Promoting Child Developmental Screening (PCDS) II in Michigan

Prepared by
The Michigan Chapter,

American Academy of Pediatrics

Final Report

May 20, 2013

Authors:

Teresa Holtrop, M.D., F.A.A.P.
Carley Kirk, M.S., C.H.E.S

Table of Contents

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) visit, (also known as well-child visits). A standardized evidence based developmental screening test should be administered at a minimum at the 9, 18, and 24 to 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 15-18% of children have developmental delays[2,3,4]. In previous decades, less than 30% of children with a developmental delay were being identified before they entered school[5]. 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 On* is part C of the Individual with Disabilities Education Act (IDEA) and serves as Michigan's early intervention system that provides services for infants and toddlers and their families, birth to three years of age, with developmental delay(s) and/or disabilities. Early identification and intervention of developmental delays in young children, particularly of children with mild to moderate delays, is critical to ensure 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 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. 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 providers. The Promoting Child Developmental Screening (PCDS) I project was able to train over 110 pediatric providers during the 2009 to 2010 contract year timeframe. This project had 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.

In 2011, the MIAAP received a contract to continue the spread of child developmental screening with the continuation of the Promoting Child Developmental Screening (PCDS) II project. The MIAAP was able to train 11 practices including 28 pediatric providers and 58 clinical staff during the 2011 to 2013 contract period. The MIAAP also initiated the Michigan Screening Tools and Referral Training (MI START) project. The MI START project was approved by the American Board of Pediatrics as a quality improvement project for pediatricians to earn required part IV credits for their Maintenance of Certification (MOC). The MI START project was an added benefit for pediatricians who participated in the PCDS II program. This report summarizes the experience of the MIAAP and the providers that have been trained during the PCDS II project.

The MIAAP would like to thank the Michigan Department of Community Health (MDCH), Early Childhood Investment Corporation (ECIC), Project LAUNCH, and *Early On* for their support and assistance with this project.

Teresa Holtrop, M.D., F.A.A.P., Medical Director

Executive Summary

The Michigan Department of Community Health (MDCH) contracted with the MIAAP in 2011 to improve developmental outcomes for young children by training primary care physicians to implement evidence-based standardized global development, socio-emotional, and autism screening tools as part of daily practice.

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' behavior, the concerns of the parent(s), and opens up opportunities to discuss appropriate developmental, behavioral, 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 opens communication between the physician and parent, and physician and early intervention network.

The overarching goals of the PCDS II project were to:

- Increase developmental screening for children
- Increase referrals to early intervention when problems were 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 was contracted to provide 14 trainings but only had a total of 11 trainings due to a change in staff during the final quarter of the first contract year. MIAAP was able to train 28 pediatric providers and 58 clinical staff during the contract period.

The significant outcomes of the project were:

1. A majority of practices trained implemented the use of developmental screening tools into the clinic work flow but there is still a need for on-going training and technical assistance to utilize evidence-based developmental screening tools at AAP recommended intervals.
2. An increase in post training data collection due to the increase of CME credits from 1.5 previously to 20 CMEs for participating providers and allied healthcare professionals and the addition of MI START quality improvement project MOC part IV credits.
3. Improved understanding of the developmental screening tools and early intervention referral sources in the surrounding community.
4. An increase in providers receiving feedback from *Early On*.

History of Developmental Screening Efforts in Michigan

ABCD

ABCD was an initiative launched in 1999, funded by the Commonwealth Fund and administered by the National Academy for State Health Policy (NASHP). ABCD was 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 developmental 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, Children's Special Health Care Services (CSHCS), Part C/*Early On*, Department of Human Services (DHS), the MIAAP, Michigan State University Institute for Health Care Studies (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 for 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 developmental 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 screening[6]. Based on the success of the ABCD Screening Academy, MDCH developed an RFP in 2009 to fund the spread of ABCD. MIAAP was awarded the contract in March 2009 and began the ABCD spread with Promoting Child Developmental Screening (PCDS) I training project.

The PCDS I project trained practices that were located in 12 different counties. The mix of practices included small private practices, one Federally Qualified Health Center, and two Health Systems. Training totals included: 15 trainings, 51 practices, 110 physicians, and 66 non-physicians.

The post-training survey results concluded 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. Anticipated barriers in implementation of developmental screening 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.

Promoting Child Developmental Screening II in Michigan

In October 2011, the Michigan Department of Community Health contracted with the MIAAP to continue the spread of child developmental screening to pediatric practices in the state. The Promoting Child Developmental Screening (PCDS) II project trained practices to incorporate the standardized evidence-based developmental screening tools Ages and Stages Questionnaire (ASQ-3), Ages and Stages Social Emotional Questionnaire (ASQ-SE), and the Modified Checklist for Autism in Toddlers (MCHAT) as

part of daily practice. The MIAAP was awarded additional funding from Project LAUNCH to create the MI START MOC part IV quality improvement project and was approved by the American Board of Pediatrics for two years.

The PCDS II project trained a total of 11 practices during 2012 through April 2013. A total of 28 physicians and 58 clinical staff were trained. In 2012, 6 practices were trained and of the 6 practices, 5 had implemented the ASQ-3, ASQ-SE, and MCHAT in less than three months. One practice only implemented the ASQ-3 and plans to provide more training to clinical staff on implementing the additional developmental screening tools into clinical work flow.

An additional 5 practices were trained in 2013 during the months of February, March and April. At the time of this report 1 of the 5 practices submitted preliminary data showing the implementation of ASQ-SE and increased use of ASQ-3 and MCHAT. Additional data will be collected from the 3 month post training implementation survey that is to be distributed in June and will be completed by the practices trained in February.

Methodology

A. Site recruitment/selection-

1. New Practices: The MIAAP conducted physician outreach to practices that were on a wait list for a period of time. Practices were contacted by phone and email to determine their current interest in participating in the training. MIAAP contacted Children's Health Access Programs (CHAP) in Wayne and Kent counties to find interested practices. Beginning in April 2012, information regarding the PCDS II project was included in the MIAAP's newsletters and membership communications.
2. Medical Champion: Each participating practice had to have a medical champion in the office that was a pediatrician and had signed the MIAAP's letter of agreement.

B. Trainers: Five physicians, including Dr. Teresa Holtrop, the pediatric medical director for the project, were trainers. All five trainers were pediatricians.

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.

D. Training participants: Since the trainings were conducted on-site, the MIAAP encouraged the entire practice to participate in the training. This helped gain staff support and facilitate changes in clinic work flow. Trainings included physicians, nurse practitioners, physician assistants, nurses, medical assistants, administrators, and billing specialists. There were a total of 28 physicians and 58 clinical staff trained.

E. CME obtained: On December 22, 2011 the PCDS II project was approved for 1.5 CME credits for one year from Michigan State Medical Society. One and one half credits of AMA PRA Category 1 Credits were provided to each physician and allied health professional. The following year on December 21, 2012 the PCDS II project was approved for 20 performance improvement (PI) CME credits through Michigan State University College of Human Medicine. The increase in the approved amount of CME credits from the first year to the second year occurred due to the fact that the PCDS II project included the MI START quality improvement MOC part IV activity. Up to twenty credit hours of AMA PRA Category 1 Credits were provided to each physician and allied health professional that met the quality improvement goals.

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 prompted[8].

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

The MIAAP chose to provide the ASQ-3 and ASQ-SE, published by Brookes Publishing, to each practice. MIAAP also provided information on how to access the MCHAT that is free and online. These tools were chosen because 1) they were a parent-driven tool, 2) they were easy to score, 3) there is a tool for every stage of development from two months through five years, and 4) the ASQ-3 is recommended by the Michigan Department of Education for use in child care, preschool, and *Early On*.

G. Evaluation: In order to evaluate the PCDS II project, the MIAAP built in five points of survey and data gathering which resulted in:

1. Assisting in the pre-training baseline data
2. Assisting in post training survey and goal setting
3. Assisting in the 3 month implementation survey
4. Assisting in monthly data collection up to 6 months
5. Assisting in monthly data collection up to 12 months if participating in MI START

Furthermore, MIAAP determined that practices should have the option to receive an on-site visit three to six months after the training to provide any technical assistance during implementation and data collection.

Results

A. Training Data

Practices that were trained were located in eight different counties. The counties represented four different regions of the state including six in southeast, two in east central, 2 in southwest, and one in west central regions of Michigan.

Who were trained:

Table 1- PCDS II Training Data

Practice Trained	Number of Physicians	Number of Clinical Staff
Bay Pediatric Clinic (Bay County)	1	9
Dr. Laurent (Oakland County)	1	2
Lansing Pediatrics (Ingham County)	3	2
ProMed (Kalamazoo County)	5	4
Union Lake (Oakland County)	3	6
Alpine IM/Pediatrics (Kent County)	2	7
Bright Start (Barry County)	2	8
Child Health Partners (Ingham County)	3	5
Healthy Futures (Saginaw County)	1	5
Northeast Pediatrics (Oakland County)	5	7
Tender Care Pediatrics (Macomb County	2	3
Totals	28	58

Training Totals to Date, including ABCD, PCDS I and PCDS II:

37 trainings

73 practices

147 physicians

124 non-physicians, clinical staff

**Note that these numbers only include the participants who attended the training and is not representative of the total of providers and clinical staff who work in each practice.*

B. Post training survey

Each practice trained was asked to complete a survey following the on-site training to assess the quality of the training, set goals, and to identify barriers. All eleven practices are represented in the survey results. Approximately 92% (N=75) of the respondents were very satisfied with the training. There were 92% (N=75) respondents who felt that the material learned would be incorporated into their practice. A majority of respondents, 93% (N=76), felt the information would help them improve the health care of their patients.

Practices did name major barriers to implementing developmental screening including:

Time,

Not understanding payment reimbursement for doing the developmental screen,
Parent compliance, and
Staff training.

Each practice was asked what they were going to do to overcome the identified barriers of implementing developmental screening and their answers included the following:

Complete more referrals, standardize workflow and protocol,
Organize forms and train who/when to give out materials,
Make process decisions to current workflow then improve screening in standard room work flow,
Incorporate screening/scoring into current EMR, and
Get the screening sheets to parents with adequate time to fill out.

Practices were asked what new abilities/strategies they gained from the training and their responses included:

Promoting child development, referring to *Early On* for children that have a developmental delay at a young age,
Increased knowledge about the process of referral to *Early On*,
Learned what the ASQ was,
Implementing screening successfully into practice,
Identifying social/emotional concerns and understanding when to refer, and
Understanding coding and billing the screening correctly.

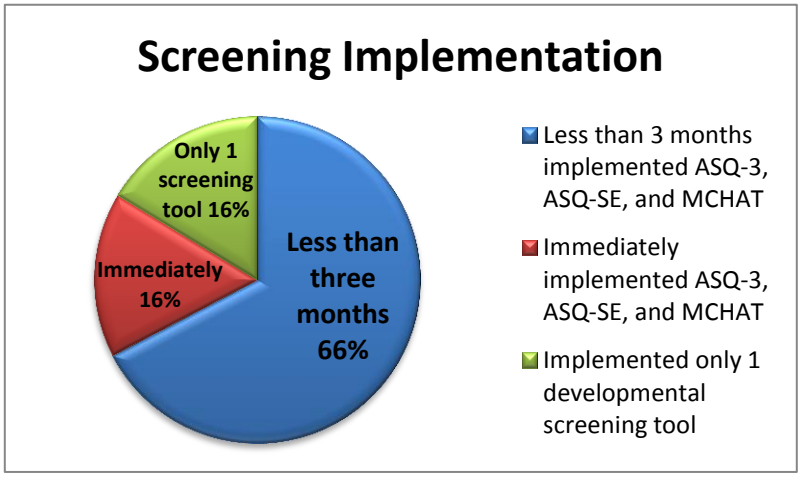
C. 3 month Implementation Survey

Each of the 6 practices trained prior to February 2013 were asked to respond to a 3 month implementation online survey. As a result, all 6 practices trained responded.

Additionally, the practices were asked:

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

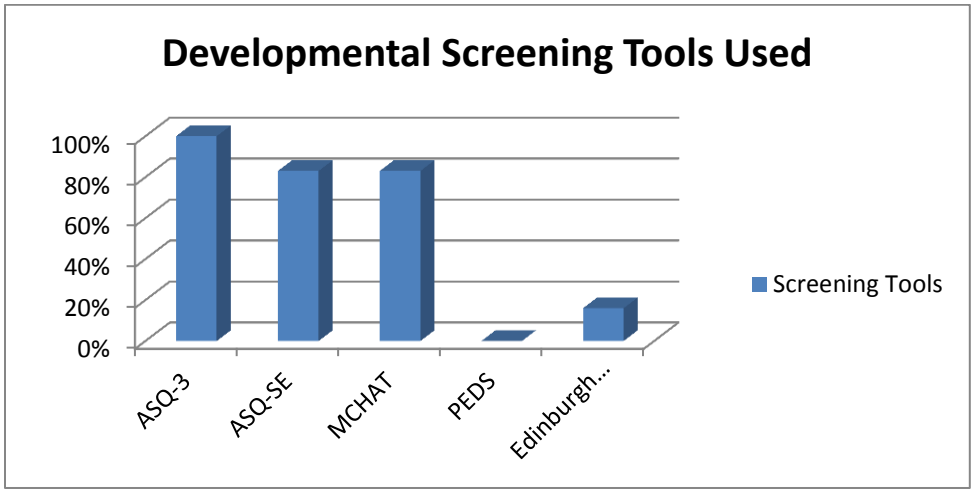
Figure 1 – 3 Month Screening Implementation Survey Results



The results show that 16% (N=1) of the practices had only implemented one out of three developmental screening tools. The practice had indicated they were using the ASQ-3. They have not implemented using the ASQ-SE and MCHAT at the recommended well-child visits due to the need for further staff training. A total of 83% (N=5) of the practices implemented all the developmental screening training components.

2. What standardized screening tool did the practices use?

Figure 2 – Developmental Screening Tools Used



During the training, the practices were taught how to integrate and use evidence-based developmental screening tools. The ASQ-3, ASQ-SE, and MCHAT were the tools included in the training. Reponses to the survey question indicated that 83% (N=5) of practices were using the three recommended screening tools. One practice had yet to use the ASQ-SE and MCHAT but plans to do so in the future after additional staff training. One practice responded they are using the ASQ-3, ASQ-SE, MCHAT, and Edinburgh Postnatal Depression Scale (EPDS). The EPDS is a validated tool used to detect maternal depression at the 6-8 week postpartum examination.

3. What did 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:

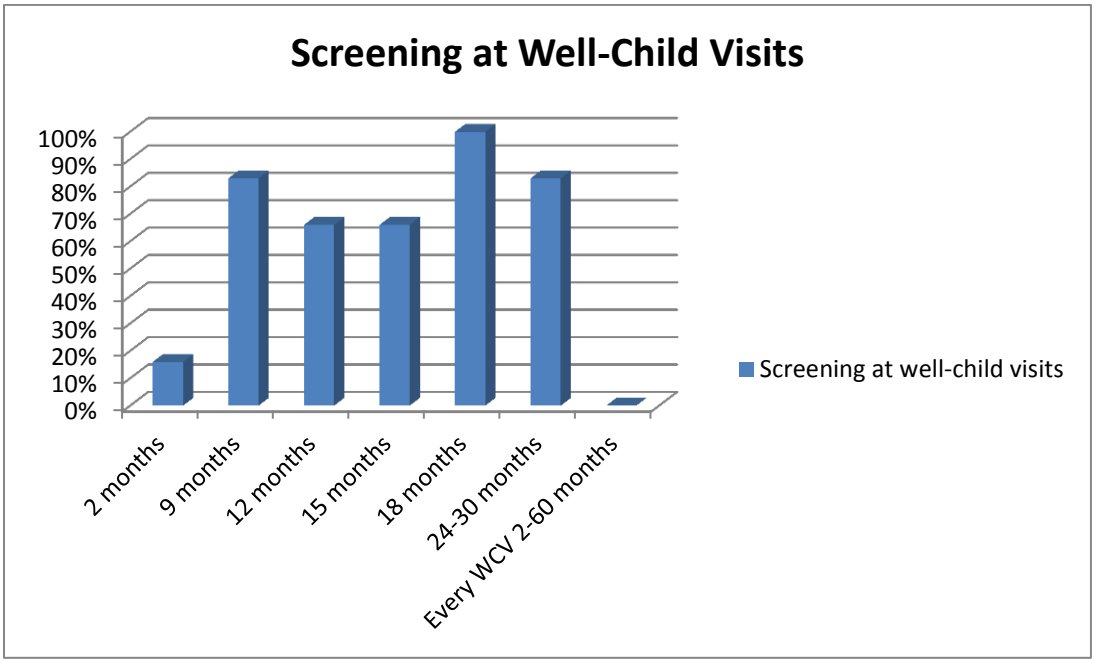
> "It is quite easy to score and parents have little questions. They can understand easily."
>
> "It is easy to score."
>
> "Measures the child's development."
>
> "Ease of scoring and the amount of good information we can easily obtain from the screen."
>
> "It's a more formal process."

"It takes more time on the parent's part, but it is a more detailed screening of the child's development. Since the parents are now filling out the ASQ, I no longer have to ask all the questions during the exam itself."

The experiences of the practices were very positive and one practice mentioned having the screening tool completed and scored saved time during the child's well-child appointment. Shifting from surveillance questions or a check list to evidence-based screening tools allowed the practice to save time and to determine the developmental needs, if there were developmental delays that had to be addressed.

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

Figure 3 – Screening at Well-Child Visits



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 and recommended the additional use of the ASQ-SE tool during the 15 month well-child visit. The recommendation was based on the fact that once the practices implemented the developmental screening, during the 18 month well-child visit, there was a potential of having to complete the ASQ-3, ASQ-SE, and MCHAT. By taking clinic time into consideration, the trainers made this recommendation to avoid three developmental screens during one appointment.

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 (WCV). From the 6 practices surveyed, the practices reported using a standardized tool during the following intervals for well-child visits:

83% 9 months

66% 15 months

100% 18 months

83% 24-30 months

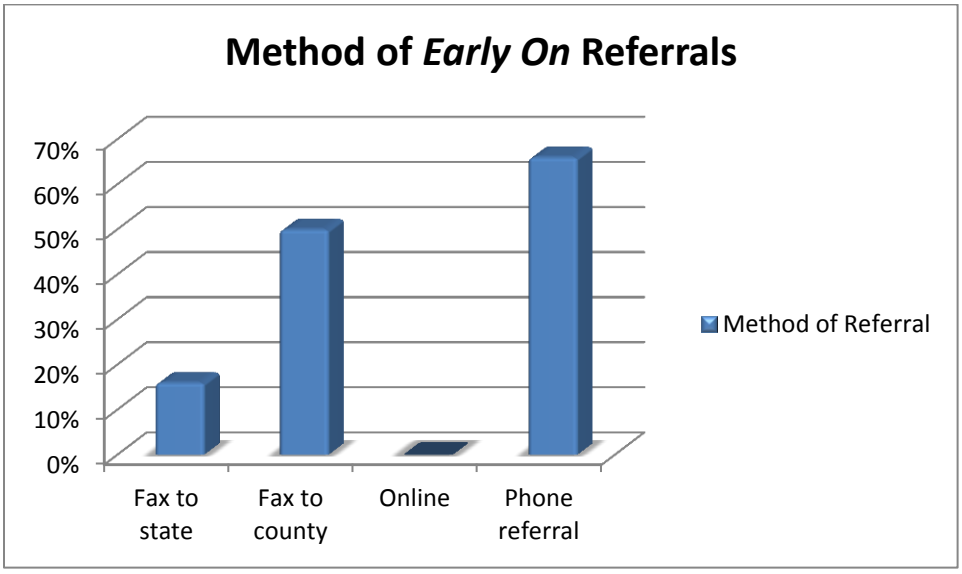
0% Every well-child visit 2-60 months

Other: 4 of the 6 practices reported an additional screening at 12 months, and 1 practice reported an additional screening at 2 months.

In reviewing the responses from the practices, the screening data is very consistent among the ages 9, 18, and 24-30 month visits as recommended by the AAP guidelines.

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

Figure 4 – Method of *Early On* Referrals

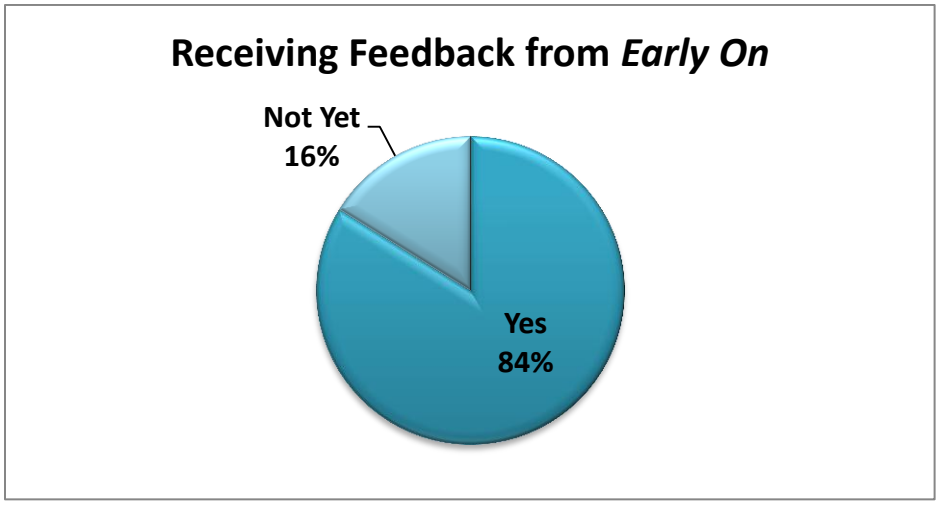


It was reported that 100% of the 6 practices were referring to *Early On*. One physician reported that they were giving the *Early On* phone number to parents to make their own referral. The other 3 practices used the phone referral method but did not indicate whether a clinical staff person was making the call or if the parent was.

As found by previous PCDS I efforts, the varied methods of making a referral made it difficult to track and follow-up on referrals made. During the PCDS II training, the trainers expressed the importance of referring through the state *Early On* versus the county *Early On* and for the practice to create their own tracking mechanism for patient referrals. Referring through the state allowed for oversight to ensure that the counties completed the referral process within the appropriate amount of time. If a referral was made directly to the county, the state had no way of tracking the referral.

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

Figure 5 – Receiving Feedback from *Early On*



The 16% not yet receiving feedback from *Early On* represents 1 practice and the medical champion physician of that practice had not been referring to *Early On* prior to the training. The fact that 84% of practices are receiving feedback from *Early On* is a significant increase from PCDS I findings where 68% of practices reported receiving feedback.

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.

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 reimbursement. **Of the 6 practices, 100% were billing for the developmental screening using the CPT code 96110.**

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:

> "Provide automation to interface with EMR and score."
>
> "Limiting paper work and having *Early On* give us more feedback."
>
> "This is a good program. Thanks."

Partnering with *Early On*

Background: National research has documented the difficulties pediatricians face when referring to early intervention services[9,10,11]. 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 trainings. This allowed for the *Early On* coordinator to describe the benefits and importance of referring to *Early On* and gave the physician and clinical staff a point person in case they had questions in the future.

During the PCDS I project the *Early On* Referral/Status Update form was created by the MIAAP and the Michigan Department of Community Health (MDCH). The form included a portion to be completed by the local *Early On* program that would determine 1) if the child had been evaluated, 2) if the child was eligible for services, 3) what services did the child receive, 4) other referrals *Early On* made on behalf of the child, and 5) *Early On* contact information for the person who completed the feedback portion. The form was then faxed back to the referring physician.

The most significant barrier to facilitating an exchange of information between medical and education communities was the fact there are two different privacy laws in effect. The referring physician information is protected by the Health Insurance Portability and Accountability Act (HIPAA) and *Early On* information is protected by Family Educational Rights and Privacy Act (FERPA). The MIAAP worked diligently with MDCH to overcome this barrier and a legal release of information form was created that met the standards of both HIPAA and FERPA. However, due to the form's length and literacy level required to read and understand it, and its complexity, the practices were told to have the legal guardian sign a standard release of information form that indicated the information would be released to *Early On*. Additionally, *Early On* would work with parents to obtain the appropriate Authorization to Share release to provide information about the referral findings to the physician.

The PCDS II training provided knowledge and resources to each practice to ensure compliance with the privacy laws. Since a majority of clinical staff were not familiar with FERPA, the training was able to address this knowledge gap.

Analysis of the Promoting Child Developmental Screening II Project and Recommendations

The PCDS I and PCDS II trainings resulted in a total of 62 trained practices. There is significant evidence that supports additional funding will increase the reach of the project.

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

Lessons learned:

1. During 2012, data was not being collected successfully from the practices trained. This meant there was no way of knowing if they had implemented the developmental screening and at what rate were they screening eligible children. In 2012, the training was offered as a 1.5 CME approved activity. In 2013, the training was offered as a performance improvement (PI) CME activity worth up to 20 CME credits. With the increased incentive to submit data, practices are submitting data on time.
2. Initially practices raised questions about the data collection component of the training. MIAAP created an Excel data collection spreadsheet and instructions that were made available to the practice prior to the training. This process reduced questions post training and during the training MIAAP was able to determine the best person to contact for data related follow-up.
3. Some practices did not have Microsoft Excel installed on their computers and were unable to complete the data collection spreadsheet. MIAAP provided the options of a Microsoft Word data collection spreadsheet along with hard copies.
4. The limited capability of integrating the developmental screening tools into EMR raises an issue. Practices that had converted over to a paperless system did not want to implement a clinical process that involved the use of more paper. One of the physician trainers shared a practical solution of laminating the developmental screens and having the parents complete the screen using an erasable marker. This allowed practices to key in the scored results into the EMR and gave the option of scanning the score sheet into the patient's medical record.
5. With more physician practices creating websites that include new patient paperwork, some practices wanted to post the developmental screens as PDF files for parents to access and complete prior to the child's appointment. This option was not available due to the copyright laws through Brooke's Publishing. For a fee, Brooke's Publishing does offer an online service to have a link on the practice's website allowing parents to complete the screen online. However, Brooke's Publishing website only includes the ASQ-3 and ASQ-SE, causing problems for practices that want to include the MCHAT or other screening tools. Further work needs to be done to investigate integration of online screening tools and EHRs, possibly through other systems such as that available through www.chadis.com.
6. The practices did not report any issues with reimbursement from Medicaid but did have some issues with private insurers. Two practices had the same problem with one private insurance company applying the charge of the developmental screening to the parent's deductible. Technical assistance was provided by MIAAP and PCDS II's Medical Director to help resolve this issue. After the practices had contacted the insurance representatives of the private insurance company, some improvement was made. The insurance company was stating that the developmental screen billed using CPT code 96110 was a diagnostic test, when in fact it is not

diagnostic but is a screening test. With the help of the National AAP, it was determined that the private insurance billing issues occurred due to the practices not appending the CPT modifier 33 (preventive services) to code 96110. A modifier is used in conjunction with a CPT code to provide detailed information to the insurance plan. Modifier 33 indicates the service took place during an age appropriate preventive medicine service as part of the Bright Futures recommendations and thus should not be subjected to cost sharing.

Recommendations:

1. The MIAAP recommends that the Michigan Department of Community Health 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 an established infrastructure and it has been utilized to promote the training through member marketing efforts. As a result there is a demand for continued training and technical assistance.
2. The MIAAP recommends that local *Early On* coordinators should continue to develop relationships with the pediatricians who practice in their county. By having a local contact, questions can be easily answered from both the medical community and the education community when it comes to sharing of information and the rules and regulations around HIPAA and FERPA. Feedback from *Early On* is critical to the patient's continuation of care and for patient centered medical home requirements.
3. The MIAAP recommends MDCH and Medicaid work together to identify referral sources for children under the age of 3 that had failed a developmental screen but did not qualify for services through *Early On*. During the trainings, providers reported that when a child failed a developmental screen and was referred to *Early On* but did not meet the eligibility requirements to receive services through *Early On*, it was difficult to locate additional community resources. The resource needs ranged from child psychiatrists, neurologists, physical therapists, occupational therapists, and speech therapists. When resources were available lengthy wait times for new patient appointments and accepting Medicaid insured patients were often a barrier to providing services in a timely manner.
4. The MIAAP recommends that MDCH and DHS work with the MIAAP to meet the need as outlined in the new Medicaid bulletin MSA 13-06, effective April 1, 2013, those physicians who see children in foster care need to complete evidence-based social emotional developmental screen within the first 30 days of the child's placement into foster care. One of the recommended tools is the ASQ-SE. The PCDS trainings have only scratched the surface of the number of trainings needed in the state of Michigan and for this new policy to be successful, the spread needs to continue.
5. The MIAAP recommends Medicaid to work with the MIAAP to increase the success rate of the new quality measurements that will measure the number of developmental screens billed and the number of eligible children screened through the Medicaid managed care health plans. The new quality measure is projected to be in place in 2014. With many practices not trained to use evidence-based developmental screening tools and the lack of knowledge of how to bill for these types of screens, the PCDS training will be in high demand.
6. The MIAAP recommends re-applying to the American Board of Pediatrics to approve the MI START MOC part IV quality improvement project for another two years. This project is currently in high demand and offers an excellent incentive for practices to complete data collection submission to the MIAAP post training.

Plan for Spread of Child Developmental Screening Sustainability

The Michigan Chapter of the American Academy of Pediatrics has researched the following plans for sustainability.

1. **MDCH**: MIAAP has indicated continued support of partnership with the Bureau of Family, Maternal, and Child Health. The Department of Health and Human Services is soliciting applications for state planning grants for improving services for children and youth with Autism Spectrum Disorder (ASD) and other developmental disabilities. This opportunity would allow the partnership work of the MIAAP to continue.
2. The MIAAP is researching opportunities to develop and submit funding proposals to foundations to continue to spread developmental screening training throughout Michigan.
3. The MIAAP's Board of Directors is considering charging for the MI START MOC part IV quality improvement project as a means for generating income. This would by no means sustain the developmental screening project but it would increase the sustainability of offering the MI START in addition to the PCDS II training.

Conclusion

The collaborative efforts between MIAAP, MDCH, and *Early On* during the contract year accomplished positive results in increasing the use of evidence-based developmental screening among primary care providers in Michigan. It is important that child developmental screening training continues across Michigan to emphasize the AAP's recommendation that evidence-based standardized developmental screening tools should be administered during the 9, 18, and 24 to 30 month well-child visits.

Currently in Michigan the education community has been educating child care providers, preschool teachers, and day care centers about the importance of early screening and detection. In order to continue communication between the medical community and the education community, on-site in office trainings for primary care providers needs to continue to support the patient's continuation of care between both communities.

Thomas Akland, D.O., F.A.A.P, a pediatrician who participated in the PCDS II project in 2012 stated the following regarding the PCDS II training:

> "I think an invaluable part of this program was the peer-to-peer training with the experienced pediatrician. Doctors get tired of electronic communication. A real strength of this program was the human touch of the person-to-person real-life contact with MIAAP staff and Dr. Holtrop (the trainer). In a large practice like ours, the educational session, training, and ongoing support made a big difference. Having providers and staff who were knowledgeable and trained really helped us make the changes that we need to need to make in order to make this program work. Also, I think this model could be used as a good vehicle for quality improvement across the state of Michigan."

There is a need for improvement in the state and the investment that the state of Michigan makes in increasing the use of evidence-based developmental screening will provide improved developmental outcomes for children. As the AAP's policy statement in 2006 discussed, "early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals." The opportunity for early detection, early referral to intervention services and ensuring school readiness ensures a brighter future for Michigan's children.

Additional Resources

- Implementing Developmental Screening and Referrals: Lessons Learned from a National Project, Pediatrics, Jan. 25, 2010. www.pediatrics.org/cgi/content/full/125/2/350
- Dunst, Carl J. TRACE Practice Guide: Providing Feedback to Primary Referral Sources, Dec. 2006.
- Bruner, Charles. "Connecting Child Health and School Readiness." The Colorado Trust: Issue Brief, February 2009, p.7.
- Developmental Screening in Early Childhood Systems, AAP Meeting Summary. March 2009.
- Medicaid policy bulletin MSA 13-06 *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Guidelines for Children in Foster Care,* March 2013. http://www.michigan.gov/mdch/0,4612,7-132--87513--,00.html

Appendix 1: Terminology

For 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 developmental screening tools

- **ASQ-3**- Ages and Stages Questionnaire 3. Evidence-based global developmental screening for children from 2 months to 5 years of age. The ASQ-3 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.
- **ASQ-SE**- In-depth screening of seven areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. Used from 6 months to 5 years of age. Published by Brookes Publishing.
- **MCHAT**- The Modified Checklist for Autism in Toddlers is a validated screening tool for toddlers between 16 and 30 months of age, to assess risk for autism spectrum disorders (ASD).
- **PEDS**- Parents Evaluation of Developmental Status, www.pedstest.com. Evidence based screening tool that elicits and addresses parent(s) 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.
- **Edinburgh Postnatal Depression Scale (EPDS)**- a validated tool used to detect depression at the 6-8 week postpartum examination.

Appendix 2

Michigan Chapter American Academy of Pediatrics
Promoting Child Developmental Screening (PCDS) II
2013
Letter of Agreement

MICHIGAN STATE UNIVERSITY | College of Human Medicine

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Michigan State University and Michigan Chapter of the American Academy of Pediatrics. Michigan State University is accredited by the ACCME to provide continuing medical education for physicians.

Michigan State University designates this PI CME activity for a maximum of **20** ***AMA PRA Category 1 Credits™.*** Physicians should claim only the credit commensurate with the extent of their participation in the activity.

At the end of participation in this activity, the learner will be able to:

1) Utilize developmental screening tools to identify children with developmental needs.
2) Describe the benefit of early referral utilizing evidence-based research and return on investment research.
3) Describe and understand the pediatrician's role in referring children for further assessment and treatment.
4) Describe and understand the community based referral services and how to refer and track progress of patients.
5) Bill for developmental screening.
6) Receive a resource list of community referral organizations including: *Early On®*, Great Start Collaborative, Head Start, Special Education.
7) Describe the benefits, process, and methods for engaging in partnership between providers, community referral agencies and parents.

Name of practice:_____

Address:_____

Email:_____

Phone: _____

Attending Physician:_____

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

In signing this letter of agreement, our practice agrees to:

1) Begin implementing the child developmental screening within 3 months of the training (*worth 5 CMEs*).
2) Participate in data collection.
    a. Complete baseline data either prior or immediately following training (*worth 5 CMEs*).
    b. Conduct monthly chart reviews for data collection for up to 6 months; until it is determined by MIAAP that developmental screening has successfully been implemented into clinic work flow with a goal of 70% of eligible children screened, 70% billed/coded, 90% referral to *Early On*.
    c. Submit data collection spreadsheets on a monthly basis to MIAAP Program Manager after implementation has occurred (*worth 10 CMEs*).
3) MOC (Maintenance of Certification) part IV quality improvement participation.
    a. If the physician(s) will be utilizing this training as an ABP qualified quality improvement project then the above stated data collection will be completed for 12 months.
    b. If it is determined that the quality improvement measures have been met, the physician(s) will print off the ABP attestation form and submit it to MIAAP for the Medical Director's review and signature.
        i. Quality Improvement Measures (screening at least 70% eligible children):
            1. ASQ or PEDS given at 9 months, 18 months, 24-30 months
            2. ASQ-SE given at 15 months
            3. MCHAT given at 18 and 24 months
        ii. Billing/coding developmental screens for at least 70% of screens completed.
        iii. 90% of children who have a positive screen will be referred for further evaluation to *Early On*.
4) Complete two surveys:
    a) Post training evaluation
    b) 3 month implementation evaluation
5) Refer children to *Early On* for further assessment and services.
6) Provide informal feedback to the MIAAP assisting in the documentation of barriers, opportunities, and successes of the Child Developmental Screening project for the grant report to the Michigan Department of Community Health.

_____

Signature of Attending Physician Date

_____

Signature MIAAP Medical Director Date

Please return to Carley Kirk, MIAAP, Program Manager:

Via mail: 106 W. Allegan Suite 510, Lansing, MI. 48933
Via fax: 517-575-6285 ATTN: Carley
Via email: carley.kirk@miaap.org

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, 95, 829-836.

[8] Glascoe FP, Dworkin PH (1995). "The Role of Parents in the Detection of Developmental and Behavioral Problems." Pediatrics, 95, 829-836.

[9] King TM, Tandon ST, et al. (2010). "Implementing Developmental Screening and Referrals: Lessons learned from a National Project." Pediatrics, 125, 350-360.

[10] "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.

[11] TRACE Practice Guide: A Universal Checklist for Identifying Infants and Toddlers Eligible for Early Intervention, Nov. 2007.