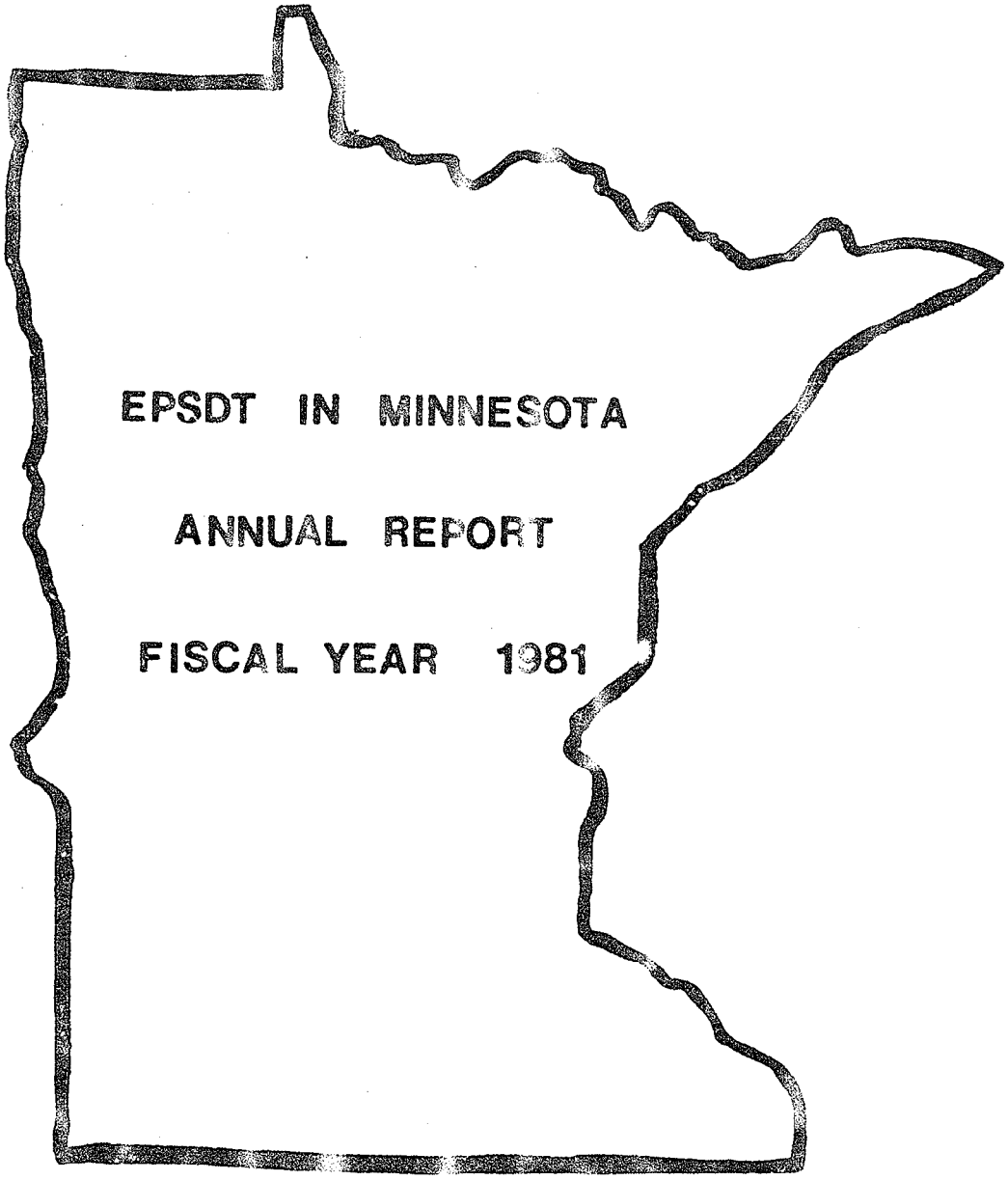

EPSDT IN MINNESOTA

ANNUAL REPORT

FISCAL YEAR 1981

PREPARED BY THE MINNESOTA DEPARTMENT OF PUBLIC WELFARE
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"A [1964-1965] study of Selective Service found that more than 35% of 18 year olds examined for military duty were rejected because of conditions including dental, eye and ear problems, orthopedic problems, internal conditions such as heart disease, and a large percentage of emotional and developmental disorders. Based on a review of medical literature, a group established by HEW estimated that 62% of the serious conditions found by Selective Service were preventable or correctable through comprehensive and continuous health care. Thirty three percent were estimated to be preventable or correctable through periodic screening and treatment. The group also found that disabling conditions and inadequate care were far more common among poor children. ... It was to deal with these problems early -- and cost effectively -- that EPSDT was established."

from: "EPSDT Does It Spell Health Care for Poor Children?" a report by the Children's Defense Fund of the Washington Research Project, Inc. June, 1977; page 25.

I. PROGRAM RESPONSIBILITY

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a requirement of Title XIX (Medical Assistance Provision of the Social Security Act) initiated because of concern that many children eligible for Medical Assistance were not receiving regular preventive health care. Promoters of the EPSDT Program felt that children should be provided with early and regular medical care so their problems would not become worse and require more costly treatment in the future.

The Minnesota Department of Public Welfare (DPW) has responsibility for supervising the program in Minnesota in accordance with federal standards. Responsibilities at the state level for assuring state compliance with federal requirements include development of standards, technical assistance to local welfare agencies, and coordinating outreach and follow-up efforts.

County welfare agencies administer the EPSDT Program at the local level. Responsibilities include conducting outreach to encourage parents to participate in the program, assisting the family in obtaining screening services, and providing follow-up and case management so that children receive needed health services. Local agencies must also maintain program records and documentation for use in federal quality control reviews of the program.

II. ELIGIBILITY

All children aged 0-20 years who are eligible for Medical Assistance are eligible for EPSDT. These include anyone under age 21 who is receiving an AFDC grant, those persons covered under the "Medically needy/needy children" provision of Medical Assistance, and those whose expenses in long term care facilities, intermediate care facilities, foster care or state institutions are paid through the Medical Assistance Program. Reimbursement for the Title XIX screening is 55.64% federal, 39.924% state, and 4.436% county dollars.

Coordination with on-going, comprehensive preventive health care is an important aim of the EPSDT Program. Because of the broad-range of services covered by the Medical Assistance Program in Minnesota, DPW urges that well-child care that meets EPSDT standards be reported as EPSDT whenever such care occurs. Eligibility for EPSDT is continuous with the length of eligibility for Medical Assistance and therefore EPSDT services may be delivered at any time during the course of such eligibility.

III. PROGRAM SUMMARY, FISCAL YEAR, 1981

An average of 116,877 children are eligible, on a monthly basis, for the Medical Assistance Program in Minnesota. All of these children are also eligible to receive Early and Periodic Screening paid for under this program as well as follow-up diagnosis (D) and treatment (T) for most conditions found during the screening.

The EPSDT Program was designed to bring comprehensive health care to children (age 0 to 21) eligible for Medical Assistance. The program is based on the preventive health philosophy of discovering and treating health problems before they become disabling and therefore more costly to treat, in terms of both human and financial resources.

The EPSDT Program goes beyond payment for health care services by providing an outreach component to bring children into the health care system and follow-up to insure that the child receives all needed diagnosis and treatment.

A. Outreach, Notification and Acceptance

EPSDT is a voluntary participation Program for eligible clients. Directly and indirectly, clients must be informed of the purposes, services and benefits of EPSDT. The element of educating clients about the importance of becoming part of an on-going comprehensive health program is intrinsic to the Program.

In order to more clearly evaluate the Outreach component of Minnesota's Program, a study was jointly carried-out by DPW and the Comprehensive Child Health Screening Unit of the Minnesota Department of Health (MDH). The study was undertaken in order (1) to identify the methods and activities practiced in more successful agencies; and (2) to offer assistance and training to less successful agencies in order to increase their acceptance rates. An Outreach manual was produced and is available upon request from the EPSDT unit.

Of those offered the EPSDT Program for the first time, 40.8% accepted screening services in fiscal 1981. The response to written re-notification by the state was 8.3%.

See Chart # [illegible] county notification/acceptance rates.

B. Screening

25,837 children were screened through the EPSDT Program in fiscal year 1981. This figure equals only 57.3% of those who "accepted" screening services during the year. This "no-show" rate occurred in spite of offers of transportation to screening sites and offers of help in making appointments for screening.

The number of screenings also represents 22.2% of the average number of children eligible for EPSDT services and may represent more than one screening per child. The American Academy of Pediatrics recommends a well-child health assessment at birth, five visits during the first year of life, three visits during the second

COUNTY NOTIFICATION/ACCEPTANCE RATE

F.Y. 81

	# OF COUNTY NOTIFICATIONS	# OF ACCEPTANCES	ACCEPTANCE RATE
AITKIN	655	313	47.8%
ANOKA	5017	2203	43.9%
BECKER	1115	432	38.7%
BELTRAMI	1826	540	29.6%
BENTON	729	332	45.5%
BIG STONE	107	59	55.1%
BLUE EARTH	1170	472	40.3%
BROWN	369	138	37.4%
CARLTON	1265	410	32.4%
CARVER	517	186	36.0%
CASS	1187	567	47.7%
CHIPPEWA	472	204	43.2%
CHISAGO	774	386	49.9%
CLAY	1061	489	46.1%
CLEARWATER	512	176	34.4%
COOK	135	36	26.7%
COTTONWOOD	164	70	42.6%
CROW WING	1896	500	26.3%
DAKOTA	3369	1562	46.4%
DODGE	275	76	27.6%
DOUGLAS	397	158	39.7%
FARIBAULT	346	125	36.1%
FILLMORE	364	6	1.6%
FREEBORN	441	248	56.2%
GOODHUE	456	181	39.6%
GRANT	86	51	59.
HENNEPIN	16464	7609	46.2%
HOUSTON	282	160	56.7%
HUBBARD	864	393	45.5%
ISANTI	927	376	40.6%
ITASCA	1694	559	33.0%
JACKSON	295	98	33.2%
KANABEC	515	274	53.2%
KANDIYOHI	1063	558	52.5%
KITTSON	71	24	33.8%
KOOCHICHING	917	323	35.2%
LAC QUI PARLE	77	35	45.5%
LAKE	297	107	36.0%
LAKE OF THE WOODS	88	23	26.1%
LE SUEUR	378	143	37.8%
LINCOLN	77	24	31.2%
LYON	470	235	50.0%
MC LEOD	452	236	52.2%
MAHNOMEN	216	53	24.5%
MARSHALL	281	169	60.1%
MARTIN	321	170	53.0%
MEEKER	384	202	52.6%
MILLE LACS	913	405	44.5%
MORRISON	836	121	14.5%
MOWER	1062	118	11.1%
MURRAY	147	39	26.5%
NICOLLET	342	89	26.0%
NOBLES	342	171	50.0%
NORMAN	139	53	38.1%
OLMSTED	1739	578	33.2%
OTTER TAIL	904	324	35.8%
PENNINGTON	373	188	50.4%
PINE	1116	552	49.5%
PIPESTONE	141	105	74.5%
POLK	990	404	40.8%
POPE	236	104	44.0%
RAMSEY	14028	5398	38.5%
RED LAKE	108	65	60.2%
REDWOOD	229	145	63.3%
RENVILLE	442	251	56.8%
RICE	633	182	28.8%
ROCK	128	72	56.8%
ROSEAU	203	106	52.2%
ST. LOUIS	6377	1302	20.2%
SCOTT	751	341	45.4%
SHERBURNE	1111	547	49.2%
SIBLEY	83	57	68.7%
STEARNS	2075	805	38.8%
STEELE	279	102	36.6%
STEVENS	159	87	54.7%
SWIFT	232	90	38.8%
TODD	772	321	41.5%
TRAVERSE	92	12	13.0%
WABASHA	451	104	23.0%
WADENA	489	182	37.2%
WASECA	180	50	27.8%
WASHINGTON	2340	1015	43.4%
WATONWAN	200	55	27.5%
WILKIN	495	98	19.8%
WINONA	814	270	33.2%
WRIGHT	1600	675	42.2%
YELLOW MEDICINE	166	84	50.6%
TOTALS	93480	37949	40.5%

years and six visits during the two to twenty-one year range. Minnesota's re-notification schedule approximates this recommendation. Considering this, it is probably not practical, even under ideal conditions to expect a screening rate in excess of 50% of the eligible children in any given year.

See Chart # 2 for individual county rates.

C. Screening Results

The EPSDT/EPS Child Screening Form is used to collect summary screening data. This form contains a list of possible problem areas which can be checked off as "abnormal" during the screening. For each problem there is also a code to indicate if a referral was made for further diagnosis (see appendix for copy of Form). A Form is completed each time a child is screened.

Complete data was available for 23,573 of the 25,837 EPSDT screenings reported. Two Title V projects (Maternal and Infant Care and Children and Youth) in the metro area conducted EPSDT-equivalent screenings and reported total numbers of children screened but did not use the EPSDT Child Screening Form on their 2,264 children served.

Of the 23,573 screenings, 7,951 were delivered to children over the age of six. The other 15,622 were to children aged six years or under. See age distribution chart # 3.

It is significant that 12,321 of the 23,573 children screened under the EPSDT Program, or 52.2% were identified as having one or more positive findings. 5,702 of these children or 24.1% of the number screened were referred for further diagnosis and treatment. If the rate of needed diagnosis and treatment held true for the entire caseload we would have 22,465 additional children in the caseload with health conditions that are in need of diagnosis and treatment, but have not been screened or referred.

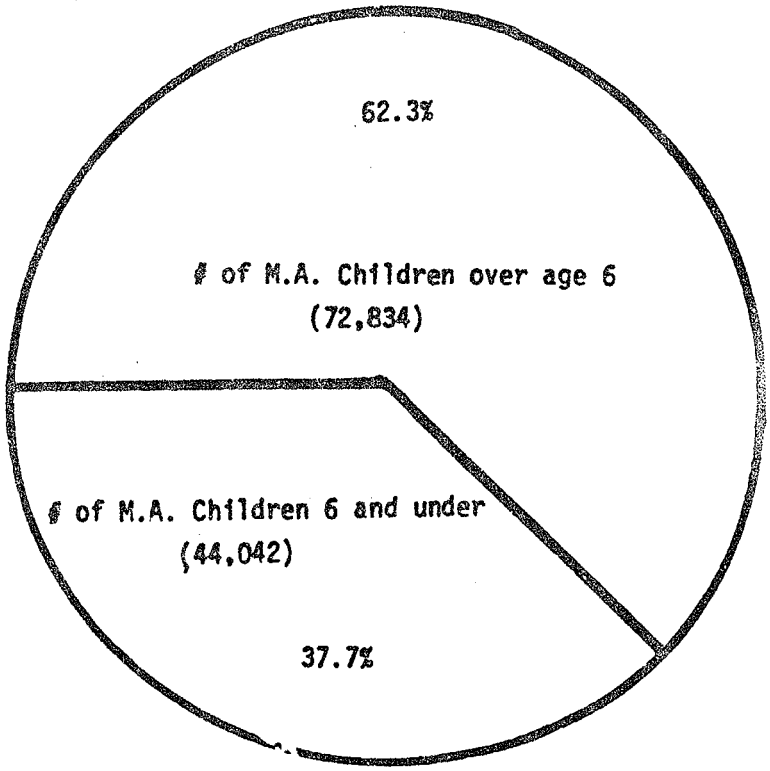
See distribution of positive findings chart #4.

F.Y. 81 SCREENING PERCENTAGES

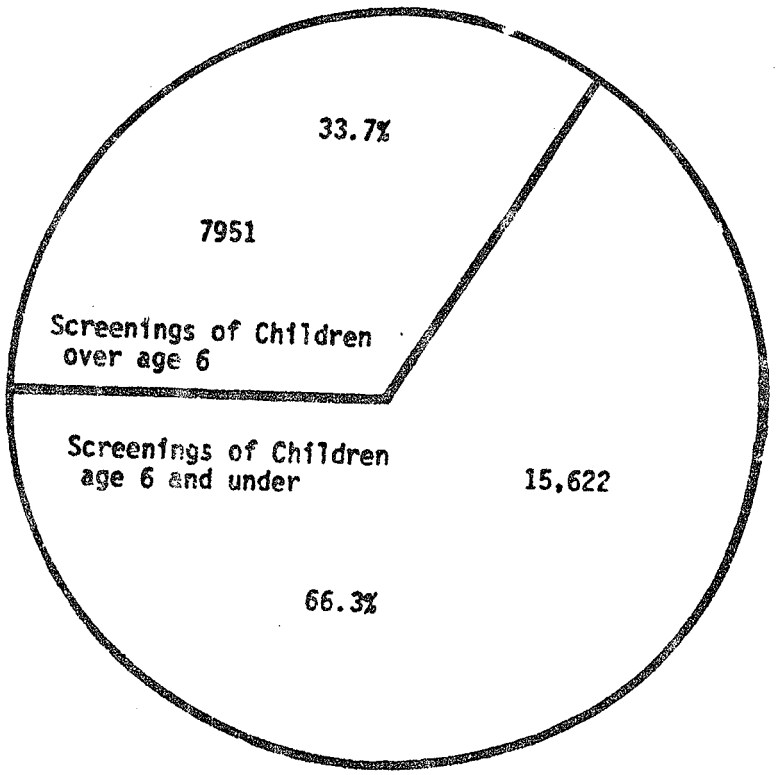
	# of Screens	# of Eligibles	% Screened
AITKIN	104	443	23.5%
ANOKA	1016	5236	19.4%
BECKER	250	1079	23.2%
BELTRAMI	280	2011	13.9%
BENTON	144	587	24.5%
BIG STONE	27	117	23.0%
BLUE EARTH	106	1240	8.5%
BROWN	119	434	27.4%
CARLTON	259	999	25.9%
CARVER	48	487	9.9%
CASS	305	1124	27.1%
CHIPPEWA	69	225	30.7%
CHISAGO	168	767	21.9%
CLAY	156	986	15.8%
CLEARWATER	124	528	23.5%
COOK	11	121	9.1%
COTTONWOOD	43	254	16.9%
CROW WING	491	1511	32.4%
DAKOTA	554	3684	15.0%
DODGE	34	242	14.0%
DOUGLAS	55	481	11.4%
FARIBAULT	103	374	27.5%
FILLMORE	289	316	91.4%
FREEBORN	167	716	23.3%
GOODHUE	123	679	18.1%
GRANT	11	106	10.4%
HENNEPIN	10268	31388	32.7%
HOUSTON	30	285	10.5%
HUBBARD	104	638	16.3%
ISANTI	113	724	15.6%
ITASCA	319	1869	17.1%
JACKSON	36	299	12.0%
KANABEC	54	362	14.9%
KANDIYOHI	165	733	22.5%
KITTSON	19	85	22.4%
KOOCHICHING	148	762	19.4%
LAC QUI PARLE	11	77	14.3%
LAKE	61	235	26.0%
LAKE OF THE WOODS	9	79	11.4%
LE SUEUR	113	359	31.4%
LINCOLN	7	78	9.0%
LYON	204	550	37.1%
MC LEOD	75	390	19.2%
MAHNOMEN	49	261	18.8%
MARSHALL	72	219	32.9%
MARTIN	193	402	48.0%
MEEKER	54	427	12.6%
MILLE LACS	199	720	27.6%
MORRISON	188	830	22.7%
MOWER	284	1044	27.2%
MURRY	40	178	22.5%
NICOLLET	62	395	15.7%
NOBLES	64	411	15.6%
NORMAN	49	118	41.5%
OLMSTED	272	1842	14.8%
OTTER TAIL	144	922	15.6%
PENNINGTON	95	344	27.6%
PINE	157	960	16.4%
PIPESTONE	43	180	23.8%
POLK	169	977	17.3%
POPE	154	214	25.2%
RAMSEY	2837	20554	13.8%
RED LAKE	10	70	14.3%
REDWOOD	78	276	28.2%
RENVILLE	48	266	18.0%
RICE	107	859	12.5%
ROCK	40	105	38.1%
ROSEAU	23	215	10.7%
ST. LOUIS	1704	8414	20.2%
SCOTT	73	683	10.7%
SHERBURNE	243	946	25.7%
SIBLEY	38	181	21.0%
STEARNS	342	1954	17.5%
STEELE	85	370	23.0%
STEVENS	42	122	34.4%
SWIFT	52	323	16.1%
TODD	125	752	16.6%
TRAVERSE	13	97	13.4%
WABASHA	53	301	17.6%
WADENA	65	501	12.9%
WASECA	63	309	20.4%
WASHINGTON	240	2068	11.6%
WATONWAN	60	209	28.7%
WILKIN	69	164	42.1%
WINONA	139	998	13.9%
WRIGHT	176	1417	12.4%
YELLOW MEDICINE	31	161	19.3%
TOTALS	25836	116685	22.2%

AGE DISTRIBUTION

TOTAL ELIGIBLE CHILDREN
116,877

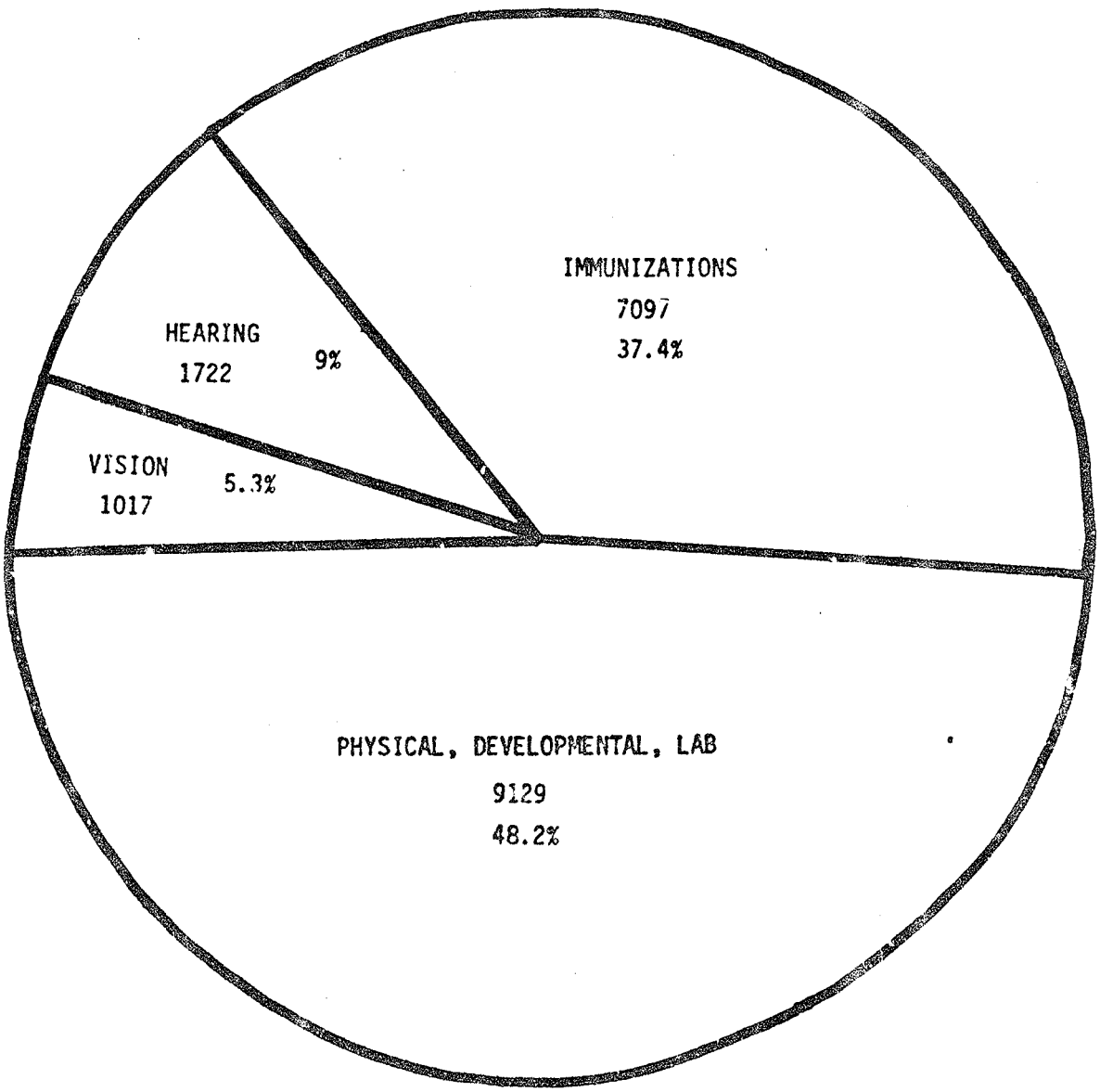


TOTAL SCREENED CHILDREN
23,573



35.4% of M.A.-eligibles under age 6 were screened.
10.9% of M.A.-eligibles over age 6 were screened.

THE FOLLOWING IS A DISTRIBUTION OF POSITIVE FINDINGS AMONG THE MAJOR SCREENING CATEGORIES. (Note that a child may have more than one positive finding.)



N = 18,965

IV. SERVICE DELIVERY

A. Provider Enrollment in EPSDT

In 1976, the Minnesota Department of Public Welfare began the process of requiring uniform EPSDT screenings and the enrollment of primary health care providers in the EPSDT Program. The Department felt that implementing an effective EPSDT Program would not be possible until clear screening standards were developed and until screening providers agreed to provide all components to each child screened.

Enrollment as an EPSDT Provider stipulates that the provider will:

- screen Title XIX children according to the screening standards
- report the results on the EPSDT Child Screening Form
- use the Screening Referral Form for children requiring additional diagnosis and/or treatment.

In 1981, this effort to enroll providers in the EPSDT Program has resulted in a system of 1589 health care providers who have agreed to participate in screening Title XIX children according to specified standards. From these enrolled providers, each local welfare agency has developed a list of those providers serving their area. When clients accept the EPSDT Program, they are given this list. The client is thus assured of receiving a screening containing all of the components in the manner specified in the screening standards of DPW Rule 61.

Of the 1589 EPSDT-enrolled providers, 1336 are primary care physicians and 253 are nurses screening in EPS Clinics or other independent practitioners. The 1336 physicians represent approximately 63% of the primary care physicians in the state. These providers are working at 531 screening sites throughout Minnesota: 456 private clinics; 54 Early and Periodic Screening Clinics; and 21 Health Maintenance Organizations, Headstarts, or EPSDT equivalent projects.

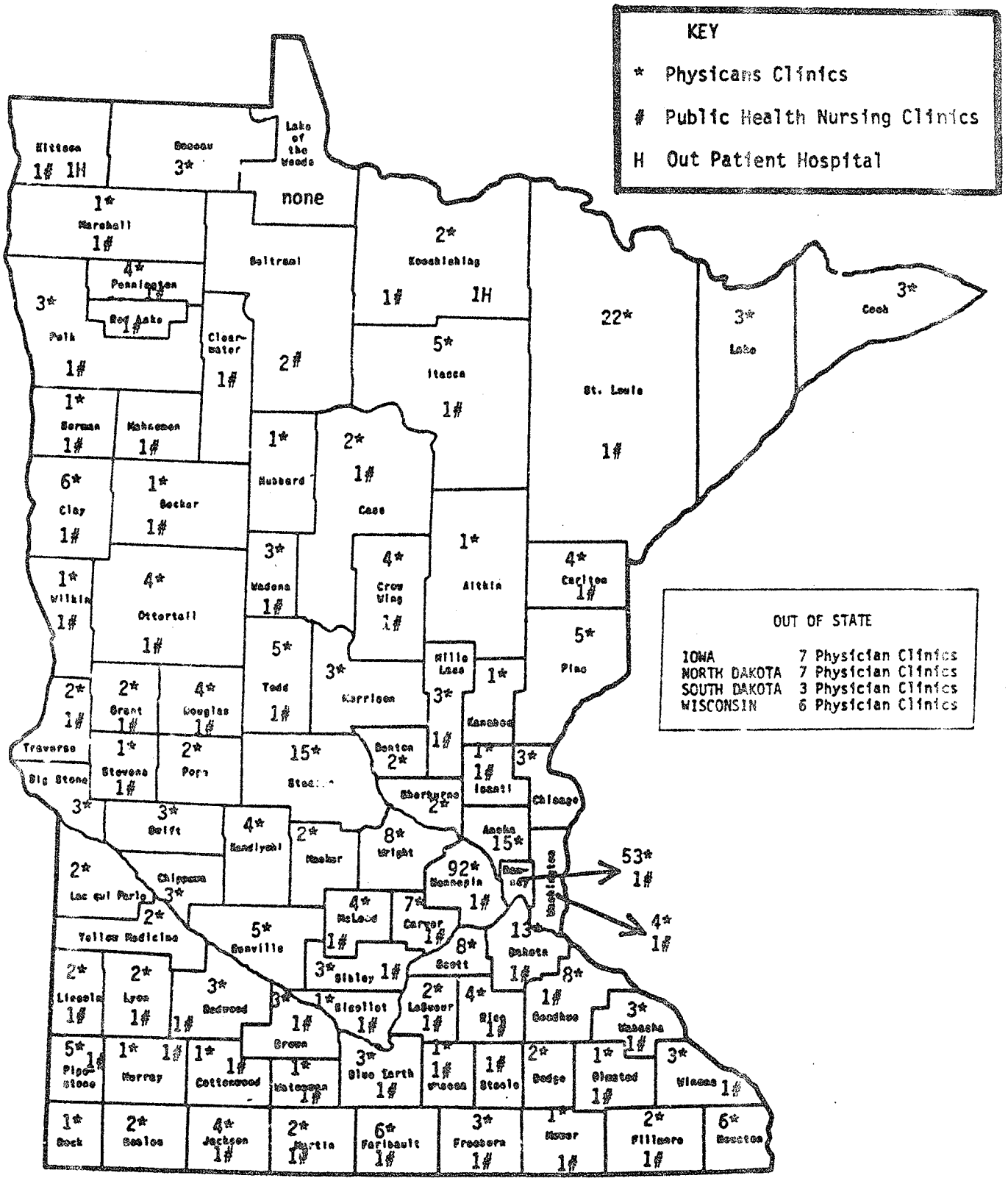
The two major provider sources are physician/clinic programs and MDH-approved EPS clinics. Additional children are screened through the State Department of Education's Pre-School Screening Program (P.S.S.). If all EPSDT screening components are delivered to a Medical Assistance-eligible child, then Title XIX reimbursement is available to the local school district and the screening is reported as equivalent to EPSDT.

See Screening Site distribution map chart # 5.

B. Re-enlistment and Provider Relations

Newly enrolled Medical Assistance providers are identified quarterly and a letter is sent asking them if they wish to enroll to provide EPSDT. If they wish to become EPSDT providers, a program representative arranges an appointment, explains the program, offers training in the screening protocol, training on billing procedures,

SCREENING SITE DISTRIBUTION



and explains the referral process. The present provider system has the capacity to screen over 280,000 children per year.

Provider Bulletins are published periodically to keep providers up to date on changes in the program, scheduled training sessions, billing information and other EPSDT screening information.

An automated invoice for reporting and billing EPSDT services has been developed and is being tested in two screening sites. The new form is designed to be used in line-type feeders, and may be available for general distribution to interested providers.

C. Dental Screening Services

The dental screening component of EPSDT is provided through a separate referral to a dentist for a dental inspection if the child is aged three years or older. Any Medicaid-participating dentist may provide this service. The dental screening is reported and billed in the customary manner of any dental claim. Since no special reporting form is utilized, no data is available (on a routine basis) as to client participation in the dental screening. Such data would be available on an individual client claims history request, if necessary.

V. STUDIES, REPORTS AND PROJECTS

In an attempt to evaluate specific aspects of the EPSDT Program in Minnesota, EPSDT unit staff have undertaken special studies of data not routinely collectible or reportable. As with most research, answering one question often leads to raising one or more additional areas of study. So it was with the reports summarized here. We have drawn no absolute conclusions on what the data represents. As trends appeared ideas for future studies emerged. The summaries contained herein are just that, a summary and caution is advised in interpretation because of imperfect data. The complete reports are on file in the EPSDT offices of DPW.

A. Equivalent Care Not Reported as EPSDT

A study was done to determine how much preventive health care Minnesota's eligible children were receiving outside of the EPSDT Program. The data does contain duplicate instances in which a given child may have had more than one such encounter in the period studied. In fiscal year 1980, 49,655 instances of preventive health care were documented as paid outside of the EPSDT Program. It should also be noted that not all the components of an EPSDT screening were necessarily a part of these examinations. The impact of these findings may be that assessing the EPSDT Program purely on the basis of the number of children for whom an EPSDT invoice was received may miss the main goal of the program, which is to provide access for eligible children to the health care system.

B. County Reimbursement of EPSDT Administrative Costs

There are several options open to a county relating to reimbursement for administrative costs from the federal and state Governments.

1. Elect to claim no EPSDT Program specific reimbursement. This means that they receive no special funds for providing EPSDT services.

2. Elect to keep track of all EPSDT specific time that is eligible for FFP and claim reimbursement at the rate of 75%.

3. Elect to contract with an eligible public health agency for administrative services in which case they receive 75% FFP plus 22.5% state reimbursement for contracted costs.

4. Elect to staff for certain EPSDT functions and contract for others in which case they will receive 75% FFP and 22.5% for the contract amount and 75% FFP for their own EPSDT staff.

See chart # 6 for county by county choice.

During the past year a study of administrative costs in EPSDT was made. There are some limitations on use of the data because 34 counties claimed no EPSDT specific reimbursement, and hence, are not included in any data reported as EPSDT administrative expense. The mean cost in non-contract counties per screening was $10.00, with a range from $1.00 to $132.00. Costs in counties that contracted-out administration had a mean cost of $37.00 and ranged from $13.00 to $278.00 per screening. The preceding data does not include the $284,312.00 in the DPW administrative budget for the Program. 37 local agencies presently contract for administrative services and 40 counties do not.

C. Comparison of Outreach Approaches and Acceptance/Screening Rates

County procedures and contracts for F.Y. 1981 were reviewed to determine if acceptance and screening rates are effected by the type of outreach approach that is used.

The following factors relating to outreach approaches were reviewed statewide to determine their effect on average acceptance and screening rates:

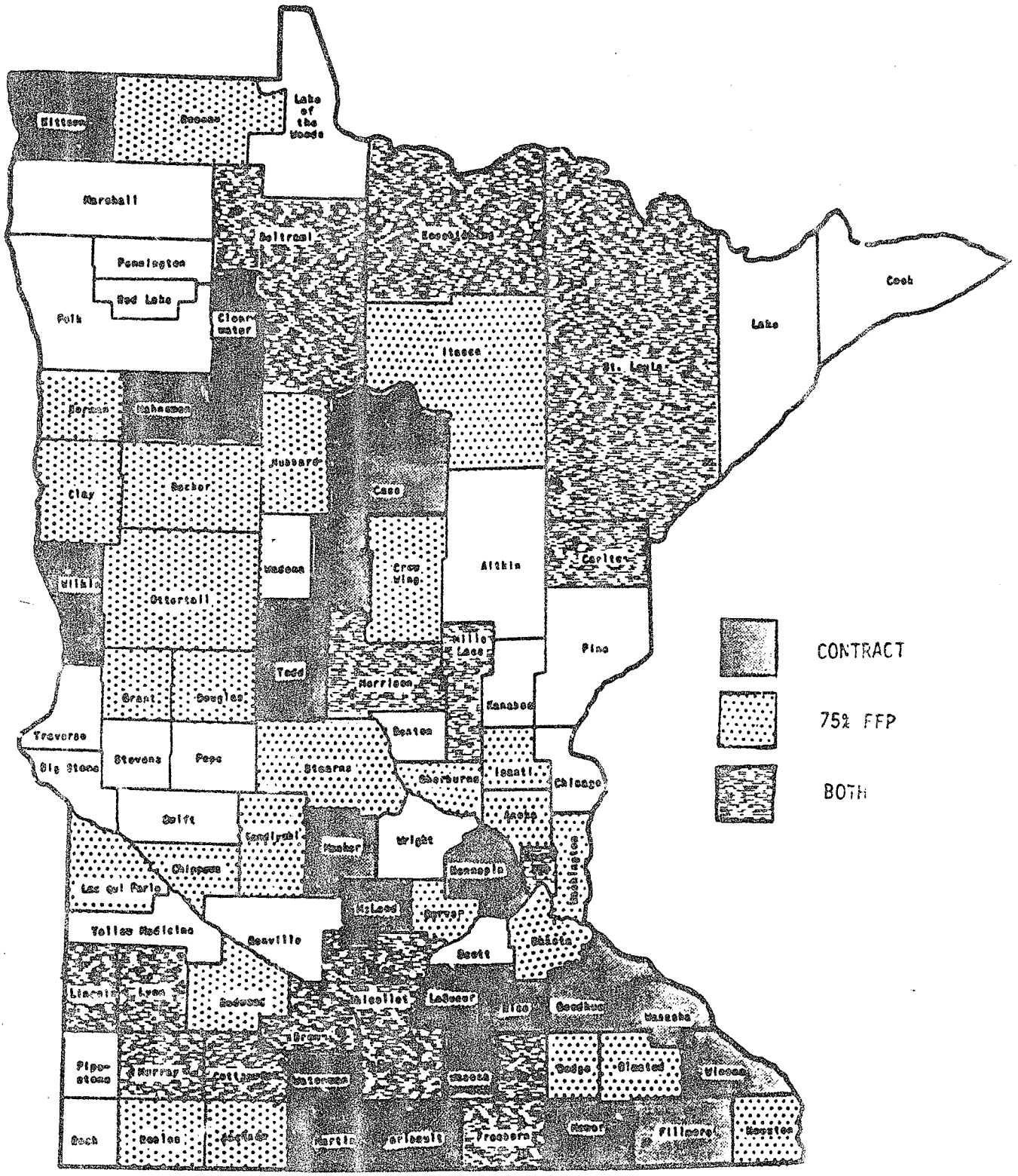
- Initial informing method (Four basic methods were identified statewide).

- Presence of a contract to another public agency for EPSDT administrative support services.

- Claim of 75% FFP for county's own staff who provide health related administrative support services.

- Presence of an EPS clinic in the county.

CALENDAR YEAR 1981



- Explanation of the program during a home visit.

- Extra outreach not required by federal regulations.

The above factors were then examined in the ten counties with the highest screening rates and the ten counties with the lowest screening rates.

The results of this review indicate the "ideal" outreach approach is not clearly evident. Many factors that were not reviewed (i.e. medical resources available in the community, initial informer's "belief" in the value of the program, client's previous exposure to preventive health, etc.) obviously enter into a county's final screening rate. However, the review's findings do seem consistant enough to suggest the following methods a county may want to consider in order to increase their screening rate:

- Offer only a brief explanation of the availability of EPSDT during the intake process. Delay a full explanation of the program and the decision to participate or not until after eligibility has been determined.

- Contract out administrative support services to a public health agency.

- Maintain an EPS clinic in the county.

- Give program explanation at the time of a home visit.

- Do extra outreach to bring clients into the health system who do not currently have a regular medical provider.

Incorporating these ideas and other county specific factors into the development of county procedures and contracts should increase the number of Title XIX children receiving preventive medical care.

D. Invoice Consistency

A 1981 study examined the reporting consistency of abnormal conditions and referrals for further diagnosis and treatment. The study indicated that 4.5% of the screening report forms (EPSDT invoices) were incorrectly completed. 54.4% of the errors involved abnormal conditions which were not reported, and 45.6% of the errors were in referrals for further diagnosis and treatment which were unreported. Comparing these results to the total number of screening report forms received, it is projected that 1061 report forms were incorrectly completed. Therefore the number of reported abnormalities would increase by 664 (5.4%), and the number of referrals for further diagnosis and treatment would increase by 556 (9.8%).

E. Minneapolis Public Schools Pilot Project

During the 1980-81 school year a project set out to explore using the school setting and hours to facilitate outreach to M.A.-eligible children who had not received an EPSDT health screening during the past three years. Two inner-city elementary schools participated in the project. Outreach mailings numbering over 700 were returned by approximately 20% of the contacted families. Follow-up phone calls reached an additional 43 families.

The project resulted in the screening of 161 children. Approximately 50% of these children had not had a preventive health care visit within the last 3½ years, and had not been "reached" by the traditional approach to EPSDT services.

VI. TRAINING

County Personnel:

In fiscal year 1981, nine training sessions were held in various locations throughout the state. 203 persons from 80 of the 87 counties in Minnesota attended. The content of these sessions was geared to bringing participants up to date on common errors being made in reporting data, techniques of outreach with special groups, program explanation, new provisions for dental screening, time limits for contacting clients, contracting, and outreach projects.

Other topics focused upon clarification of policy, the penalty regulations, Federal Quality Control Review, the program's lawsuit with Legal Aid of Minneapolis, proposed Child Health Assessment Program and the Pre-School Screening Program.

Providers:

A total of 58 persons from 39 medical clinics attended training sessions conducted by the Minnesota Department of Health at 10 locations the state. These sessions were designed to train clinical personnel in delivering the vision, hearing, nutritional and developmental components of EPSDT. These sessions are offered annually in order to train newly-enrolled EPSDT provider staff and as a refresher for on-going personnel. Continuing education credits are available for these courses.

VII. COMPLIANCE WITH FEDERAL REGULATIONS

New federal regulations for the EPSDT Program were issued in May, 1979. A portion of the requirements specified certain performance standards which a state must meet in order to avoid a fiscal sanction. Quality Control (Q.C.) reviews were scheduled to occur twice within this fiscal year for the purpose of determining compliance with these requirements. State EPSDT Program staff carried out their own review of state/county compliance utilizing the federal QC format, between December, 1980 and April, 1981. A total of 1,269 cases were reviewed to indicate that the state was .4% negligent in informing cases about the EPSDT Program in a timely manner. All other required activities of delivering services to clients who had been informed and accepted services were within the acceptable compliance range.

After this comprehensive review, DPW was informed that a federal QC review would not be conducted. Rather, the Regional Office of the Health Care Financing Administration (HCFA) selected Minnesota as one of several state agencies to field test an assessment guide being developed for future Program compliance reviews. The field test turned up additional problems with the assessment tool and thus the status and form of future federal reviews is in question.

The EPSDT regulations themselves are undergoing federal review. The intent of such review is reportedly toward reducing the amount of administrative burden upon state programs. Any such reduction would be considered a welcome and necessary step which would then be passed along to local agency operations via policy and manual revision.

VIII. INTERAGENCY COORDINATION

In Minnesota, two public child health screening programs work together with the EPSDT Program to deliver services intended to be equivalent. Reporting forms, standards, and data collection are merged so that duplication of services is reduced. The EPS Program of the Minnesota Department of Health and the PSS Program of the State Department of Education together with the private sector Medicaid providers form a balanced delivery system of screening, diagnosis and treatment to Minnesota's eligible children.

Title XIX-eligible children screened through either EPS or PSS qualify as receiving an EPSDT screen. Invoices submitted for these children record the date of screening and age at the time of screening on the Health History File at DPW. Renotification of a due date for a re-screening is then based upon when these services were previously delivered. (Physician screenings submitted on the EPSDT invoice do the same.) These programs utilize the same periodicity schedule and are disallowed from duplicating known services already received from another source.

Whereas, the EPSDT Program serves Title XIX-eligible children only; both the EPS and PSS Programs serve children regardless of economic status and seek reimbursement through sliding-fee schedules (EPS) or state funds (PSS).

The intricacies of coordinating services among the three Programs are managed through the Inter-Agency Advisory Committee on Child Health Screening; a committee composed of members representing the many professions and providers concerned with child health screening in Minnesota. (The Membership List for the coming year is contained in the Appendix.) The Committee meets every other month, on the third Tuesday.

Coordination efforts in addition to these two major Programs occur with Headstart Programs, residential and other group homes, day care centers and should exist with <u>any</u> child care program which serves Title XIX clients and requires a comprehensive physical and developmental assessment for participation.

IX. CONCLUSIONS AND FUTURE PLANS

1) Fiscal Year 1981, brought a 33.8% increase in numbers of screenings over F.Y. 1980 data. The growth in numbers of EPSDT screenings per year is indicated on the Grow Power chart in the appendix.

2) Less than 50% (statewide) of the clients who were notified/informed about the EPSDT Program at the time that eligibility was determined, actually accepted the Program. A more thorough study is necessary in order to identify practices which lead to a better understanding and acceptance of the preventive health benefits of EPSDT in some county agencies as compared to others where the acceptance rate is low.

3) The acceptance response to mailed re-notification forms was 8.3%. Though this is a relatively good response rate to a written informing document, we feel that the form (DPW-1974) may not enhance the offer of the EPSDT Program to the optimum. A revised form and a new brochure design are being developed.

4) Approximately 43% of the clients who requested EPSDT did not receive the screening (or the screening was not reported as EPSDT). This is a many faceted problem and one which is probably best researched by asking the client "what happened?"

   a. Did the client change his or her mind? Why?
   b. Was transportation or appointment scheduling a problem?
   c. Was there difficulty in locating a provider?
   d. Did the client receive services not reported as EPSDT?

   Points a. and b. relate again to the quality of the initial notification process. It cannot be over-emphasized in importance to the spectrum of actions necessary in delivering EPSDT to the client.

Points c. and d. are being addressed by the DPW-EPSDT Program staff through on-going contact and training of providers. Enrollment of new providers is continuous. EPSDT Provider participation data is being researched to determine which providers are not reporting comparable serices as EPSDT. Training will encourage the reporting of all equivalent preventive health care as EPSDT.

5) 66% of the EPSDT screenings were provided to children under the age of 6 years. Though important in the sense of early detection of problems; periodic screenings and screenings of older children and adolescents are important, too. It is necessary to remember that another surge of growth and development occurs when the child enters adolescence. Outreach materials directed specifically to teen-age clients are being developed.

6) In order to maximize the reporting of equivalent well-child care as EPSDT, provider training sessions will be conducted statewide.

7) A repeat study will be done to obtain an unduplicated count of preventive health encounters for EPSDT-eligible children.

8) A study will be done to further examine the reliability of data about diagnosis and treatment resulting from an EPSDT screening. This is in response to a criticism of under-reporting needed diagnosis and treatment, even though such service is delivered.

9) The results of two studies on administrative methods and administrative costs will be examined and used to assist local agencies in determining the quality of service delivered to clients compared to the administrative expense incurred.

10) Affirmative action will be taken to develop and promote outreach tools which inform parents and children of the benefits of early and on-going comprehensive health care.

11) The review of EPSDT Program regulations at the federal level leads the state program office to believe that states will be able to develop their own state plans for EPSDT objectives. An in-depth Child Health Assessment Plan will be produced during F.Y. 1982. This Plan will address goals and objectives identified within this report as well as needs identified by the local agencies who administer the EPSDT Program and the providers who deliver services. The impact of the current regulations has been documentation rather than delivery of services. Our goal is to reverse this priority.

APPENDIX A

SEND FORM TO: Minnesota Medical Assistance Program -- DPW -- P.O. Box 43200, St. Paul, Minnesota 55164

EPSDT/EPS

CHILD SCREENING FORM

CLAIM PROCESSING DOCUMENT CONTROL NUMBER

ELITE PICA — TYPEWRITER ALIGNMENT — USE CAPITAL LETTERS ONLY — ELITE PICA

PROVIDER'S NAME 3 PROVIDER ID # 4 OWN REFERENCE # 5 BILLING DATE

STREET/STATE/ZIP 9 SCREENING DATE

SCREENING IS INITIAL 10 PERIODIC 11

CHILD'S NAME (LAST, FIRST, INITIAL) 13 MEDICAL ASSISTANCE NUMBER

14 SEX 15 BIRTHDATE

ABNORMAL	REFERRAL CODE
WEIGHT 16	
HEIGHT 17	
HEAD CIRCUMFERENCE 18	
PULSE 19	
BLOOD PRESSURE 20	
HEAD 21	
EYES 22	
EARS 23	
NOSE 24	
PHARYNX 25	
NEUROLOGICAL 26	
NECK 27	
CHEST/LUNGS 28	
HEART 29	
ABDOMEN 30	
GENITALS/SEXUAL DEVELOPMENT 31	
MUSCULAR/SKELETAL 32	
SKIN 33	
VISION 34	
HEARING 35	
AUDIOMETER USED YES	
NUTRITION 38	
FINE MOTOR 39	
GROSS MOTOR 40	
SPEECH/LANGUAGE 41	
SOCIAL/EMOTIONAL 42	

DEVELOPMENTAL

* IF PHYSICAL NOT DONE (ITEMS 21 THROUGH 33), MARK BOX

NORMAL	ABNORMAL		REFERRAL CODE
		URINE 44	
		HEMATOCRIT/HEMOGLOBIN 45	
		BLOOD LEAD 46	
		TB 47	
		PELVIC/PAP SMEAR 48	
		VENEREAL DISEASE 49	
		SICKLE CELL 50	
		OTHER 51	

TEST USED PDQ DOST OTHER

MARK WITH A STRAIGHT HORIZONTAL LINE

DTP/DT — CURRENT | GIVEN | REFERRED | REFUSED | NOT AVAILABLE

POLIO — CURRENT | GIVEN | REFUSED | NOT AVAILABLE

MMR OR MEASLES (RUBEOLA) — CURRENT | GIVEN | REFERRED | NOT AVAILABLE

OTHER

MUMPS — CURRENT | GIVEN | REF. | N/A

RUBELLA (GERMAN) — CURRENT | GIVEN | REF. | N/A

REFERRED TO 52

ACTUAL READINGS -- OPTIONAL

WEIGHT	HEIGHT	HEAD CIRCUMFERENCE	PULSE	BLOOD PRESSURE	HEMOGLOBIN/HEMATOCRIT
53	54	55	56	57	58

ENTER NUMBER OF MONTHS SINCE LAST HEALTH MAINTENANCE EXAM 59 REFERRAL CODE 60

CHARGE INFORMATION

PHYSICAL 62

LAB TESTS 63

IF NOT FOR PAYMENT 61 ENTER 'X'

IMMUNIZATIONS 64

OUTREACH 65

TOTAL 66

COMMENTS SECTION PLEASE EXPLAIN ALL BOXES MARKED ABNORMAL AND/OR OTHER

PROVIDER CERTIFICATION

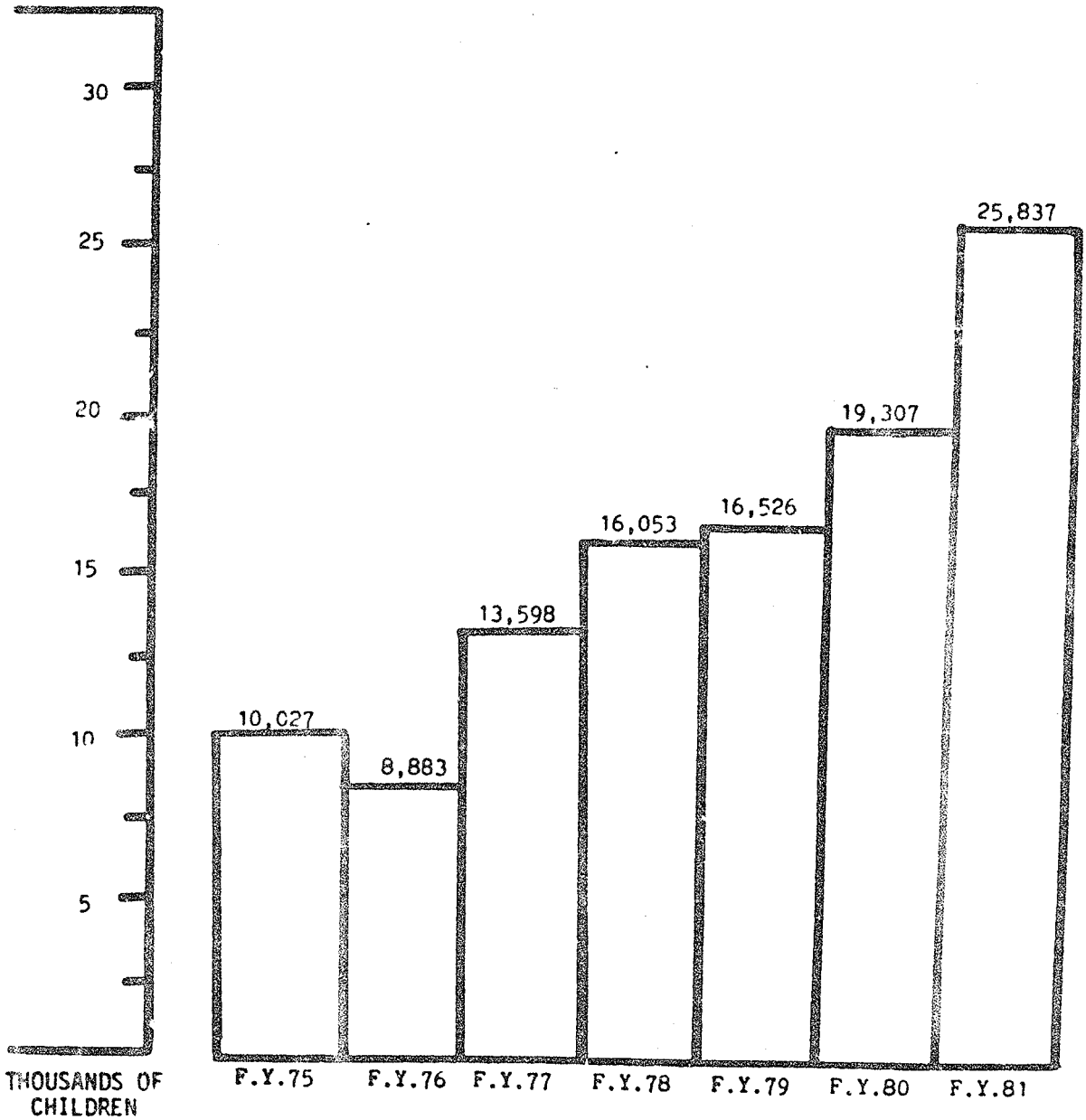
This is to certify that all information given on this form is true, accurate and complete and all medical services indicated have been rendered. I understand that payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws. I certify that all applicable screening standards have been followed.

X 67 Authorized Signature

Top Copy (Brown) to DPW - 2nd (Green) Provider - 3rd (Blue) Parent/Child - 4th (Purple) Referral

PZ-00197-3 02 (7-79)

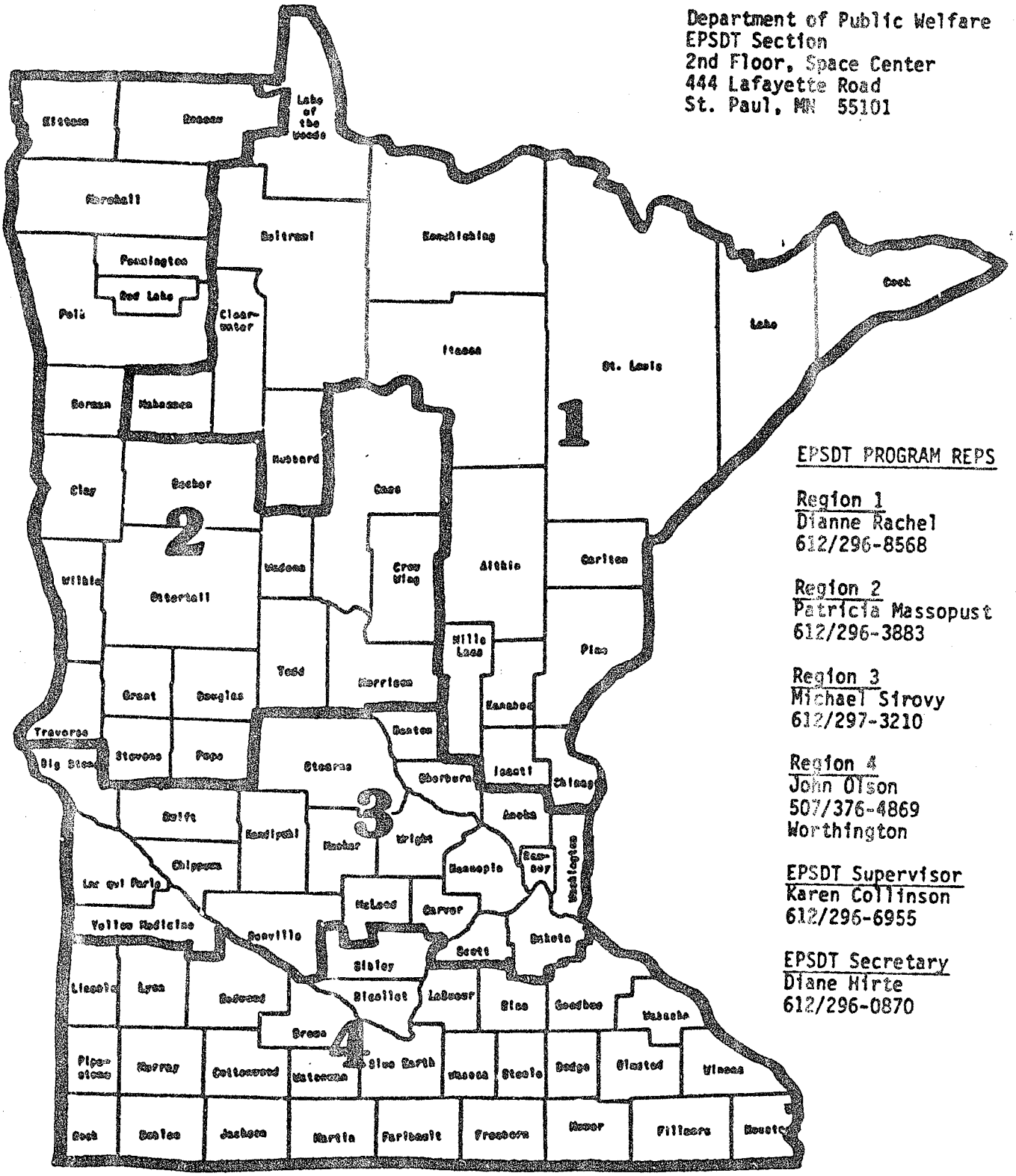
CHECK OUR GROW POWER!



EPSDT SCREENINGS

APPENDIX C

EPSDT REGIONS AND REPRESENTATIVES



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