CARE FOR KIDS
Early & Periodic Screening, Diagnosis & Treatment
Volume 14 • Number 1 • Winter 2007

Healthy Mental Development in the Young Child: *The Case For Practice Change*

Alfred Healy, MD, Professor Emeritus, Department of Pediatrics, Children's Hospital of Iowa
Kay DeGarmo, Director, Iowa Prevention of Disabilities Policy Council

Science Supports a Call for Change

New scientific understandings in child development document the need for health providers to alter their current practices. Research confirms that the foundations for learning, school success, interpersonal relationships, health, and general well-being are established well before a child enters kindergarten (VanLandeghen).

Emotional development in young children is now known to be as important as physical, cognitive, and language development. Research (Peth-Pierce) shows that children who do not reach age-appropriate social and emotional milestones are at far greater risk of school failure, which places them at increased risk for juvenile delinquency and welfare dependency.

Young children of depressed mothers are at particular risk for delays in school readiness, verbal comprehension, and expressive language skills. They are also 6 to 8 times more likely to be diagnosed with a major depressive disorder, and 5 times more likely to develop conduct disorders (Lennon). Services that support healthy mental development in young children have been shown to improve school readiness, health status, and academic achievement; they also reduce the need for grade retention, special education services, and welfare dependency (Peth-Pierce).

The health system is the one system with which nearly all families have contact during a child's first five years of life.

Evidence now suggests that early diagnosis and prevention increase effectiveness and efficacy, both for children with social-emotional risk factors and for those with biologically based conditions (Knitzer, 2002). Indeed, well-designed early childhood interventions have been found to generate a return to society ranging from $1.80 to $17.07 for each dollar spent (Rand).

What Needs to Change

The involvement of health care providers is essential to addressing the healthy mental development of Iowa's young children. The health system is the one system with which nearly all families have contact during a child's first five years of life. Studies also show that parents rely on

(continues on page 2)

(continued from page 1)

their child's health care provider for developmental monitoring, and expect to get information from their provider about parenting and child development (Schor). Without your involvement, many developmental problems will go undetected until the school years, and key prevention opportunities will be missed.

Unfortunately, considerable evidence suggests that current practices are not working well. While 15-18% of school-age children have a developmental or behavioral disability, less than half are identified prior to starting school. Studies show that most health care providers rely on clinical judgment to assess a child's development; however, clinical judgment has been shown to detect fewer than 30% of children who have developmental concerns (Glascoe).

The challenge to today's health care provider is to establish office practices and processes that:

- Provide consistent, systematic surveillance of each child's development at every well-child exam, and identify risk factors
- Ensure that each child who needs it receives further screening or evaluation specific to the area of concern
- Identify and establish referral relationships with local social, educational, health, and other resources
- Seek input from parents about whether their methods are meeting the family's needs
- Involve colleagues, nurses, and office personnel in developing and implementing practice changes

Blueprints for Change

Two recent events can assist Iowa health care providers to better promote the healthy mental development of young children.

First, the American Academy of Pediatrics has published a policy statement on developmental screening (http://aappolicy.aappublications.org/) that:

- Encourages surveillance at each well-child visit
- Recommends screening with standardized tools at specific intervals
- Provides an algorithm to help implement the policy

Second, Iowa's ABCD II Healthy Mental Development Initiative, a 3-year systems change effort funded by the National Academy for State Health Policy and the Commonwealth Fund, has produced recommendations for integrating developmental services into Iowa health care practices and communities (see page 4). These include:

- Defining a health care system that promotes the healthy mental development of Iowa's young children through three levels of care:

  Level 1: Care for all children
  Level 2: Care for children at risk
  Level 3: Care for children with diagnosed developmental problems

- Developing guidelines for the identification of children at each of the three levels of care (see page 5; these guidelines are endorsed by many Iowa health provider associations).
- Designing and testing a surveillance tool for use at each well-child exam for children 0-5. The Iowa Development and Behavior Checklist can be used as a stand-alone tool. It can also be found within Iowa's Health Maintenance Clinical Notes (HMCN), which are age-specific forms that provide guidance to providers for all components of the well-child exam (see page 5).
- Identifying and recommending a short list of standardized screening tools in each domain (see page 6), tools that are recommended by a team of Iowa clinicians who practice in the field.
- Examining referral processes and testing a model process to support health care providers in linking families with appropriate community services (see page 4).

Opportunities for Your Practice

With funding from Iowa Empowerment and Medicaid, the Children's Hospital of Iowa Center for Disabilities and Development is partnering with the Iowa Chapter of the American Academy of Pediatrics to offer additional

(continues on page 3)

(continued from page 2)

training, technical assistance, and mentoring to practices interested in implementing recommended practice changes. Learn more about the opportunities available to your practice from:

Kris Tiernan, RN, MSN, ARNP, CPNP, Initiative Coordinator
kris-tiernan@uiowa.edu

"Childhood Development" has also been selected as a theme for the 2007 Iowa Medical Home Initiative Learning Collaborative for primary care practices. Learn more about this opportunity from:

Susie Kell
Executive Vice President
Iowa Academy of Family Physicians
susiekell@iaafp. org
515-283-9370

Resources

Glascoe FP. "Early detection of developmental and behavioral problems." *Peds Rev* 2000.

Knitzer J. Building services and systems to support the healthy emotional development of young children (Nat Ctr for Children in Poverty, 2002).

Lennon MC et al. "Depression and low-income women: Challenges for TANF and Welfare-to-Work politics and programs" (Nat Ctr for Children in Poverty, 2001).

Peth-Pierce R. "A good beginning: Sending America's children to school with the social and emotional competence they need to succeed (Child MH Foundations, 2000).

Rand Labor and Population Research Brief: Proven Benefits of Early Childhood Interventions, 2006.

Schor E. "Rethinking well child care." *Peds* 2004.

Coming Your Way:

A New Resource for Linking Families with Needed Services

Kay DeGarmo

Identifying young children at risk for developmental, behavioral, or social-emotional disabilities seems to accomplish little if the child has no access to follow-up services. Health care providers are often reluctant to adopt practices to screen young children unless they are confident that the children they identify will actually receive assistance.

Iowa Early ACCESS has been a consistent source of services for children who have or are at high-risk for developmental problems. Now Iowa Empowerment and a number of community public health agencies are developing services geared toward at-risk children and families. However, finding, tracking, and matching families to services is a complex and time consuming task that can be difficult to handle within the office practice setting.

Iowa's ABCD II Healthy Mental Development Initiative examined referral patterns and tested a public-private partnership model to link children with appropriate community services. The next issue of this newsletter will highlight what participants learned as they tested this partnership model in demonstration sites, and offer information about a new resource that health providers statewide can use to link families to resources.

Promoting the Social and Emotional Health of Children through Early Identification

Iowa's ABCD II Demonstration Project

Scott Lindgren, PhD, Professor, Department of Pediatrics
Kay Leeper, MSN, Community Health Consultant, Center for Disabilities and Development
Children's Hospital of Iowa

This past December, Iowa's Assuring Better Child Health and Development II (ABCD II) project completed the testing of a model for a public-private system of collaborative practice to:

- Promote social and emotional health in children
- Develop stronger relationships among community resource networks

The primary objective of this project was to better equip primary health care providers with the tools and resources they need to provide systematic surveillance, screening, and follow-up of a child's social-emotional development.

ABCD II goals included:

- Identifying, as part of each well-child exam, risk factors in the child and the family
- Connecting providers to a network of resources to help carry out an integrated plan of care that responds to a family's strengths, needs, and choices

Rural and Urban Demonstration Sites

Two group practices, an urban pediatrics practice and a rural family medicine practice, agreed to implement the model. Evaluation was based primarily on audits of medical records for children who received Medicaid services, information in public health records from care coordinators assisting families, and feedback from medical professionals about the costs and benefits of changes in their practices. Providers were given:

- Health Maintenance Clinical Notes forms that include the Iowa Development and Behavior Checklist (see page 5)
- Iowa guidelines for the identification of young children at three levels of care (see page 5)
- Referral resources
- Training on such topics as social-emotional concerns in the young child, autism, and maternal depression

Surveillance/screening Rates

At baseline, surveillance/screening for general developmental problems was adequate for 89% of children in the urban pediatric practice and 70% of children in the rural family medicine practice (see tables 1 and 2), indicating reasonably capable screening performance in both group practices, but especially in the pediatric practice. After implementation of the enhanced surveillance/screening

(continues on page 7)

Percentage of Adequate Screens

Table 1. Urban Pediatric Practice

Domain	Baseline		Post-Intervention	
	Cases	Percentage	Cases	Percentage
Development	207/232	89%	245/24	998%
Social-emotional	151/232	65%	237/249	95%
Family stress	0/23	20%	201/249	81%
Parent depression	0/23	20%	133/249	53%

Table 2. Rural Family Medicine Practice

Domain	Baseline		Post-Intervention	
	Cases	Percentage	Cases	Percentage
Development	118/168	70%	133/151	88%
Social-emotional	60/168	36%	135/151	89%
Family stress	0/16	80%	121/151	80%
Parent depression	0/16	80%	114/151	75%

Recommendations for Implementing Iowa Medicaid Guidelines:

Identifying Young Children with Developmental or Behavioral Concerns

LEVEL 1: **Surveillance for All Children**

GUIDELINE: Every EPSDT well-child exam for a child 0-3 years must include:

- Surveillance of cognitive, motor, language, adaptive, and social-emotional development
- A review of:
  - Developmental milestones
  - Social, emotional, and behavioral health, including early signs of autism
  - Family risk factors, including parental stress and maternal depression
- Eliciting and addressing parental concerns about the child's growth and development

Level 1 goals can be accomplished using either of the options below:

OPTION 1 Meets current AAP recommendation for surveillance at each well-child visit.

Recommended protocols & tools

Either of the tools below may be administered in the office by the health care provider and nurse teams. Each of these tools:

- Is age-specific for each standard well-child visit up to age 5
- Provides a checklist of developmental and social-emotional milestones, and screens for family risks
- Can be downloaded free at the link provided
- Is easy to insert into an electronic medical record

Health Maintenance Clinical Notes (HCMN)
http://www.iowaepsdt.org/ScreeningResources/clinNotesForms.htm
HMC Notes gather information on such topics as nutrition, medications, immunizations, and lead screening. The checklist format makes it easy to gather information and to provide anticipatory guidance. HMC Notes also contain the Iowa Development and Behavior checklist discussed below.

OR

Iowa Development and Behavior Checklist
Administration and interpretation of this tool take 3-5 min. If a child cannot execute an activity that about 90% of other same-age children are able to perform, this is a "red flag" that signals the need to refer the child for further assessment.

OPTION 2 Health care providers who do not choose to use either of the tools in Option 1 should complete comprehensive surveillance in **all three domains** below during the well-child exam.

1. ***Domain:*** **Development**
One of the developmental questionnaires below can be completed by a paraprofessional with the parent, or by the parent alone, and then reviewed by the primary health care provider. All children with speech delay should be referred for audiological evaluation.

Recommended tools include:

PEDS -- 0-8 yrs (Glascoe 1998), http://www.pedstest.com/test/peds_intro.html

Ages and Stages, 2 mo.s to 5 yrs (Bricker and Squires 1999), http://www.pbrookes.com/

Child Development Inventories, 3 mo.s to 6 yrs (Ireton 1994), http://www.childdevrev.com/index.html

2. ***Domain:*** **Social-emotional and behavioral, including autism**
Administer a screening questionnaire at intervals determined by the health practitioner. Please note that the AAP also recommends specific screening for autism at 18 months.

Recommended tools include:

Ages and Stages - Social-Emotional (ASQ-SE, 2002), http://www.pbrookes.com/

Brief Infant-Toddler Social and Emotional Assessment (2000),

Infant Development Inventory/Child Development Review (1994), http://www.childdevrev.com/index.html

3. ***Domain:*** **Parenting stress and family risk factors**
The practitioner should review for postpartum depression during the first few newborn visits and periodically check for parenting stress, parental depression, and other family risk factors.

Recommended tools include:

At the first visit: Pediatric Intake Form, available from Bright Futures, http://www.brightfutures.org

At subsequent visits, at least annually: Pediatric Intake Form

In addition to the routine Level 1 surveillance described above, the AAP recommends periodic screening using a standardized tool at 9, 18, and 24-30 months.

(continues on page 6)

LEVEL 2: **Screening for Children at Risk**

GUIDELINE: Every child 0-3 years old who is identified as at-risk during a well-child exam, as well as any child the provider feels should have additional screening, must receive Level 2 screening. If one of the standardized tools recommended below was used during surveillance, or if the provider feels it is indicated, proceed to Level 3 assessment.

1. Developmental Screening

A health professional should provide screening; paraprofessionals may assist with administration of parent report scales. The AAP recommends developmental screening for all children at 9, 18 and 24-30 months. All children with speech delay should be referred for audiological evaluation.

Recommended tools include:

Ages and Stages (**ASQ**, 2nd ed.)
www.brookespublishing.com

Sensitivity	70-90%
Specificity	76-91%
Age	0-60 mo.s
Administration	Parents complete
Time	10-15 min, less if parent completes alone
Languages	English, Spanish, French, Korean
Cost	$12.41-16.68*; $4.60 if parent completes alone**

Comments: Single, pass/fail scoring; reading level varies per question from grade 4-12

Bayley Infant Neurodevelopmental Screen (**BINS** 1995)
www.psychcorp.com

Sensitivity	75-86% across ages
Specificity	75-86%, across ages
Age	3-24 mo.s
Administration	Direct elicitation
Time	10-15 min
Languages	English
Cost	$22.22-$26*; $10.45 for materials**

Comments: Cut scores for low, moderate, or high risk in domains; training helpful for checking reflexes and tone

Brigance Screens (2002)
www.curriculumassociates.com

Sensitivity	70-82% across ages
Specificity	70-82% across ages
Age	0-90 mo.s
Administration	Infant/toddler, parent report. Early preschool, direct elicitation
Time	10 min
Languages	English, Spanish
Cost	$11.68 for materials and time**

Comments: Helpful scoring software; cutoffs indicate potential giftedness, psychosocial risk

Denver II (1992)
www.denverii.com/DenverII.html

Sensitivity	56-83%
Specificity	30-80%
Age	0-72 mo.s
Administration	Direct elicitation
Time	15-20 min
Languages	English, Spanish
Cost	Complete kit $90; 100 test forms for $25

Comments: Uses risk groups; classifies children as normal, suspect, or delayed

2. Social-Emotional and Behavioral Screening

Screening by a health professional; paraprofessionals may assist with administration of parent report scales.

Recommended tools include:

Ages and Stages Social- Emotional (ASQ-SE, 2002)
http://www.brookespublishing.com

Sensitivity	71-85%
Specificity	90-98%
Age	6-60 mo.s
Administration	Parent completes
Time	10-15 min, less if parent completes alone
Languages	English, Spanish, French
Cost	$4.60 for materials if parent completes alone

Comments: See ASQ, above

Brief Infant and Toddler Social and Emotional Assessment (BITSEA, 2000)
http://harcourtassessment.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8007-352

Accuracy	Fair to good
Age	12-36 mo.s
Administration	Parent completes 60 items
Time	Unknown
Languages	English
Cost	Kit, $99; $35 for 25 test forms

Comments: Normed on diverse population

Infant Development Inventory (IDI) and Child Development Review (CDR, 1994)

CDR
http://www.childdevrev.com/index.html

Accuracy	Not known
Age	18-60 mo.s
Administration	Parent completes 6 questions, 25-item checklist
Time	Unknown
Languages	English, Spanish
Cost	$65 starter kit; $11 replacement materials

IDI
http://www.childdevrev.com/index.html

Accuracy	Good
Age	18 mo.s
Administration	Parent complete one page, both sides
Time	Unknown
Languages	English, Spanish
Cost	$65 starter kit; $11 replacement materials

3. PDD/Autism Screening

AAP recommends screening all children for autism at 18 months by a health professional; para-professionals may help administer parent report scales. If an autism screen is positive or a high degree of concern exists, refer for diagnostic assessment. Refer children with speech delay for audiological evaluation.

Recommended tools include:

M-CHAT (2001)
http://www.nas.org.uk/nas/jsp/

Sensitivity	87%
Specificity	99%
Age	16-48 mo.s
Administration	Parent completes
Time	5-10 min
Languages	English, Chinese, Japanese, Spanish, Turkish
Cost	Materials free; administration cost unknown

Comments:
Risk categorization scorig (pass/fail)

4. Parenting Stress/Family Risk Factors

Screening by health professional.

Recommended tools include:

Edinburgh Postnatal Depression Scale - EPDS (1987) five questions; in the public domain; free download. http://www.dbpeds.org/articles/detail.cfm?TextID=485

Parenting Stress Index Short Form (1995)
http://www.parinc.com/product.cfm?ProductID=127

LEVEL 3: **Assessment for children with developmental or social-emotional concerns**

GUIDELINE: Refer all children 0-3 years who do not pass standardized screening, or who, in your opinion, require further evaluation, for systematic, comprehensive assessment. This assessment should include standardized measures of the child and family functioning, and should provide a diagnosis as well as a treatment plan.

Recommended protocols & tools

Professionals who provide testing as authorized by their scope of practice should determine domains to be tested.

Table footnotes

*Resource-Based Relative Value Scale (RBRVS) used to calculate Medicare rates, as reported in "Estimating the Cost of Developmental and Behavioral Screening of Preschool Children in General Pediatric Practice," *Peds* 108:4 (Oct 2001).

** http:/www.dbpeds.org

(continued from page 4)

procedures, rates of adequate screening increased to 98% in the pediatric practice and 88% in the family practice; only 22 of 400 children did not get adequate developmental surveillance.

Screening for social-emotional problems was lower in both practices at baseline than it had been for general developmental problems, with adequate screening for 65% in the pediatric practice and 36% in the family practice. When records were reviewed after implementation of the model, screening rates improved to 95% in the pediatric practice and 89% in the family practice.

Neither practice provided systematic screening for family stress or parental depression at baseline. Screening improved dramatically when practices were provided with a simple surveillance/screening tool for this purpose. Family stress was adequately reviewed in 80-81% of cases seen at follow-up, while risk for parent depression was reviewed in 53% of cases seen in pediatrics and 75% of cases seen in family medicine. The somewhat higher depression screening rates in family medicine were accompanied by physician report that family physicians were accustomed to interviewing and treating parents for personal problems, while pediatricians felt less comfortable raising these questions with parents during an evaluation that focused on the child.

Provider Comments

While providers recognized the potential value of including social-emotional, developmental, and family risk screening and follow-up in the well-child exam, they were wary of the extra time and work the surveillance/screening might require. "Initially," commented one pediatrician, "I thought, 'How much time and work will this be? It's going to throw us off kilter.' Then after hearing about it, I thought it made sense."

A family physician said, "It is more structured than before, a more organized approach. It takes a little more time, but not much." Another commented, "Many times you didn't think about those things until a child isn't doing them. Now we are being more attentive to those types of problems."

Apprehension also existed about asking adult caretakers about maternal depression and other socio-emotional risk factors. These doubts generally disappeared as providers became more accustomed to doing the screening and realized how it helped children and families. "Maternal depression is an easy question to avoid because it deals with the mother or caretaker, but it is an important issue that affects children," said a pediatrician. "The screening is a great way to begin a dialogue with parents. It is a start; doing something is better than doing nothing."

A pediatric nurse commented, "Parents seemed to appreciate that we cared. As our comfort went up, so did the parent's." A family physician noted that the "physical development red flags didn't change. That is straightforward. It was the emotional support that was new."

Another pediatrician remarked, "The project has been very helpful--especially with a good team of providers in the clinic and in the community where everyone knows their role."

"...screening is a great way to begin a dialogue with parents..."

"Parents...felt they were cared about. It built rapport."

"Better be incorporating this into medical training. This is a solid framework."

Providers from both practice sites agree they will continue using the model. They believe the social-emotional component is useful in drawing out concerns from parents; as one provider said, "The HMCN forms were good in identifying risk history and concerns from parents. Parents were glad to hear providers asking those kinds of questions and felt they were cared about. It built rapport." And parents commented, "No one has ever asked me about that before."

Both pilot sites made valuable suggestions about ways to improve the HMCN forms and to spread the concept of the surveillance/screening model to other Iowa primary care practices, both pediatric and family medicine.

As one provider noted, "Better be incorporating this into medical training. This is a solid framework."

What's in this issue

Healthy Mental Development in the Young Child: *A Case for Practice Change* 1

Coming Your Way: New Resource for Linking Families with Needed Services 3

Promoting the Social and Emotional Health of Children through Early Identification: *Iowa's ABCD II Demonstration Project* 4

Recommendations for Implementing Iowa Medicaid Guidelines: Identifying Young Children with Developmental or Behavioral Concerns 5-6

If you have questions about **billing** related to EPSDT Care for Kids services, please call Provider Services: **1-800-338-7909**

If you have questions about **clinical issues** and EPSDT Care for Kids services, please call **1 -800-383-3826**

Please note: Due to budget restraints, the *EPSDT Care for Kids Newsletter* is sent to offices and organizations, rather than to individuals.

The newsletter is also available online at http://www.iowaepsdt.org/EPSDTNews/

The **EPSDT Care for Kids Newsletter** is published three times a year, in print and online, as a joint effort of the Iowa Prevention of Disabilities Policy Council, the Iowa Department of Human Services, the Iowa Department of Public Health, and the Center for Disabilities and Development, which is nationally designated as Iowa's University Center for Excellence on Disabilities. The goal of this newsletter is to inform Iowa health care professionals about the EPSDT Care for Kids program, to encourage them to make use of this important resource, and to provide them with information about a wide range of developments in the field of health care.

NEWSLETTER STAFF

Executive Editors
Claibourne I. Dungy, MD, MPH
Ellen Link, MD
Don Van Dyke, MD

Production Editor
Susan S. Eberly

Graphics Editor
Loretta Popp

Editorial Board
Robert Anderson, MD
Kay DeGarmo
Carol Hinton
Dianne McBrien, MD
Sally Nadolsky
Steven Wolfe, MD

Any correspondence concerning the newsletter should be addressed to:

Claibourne I. Dungy, MD, MPH
or Ellen Link, MD
Family Care Center – Pediatrics
University of Iowa Hospitals and Clinics
200 Hawkins Drive 01212 - PFP
Iowa City, IA 52242-1083

Children's Hospital of Iowa
Center for Disabilities and Development
University Center for Excellence on Disabilities
100 Hawkins Drive
Iowa City IA 52242-1011

PRSRT STD
US Postage
PAID
Permit 45
Iowa City, Iowa

Attention all EPSDT Care for Kids Newsletter *readers:*

Please answer the questions below and return this postage-paid survey today! *Thanks!*
(Fold along dotted lines and tape the edges closed.)

1. My profession is:

a. ❑ Family physician
b. ❑ Pediatrician
c. ❑ Physician, other specialty: _____
d. ❑ Health care office manager
e. ❑ Nurse
f. ❑ Nurse practitioner
g. ❑ Nurse, public health
h. ❑ Physician assistant
i. ❑ Dietitian
j. ❑ Psychologist
k. ❑ HeadStart provider
l. ❑ School nurse
m. ❑ Social worker
n. ❑ Teacher or other educator
o. ❑ Other: _____

2. Topics that interest me

	Most	Some	Least
a. ❑ Well-child care			
b. ❑ Health issues: Children birth to age 5 years			
c. ❑ Heath issues: Children age 5 to 12 years			
d. ❑ Health issues: Adolescents age 12 to 18 years			
e. ❑ Health issues: Children with special needs			
f. ❑ Health issues: Family			
g. ❑ Preventive health care			
h. ❑ Updates: Recommended clinical protocols			
i. ❑ Updates: State and federal programs			
j. ❑ Referral information: Community resources			
k. ❑ Care coordination			
l. ❑ Handouts I can provide to families			
m.❑ Topic-specific coding and billing information			

Additional comments or suggestions on newsletter content:

3. I would like each issue of this newsletter to:

	Always	Sometimes	Never
a. ❑ Focus on single topic			
b. ❑ Cover a range of topics			
c. ❑ Have fewer articles of greater depth			
d. ❑ Have more short articles with references on how to find more information			
e. ❑ Provide information in a more clinical way			

4. When the *EPSDT Care for Kids Newsletter* comes, I usually *(please check all that apply):*

a. ❑ Read all of it
b. ❑ Read some articles
c. ❑ Scan the headlines
d. ❑ Look for the handouts
e. ❑ Put it aside to read later
f. ❑ Route the newsletter to others in my workplace
g. ❑ Share it with families
h. ❑ Talk about it with others
i. ❑ File it for future reference
j. ❑ File some articles for future reference

5. In our workplace, the people most likely to read this newsletter are *(please check all that apply):*

a. ❑ Family physician
b. ❑ Pediatrician
c. ❑ Physician, other specialty: _____
d. ❑ Health care office manager
e. ❑ Nurse
f. ❑ Nurse practitioner
g. ❑ Nurse, public health
h. ❑ Physician assistant
i. ❑ Dietitian
j. ❑ Psychologist
k. ❑ HeadStart provider
l. ❑ School nurse
m. ❑ Social worker
n. ❑ Teacher or other educator
o. ❑ Other: _____

6. Our office provides care to (please indicate the populations you serve, and the approximate per cent of your practice that each group represents):

a. ____% Well-child care patients
b. ____% Children birth to age 5 yrs
c. ____% Children age 6 to 11 yrs
d. ____% Children age 12 to 21 yrs
e. ____% Children with special health care needs
f. ____% Prenatal care for women

7. The community in which we provide services has a population of:

a. ❑ Less than 1,000
b. ❑ 1,000 to 2,000
c. ❑ 2,000 to 5.000
d. ❑ 5,000 to 10,000
e. ❑ 10,000 to 20,000
f. ❑ 20,000 to 30,000
g. ❑ 30,000 to 50,000
h. ❑ 50,000-100,000
i. ❑ 100,000 to 250,000
j. ❑ 250,000 or more

Fold here first

8. Our services are provided through:

a. ❑ Private practice
b. ❑ Hospital-based service
c. ❑ County health department
d. ❑ Child Health Specialty Clinic
e. ❑ School
f. ❑ Daycare center
g. ❑ Other, please describe _____

9. I prefer to get this newsletter:

a. ❑ In print, by regular mail
b. ❑ Via email link to online newsletter
c. ❑ Twice a year
d. ❑ Three times a year
e. ❑ Four times a year

10. I like having the newsletter available online. ❑ Yes ❑ No

11. I have read this newsletter online or downloaded articles from it. ❑ Yes ❑ No

12. In my opinion, the most significant health concern of the children and their families I serve is:

Fold here second

Please fold survey so that address panel shows on outside, and tape all three open edges.
Don't staple -- staples jam post office machines and cut postal workers' hands. This is postage-paid, no stamp needed.

~*Thank You*~ for helping make the *EPSDT Care for Kids Newsletter* an even better resource for those who care for Iowa children and their families.

(Business Reply setup)

Brenda Nosbish
Center for Disabilities and Development -- 1 5575700
100 CDD
The University of Iowa
2222 Old Hwy 218 S
Iowa City IA 52246-9901