Improving Provider Knowledge of School Accommodations and Confidence When Educating Families: A Quality Improvement Project

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Doctoral of Nursing Practice Final Project

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This paper is submitted in partial fulfillment of the requirements for

the Doctor of Nursing Practice degree.

Abstract

Mental health is a growing concern for youth and can impact multiple areas of their lives, including the academic setting. Psychiatric providers are one of the first point-of-contacts for these children, providing them with an opportunity to support their patients in obtaining appropriate school accommodations. However, the literature suggests that providers lack knowledge of education legislation and confidence in educating patients on school accommodations. This QI project responds to these deficits by proposing interventions that improve provider knowledge and serve as a tool to improve confidence when educating patients. The interventions include an educational video on school accommodations and the provider's role in helping their patients with accessing those academic supports, as well as an educational brochure that providers distributed to patients with details on types of school accommodations. The results indicate the educational video was an effective way to increase provider knowledge, with significant increases in scores from pre- to post-survey responses. The brochure is also a tool that improved providers confidence and was used when educating patients, with an increase in brochure distribution throughout the project. This QI project demonstrates there is a deficit in provider knowledge and confidence that can be addressed through educational interventions. Further iterations of this project could focus on strategies to improve the brochure for better integration into practice or track the impact these interventions have on patients' ability to then access accommodations.

Keywords: school accommodation, 504 accommodation plan, Section 504, Individualized Education Plan (IEP), Individuals with Disabilities Education Act (IDEA), provider education, provider role in academic supports, special education, mental health in schools

Improving Provider Knowledge of School Accommodations and Confidence When Educating Families: A Quality Improvement Project

The number of school-aged youth with mental health concerns is on the rise. The most commonly diagnosed mental disorders in children ages 3-17 include attention-deficit/hyperactivity disorder (ADHD) (9.8%), anxiety (9.4%), behavior problems (8.9%), and depression (4.4%) (Centers for Disease Control and Prevention [CDC], 2023). In 2016, 17.4% of children ages 2-8 were diagnosed with a mental, behavioral, or developmental disorder, indicating mental health needs at a young age. Approximately 78% of children with depression receive treatment by a mental health professional, along with 59% with anxiety and 53% with behavior disorders (CDC, 2023). Students may experience academic challenges related to their mental health, leading to behavioral challenges, chronic absenteeism, and disciplinary actions from the school (Kardona & Neas, 2021; Oregon Department of Education, n.d.).

There are two important pieces of legislation protecting the rights of children with psychiatric disorders to receive accommodations at school: Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Act (IDEA) of 1990 (Walter & Berkovitz, 2005). Both legislations cover a wide range of disabilities, including mental health disorders, such as ADHD, behavioral problems, and anxiety (Jacoby, n.d.). By partnering with their patients, providers can support their patients' educational experiences (Walter & Berkovitz, 2005). The Journal of the American Academy of Child and Adolescent Psychiatry's (JAACAP) recommends that providers be knowledgeable over legislation that protects the educational rights of students with mental disabilities and how legislation can vary between local, state, and federal laws. JAACAP encourages psychiatrists to advise schools and parents about accommodations, special education, and placements for children with mental disabilities. Since a high percentage of youth with psychiatric disorders seek care from mental health professionals, it is imperative these mental health providers understand the laws so they may better guide patients on how to utilize services for receiving accommodations for their in-school needs (Walter & Berkovitz,

2005). However, providers experience barriers of a lack of legislative knowledge and an unfamiliarity with processes for obtaining school accommodations. Consequently, providers lack confidence in educating and supporting school-aged patients that qualify for additional academic support (Stransky, 2024).

Literature Review

The literature identifies three prominent themes: parents' knowledge about resources and processes to obtain school accommodations, parents' collaboration with the schools, and the provider's role in providing education to families about accommodations.

Although many parents identified concerns with their child's education, 63% had not had their child formally tested for learning problems and 55% did not have a 504 plan or IEP in place for their child (Hocking, 2018). Parents described difficulties in not knowing how to start the accommodations process with the school (Stransky, 2024). The terminology associated with special education is complex, making it difficult to advocate for their children's needs and leading to increased stress for the parents (Stransky, 2024; Rossetti et al., 2021).

Parents also struggle to coordinate with schools to obtain necessary information about special education resources and make progress on implementing service plans for their children (Lu et al., 2022; Rossetti et al., 2021; Stransky, 2024). Families feel the advocacy for their child is ignored by the school, describing the school's response as adversarial (Rossetti et al., 2021).

Health care providers play are essential in educating families on special education services and how to acquire them (Walter & Berkovitz, 2005). Parents of children who receive treatment by a mental health professional commonly look to the psychiatric provider for recommendations on how to receive school-based accommodations for their child (Walter & Berkovitz, 2005). Providers must improve communication with parents regarding appropriate education services, as well as increase the resources provided to parents of children with ADHD. Providers must also increase screenings of education needs

and improve their coordination of care with schools concerning the children's academic needs (Bisset et al., 2023; Hocking, 2018). However, providers have identified barriers, including not receiving adequate training on special education resources, not having sufficient knowledge about school accommodations, and not having enough time in appointments to fully address educational concerns (Stransky, 2024).

Rationale

A root cause analysis of the clinic identified a gap in provider comfort when educating families about accommodations at schools for children with psychiatric disorders, aligning with barriers identified by providers in the literature review. The Institute for Healthcare Improvement (IHI) Model for improvement framework was used for this quality improvement (QI) project, utilizing the Plan-Do-Study-Act (PDSA) cycle to trial and adapt interventions to achieve the desired improvement goal (Institute for Healthcare Improvement [IHI], n.d.). The IHI Model for improvement was chosen since it is a low-cost method that has been used to promote change in multiple healthcare settings. Additionally, the PDSA cycle model can guide changes to the project interventions throughout its course (IHI, n.d.).

Specific Aim

By February 6th, 2025, participating providers at the clinic will exhibit improved proficiency and comfort in educating about school accommodations through a 25% increase from pre- to post-survey scores.

Methods

Context

The project site was a child and family outpatient psychiatric clinic serving clients of all ages: school-aged youth to older adults. The clinic has two urban settings in Oregon and offers both in-person and virtual appointments, allowing it to provide psychiatric care to a larger geographical region of the state. The clinic accepts both private insurances and self-pay for mental health care services. The clinical team consists of 7 doctors, 8 psychiatric mental health nurse practitioners (PMHNP), and 4 therapists.

The patient population fluctuates depending on the age ranges that providers primarily treat. There are fewer providers that will treat patients under 12 years old, reflected in the patient population age breakdown. Approximately 39% of the patient population is under 18 years old, with 75% from ages 12-17 and 25% under the age of 12. The clinic treats a wide range of diagnoses, with many patients having more than one diagnosis. The most common diagnoses for patients under age 18 are ADHD, anxiety, and depression.

There is not data available on how many patients at the clinic currently have an IEP or Section 504 plan in place. However, in Oregon, it was estimated that 15.1% of students had an IEP in the 2020-21 school year, along with 3.6% of students with a Section 504 plan (Jacoby, n.d.). The clinic has no policies or procedures related to educating patients and their families on their educational rights. Providers are responsible for educating families to the best of their abilities, despite receiving no formalized training or education about academic legislations. Providers frequently struggle with explaining the complexity of these accommodations to patients, especially in the limited time they have during an appointment.

Intervention

The participation in this QI project was limited to the 8 PMHNPs at the clinic, with the option to expand the use of these interventions to the other mental health providers at the clinic based on the perceived usefulness of the project. The PMHNPs are referred to as NPs throughout this paper. The first intervention was an 18-minute education video addressing the differences between Section 504 plans and IEPs, the process of obtaining school accommodations, and how providers can play a role in helping families obtain these accommodations. The NPs received this education during their scheduled weekly meeting, ensuring maximum participation and engagement. Three NPs were unable to attend the meeting but were provided the education video to review independently. The presentation materials were distributed to all NPs for their reference throughout the project. A pre-survey was distributed

before the education video and a post-survey was distributed after the video. The second intervention was an educational brochure for the NPs to distribute to families when educating on school accommodations (Appendix E). The NPs independently tracked their brochure distribution each PDSA cycle. The brochure featured a QR code for families to scan and provide feedback on the brochure's perceived usefulness. A follow-up survey was distributed to all NPs at the end of each PDSA cycle, and the brochure was updated to reflect feedback received. Feedback from PDSA cycle 1 determined a virtual option of the brochure would be beneficial, as many of the providers see patients via telehealth, so the brochure was distributed to all NPs virtually at the start of PDSA cycle 2. Feedback from PDSA cycle 2 revealed that providers would find examples of accommodations and letters parents can use to request evaluations at schools to be helpful additional resources. At the start of PDSA cycle 3, resources regarding examples of accommodations and letters for schools were distributed to the NPs to review independently. Feedback from PDSA cycle 3 indicated continued barriers to distribution, mostly related to workflow, which was relayed to the clinic since the project concluded after this cycle. After the project concluded, the QR code feedback survey was changed to a QR code linking to the resource with examples of accommodations that NPs were provided during the project. The clinic was provided a digital copy of the education video and brochure to then distribute to the other providers at the clinic so they may continue implementing the interventions.

Study of Intervention

The study of this intervention included a pre-survey before the education video and a post-survey after the education to measure the NPs' knowledge of school accommodations and confidence in providing education to families about accommodations (Appendix F). The survey included 6 confidence statements reflecting the objectives of the education video, measured using a Likert scale. The brochures were created following recommendations from the CDC Simply Put guide for creating educational materials for patients (CDC, 2010). The brochures were printed and distributed to the NPs

for use at the beginning of the project, and then they were provided virtually via email at the start of PDSA cycle 2. At the end of each PDSA cycle, follow-up surveys were distributed; these surveys included 4 confidence statements measured by a Likert scale related to comfort when using the brochure and educating families and 2 open-ended questions about changes needed to the brochure and reasons the brochure wasn't used (Appendix F). Printed copies of surveys were distributed to NPs that attended in-person, and surveys were distributed electronically to NPs who attended virtually or completed the education independently. The QR code linking to a parent feedback survey included 2 questions measured using a Likert scale and 1 open-ended question related to the perceived usefulness of the brochure (Appendix F).

Measures

The primary outcome measure was NP knowledge and confidence in educating families about school accommodations. Data on NP confidence was gathered through the pre-, post-, and follow-up surveys. This measure was used to evaluate if the intervention resulted in positive changes to NP knowledge and confidence. The process measures for this QI project were how often the NPs utilized the educational brochure when providing education to families and qualitative feedback on how helpful the brochure was when educating families. These measures were gathered through NPs tracking the frequency they distributed the brochures and responses to the open-ended questions on the follow-up surveys. Data from the electronic parent feedback surveys on the brochures also helped track the process measures. Balancing measures that were considered include cost and time for creating and distributing the brochures, along with the time needed to discuss the brochures during patient appointments.

Data Analysis

The scores for each question on the pre- and post-survey were averaged, and the overall mean score for the pre- and post-survey was also found. The mean scores per question and overall mean were

depicted in a bar graph with the percent change noted. Data analysis included a Welch's paired t-test for the overall average score and the average score per question for the pre- and post-surveys. The overall average score for the follow up survey was found for PDSA cycle 1, PDSA cycle 2, and PDSA cycle 3 and analyzed using the Welch's paired t-test to compare the change from one PDSA cycle to the next and the change from the first to last cycle. A combination bar-line graph was used to depict changes in frequency of brochures distributed in combination with the number of NPs participating in each PDSA cycle. Common qualitative themes from the open-ended responses on the follow up surveys were analyzed and categorized based similarity, then depicted in a table.

Ethical Considerations

Protected patient health information and identifiable data were not included in the project. The NPs participated in the project on a voluntary basis and were permitted to withdraw at any time. The online survey for parents was voluntary, and the survey did not collect any personal data. The project was submitted to the Oregon Health & Science University's Institutional Review Board and determined to not be research.

Results

At the end of the data collection, 8 NPs participated in the quality improvement project. Out of the 8 NPs, 5 of them completed all 3 PDSA cycles, with 2 NPs joining for the second and third cycle and 1 NP joining for the third cycle. All 8 NPs watched the education video and completed the pre- and post-surveys. Figure 1 depicts an increase in mean scores for each question from the pre- to post-survey, as well as an increase in the overall mean score (Appendix C). There was a 28.7% increase in the overall survey responses, with question 6, having resources to provide families, showing the largest increase in mean score at 85%. A Welch's paired t-test was performed to evaluate the change in the mean pre- and post-survey scores at the 0.05 level of significance (Appendix D, Table 1). Significant differences were

found for question 1 ($p<0.01$), question 2 ($p<0.01$), question 5 ($p=0.02$), and question 6 ($p<0.01$), as well as the overall score ($p<0.01$).

The follow-up surveys at the end of the PDSA cycle did not show a significant improvement from one PDSA cycle to the next, or from the first PDSA cycle to the third (Appendix D, Table 2). Qualitative data was gathered from the open-response section of the follow-up surveys and categorized based on themes and frequency of response (Appendix D, Table 3). The most common theme for why providers were not using the brochure was related to patient population, and the most common theme for suggested changes to the brochure was making a virtual option.

The NPs tracked the number of brochures they each distributed each PDSA cycle. The distributed brochures increased each PDSA cycle at a greater rate than the number of NPs participating in the project increased (Appendix C, Figure 2).

The QR code linking to a survey for parents to provide feedback on the usefulness of the brochure yielded no results due to no survey completions.

Discussion

Summary

This quality improvement project sought to improve psychiatric provider knowledge of school accommodations and confidence in educating families on this topic using interventions of a provider education video and an educational brochure for families. The specific aim was to improve proficiency and comfort in educating about school accommodations through a 25% increase in scores from pre- to post-survey responses. This aim was met by an increase of 27.3% in overall average scores. There was also significant improvement in confidence to 4 of the 6 survey questions. The increase in brochure distribution each PDSA cycle greater than the increase in NP participation also suggests an increase in confidence to educate families.

Interpretation

There was a 27.3% increase in the mean overall scores from the pre-survey responses before the education video to post-survey responses, indicating the NPs felt more confident in their knowledge of school accommodations and discussing them with patients. There was the greatest increase in confidence related to having resources to share with families about accommodations (85%). There were also notable increases in confidence in defining 504 plans and IEPs (28.6%), describing the differences between 504 plans and IEPs (44%), and discussing school accommodation options with families and answering their questions (29.6%). There was the least increase in confidence of recognizing the reasons why children with psychiatric disorders may need education accommodations (2.7%) and identifying when children with psychiatric disorders are eligible for accommodations (5.7%), which appears to be due to the NPs having higher baseline proficiency on these topics in pre-survey. The increase in brochure distribution each month being greater than the increase in NP participation is an indication that the NPs found the brochure to be a useful tool and were increasingly confident in educating families about school accommodations throughout the project.

While the follow-up surveys did not provide significant quantitative data, there was useful qualitative data regarding the brochure usefulness and barriers brochure distribution. The qualitative themes provided guidance for improving the brochure throughout the project. These themes can also be used to make further improvements to the brochure in future iterations of this intervention. The parent feedback survey yielded no responses, indicating increased difficulty obtaining data from patients compared to clinicians during a QI project.

Limitations

Due to the small sample size of 8 NPs who participated by the end of the project and only 5 NPs participating in the project's entirety, generalizability is limited. Participation was also limited to PMHNPs, so it is unclear if these interventions would be effective for other psychiatric providers. The

brochure was unable to be incorporated into the clinic's EHR, making distribution more difficult. Data collection for brochure distribution was limited by the inability to track how often NPs had the opportunity to distribute the brochure but did not do so, limiting the ability to quantify the frequency of brochure in practice. Due to no responses from the parent feedback survey, along with not tracking if patients given the brochure subsequently accessed school accommodations, it is beyond the scope of this project to determine if these interventions led to improvement in students accessing services at schools.

Conclusion

Providers lack confidence in educating patients with psychiatric disorders on available school accommodations due to a lack of knowledge about legislation for educational rights and how to support patients in accessing the appropriate accommodations (Stransky, 2024). This QI project improved provider confidence through interventions of an education video on school accommodations and a supportive tool to use when educating patients, the educational brochure. There were workflow barriers that prevented consistent use of the brochure. Future projects could address strategies for improving assimilation of the brochure into practice or track the impact that interventions have on patients subsequently accessing accommodations in school. Psychiatric providers are typically the first point-of-contact for children with psychiatric disorders, and families frequently look to these providers for guidance on accessing academic supports (Walter & Berkovitz, 2005). Educating psychiatric providers on the educational rights of school-aged patients and supporting providers with educational materials for families can lead to improved provider confidence when navigating how to support their patients in the academic setting.

Resources

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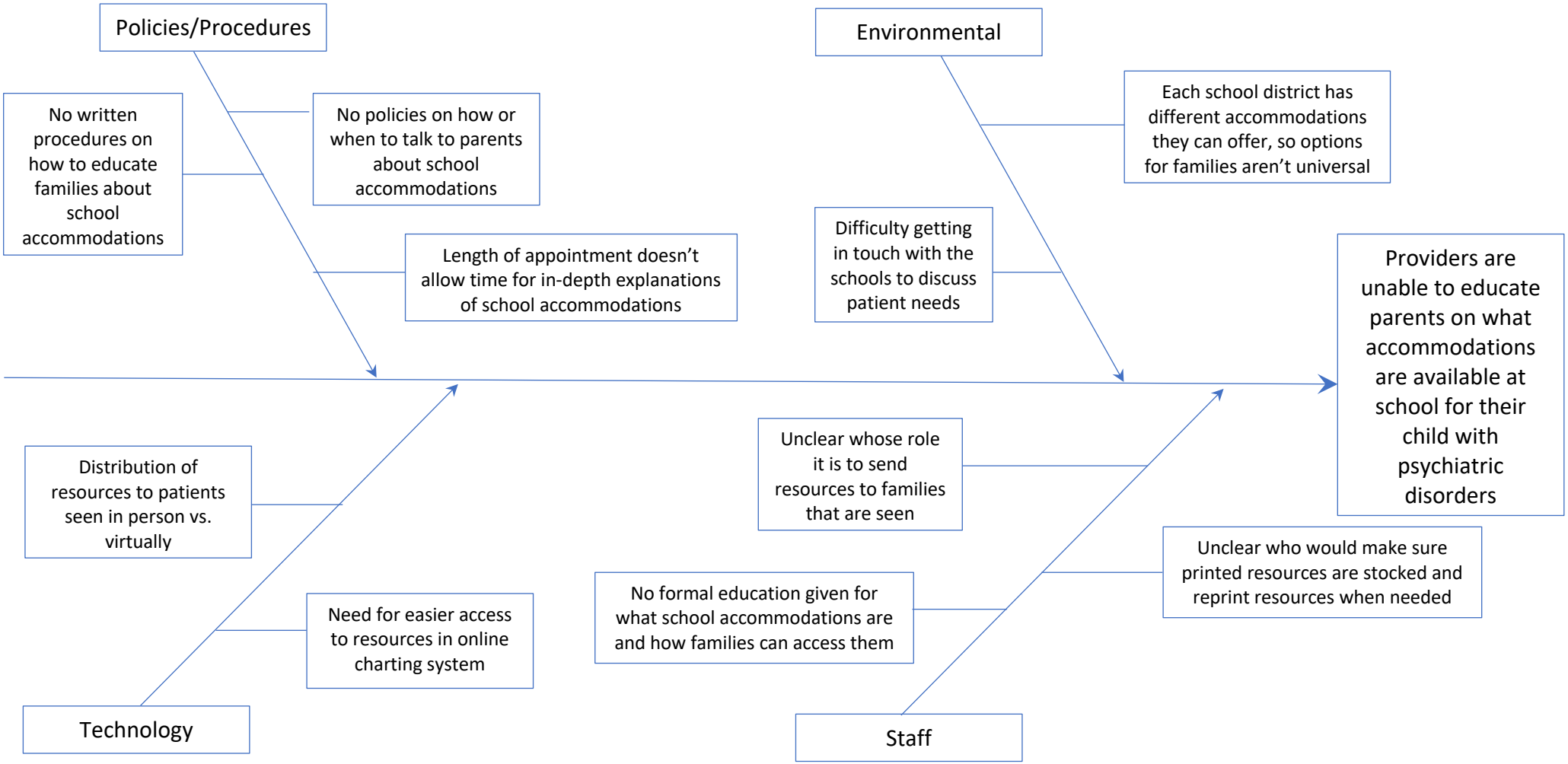
Appendix A

Root-Cause Analysis for Providers Educating Parents on School Accommodations for Their Child



Appendix B

Projected QI Project Timeline

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Finalize project design and approach		X						
Complete IRB determination or approval		X	X					
PDSA Cycle 1				X				
PDSA Cycle 2					X			
PDSA Cycle 3						X		
Final data analysis (703B)							X	
Write sections 13-17 of final paper							X	
Prepare for project dissemination								X

Appendix C

Figure 1

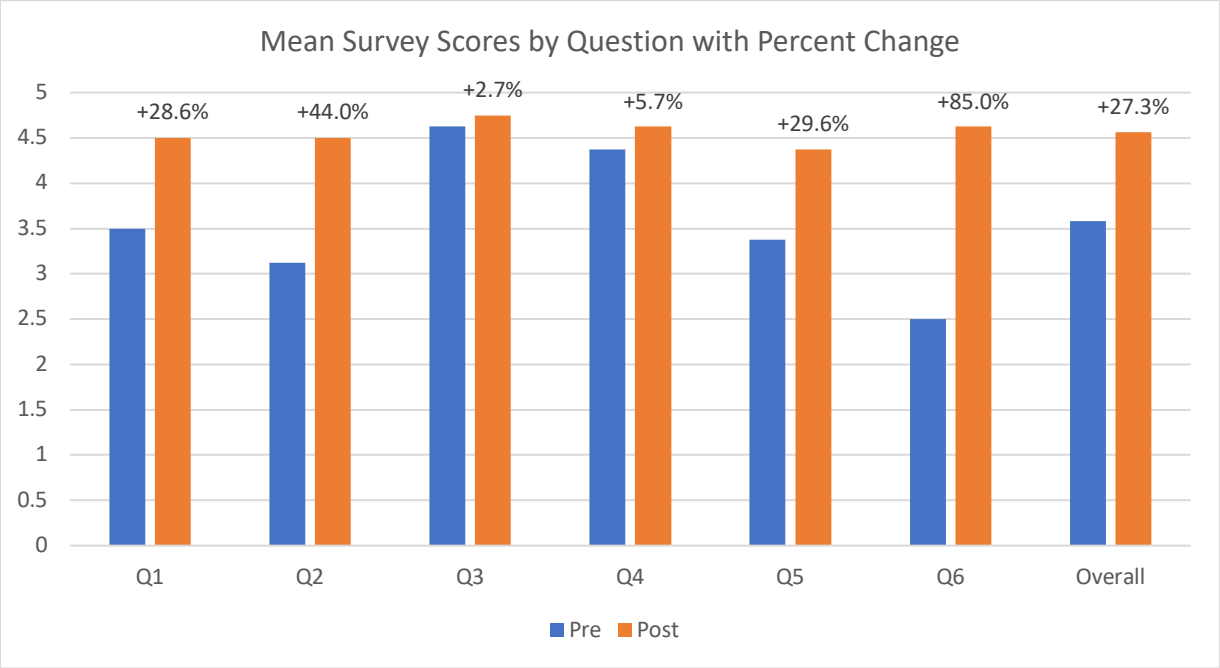
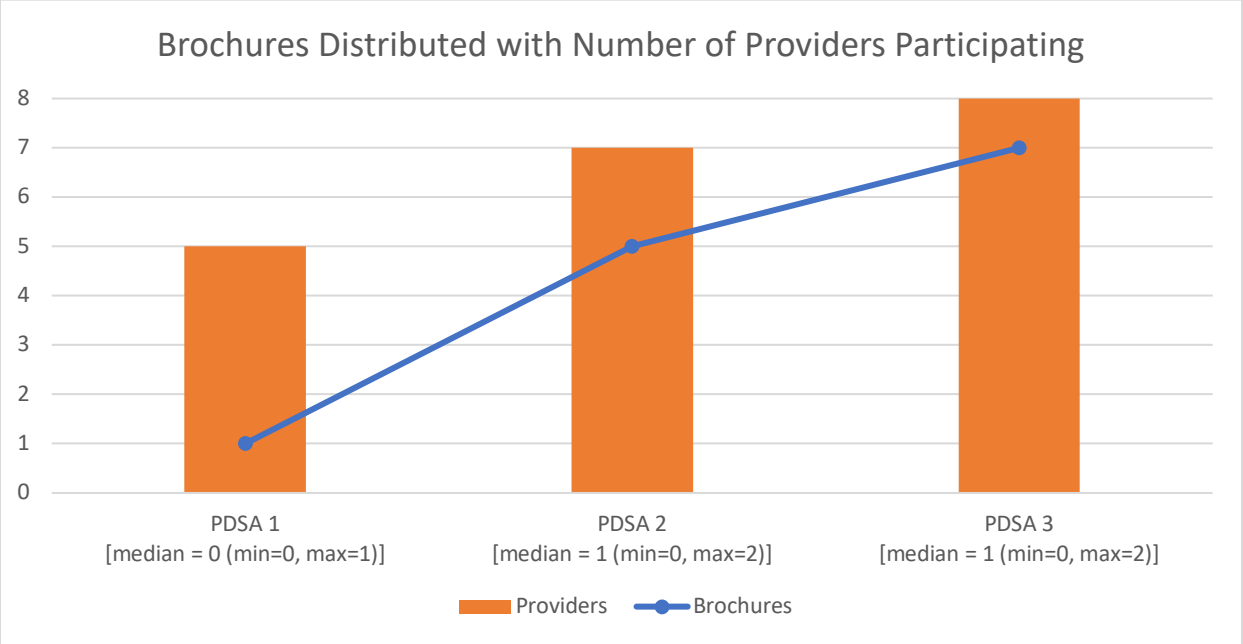


Figure 2



Appendix D

Table 1

	Pre	Post	p-value
Q1	3.5 (0.93)	4.5 (0.53)	< 0.01
Q2	3.13 (1.12)	4.5 (0.53)	< 0.01
Q3	4.63 (0.52)	4.75 (0.46)	0.35
Q4	4.38 (0.52)	4.63 (0.74)	0.35
Q5	3.38 (1.19)	4.38 (0.74)	0.02
Q6	2.5 (1.20)	4.63 (0.52)	<0.01

Welches paired t.test to evaluate if the overall scores are significantly different at (0.05). Values shown include the mean score, with the standard deviation in parentheses.

Table 2

PDSA Cycles	p-value
1 & 2	0.77
2 & 3	0.48
1 & 3	0.55

Welches paired t.test to evaluate if the overall scores are significantly different at (0.05).

Table 3

If you have not been using the brochure, why?

Common Themes	Frequency of Theme	Example Quote from Responses
Patient Population	5	*"Lack of opportunity - no patients in need of this discussion"*
Forgot to Give to Patients	4	*"I had one opportunity and forgot to give it - although I touched on the information"*
Difficult to Distribute During Virtual Appointments	4	*"Hard to use with virtual sessions"*

Patients Already Have Accommodations	2	*"Families already have IEPs or other kids in their families so they are familiar"*
Patient Declined	1	*"Offered to one family who declined"*

Are there any changes that would make the brochure easier to integrate?

Common Themes	Frequency of Theme	Example Quote from Responses
Virtual Option	4	*"Virtual option would be useful"*
Examples of Accommodations	3	*"Details about suggested accommodations"*
Information on Brochure about Disability Law and Qualifications	2	*"Add a blip that a "disability" can be anxiety, ADHD, depression, etc. Disability to the lay person could represent a level parents feel their kids do not qualify for."*
Templated Statements for Parents	1	*"Templated statement for requesting evaluation to school"*
More Practice Using Brochure	1	*"I think I just need more time to practice using it"*

Appendix E

Educational Brochure

Requesting School Accommodations for Your Child

Who To Reach Out To:

Contact your child's school counselor or teacher

What To Ask For:

Make a request ***in writing*** that you would like to meet with the school about your child's educational needs.

Request that the school consider if your child's needs could be supported with a 504 plan or IEP.

Be specific about the academic areas you're concerned about.

Include any supportive documentation you might have (school work, report cards, evaluations).

Resources for Families

Disability Rights Oregon

FACT Oregon

OHSU Oregon Family-to-Family Health Information Center

We would love your feedback!

Scan the QR code to complete our short two-question survey

Special Education & Related Services

In Oregon Public Schools

Information for Parents

Types of School Accommodations

504 Plans

What is it?
A plan for how the school will accommodate a student with a disability so the student can learn alongside their classmates in general education

What law protects this?
Section 504 of the Rehabilitation Act of 1973

Who is eligible?
Students with a disability that significantly impacts a major life function **and** has need for accommodation in the school setting

What does it include?
Accommodations and modifications that the student needs in order to access the **general education curriculum**

IEPs (Individualized Education Programs)

What is it?
A plan for special education and services the school will provide to meet the specific education needs of the student with a disability

What law protects this?
The Individuals with Disabilities Act (IDEA)

Who is eligible?
Students who meet criteria for a disability as defined by IDEA **and** need special services to be successful in school

What does it Include?
An individualized plan for the student that includes **specially designed instruction and services** needed to progress in their education, along with educational and/or functional goals

Preparing to Meet with the School

The Academic Impact
Consider how your child's medical condition is affecting their education.

Start a List
Think about your child's strengths and what is helpful for them. Also write down concerns and questions you want to discuss with the school.

Begin Brainstorming
Brainstorm solutions that you and your child think could be helpful at school. All solutions you brainstorm may not be feasible at your child's school, but it's great to start thinking of ideas early!

Remember that this is a process!
There will likely not be an immediate solution after the first meeting.

Appendix F

Pre/Post Survey

Please identify how strongly you agree or disagree with each statement by circling a number between 1 and 5 where the numbers mean the following:

1: Strongly Disagree 2. Disagree 3. Neither Agree nor Disagree 4. Agree 5. Strongly Agree

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I can define what 504 plans and Individualized Education Plans are.	1	2	3	4	5
I can describe the differences between 504 plans and Individualized Education Plans.	1	2	3	4	5
I can recognize the reasons why children with psychiatric disorders may need educational accommodations.	1	2	3	4	5
I can identify when children with psychiatric disorders are eligible for educational accommodations.	1	2	3	4	5
I can discuss school accommodation options with families and answer questions they have about accommodation options.	1	2	3	4	5
I have resources I can share with families about education accommodations.	1	2	3	4	5

Follow Up Survey

Please identify how strongly you agree or disagree with each statement by circling a number between 1 and 5 where the numbers mean the following:

1: Strongly Disagree 2. Disagree 3. Neither Agree nor Disagree 4. Agree 5. Strongly Agree

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I am comfortable discussing school accommodation options with families.	1	2	3	4	5
I use the brochure when discussing school accommodations with families.	1	2	3	4	5
The brochure is easy to incorporate into my appointments when discussing school accommodations.	1	2	3	4	5
The brochure enhances my ability to educate families on school accommodations.	1	2	3	4	5

If you have not been using the brochure, why?

Are there any changes that would make the brochure easier to integrate into your practice?

Parent Feedback Survey

Please identify how strongly you agree or disagree with each statement by circling a number between 1 and 5 where the numbers mean the following:

1: Strongly Disagree 2. Disagree 3. Neither Agree nor Disagree 4. Agree 5. Strongly Agree

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I found the information in the brochure easy to read and applicable to what I need to know about school accommodations.	1	2	3	4	5
The information in the brochure helped me start the process of obtaining school accommodations for my child.	1	2	3	4	5

If the brochure was not helpful, please explain why: