

Promoting Child Developmental Screening in Michigan

Prepared by
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Authors:

Teresa Holtrop, M.D., FAAP

Michele Strasz, M.P.A



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Introduction and Acknowledgements

Why developmental screening?

In 2006, the American Academy of Pediatrics (AAP) issued a developmental screening policy, *Identifying Infant and Young Children with Developmental Disorders in the Medical Home: an Algorithm for Developmental Surveillance and Screening*¹. The AAP recommends that developmental surveillance be incorporated into every Early and Periodic, Screening, Diagnosis and Testing (EPSDT) visits, (also known as well-child visits). A screening test should be administered at a minimum at the 9, 18, and 24 or 30 month visits. The early identification of developmental problems is followed up with further developmental and medical evaluation, diagnosis, and treatment.

Research has shown that approximately 12-18% of children have developmental delays^{2, 34}. In previous decades, less than 30% of children with a developmental delay were being identified before they entered school⁵. These statistics clearly show the need to improve screening for developmental delays and when children are found with a delay to begin providing interventions and refer to the *Early On* program. Early identification and intervention of developmental delays in young children, particularly of children with mild to moderate delays, is key to ensuring the best possible outcome for these children.

Background and Acknowledgements

As Michigan continues to increase Medicaid beneficiary developmental screening in combination with developing its school readiness strategy, incorporating linkages between well-child visits and school readiness is critical. Over the past few years, the National Academy for State Health Policy and the Commonwealth Fund promoted the AAP's emphasis on formal developmental screening by providing training to states through the Assuring Better Child Health and Development program (ABCD), which emphasizes incorporation of formal developmental screening tools in physicians' clinical work-flow.

The Michigan Department of Community Health (MDCH), Michigan Department of Human Services (DHS) and the Michigan Department of Education (MDE) were fortunate to be able to participate in ABCD with several pediatric practices across the state joining in a learning-collaborative. ABCD became the first of hopefully many projects to be conducted under a new initiative called the Michigan Child Health Improvement Partnership (MI-CHIP). MI-CHIP's goals are to disseminate quality improvement standards to a wide range of pediatric practices across the state through a learning collaborative model in which early adopters inform a broader audience, setting the bar for best practices. This collaborative was designed to create a more effective, comprehensive early learning system to link health care services with early intervention.

In 2009, the Michigan Chapter of the American Academy of Pediatrics (MIAAP) received a contract to increase the spread of child developmental screening by training a number of Michigan practicing pediatric practitioners.

MIAAP was able to train over 110 pediatric providers in Michigan during the 2009 to 2010 contract year timeframe. This project has been successful in not just introducing pediatricians to formal developmental screening tools but also in familiarizing them with early intervention services and support programs in the early childhood community, thus strengthening connections that in many cases had not existed previously. This report summarizes the experience of the MIAAP and the providers that have been trained.

The MIAAP would like to thank the Michigan Department of Community Health, Medical Services Administration (MSA), Early On, Children's Special Health Care Services (CSHCS), and the Michigan State University Institute for Health Care Studies (IHCS) for their support and assistance with this project.

Teresa Holtrop, MD, FAAP, Medical Director

Executive Summary

MSA developed an RFP to fund the spread of the ABCD initiative to train physicians to implement child development screening. The MIAAP applied for the Request for Proposal (RFP) and was awarded the contract in March 2009.

All children benefit from regular developmental screening performed by the physician during an EPSDT well-child visit. The screening process provides valuable feedback to the pediatric provider about the parent's observations of their child's behavior, the concerns of the parent(s), and opens up opportunities to discuss appropriate development, behavior, and parenting skills. The majority of well-child visits are focused on healthy development and not acute care. The developmental screening process lays the foundation for a strong relationship and open communication between the physician and parent, and physician and early intervention network.

The overarching goals of the ABCD project are to:

- Increase developmental screening for Medicaid children
- Early intervention when problems are found
- Improve interaction between the parent, the physician and the *Early-On* Network.

These goals were achieved through provider focused training, which included: information on evidence-based developmental screening tools, how to implement the tool in the office and address clinic flow, how to bill for developmental screens, how to make referrals to early intervention services, and how to facilitate feedback to and from pediatric providers with Early On.

The MIAAP significantly exceeded the number of trainings required by the contract by providing 15 trainings to a total of 51 practices. Over 110 pediatric providers and 66 allied health professionals were trained during the contract period.

The significant outcomes of the project are:

- 1) While practices improved their developmental screening techniques, there is a need for on-going training and technical assistance to utilize evidence-based developmental screening tools at AAP recommended intervals.
- 2) The development of a feedback form for use by physicians when making a referral to Early On, which improved communication about the results of the referral and recommended intervention plan.
- 3) Improved understanding of the developmental tools and how the tools also helped providers identify parents with literacy issues.

History of Developmental Screening Efforts in Michigan

ABCD

ABCD is an initiative launched in 1999, funded by the Commonwealth Fund and administered by the National Academy for State Health Policy (NASHP). ABCD is designed to assist states in improving the delivery of early childhood development service for low-income children and their families.

In January 2007, Michigan participated in the *Setting the Stage for Success* grant funded by Commonwealth to introduce ABCD to physician practices in Michigan. Six pilot practices were recruited to start implementing child development screening. In February 2007, the Michigan Chapter of the American Academy of Pediatrics (MIAAP) received a Community Access to Child Health (CATCH) grant from the American Academy of Pediatrics to focus on developmental screening in Detroit/Wayne County. Five additional practices were recruited. In April 2007, Michigan hosted an ABCD Screening Academy funded by the National Academy for State Health Policy (NASHP), the purpose of which was to help align state governmental policies with the goals and objectives of ABCD.

MDCH was the recipient of an award in 2007 from the Vermont Child Health Improvement Program (VCHIP) to form a sustainable quality improvement collaborative to address health and well-being issues for all infants, children, adolescents, and their families. As a result, a state advisory group of public and private partners formed MI-CHIP. The advisory group included Medicaid, Community Mental Health, Family and Children Services, CSHCS, Part C/*Early On*, DHS, the MIAAP, IHCS, and the University of Michigan Child Health Evaluation and Research Unit (CHEAR). The purpose of MI-CHIP was to improve the quality of care of children. MI-CHIP's goals were to disseminate quality improvement standards to a wide range of pediatric practices across the state through a learning collaborative model in which early adopters inform a broader audience, setting the bar for best practices. Child development screening was chosen as the first project.

Michigan's Assuring Better Child Health and Development Screening Academy

During the pilot phase, 10 of the 11 pediatric practices that had been recruited to participate in the ABCD Screening Academy met regularly to discuss progress and share ideas. The IHCS evaluated ABCD in the Michigan pilot practices as part of the Screening Academy in 2008. IHCS conducted medical record reviews to assess the records for presence of a standardized developmental screen. IHCS looked for abnormal screens and evidence of referrals among those medical records with abnormal screens. All 10 practices were able to successfully implement developmental screens using approved standardized screening tools such as *Ages and Stages*, and attempted to make referrals for further evaluation and treatment to other health care and community partner agencies.

The Evaluation conducted by IHCS identified additional positive outcomes through a focus group discussion with practice providers. Generally, the study found that:

- ▶ Practices appreciated implementing AAP guidelines – utilizing validated developmental screening and improvement in appropriate referrals;
- ▶ Practices improved communication with parents;
- ▶ Practices thought the project was valuable especially as a Quality Improvement (QI) project that enabled them to network with colleagues and health care providers; and
- ▶ Practices were rethinking well-child, preventive care, proactively focusing on behavioral and developmental issues.

The Evaluation identified barriers for implementation of child developmental screening. The practice barriers included:

- ▶ Delays in implementation due to internal planning and implementation procedures in the practice, including lack of support by key staff;
- ▶ Problems billing and receiving reimbursement;
- ▶ An overall lack of knowledge regarding community resources and referral processes; and
- ▶ Inconsistent follow-up including timely assessment and evidence of communication from *Early On* agencies.

The Spread of ABCD in Michigan

It was clear from national research on ABCD that creating an infrastructure to train pediatric providers and provide on-going technical assistance was critical to facilitate the spread of child developmental screening⁶. Based on the success of the ABCD Screening Academy, MDCH developed an RFP in 2009 to fund the spread of ABCD. MIAAP applied for the RFP and was awarded the contract in March 2009.

The Goals of the ABCD Spread in Michigan

The MIAAP set the following goals and objectives for the ABCD Spread in its proposal to MDCH.

- Increase the number of pediatric providers serving Medicaid enrolled children who are conducting standardized developmental screening,
- Early identification of children with potential developmental issues, and
- Timely referral of the children for further evaluation and intervention to community based early intervention services like *Early On*.

Objectives

- Train a minimum of 11 pediatric and family practice sites;
- Provide training on-site for doctors, nurses, administrative and support staff; and
- Partner with MDCH, DHS, MDE, *Early On* Program, and the Early Childhood Investment Corporation (ECIC) to coordinate community referrals.

Methodology

A. Site recruitment/selection-

1. **Pilot Practices:** The MIAAP followed up with the initial 10 pilot practices to determine their needs for additional training and to seek trainers. The MIAAP was able to recruit three of the five pediatric trainers from the initial 10 pilot practices. Four other pilot practices wanted to remain part of the learning community that would grow out of the Spread. None of the practices required additional training.
2. **New Practices:** The MIAAP conducted outreach among its board of directors, the 101 existing Reach Out and Read sites, and the Michigan Academy of Family Physicians to recruit practices for the training. From this recruitment, 20 practices were identified that were initially interested in being trained. After updating MIAAP membership in a Chapter newsletter, additional interest in participating in the training was received.
3. **Medicaid eligibility:** The contract required that Medicaid children be served by this project. MIAAP chose to train practices that served at least 30% Medicaid patients. The vast majority of the practices trained through this contract were Reach Out and Read programs who have the minimum 30% Medicaid population requirement as well. Each practice certified that they met the MIAAP 30% Medicaid threshold in signed letters of agreement.

B. Trainers: Five physicians, including Dr. Teresa Holtrop, the pediatric medical director for the project, were recruited to be trainers. In total four of the trainers were pediatricians and one was a family practice physician. Each participated in a “train the trainer” session conducted by Dr. Holtrop.

C. Training: Research and experience within the AAP has demonstrated that peer to peer on-site training is the most efficient and effective means of training physicians and maintaining fidelity to an evidence-based practice model. With the exception of two trainings at the Henry Ford Health System and one at Memorial Health Care in Shiawassee County, and a webinar with Kids Creek in Traverse City and Mackinac Straits Hospital, the majority of the trainings were conducted on-site.

D. Training Participants - Since the trainings were conducted primarily on-site, the MIAAP encouraged the entire practice to be involved in the training. This helped to gain staff support and facilitate clinic flow. Trainings included physicians, nurse practitioners, physician assistants, medical assistants, administrators, and billing specialists. There were approximately 110 family practice and pediatric physicians, and 66 non-physicians, including Registered Nurses, medical assistants, physician assistants, billing specialists, and office managers.

- E. **AAP CME obtained-** The MIAAP sought joint sponsorship for the training from the AAP to offer Continuing Medical Education credits from the Accreditation Council for Continuing Medical Education (ACCME). One and one half hours of AMA PRA Category 1.5 Credits was provided to each physician and allied health professional.

F. Standardized tool selected

A National Survey of Early Childhood Health conducted in 2000 and published in *Pediatrics* found that when parents were questioned about their child's development, they more frequently reported concerns about social emotional functioning than about physical abilities. (48% Behavior, 45% Speech, 42% Emotional Well-being)⁷. Glascoe and Dworkin, (1995) previously had demonstrated that only 30-40% of parents volunteer concerns if not prompted⁸

Parent-driven child development screening tools have demonstrated improved efficiency and clinic workflow, and improved parental satisfaction in the process.

The MIAAP reviewed a number of standardized screening tools. The MIAAP chose to provide the Ages and Stages Questionnaire 3 (ASQ), published by Brookes Publishing, to each practice. This tool was chosen because 1) it was a parent-driven tool; 2) it was easy to score, 3) there is a tool for every stage of development from two months through five years; and 4) the ASQ is recommended by MDE for use in child care, preschool, and Early On.

However, the use of the ASQ did not preclude the MIAAP from encouraging practices to use multiple standardized screening tools during each visit. For example, the Modified Checklist for Autism in Toddlers (MCHAT) Screening Tool is appropriate to use with the ASQ during the 18-month visit. Also the MIAAP supported practices and individual physicians who chose to use other screening tools such as the PEDS (Parents' Evaluation of Developmental Status).

- G. **Evaluation-** The MIAAP conducted four points of survey and data gathering in the evaluation process, which resulted in:

1. Assisting in the pre-training data based on the type of practice, and the number of providers
2. Assisting in post training survey and goal setting
3. Assisting in the 3-6 month Implementation survey
4. Assisting in the Best Practices webinar to discuss the results of the surveys and gather anecdotal feedback from the practices about implementation.

Furthermore, MIAAP determined that one practice should receive an on-site visit due to the fact that their initial training was conducted via webinar.

Results

a. Training data

Practices that were trained were located in 12 different counties. The counties represented were geographically diverse including one in the Upper Peninsula, one in Northern Michigan, one in the northeast area of Michigan, one in Southwest Michigan, four in Mid-Michigan, with the remaining in Wayne, Oakland, and Macomb counties. The mix of practices included small private practices, one Federally Qualified Health Center, and two Health Systems.

Who were trained:

Table 1 – Training Data

Agency Trained	Number of Practices	Number of Trainings	Number of Physicians
Henry Ford Health System (Wayne, Oakland, Macomb, Washtenaw Counties)	19	2	57
Memorial Health Care (Shiawassee County)	21	1	10
St. Joseph Trinity (Iosco County)	1	1	1
St. Joseph Mercy Adult and Pediatric Medicine (Washtenaw County)	1	1	3
Heritage St. Mary, Grand Rapids (Kent County)	1	1	3
Pediatric and Adolescent Care (Macomb County)	1	1	2
Kids Creek (Grand Traverse County)	1	Webinar/Site Visit	6
Mackinac Straits Hospital Health Clinic-Pediatrics (Mackinac County)	1	Webinar	1
Covenant Community Health Care (Wayne County)	1	1	3
Bronson Rambling Road, Portage (Kalamazoo County)	1	1	6
Drs. Cecilia and Jose Lopez, Burton (Genesee County)	1	1	2

Agency Trained	Number of Practices	Number of Trainings	Number of Physicians
Pediatric Care Lansing PC (Ingham County)	1	1	5
Edgewood Pediatrics, Commerce Township, (Oakland County)	1	1	6
MIAAP “Trained the trainer”	N/A	2	5
Totals	51	15	110

Training Totals to Date:

15 trainings

51 practices

110 physicians

66 non-physicians

b. Post Training Survey

Each practice trained was asked to have their lead physician respond to an online survey within one week of the training to assess the quality of the training, set goals, and to identify barriers. The survey also provided an opportunity to request additional information needed to implement the screening. Of the practices trained, 13 practices responded within one week of their training. Roughly 70% of the respondents were very satisfied with the training provided and felt it would assist them in implementing developmental screening in their practices.

When asked about the survey, 92% of the physicians said they would implement developmental screening; 62% of the physicians wanted more information on *Early On*; and 62% of the physicians wanted more information on other community resources to refer patients.

Practices anticipated a number of barriers in implementation of developmental screening. The identified barriers included:

Consistency in utilization of screening,

Clinic flow issues,

Problems with follow-up and communication with *Early On*,

Lack of time, and

Lack of staffing.

Each practice was asked to set individual goals for the implementation of child developmental screening in their practices, including an improved process for referrals, utilizing the ASQ at 9, 18, and 24-30 months of age, and establishing a billing process.

c. 3- 6 month Implementation Survey

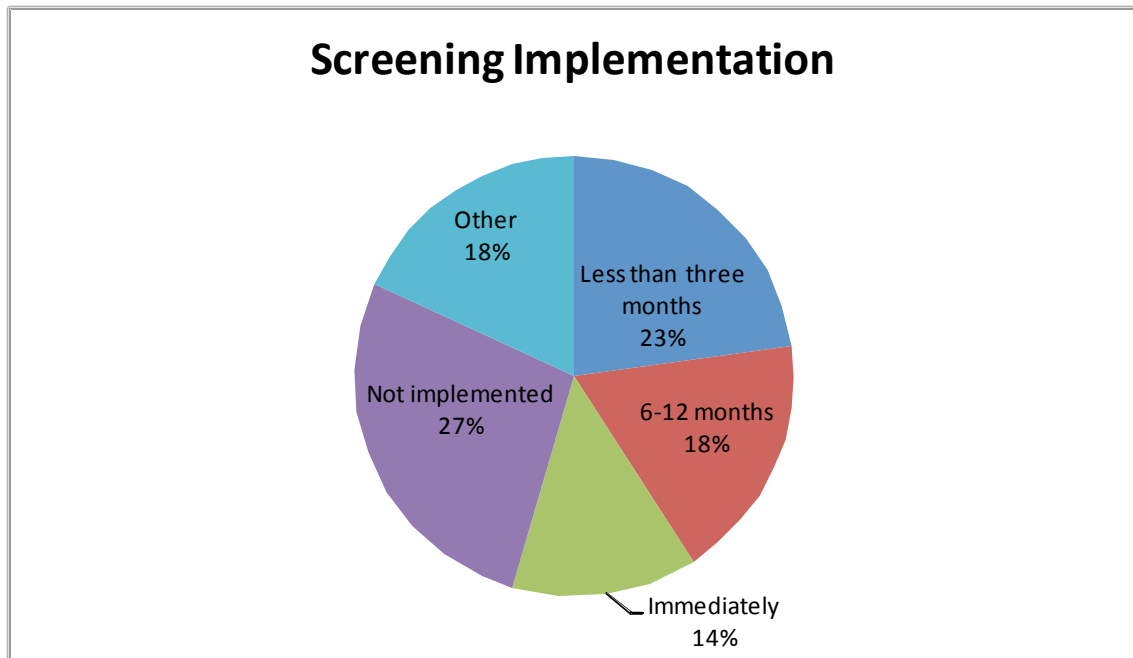
Each practice trained prior to April 2010 was asked to respond to a 3-6 month post-training implementation online survey. As a result, 23 out of 51 practices responded, which yielded a 43% survey response rate. The responses indicated a mix of success. While the majority expressed positive sentiments about the training and implementation experience, several of the responses seemed to indicate that there was a lack of understanding regarding the AAP recommendation to conduct standardized screening at fixed intervals.

Such responses included: “I have done developmental screening without the long questionnaire” and “I do it when there is a problem,” etc. In addition, responses indicated that practices that were trained in a grand-round like setting (i.e. Henry Ford Health System and Shiawassee County practices) seemed to have greater difficulty successfully implementing the ASQs.

Additionally, the practices were asked:

1. “How long after the developmental screening training were you able to implement the tool in your practice?”

Figure 1 – 3-6 Month Screening Implementation Survey Results

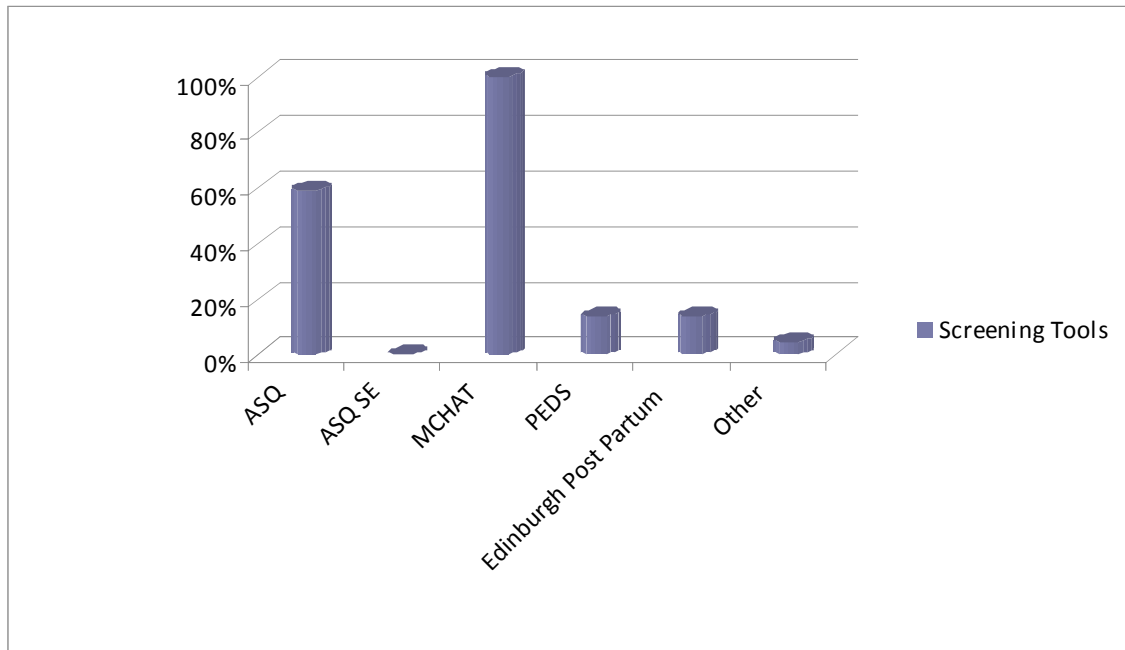


The results show that 27% of the practices still had not implemented developmental screening by the time they responded to the survey. Of the 18% that reported the response “other,” two practices had indicated, “between 3-6 months after the training”, and one reported they had been conducting child development screening since July of 2009 before their training.

2. What standardized screening tool did the practices use?

During the training, the MIAAP exposed the practices to multiple standardized developmental screening tools including ASQ 3, PEDs, MCHAT, etc. One of the points of the training was that a physician could use and also bill for up to three screenings in one well-child visit. The survey asked practices what standardized child development screening tools they were using. The 23 out of the 51 practices responded that they were using multiple screening tools, but the MIAAP did not ask if the practices were using more than one tool at a time.

Figure 2 – Developmental Screening Tools Used



3. What did the practices like about the standardized screening tool?

The practices were asked an open-ended question to assess their experience with the standardized tool. The responses provided by the practices are as follows:

“Much more comprehensive than before”

“It really does help to identify at-risk patients”

“Short and relevant”

“Easy to identify issues”

“ASQ is easier to use than MCHAT”

“Standardized, can give to patients before they meet with doctor”

“High Quality”

“I have done it without long questionnaire”

“Simple response process and scoring”

“Able to track child development for early intervention”

“I do it when there is a problem”

“We’ve been doing MCHAT for quite some time; we have not found a way to implement other formal screenings yet.”

The experience of the practices were consistent with the research, which revealed that evidence-based parent-driven tools are useful in evaluating a child’s development and enables physicians to have positive discussions with parents about their concerns. However, it is important that training continues to emphasize the AAP recommendation that standardized developmental screening tools should be used rather than check lists and that the tools should be used at regularly recommended intervals.

4. At which well-child visits were practices using the screening tools?

The AAP recommended that physicians implement a formal screen using a standardized tool at ages 9, 18 and 30 months. During the MIAAP training, the trainers reinforced this policy, but also explained that up to 3 tools could be used during each well-child visit. The trainers referred to other standardized screening tools available for use between the ages of 2 months through 60 months.

In the survey, the practices were asked at which well-child visits they were using standardized screening tools or if they were using screening tools at every well-child visit. From the 23 practices that responded, the practices reported using a standardized tool during the following intervals for well-child visits:

23% at 2 months

38% at 9 months

28% at 12 months

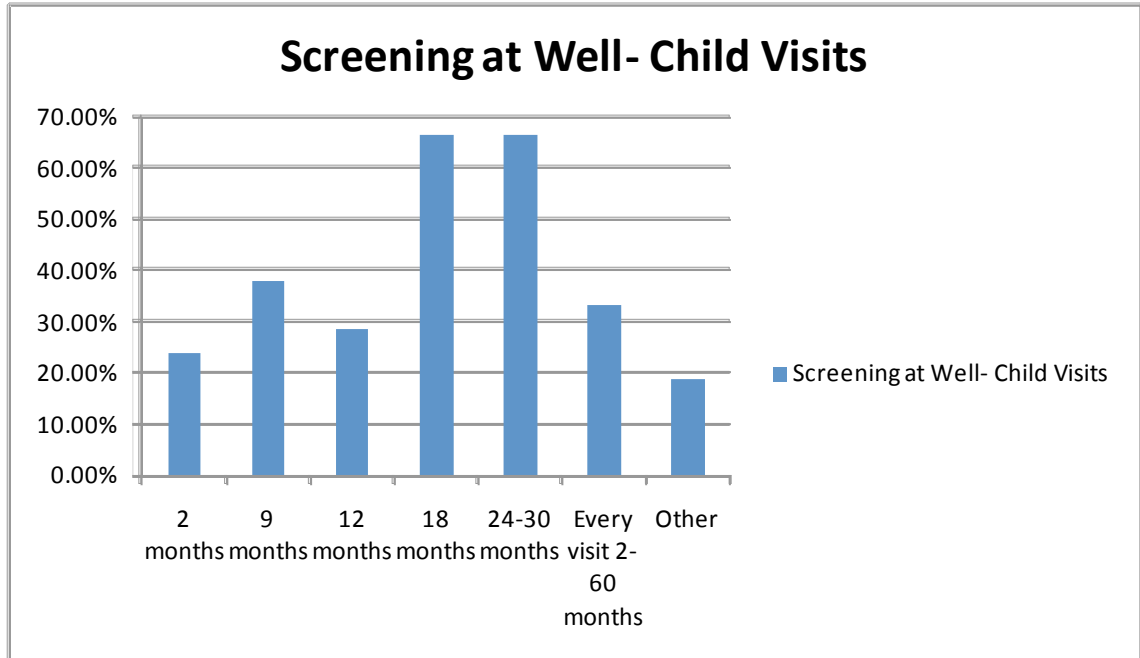
66% at 18 months

66% at 24-30 months

33% at every well child visit 2 months to 60 months

Other: Individual practices reported 9-60 months; 36 and 48 months; 15 months

Figure 3 – Well-Child Visits Screening



In reviewing the responses from the practices, the screening data should be more consistent between the ages 9, 18, and 24–30 month visits, if they are following the AAP guidelines. What appears to be skewing the data is the use of the MCHAT Autism Screen at 18 months which has been reported as 100% in the previous question instead of or in addition to the ASQ screening tools.

5. Are practices referring to *Early On* for early intervention assessments and services?

During the ABCD pilot project, physicians requested a process in which to obtain feedback about the referrals from *Early On*. According to research conducted by Dunst in 2006, when physicians do not receive timely and thorough feedback, referrals to Early Intervention services are often discontinued⁹. The research revealed that primary care physicians want acknowledgement of the referral; information about the child’s developmental status and eligibility for services; information about the services provided by the Early Intervention service; periodic updates about the child’s progress; and any other changes in the child’s development or services.

The survey distributed to the practices asked if they were referring to *Early On* and what mechanism they were using to make the referral. The 23 practices reported:

95% of the practices are referring to *Early On*

33% of the practices are faxing the referral to the State

33% of practices are faxing to their individual counties

38% of practices are using the online referrals

42% of practices are using phone referrals to *1-800-EarlyOn*

Two physicians reported that they are giving the *Early On* phone number to parents to make their own referral.

The varied methods of making referrals offered many convenient options to physicians. However, there is much confusion among physicians about the various referral forms from the State or County. The *Early On* training and technical assistance staff at the State level monitored referral data from physicians who used the centralized *1800EarlyOn* referral system rather than County referral mechanisms. There was no way to gather the same data from the individual counties, therefore making it extremely difficult to compare the results of referrals from the State and from each individual county.

6. Are practices receiving feedback from *Early On*?

Responses are described in detail under “Additional Liaison Work with *Early On*”

7. Are practices billing for the 96110 Procedure Code (Developmental Testing Limited)?

Physician practices use the Current Procedural Terminology (CPT) code 96110 for *Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report*. The CPT Code 96110 is often reported when performed in context of preventive medicine services. However, the code may also be reported when screening is performed with other services such as Evaluation/Measurement acute illnesses or follow-up office visits. As of January 2010, the reimbursement rate for the CPT code was reduced by 8% because of cuts to Medicaid rates in the FY 2010 state budget. This reduction overall has put increased fiscal stress on pediatric practices because of the disproportionate share of Medicaid patients they see. The MIAAP is uncertain if there has been any significant impact on billing for 96110 since many practices were not previously billing for the 96110 CPT code.

In the ABCD Screening Academy, the practices reported they were either not billing, or were billing but having difficulty receiving payment for the procedure. The MDCH has committed itself to assist the MIAAP with the process with the Medicaid Health Maintenance Organizations (HMOs).

The MIAAP invited billing specialists to participate in the training so they could learn more about the AAP Policy on developmental screening, the billing process, and how to obtain assistance from Medicaid if they had difficulties with a Medicaid HMO. The MIAAP Pediatric Council under the leadership of MIAAP President, Dr. Charles Barone, facilitated meetings with Blue Cross Blue Shield of Michigan and other Detroit-based private HMOs. The standard of practice to conduct developmental screening complies with AAP and Bright Futures policies. To ensure that HMOs pay for procedure code 96110, Blue Cross agreed to begin payments starting in the final quarter of 2009.

The 23 practices that responded reported an increase in billing.

56.5% of practices are billing

17.3% of practices are not billing

13% were uncertain

8.6 % were sporadically billing

4.3 % no response on billing

Of the 23 practices that responded 61% reported they are billing Medicaid HMO, 50% are billing private HMO, 54% are billing Blue Cross Blue Shield of Michigan.

The MDCH reported they paid 2,044 claims for the CPT code 96110 during a 7-month period between October 1, 2009 and May 26, 2010, during the Child Development Screening project. This appears to be a significant change because the MDCH's data for a 16-month period from May 1, 2008 through September 30, 2009 was only 3,395 claims.

However, problems still remain for billing. Billing specialists from smaller practices reported that more technical assistance is needed on how to use the billing code and also on how to provide documentation to the HMO to obtain payment. Some practices reported that they have not started billing because their Electronic Medical Record (EMR) does not recognize the 96110 code. Practices wanted assurance that they could at least write off the procedure code 96110 when they were not reimbursed.

8. Overall suggestions for improvement

The practices were asked this open ended question at the end of the online survey. These were the individual responses, which do not reflect any overarching themes:

“Make the referral process short and simple”

“Make the screening questionnaire shorter with more common/practical activities”

“Early On takes too long to do the assessment after referral”

d. Best Practices Webinar

A Best Practices webinar was conducted in April 2010 in which five practices participated. The MIAAP asked practices to provide additional comments on what they were experiencing with the developmental screening process. Two practices reported that they were not consistently using standardized tools such as ASQ 3, but rather they were using paper checklists or checklists that were provided within their EMR.

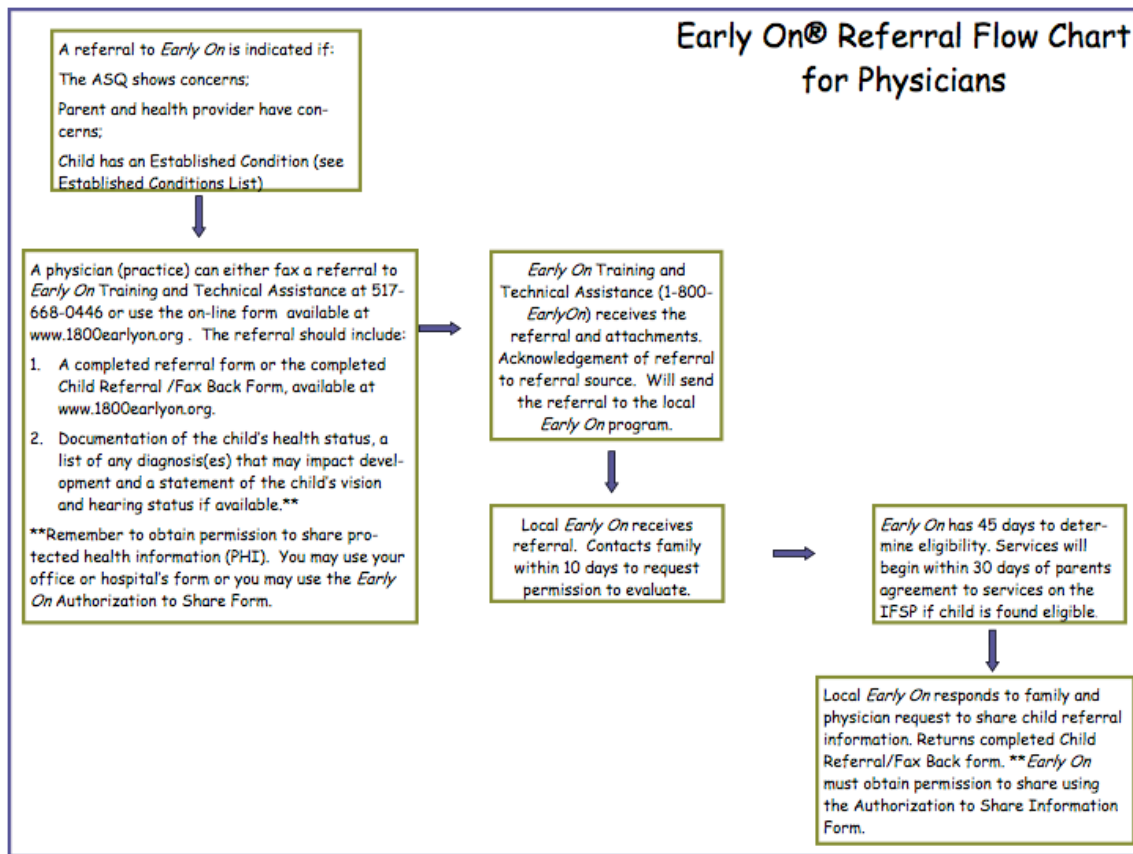
Practices reported needing standardized tools in additional languages particularly Spanish and Arabic. Practices requested additional resources for non-English speaking families mostly for those languages not available in the ASQ. Prior to starting the screening process, some practices reported being concerned about using the ASQ with parents who had limited literacy skills. To date, they reported that they were not observing this as a significant problem except in cases where English was the second language. One practice reported having successfully identified a parent with low level literacy when the parent filled out both the ASQ and the MCHAT. Since the best answer on the ASQ is always “Yes”, but on the MCHAT is sometimes “No”, parents who have difficulty reading, but don’t wish to acknowledge their literacy difficulties, may mark “yes” for all answers on the MCHAT. The webinar highlighted the opportunity for physicians to help parents by exploring with them whether they wish literacy training support and referring them to appropriate literacy services in the community. By identifying parents with literacy issues, help is indirectly being provided to their young children who will benefit from their parents’ improved literacy skills.

During the best practice webinar, practices shared their tips for getting reimbursed for procedure code 96110. These tips included information provided by the Henry Ford Health System. The Henry Ford Health System built the billing structure into their EMR system before starting the screening process. Practices asked the system for help with the EMR integration.

Another suggestion made is when an HMO denies a claim; the billing office sends the AAP policy statement to the insurance company with a cover letter. If the HMO is a Medicaid contractor, it was recommended that the billing office copy the State Medical Services Administration (MSA) with any correspondence regarding payment issues for the 96110 CPT code.

Partnering with *Early On*

Background: National research has documented the difficulties pediatricians face when referring to early intervention services^{10, 11, 12}. The MIAAP is committed to improving referral connections between physicians and *Early On*. To facilitate this collaboration, the MIAAP invited the relevant county *Early On* coordinator to participate in the training and/or guided the coordinator directly to the practice through a phone call or email. This strategy was very well received by both the physicians and *Early On*.



Another product of the project has been the development of a Child Referral Feedback form which helps to increase communication between physicians and *Early On*. The communication exchange may include such help as a particular patient who has been referred to *Early On* for further assessment and potential services.

Early On® Michigan Referral Form / Child Status Fax Back Form (Page 1)

Medical Provider Information (Completed by Provider's Office. Fax to Early On: 1-517-668-0446)

Referring Medical Provider: _____ Date: _____

Phone: (____) _____ Fax: (____) _____

Office Contact: _____ E-Mail: _____

I would like a copy of:

Individualized Family Service Plan (IFSP): Yes _____ No _____ and/or Evaluation: Yes _____ No _____

I am the Primary Care Provider: Yes _____ No _____

Parent/Guardian has signed an authorization that allows sharing of protected health information

Parent / Guardian Information

Parent Foster Parent Grandparent Adoptive
Legal Guardian Other / Relative (specify): _____

Name: _____

Phone: Home (____) _____ Cell (____) _____ Work (____) _____

Address: _____

City: _____ Zip: _____ E-mail: _____

Child Information

Address: _____

Birth Date: _____ Gender: Male Female

Premature: No Yes: Weeks gestation _____ Low Birth Weight: No Yes: _____

Reason(s) for Referral (please check all that apply):

_____ Identified condition or diagnosis (e.g., Down syndrome): _____

_____ Suspected developmental delay (Please circle areas of concern):

Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other

_____ Other (Please describe): _____

Please check the following records that have been included:

_____ Screening Results (circle): ASQ 3 ASQ SE MCHAT Denver PEDS Other

_____ Health Status

_____ Vision/Hearing Status

_____ List of pertinent diagnoses

Referral/Fax Back 4/30/10 TK

This *Early On* feedback form was originally piloted at Henry Ford and then modified reflecting their feedback responses. MDE has plans to integrate this form with the online-referral form so that there is only one form to submit to the State. Thirty-nine referral feedback forms were processed from hospitals and physicians engaged in the Promoting Child Development Screening Project.

Early On is reporting a 3.5% increase in referrals and the increased numbers of referrals are called in to the *1-800-EarlyOn* telephone system by physicians in the nine months of this project. This is to be compared to a comparable time period the year immediately prior to the start of the Child Development Screening project (i.e. 1828 referrals from October 1, 2009- June 1, 2010 compared to 1765 referrals in October 1, 2008 to June 1, 2009).

Referral Data – ABCD Outreach
MI Chapter American Academy of Pediatrics

Snapshot of Public Awareness Referrals Time Period: 10/01/08 to 06/01/09													
	Call Type				How callers learned about us								
	Early On	Project Find	General Info	Total Calls	Physician	Hospital	Educator	DHS	Day Care	Family	Web	Ad	Other
All Calls	3540	763	271	4574	1765	966	1085	267	60	123	88	31	783
Percentage of Calls	77.4%	16.7%	5.9%		43.2%	23.7%	26.6%	6.5%	1.5%	3%	2.2%	0.8%	19.2%

Snapshot of Public Awareness Referrals Time Period: 10/01/09 to 06/01/10													
	Call Type				How callers learned about us								
	Early On	Project Find	General Info	Total Calls	Physician	Hospital	Educator	DHS	Day Care	Family	Web	Ad	Other
All Calls	4023	849	559	5431	1828	999	1295	407	55	141	98	28	973
Percentage of Calls	74.1%	15.6%	10.3%		40.4%	22.1%	28.6%	9%	1.2%	3.1%	2.2%	0.6%	21.5%

COMMENTS:

The statewide referral line at 1-800-EARLY ON received and processed 39 *Early On* Michigan Child Referral/Fax Back from hospitals and physicians. If the Michigan Chapter of the AAP would like a list of physicians and/or hospitals that used this form, we could provide that demographic information for your grant application review.

In the 3-6 month implementation survey, the 23 practices that responded reported that they were generally receiving feedback from *Early On*. Specifically,

68% of the practices reported they are receiving feedback from Early On regarding the status of the referral and the recommended eligibility and services.

13% of practices report they are not receiving feedback from *Early On*.

13% of practices are uncertain if they are receiving feedback from *Early On*.

One difficulty the MIAAP learned of in the Promoting Child Development Screening project is that there are not any federal or State regulations requiring the local *Early On* offices to use standardized forms, and additionally, a central state referral line (phone, fax or web). Therefore, there is a wide variety of forms being used in various counties across the state. This is particularly problematic for practices that see children from multiple counties. During the best practices webinar, practices said that it is confusing to have an option of making a referral to either to the State or to individual counties.

Practices acknowledged during the trainings that they were previously not aware of nor were they using the State's online referral mechanisms. The MIAAP recognizes that as more practices go to EMR, there will be a greater need to integrate this web-based tool into pediatric practices.

Another problem the MIAAP encountered during the training was facilitating the exchange of information between parent, physician, and *Early On*. One reason the problem developed is because of the two different privacy laws governing health, the Health Insurance Portability and Accountability Act (HIPAA) and governing education, Family Educational Rights and Privacy Act (FERPA). The MIAAP initially trained the Henry Ford practices to implement the *Authorization to Share* form that is both HIPAA and FERPA compliant, but unfortunately the form was too time-consuming for use in the physician's offices.

The MIAAP adapted the subsequent trainings to recommend that practices use a standard permission form to release information from medical records with parents. Additionally, *Early On* would work with parents to obtain the appropriate Authorization to Share releases.

Throughout this project, providers reported during the trainings that they were frustrated with a lack of referral services for older children or when a child is deemed ineligible by *Early On*. Additional education for physicians is needed on what the eligibility criteria are for *Early On* and Project Find for older children. Project Find of Michigan is a statewide system of service which promotes the awareness of special education supports and/or the services provided by the public school system. In clarifying with MDE, the MIAAP learned that 1-800EarlyOn is also the primary telephone number for Project Find services for all children who are over 3 years old. The increased personal contact that the project fostered between the physicians and Early Intervention professionals did indeed increase the referrals, the quality of referrals, and the improved trust between the two systems.

Analysis of the Promoting Child Development Screening Project and Recommendations

The Promoting Child Development Screening in Michigan project carried out by the MIAAP resulted in far more practices being trained than had been anticipated. In this respect the project has been a resounding success. However, while developmental screening in physician practices is clearly becoming more common and accepted as the norm, developmental screening is likely to grow with or without further support. There are some lessons learned that will guide future providers and practices through training for developmental screening.

The results of the surveys, the on-site discussions with practices, and the experiences of the MIAAP in providing technical assistance to the practices, have highlighted policy and process issues that should be addressed by the MDCH, Early On and the MIAAP. This will help to improve implementation of child development screening, referrals, and long-term outcomes for children.

Lessons learned:

1. Practices that were trained as part of large groups, such as the Memorial Health Care in Shiawassee and the Henry Ford Health System trainings, rather than through on-site practice training, required significantly more follow-up to determine the progress of the practices. The practices from large groups which implemented developmental screening, were less likely to respond to the surveys, and did not have a clear “physician champion” on-site to provide leadership and guidance on clinic flow and other implementation issues. Future trainings are best done on-site in order to address site-specific issues such as clinic flow. On-site trainings are also more likely to identify strong “physician champions” and to support staffs that are willing to take ownership of the project, ensuring greater likelihood of successful implementation.
2. Questions that arose after the initial training and were addressed through additional technical support indicated that with future trainings, more attention should be paid to practical clinic flow processes, on how practices can build in regular and ongoing measurement of process improvements, and on billing issues.
3. Developmental screening in early childhood systems involves inter-disciplinary coordination. However, this coordination offers the most challenges to implementation because of programmatic and fiscal constraints, along with different understanding of the roles of each professional in the system. Health care providers are typically the “first responder” to a wide variety of issues that affect a young child’s healthy development and readiness for school. Early identification of developmental delays falls squarely on the child’s physician¹³. Physician champions who are able to understand and effectively interface with Early Childhood Systems are more likely to screen and refer to early intervention services. This is why the MIAAP connected physicians to *Early On*, Head Start, and the local Great Start collaboratives in the training processes.

4. An unexpected lesson learned about the beneficial nature of standardized screening was that literacy issues in parents could be identified and addressed when using the MCHAT. While the MCHAT is not a global developmental screener, and is therefore not adequate for screening for developmental delays, it does have the advantage over the ASQ that the “best” answer isn’t always “Yes”. Thus, parents who may have undisclosed literacy issues, and who complete the ASQ by answering “yes” to every question (thus making it appear as if the child is developmentally on target), are identified as having reading issues when they do the same on the MCHAT. They can then be referred to literacy support resources.
5. Billing issues for developmental screening continue to be a problem. While Medicaid Health Plans reimburse, many private insurances still do not. Further work needs to be done to encourage reimbursement of developmental screening by commercial insurance carriers.

Recommendations:

1. The MIAAP recommends that the State of Michigan, MDCH continue to invest in the spread of Child Developmental Screening to pediatric practices throughout the state of Michigan. This will help to improve child well-being outcomes in physical, social emotional and developmental domains. The MIAAP has established an infrastructure and promoted child developmental screening, thereby has created a demand for continued training and technical assistance. However, with the completion of the MDCH contract, there will not be consistent resources to sustain the training to meet the demand. Continued investment in child development screening initiatives is likely to create further collaboration between the health and educational systems, thus strengthening services to young children and providing more efficient and cost-effective benefits for Michigan.
2. The MIAAP recommends that *Early On* data be monitored both on a local level as well as on a state level so as to determine:
 - a. Number of referrals made by physicians to *Early On*
 - b. Number of *Early On* eligible children identified through referrals by identified physicians

Throughout this project it was difficult to ascertain how the trainings affected how referrals were made to *Early On* by physicians because local agencies do not track where a referral comes from. Since many of the referrals, however, are made locally and not to the State of Michigan hotline, it continues to be difficult to assess the full impact of the promotion of the Michigan child development screening. By tracking such information, MDCH will have powerful information available to be able to target scarce resources more effectively.

3. MDCH and MDE should continue to work on interagency agreements regarding communication of referrals and supportive documents to assist in the comprehensive evaluation, care and treatment across systems. Fully implementing the draft feedback form and integrating this form in the web-based referral system, will help to increase the use of the form and to increase communication between early intervention services and all referring sources, including physicians.
4. *Early On* should continue to work to improve communication with physicians about the outcome of developmental screening referrals. Physicians not only want to know that the referrals were received, but also the outcome of the evaluations and the intervention plans developed by *Early On*. This will help physicians to provide significant advocacy and case management for their patients. As pediatricians become more engaged in the process of becoming certified medical homes, the coordination and communication by partner agencies such as *Early On* with physicians are critical in ensuring the health and developmental needs of Michigan's children are met. By providing such information, referral sources are more likely to improve their referral habits and their understanding of the early childhood system of care within their counties.
5. The MIAAP should pursue the development of a Quality Assurance Initiative for Child Developmental Screening, formally approved by the American Board of Pediatrics (ABP), for Maintenance of Certification (MOC), Part 2. Such QI activity has recently become required by the ABP, and strongly motivates practicing physicians to develop ways and means within their practices of monitoring their developmental screening activities. Under the current project, such QI monitoring was encouraged but was left completely up to the discretion of the individual practitioner. It is unlikely that many practices will monitor how they are doing without some additional encouragement, and MOC may be the best choice.
6. The MIAAP, in partnership with the Michigan Department of Community Health, should advocate for the development of Electronic Health Records (EHR/EMR) web-based software to be pediatric-focused and include the tracking of child developmental screening.
7. MIAAP, in partnership with the *Early On*, should develop additional training for physicians on how to foster parents as partners in child developmental screening. According to *Child Development and Medicaid: Attitudes of Mothers with Young Children Enrolled in Medicaid*¹⁴, "Pediatricians should continue to be the main source of information about child development, but they can improve their interaction with mothers" by spending more time discussing development using standardized screening tools as a conversation starter.

Plan for Spread of Child Development Screening Sustainability

The Michigan Chapter for the American Academy of Pediatrics has developed the following plans for sustainability in conjunction with members of the MICHIP Executive Committee and outside entities.

- 1) **Project Launch:** MIAAP is under contract with the Saginaw Intermediate School District to provide child development screening training to 5 practices in Saginaw County during the 5-year grant period for the Project Launch grant received by the MDCH.
- 2) **Early On:** MIAAP is under contract with the MDCH *Early On* Division to provide two webinars to the practices who participated in this phase of the developmental screening spread. The training will focus on incorporating social emotional screening and referrals into the practices, and to continue the dialogue with *Early On*. This will allow MDCH to improve referrals and feedback between early intervention services and pediatricians. These webinars are taking place in August and September 2010. The materials will then be incorporated into the training curriculum for future practice trainings.
- 3) The MIAAP is also researching opportunities to develop and submit funding proposals to continue building the infrastructure for continuing professional development around developmental screening.

Conclusion

Child development screening, particularly from birth through age five, is a center point of the Bright Futures standards of care adopted by the AAP for children across the developmental screening spectrum. Michigan has the opportunity to continue to build on the successes of promoting child developmental screening training to not only provide evidence-based training for pediatricians and other pediatric providers, but to improve policies, procedures, and financing around this standard of care. The collaboration that the pediatric community has had during the contract with the MDCH, *Early On* and other early interventional services has resulted in positive outcomes, such as increased billing and feedback about referrals, and improving the communication and service coordination for children.

All children benefit from regular developmental screening, and from the dialogue between parents and the pediatric primary care provider. The screening process provides valuable feedback to the pediatric provider about the parent's observations of their child's behavior, the concerns of the parent(s), and furthermore, opens up opportunities to discuss appropriate development, behavior, and parenting skills. The majority of well-care visits are focused on healthy development not acute care. The developmental screening process lays the foundation for strong relationships and open communications between the physicians and the parents, and with the physicians and early intervention network.

The State's investments in child development screening and referrals to early intervention services will continue to result in improved developmental outcomes for children, school readiness, and more efficient utilization of special education and Medicaid funded services.

Additional Sources

- ▶ <http://www.medicalhomeinfo.org/screening/DPIP%20Follow%20Up-National%20Initiatives.html> (National Center for Medical Home Implementation)
- ▶ The Commonwealth Fund , *Improving the Delivery of Health Care that supports Young Children’s Healthy Development (ABCD II)*, Feb. 2008
- ▶ Implementing Developmental Screening and Referrals: Lessons Learned from a National Project, **Pediatrics**, Jan. 25, 2010. www.pediatrics.org/cgi/content/full/125/2/350

Appendix 1: Terminology

For the purposes of this report, the MIAAP defines:

Developmental Surveillance: A flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems

Developmental Screening: The administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder.

Developmental Evaluation: Aimed at identifying the specific developmental disorder or disorders affecting the child.

Referrals: Recommended services and supports to aid the child in meeting their developmental milestones. Services may include both medical and early intervention:

Medical: Ex. referral to developmental pediatricians, neurology, and speech therapy.

Early Intervention: Ex. Referral to Early On or Project Find, Community Mental Health

Standardized screening tools

- **ASQ 3-** Ages and Stages Questionnaire 3. Evidence-based developmental and social-emotional screening for children from one month to 5 ½ years. ASQ looks at strengths and trouble spots, educates parents about developmental milestones, and incorporates parents' expert knowledge about their children. Published by Brookes Publishing, www.agesandstages.com
- **PEDS-** Parents Evaluation of Developmental Status, www.pedstest.com. Evidence-based screening tool that elicits and addresses parents concerns. The PEDS can be used from birth to 8 years of age.
- **PEDS-DM-** Parents' Evaluation of Developmental Status, Developmental Milestones. Screening tools are completed by parent report (but can also be administered directly to children). PEDS:DM examines different developmental domains (fine motor, gross motor, expressive language, receptive language, self-help, social-emotional, and for older children, reading and math). The PEDS:DM is for children birth to 7-11 years of age.
- **Other screening tools for social/emotional issues**
 - **ASQ-SE-** Ages and Stages Questionnaire, Social Emotional. www.agesandstages.com
 - **MCHAT,** Modified Checklist for Autism in Toddlers, <http://www.dbpeds.org/articles/detail.cfm?TextID=466>

Appendix 2
Michigan Chapter American Academy of Pediatrics
Promoting Child Development Screening
2009-2010
Letter of Agreement

Name of Practice: _____

Address: _____

Email: _____

Phone: _____

Attending Physician/Medical Champion: _____

The _____ practice agrees to complete the Child Development Screening Training provided by the Michigan Chapter American Academy of Pediatrics (MIAAP).

In signing this agreement, our practice agrees to:

- 1) *Begin implementing the child development screening within 3 months of the training.*
- 2) *Complete two online surveys*
 - i. *Post training evaluation*
 - ii. *Implementation evaluation*
- 3) *Refer children to Early On for further assessment and services.*
- 4) *Provide informal feedback to the MIAAP to assist in the documentation of barriers, opportunities, and successes of the Child Development Screening Project for the final report to the Michigan Department of Community Health, Medical Services Administration.*

Signature of Attending Physician

Date

Footnotes

- ¹ Policy Statement American Academy of Pediatrics (2006). "Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening." *Pediatrics*, 117, 405-420.
- ² Newacheck PW, Strickland B, et al. (1998). "An Epidemiologic Profile of Children With Special Health Care Needs." *Pediatrics*, 102(1), 117-123.
- ³ Boyle CA, Decoufle P, Yeargin-Allsopp M (1994). "Prevalence and health impact of developmental disabilities in US children." *Pediatrics*, 93(3), 399-403.
- ⁴ Glascoe FP (2000). "Detecting and Addressing Developmental and Behavioral Problems in Primary Care." *Pediatric Nursing*, 26(3), 251-257.
- ⁵ Palfrey JS, Singer JD, Walker DK, Butler JA (1987). "Early identification of children's special needs: a study in five metropolitan communities." *J Pediatrics*, 111(5), 651-9.
- ⁶ Earls MF, Hay SS (2006). "Setting the Stage for Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice – The North Carolina Assuring Better Child Health and Development (ABCD) Project." *Pediatrics*, 118(1), e183-88.
- ⁷ "Content and Quality of Health Care for Young Children: Results from the 2000 National Survey of Children's Health (2004)." *Pediatrics*, 113(6), 1894-1990.
- ⁸ Glascoe FP, Dworkin PH (1995). "The Role of Parents in the Detection of Developmental and Behavioral Problems." *Pediatrics*, 95, 829-836.
- ⁹ Dunst, Carl J. TRACE Practice Guide: Providing Feedback to Primary Referral Sources, Dec. 2006.
- ¹⁰ King TM, Tandon ST et al. (2010). "Implementing Developmental Screening and Referrals: Lessons Learned from a National Project." *Pediatrics*, 125, 350-360.
- ¹¹ "Overcoming Barriers to Referral and Care Coordination for Children Eligible for Early Intervention Services," National Academy of State Policy, Feb. 3, 2009, <http://www.nashp.org/node/1704>.
- ¹² TRACE Practice Guide: A Universal Checklist for Identifying Infants and Toddlers Eligible for Early Intervention, Nov. 2007.
- ¹³ Bruner, Charles. "Connecting Child Health and School Readiness." *The Colorado Trust: Issue Brief*, February 2009, p.7.
- ¹⁴ Developmental Screening in Early Childhood Systems, AAP Meeting Summary. March 2009.

Michigan Chapter American Academy of Pediatrics
 ABCD Child Development Screening Training
 3-6 month implementation Survey
 2009-2010
 23 responses

1 *How long after the developmental screening training were you able to implement the tool in your practice?

Answer	0%	100%	Number of Responses	Response Ratio
Less than 3 months			<u>5</u>	21.7%
6 months to less than 1 year			<u>4</u>	17.3%
immediately			<u>3</u>	13.0%
still have not implemented screening			<u>6</u>	26.0%
Other (View all)			<u>5</u>	21.7%
No Responses			0	0.0%
	Totals		23	100%

[View comments \(7\)](#)

2 *Which screening tools are you using in your practice? Select all that apply.

Answer	0% 100%	Number of Responses	Response Ratio
Ages and Stages (ASQ)		13	56.5%
Ages and Stages Social Emotional (ASQSE)		0	0.0%
MCHAT Autism screen		23	100.0%
PEDS		4	17.3%
Edinburgh Postpartum Depression Screener		3	13.0%
Other (View all)		1	4.3%
Totals		23	100%

[View comments \(3\)](#)

3 ***How satisfied are you with the developmental screening tool?**

1 = Not Satisfied , 5 = Very Satisfied

	1	2	3	4	5	Number of Responses	Rating Score*
						22	3.9

*The Rating Score is the weighted average calculated by dividing the sum of all weighted ratings by the number of total responses.

[View comments \(7\)](#)

[▶ Show Details](#)

Details

	1	2	3	4	5	Number of Responses	Rating Score*
	1 (4%)	0 (0%)	8 (36%)	5 (22%)	8 (36%)		
						22	3.9

4 ***What do you like about the developmental screening process in your practice?**

	Number of Responses
View Text Answers	22

5 *What difficulties are you encountering with the developmental screening process?

	Number of Responses
View Text Answers	22

6 *At which well child visits are you using the screening tools? Select all that apply.

Answer	0% 100%	Number of Responses	Response Ratio
2 months		5	22.7%
9 months		9	40.9%
12 months		6	27.2%
18 months		15	68.1%
24-30 months		15	68.1%
Every well-child visit 2 months - 60 months		7	31.8%
Other (View all)		4	18.1%
	Totals	22	100%

[View comments \(3\)](#)

7 *Are you billing for developmental screening Code 96110?

Answer	0%	100%	Number of Responses	Response Ratio
Yes			13	56.5%
No			4	17.3%
Uncertain			3	13.0%
Other (View all)			2	8.6%
No Responses			1	4.3%
Totals			23	100%

[View comments \(6\)](#)

8 *What entities are you billing Code 96110?

Answer	0%	100%	Number of Responses	Response Ratio
Medicaid HMO			14	63.6%
Private HMO			11	50.0%
Blue Cross Blue Shield of MI			12	54.5%
Other (View all)			9	40.9%
Totals			22	100%

[View comments \(3\)](#)

9 *Please describe any problems you are having billing or receiving payment for Code 96110.

	Number of Responses
View Text Answers	22

10 *Are you referring to Early On?

Answer	0%	100%	Number of Responses	Response Ratio
yes			22	95.6%
no			0	0.0%
No Responses			1	4.3%
Totals			23	100%

[View comments \(4\)](#)

11 *What method are you using to refer to Early On? Please select all that apply.

Answer	0%	100%	Number of Responses	Response Ratio
By Fax to state			7	31.8%
By Fax to county			8	36.3%
online			8	36.3%
Phone referral			9	40.9%
Totals			22	100%

[View comments \(4\)](#)

- 12 ***Are you receiving feedback from Early On regarding the status of the referral and the recommended eligibility and services.**

Answer	0%	100%	Number of Responses	Response Ratio
Yes			<u>16</u>	69.5%
No			<u>3</u>	13.0%
Uncertain			<u>3</u>	13.0%
No Responses			1	4.3%
Totals			23	100%

[View comments \(6\)](#)

- 13 **Do you have any suggestions for improvement?**

	Number of Responses
View Text Answers	11

14 Please enter the information indicated below.

Remember, you can import these responses into your Contacts. [View the answers](#) to do this.

Answer	Number of Responses
First Name	19
Last Name	19
Job Title	19
Company Name	17
Work Phone	18
Email Address	19
Address 1	17
Address 2	2
City	17
State/Province (US/Canada)	17
Postal Code	17

[View answers](#)