Help Me Grow
Contra Costa

HELP ME GROW READINESS ASSESSMENT / SITE PROFILE DATE:

Pediatric Site Name		Medical Director	
Site Address	Unit	City	Zip Code
Phone Number		Fax Number	

What is the population served:

_________% American Indian/ Alaskan Native _________% Hispanic/Latino
_________% Asian _________% White/Caucasian
_________% Black/African American _________Other _________________________

Estimated % of families served who speak the following languages:

_______% Arabic _______% Farsi _______% Tagalog
_______% Cantonese _______% Mandarin _______% Vietnamese
_______% English _______% Spanish _______% Other ____________________

Estimated total # of patients: _____
Estimated percent by age served: _____% 0-5 years old
Estimated % of patients 0-5 years with Special Needs: _____%
Estimated % of patients 0-5 years with Medi-Cal: _____%

1. How do you screen children in your practice for emotional, cognitive, and developmental concerns?
   - ☐ Surveillance/observation ☐ Standardized tool, please name: ______________________________
   - ☐ Checklist ☐ Other, please explain: _____________________________________

2. What do you need to participate in the HMG program?

3. In addition to universal screening at 18 months, which of the following would you like to implement?
   - ☐ 9 Month ASQ-3 Screener
   - ☐ 48 Month ASQ-3 Screener (School Readiness)
   - ☐ 36 Month ASQ-3 Screener
   - ☐ Maternal Depression Screener
   - ☐ M-CHAT (24 month: universal or targeted (circle one)
   - ☐ Maintenance of Certification (ABP)
   - ☐ ASQ: Social Emotional: universal or targeted (circle one)
   - ☐ Other(Specify) ____

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4. Who in your office will participate in Help Me Grow in order to integrate developmental screening? (check all that apply)

☐ Physicians # ______ ☐ Nurse Practitioners/Physician Assistants # _____

☐ Receptionists/Front Office Staff # _____ ☐ Medical Assistants # _____ ☐ Nurses # _____

☐ Other, please specify____

5. What type of training and technical assistance would you and your staff require to conduct developmental screening? (check all that apply)

☐ Child development training ☐ Monthly phone check-ins

☐ Incentive supplies for families ☐ Monthly office visits/technical assistance

☐ Technical assistance to address office flow ☐ Technical assistance to address referrals

☐ Other, please explain ____

6. How do you address identified developmental concerns in your practice?

☐ We give information to the parent(s) and have them call referrals/resources

☐ We make the referral

☐ Other, please explain ____

7. What is most challenging about obtaining needed resources and referrals for your patients?

8. What assistance would help make these referrals easier?

9. Is the practice involved in other quality improvements efforts (i.e. Asthma, immunization registry)?

10. What Electronic Medical Record (EMR) are you using or intend to use?

Name of person completing the survey		
Position at the pediatric site		
Phone Number	Fax Number	Email