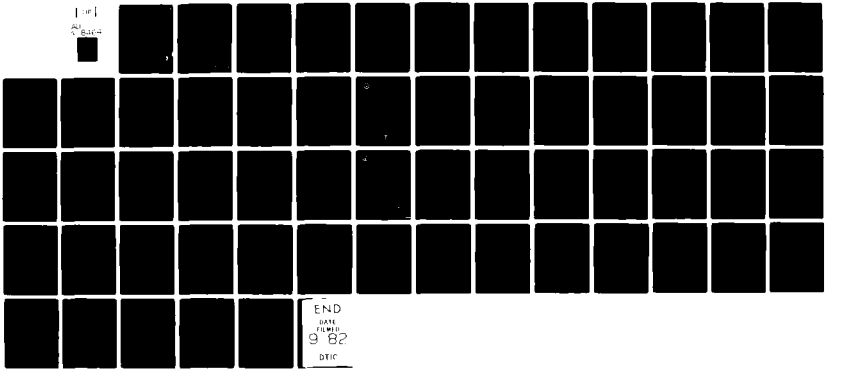
AD-A118 464 ACADEMY OF HEALTH SCIENCES (ARMY) FORT SAM HOUSTON TX--ETC F/G 5/11
CHILD PROTECTION AND CASE MANAGEMENT TEAM PERFORMANCE EVALUATIO--ETC(U)
MAY 82 T P FURUKAWA, C M WAITS

UNCLASSIFIED HCSD-82-004 NL



END
DATE FILMED
9 82
DTIC

HEALTH CARE STUDIES DIVISION REPORT #82-004

CHILD PROTECTION AND CASE MANAGEMENT TEAM PERFORMANCE EVALUATION TOOL (CPCMT P.E.T.)

by

MAJ Theodore P. Furukawa, MSC
MAJ Charles M. Waits, AGC

Health Care Studies Division
Academy of Health Sciences, US Army
Fort Sam Houston, Texas 78234

Final Report
May 1982

Approved for Public Release
Distribution Unlimited

Prepared for:
Human Resources Division
Headquarters, Health Services Command

NOTICE

The findings in this report are not to be construed as an official Department of the Army position unless so designated by other authorized documents.

Regular users of the services of the Defense Technical Information Center (per DOD Instruction 5200.21) may purchase copies directly from the following:

Defense Technical Information Center (DTIC)
ATTN: DTIC-DDR
Cameron Station
Alexandria, VA 22314

Telephones: AUTOVON (108) 28-47633, 34, or 35
Commercial (202) 27-47633, 34, or 35

All other requests for these reports will be directed to the following:

US Department of Commerce
National Technical Information Services (NTIS)
5285 Port Royal Road
Springfield, VA 22161

Telephone: Commercial (703) 487-4600

SECURITY CLASSIFICATION OF THIS PAGE *(When Data Entered)*

REPORT DOCUMENTATION PAGE	READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER: Health Care Studies Div Rpt #82-004 — 2. GOVT ACCESSION NO. A118 464	3. RECIPIENT'S CATALOG NUMBER
4. TITLE *(and Subtitle)*: Child Protection and Case Management Team Performance Evaluation Tool (CPCMT P.E.T.)	5. TYPE OF REPORT & PERIOD COVERED: Final Report May 1982
	6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s): MAJ Theodore P. Furukawa, MSC MAJ Charles M. Waits, AGC	8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS: Health Care Studies Division Academy of Health Sciences, US Army Fort Sam Houston, Texas 78234	10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS
11. CONTROLLING OFFICE NAME AND ADDRESS	12. REPORT DATE: May 1982
	13. NUMBER OF PAGES
14. MONITORING AGENCY NAME & ADDRESS *(if different from Controlling Office)*	15. SECURITY CLASS. *(of this report)*: Unclassified
	15a. DECLASSIFICATION/DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT *(of this Report)*

Unlimited distribution.

17. DISTRIBUTION STATEMENT *(of the abstract entered in Block 20, if different from Report)*

18. SUPPLEMENTARY NOTES

19. KEY WORDS *(Continue on reverse side if necessary and identify by block number)*

child protection, child abuse, child neglect, child advocacy, child protection team, multidisciplinary team, performance evaluation, Delphi Technique

20. ABSTRACT *(Continue on reverse side if necessary and identify by block number)*

The study was requested by HQ HSC for the purpose of developing a standard CPCMT Performance Evaluation Tool for use by Army child protection teams. A staff group of subject-matter experts employed the Delphi Technique (two iterations), and a panel comprising representation from all CONUS CPCMTs served as respondents. The resulting performance evaluation tool is a three-part, 26-item form which is recommended for use by CPCMTs and for inclusion in future revisions of regulations and directives.

DD FORM 1 JAN 73 1473 EDITION OF 1 NOV 65 IS OBSOLETE

SECURITY CLASSIFICATION OF THIS PAGE *(When Data Entered)*

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The authors wish to thank the following Army Medical Department officers who served with enthusiasm and with diligence as staff group members: COL Anna K. Frederico, ANC, Community Health Nurse Staff Officer, Preventive Medicine Division, Headquarters, Health Services Command; LTC David L. Garber, MSC, Social Work Staff Officer, Clinical Medicine Division, Headquarters, Health Services Command; MAJ Stonell B. Green, MSC, Social Work Service, Chairperson, CPCMT, Brooke Army Medical Center; CPT J. William Parker, MC, Pediatric resident, Department of Pediatrics, Brooke Army Medical Center; MAJ Wayne St. Pierre, MSC, Class Adviser, USAADATT/USACART, Behavioral Science Division, Academy of Health Sciences; and CPT Peter L. Staresnick, MSC, Instructor, Community Sciences Branch, Behavioral Science Division, Academy of Health Sciences. Special recognition is also deserved by the chairpersons of CONUS Child Protection and Case Management Teams who served as points of contact, liaisons, and panelists. Finally, our appreciation is extended to the clerical staffs of Health Care Studies Division, Academy of Health Sciences, and of Human Resources Division, Headquarters, Health Services Command, for their quality work.

SUMMARY

This AMEDD Study Program priority study for FY 81-82 was requested by Headquarters, Health Services Command (HSPE-H) for the purpose of developing a Standard Child Protection and Case Management Team Performance Evaluation Tool for use by Army child protection teams. A staff group of subject matter experts employed a modified Delphi Technique with two iterations. The chairpersons of each CONUS CPCMT served as Delphi panelists and were urged to use the expertise on their team to complement their own responses. The study product is a three-part (organization, function, and administration), 26-item form which is recommended for use by CPCMTs and for inclusion in future revisions of regulations and directives.

CHILD PROTECTION AND CASE MANAGEMENT TEAM PERFORMANCE EVALUATION TOOL

1. INTRODUCTION.

a. Purpose. The study was requested by the Human Resources Division, DCSPER, Headquarters, Health Services Command, for the purpose of developing a standard Child Protection and Case Management Team (CPCMT) Performance Evaluation Tool for use of CPCMTs established under the provisions of Army Regulation 608-1, Chapter 7, October 1978.

b. Background.

(1) Child maltreatment is a serious nationwide social problem which occurs among all major social groupings and at all income levels. Childhood injuries attributed to child maltreatment number in excess of one million cases in the United States annually (10 cases per 1,000 population) and include over 5,000 deaths (0.025 cases per 1,000 population) (4, 7). Studies of the prevalence of maltreatment indicate that the rate of reported cases in military communities is similar to the rate in American civilian communities (12, 17). Among Army children in 1979-80, the rate of reported cases of maltreatment was 250 per 100,000 children at risk per year (11).

(2) In accordance with AR 608-1 (1), all CONUS Army installations with 2,000 or more military dependents are required to establish an Army Child Advocacy Program (ACAP), a key element of which is a Child Protection and Case Management Team (CPCMT). The CPCMT is defined as the Army multidisciplinary team appointed and supervised by the medical treatment facility commander to investigate and evaluate all allegations of child maltreatment. The team is further impowered to determine the disposition of specific cases, coordinate and use available military and civilian resources to treat children and families, and recommend corrective actions on conditions that lead to child abuse and neglect. According to the National Center on Child Abuse and Neglect (NCCAN) and to other child protection authorities, the multidisciplinary team approach provides (a) better assessment of clients' treatment needs and (b) better treatment planning and delivery than individual child protection work (6).

(3) The US Army already dedicates a sizeable portion of medical expertise to child protection. In a survey of all CONUS CPCMTs covering FY 78, over 350 US Army personnel and Department of the Army civilians, primarily from the Army Medical Department, committed an average of ten percent of their duty time in child protection and case management activities (5).

(4) While informal prescriptive guidelines for child maltreatment case management have been published (19), no measure of performance effectiveness (similar to the criteria guidelines employed in medical audits) has been developed for use by CPCMTs (3, 8, 9, 10, 14, 18).

2. OBJECTIVE. The study objective was to develop a CPCMT Performance Evaluation Tool.

3. METHODOLOGY.

a. Overview. Since explicit criteria on child protection team performance

had not been developed, the Delphi Technique was selected as the appropriate data collection/analysis approach (2, 13, 16, 20). A study group of subject-matter experts and a panel of all CONUS CPCMT chairpersons were employed through two iterations, using mailed questionnaires.

b. Procedures.

(1) An overview description of the study proposal and of the roles of the respondent group and staff group was prepared; this document served as the methodological framework (Appendix A).

(2) A staff group of subject-matter experts and consultants was carefully selected from health service commands at Fort Sam Houston, Texas. The members received formal appointment by the commanders of Health Services Command, Academy of Health Sciences, and Brooke Army Medical Center (Appendix B).

(3) The first iteration draft tool was developed by the staff group and mailed to the chairpersons of each CPCMT (Appendix C). This tool (in the form of a questionnaire) elicited opinions on (a) which items should or should not be regarded as criteria in judging CPCMT effectiveness and (b) proposed standards.

(4) The responses on the first draft tool (questionnaire) indicated that specific proposed criteria were consistently judged to be either important or unimportant. Consequently, the staff group decided to modify the tool substantially by (a) eliminating the "unimportant" criteria thus reducing the number of criteria from 50 to 26; (b) operationally defining each of the 26 remaining criteria; (c) dividing the criteria conceptually into three categories (organization, function, and administration); (d) weighting the criteria by category based upon the relative importance assigned in the first iteration (each criterion in the "organization" category given the value of five points, each in the "function" category four points, and each in the "administration" category three points); and (e) simplifying the scoring by granting full point credit when a criterion was met or was present (five, four, or three points) and denying any points (zero points) when a criterion was not met or was absent. The point values for the three categories of criteria were also chosen to facilitate ease in counting: If all criteria are met or are present, the points total 100.

(5) The second draft tool was designed and mailed to the respondent panel for concurrence, modification, or nonconcurrence (Appendix D). Panel responses were compiled, compared, and analyzed.

4. FINDINGS.

a. The panel responses from the first iteration of the Delphi Technique clearly indicated the need for a significant revision for the second iteration. These revisions are discussed above in paragraph 3.b.(4). The responses are summarized in Appendix E.

b. The panel responses from the second iteration clearly indicated support for, and concurrence with, the second draft tool. This tool, without modification,

is submitted as the proposed Child Protection and Case Management Team Performance Evaluation Tool (CPCMT P.E.T.) Additional respondent comments are summarized in Appendix F.

5. DISCUSSION.

a. The consensus of panelists on a CPCMT performance evaluation tool (P.E.T.), derived through a modified Delphi Technique (two iterations), demonstrated both a need for such a tool and similar perceptions of what elements should constitute this tool.

b. While further experience may eventually lead to subsequent revisions, the proposed CPCMT P.E.T. can provide teams with the bases for (1) their own self-evaluation, (2) their contribution of a standard medical audit criteria on child protection for their medical treatment facility, and (3) suggested guidelines for routine inspections.

6. CONCLUSIONS.

The study objective of developing a CPCMT Performance Evaluation Tool was met.

7. RECOMMENDATIONS.

a. Recommend that a copy of this report be made available throughout the AMEDD to each Child Protection and Case Management Team.

b. Recommend that the proposed Child Protection and Case Management Team Performance Evaluation Tool be incorporated, where feasible, in revisions of the appropriate Department of the Army and major command regulations or supplements to regulations.

8. LITERATURE CITED.

1. Army Regulation 608-1, "Army Community Service Program," Chapter 7, "Army Child Advocacy Program," October 1, 1978.

2. A.L. Delbecq, A.H. Van de Ven, and D.H. Gustafson, Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes (Glenview, IL: Scott, Foresman, and Co., 1975).

3. K. Donabedian, "Evaluating the Quality of Medical Care," The Milbank Memorial Fund Quarterly (July 1966).

4. V.J. Fontana, Maltreated Child: The Maltreatment Syndrome in Children - A Medical, Legal, and Social Guide (4th Edition, Springfield, IL: C.C. Thomas, 1979).

5. T.P. Furukawa, Intervention Judgments of Army Child Protectors, Ann Arbor, MI: University Microfilming, November 1981.

6. General Accounting Office, U.S., "Increased Federal Efforts Needed to Better Identify, Treat, and Prevent Child Abuse and Neglect," report to the Congress of the United States by the Comptroller General, HRD-80-66, April 1980.

7. D.G. Gil, Violence Against Children (Revised Edition, Cambridge, MA: Harvard University Press, 1973).

8. M.J. Goran, "The Evolution of the PSRO Hospital Review System," Medical Care (Supplement), 17 (May 1979), 1-47.

9. R.M. Grimes and S.K. Mosely, "An Approach to an Index of Hospital Performance," Health Services Research (Fall 1976).

10. B.S. Hulka, F.J. Romm, G.R. Parkerson, I.T. Russell, N.E. Clapp, and F.S. Johnson, "Peer Review in Ambulatory Care: Use of Explicit Criteria and Implicit Judgment," Medical Care (Supplement), 17 (March 1979), 1-73.

11. J.J. James, T.P. Furukawa, N.S. James, and A.D. Mangelsdorff, "Child Abuse and Neglect Reports in the US Army Central Registry," unpublished report, April 1982.

12. D. Lanier, "A Retrospective Analysis of Child Abuse and Neglect Among Military Families," unpublished paper presented at the Military Family Research Conference, Naval Health Research Center, San Diego, CA, September 2, 1977.

13. H.A. Linstone and M. Turoff, eds., The Delphi Method (Reading, MA: Addison-Wesley, 1975).

14. A. Lurie, ed., Development of Professional Standards Review for Hospital Social Work (Chicago: American Hospital Association, 1977).

15. A.D. Mangelsdorff and T.P. Furukawa, "An Analysis of a Sample from the Case Management Incident Reports of the US Army CHild Protection Case Management Files," Health Care Studies Division Consultation Report #82-002, April 1982.

16. C.R. McLaughlin, A. Sheldon, R.C. Hansen, and B.A. McIver, "Management Uses of the Delphi," Health Care Management Review, 1 (Spring 1976), 51-62.

17. J.K. Miller, "Child Abuse Problems Related to Civilian and Military Communities," unpublished paper, April 1978.

18. S.K. Moseley, and R.M. Grimes, "The Organization of Effective Hospitals," Health Care Management Review (Summer 1976).

19. B.D. Schmitt, ed., The Child Protection Team Handbook, (New York: Garland STPM Press, 1978).

20. A.H. Van de Ven and A.L. Delbecq, "The Effectiveness of Nominal, Delphi, and Interacting Group Decision Making Processes," Academy of Management Journal, 17 (December 1974), 605-621.

APPENDIX A

Overview Description of the Study Proposal, and the Roles of the Respondent Group and Staff Group

OVERVIEW DESCRIPTION OF THE STUDY PROPOSAL, AND
THE ROLES OF THE RESPONDENT GROUP AND STAFF GROUP

1. Study Proposal

a. Basically, the proposal states that: (1) the seriousness of child maltreatment acts, (2) the alarming incidence of child maltreatment in military and civilian communities, and (3) the current sizable commitment of AMEDD staff to the Army's child protection effort all support the need for standards (either mandatory or voluntary) for assessing the effectiveness of Army child protection team programs. Measures of effectiveness include both patient care and administrative (efficiency) measures. Such measures allow comparisons among programs, or between the same program at two different times, when they include quantifiable concrete criteria against which medical record entries, team meeting minutes, or written survey results can later be compared.

b. The list of quantifiable and concrete criteria may be divided into four major components (analogous to the components of a departmental medical audit):

(1) Structural measures - the environment, physical facilities, personnel capability, and organizational characteristics of the program (e.g., types of disciplines represented on the child protection team, evidence of coordination with local civilian child protection agencies);

(2) Process measures - functions, activities, and aspects of medical and administrative practice (e.g., frequency of case review, publication of standard operating procedures for case reporting, written agreements between the installation commander and civilian agencies);

(3) Outcome measures - results of health care on patients and the corresponding cost-benefit analysis (e.g., numbers of maltreatment-related deaths, recidivism rate, ratio of treaters to cases); and

(4) Attitudinal measures - opinions and assessment of consumers, providers, and evaluators (e.g., patient satisfaction, health care provider job satisfaction).

A comprehensive analytical framework may include some combination, or all, of the four major components (Donabedian, 1966; Grimes and Moseley, 1976; Moseley and Grimes, 1976).

c. The study intent, in short, is to:

(1) Employ a staff group of subject-matter experts to word the questionnaire in a way that best achieves the study purpose and tightly focuses on the topics;

(2) Obtain the professional judgments of key child protection members of CPCMTs (a respondent group) on what criteria belong in an assessment of program effectiveness and which criteria are more important than others; and

(3) Employ the staff group to categorize and summarize the questionnaire responses.

d. The final product of the study will be a written report sent through the Study Advisory Committee to the Commander, HSC, which will:

(1) State the feasibility of promulgating standards for an Army-wide program effectiveness evaluation procedure for CPCMTs;

(2) Propose such standards in the form of voluntary or mandatory guidelines to the elements of HSC; and

(3) Recommend the adoption or modification of these guidelines to OTSG for use by Army child protection teams worldwide.

e. Portions of the final product may be suitable for dissemination to military and civilian child protection audiences through publications and presentations at professional meetings.

2. Respondent Group

a. The respondent group will include selected representatives from all CONUS CPCMTs. Each respondent must be a key team member who is experienced in both clinical and administrative team matters. The final decision on the specific respondent qualifications will be made by the principal investigator and study advisor, with the advice of the staff group.

b. The written questionnaire responses from the respondent group will provide the primary source of data for the study. This group will be surveyed two or more times. The questions on successive questionnaires will be based, in large part, upon the responses to prior questionnaires.

c. The respondent group will serve as the sample for the present study and, in turn, will be the recipients of a compilation and summary of the findings for use in team program assessment.

3. Staff Group

a. The staff group consists of subject-matter experts (a carefully-selected multidisciplinary grouping with extensive clinical and child protection team leadership experience) and collateral research-administrative personnel (principal investigator and study advisor's representative). The final selection of the staff group will be made by the principal investigator and study advisor after a review of qualifications.

b. The responsibilities of the subject-matter experts are to:

(1) Review the approved study proposal and recommend ways of best achieving the study objectives;

(2) Meet to propose the wording for the pilot test questionnaire and the first questionnaire;

(3) Meet to review the responses to the first questionnaire, summarize the responses, and propose the wording for the second questionnaire;

(4) Meet to review the responses to the second questionnaire, summarize the responses, and (unless additional questionnaire iterations are recommended) prepare a summary of findings to the respondent group; and

(5) Generate recommendations for the final report to the decision-makers (HSC SAC and Commander, HSC).

4. References

a. Donabedian, A., "Evaluating the Quality of Medical Care," The Milbank Memorial Fund Quarterly (July 1966).

b. Grimes, R.M. and Moseley, S.K., "An Approach to an Index of Hospital Performance," Health Services Research (Fall 1976).

c. Moseley, S.K. and Grimes, R.M., "The Organization of Effective Hospitals," Health Care Management Review (Summer 1976).

APPENDIX B

Directory of Key Study Personnel

DIRECTORY OF KEY STUDY PERSONNEL

Staff Group

COL Anna K. Frederico, ANC
Community Health Nurse Staff Officer
DCSPA, Prev Med Div (HSPA-P)
HQ HSC
221-3167, 6612

CPT J. William Parker, MC
Pediatric resident (3rd year)
Department of Pediatrics (AFZG-MDP-E)
BAMC
221-4024, 5009

LTC David L. Garber, MSC
Social Work Staff Officer
DCSPA, Clin Med Div (HSPA-C)
HQ HSC
221-6616, 6516

MAJ Wayne St. Pierre, MSC
Class Adviser, USAADATT/USADART
Beh Sci Div (HSA-IBS)
AHS
221-3755, 5290

MAJ Stonell B. Greene, MSC
Social Work Service (AFZG-MDS-W)
Chair, CPCMT
BAMC
221-3325, 6129

CPT Peter L. Staresnick, MSC
Instructor, Comm Sci Br
Beh Sci Div (HSA-IBS)
AHS
221-3755, 5290

Principal Investigator

MAJ T. Paul Furukawa, MSC
Social Work Research Officer
Health Care Studies Div (HSA-CHC)
AHS
221-6514, 4541, 3331, 3116

Study Adviser

COL Edgar J. Habeck, MSC
Chief, Human Resources Div
DCSPER (HSPE-H)
HQ HSC
221-6841, 6842, 6843

Staff Group Support

MAJ Charles Waits, AGC
ACS Officer, Hum Res Div
DCSPER (HSPE-H)
HQ HSC
221-6841, 6842, 6843

HSC Study Program Coordinator

LTC James J. James, MC
Chief, Health Care Studies Div
DCDHCS (HSA-CHC)
AHS
221-3331, 3116

Technical Consultants

LTC Kenneth H. Nolan, MSC
Chief, Social Work Service
BAMC (AFZG-MDS-W)
221-2020, 6129

Ms. Betsey T. Cunningham, DAC
Registered Records Administrator
Chief Medical Record Admin
Patient Admin Div (HSOP-P)
DCSOPS
HQ HSC
221-6791, 6517

APPENDIX C

First Iteration: First Draft
Questionnaire and Cover Letter

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234

REPLY TO
ATTENTION OF:

S: 20 Feb 81

HSPE-HD

23 JAN 1981

SUBJECT: Child Protection Team Study (RCS HSPE-104(OT))

Commanders
HSC MEDCEN/MEDDAC

1. Child Protection and Case Management Teams (CPCMT) in US Army Health Services Command facilities have devised a variety of innovative and productive programs under the general guidelines of Army Regulation 608-1, Chapter 7. These programs have as their primary purpose the provision of quality child protection in military communities. In some instances, Army programs have attracted statewide and national attention and acclaim. In order to identify common elements of team effectiveness and efficiency among CONUS programs, a health care study entitled "Child Protection and Case Management Team Performance Evaluation Tool" (CPCMT PET) was approved by the HSC Study Advisory Committee. This study, a priority item of the US Army Study Program for FY 81, will result in a sharing of professional judgments and programmatic developments among all child protection teams (see inclosed Study Summary).

2. All MEDCEN and MEDDAC with developed child protection programs such as yours will participate in the survey. Please have the Chairperson of your Child Protection and Case Management Team complete the questionnaire according to the written instructions. The questionnaire is designed to require coordination with, and solicitation of, opinions from other team members. In addition, please forward to us a copy of any written MTF or installation SOP, LOI, or regulation, and any letters of agreement between the post and civilian authorities (e.g., on federal-state jurisdiction), relevant to the operation of your CPCMT.

3. The success of the CPCMT PET Study depends upon your thoughtful participation and the prompt return of your response by 20 Feb 81. If you have questions, please contact either MAJ T. Paul Furukawa (AUTOVON 471-6514/3116) or MAJ Charles Waits (AUTOVON 471-6843/6807).

FOR THE COMMANDER:

ALFORD W. GREEN
Colonel, AGC
Adjutant General

2 Incl
1. Study Summary
2. Questionnaire

CHILD PROTECTION AND CASE MANAGEMENT TEAM
PERFORMANCE EVALUATION TOOL:
STUDY SUMMARY

Military and civilian child protection authorities generally agree that the multidisciplinary team is the most comprehensive vehicle in preventing, identifying, and treating child maltreatment. However, there is little uniformity among child protection teams, and no published standards or tested guidelines for these programs.

"Child Protection and Case Management Team Performance Evaluation Tool" is an HSC Study Program health care administrative study which will produce a standard set of criteria by which CONUS CPCMTs can measure their own program effectiveness. This evaluation tool may also serve as part of an MTF's quality assurance plan in complying with the new JCAH standards.

The study will use the Delphi Technique in surveying key members of CPCMTs at all CONUS MEDCEN and MEDDAC for their professional judgments of the most important program performance criteria. A panel of six subject-matter experts from HQ HSC, the Academy of Health Sciences, and Brooke Army Medical Center will assess the survey responses. The principal investigator from the Health Care Studies Division, AHS, and the study adviser from the Human Resources Division, HQ HSC, will formulate the final version of the performance evaluation tool.

The study commenced on 4 Sep 80 when the study proposal was approved by the HSC Study Advisory Committee. The data collection is scheduled to begin in Feb 81, and the final report should be prepared and staffed by Jun 81.

For information on the status of the study, contact: MAJ T. Paul Furukawa, Health Care Studies Div, AHS (AUTOVON 471-6514, 3116) or MAJ Charles Waits, Human Resources Div, HQ HSC (AUTOVON 471-6843,2767).

CHILD PROTECTION AND CASE MANAGEMENT TEAM
PERFORMANCE EVALUATION TOOL STUDY

Questionnaire

PURPOSE. The intent of this questionnaire is to have you identify and rate in importance as many major criteria as possible for measuring the program effectiveness and efficiency of Army child protection teams. You may wish to base your opinion on your current team performance evaluation standards, if already developed, or on standards which in your opinion should be employed. As a pilot instrument, this questionnaire will be critiqued and revised in accordance with your recommendations before the final version is established.

INSTRUCTIONS. On the following pages, you will find three columns. The left-hand column is entitled "CRITERIA." Under this column are listed a preliminary set of criteria, some which may seem important to you and some which may not. Complete the list by adding criteria not already represented in the given list which you judge to be important in determining team effectiveness and efficiency.

The middle column contains a 5-point scale of agreement and disagreement. Note that for each criterion listed (or added by you), you should rate by circling the number (1 through 5) which best represents your judgment.

The right-hand column lists standards for each criteria. The standards have been developed through the use of a pilot questionnaire and study group input. If you feel the standard is appropriate do nothing with it, but if you feel it is invalid or should be modified please do so on the following line.

CRITIQUE. This questionnaire is meant to be critiqued. After you complete the questionnaire as well as possible, scan the entire questionnaire, these instructions, and the study summary. Marking on the materials directly, please recommend additions, modifications, or suggestions that may clarify the materials for later respondents.

SUSPENSE. Please return materials by 20 Feb 81.

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
I. ORGANIZATION						
a. Team Structure						
1. Interdisciplinary mix	5	4	3	2	1	8-10 Separate Disciplines ---------- ---------One Discipline
2. Defined written responsibilities (MTF Regulation, SOP)	5	4	3	2	1	Specified Duties ---------- No Defined Guidance
3. Formal professional staff training & credentialing process	5	4	3	2	1	Mandatory on-going training ---------- No training
4. Full compliance with AR 608-1	5	4	3	2	1	Full Compliance ----------Less than Full
5. Formal liaison to ACAP	5	4	3	2	1	Full Cooperation ---------- None
b. Team Process						
1. Record keeping (team minutes)	5	4	3	2	1	Secured Detailed Records ---------- No Records (including photo copies of medical records & on going interactions)

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst Case
	(Circle One)					
b. Team Process (Continued)						
2. Formal leadership (chairperson and coordinator)	5	4	3	2	1	*Designated leaders* ---------- Not Designated
3. Coordinator of investigation and treatment	5	4	3	2	1	Individual Coordinator with mechanism for periodic review ---------- No formal plan of intake
4. Liaison with civilian child protective agencies	5	4	3	2	1	Full cooperation with civilian agency representation as full team member ---------- No cooperation
5. Liaison with civilian court system and law enforcement	5	4	3	2	1	Regular cooperation with good understanding between team and local court and law enforcement ---------- No cooperation
C. Team Attitude						
1. Member satisfaction (attitude check)	5	4	3	2	1	Formal means to evaluate member attitude ---------- No means

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case---------- Worst
	(Circle One)					
c. Team Attitude (Continued)						
2. Avoidance of "burnout"	5	4	3	2	1	Procedures established to help avoid burnout ---------- No Procedures
II. CASE DEVELOPMENT						
Case Structure						
1. Sources of reported cases (outside team)	5	4	3	2	1	Established network ---------- No network
2. Sources of reported cases (inside team)	5	4	3	2	1	Established network ---------- No network
3. Confidentiality	5	4	3	2	1	Rigid Procedures ---------- Lax Strictly protected Not protected
4. Availability of point-of-contact for reporting cases & for info	5	4	3	2	1	Well Publicized ----------Not well known

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
b. Case Processing						
1. Initial assessment of suspicion	5	4	3	2	1	All cases screened by M.D. social worker & community health nurse prior to acceptance as case ---------- Assessment primarily made on basis of record review, only, or hearsay
2. Medical examination	5	4	3	2	1	Promptly done by M.D. (pediatrician) in all cases ---------- Delayed or done by non-MD
3. Police investigation	5	4	3	2	1	Coordinated with team ---------- Refused to investigate
4. Psychosocial assessment	5	4	3	2	1	Regular part of family evaluation ---------- Not utilized
5. Community health nurse home visit	5	4	3	2	1	Each home visited ---------- Not used

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
6. Local/state registry inquiry	5	4	3	2	1	Each case/suspected case checked ---------- Never used
7. US Army Central Registyr inquiry	5	4	3	2	1	Each case suspected case checked ---------- Never used
8. Filing report to local/state registry	5	4	3	2	1	All state laws followed Good rapport maintained ---------- Cases not reported
9. Filing report to Central Registry	5	4	3	2	1	All cases (promptly) ---------- None
10. Maintenance of medical record	5	4	3	2	1	Protected record maintained w/copies of lab work, x-ray and consultations ---------- Records incomplete or not protected
11. Maintenance of CPCMT record	5	4	3	2	1	Complete medical, social, psychological and photographic documents in secure records --------Not maintained

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
12. Development of treatment plan	5	4	3	2	1	Multispeciality treatment ---------- *No specific* ment plan plan established for all cases
13. Appointment of case manager for each case	5	4	3	2	1	Each case has individual manager ---------- None
14. Periodic update of treatment plan	5	4	3	2	1	Treatment plan reviewed at least ---------- Not reviewed monthly by case managers
15. Post-mortem psycho/social/medical autopsy on active cases	5	4	3	2	1	Conducted ---------- Not conducted
c. Case Attitude						
1. Child's reaction to intervention	5	4	3	2	1	Child's emotional well-being ---------- No special at enhanced by support provided tion given to child's well-being

C-8

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
2. Parental/caretaker reaction to intervention	5	4	3	2	1	Parent/caretaker become active participant ---------- Alienation
3. Siblings' reaction to intervention	5	4	3	2	1	Active program conducted to ensure sibling understand & are supported through crisis ---------- No care given to siblings
III ADMINISTRATION						
a. Structure						
1. Interaction and support from military activities	5	4	3	2	1	Active participation ---------- None
2. Interaction and support from civilian activities	5	4	3	2	1	Active participation ---------- None
3. Case transfer written procedures	5	4	3	2	1	Proper procedures followed (cases transferred but "not closed" until written accept-ance from gaining unit received) ---------- Transfer not done in timely manner

C-9

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst Case
	(Circle One)					
4. Clerical support for team	5	4	3	2	1	Priority clerical support ---------- No clerical support (forced on board members or "farmed" out.) provided
b. Process						
1. Orientation of new community personnel	5	4	3	2	1	Child advocacy is integral ---------- Not included part of post orientation
2. Continuing education of community personnel	5	4	3	2	1	Periodic public relations ---------- Not conducted (articles published) Periodic followup orientations conducted
3. Publicity of results	5	4	3	2	1	Commanders (at all echelons) ---------- None kept informed of program effectiveness
4. Rapid responses to reports from sources	5	4	3	2	1	All cases evaluated within ---------- More than 24 hrs 24 hours on followup
					8	

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
5. Source feedback	5	4	3	2	1	Regular feedback to sources that case was valid or invalid ---------- Excessive delay or no feedback
6. Mother-child bonding assessment	5	4	3	2	1	Active program in obstetrics/new born nursery ---------- No program
7. Community Awareness	5	4	3	2	1	Community regularly informed of team and its functions ---------- No awareness of team
8. Resolving federal-state jurisdictional matters	5	4	3	2	1	Clear rigid agreement between post/ civilian authorities (if needed) ---------- Inactive
c. Administrative Attitudes						
1. Satisfaction of installation with team	5	4	3	2	1	Satisfied ---------- Dissatisfied
2. Satisfaction of MTF with team	5	4	3	2	1	Satisfied ---------- Dissatisfied

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best ---------- Worst
	(Circle One)					
3. Satisfaction of CPCMT with its results	5	4	3	2	1	Satisfied ----------Dissatisfied
4. Satisfaction of local community with team	5	4	3	2	1	Satisfied ----------Dissatisfied

10

APPENDIX D

Second Iteration: Second Draft
Questionnaire and Cover Letter

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234

REPLY TO ATTENTION OF:

S: 31 Jul 81

HSPE-HD

13 JUL 1981

SUBJECT: Child Protection Team Study (RCS HSPE-104(OT))

Commanders
HSC MEDCEN/MEDDAC

1. Child Protection and Case Management Teams (CPCMT) in US Army Health Services Command facilities have devised a variety of innovative and productive programs under the general guidelines of Army Regulation 608-1, Chapter 7. These programs have as their primary purpose the provision of quality child protection in military communities. In some instances, Army programs have attracted statewide and national attention and acclaim. In order to identify common elements of team performance criteria, a health care study entitled "Child Protection and Case Management Team Performance Evaluation Tool" (CPCMT PET) was approved as a priority item of the US Army Study Program for FY 81. This study will result in a sharing of professional judgments and programmatic developments among all child protection teams (see inclosed Study Summary).

2. In February 1981, the CPCMT from your command participated in the first phase of the CPCMT PET Study. The data from that phase were compiled and analyzed, resulting in a draft Performance Evaluation Tool (PET). A critique of that draft CPCMT PET will constitute the second study phase. All MTF with developed child protection programs such as yours will participate in the second phase. Please have the Chairperson of your Child Protection and Case Management Team complete the questionnaire according to the written instructions. The questionnaire is designed to require coordination with, and solicitation of opinions from other team members.

3. The success of the CPCMT PET Study continues to depend upon your thoughtful participation and the prompt return of your response by 31 Jul 81. If you have questions, please contact either MAJ T. Paul Furukawa (AUTOVON 471-6514/3116) or MAJ Charles Waits (AUTOVON 471-6843/6807).

FOR THE COMMANDER:

2 Incl
1. Study Summary
2. Questionnaire

W. C. COSGROVE
LTC, AGC
Adjutant General

WAITS
MAJOR, AGC

Released by _____
Signature _____
Date _____

Herman A. Jones 9 Jul 81

RECORD COPY - HSPE-HD

CHILD PROTECTION AND CASE MANAGEMENT TEAM
PERFORMANCE EVALUATION TOOL:
STUDY SUMMARY

Military and civilian child protection authorities generally agree that the multidisciplinary team is the most comprehensive vehicle in preventing, identifying, and treating child maltreatment. However, there is little uniformity among child protection teams, and no published standards or tested guidelines for these programs.

"Child Protection and Case Management Team Performance Evaluation Tool" is an HSC Study Program health care study which is intended to produce a standard set of criteria by which CONUS CPCMT can measure their own program effectiveness. This evaluation tool may also serve as part of an MTF's quality assurance plan in complying with the new JCAH standards.

The study will use the Delphi Technique in surveying key members of CPCMT at all CONUS MEDCEN and MEDDAC for their professional judgments of the most important program performance criteria. A panel of subject-matter experts from HSC, the Academy of Health Sciences (AHS), and Brooke Army Medical Center will assess the survey responses. The principal investigator from the Health Care Studies Division, AHS, and the study advisor from the Human Resources Division, HSC, will formulate the final version of the performance evaluation tool.

The study commenced on 4 Sep 80 when the study proposal was approved by the HSC Study Advisory Committee. The data collection began in Feb 81, and the final report should be prepared and staffed by Aug 81.

For information on the status of the study, contact: MAJ T. Paul Furukawa, Health Care studies Div, AHS (AUTOVON 471-6514, 3116) or MAJ Charles Waits, Human Resources Div, HQ HSC (AUTOVON 471-6843,2767).

CHILD PROTECTION AND CASE MANAGEMENT TEAM
PERFORMANCE EVALUATION TOOL (CPCMT PET) STUDY

Questionnaire

PURPOSE. The intent of this questionnaire is to have you concur/nonconcur with the draft CPCMT PET. Your comments and/or recommendations will be incorporated into the final version when supported by the study panel. The final version may become part of a proposed HSC regulation on the Child Advocacy Program.

SUSPENSE. Please return materials by 31 Jul 81.

INSTRUCTIONS. On the following pages, you will find an introductory section (with "purpose," "scores," and "summary" parts), and three sections of criteria. The criteria are grouped under the labels of "organization," "function," and "administration;" by means of an earlier survey of CPCMT teams, weighted values for criteria in each section were determined to be 5 points, 4 points, and 3 points, respectively. You are asked to read the draft CPCMT PET and to mark directly on the draft if you wish to challenge, delete, or clarify the wording of any of the criteria. In addition, you are asked to respond to the following questions and add any general comments you desire.

1. Overall, do you feel that the PET will accomplish its objective (i.e. providing an appraisal of the operations and functions of a CPCMT)?

Yes
No (please explain)
Somewhat (please explain)

2. When completed, will the PET support your estimation of your team's performance?

Yes
No (please explain)

3. Do you feel that the PET, when used by an individual upon assuming Chairmanship of a CPCMT, will provide initial insight into the strengths and weaknesses of the team?

Yes
No (please explain)

4. Do you feel that the PET will provide an aid to the evaluation of "quality assurance" within your area of responsibility in the MTF?

Yes
No (please explain)

5. Please provide any comments you would like about the PET and its use.

HSC Form 384 R (One-Time)(DCSPER)
1 Jul 81

CHILD PROTECTION AND CASE MANAGEMENT TEAM PERFORMANCE EVALUATION TOOL (CPCMT PET)

Purpose. The CPCMT PET provides each CPCMT with a self-assessment tool. This tool was validated through consensus of Army CPCMT leaders.

Scores. A team's total CPCMT PET score is the sum of organization, function, and administration points. A "yes" answer to each organization item yields 5 points, a "yes" answer to each function item yields 4 points; a "yes" answer to each administration item yields 3 points.

Summary	Points
Organization	_____/30
Function	_____/40
Administration	_____/30
	_____/100

ORGANIZATION

	Yes	No
1. Interdisciplinary Mix. The team has a complete interdisciplinary composition according to the available professional resources.	___(5)	___(0)
2. Written Directive. There are one or more local written directives (e.g., SOP, MTF regulation, post regulation) establishing the CPCMT and describing its function.	___(5)	___(0)
3. Team Minutes. Minutes of team meetings are authenticated by an appropriate authority and maintained properly.	___(5)	___(0)
4. Leadership. Formal team leadership is established (e.g., chairperson, coordinator, alternates).	___(5)	___(0)
5. Civilian Agencies. A satisfactory working liaison is established with local civilian child protection agencies.	___(5)	___(0)
6. Team Point-of-Contact. A well-publicized point-of-contact for information and case-reporting is named.	___(5)	___(0)

Organization Total Pts = _____

FUNCTION

	Yes	No
1. Case Record. There is a case record for every case handled by the team.	___(4)	___(0)
2. Central Registry. Each case that meets the established guidelines is reported to the Army Child Maltreatment Central Registry (Ft Sam Houston, TX).	___(4)	___(0)
3. Treatment Plan. A treatment plan is developed for each case and is part of the CPCMT case record.	___(4)	___(0)
4. Case Manager. A case manager is appointed for every case.	___(4)	___(0)
5. Case Revision and Update. There are established procedures for revising and updating cases periodically.	___(4)	___(0)
6. Initial Medical Exam. There are guidelines for use by medical personnel in their initial examination of the child (e.g., whom to contact).	___(4)	___(0)
7. Psychosocial Assessment. There are guidelines for use by behavioral science personnel in their assessment of the child and family.	___(4)	___(0)
8. Home Visit. There are guidelines for use by community health nursing personnel, if in-the-home assessment and therapeutic intervention is required.	___(4)	___(0)
9. ACAP Officer and Command. There are procedures which define and enhance the relations among the team, the ACAP officer, and the post commander.	___(4)	___(0)
10. Local/State Registries. Requirements for reporting cases to local and state registries are met.	___(4)	___(0)

Function Total Points = _____

ADMINISTRATION

	Yes	No
1. Military Community Support. In general, the military community and agencies support the CPCMT effort.	___(3)	___(0)
2. Civilian Community Support. In general, the civilian community and agencies support the CPCMT effort.	___(3)	___(0)
3. Case Transfer. The team adheres to established procedures for transferring cases to and from other CPCMT's.	___(3)	___(0)
4. Clerical Support. The team receives adequate and dependable clerical support.	___(3)	___(0)
5. Orientation. All newly-assigned commanders, staff, and military community members receive adequate orientation to the CPCMT effort.	___(3)	___(0)
6. Prevention. There is a post-wide child maltreatment prevention and awareness project.	___(3)	___(0)
7. Responsiveness. There are procedures which ensure timely response to case report sources.	___(3)	___(0)
8. Training. New CPCMT members receive adequate local training, and experienced members have access to continuing education.	___(3)	___(0)
9. Consumer Evaluation. When possible, evaluation of the effectiveness of the intervention is solicited from the child, the sponsor, and the maltreator.	___(3)	___(0)
10. Performance Evaluation. There are procedures used by the team to assess its performance and effectiveness periodically.	___(3)	___(0)

Administration Total Points = _____

APPENDIX E

Responses to First Iteration

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst Ca
	(Circle One)					
I. ORGANIZATION						
a. Team Structure						
1. Interdisciplinary mix	5	4	3	2	1	8-10 Separate Disciplines ---------- ---------One Discipline
	30	7				
2. Defined written responsibilities (MTF Regulation, SOP)	5	4	3	2	1	Specified Duties ---------- No Defined Guidance
	25	10	1	1		
3. Formal professional staff training & credentialing process	5	4	3	2	1	Mandatory on-going training ---------- No training
	12	15	5	2	2	
4. Full compliance with AR 608-1	5	4	3	2	1	Full Compliance ----------Less than Full
	18	14	2	3		
5. Formal liaison to ACAP	5	4	3	2	1	Full Cooperation ---------- None
	21	15	1			
b. Team Process						
1. Record keeping (team minutes)	5	4	3	2	1	Secured Detailed Records ---------- No Records (including photo copies of medical records & on going interactions)
	31	6	1			

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst Case
	(Circle One)					
b. Team Process (Continued)						
2. Formal leadership (chairperson and coordinator)	5 30	4 7	3	2	1	Designated leaders ---------- Not Designated
3. Coordinator of investigation and treatment	5 31	4 7	3 1	2 1	1	Individual Coordinator with mechanism for periodic review ---------- No formal plan of intake
4. Liaison with civilian child protective agencies	5 34	4 3	3	2	1	Full cooperation with civilian agency representation as full team member ---------- No cooperation
5. Liaison with civilian court system and law enforcement	5 26	4 8	3 2	2	1	Regular cooperation with good understanding between team and local court and law enforcement ---------- No cooperation
C. Team Attitude						
1. Member satisfaction (attitude check)	5 7	4 14	3 9	2 3	1	Formal means to evaluate member attitude ---------- No means

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
c. Team Attitude (Continued)						
2. Avoidance of "burnout"	5 12	4 14	3 9	2	1	Procedures established to help avoid burnout ---------- No Procedures
II. CASE DEVELOPMENT						
Case Structure						
1. Sources of reported cases (outside team)	5 22	4 11	3 3	2 1	1	Established network ---------- No network
2. Sources of reported cases (inside team)	5 22	4 12	3 1	2	1	Established network ---------- No network
3. Confidentiality	5 27	4 10	3 1	2	1	Rigid Procedures ---------- Lax Strictly protected Not protected
4. Availability of point-of-contact for reporting cases & for info	5 30	4 6	3 1	2	1	Well Publicized ----------Not well known

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
			(Circle One)			
b. Case Processing						
1. Initial assessment of suspicion	5 18	4 15	3 1	2 2	1 2	All cases screened by M.D. social worker & community health nurse prior to acceptance as case ---------- Assessment primarily made on basis of record review, only, or hearsay
2. Medical examination	5 23	4 13	3 1	2 1	1	Promptly done by M.D. (pediatrician) in all cases ---------- Delayed or done by non-MD
3. Police investigation	5 10	4 20	3 3	2 3	1	Coordinated with team ---------- Refused to investigate
4. Psychosocial assessment	5 26	4 9	3 1	2	1	Regular part of family evaluation ---------- Not utilized
5. Community health nurse home visit	5 15	4 13	3 5	2 4	1	Each home visited ---------- Not used

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
6. Local/state registry inquiry	5 18	4 8	3 5	2 3	1 2	Each case/suspected case checked ---------- Never used
7. US Army Central Registyr inquiry	5 15	4 15	3 3	2 2	1 2	Each case suspected case checked ---------- Never used
8. Filing report to local/state registry	5 21	4 12	3 3	2 2	1	All state laws followed ---------- Cases not reported Good rapport maintained
9. Filing report to Central Registry	5 17	4 12	3 3	2 4	1 2	All cases (promptly) ---------- None
10. Maintenance of medical record	5 22	4 12	3 2	2 2	1	Protected record maintained ---------- Records incomplete or not protected w/copies of lab work, x-ray and consultations
11. Maintenance of CPCMT record	5 28	4 10	3	2	1	Complete medical, social, psychological and photographic documents in secure records ---------- Not maintained
					5	

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
12. Development of treatment plan	5	4	3	2	1	Multispeciality treatment ----------No specific treatment plan established for all cases ment plan
	26	10	1			
13. Appointment of case manager for each case	5	4	3	2	1	Each case has individual manager ----------None
	24	10	2	1		
14. Periodic update of treatment plan	5	4	3	2	1	Treatment plan reviewed at least ----------Not reviewed monthly by case managers
	21	10		2		
15. Post-mortem psycho/social/medical autopsy on active cases	5	4	3	2	1	Conducted ---------- Not conducted
	19	8	8		1	
c. Case Attitude						
1. Child's reaction to intervention	5	4	3	2	1	Child's emotional well-being ----------No special attention given to child's well-being enhanced by support provided
	20	6	4	5		

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst
	(Circle One)					
2. Parental/caretaker reaction to intervention	5 17	4 11	3 3	2 5	1	Parent/caretaker become active participant ---------- Alienation
3. Siblings' reaction to intervention	5 10	4 18	3 3	2 6	1	Active program conducted to ensure sibling understand & are supported through crisis ---------- No care given to siblings
III ADMINISTRATION						
a. Structure						
1. Interaction and support from military activities	5 22	4 14	3	2	1	Active participation ---------- None
2. Interaction and support from civilian activities	5 23	4 13	3	2	1	Active participation ---------- None
3. Case transfer written procedures	5 20	4 14	3 2	2 1	1	Proper procedures followed (cases transferred but "not closed" until written acceptance from gaining unit received) ---------- Transfer not done in timely manner

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best Case ---------- Worst Case
			(Circle One)			
4. Clerical support for team	5 25	4 11	3 3	2	1	Priority clerical support provided ---------- No clerical support (forced on board members or "farmed" out)
b. Process						
1. Orientation of new community personnel	5 17	4 13	3 1	2 4	1 1	Child advocacy is integral part of post orientation ---------- Not included
2. Continuing education of community personnel	5 14	4 16	3 2	2 3	1	Periodic public relations (articles published) ---------- Not conducted Periodic followup orientations conducted
3. Publicity of results	5 12	4 14	3 5	2 5	1 1	Commanders (at all echelons) kept informed of program effectiveness ---------- None
4. Rapid responses to reports from sources	5 24	4 12	3	2 3	1	All cases evaluated within 24 hours ---------- More than 24 hr on followup
					8	

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own)
			(Circle One)			Best Case ---------- Worst
5. Source feedback	5	4	3	2	1	Regular feedback to sources that case was valid or invalid ---------- Excessive delay or no feedback
	12	13	5	7		
6. Mother-child bonding assessment	5	4	3	2	1	Active program in obstetrics/new born nursery ---------- No program
	19	12	5		1	
7. Community Awareness	5	4	3	2	1	Community regularly informed of team and its functions ---------- No awareness of team
	17	17	3			
8. Resolving federal-state jurisdictional matters	5	4	3	2	1	Clear rigid agreement between post/ civilian authorities (if needed) ---------- Inactive
	25	8	3		1	
c. Administrative Attitudes						
1. Satisfaction of installation with team	5	4	3	2	1	Satisfied ---------- Dissatisfied
	15	14	5	1	1	
2. Satisfaction of MTF with team	5	4	3	2	1	Satisfied ---------- Dissatisfied
	19	16	3			
					9	

CRITERION	This item should be a criterion in judging a CPCMT's effectiveness: Strongly Agree 5	Agree 4	No Opinion 3	Dis-agree 2	Strongly Disagree 1	PROPOSED STANDARDS (If you do not agree with proposed standards then enter your own) Best ---------- Worst
	(Circle One)					
J. Satisfaction of CPCMT with its results	5	4	3	2	1	Satisfied ----------Dissatisfied
	20	13	2			
I. Satisfaction of local community with team	5	4	3	2	1	Satisfied ----------Dissatisfied
	14	14	5			

10

APPENDIX F

Responses to Second Iteration

RESPONSES TO SECOND ITERATION

As part of the second iteration of the modified Delphi Technique, respondents were asked the following five questions:

1. Overall, do you feel that the PET will accomplish its objective (i.e. providing an appraisal of the operations and functions of a CPCMT)?

2. When completed, will the PET support your estimation of your team's performance?

3. Do you feel that the PET, when used by an individual upon assuming Chairmanship of a CPCMT, will provide initial insight into the strengths and weaknesses of the team?

4. Do you feel that the PET will provide an aid to the evaluation of "quality assurance" within your area of responsibility in the MTF?

5. Please provide any comments you would like about the PET and its use.

Below is a compilation of the responses. The numbers refer to labels given randomly to each returned questionnaire.

Question 1:

OVERALL, DO YOU FEEL THAT THE PET WILL ACCOMPLISH ITS OBJECTIVE (i.e. PROVIDING AN APPRAISAL OF THE OPERATIONS AND FUNCTIONS OF A CPCMT)?

YES - 24 Responses

NO - 1 Response

SOMEWHAT - 3 Responses

17 - All questions too general in nature.

26 - No instrument this simple can accurately apprise the functioning of all the diverse and unique CPCMTs.

30 - It will be a guideline, however, much is still subjective, e.g. "satisfactory," "in general," "when possible," etc.

29 - Need objective criteria for the measurement - define terms. Examples: Under organization, what is (1) "complete interdisciplinary composition" and (5) "satisfactory working liaison", and under administration, what is (2) "support of CPCMT effort" and (8) "adequate local training"?

31A- It is ideal and very well done.

31B- There may be procedures and guidelines in effect which I am not familiar with. PET does not allow room for comment/feedback.

Question 2:

WHEN COMPLETED, WILL THE PET SUPPORT YOUR ESTIMATION OF YOUR TEAM'S PERFORMANCE?

YES - 24 Responses

NO - 4 Responses

5 - Safety of the child must be insured. Some administrative and function category items, while being important, must be set aside at small installations with limited resources in order to insure time and energy to take care of the dangerous family situation. Some criteria may hinder direct care.

15 - Under "function" item 3-8 seems to make an assumption that the CPCMT is also the treatment provider. If the CPCMT is the treatment provider, then these points are an adequate measure of functioning. In the case where the CPCMT provides referral and coordination with treatment providers, then functions 3-8 are activities of the treatment provider and not the CPCMT.

17 - Anyone could answer most questions with a "yes" - The way the questions are written - as a result some will be misled into a sense of self satisfaction.

29 - It would depend on person completing it because of subjectivity.

31A- No doubt about this.

31B- Gives a better idea of what to look for.

31D- For the most part.

Question 3:

DO YOU FEEL THAT THE PET, WHEN USED BY AN INDIVIDUAL UPON ASSUMING CHAIRMANSHIP OF A CPCMT, WILL PROVIDE INITIAL INSIGHT INTO THE STRENGTHS AND WEAKNESSES OF THE TEAM?

YES - 27 Responses

NO - 1 Response

17 - It would have been nice to know some of these areas of consideration when first assigned to the team.

29 - Same as 1 and 2.

31A- Definitely

31B- Probably, still doesn't have an area for correction of deficiencies which may or may not exist.

Question 4:

DO YOU FEEL THAT THE PET WILL PROVIDE AN AID TO THE EVALUATION OF "QUALITY ASSURANCE" WITHIN YOUR AREA OF RESPONSIBILITY IN THE MTF?

YES - 25 Responses

NO - 3 Responses

8 - I have some concern RE: quality assurance. There is no doubt in my mind that this evaluation will provide for administrative clarity. However, if it becomes a tool of an IG or inspector it can provide overworked case managers and chairmen with just another "administrative" headache. In my case, I feel that our CPCMT is in compliance with 95% of the PET criteria. However, If I were to be faced with an inspector who was using the tool to evaluate our CPCMT, I will find myself dealing more with the administration of the program and less with quality assurance. Otherwise, it is a fine tool. It provides an adequate checklist to measure one's program against.

17 - I am not certain.

21 - Not necessarily. For example, not only is it necessary to know if there are guidelines (i.e. item 7, Function), but also <u>whether or not they are observed</u>.

29 - Same as 1 and 2.

31A- Definitely

31B- Should be helpful, perhaps not the sole evaluation criteria.

31D- However perhaps under title "Function" more emphasis on Drug/ETOH assessments.

Question 5:

PLEASE PROVIDE ANY COMMENTS YOU WOULD LIKE ABOUT THE PET AND ITS USE.

WITH COMMENTS - 16

WITHOUT COMMENTS - 12

2 - It looks good to me. Have you come up with any figure less than 100 that would indicate an acceptable program? Or will this ever be used for anything other than a self evaluation tool?

6 - Long overdue inter-committee coordinating tool. Essential. (Addendum: our CPCMT would fare well).

9 - I am very pleased with the content and format of the PET. It seems to reflect the input I have in Feb 81. Thank you for your efforts.

11 - Care should be taken to insure that the PET remains an aid - an instrument - not become a rigidly applied yardstick.

13 - The PET is well-organized & easy to understand. It should be a useful tool for evaluating each CPCMT.

14 - I agree with the PET as it stands. No additional comments.

15 - The PET needs to be augmented with some type of procedure or operations manual for the CPCMT functions which takes into account the variety of installation implementation methods. Also consideration of CPCMT functioning as impacted by interlocking jurisdiction with Civilian Social Services Agencies is necessary.

16 - The system will have subjective findings if each CPCMT does its own rating and this may have to be addressed in the future.

17 - Perhaps PET could have been written with answers such as: Always (5), Most Always (4), Sometimes (3), Seldom (2), None of the time (1). When adding these scores - if honest - a more true eval would be obtained.

20 - Only two comments from our CPCMT: (1) (From JAG) Suggest looking at AR 608-1 to insure all regulatory requirements of CPCMT operations are accounted for in the PET. That way it will be a checklist for legal sufficiency of CPCMT actions. (2) (From Community Health Nurse) The PET should be most effective if respondents are honest.

21 - Recommend addition of a 4th major category, "Outcome," which would elaborate upon items 9 and 10 (Admin) and would receive increased point values. Also a mechanism is needed, Army-wide, by which longitudinal studies can be done on children seen by CPCMT's and the effectiveness of CPCMT intervention assessed.

Question 5 (CONT)

PLEASE PROVIDE ANY COMMENTS YOU WOULD LIKE ABOUT THE PET AND ITS USE.

23 - It is predictable that PET may soon reveal CPCMT membership finding it more difficult to administer program. Each member is double hatted and case finding/load increases to point of full time demands. This will result in burnout, denial of service to valid cases and lack of accurate reporting.

24 - Excellent Tool.

25 - 1) I would caution any one thing,[sic], i.e. PET, that has multiple uses, i.e. internal control (chairman), external control (ICAH) and establishing policy (regulation). Would prefer broad guidelines (external) and specific guidelines (internal) as each post has many variables worth considering of which personalities of CPCMT members should not be an area for apology. Such things as mission, staffing, community support, would also lend credibility to broad external guidelines.

2) PET as advertised (note purpose, this PET) is a self assessment (internal) tool. Responses may have been different if it were advertised as setting policy (external).

26 - It may help unify the approaches used by various CPCMTs currently functioning.

29 - Would prefer the PET to be more clearly and objectively defined with simple yes and no answers. Total scores are meaningless - the individual negative answers are significant!

30 - Should be a good tool.

31A- a) Reverse the weightings: function - 5 pts each item (THIS IS CLEARLY MOST CRITICAL); organization - 4 pts each item or 3 pts; administration - 3 pts each item or 4 pts.

b) Replace items 1 and 2 in Admin section as recommended on last page

31B- Shows areas to improve.

31C- The PET should be presented to officials in responsible positions and who could contribute objective feedback to CPCMT chairperson (and create more interest and support). e.g. Post Commander, Hospital Commander, Post Chaplain. If this procedure is adopted, I recommend adding response choice "Not in position to Know" or "Don't Know."

31D- A workable tool

10. DISTRIBUTION LIST:

Headquarters, Health Services Command, ATTN: HSPE-H

Academy of Health Sciences, ATTN: HSHA-IBS

HQDA (DASG-HCD-D) (1)

Defense Documentation Center (2)

Director, Joint Medical Library, Offices of The Surgeons General, USA/USAF (1)