as a result of the PMHCA program, more of my pediatric patients **received treatment** (e.g., counseling, medication) for a behavioral health condition either in my office or from a behavioral health clinician.
   - o Strongly Disagree
   - o Disagree
   - o Neither Agree or Disagree
   - o Agree

   - o Strongly Agree

12. In the last 12 months, my interaction with the PMHCA program increased my pediatric patients' use of services in the community to support their behavioral health.

| | Strongly Disagree | Disagree | Neither Agree or Disagree | Agree | Strongly Agree | N/A |
|---|---|---|---|---|---|---|
| Childcare | 0 | 0 | 0 | 0 | 0 | 0 |
| Employment/job-seeking training | 0 | 0 | 0 | 0 | 0 | 0 |
| Food programs | 0 | 0 | 0 | 0 | 0 | 0 |
| Housing support | 0 | 0 | 0 | 0 | 0 | 0 |
| Parenting support | 0 | 0 | 0 | 0 | 0 | 0 |
| Support groups | 0 | 0 | 0 | 0 | 0 | 0 |
| Transportation support | 0 | 0 | 0 | 0 | 0 | 0 |
| Education support | 0 | 0 | 0 | 0 | 0 | 0 |
| Other (specify) | 0 | 0 | 0 | 0 | 0 | 0 |

13. What clinical practices have you adopted as a result of your participation in the PMHCA program?

   o   [OPEN-ENDED RESPONSE]

14. Overall, how have your pediatric patients benefited from your participation in the PMHCA program?

   o   [OPEN-ENDED RESPONSE]

15. Currently, what additional assistance do you still need to improve the behavioral health of your pediatric patients?

   o   [OPEN-ENDED RESPONSE]

## SCREENING, ASSESSMENT, AND TREATMENT OF BEHAVIORAL HEALTH CONDITIONS

16. What behavioral health screening tool(s) do you administer, interpret, or act upon?
    *Select all that apply.*
    o   ACE Screening Tool
    o   ASQ: SE-2
    o   BSTAD
    o   CRAFFT
    o   GAD-7
    o   NICHQ Vanderbilt Assessment Scales
    o   PSC-17
    o   PHQ-2
    o   PHQ-9/PHQ-9 modified/PHQ-A
    o   PIRAT
    o   RAAPS
    o   S2BI
    o   SWYC
    o   Other (specify)

17. What behavioral health interventions do you personally provide? *Select all that apply.*
    o   Prescribe medication
    o   Counseling (e.g., Motivational Interviewing, problem-solving therapy)

    o   Other (specify)

18. I am as comfortable assessing and treating pediatric patients with common behavioral health conditions as I am assessing and treating common medical conditions in pediatric patients.
    o   Strongly Disagree
    o   Disagree
    o   Neither Agree or Disagree
    o   Agree
    o   Strongly Agree

## DEMOGRAPHIC INFORMATION

19. What type of health care provider are you?
    o   Pediatrician
    o   Family physician
    o   Advanced practice nurse/nurse practitioner
    o   Physician assistant
    o   Other (specify

20. Which best describes your primary clinical practice site? *Choose one option.*
    o University-based practice
    o Non-academic, hospital-based practice
    o Emergency department
    o Managed care organization
    o Private practice
    o Community health center/Federally Qualified Health Center
    o School-based health center

    o Other (specify)

21. In what setting(s) does your patient population live? *Select all that apply*.
    o Urban, inner city
    o Urban, non-inner city
    o Suburban

    o Rural
    o Frontier

22. Please provide the ZIP code for the **primary** location in which you practice.

    o [OPEN-ENDED RESPONSE]

23. Including yourself, how many providers (including physicians, advanced practice nurses, and physician assistants) work in your practice?
    o 1 (just myself)
    o 2 – 5
    o 6 – 10

    o ≥ 11

24. What is your ethnicity?
    o Hispanic or Latino
    o Not Hispanic or Latino

25. What is your race? *Select all that apply.*
    o Black or African American
    o White
    o Asian
    o Native Hawaiian or Other Pacific Islander
    o American Indian or Alaska Native

    o Other

## ADDITIONAL FEEDBACK

26. What else would you like to share with HRSA about the PMHCA program?
    o [OPEN-ENDED RESPONSE]