PLANNING AND MANAGING THE
EARLY PERIODIC SCREENING, DIAGNOSIS
AND TREATMENT PROGRAM AT
THE STATE LEVEL

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Health Care Financing Administration
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Evanston, Illinois
PLANNING AND MANAGING THE EARLY, PERIODIC
SCREENING, DIAGNOSIS AND TREATMENT
PROGRAM AT THE STATE LEVEL

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FOREWORD

Community Health Foundation (CHF) was retained by DHEW/SRS-HCFA to provide assistance to 12 state EPSDT programs from 1975-1979. The selection of states was based on their willingness to receive technical assistance and the Office of Child Health's concurrence in their need for it. This publication grew out of the recommendations to consolidate the written products and articulate the expertise which CHF staff gained in providing this assistance. CHF retained a multidisciplinary staff in order to address general program management and implementation needs. One of the limitations experienced by all states is their lack of information about effective program development in other states. The strength of this manual is its compilation of good practices as well as its emphasis on relating all program activities to a fully developed planning, implementation and evaluation cycle.

Mary E. O'Connor

Walter D. Campbell, M.D.
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CHAPTER 1

AN INTRODUCTION TO EPSDT

EPSDT is a cooperative federal-state program of comprehensive health services for 11-12 million low-income and medically needy persons under the age of 21. The goal of the program is to ensure that every child eligible for Medical services under Medicaid (Title XIX of the Social Security Act) has a source of health care and receives periodic screening, diagnosis and treatment for specific health problems. EPSDT provides outreach, follow-up and support services to encourage participation and ensure that eligible children use the program. No other health program has ever attempted to provide such comprehensive service; as a result, EPSDT has had a difficult and controversial history. This initial chapter will review that history and the problems of implementing the program.

CONGRESS ESTABLISHED EPSDT IN 1967. Title XIX of the Social Security Act was amended because of a growing public concern for the health problems of the poor and for the large number of children with handicapping conditions. Public hearings were held in the House and Senate and the proposed EPSDT program passed both houses of Congress by large margins in December 1967. President Lyndon B. Johnson signed the 1967 Social Security Amendments (P.L. 90-248) on January 2, 1968.

After 2½ years of discussion, EPSDT regulations drafted by the Social and Rehabilitation Service were published in the Federal Register (December 1970). Because some states objected strongly to the comprehensiveness of the proposed regulations, they were revised. Final regulations were approved and published in the Federal Register in November 1971 and became effective in February 1972. The final regulations required:

"that early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of conditions discovered within the limits of the state plan on the amount, duration and scope of care and services, will be available to all eligible individuals under 21 years of age; and that, in addition, eyeglasses, hearing aids, and other kinds of treatment for visual and hearing
defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health, will be available, whether or not otherwise included under the state plan, subject, however, to such utilization controls as may be imposed by the state agency. If such screening, diagnosis, and such additional treatment are not available by the effective date of these regulations to all eligible individuals under 21 years of age, the state plan must provide that screening, diagnosis, and such additional treatment will be available to all eligible children under six years of age, and must specify the progressive stages by which screening, diagnosis and such additional treatment will be available to all eligible individuals under 21 no later than July 1, 1973.

STATES' IMPLEMENTATION OF THE EPSDT PROGRAM has been slow and has not met the expectations of Congress. The Senate Finance Committee report on the Social Security Amendments of 1972 noted that in the five years since the initial legislation was passed, many states had failed to implement the requirements, in whole or in part, because of the lack of state financial and health resources. The Committee recommended cutting federal matching funds for Aid to Families with Dependent Children (AFDC) in states not meeting program specifications. In October 1972, Congress passed Social Security Amendments, which assessed a one percent reduction in the federal share of AFDC matching funds beginning in FY 1975 if a state failed to:

1. Inform all families in the State receiving Aid to Families with Dependent Children under the State's Title IV-A Plan of the availability of child health screening services under the State's Title XIX plan. For purposes of this provision, to "inform" means to notify all AFDC families in writing no less often than annually of the availability of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under the State Title XIX plan by providing pamphlets, brochures, or other written materials,

which clearly and specifically describe (a) what EPSDT services are available and (b) where and how they may be obtained. States must also have arrangements to inform those individuals for whom printed material is inappropriate.

2. Provide or arrange for the provision of such screening services in all cases where they are requested. This means that a State must:

a. inform recipients requesting screening services of the names and locations of providers offering such services, and of the transportation services available under the State plan as required; and

b. take steps to assist recipients requesting screening services so that such recipients are able to receive them within a reasonable period normally not to exceed 60 days from the date of request.

3. Arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is indicated by such screening services and which is available under the State plan. This means that the State must:

a. inform recipients in need of diagnostic and treatment services of the names and locations of health providers offering such services, and of the transportation services available under the State plan as required; and

b. take steps to assist recipients needing diagnostic and treatment services so that such recipients are able to receive them within a reasonable time period. Initial diagnosis and treatment must be available normally within 60 days of the screening.

Although the penalty regulations, as these amendments have been called, emphasize only limited aspects of the program, for many state administrators they offered a definite framework around which to design their program. In this sense, they were helpful. They also afforded an opportunity for regular contact between HCFA (then SRS) regional staff and state administrators.

When federal enforcement of the EPSDT program began in 1974, nine states were found out of compliance with EPSDT requirements. What followed was a test of the federal government's ability to force states to implement the program as attempts were made to assess the penalty against these states. To date, no federal funds have been withheld although the threat of this action provided the impetus for program development and improvement.

MEANWHILE, NATIONAL-LEVEL EFFORTS TO IMPLEMENT the program have not been consistent. The staff and the level of support for the program have failed to provide the leadership needed by the states. The HEW staff responsible for preparing the program regulation was not retained for implementation. The replacement staff was small and, in many cases, inexperienced in program implementation and administration. The Medicaid Division of the Health Care Financing Administration (formerly Social and Rehabilitation Service) has not provided the administrative encouragement and guidance needed for such a new and ambitious program. HEW staff and contractors have not provided the amount of technical assistance needed by the states, because of the lack of funding available to the program. The result has been a slow and controversial development of EPSDT.

In most instances, the effectiveness of the state program has depended on administrative effort and ability, and the size of the EPSDT population. Although some states with small populations have had more effective programs, some of the most poorly developed programs can be found in states with a small number of eligible children. Some problems common to all states are:

1. the assumption that a motivated client population existed as did a willing network of provider resources. States originally believed that resource coordination rather than development was their main task;

2. the unique requirements of EPSDT to provide substantial support services and to develop a complex case management system;

3. insufficient funding;
4. Inexperience in designing (administrator), delivering (provider), and receiving (client) preventive health services.

While these legislative and administrative factors help explain the slow progress of the EPSDT program, they are not the only problems associated with it. The components of program management, provider resources, outreach, case management and data systems present special problems which have impeded progress.

Program management requires planning, directing, coordinating, and evaluating the EPSDT program at all levels. HEW issues objectives to the states and provides them with technical assistance. State administrators then develop plans, criteria, and interpretations to direct and assist local programs. While HEW holds the state Title XIX agency accountable for the EPSDT program, service is delivered locally. The state administrator(s) must inform local agencies of the program requirements and explain implementation. Then, local administrators must develop individual plans for their areas and carry out state and local requirements to ensure that EPSDT services are delivered.

Effective state-level program management begins with a comprehensive EPSDT plan. Many states have EPSDT procedures outlined in the Medicaid agency manuals, but they do not identify the annual objectives of the program or the resources required, nor do they assess the problems or plans to resolve those problems. The state level staff can help to plan program activities with local agencies with limited staffs. Local program administrators then can concentrate on adopting the EPSDT plan, implementing services and collecting information for required reports. Chapter 2, "Administrative Issues," discusses program management issues at length. Chapter 3, "Planning and Setting Objectives," offers suggestions for planning.

EPSDT providers are poorly distributed and all states have observed a lack of EPSDT providers in at least a few areas. Involving providers in planning and problem solving, responding to their criticism of the EPSDT program and keeping them well-informed can aid in recruiting and retaining them. Chapter 4 discusses management issues related to the screening package and periodicity schedule and attempts to prepare state administrators to discuss these issues with medical professionals. Chapter 6, "Private Provider Participation: A Systems Approach," outlines a systematic plan for this process. The last half of Chapter 3 discusses ways of developing other resources for the program.

Outreach and case management activities ensure an eligible child's timely progress through the EPSDT system. These activities can be viewed as including notification, help in choosing a provider, scheduling assistance, transportation, follow-up and verifi-
cation of service. These activities require considerable time and effort and will vary depending upon the place and agency performing them and the identified need. Chapter 5, "Outreach and Case Management: Management Issues," discusses outreach and case management.

An EPSDT data system provides program administrators and case managers with data for documenting, tracking, reporting and evaluating program activities. Since this requires quick turnaround of information obtained at all levels, case management functions should be automated when there is a large number of eligible children. This information flow is essential and can be expedited by efficient lines of manual communication or by terminals with on-line capabilities in local EPSDT offices. Although this manual provides no specific recommendations for data systems development, there are many recommendations for type and amount of data which good program management requires. Chapter 7, "Program Evaluation," discusses the data required to conduct various types of program evaluation. Chapter 8, "Planning for Change," offers a model for understanding various forces for change within an organization.

The suggested reading list prepared for this manual corresponds to the topics covered in each chapter. Items were selected on the basis of their general usefulness and potential accessibility. In some instances, references cited have formed the basis for this material, in others they are supplemental.

The two addenda are assessment guides which have proven useful to states in assessing their overall program status, (A) "Framework for Program Analysis," and the health services capacity offered by the provider community, (B) "Screening Resource Assessment Guide." Both instruments have been used to assist program administrators in planning and managing their programs.
CHAPTER 2
ADMINISTRATIVE ISSUES

Sound EPSDT program administration cannot be overemphasized. Because the delivery of specific health services, in combination with required support services, has not been undertaken previously for a large, widely dispersed and constantly changing population, the administrative difficulties associated with EPSDT implementation and management have been great. The success of the program depends largely on the state agency responsible for EPSDT, the perceived scope and distribution of EPSDT activities, the nature of the state-local EPSDT relationship, the position of EPSDT with the agency, the staff responsible for EPSDT, and the management of the EPSDT program.

Most state Medicaid programs are administered by Welfare Departments and, for this reason, the Welfare Agency is most often responsible for the EPSDT program. In some states, however, the Health Department has responsibility for EPSDT. A few states have umbrella agencies which contain both the Health and Welfare Departments. There are advantages and disadvantages associated with each of these administrative placements because of the functional requirements of EPSDT.

Welfare Departments determine Medicaid eligibility, administer Medicaid programs, conduct claims payment functions and administer many other programs requiring support services. Therefore, they are uniquely qualified to inform eligible persons about EPSDT and to manage reimbursement functions. However, Welfare Departments have had limited experience in planning and managing health care delivery systems and support functions to these systems such as outreach and case management; they have no capability for direct delivery of health services.

Health Departments, on the other hand, have skill and experience in planning and managing health care programs as well as public health personnel who actively provide case management and follow-up services. Most public health department programs are not, however, providing diagnostic and treatment services or conducting claims payment activities.

It is apparent that neither Welfare nor Health Department is fully capable of conducting the EPSDT program at this time. This is especially true at the county and local levels, the point
of service to the eligibles, where agency personnel of either type are few and frequently are responsible for more than one program. Yet, each agency has some of the required strengths at both the state and local levels. In this regard, it is not surprising that when EPSDT services have been successfully provided locally or statewide, interagency agreements and shared responsibility have characterized the effort. In short, EPSDT needs to be a joint effort.

The distribution of responsibilities between the Health and Welfare agencies at each level must be explicit. To assist in doing this, it is helpful, initially, to list all responsibilities, indicate the level at which they exist and identify the department best suited to handle them. The working table on the following page demonstrates how this is done.

When the process of distributing responsibilities has been completed, interagency committees at the local level should be established to plan and define local activities. Simultaneously, state level interagency committee(s) should undertake planning and development of interagency agreements which will govern the implementation and operation of the EPSDT program. With the completion of the EPSDT state plan and the state-level interagency agreements, the committees at both levels should assume a monitoring and an advisory role in relation to the program.

Some EPSDT components can be managed entirely at either the state or local level while the administration of other components must be shared. It is important to clarify the role that each level will assume in implementing the EPSDT program. In general, management should be the responsibility of the state staff and delivery of services should be the responsibility of local staff.

As managers, state staff should conduct overall program planning, provide direction and support to local staff, monitor program operations, and report program activity as required to state and federal offices. As deliverers of EPSDT services, local level staff plans, coordinates, facilitates, documents, and reports services provided to the eligible population. The basis for this is the local level staff's implementation of eligibility determination, informing, outreach, case management and some health services delivery.

Because the activities to be undertaken within the EPSDT program are numerous and shared, occur in a spectrum of locations and involve multiple disciplines, communication between departments, levels and individuals is critical to program operation. Although there are several potential ways of communicating between program personnel, there are three basic approaches which result in both a horizontal and a vertical flow of information:

1. Regular written communication between agencies and levels. This includes regular policy communiques
<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>STATE LEVEL</th>
<th>LOCAL LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Administration Planning</td>
<td>Welfare</td>
<td>Welfare &amp; Health</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Welfare</td>
<td>Welfare &amp; Health</td>
</tr>
<tr>
<td>Determination</td>
<td>Health</td>
<td>Health to some degree</td>
</tr>
<tr>
<td>Informing</td>
<td></td>
<td>Welfare &amp; Health</td>
</tr>
<tr>
<td>Outreach</td>
<td>Welfare</td>
<td>Welfare &amp; Health</td>
</tr>
<tr>
<td>Provider Recruitment</td>
<td></td>
<td>Welfare &amp; Health</td>
</tr>
<tr>
<td>Screening, Diagnosis and Treatment</td>
<td>Welfare &amp; Health</td>
<td>Welfare &amp; Health</td>
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<tr>
<td>Case Management</td>
<td>Health</td>
<td>Welfare &amp; Health</td>
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<tr>
<td>Follow-up</td>
<td>Welfare</td>
<td>Welfare &amp; Health</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Health</td>
<td>Health</td>
</tr>
<tr>
<td>Data Processing</td>
<td>Welfare</td>
<td>Welfare &amp; Health</td>
</tr>
<tr>
<td>Claims Reimbursement</td>
<td>Welfare</td>
<td>Welfare &amp; Health</td>
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<td>Reporting</td>
<td>Health</td>
<td>Health</td>
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<td>Management of Service</td>
<td></td>
<td>Welfare &amp; Health</td>
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</tbody>
</table>

**FIGURE 2-1**

This chart displays a probable distribution of EPSDT functions (left column) between the Health and Welfare Departments at both the state (middle column) and local (right column) levels. In this model, the Welfare Department is the single state agency responsible for EPSDT administration. The purpose of the chart is to show the need for interagency cooperation rather than to suggest an ideal arrangement.
from managers and regular progress reports from local and component staff. In addition, monthly or quarterly newsletters are useful in describing new developments and positive practices from other areas of the state.

2. **Regular meetings of interagency committees at the state and local levels and of committees consisting of state and local level representatives.** Improving communication is the ultimate function of the interagency committees discussed earlier. The combined state-local committee may be a carryover from the time of state plan development or it may be initiated after the plan has been written and the program is operational.

3. **Regular visits to local EPSDT staff and providers by state staff from both departments.** On-site visits should occur routinely whether or not problems exist. These visits accomplish many things including training, screening site inspections, preparation for federal site visit and the opportunity for information exchange and morale building.

The level from which a program is administered usually reflects the complexity of the program and the importance attached to the program by the responsible agency. The administration of a complex program requiring the coordination of multiple resources can be most effectively undertaken from a level capable of functioning with clarity, decisiveness and authority. EPSDT programs in many states were assigned initially to an office within the Medicaid Division of either the Welfare or Health Department. To most observers, the EPSDT program appeared to be an addition to Medicaid and to fall within the Medicaid operational framework. As a result, EPSDT began sharing the expectations, leadership, reputation and fate of Medicaid. This implied relationship proved to be a handicap for EPSDT when coordination of agencies, divisions, personnel and outside resources was attempted. Despite its close relationship to Medicaid, EPSDT requires a separate program authority, design and administration.

**THE MANAGEMENT PROCESS IS A CONTINUOUS CYCLE** consisting of planning, directing, monitoring and evaluating program performance. This process, combined with the free flow of information, is the major determinant of program function.

Program planning for EPSDT involves understanding the
current federal priorities and regulations. The next requirement is to conceptualize how EPSDT can be established according to federal regulations while staying within the political and resource limitations of the state. Ultimately, the EPSDT concept needs to be described in detail in the form of a state EPSDT plan complete with goals and objectives to guide program activities at all levels. The resources necessary for carrying out each component must be identified, quantified and developed. These same resources are then implemented in a coordinated fashion. Program progress is monitored closely and periodic adjustments in program operations are undertaken based on experience.

The EPSDT program staff is an important factor in program implementation at all levels and staffing must be undertaken with a clear awareness of the required functions. All states have to name staff to administer the program at the state level and deliver the program at the local level. The administrator of the state EPSDT program must assume a broad range of responsibilities which include maintaining a current and complete understanding of program requirements; conceptualizing the development and implementation of the program; interpreting and explaining the program to staff and participants; enlisting and coordinating necessary resources; and providing direction and support to program staff. These responsibilities require that the state EPSDT administrator be a trained, experienced and creative program manager who is familiar with the organization of the responsible agency at all levels and who is capable of working effectively with the necessary resources. Each state needs at least one full-time staff person to administer the EPSDT program. States with many eligible children and complex programs need additional administrative staff.

States with large EPSDT populations, extensive geography or areas having special needs may find it necessary to employ regional staff. Regional personnel are representatives of the state administrator, share similar responsibilities and must possess comparable capabilities. Their role is to provide local orientation and training, to provide assistance in local program development and implementation, to maintain state-local liaison and to monitor local program performance.

The design and delivery of services is a complex and time-consuming task which must be carefully planned and detailed. This task may be undertaken by field staff belonging to the agency responsible for EPSDT, by field staff from an agency under contract with EPSDT and/or new staff specifically employed by either agency to carry out support service delivery. Services provided by existing staff may be combined with non-EPSDT duties in some locations. However, states with large EPSDT populations or densely populated areas will probably need to identify local staff to work exclusively on EPSDT.
Chapter 4, "Screening Package and Periodicity Schedule: Management Issues," and Chapter 5, "Outreach and Case Management: Management Issues," suggest ways to establish norms and measure program activity in health services, outreach and case management. Although federal reporting requirements mandate the collection of selected data, each state program should ascertain its specific information needs and design systems to procure this information.

The program must undergo evaluation on a regular schedule. This should be done internally by comparing program performance to the goals and objectives of the state plan. External evaluations will be done by federal staff or federal contractors based on federal regulations and performance expectations. As a result of these evaluations, additional program planning should be undertaken, new directives issued and the management cycle continued.
CHAPTER 3
PLANNING AND SETTING OBJECTIVES

Quarterly performance reviews conducted by regional DHEW/HCFA offices have assisted the states by identifying EPSDT program weaknesses. Subsequently, some states have improved their EPSDT programs while others have had difficulty understanding the concept, estimating the effort, establishing the necessary capabilities, matching available resources with service demands and measuring performance. For individual EPSDT programs to make progress toward meeting federal requirements and the needs of their eligible populations, state and local review and planning must be undertaken regularly. Objectives must be established for each component at each level of the program and methods for meeting objectives must be developed. Recently, states have enhanced this process by preparing Program Improvement Plans. This chapter will help states plan and set future objectives by suggesting ways to estimate potential demand for EPSDT and suggest ways to enhance resources.

Definitions of commonly-used terms become important when estimating the EPSDT effort. The need for service refers to the number of individuals who are eligible for EPSDT service. The demand for service refers to the number of eligible individuals who wish to receive services. Penetration rate refers to the documented percentage of eligible individuals who have received EPSDT services. Periodicity is the schedule of intervals at which EPSDT services are to be provided.

The first step in estimating the effort is to determine which services will be included in the EPSDT package and at what ages they will be provided. This undertaking, or the revision of an existing EPSDT package can be enhanced by the participation of provider organizations. The resulting screening package and periodicity schedule will be the basis for planning program services, setting objectives and measuring performance. A screening package and periodicity schedule developed in this way will minimize criticism, engender provider participation and allow for easy modification later.

Under current program regulations, each state is free to develop a screening service package which meets minimum standards.
The schedule should be simple and flexible enough to allow for variation. The need for specific health services should be indicated between certain ages rather than at a precise age. An example of such a schedule may be found in Standards of Child Health Care (pp. 13-14) prepared by the American Academy of Pediatrics. It is very likely, however, that the Child Health Assessment Program (CHAP) will mandate a uniform screening package and periodicity schedule.

**THE NEXT STEP TOWARD ESTIMATING THE EFFORT IS TO ESTABLISH THE TOTAL NEED.** Most EPSDT administrators project the need for services annually. This can be done by multiplying the services to be provided, as they have been listed on the periodicity chart, by the number of eligible children. In making this and subsequent calculations of the need for screening, it is important to know the age breakdown of the eligible population; to know how many eligibles already are receiving documented services which meet EPSDT requirements; and to estimate the penetration rate. General health demographics as well as past EPSDT experience provides the basis for estimating the need for diagnosis and treatment.

Screening need determination requires determining the number of children eligible for service and subtracting two figures from this number. The two figures subtracted are the number already served (penetration rate) and the number who, although eligible, do not require EPSDT services because they are already receiving similar services from another source (equivalent care). All the information needed to estimate need can be arranged in a matrix as seen in Figure 3-1 on the following page.

Determining equivalency is difficult. Medicaid agencies have not previously been responsible for administering programs which include primary preventive services and, as a result, information on such services is not usually available within the agencies. However, state health departments and county or local health departments in urban settings have for several years administered health programs which are designed to provide EPSDT-like services to low-income persons. These programs, which include MCH, MIC, C & Y, plus other non-health department programs provide primary preventive health services to a part of the EPSDT eligible population. Hospital clinics and private physicians provide similar services to another substantial portion. Rough estimates of the number of EPSDT eligible children being served through these sources and the types of services they receive can be made by contacting the state and county health departments and a representative sample of hospital clinics and private physicians who serve children. All services covered by EPSDT must be accounted for before equivalency can be established. If some of the services are missing, they must be added to the need figure.

Another way of estimating the number of EPSDT eligibles
<table>
<thead>
<tr>
<th>AGE GROUPINGS</th>
<th>COL 1</th>
<th>COL 2</th>
<th>COL 3</th>
<th>COL 4</th>
<th>COL 5</th>
<th>COL 6</th>
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<tr>
<td>0-1</td>
<td>1,000</td>
<td>1,000</td>
<td>.25</td>
<td>750</td>
<td>.10</td>
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<td>1-2</td>
<td>1,000</td>
<td>1,000</td>
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<td>800</td>
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<td>360</td>
<td>.10</td>
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<td>4-6</td>
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<td>9-12</td>
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<td>15-18</td>
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<td>18-21</td>
<td>etc.</td>
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CALCULATING NET NEED FOR SCREENING

FIGURE 3-1

Col. 1: The age groupings of the periodicity schedule.

Col. 2: The total number of children eligible for services within each group.

Col. 3: The penetration rate for each group. Multiply percentage in Col. 3 by Col. 2 and subtract from Col. 2.

Col. 4: Total number of eligible children not served by EPSDT.

Col. 5: The estimated percentage receiving equivalent services (subtract).

Col. 6: Net need.
being served by Medicaid requires tabulating services noted on Medicaid claim forms. This approach is an indirect way of determining the degree to which EPSDT-like services now are being provided, but it is useful in estimating need.

The information supplied by these exercises is useful. First, providers who supply equivalent services to the eligible population are identified and can be recruited to provide EPSDT services so that quality and range of services can be monitored. Second, providers who already deliver EPSDT-like services to members of the eligible population and who become certified represent potential sources of service to others needing it.

THE TASK OF DETERMINING DEMAND FOR SCREENING SERVICES may be approached by sampling the intent to participate after information about the program has been given at eligibility determination. When a sample of a representative portion of those not already receiving EPSDT-like services has been taken, it will yield a percentage of the unserved eligible children who wish to receive EPSDT services. This figure may be readily available from welfare department data and represents an estimate of the demand for services. A simple calculation yields the estimated demand for screening services:

<table>
<thead>
<tr>
<th>AGE GROUPINGS</th>
<th>NET NEED</th>
<th>% WHO WANT SERVICES</th>
<th>ESTIMATED DEMAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>675</td>
<td>.80</td>
<td>540</td>
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<tr>
<td>1-2</td>
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<td>.60</td>
<td>432</td>
</tr>
<tr>
<td>3-4</td>
<td>324</td>
<td>.50</td>
<td>162</td>
</tr>
<tr>
<td>etc.</td>
<td>etc.</td>
<td>etc.</td>
<td>etc.</td>
</tr>
</tbody>
</table>

CALCULATING ESTIMATED DEMAND FOR SCREENING

FIGURE 3-2

Col. 6: Net need (calculated in Figure 3-1).

Col. 7: Fraction of the total population which needs services and actually wants screening service.

Col. 8: Estimated demand for service.

Ideally, the demand for service would equal need, but experience with EPSDT and all other primary preventive health service
programs shows that demand will be quite different from need. The factors which contribute to this difference in the EPSDT program include the perceived importance of primary preventive health service; knowledge about the program; the availability of screening, diagnosis and treatment services; and the outreach and case management assistance given to eligibles who wish to receive EPSDT services.

The states must inform eligible families about the EPSDT program at the time of initial eligibility determination and at least annually thereafter. This information is to be in writing and, if the eligible person is illiterate or is illiterate in English, then the information must be given verbally or in writing in a language he/she understands. What the individual decides when informed of his/her eligibility for services will determine what additional information is necessary.

The health profile, or the incidence of abnormal findings in each category of screening in the eligible population, helps to ESTIMATE THE DEMAND FOR DIAGNOSIS AND TREATMENT. Existing health programs providing primary preventive health services to low-income populations should have this information. Examining referrals from screening forms can also provide a good estimate. Using the best health profile information available, the diagnosis and treatment effort for the entire EPSDT population can be calculated:

<table>
<thead>
<tr>
<th>AGE GROUPINGS</th>
<th>Col 8</th>
<th>Col 9</th>
<th>Col 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ESTIMATED DEMAND FOR SCREENING</td>
<td>% ABNORMAL SCREENINGS</td>
<td>ESTIMATED DEMAND FOR DIAGNOSIS AND TREATMENT SERVICES</td>
</tr>
<tr>
<td>0-1</td>
<td>540</td>
<td>.20</td>
<td>108</td>
</tr>
<tr>
<td>1-2</td>
<td>432</td>
<td>.15</td>
<td>65</td>
</tr>
<tr>
<td>3-4</td>
<td>162</td>
<td>.65</td>
<td>106</td>
</tr>
<tr>
<td>etc.</td>
<td>etc.</td>
<td>etc.</td>
<td>etc.</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CALCULATING ESTIMATED DEMAND FOR DIAGNOSIS AND TREATMENT

FIGURE 3-3

Col. 8: Estimated demand for screening (calculated in Figure 3-2).
Col. 9: Fraction of total screenings which require follow-up.
Col. 10: Estimated demand for all follow-up.
In order to be useful, THE TOTAL DEMAND FOR DIAGNOSIS AND TREATMENT FIGURE MUST BE BROKEN DOWN to show the specific type of follow-up which may be required. Because medical specialty needs are more important than age categories, a minor change in the matrix provides a method of calculating estimated demand for specific types of service:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>Col 11</th>
<th>Col 12</th>
<th>Col 13</th>
<th>Col 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>.80</td>
<td>8,000</td>
<td></td>
<td>6,400</td>
</tr>
<tr>
<td>Optometric</td>
<td>.20</td>
<td>8,000</td>
<td></td>
<td>1,600</td>
</tr>
<tr>
<td>General Medical</td>
<td>.35</td>
<td>8,000</td>
<td></td>
<td>2,800</td>
</tr>
<tr>
<td>Developmental</td>
<td>.10</td>
<td>8,000</td>
<td></td>
<td>800</td>
</tr>
</tbody>
</table>

CALCULATING ESTIMATED D & T DEMAND BY SERVICE

FIGURE 3-4

Col. 11: A list of screening areas where a significant number of abnormalities is found.

Col. 12: The fraction of screening forms which show selected abnormal findings. The percents do not total 100 since there may be more than one abnormality per form.

Col. 13: The total estimated number of screens (all age groups). The number repeated in this column should be the total from Col. 8.

Col. 14: (The product of Cols. 12 x 13.) A rough estimate of diagnosis and treatment services which will be required from 8,000 screenings. The figure is necessarily rough since this process does not attempt to predict the number of units of diagnosis and treatment which may be requested. For instance, a dental follow-up may require one visit or many, but that fact is not reflected here.

WHEN THE NEED AND DEMAND FOR EPSDT SERVICES HAS BEEN ESTABLISHED, it is necessary to estimate the resources required for informing, case management, and health services. These determinations begin with a clear, detailed description of each service and when it is to be offered. States which have not planned their EPSDT program in enough detail to make such a determination will need additional planning before resource
requirements can be assessed, along with the capacity for providing the required services. When resource requirements have been established, they can be compared with existing resources. If existing resources are inadequate, either they must be increased or the services must be reduced.

Providing information about the EPSDT program and the importance of primary preventive health services seems simple but becomes more complex when done as required. The time, effort and dollars required to prepare a brochure on the program will not be great. However, when the program must be explained verbally as well as in writing, personnel time and costs increase substantially. In assessing the resources required for informing the eligible population about the program, the program administrator will need to know:

1. how many eligibles are in the program at any one time;
2. how many new eligibles enter and leave the program each year;
3. how often eligibles will be informed;
4. how the informing will be done;
5. what percent of the eligibles are illiterate;
6. who will do the verbal informing;
7. how long it takes to inform an eligible verbally;
8. what cost categories are associated with informing.

The two major cost categories associated with the informing function are the cost of brochure publication and distribution, and the personnel costs for face-to-face informing.

Providing the required outreach and case management services is a big job. A detailed plan for making repeated patient contact, assuring a timely flow of information, maintaining up-to-date records, developing knowledge of community resources and ways to use them is required by any agency attempting to handle cases. Many state agencies administering the EPSDT program cannot offer such services or are not experienced in doing so. While many states have struggled with the requirement to provide EPSDT outreach and case management services, those which have made a detailed assessment of the requirements for outreach and case management have developed adequate arrangements for carrying out this part of the program.

Delivering EPSDT outreach and case management services requires sharing responsibility between the administering state agency, implementing state or local agencies, providers of screening, diagnosis and treatment, and case managers. Because so many administrative levels and individuals are involved, an outreach-case management flow diagram must be developed. It should contain provisions for tracking persons throughout their
involvement with the EPSDT program. After developing the flow diagram, consider how and by whom each activity might be carried out. For each consideration, it is necessary to know the average time required to provide the outreach and case management services. The costs of providing outreach and case management services depend upon the number and types of personnel employed and the number of eligible persons which they can serve. Chapter 5 provides details on estimating these costs. It is recommended that the agency administering the EPSDT program in each state make the preceding calculation as if outreach and case management were to be handled within the agency. This will provide cost estimates to be used when contracting or purchasing these services. These costs should be considered administrative and eligible for 75 percent federal financial participation. They should not be added to the cost per case for medical care.

As was noted earlier, a substantial number of eligible children already receive equivalent EPSDT services and the remaining represent the total adjusted need for service. An estimate of provider resources required can be made by looking at current providers and the number of children they serve. This may be done by surveying a sample of local caseworkers or by reviewing a sample of reimbursement vouchers. With the information obtained from these sources, administrators can see how many children are being seen by each type of provider, the types of providers in different areas and the number of children individual providers in various areas can accept. Subsequently, program administrators can better estimate the number and types of additional providers which are needed in each area of the state, county and city.

In general, children in urban settings will be served by neighborhood health centers, Model Cities programs, Title V programs, public health clinics, hospital outpatient departments, public schools and Head Start programs, or by physicians in private practice. In rural settings children will likely be served by private physicians or public health department personnel. Unfortunately, guidelines cannot be provided on the percentage of EPSDT eligible children which can be enrolled in any type of health care setting. All providers of each type have limitations and priorities; thus, each must be sounded out regarding EPSDT capacity. More detailed information for accomplishing this may be found in the final section of this chapter and in Appendix B, the Screening Resources Assessment Guide.

The current trend toward use of private providers has led to increased screening reimbursement rates and a shift to administrative rather than service functions locally. States are now required to use all available resources to provide EPSDT services.

Careful analysis of the different types of costs associated with different providers should be undertaken in planning for
changes in provider composition. There is a trade-off between
direct services and administrative staff depending on the type of
provider used. When health departments provide screening services,
they usually perform case management and limited outreach duties
as part of their service delivery. When the program begins to rely
heavily on private providers, more administrative staff are needed
to perform tasks related to private physician participation. These
include recruitment, certification, monitoring, coordination, sched-
uling and follow-up. The program administrator must calculate the
added costs or savings realized when there is a shift in provider
makeup. This means comparing the total costs of serving a number
of patients through a state or county-supported service site or
serving the same number through private physicians, who must be
supported by state or county administrative staff. Some issues to
compare are: personnel costs; administrative overhead costs; rent,
utilities (if not in overhead); differences or changes anticipated
in screening reimbursement rates for private vs. public providers;
and comparison of costs in forms handling and claims payment pro-
cesses for public and private providers. This analysis requires
data collection over at least a one year period to account for
recurring but unanticipated costs in both settings; for example,
staff turnover in health departments and the attrition rate of
private providers (with the associated costs of recruiting, certi-
fying, etc., new providers).

Because of increased emphasis on using comprehensive care
providers and the private medical community's more positive atti-
dude toward the program, some communities have found their health
department screening services underused. When this happens, it may
be possible to reallocate underused resources to underserved areas.
Physicians in these underserved areas may already be working to
capacity, seeing patients on an episodic basis, and be unable to
provide screening services. Situations like this are ripe for
administrative intervention at the state or county level, to re-
distribute health department resources. The county screening
staff could be converted to an itinerant team that visits under-
served areas. Temporary facilities might be arranged in schools,
Head Start programs or churches. This would maximize the use of
both public and private resources—a step toward keeping program
costs low and effectiveness high by avoiding duplicated effort.
This option is very difficult to consider where local municipal
or county taxes contribute to the support of service facilities.

THE TASK OF MATCHING RESOURCES WITH DEMAND should not be
difficult if the demand and the resources have been assessed care-
fully and accurately. In most cases, demand for EPSDT will exceed
the resources or the stage of program development needed to de-
lever the services; implementation of the program then is limited
by the resource in shortest supply. It is essential that program administrators are aware of capabilities for funding, informing, providing outreach and case management, and delivering screening, diagnosis and treatment. Program administrators also must know how each of the components in his/her program interacts. For example, if it takes \( x \) number of hours to administer \( y \) outreach and case management services to result in \( z \) number of screening, diagnosis and treatment services resulting from \( w \) amount of information, then the ratio of these activities is \( w:x:y:z \). The same example can be worked in dollars. This information helps in planning and setting objectives so that service and funding resources are budgeted carefully and expended in a balanced manner. The adequacy ratio, developed in the table in Figure 3-5, measures capacity against demand. The lowest ratio, in this case 1:4, identifies the program component with the poorest match between resources and demand.

<table>
<thead>
<tr>
<th>PROGRAM COMPONENT</th>
<th>ESTIMATED CAPACITY</th>
<th>PROJECTED DEMAND</th>
<th>ADEQUACY RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informing</td>
<td>20,000</td>
<td>30,000</td>
<td>2:3</td>
</tr>
<tr>
<td>Outreach</td>
<td>6,000</td>
<td>12,000</td>
<td>1:2</td>
</tr>
<tr>
<td>Screening</td>
<td>20,000</td>
<td>10,000</td>
<td>2:1</td>
</tr>
<tr>
<td>Diagnosis &amp; Treatment</td>
<td>5,000</td>
<td>6,000</td>
<td>5:6</td>
</tr>
<tr>
<td>Case management</td>
<td>2,000</td>
<td>8,000</td>
<td>1:4</td>
</tr>
</tbody>
</table>

FIGURE 3-5

The resource in shortest supply is the limiting factor in overall program progress. When one resource is in much shorter supply than others, priorities for program development and the use of funds may need to be changed. As the limited resource expands, the program will grow until the limit of another resource has been reached. It will then be important to plan and set objectives for developing other service resources. The delivery of any one service should not exceed the capacity of other component services to keep pace. In the example given in Figure 3-5, there is more than adequate capacity to deliver screening services. The case management capacity is very poor, however.

DEVELOPING RESOURCES IS A KEY TASK, since it is not unusual to find that those available to the EPSDT program cannot meet the demand for services. This gap may be major and chronic or may show up only when temporary factors stretch financial and human resources beyond capacity. The next section describes ways of
expanding program resources through federal financial support or by collaborating with other programs with similar goals that serve portions of the EPSDT target population. All of the suggestions outlined increase resources of the program, by direct dollar support or by contributing personnel, vehicles, equipment, space or services to the program.

Increased federal support for the Medicaid program is available in four areas that are particularly important to EPSDT program development. Federal funds are available for:

* state and local staff administering the medical assistance program (75 percent);

* staff compensation for the design, development, or installation of mechanized claims processing and information retrieval systems (90 percent);

* expenditures for administering approved claims processing systems (75 percent);

* for services delivered to Native Americans who are eligible for medical assistance and receive services in Indian Health Service sites (100 percent).

There are specific guidelines provided for the use of these funds; administrators are urged to consult the Code of Federal Regulation, 45-250.90 and 45-250.120 as well as their regional HCFA staff.

Some states have used the funds for state and local administrative staff to expand local EPSDT services, particularly the outreach and case management functions. One state established "EPSDT units" in most counties, in health or welfare offices which carried out these functions and were staffed by specially-trained workers whose salaries, travel and training costs were covered by 75 percent federal funds. EPSDT workers within these units offer health education, scheduling assistance and support services to clients who request them as part of their EPSDT service. A significant increase in the number of requests for screenings has resulted, most likely because EPSDT workers explain the program in detail, in contrast to the brief explanation offered by the eligibility worker.

DEVELOPING AGREEMENTS WITH OTHER PROGRAMS serving segments of the target population can substantially reduce the administrative and staff costs of the EPSDT program. The program components which are costly and difficult to administer--outreach, tracking and follow-up--are often handled very efficiently by agencies with more experience. Head Start, WIC, infant care, neighborhood health
centers, Title V programs, drug abuse and mental health programs and some public school programs are accustomed to providing support services, which include outreach, case management and follow-up. Many of their clients are also EPSDT clients.

For children under six, Title V, Head Start and-WIC programs are important sources of care. Head Start programs have already received specific instructions to link their Medicaid-eligible children to EPSDT services, and state level interagency agreements are in effect or being developed in many states. EPSDT can offer the full range of diagnostic and treatment services to eligible children who receive screening services through Title V grantees. In some states, Title V grantees have expanded the scope of their services using EPSDT protocol and forms. EPSDT-Title V relationships can be specified as part of the overall agreement between the health and welfare agencies.

Schools offer an effective way to reach children from 6-17 years who are eligible for EPSDT services. State-supported school systems must provide or ensure the provision of some health services and immunizations. Some EPSDT programs have contracted with schools to deliver services equivalent to EPSDT to eligible children. Successful negotiations with schools require: expansion of existing school health services; addressing the issue of confidentiality; negotiating staff and facilities commitment; and arranging for follow-up. Some large cities have successfully implemented contracts with their public school districts for equivalent screening and related services. One state ensures the provision of all vision and hearing screening services through schools—both public and private.

Prototype interagency agreements, in response to national calls for eliminating duplication of services, are being developed at national and state levels. These agreements are most effective when they specify: the needs and objectives of each agency; methods of coordinating services; and arrangements for reimbursement or funds transfer. Interagency and interprogram agreements are needed at all levels. In developing agreements, representatives from each program must specify requirements and negotiate terms. This is a large "front-end" investment in administrative time, but returns should be great when the collaboration is implemented. To justify the administrative cost of negotiating these agreements and to maintain and evaluate their function, plans should be made to document the various ways in which requirements of the involved programs are met—hopefully without excessive staff or facilities expansion by either program. Following are a few examples of how federally funded programs can be coordinated:

1. **Existing programs can provide EPSDT service.** For example, programs such as community or neighborhood
health centers, Maternal and Child Health programs and National Health Service Corps sites are sources of health services for low-income populations. The Indian Health Service, migrant health programs and Head Start also can provide or arrange these services. Public health departments, mental health programs and social service agencies are good sources of support, health education, case management and transportation.

2. Developing new programs where resources are lacking. For example, the EPSDT staff in charge of resource development can encourage communities with health manpower shortages to apply for funds to develop a community health center or National Health Service Corps site.

3. Increasing staffing in existing programs. For example, several states have used CETA (Comprehensive Employment and Training Act) funds to provide support for outreach workers.

4. Expanding the range of services provided by existing programs. For example, providers can increase nutritional services by participating in the Women's, Infants and Children (WIC) Supplemental Food Program. Or, programs may develop new components for outreach and support services by using VISTA volunteers, Foster Grandparents or CETA workers.

5. Developing, improving and expanding existing services. For example, the National Center for Child Advocacy, the National Center on Child Abuse and Neglect, and the Office for Handicapped Individuals are resources for training, evaluation, research and program planning and development. The Administration for Children, Youth and Families (ACYF) has provided four years of funding to improve EPSDT/Head Start collaboration.

Many local programs receiving federal funds are listed in "Financial Assistance by Geographic Location," published annually by the Office of the Assistant Secretary, Comptroller, HEW. There is a book for each of the ten HEW regions, which provides information on all HEW domestic assistance programs within that region. It lists all organizations receiving funds, their funded programs, and reveals the amount of the grant or award. This information is organized by state, county, Congressional District and city. Information on all HEW funds which are distributed by state agencies
is included under the county and city where the state capitol is located.

As the EPSDT program expands and matures, other forces will produce changes to which administrators must respond. Responses should avoid excessive expense or diminution of any progress already made. This chapter provides some guidance to the administrator responding to requirements to develop adequate resources to meet the demand for service. As in other areas of program management, all actions should be evaluated in terms of overall goals and objectives, both quantitative and qualitative. These are the only reliable guides for selecting appropriate courses of action from available alternatives.
CHAPTER 4

THE SCREENING PACKAGE AND PERIODICITY SCHEDULE: MANAGEMENT ISSUES

The topics of this chapter—screening packages and periodicity schedules—plus outreach and case management, are the characteristics which most distinguish EPSDT from the Medicaid program. While Medicaid for adults simply pays bills, EPSDT clients must be identified and their progress through the system monitored. Also, those who request services must receive a minimum set of tests and procedures regularly.

These requirements present special difficulties for the EPSDT manager. They are often understood poorly by other personnel in the state health/welfare agency, and that makes it difficult to get adequate help from data processing, finance, personnel and other departments which normally assist in management. Budget requests for outreach and case management can be difficult to justify because there is little information about the cost-effectiveness of outreach and case management, or of screening and periodicity schedules. Although periodic screening has intuitive appeal as a beneficial approach to health care, little information is yet available on its actual value. Early indications, however, are that periodic rescreens are finding fewer abnormal conditions. One study, conducted by Community Health Foundation, compared use of various medical services by screened and unscreened persons.\(^1\) The study showed a lower use rate for screened persons; however, no data about medical service use by the screening population prior to screening was available.

Even though definitive research has not been done, there are good reasons for the procedures, frequency and support systems recommended by EPSDT regulations. Some of the reasons were drawn from experience in other systems, some from current practices in the private sector. This chapter will describe first the basis for the screening package and periodicity schedule, suggest criteria for making selections, and discuss their management applications. The focus of this discussion is to upgrade the EPSDT

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administrator's ability to hold effective planning sessions with medical personnel.

SCREENING IS THE USE OF SIMPLE PROCEDURES to sort out from apparently well persons those who have suspected disease or abnormality and to identify those in need of more definitive study of potential physical, mental or other health problems. Some providers object to EPSDT because the contents of the screening package and intervals in the periodicity schedule are specified rather than left to their discretion. Private practice has traditionally been a free enterprise activity, and the idea of government-specified care is unique to the EPSDT program. Some physicians have had difficulty accepting a program-specific screening package. Administrators must recognize and understand this reaction and minimize its effect on the program. (Chapter 6 discusses this in detail.)

One way to minimize negative reactions is to aim for a high degree of involvement from organized medicine in defining the screening package and periodicity schedule. Some states have worked successfully, for example, with their state medical society and/or pediatric society. Although this can be time-consuming, the payoff is substantial. Physicians tend to find the program more acceptable if they know of input from their peers. The following sections were developed to help administrators converse more productively with the medical community about periodic screening as a health protocol, its benefits, and limits.

FEDERAL PROGRAM REGULATIONS SET MINIMUM REQUIREMENTS for screening packages. Some decisions left to the state administering agency are: which additional conditions to screen for, which tests to use, what levels determine normal results, and how often to screen. Valuable research has been done on setting criteria for choosing the diseases for which to screen. The classic reference is Pediatric Screening Tests, edited by Drs. Frankenburg and Camp. These ten criteria for disease selection are drawn from that work and summarize the issues, although the reader is encouraged to read from the source.

1. The disease or conditions should be serious or potentially so. Seriousness can be measured by individual as well as public health standards.

2. Diagnostic tests and procedures should differentiate

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diseased from non-diseased or borderline individuals.

3. The prognosis should be improved if the disease is detected and treated prior to the usual time of diagnosis. If the optimal time to initiate treatment coincides with the usual time of diagnosis, the value of presymptomatic screening is questionable.

4. The disease and condition should have an adequate lead time (amount of time between screening-related diagnosis and the usual time of diagnosis under current medical practice). It is unlikely that annual screening for a disease with a two-month lead time will uncover a significant number of cases.

5. The disease should be treatable and controllable.

6. The condition being screened for should be relatively prevalent.

7. Screening should not harm the patient. This refers both to bodily and psychological injury.

8. Diagnosis and treatment must be available for persons with positive findings.

9. The cost of all procedures and care (screening, diagnosis and treatment) should be evaluated in light of human misery and cost of treatment after the usual time of diagnosis.

10. The public should accept screening for the disease of or condition in question.

These guidelines are presented to help EPSDT administrators understand the rationale, purpose and limits of screening. Trained medical professionals are usually aware of the role of screening in comprehensive care. However, many other persons who work in the program (social workers and eligibility workers, for instance) may not be so well informed. The many "publics" of the program (consumers, legislators, taxpayers, etc.) also may be unaware of the benefits of screening. Effective program leadership requires continuing education of all these groups to screening issues. It is important for physicians to accept the screening package, even in states where health departments are the primary screening agents, because physicians must have confidence in the tests and criteria in order to accept referrals from screenings. The benefits of
professional endorsement of the screening package cannot be over-emphasized.

Once the diseases to be screened for have been selected, the most appropriate test used to identify that disease must be chosen. For some diseases, like iron deficiency anemia, more than one test can indicate the presence of disease (hemoglobin or hematocrit determination). Test selection is an ideal opportunity for physicians to advise the EPSDT program administrator. In general, tests should yield reliable results, be cost-effective, and should be evaluated against these criteria:

1. acceptable: minimum pain, embarrassment, discomfort;
2. simple: maximizes manpower, minimizes cost;
3. reliable: consistent results;
4. valid: test result is confirmed by diagnosis;
5. appropriate for the population: age, ethnic, socio-economic considerations.

Every test used has a range of normal and abnormal results. Medical practitioners, however, do not always agree on exact criteria for referral for further diagnosis. Some states have attempted to standardize criteria for "abnormal" results. However, it may be advisable to permit physicians some flexibility in interpreting screening results. When results are borderline, it makes sense to retest rather than to refer automatically.

SCREENING FOR DISEASES SHOULD BE REPEATED REGULARLY in order to be effective. These intervals should be determined by the lead times of diseases screened for, their incidence, and their prevalence in the population at the time. Frequent screening of young children is based on their rapid early development as well as the inability of very young children to communicate verbally. Two of the most often used periodicity schedules are the schedule recommended by the American Academy of Pediatrics, and an annual schedule—with or without more frequent visits for infants. Some states have only one screening package for all visits while others recommend a specific set of procedures depending upon the child's age and the time elapsed since the last test.

Periodicity schedules should strike a balance between potential health benefits and screening costs. Acceptable schedules are best based on current practices. This is a legitimate approach, but it must be recognized that the assumptions and criteria behind the decisions are not always made explicit or based on conclusive

research. There are, however, two ways to evaluate the effectiveness of periodicity schedules. One is based on screening yield; the other is a cost-effective analysis.

Screening yield is defined as the number of cases identified (true positives) divided by the number of clients screened:

\[
\text{Screening yield} = \frac{\# \text{ true positives}}{\# \text{ screened (total)}}
\]

Yield can be calculated for one test or for the entire package. Calculations for one test, for example, might require a comparison of the number of vision or eye defects detected in vision screening to the total number of vision screenings. The total incidence of disease or disability found through screening, as a percentage of all complete screens is the composite yield.

Most referral counts include a certain number of false positives (cases in which results appeared to indicate a disease or disability, but further examination failed to confirm the presence of pathology). These referrals should not be included in the yield calculations. The periodicity schedule with the highest overall screening yield will be the most effective schedule, where the criterion for effectiveness is the number of cases identified. Although screening yield is the most easily calculated indicator of the effectiveness of a periodicity schedule, it is not the most precise. The issue to be resolved includes not only which schedule will produce the most identified cases, but which schedule will produce the highest yield for a given amount of resources. Information required to evaluate the cost-effectiveness of a different periodicity schedule is the cost per case identified with each schedule:

\[
\text{Cost/screen} \times \frac{\text{children screened}}{\text{cases identified}} = \text{cost/case identified}
\]

The schedule with the highest yield and lowest cost per case identified is the most cost-effective. Costs of screening include administrative overhead and outreach, case management costs and costs for support services if these are not included in overhead. In performing cost comparisons, it is most important to include the same group of costs in all calculations.

Norms for screening yield and cost-effective schedules have not been established. There is national data available on referral rates for dental, vision and hearing disorders, but no systematic count on other conditions. State administrators are encouraged to set their own norms, based on current practices in their states and budget restraints. Trend analysis can provide a basis for future adjustment of norms.
As conditions warrant, periodicity schedules, diseases screened for, and individual screening tests and procedures can be eliminated, modified or substituted. Medical and technological advances may reduce the seriousness or prevalence of conditions; new tests may be designed; prevalence of a condition may change; feedback from providers may require a change in procedures or periodicity; the demography of a population may change and require the elimination or addition of components. Program administrators should perform an annual review of the screening package and periodicity schedules to see if they continue to meet program objectives.
CHAPTER 5
OUTREACH AND CASE MANAGEMENT:
MANAGEMENT ISSUES

Health care for children traditionally has been organized according to sound health practices, emphasizing routine care and early diagnosis. If this is true, why, then, is there such strong resistance to the program? Why do we need outreach and case management? They are needed because federal regulations specify that a set of minimum services be delivered regularly, and because EPSDT has combined several entities that have traditionally been separate. For example:

- poor children and high quality health care;
- welfare eligibility determination and health education;
- dental care and medical care;
- physical assessments and vision screening;
- rural health departments and urban medical specialists;
- transportation and health care;
- dentists and welfare programs;
- schools and welfare programs;
- outreach and health services.

Outreach is the process of seeking and identifying persons eligible for service and encouraging them to use EPSDT services appropriately. Case management ties these functions together. There are no new functions involved—just new relationships on a large scale.

THERE IS A LIMITED PRECEDENT FOR OUTREACH SERVICES in some health programs—neighborhood health centers, for example. In these settings, program representatives tell potential clients about services and help them get services if they request them. At the end of the month, each worker evaluates the effectiveness of his or her efforts—clients either have appeared or have not; it is a closed system as Figure 5-1 illustrates on the following page.

All EPSDT activities, on the other hand, are conducted within an open system—a system that interacts with other systems at many points. Compare Figure 5-2 with Figure 5-1:
EPSDT has taken outreach functions from small, closed systems and tried to apply them in a large, open system. The "out" designations can occur when eligibility changes, clients relocate or the outreach worker has difficulty tracking the next activity of the client. The new system designations represent the other systems the client may enter while receiving EPSDT services. An important objective of outreach and case management requires a systems integration of all these parts to the major system.

In designing outreach programs, several issues must be considered and two issues in particular should be analyzed: local areas' current performance in meeting screening rate goals; and the availability of resources to handle the increased demand for services which outreach activities generate. When the screening volume is satisfactory for a given population, the objectives of outreach are met, even though there may be no outreach activity. It is hoped that outreach will be less necessary as the EPSDT program becomes known and accepted by a large number of persons. This may occur already in settings where the program is mature and
visible and client acceptance is high. It may be the result of an exceptionally good notification process or of the outreach activities of other programs serving the same population. When this occurs in an area, EPSDT administrators may want to determine the probable causes for this success and introduce these same conditions to other areas where client acceptance is not satisfactory.

It is critical to evaluate the capacity of screening, diagnostic and treatment provider resources before introducing a program which will increase demand. Good planning may require an intensive provider recruitment program before implementation of an outreach program. (Suggestions for this are offered in Chapter 6.)

In designing or redesigning an outreach program, specific goals should be established for this component. Sub-goals should be set which relate to the overall goal. An example of a general, state-level goal for outreach is "to provide information about the EPSDT program to families of eligible children in order to motivate them to use services." This must be further specified to encompass all different types of outreach activities. Some sample sub-goals and appropriate activities are:

1. sub-goal -- to increase the level of general knowledge about the EPSDT program;
   activity 1.1 -- develop or adopt suitable advertising. Promote the program through channels of influence within the community (e.g., churches);

2. sub-goal -- to identify persons who may be eligible for EPSDT but who may not have made application for benefits and encourage these persons to apply;
   activity 2.1 -- provide in-service training to workers in agencies serving low-income families to increase their ability to identify potential EPSDT clients and to refer them for certification;
   activity 2.2 -- extend telephone and home visit outreach efforts to all residents, regardless of Medicaid eligibility, in areas with dense low-income population;
3. sub-goal — provide specific encouragement to use services to all persons already identified as eligible for services;

activity 3.1 — follow up routine notification of all eligible families to motivate them to use services. This will include developing specific appeals for high-risk persons, providing transportation and other support when necessary.

While it is clear that all three sub-goals support the major goal, it is also clear that attempting to meet all of them simultaneously in all parts of the state would require a substantial expenditure. Sub-goal 2, for example, would be effective in areas with a low Medicaid enrollment/eligible population. After this is resolved, activities of sub-goal 1 may be implemented. Outreach activities should be specified on a region by region basis. The state’s leadership role in specifying outreach activities locally includes:

• collecting and analyzing data needed to design an appropriate outreach program in a given area;
• providing models for outreach service design and training programs for outreach workers;
• developing appropriate measurements for evaluating the impact of outreach programs;
• collecting statewide impact data and developing norms for outreach program efforts.

EACH TYPE OF OUTREACH ACTIVITY REQUIRES A DIFFERENT WORKER-CLIENT RATIO, with home visits requiring the highest ratio. More workers/clients are required in rural areas than in urban areas due to travel time. Other outreach services will require still different ratios. The first step in projecting outreach manpower needs is to choose the type of outreach services to be provided to different client groups. The second step requires projecting the outreach workload; the third requires determining a ratio of workers to clients for each service.

Projecting the outreach workload requires estimating the number of persons needing service in each category. One way to estimate is by adding the totals in appropriate categories. For instance, one objective might be to contact all those clients who refused EPSDT service at the time of eligibility determination and explain the program again, in the hope of convincing them to accept service. The protocol for this might include the items below (these
are offered only as a sample, not a recommendation):

- mailing notices to all persons in this category;
- following the mailed notices with telephone calls to 50 percent of these persons—selected at random;
- scheduling home visits to a proportion of the clients who were contacted by mail or phone and who qualify for pre-determined high risk categories (examples are: large families, young children, etc.).

Further refinement of the workload estimate requires quantifying population projections for a given time period for each of the three steps. At the outset, a certain segment of backlog cases should be included in the workload. Estimates then can be made which include backlogged cases and new cases. Most of the figures can be obtained from welfare office statistics. The next step is projecting the number or percent of full-time equivalent workers needed on each task. The following sample illustrates a way to make this projection. It is based on the protocol given above.

<table>
<thead>
<tr>
<th>A. INFORMATION REQUIREMENT</th>
<th>B. PLANNING REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. # of persons per month who refuse service (average figure).</td>
<td>1. Manpower requirement to prepare and send letters to this number of persons. (Expressed as a full-time equivalent.)</td>
</tr>
<tr>
<td>2. 50% of this number.</td>
<td>2. Manpower requirement to make telephone calls to this number of persons.</td>
</tr>
<tr>
<td>3. Estimate of # of high-risk families.</td>
<td>3. Manpower requirement to perform home visits to this population.</td>
</tr>
</tbody>
</table>

PROJECTING OUTREACH MANPOWER

FIGURE 5-3

Estimating the manpower requirement entails multiplying the time per unit of work (e.g., phone call or visit) by the number of work units (phone calls or visits completed per time period) and dividing this number by the number of hours per time period. If the objective is to reach all persons refusing service within the month following the month in which service was refused, then
one month (or 176 hours) is the time period, and the manpower projection will be the requirement for one month. Annual projections can also be made.

\[
\frac{.25 \times 500}{176} = \frac{125}{176} = .71
\]

Where: 25 = fraction of hour per call (15 minutes includes 12 minutes for average conversation plus three minutes average time for unsuccessful calls distributed over successful calls.)

500 = # clients to be called.

176 = # hours in one month.

.71 = fraction of full-time worker required to perform this task.

FORMULA FOR CALCULATING MANPOWER REQUIREMENT FOR TELEPHONE WORK

FIGURE 5-4

In estimating time for telephone work and home visits, time spent on unanswered calls, wrong numbers, persons not home, etc., must be included. These averages can be added to the time required for successful attempts.

MONITORING OUTREACH PERFORMANCE requires measuring the effectiveness of outreach efforts against established objectives. Appropriate objectives for outreach all require increasing the appropriate use of medical services. This includes increasing the penetration rate, reducing the number of broken appointments, etc. These goals should be quantified. Measuring outreach effectiveness requires collecting and tabulating data monthly. At a minimum, this should include:

- the number of clients needing outreach service (current number plus the number of backlogged cases allocated to the month being evaluated);
- the number of clients contacted;
outreach yield = \frac{\text{number kept appointments}}{\text{total number contacted}}

the show rate = \frac{\text{number kept appointments}}{\text{number appointments scheduled}}

The best indicator of outreach performance is outreach yield. The "show rate" illustrates the effectiveness of selected aspects of the outreach effort. For instance, a high acceptance rate and low show rate may reveal a need to retrain outreach workers who present program information in order to ensure that clients fully understand what they are accepting, or it may show a need for more support services to help clients keep appointments.

The basic measurement of outreach cost-effectiveness is outreach costs per child screened. Studies have shown that outreach costs can vary considerably. Some of the variance is due to the method of calculation; for example, outreach expenses might be considered a direct cost and allocated over the entire population, or just the population who eventually receives services. The latter calculation gives a much higher cost/child figure. Outreach costs can also be considered an administrative overhead expense and not allocated to individual cases. Outreach costs include salaries, transportation (where they are considered direct costs) and administrative overhead. Several factors should be kept in mind in planning for and managing these services. Training welfare recipients to perform outreach services represents a double savings—fewer dollars paid for public aid benefits, use of low-cost personnel. The costs of training and employing welfare recipients may be underwritten by CETA or WIN (Work Incentive) or another subsidized training program. Because personnel costs keep the total outreach expenses high, they should be kept as low as possible by using other sources of funding. Analysis of outreach yield and performance will reveal an optimal mix of outreach services which increases the yield and meets state quantified goals. Management's responsibility is to obtain the highest outreach yield for a given mix of services. This requires the use of the least expensive resources to achieve the most effective result.

THE TRACKING FUNCTION OF CASE MANAGEMENT CONTINUES THE CYCLE BEGUN BY OUTREACH. In a large open system offering many choices, it is difficult to "track" client decisions and concurrent actions. Because of the length of the cycle, choice points can
vary considerably and it often is very difficult to distinguish "rest" points, where the client may be temporarily inactive, from "out" points. This problem is inherent in both manual and automated tracking systems.

The function of case management is to assure the timely delivery of all appropriate services to eligible families. Assuring the delivery of services—linking children with the health care system—is the crux of the entire EPSDT program. It requires that EPSDT staff monitor the status of each individual eligible for the program, assure that services are available and that clients be encouraged to take advantage of the appropriate services or activities. The periodic nature of EPSDT services means that the process must be repeated continually while children are eligible for the program. The administrative process necessary to accomplish this is case management. The efficient and effective organization of these steps is a case management system.

Case management enables EPSDT to meet the objectives set forth by Congress and HEW. Although it may be viewed as one component of an EPSDT program, it is the component that links the other components together. It relates the identification of eligibles to informing and outreach activities; it relates outreach to referral to health care providers for screening, diagnosis and treatment; and it relates the need for health and medical care to the identification and delivery of other support services that families may need. It integrates welfare eligibility and social services information with health service delivery data and compares this information against a standard schedule of screening components and frequency as well as time frame for follow-up care.

To identify eligibles within welfare departments, AFDC, SSI, medically needy and indigent rosters, at the minimum, must be culled. To determine service needs, income maintenance, social service, EPSDT and outreach workers' records must be reviewed. In some states, the difficulty of this task is magnified infinitely when some information is available only in each county and, in these cases, a system must first be developed to aggregate this information at the state level.

Health information, too, must come from a variety of sources, some of which are traditionally not accustomed to sharing information. In particular, data from private providers on services to individual children must be gathered and combined with data from other health resources to demonstrate that the children have received all necessary and required services or highlight the need for further action. This requires links between health departments and private providers and among private providers so that the federal requirements of timely delivery of screening, diagnosis and treatment services can be met and documented.

Services which may be necessary for families to take
advantage of EPSDT, such as transportation or child care, must also be identified and their delivery documented. These important services frequently involve additional public or private agencies which traditionally operate independently from the health, welfare or Medicaid agency administering the EPSDT program. Information about these services, too, must be linked to the child's record and become another component of the case management system.

Given the many linkages which are required, it is not surprising that states have had difficulty designing and implementing case management systems. The problems of designing a system to monitor clients' progress from application for AFDC or Medicaid eligibility through completion of treatment are many and complex. There is a decision point at each phase of the process since clients have free choice to accept or reject any or all services.

A case management system must:

1. identify those who meet the state's eligibility criteria;
2. record date of eligibility;
3. document offer of EPSDT service;
4. document client's response;
5. document the offer of support services and client's response;
6. document provision of support services;
7. identify clients who need to be reminded prior to their appointment;
8. identify those who have missed appointments;
9. document results of health assessment;
10. document need and provider selected for diagnosis and treatment for each suspected condition;
11. monitor client progress through each step of EPSDT process;
12. identify clients for periodic renotification.

Steps 7, 8, 11 and 12 require the development of time-frame criteria.

Recording notification and the offer, acceptance and delivery of appropriate social services is a complex process. Documenting the delivery and result of each component of the screening package and the need for and receipt of related diagnosis and treatment is even more taxing given the many different providers participating in the program. Furthermore, the entire process must be repeated regularly for each eligible individual throughout their period of eligibility and started anew after each period of ineligibility.

The case management workload is a rough estimate of the number of cases requiring case management services. (The measure is not precise because some cases may be counted under more than
If this workload is projected for one month, it should include a certain number of new cases as well as a portion of backlogged cases. Both categories include:

- persons with positive screening results who must be followed to treatment;
- persons with broken diagnosis and treatment appointments who must be contacted and rescheduled;
- persons who have requested, but not yet received, support services such as scheduling assistance, transportation, child care, or other services.

The system should be able to distinguish between open and completed cases and store all data in the event that it is needed for future periods. Staffing requirements can be projected by dividing the total workload by the average number of cases one case manager can handle when working at full capacity. The formula provided in the outreach section (Fig. 5-4) can be used for this. Again, there are no norms and administrators will need to sample activity in different areas of the state in order to develop standards. One output measure is case management yield: the number of kept diagnosis and treatment appointments divided by the number of positive screens.

There is no one agreed upon representative output measure for case management nor are costs easily allocated between the various types of case management output. Although measures of case management cost-effectiveness do vary, there is a simple measure which can be useful in the EPSDT program—the cost of case management per screen. The cost elements to be included in this measure are personnel, salaries, transportation and administrative overhead costs. Administrative overhead includes space, utilities, supplies, etc.

THE EVIDENCE THAT OUTREACH AND CASE MANAGEMENT contribute to the effectiveness of the EPSDT program is strong. It is very difficult to measure the effect these have on service use; particularly in attempting to show a causal relationship. Yet a causal relationship is the best justification for outreach and case management expenditures. Outreach and case management services are intended to help clients who need and want services to obtain and use them effectively. Critical decisions include: what kind of services will be offered; what proportion of clients should be served; how they should be selected; how many staff are needed for each function; how can outreach and case management be evaluated.

Managing case management requires the same planning, organizing, directing and controlling activities required by overall general management. Each activity should have measureable objectives which should relate directly to program goals. Responsibility
for case management is usually divided between the state and local levels. This shared arrangement requires specific feedback to state administrators about local performance. Overall state plans can be developed only when adequate measures of local need and activity are available; these can be compared to objectives, priorities established, programs planned and implemented.
CHAPTER 6
PRIVATE PROVIDER PARTICIPATION:
A SYSTEMS APPROACH

The delivery of EPSDT services to the target population depends upon cooperation between public and private medical sectors. To provide services, states must:

Seek out and develop agreements with facilities and practitioners throughout the state that can provide screening and diagnostic services for early casefinding purposes. When screening and diagnostic services throughout the state are insufficient to meet the needs of the Medicaid program, the development of additional centers should be encouraged.¹

Current HCFA/OCH objectives require states to encourage the participation of all existing providers.

Data from 1975 show that 22 states recognized only health departments as screening agencies. Nine others allowed only private physicians to screen; the rest sanctioned mixed sources.² All states relied upon private physicians, dentists and optometrists to provide treatment. Since 1975, many states which had excluded physicians in private practice from the delivery of screening procedures began to include them. This has occurred because physicians began to show more interest in screening, greater demand has required more screening capacity, and screening itself has gained acceptance as part of routine health care.

State EPSDT administrators have, however, reported difficulty in working out the needed cooperation between public health programs and private physicians. Problems include:

1. A failure by most private physicians to perceive differences between EPSDT and Medicaid. Problems

¹EPSDT Guidelines MSA PRG-21, p. 5.

in billing and claims payment associated with Medicaid are assumed by some doctors to exist with EPSDT as well.

2. **A belief that EPSDT requirements infringe on their prerogatives to practice medicine.** Some doctors find EPSDT standards unacceptable.

3. **Some tests required by EPSDT were not performed routinely by all private physicians.** Vision and hearing tests, plus formal development assessments, were frequently omitted.

Since these problems were recognized, many private physicians have begun to change their attitudes toward these problems, and many states have made their programs more appealing to doctors. State administrators, however, still struggle to recruit, certify, and monitor physicians to deliver EPSDT services. This chapter describes a systematic approach to minimizing and solving these problems; an approach which requires that all components of the program be looked at in relation to each other, and that the process of provider network development be viewed within the larger system of program management.

The two main objectives of the communication program described in this chapter are: to recruit as many screening providers as needed in the least expensive way; and to keep certified providers from leaving the program. The approach to provider communications outlined in this chapter is essentially a marketing approach. The EPSDT program is viewed as a "product" for which the provider is a "consumer". As in other marketing situations, the provider will decide whether or not he wants the product. It is hoped that he/she will fully understand what participation in the program entails before making this decision. The communication program described in this chapter consists of six major components and is designed to increase physician participation in the EPSDT program.

1. **Planning and setting objectives:** determine the amount, type and location of screening providers needed.

2. **General communication:** employ techniques to raise the general level of knowledge about the program.

3. **Targeting:** provide specific information to physicians who are potential providers or who may influence potential providers.
4. **Recruiting**: compare qualifications of interested providers with program requirements and solicit participation.

5. **Certifying**: develop contracts.

6. **Monitoring**: keep track of providers' activities within the program.

The unusual feature of this plan is the placement of recruitment as a part of the provider network development program. Some states that focused exclusively on recruitment found that they developed contracts with providers who have not met the program's needs. They may be located in the wrong areas, have the wrong specialty, or may not deliver the services required by EPSDT. An undesirable result of a recruitment-only emphasis is an information gap about which physicians are actively participating. Viewing recruitment as one step in a communication program helps to ensure the certification of providers who have a clear understanding of their obligations to the program.

**PLANNING AND SETTING OBJECTIVES** is based on estimating the demand for services which was discussed in Chapter 3. The projected demand will determine what types of providers will be needed, and where they will be needed. However, since the capacity of providers differs in various cases, it is difficult to establish a ratio formula, such as $x$ providers can serve $y$ population. (Appendix B, the "Resource Assessment Guide," tells more about collecting this kind of data.) Instead it may be more effective to sample providers of each type to determine their capacity for seeing EPSDT patients—large group practices, for example, will have a greater capacity than single practitioners. Practices with physician extenders may be able to see more patients than those without.

In developing a network of providers, the EPSDT administrator must determine what capacity is needed, and what already exists. This planning should be done with maps, county population statistics and past data and input from local EPSDT workers. Areas lacking providers should be rated according to their degree of shortage. For example, a shortage can result from a lack of qualified providers working in the area or from too few providers willing to participate in the Medicaid program even though there may be a high ratio of doctors/population. The first type of shortage will require more administrative effort to resolve. The second will require careful diplomacy.

After statewide and local objectives have been set, the state should develop a plan to meet them, and set a deadline. It may be productive to begin developing a network of providers in a
few selected areas or counties at first, since it is easier to control, evaluate and correct an effort begun on a limited basis. The plan should list criteria for selecting areas having a shortage of providers, quantify the shortages, specify the needs of such areas, and outline a plan for meeting those needs.

GENERAL COMMUNICATION IS DESIGNED TO INCREASE KNOWLEDGE OF THE EPSDT PROGRAM AMONG THE ENTIRE COMMUNITY, including the public, potential clients, physicians, legislators and other governmental representatives. Such communication will make it more likely that physicians will be familiar with the program when they are approached with specific information.

Strategies to gain publicity can include mass media. Clarity and uniformity are critical elements of such strategies. The point is simply to increase recognition of the program at this stage. Brief informational messages are best; identifying symbols, logos, slogans and colors also are important.

Relatively inexpensive media techniques can be used effectively—especially mass transit advertising and public service television even though such messages are often aired too late or too early in the day to reach a sizeable group. Messages should be short but significant. Since the letters "EPSDT" are almost never remembered, messages might speak of a preventive program offering health checkups or assessments. Some suggestions for this stage in the communication process are: provide bibs for newborns in hospitals or for infants during office visits; use electronic billboards in front of local businesses; distribute coloring books for older children; offer continuous slide/tape presentations at health fairs or medical and hospital conventions; use mass transit ads with maps showing where EPSDT services are available (not identifying private practice groups or individuals); use transit ads with tear-off sheets containing more information.

TARGETING AIMS A MESSAGE AT A PARTICULAR GROUP. Here, it will refer to communications intended for potential providers. The objectives of targeting are two-fold: to provide physicians with information which has been prepared specifically for them, and to capitalize on the influence and communications which physicians have with each other. Researchers have noted that "the greater the difficulty of entering a group, the more the individual is likely to value group membership and adhere to group norms."^3

Physicians have many reasons for participating, or not participating, in the EPSDT program and the right contact with physicians can promote their participation. When some physicians are disposed to participate, the key is to maximize the positive effect they may have on their colleagues. For those who are disposed not to participate, the key is combating the negative image those doctors have of the program (an image often resulting from association with Medicaid). Elements of that negative image include:

1. **fees**—the reimbursement rate may be considered too low;
2. **forms**—overly complex and time consuming;
3. **claims handling**—physicians often are not paid promptly or fully;
4. **patients**—Medicaid patients are thought to abuse the medical care system (by using services excessively or failing to keep appointments, for example);
5. **government interference**—physicians who receive federal or state money are subject to government monitoring.

Some factors which motivate physicians include:

1. **altruism**—the program serves poor children;
2. **prevention**—since the program requires screening and early detection of disease, it is deemed worthwhile from a medical standpoint;
3. **competition**—physicians in primary care are increasingly competing for the same patients and may welcome an opportunity to see additional patients whose regular care is reimbursable;
4. **increased involvement in government programs**—since Medicare and Medicaid were introduced in 1965, physician involvement in government programs has gradually increased.

Targeting activities should focus on doctors in groups: national and professional groups, specialty groups (pediatricians, family practitioners, and mixed specialty group practices). While not all physicians are active in medical societies, most join and

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AUTHORS' NOTE: Medi-Cal is the California Medicaid program.
follow the groups' positions on issues. Those who set policy for these groups, the opinion leaders, deserve special attention. One recommended strategy is to present information about the program at professional gatherings, medical conferences, continuing education seminars and trade association gatherings. Booths and other displays appear to be more acceptable to doctors than lectures because they offer doctors more choice in approaching the information, more control over his/her approach, and a chance to have simultaneous discussions with other doctors. In addition to direct contact, targeting includes doctors influencing doctors. The most successful approaches would use presentations and favorable testimony from participating physicians, informally in hospitals or offices, or formally in live or taped presentations. Communications should be designed to speak to doctors as doctors, and address their special concerns. More facts should be offered here than in general communication, but detailed explanations of some aspects of participation, such as forms' completion, should await a commitment from physicians.

Although the EPSDT program is relatively complex, information presented during the targeting phase should be simple and positive. A good rule to remember is to match the amount of information to the amount of interest at every stage of persuasion.

RECRUITMENT MEANS SOLICITING PARTICIPATION FROM PROVIDERS who meet general requirements for participation in the EPSDT program. Appropriate communications during the recruitment phase include speaking to individuals and small groups of potential participants and attaching "expression of interest" forms to newsletters of specialty groups. Personal contact is usually more effective than any other method at this stage and is considerably more successful when the audience knows of the EPSDT program. This task can set the stage for certification and monitoring when it clearly communicates standards and mutual expectations. At a minimum, the recruitment program should:

1. specify the target group from which to recruit providers;
2. include a method for identifying new providers in the community;
3. use a systematic method for approaching providers;
4. organize written and verbal presentations in a way that is acceptable to most providers;
5. separate tasks and delegate responsibilities to appropriate workers;
6. adapt as feedback comes from the field;
7. be flexible enough to respond to the concerns and needs of the target group.
A successful screening provider recruitment program developed in Los Angeles, California, could serve as a model and could be modified for use in other areas. In one county, the public health nurse is responsible for face-to-face screening provider recruitment. The nurse locates non-participating physicians through the telephone directory, through participating providers and by observing new practice openings in medical buildings. She focuses first on pediatricians and general practitioners who already participate in the Medicaid program. She determines their Medicaid status through the Welfare Department or by calling the providers' offices. Next, the nurse visits their offices and leaves a packet of information with the clerical staff. She also schedules a convenient time for a return visit when physicians and their staffs generally have fewer patients. During her next visit, she makes a presentation designed to emphasize appealing aspects of the program and to de-emphasize unappealing or routine elements. If the physicians express interest, she returns at a later date to instruct the office staff in forms completion and billing procedures. The initial presentation requires 30-60 minutes and another 60 minutes is spent with the clerical staff. One to three telephone calls normally will be made during the first month to reinforce instructions and answer questions. The nurse schedules a routine annual visit to participating providers to share new program information and handle questions and complaints. These last two activities also serve as a monitoring function.

The public health nurse who devised this plan used existing county material and a trial-and-error approach. She was flexible in the early stages of implementation and responded to complaints. The plan is recommended because it uses existing personnel and materials; it is consistent and makes economical use of time; and it appeals to physicians as evidenced by their response.

Another noteworthy feature is its flexibility in meeting special needs. For instance, medical corporations and mixed specialty practices present special difficulties in recruitment. They require more time to make decisions since they are larger organizations. Decisions about forms, procedures and practice size are made more formally than in small groups or with individual doctors. More skill is needed to recruit large or institutional providers and recruiting personnel should become familiar with the internal operations of clinic/hospital patient care and billing departments before approaching administrators in these settings.
Face-to-face recruitment is very costly,* and less expensive methods may need to be used. However, as more physicians become familiar with the program, the recruitment part of provider network development will require less time.

CERTIFICATION IS THE PROCESS OF ESTABLISHING A PROVIDER'S QUALIFICATIONS for delivering EPSDT services and setting forth mutual expectations in a contract or agreement. Some of the qualifications which should be considered in developing certification criteria are provider training and credentials; support staff training and responsibilities; and type, size, location and adequacy of facilities and equipment.

The EPSDT program must decide how to relate EPSDT certification to Medicaid certification. Basically, the options are to recognize Medicaid certification as EPSDT certification, or to certify separately. Since the requirements for EPSDT, as well as reimbursement rates (and sometimes reimbursement process) are quite different from Medicaid, a separate certification process is preferable. Certifying separately offers an ideal opportunity to emphasize the critical differences between the programs.

Certification can be for open or closed periods of time. Most states certify providers for an indefinite period. Certification for a limited time period provides opportunity to communicate with providers as renewal time approaches and also conveys a sense of selectivity, control and concern over provider activity.

Contracts or agreements developed with providers can be as simple or elaborate as deemed necessary for good relations. Some items which might be included are specifications for:

- scope and frequency of required services;
- protocol for optional tests and screenings out of schedule;
- forms' completion and disposition of copies;
- record-keeping;
- claims filing;
- reimbursement criteria and fee schedules;
- expectations and protocol for on-site record review or other types of monitoring.

*Assume one worker devotes .50 time to face-to-face recruitment and recruits one new provider per week. At a salary of $15,000 plus fringe benefits (calculated at 33%), the cost/physician recruited is $192. Assuming 35 percent of the physicians who join the program may decide to leave it, the cost per successfully recruited provider is $294, not including transportation, supplies, etc.
Certification primarily communicates a community-endorsed standard of care in fulfilling the obligation to provide adequate services.

MONITORING IS USUALLY VIEWED AS A PUNITIVE, EXCEPTIONAL, REACTIVE ACTIVITY in this program. In the six-part systems approach described in this chapter, it is seen rather as a reinforcing and educational activity. Participation in EPSDT will have few initial rewards for the physician, but close contact with EPSDT representatives should be reinforcing. Using the questions most frequently asked and the mistakes most often made, program representatives can develop a helpful approach which anticipates problems for participating physicians and helps the physician avoid encountering difficulties with the program. This expedites program monitoring of services while minimizing the development of ill will. The objective of monitoring is to keep all recognized physicians participating successfully.

For a 30-60 day period following certification, providers should be given written materials and other types of assistance as needed. Established providers can benefit from newsletters which discuss prevalent problems and communicate changes in the program. This strategy serves three purposes: to raise the general level of knowledge and skill; to correct specific minor abuses; to preserve anonymity among providers.

An information exchange that offers providers a chance to ask for direction or clarification can be developed. In all cases, the identity of the provider should be protected. Like prevention, there is no end to monitoring—it is continuing communication. A successful monitoring program, may diminish the need for recruitment as the number of participating physicians fulfills program needs and few physicians leave the program.

Monitoring provider performance can be conducted through routine on-site appraisals. These should be random or selected on the basis of geography, specialty or any other variable which can be applied fairly to all participants in an attempt to avoid suspicion of malperformance. Program needs and experience with providers will dictate which aspects of the program to monitor. The goal here is to continually assist providers with difficulties before complaints are received from clients or another source.

Provider review can be performed by EPSDT county or state staff or can be contracted to an outside agency. Professionals generally accept review more easily from their peers than from others, and staffing patterns for review must consider this. Peer involvement can be used to develop standards and to conduct monitoring.

The most difficult type of monitoring is a review triggered by complaints or inquiries from a third party. Although these are usually received from clients, they may also be received from
another health care professional or they may originate in the state claims processing unit. It is important for the EPSDT program to develop a process to handle complaints about providers' services. The process should include protocol for complaint specification and recording, fact-finding, reporting to all parties, and follow-up action. The investigator has chief responsibility for fact-finding and following the investigation through. Different investigators may be needed for different types of complaints. The state or county will need a system to handle minor and major complaints as well as to handle situations involving many complaints against the same provider. A file of all complaints should be kept in order to follow trends. Some participating providers might be asked to recommend ways to communicate effectively with providers about complaints. (This part of the process will communicate a community-endorsed standard of performance as well as gather additional information about the incident under investigation.) The provider must have ample opportunity to contribute any information about the incident; this can be accomplished by telephone calls or personal visits. All visits should be scheduled in advance. In discussion with the provider, it may become clear that he/she needs more information in order to comply with requirements. This can be provided without further emphasis on the complaint. It also may be evident that the provider cannot comply with requirements. This should be handled explicitly and suitable arrangements should be made to help the provider attain proper participating status or the program must determine that he/she has been certified in error. In this case, decertification as a provider may be required. After the investigator completes the fact-finding stage, he/she should report back to all parties involved—especially the person originating the complaint and the provider. This report should be written but it need not contain a judgment. All parties should be informed of the facts accumulated during the investigation. The report might also describe actions to be taken.

Ultimately, the program may be required to respond to flagrant abuse. Sanctions range from various legal actions to decertification as a participating provider. Decertifying providers becomes a moral dilemma for programs operating in areas where the total number of providers is low. Some difficult decisions may have to be made about tolerating poor performance in order to have a participating provider. Since scarce resources often allow lower standards to prevail, it is important to develop resources in these underserved areas so that free enterprise forces can raise the standard of care. Although this aspect of monitoring is most unpleasant, the unpleasantness can be minimized by viewing this as part of maintaining community-endorsed standards of care.
CHAPTER 7
PROGRAM EVALUATION

"Program evaluation concentrates on evaluating how the condition of citizens and the community has changed as a result of a specific program or set of objectives."¹ Program evaluation, like planning and implementing, is a major part of overall program administration but program managers become so involved in implementation issues that they often overlook basic questions about the program, such as, "What conditions should change?" "In what direction?" "For whom?" "How much?" Annual goal-setting and budgeting meetings should not be conducted in a pro forma manner that precludes addressing the questions. Instead program managers should evaluate past performance, then plan for the future and finally undertake new implementation strategies.

Broad answers to the questions raised above can be found in the federal and state goals for the program. More specific questions which result in more focused answers must then be formulated to evaluate the program. For instance, many conditions should change as a result of EPSDT: health should improve, inappropriate utilization of health services should be reduced, linkage with on-going health resources should be established, and costs should be contained.

Due to the age, the purpose and the importance of the EPSDT program, several formal evaluation studies have been initiated. Usually the type of evaluation performed is determined by the interests of the group requesting the evaluation. Federal evaluators are concerned with the quantification and timeliness of service delivery; citizen groups usually focus on access to care and quality issues; state and federal legislators are very concerned with cost savings; and state administrators want interagency cooperation, staff activity measurements, and trend analysis. Obviously, it is costly and disruptive to conduct separate evaluation programs for each of these areas of interest. Therefore, evaluation programs

must be coordinated and related to state priorities.

This chapter will discuss some issues relevant to program evaluation and relate them to problems inherent in evaluating the EPSDT program. The suggested reading list for this chapter identifies useful references for evaluation programs in general as well as some of the major evaluation studies which have been performed for EPSDT. Both types of sources should be helpful to the state administrator who wishes to design or enhance an existing program evaluation effort.

MEASURING PROGRAM PERFORMANCE IS DIFFICULT OR IMPOSSIBLE UNLESS CLEAR AND RELEVANT OBJECTIVES HAVE BEEN SPECIFIED. Consensus on objectives must be reached by sources of program influence. In addition, it is important that the objectives of all program components support overall program goals. For instance, quantified objectives for outreach should not be greater than the quantified objectives set for health services capacity. Similarly, methods for providing assistance in scheduling appointments should support overall program objectives which aim to assist clients to function autonomously within the health system.

Some states have formulated program objectives which approximate the federal EPSDT objectives. Others have developed more specific objectives which, while supporting the federal objectives, tailor the program to state-specific needs and priorities. Every state has designed and implemented the program to address specific conditions, but few states have articulated these specific conditions in a separate statement of objectives. The following list of state-level objectives, selected from actual state EPSDT plans, illustrates the variations in specificity which exist among state EPSDT objectives.

1. To create an awareness of the availability and value of preventive health care services and to encourage maximum participation in the program.
2. To provide necessary auxiliary services to the family when needed.
3. To draw those children eligible for Title XIX benefits, who have not had an opportunity for an assessment of their state of health, into the health care mechanism, to determine their basic health needs and to guide them in obtaining the medical care to meet these needs.
4. To provide each child eligible for program benefits the opportunity for optimal physical, intellectual, and emotional growth and development.
5. To discover and treat health problems before they become disabling and, therefore, far more costly to treat in terms of both human and financial resources.
6. To provide Title XIX children under 21 with medical screening, diagnosis and treatment.

7. To provide to eligible persons comprehensive and continuous health care designed to prevent illness and disability and to establish an on-going provider-patient relationship.

These objectives are not measurable as stated, although they lend themselves to measurement through the development of performance indicators. Chapter 5 illustrates the relationship between objectives and performance indicators in the outreach and case management components. The same process can be used with other components.

A performance indicator should be developed for each objective if the objective itself is not quantified. This measure will specify which data must be collected in order to evaluate the objective. The other major factor needed in performing program evaluations is the selection of relevant population segments. This is particularly critical in evaluating a program as complex as EPSDT since individuals can participate in some portions of the program, but not others. For example, a child may receive outreach and screening services, but no diagnosis and treatment. Separate groups of populations must be identified for each set of services.

Some of the major objectives of the EPSDT program include:

- effective delivery of health services;
- improving access to health care;
- cost reduction;
- utilization control;
- improved health outcome.

All of the major program components (outreach, case management, screening services, diagnosis and treatment services, and the periodicity schedule) can be evaluated around any and all of these objectives provided performance indicators and population segments have been specified for each objective of the components to be evaluated.

An important but often overlooked objective in evaluating program performance is the limitation of potential negative effects. This objective should be explicitly stated for each program component. Examples of negative effects are excessive costs, detecting conditions through screening for which no treatment is available, and increasing the dependency of welfare recipients through an overly solicitous outreach, case management, or transportation program. Negative aspects of program performance limit overall program effectiveness and, as a result, are an important part of program evaluation. For example, negative aspects of the program
can limit program performance just as a limited resource can limit
overall service delivery.

IN ORDER TO COMPLY WITH FEDERAL REPORTING REQUIREMENTS,
states have quantified various processes of the EPSDT program, i.e.,
how many screenings, how many referrals for vision, hearing and
dental. This data provides a basis for a type of program monitoring
which indicates activity levels and highlights trends. The collection
of this data and additional data of the same type provides the
basis for evaluation which only measures the degree of program
implementation.

OTHER TYPES OF EVALUATION APPROPRIATE FOR EPSDT measure
"outcome" such as change in health status levels and utilization
patterns. This type of evaluation is difficult to perform for
EPSDT since specific, measurable outcome norms have not been
specified. In addition, the methodological problems associated
with measuring before and after status and proving causality in
health care programs such as EPSDT are great. In the case of
EPSDT, it would need to be demonstrated that, due to the screening,
conditions found were more amenable to correction and less serious
than they would have been if screening had not occurred. This
requires measuring the seriousness and length and extent of dis-
ability in non-screened and screening populations. Therefore,
there are justifications for delaying "outcome" or impact evalua-
tion of a statewide program until it has reached a level of imple-
mentation which allows for adequate measurement.

Effectiveness measures are very appropriate in evaluating
EPSDT. Chapter 4 discusses effectiveness issues relevant to screen-
ing packages and periodicity schedules. In using effectiveness
measures in evaluation, it is important to be aware of underlying
assumptions which may or may not have been proven. For example,
if one objective of a case management system is to ensure that
diagnosis and treatment appointments are kept within 60 days by
all persons who have a positive screen, one would simply count
the number of successes to measure effectiveness. The assumptions
which underlie this objective are:

1. diagnosis and treatment is the appropriate response
to a positive screen;
2. 60 days is the most effective time period within which
to provide diagnosis and treatment.

This example is not offered to stimulate discussion on the assump-
tions above, but rather to emphasize the importance of articulating
the assumptions which underlie most effectiveness measures used in
evaluation. After the assumptions have been identified, they can be evaluated for their relevance and significance in evaluating the activity under consideration.

There are cost studies appropriate for both outcome and effectiveness measurement. Cost-benefit analysis attempts to relate the outcome or benefit to the cost of achieving it. For social service programs, this presents the major problem of quantifying outcomes which are not readily quantified, like "corrected vision" or "knows how to brush teeth properly." Each of these outcomes has an associated cost—the personnel, materials and overhead expenses associated with correcting vision or teaching toothbrushing. The benefit is not easily converted to a dollar measure.

Cost-effectiveness is a relative method of evaluating costs. The underlying assumption is that the outcome is desirable. The question is, "Which of several methods is the least expensive way to achieve the outcome?" Using the toothbrush example, a relevant issue might be the use of least expensive personnel, but how is expense to be calculated? A dental aide may be half as expensive as a hygienist but may require four times as long to provide instruction. Another relevant issue is the measurement of effectiveness. Do children pay attention and remember as well when instructed by an aide? Are there differences in the rate of forgetting when different personnel are used? Is the authority impact of a dentist so effective in developing long-term habits that the initial personnel cost of the visit can be justified? This simple example reveals the complexity of measuring cost-effectiveness.

THE USE OF THE SCIENTIFIC METHOD DISTINGUISHES FORMAL PROGRAM EVALUATION from day to day evaluative decisions. The hallmark of the scientific method is its attempt to isolate causes and accurately relate them to effects. This relationship between cause and effect is called the validity of the evaluation study. There are many threats to validity. For example, assume that a state administrator wanted to measure the change in dental health effected by the EPSDT program. A simple way to measure this would be to randomly assign individuals with matching characteristics to two groups. One group is called the control group; the other is the experimental group. The control group does not receive dental care and the experimental group does. If the experimental

2One reason to begin impact evaluation research early in the life of a program is the greater probability of selecting a control group which shares the characteristics of the experimental group (those receiving services) but has not been exposed to the EPSDT program to any significant extent.
group shows improved dental status, as measured by pre-established criteria, such as a reduced incidence of caries, it may be valid to conclude that EPSDT services were responsible. A few of the many other possible reasons for change are:

1. **Other cause:** Either or both groups may have been exposed to other conditions which contributed to the outcome. Examples of other conditions are: water fluoridation programs or dental health programs in schools.

2. **Time:** Some conditions are self-limiting. Although this is not true of caries, it is true of many acute viral illnesses, such as influenza.

3. **Selection basis:** Although the experimental and control groups may have been adequately randomized according to certain criteria, other critical criteria may not have been used in selection but may be very relevant to the dependent variable (incidence of caries). An example of this type of criterion is dental hygiene habits.

Additional threats to validity are those related to attribution, changes in the measuring instruments and effects which result from incidental interaction with subjects. An example of the latter is subjects' change in eating habits due to information gained during a pretest.

The limitations described above can affect other types of evaluation research as well as health status studies. There are similar threats to validity in studies of utilization behavior, effectiveness studies, and cost studies. The reader is referred to *Health Program Evaluation* by William Shortell, pp. 38-48, for a considerably more detailed treatment of validity.

Other important questions which must be addressed in selecting an evaluation design are the intended uses of the results, the limits and applications of the design, the amount of data which can be obtained and the costs involved. Cost-effectiveness principles apply to selecting evaluation designs, also. The least costly approach which will satisfy the requirements should be selected. Hatry, Lunnie and Fisk in *Practical Program Evaluation for State and Local Government Officials* offer five major designs appropriate for government program evaluation (pp. 41-67). These are:

1. Before and after comparison;
2. Comparison of actual post-program data with projected pre-program data;
3. Comparison of served population with subjects in other areas or population segments not served by the program;
4. Controlled experimentation (classic);
5. Performance comparison: planned vs. actual.

Each of these designs is discussed in terms of:

a. steps in preparing for research;
b. types of application;
c. cost;
d. problems and limitations.

This discussion is exceptionally practical for program administrators who wish to improve their overall awareness of issues in evaluation studies. As the list of five designs illustrates, various forms of quasi-experimental designs are very acceptable and appropriate for evaluating social service programs. Administrators need not be intimidated by the overly rigorous requirements of the classic experimental design.

After all the issues and questions raised in this chapter are understood and resolved, the program administrator must oversee the evaluation study to ensure that the traditional managerial functions are carried out. The evaluation study must be planned, directed and controlled.

Frequently, evaluation studies are conducted by agency divisions outside of the operations division where the manager may be positioned. They may also be conducted by outside consulting firms. The administrator's role in this situation is to ensure the availability of data and the allocation of staff necessary to assist in the evaluation. Results of evaluation studies from any source are valuable input to further program planning and implementation. They are sources of feedback which complete the loop of goal and objective setting, planning, implementation and evaluation.

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CHAPTER 8
PLANNING FOR CHANGE

Organizational leadership entails planning and controlling what kinds of change the structure will undergo and how fast. The changes themselves result from the organization's adjustment to the environment, both internal and external. The impact model of communication in the Program Management section of the "Framework for Program Analysis (Appendix A) shows many forces which can press for change on a program. The EPSDT administrator must be able to make the proper changes, at the proper time, and this must often be done with imperfect information.

A planned, change if it is to be successful, requires adjusting the rate of organizational reaction to pressures from within and without. Two models for this are incremental adjustment and aggregate adjustment. The incremental model requires the organization to make minor adjustments to demands as they occur. It is a "reactive" process, often called "putting out fires."

The aggregate model requires fewer changes, but more drastic structural responses to environmental forces. Aggregate model changes often result from a series of demands. For instance, frequent reports of provider shortage might prompt an administrator to perform a statewide survey of provider resources, set priorities and develop a provider recruitment strategy. An incremental-type response to the same problem would entail individual responses to each situation.

Although the incremental approach is less traumatic, it requires a continued allocation of resources to respond to pressures on the organization. The aggregate approach is also difficult because forces within the organization tend to protect the status quo and resist change.

A methodical process for analyzing the nature and assessing the impact of change is critical. Many programs resist change because they have not developed this capacity. Sometimes this may be an administrator's deficiency; more often it is the lack of structure and process for making changes. The worksheet for analyzing problems and effecting solutions, at the end of the chapter, offers a model for structuring the process and activities involved in planned change. It will be most helpful when used to address
problems found through internal reports and routine program assessment. The "Framework for Program Analysis" (Appendix A) is a diagnostic tool designed to assess a program by reviewing each part of it. Although specific parts of the program can be reviewed as often as desired, administrators should review their entire programs annually. Since the program is a system, changes in one part will affect the rest and administrators will find it beneficial to think through the implications of any anticipated change on the whole program. In time, this process will shift the emphasis from reactive to proactive change and will allow the administrator to plan for change.

A WELL-DESIGNED EPSDT PROGRAM WILL PROVIDE A FLOW OF MANAGEMENT INFORMATION. Each state EPSDT program is different, however, and requires unique types and numbers of reports. The type, amount and frequency of data collected should be reviewed annually in order to relate to specific short-term program objectives. In addition to specifying type, amount and frequency, administrators have options in selecting the type of reports which display the information they have selected. (Some, of course, are required by federal regulations.) Reviewing the information provided in reports and assessing the usefulness of these reports is a regular management responsibility. Administrators are often reluctant to question the usefulness of reports which were originated by their predecessors. Although operations research and systems analysis staff and consultants may intimidate managers who know little about these activities, EPSDT administrators should remember that these functions are staff functions serving the overall program need. Program administrators should specify how these departments can be most useful in helping make management decisions at the administrative level.

Automated data collection and processing systems are valuable control tools, and will become more and more prevalent as such systems become less expensive. Managers should seek ways to learn about these systems, since they are valuable resources. However, they are only tools—computers should help attain program goals, not obstruct them. This area is singled out because managers seem to have particular problems assessing computer-related operations. Data collection and processing systems are not inflexible. As programs develop, needs will change and support systems must be adapted to meet these needs.

In order to use management reports effectively, program administrators should compare information on program activity to established goals. When both goals and information are quantified, it is easy to spot deficiencies. Because of the nature of EPSDT program responsibilities, some administrative problems concern the
state, some the local agency, and some both. In conducting planned program review, it is important to identify where the problem exists, when it began and how severe it is. For instance, if statewide statistics show an unacceptable rate of completed diagnostic and treatment services following positive screenings, the administrator will want to study the problem closely to identify the localities with greatest difficulty, how long it has existed and to what degree.

The worksheets at the end of this chapter offer a sample analysis of such a problem. Observe that the problem could have been detected through the data currently required on the NCSS 120 which all states are required to complete. The unique benefit provided in the worksheets is the method for structuring the analysis and planning for action in response to the presenting problem. All too often, administrators faced with the problem statement, "Diagnosis and treatment have been completed for only 40 percent of positive screens in ______ County," tend to respond with a general statement, such as "There just aren't enough specialists in our rural areas." Although this may also be true, it is clear that in the example given, something much more specific is aggravating the situation.

The implementation plan for correcting this problem is not completed here, but provides a model for designing one. A complete implementation plan would continue until sufficient resources were identified to meet the 60 percent goal. This might entail developing a temporary transportation system to have children served in a nearby county. Concurrently, efforts should continue to correct the claims payment system deficiency. This is very possible since different staff are assigned to the two projects. The administrator should also be alert to the need to conduct similar communication programs throughout the state—and possibly, with all providers if they are affected.

If this exercise were completed for the other counties involved, the causes and solutions identified may or may not be the same. If the same cause was found in several counties, the malfunction would indicate a basic problem in the program plan. A localized problem, on the other hand, would point to a unique problem or the first indication of a larger problem. In making these assessments, the administrator sets priorities for addressing the problems uncovered through systematic review. Widespread problems naturally demand the most attention, but all solutions require planning for and implementing change.

ORGANIZATIONS MUST CHANGE TO REDUCE ACCUMULATED TENSION. Force-field analysis describes this process by postulating that the energy field surrounding an entity (individual, work unit, or
organization, for example) exerts external pressure which must be balanced by internal pressure to prevent a change in tension. The model states generally that the sum of the positive forces should equal the sum of the reactive forces. The energy of a positive force in one area need not be countered by an equal negative force in the same area; the system will be in equilibrium if total positive equals total negative. Many forces cannot be quantified precisely, but the theory offers a way to anticipate and understand impetus for change. The following diagram shows vectors (arrows) which represent external and internal forces.

Both sides equal 11 even though there is no equality across the lines. If, for instance, the top line, given a value "4" for external and "2" for internal, represents the respective strength ratio of a force from outside the system to one within the system, it is apparent that the outside force is twice as powerful. Let us assume that this 4:2 ratio represents the strength of forces attempting to increase the screening reimbursement rate, now a source of dissatisfaction to participating doctors. Looking at the same rates from internally, the ratio, 2:4, shows a relatively weak ability of the program to resist the external force. This could mean many things, such as lack of staff to respond to demands, inadequate justification for the current rate, or a general weakness such as a change in top administration. In this system, however, the forces in the top line are more than offset by the forces in the third line, 2:6. Let us assume that this line represents the program strengths (6) in paying provider claims. The 2 represents external forces in opposition to the claims payment system. Obviously, the payment system now in effect will prevail. Since, these two items, reimbursement rates and claims payment, are generally related and nearly in balance, it is unlikely that the forces will result in system changes now. This complex concept is usually
reflected in a comment something like, "The doctors may not be getting as much as they want, but they're getting 100 percent of their approved billing rate and within 30 days, too!" or "We may have a low screening penetration rate, but every one of those kids is fully immunized."

When external and internal forces are unequal, the system is unbalanced and open to change. For instance, a legislative investigation of the program represents an increased external force requiring stronger internal forces, perhaps preparation of explanatory documents. If the investigation is simply endured or the program is not defended, it results in disequilibrium. Failure to act creates a tension state like this:

![Force-Field Diagram: Increase in External Forces](image)

Eventually balance will be re-established. The administrator must respond to these situations and ensure that balance is reached in a way most benefitting the program.

Programs also can become unbalanced through a reduction of internal forces. This can occur when key persons leave the program or the program is reorganized. Then, the force field looks like this:

![Force-Field Diagram: Decrease in Internal Forces](image)
The organization is now more vulnerable to external forces even though these forces have not increased. When the internal changes are completed, the new configuration may or may not re-establish equilibrium.

Although this theory is complex and abstract, it explains processes which all persons and organizations have experienced, consciously or unconsciously. Awareness of these can help administrators watch for potential crises in the organization. Administrators must exercise care in coordinating internal changes with times of low external pressure.

**SYSTEMATIC PLANNING FOR CHANGE FROM WITHIN** means responding to indicators for change as early as they become evident, and thus reducing the need to respond to outside forces. "Reduce" is a key word because outside forces for change never will be eliminated; there always will be times when the program will have to react, sometimes quickly. Some examples of such forces are:

1. new legislation or regulations;
2. legal action;
3. state or regional program improvement plans;
4. new demands of providers;
5. needs of consumers.

These require specific responses which often are impossible to anticipate. In order to make these changes, a process must be designed to keep staff and service disruption to a minimum. Whenever the program must respond to a new requirement, program administrators should be aggressive in integrating it into overall policy. For instance, suppose state EPSDT programs are required to provide additional scheduling help to clients who miss their first appointment. Responding to this requirement might help meet another state objective, that of increasing the number of screenings. Assume the broken first appointment rate is 40 percent. In this case, the state can develop a specific, but combined, objective: "All counties should try to increase their annual screening rate by one-third. This will be accomplished by successfully rescheduling 50 percent of the missed first appointments (where success means the appointment was kept)." This illustrates how states can redefine federal program regulations to fit their own goals.

WHEN FORCED TO REACT TO EXTERNAL DEMANDS, administrators will find it easier to adapt if they develop a protocol similar to the one below, which uses the "offer to reschedule" example described:
1. **Clearly state the requirement.** States will contact persons missing first appointments by mail, telephone or face-to-face and offer rescheduling help.

2. **Locate responsibility.** Will the existing case management system be able to handle this additional activity? If not, where will resources be found?

3. **Specify any conflict with existing state protocol or state regulations.** Current regulations clearly state that follow-up to broken appointments is not required but may be offered at provider's discretion.

4. **Need for action?** Yes, the program director must prepare a memo outlining the requirements. There may be a need to change the procedure manual.

5. **Are there options?** Yes, each county must determine who will be responsible, what they will do, and how they will report.

6. **Can we predict the cost-effectiveness of any of the choices?** No, there is insufficient data about alternatives.

7. **Would it be worthwhile to design pilot projects using various options for a short time and then decide on a model for general use?** Maybe, depending on demand and the circumstances.

After this analysis is complete, this requirement can be broken down into specific tasks which follow the format of the Implementation section of the Problem Analysis and Solution Implementation worksheet which follows. This type of activity can be included in meetings of state and county EPSDT staff. The "Framework for Program Analysis" (Appendix A) can augment this process since its questions clarify connections and suggest relationships with other parts of the program which are not always apparent in planning for change.

In conclusion, program and organizational change occurs as a result of the imbalance between internal and external forces which are constantly active. These changes may be reactive or planned. A well-designed program will provide a timely flow of management information which can assist program administrators in identifying at an early time the need for making changes. When these needs have become apparent, the problem analyzed and an action plan prepared, change can be undertaken in a planned and controlled manner.
## PROBLEM ANALYSIS WORKSHEET

<table>
<thead>
<tr>
<th>PROBLEM STATEMENT</th>
<th>PROGRAM GOAL OR NORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and treatment completed for only 40% of positive screenings.</td>
<td>Diagnosis and treatment for 80% of suspected conditions.</td>
</tr>
</tbody>
</table>

### PROBLEM SPECIFICATION

<table>
<thead>
<tr>
<th>Where:</th>
<th>La Grange County</th>
</tr>
</thead>
<tbody>
<tr>
<td>When:</td>
<td>Reporting Period—3rd quarter, FY 78</td>
</tr>
</tbody>
</table>

| Quantify: | percent change: -20% since 1st quarter, '78 |
| Person Responsible for Activity: | County Program Administrator—Willis Long, DSS |

### POSSIBLE CAUSES (Generate as many as possible)

- Inadequate case management system
- Provider shortage
- Increase in screening activity
- Increase in positive screens
- Increase in eligible population
- Transportation difficulties

### PROBABLE OR DETERMINED CAUSE

15 participating dentists refusing referrals due to claims payment delay caused by use of new fiscal intermediary (installed March 15, 1978).

**Reason for selecting this cause:**
No documented change in other possible causes.

### POSSIBLE SOLUTIONS

- Seek alternate providers
- Ensure payment of back claims
- Begin communication program with dentists

### BARRIERS TO SOLUTION

- No alternate providers available
- Claims payment system not expected to function well for six months
- County staff has no contact with group

### TENTATIVE CHOICE OF SOLUTION

State program administrator will meet with LaGrange County Dental Society to explain the problem, offer assurance and enlist their cooperation.

### POSSIBLE ADVERSE OUTCOMES

More dentists (and doctors) may refuse patients when the problem is acknowledged.

### EVALUATE POSSIBLE ADVERSE OUTCOMES

Do possible adverse outcomes require selection of another solution?

There are no other appropriate solutions, although adverse outcomes would be harmful.
A. Problem Restated as Goal: Improve diagnosis and treatment services for dental conditions in LaGrange County until 80% of conditions are treated.

B. Restate Choice of Solution: Initiate communication program with dentists through local Dental Society.

Develop Implementation Plan which uses selected solution (B) to attain goal (A):

<table>
<thead>
<tr>
<th>ACTIVITIES/TASKS</th>
<th>RESPONSIBILITY OF</th>
<th>RESOURCES REQUIRED AND TIME FRAME</th>
<th>INDICATORS OF COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Survey LaGrange dentists to determine extent of problem and identify those affected.</td>
<td>LaGrance County EPSDT administrator</td>
<td>Two weeks of provider recruitment staff assistance (4/1-4/15)</td>
<td>Problem will be precisely specified and quantified.</td>
</tr>
<tr>
<td>2. Meet with fiscal intermediary to obtain facts about fee system, register LaGrange County problems and obtain commitment for change.</td>
<td>County administrator and state EPSDT administrator</td>
<td>Three person days from state, county and fiscal intermediary staff (5/1)</td>
<td>Fiscal intermediary aware of problems; state and county administrators informed of details of the claims payment system and plans for correction</td>
</tr>
<tr>
<td>3. Contact local Dental Society to schedule meeting to discuss problem</td>
<td>County administrator</td>
<td>Name of society president. Data from 1 and 2. (5/5)</td>
<td>Date, time and place for meeting selected.</td>
</tr>
</tbody>
</table>
SUGGESTED READING LIST

CHAPTER 1


CHAPTER 2


**CHAPTER 3**


**CHAPTER 4**


**CHAPTER 5**


CHAPTER 6


CHAPTER 7

Books:

Articles:


Government Publications:


• EPSDT in an Urban Setting -- Dallas, Texas. SRS Grant No. 09-P-56107/6-05, November 1976.

• EPSDT Phase II Evaluation and Impact Study. SRS Grant No. 18-P-56608/6-02.


CHAPTER 8

APPENDIX A

FRAMEWORK FOR PROGRAM ANALYSIS

The Framework for Program Analysis offers a means to conduct a systematic review of the EPSDT program. It leads the reviewer through the entire program, component by component, and identifies areas of program design and operation which may need change, stepped-up implementation or emphasis. The Framework is based on an implied model of a well-designed program; the model is not explicit but the questions should stimulate the reviewer to envision the model program.

The Framework has been written primarily for EPSDT state-level program coordinators, but may be of interest to medical directors, county program workers, regional HCFA staff and others. It may also be used as a diagnostic management tool by Medicaid directors and health and welfare agency directors and commissioners. It was designed for annual program review, but can be used as often as necessary. Segments of the program can be reviewed separately, or the entire system can be examined.

The components of the program which are reviewed in the Framework are:

1. Program Management;
2. Resource Identification;
3. Identification of Eligible Persons;
4. Notification of Eligible Persons;
5. Outreach;
6. Screening;
7. Diagnosis and Treatment;
8. Case Management and Follow-Up;
9. Information and Reporting.

Each section of the Framework reviews only one component. This format facilitates duplicating and distributing sections of the Framework to appropriate staff.
PROGRAM MANAGEMENT

Organization

1. Look at an organization chart for the Medicaid agency. (Not appropriate for states which have separated EPSDT from Medicaid.) Does it include EPSDT personnel? Is it current?

2. Draw an organization chart which shows actual (in practice) lines of communication and authority. Are there differences between it and the chart reviewed in #1? (If so, list them.) Try to assess the impact the differences may have on the program.

3. How many people are assigned to EPSDT at the state level?

4. Is the state divided into regions or other divisions for administrative purposes?

5. Are staff assigned to these divisions?

6. How many people are assigned to EPSDT at the local level?

7. What formulae or ratios are used in staffing?

Policy

1. How is general program policy determined? Administrative policy? Medical policy?

2. Who has input into policy?

3. Who has the ultimate responsibility for policy?

4. How often does the policy-making group meet?

5. How often are policies reviewed?

6. What information base is used in determining policy?

7. Who has authority for planning and designing services for EPSDT?

8. What opportunities are there for community input in the planning process?
9. What opportunities are there for provider input?

10. Has the state evaluated the EPSDT program?

11. Has the state received technical assistance or other consultation services?

12. What was the focus of consultation?

13. What needs or deficiencies of the program have been identified?

14. What is the priority of needs of the EPSDT program?

15. How is this information used in planning?

16. What is the time schedule for implementing plans to meet these needs?

Goals and Objectives

1. Are there formally stated goals and objectives for the EPSDT program?

2. How are they developed?

3. How often are they reviewed and revised?

4. Who participates in developing them?

5. Are goals and objectives quantified?

6. If not, what information is needed to quantify them?

Planning

1. Who has major responsibility for the EPSDT planning process?

2. Is the planning process related to the budgeting process? To the budget cycle?

3. Do medical providers participate in planning?
4. Do consumers participate in planning?

5. If not, try to assess the impact the involvement of these two groups might have.

6. Is planning relevant to the goals and objectives of the program?

7. Are time frames assigned to meet objectives?

8. What are the current priorities of the program?

9. How does this year's plan address them?

Evaluation

1. Has the state formally evaluated the EPSDT program?

2. Has the state received consultation in its program development?
   From: regional office staff?
   other state agencies or departments?
   other HCFA contractor?

3. What was the focus of consultation?

4. What was the impact or outcome of consultation?

5. Do you perceive a need for additional consultation?

6. Do you know current sources for consultation?
APPENDIX A

FRAMEWORK FOR PROGRAM ANALYSIS

The Framework for Program Analysis offers a means to conduct a systematic review of the EPSDT program. It leads the reviewer through the entire program, component by component, and identifies areas of program design and operation which may need change, stepped-up implementation or emphasis. The Framework is based on an implied model of a well-designed program; the model is not explicit but the questions should stimulate the reviewer to envision the model program.

The Framework has been written primarily for EPSDT state-level program coordinators, but may be of interest to medical directors, county program workers, regional HCFA staff and others. It may also be used as a diagnostic management tool by Medicaid directors and health and welfare agency directors and commissioners. It was designed for annual program review, but can be used as often as necessary. Segments of the program can be reviewed separately, or the entire system can be examined.

The components of the program which are reviewed in the Framework are:

1. Program Management;
2. Resource Identification;
3. Identification of Eligible Persons;
4. Notification of Eligible Persons;
5. Outreach;
6. Screening;
7. Diagnosis and Treatment;
8. Case Management and Follow-Up;
9. Information and Reporting.

Each section of the Framework reviews only one component. This format facilitates duplicating and distributing sections of the Framework to appropriate staff.
PROGRAM MANAGEMENT

Organization

1. Look at an organization chart for the Medicaid agency. (Not appropriate for states which have separated EPSDT from Medicaid.) Does it include EPSDT personnel? Is it current?

2. Draw an organization chart which shows actual (in practice) lines of communication and authority. Are there differences between it and the chart reviewed in #1? (If so, list them.) Try to assess the impact the differences may have on the program.

3. How many people are assigned to EPSDT at the state level?

4. Is the state divided into regions or other divisions for administrative purposes?

5. Are staff assigned to these divisions?

6. How many people are assigned to EPSDT at the local level?

7. What formulae or ratios are used in staffing?

Policy

1. How is general program policy determined? Administrative policy? Medical policy?

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4. How often does the policy-making group meet?

5. How often are policies reviewed?

6. What information base is used in determining policy?

7. Who has authority for planning and designing services for EPSDT?

8. What opportunities are there for community input in the planning process?
9. What opportunities are there for provider input?
10. Has the state evaluated the EPSDT program?
11. Has the state received technical assistance or other consultation services?
12. What was the focus of consultation?
13. What needs or deficiencies of the program have been identified?
14. What is the priority of needs of the EPSDT program?
15. How is this information used in planning?
16. What is the time schedule for implementing plans to meet these needs?

Goals and Objectives
1. Are there formally stated goals and objectives for the EPSDT program?
2. How are they developed?
3. How often are they reviewed and revised?
4. Who participates in developing them?
5. Are goals and objectives quantified?
6. If not, what information is needed to quantify them?

Planning
1. Who has major responsibility for the EPSDT planning process?
2. Is the planning process related to the budgeting process? To the budget cycle?
3. Do medical providers participate in planning?
4. Do consumers participate in planning?

5. If not, try to assess the impact the involvement of these two groups might have.

6. Is planning relevant to the goals and objectives of the program?

7. Are time frames assigned to meet objectives?

8. What are the current priorities of the program?

9. How does this year's plan address them?

Evaluation

1. Has the state formally evaluated the EPSDT program?

2. Has the state received consultation in its program development?
   From: regional office staff?
   other state agencies or departments?
   other HCFA contractor?

3. What was the focus of consultation?

4. What was the impact or outcome of consultation?

5. Do you perceive a need for additional consultation?

6. Do you know current sources for consultation?
Communication

1. This is a typical communication/impact model of an EPSDT program.

All the groups on this diagram need regular though different amounts of communication.

Draw a communication/impact model for your program such as the one above.

Determine the frequency and type of communication which would be ideal for each of the groups which "impact" on the EPSDT program. Compare this with the amount and type of communication now in practice. Discrepancies between the ideal and current practice require attention in your communications program.
2. What are the procedures for disseminating basic program information to EPSDT personnel?

3. What are the procedures for disseminating information among relevant health and welfare agencies?

4. How is information disseminated to the county agencies?

5. What strategies are in use to keep the program visible, at the state level (to other programs, agencies)? Locally? To providers? To consumers? To taxpayers?

Monitoring

1. How does the state monitor the county EPSDT program?

2. Who is responsible for monitoring?

3. What actions are taken if a county is having difficulties with the EPSDT program?
1. What is the process for identifying resources in the following program aspects: providers for screening? providers for diagnosis and treatment? transportation? alternatives for outreach? alternatives for transportation? health education?

2. How is the availability of resources determined?

3. Are there formulae or ratios to project the adequacy of a given level of resources to meet needs?

4. Who is responsible for resource assessment and development at the state level? County level?

5. Are there directories listing these resources at the local level?


7. Have steps been taken to meet identified needs or deficiencies?

8. What plans exist for correcting deficiencies and meeting needs?

9. What are the formal policy positions and actions concerning EPSDT taken by professional associations (AMA, ADA, AHA, ANA, etc.)? At the state level? At the county level?

10. Have these affected the availability of resources?

11. Have you used the Resource Assessment Guide provided with this manual? (Appendix B)
IDENTIFICATION OF ELIGIBLE PERSONS

1. How many people are eligible for EPSDT in your state?

2. How many are eligible for screening annually? (Age distribution of eligibles must be known and compared to periodicity schedule.)

3. What are the EPSDT eligibility criteria (i.e., AFDC, SSI, medically needy)?

4. How long (on an average) do families remain eligible for Medicaid benefits?

5. How is the federal requirement to extend eligibility for treatment in progress (45 CFR 248.10) met?

6. Is the eligible population concentrated heavily in some areas of the state? In cities? In rural areas?

7. Are there any significant characteristics of the eligible population in your state (i.e., migrant, Indian, etc.)?

8. Where in the organization does the identification of eligible persons take place?

9. Who does the identifying? County welfare? A state function?

10. Are lists of eligible children generated?
    How are they developed?
    How are they distributed?
    How are they used?
    How frequently are they updated?

11. Do eligibility lists indicate eligibility for services according to the periodicity schedule?
NOTIFICATION OF ELIGIBLE PERSONS

1. When are clients notified of the availability of EPSDT services and their eligibility for them?

2. How are they notified?

3. How often are they notified?

4. Who notifies them?

5. What approaches are used for the blind, illiterate, non-English speaking? Other special categories?

6. What special efforts are made for parents who initially refuse participation in the program? Who does this?

7. Are attempts made to verify that clients are under some other type of care if they offer that reason for refusing services?

8. If clients are notified during the intake process, what attempts are made to counteract the fear and confusion which this process generates?

9. If eligibility workers are informing persons about the program, how are they trained?

10. How much attention is given to the concept of health education during informing?

11. Are there other workers available to give more detailed information during the intake process?

12. How does the outreach program in your state link with the notification process?
OUTREACH

State Level
1. Which agency is responsible for outreach?
2. If responsibility is shared between or among agencies, is there a written contract indicating responsibilities?
3. Do outreach workers have responsibility to other programs besides EPSDT?
4. Are there outreach objectives, both qualitative and quantitative?
5. If yes, are these set at the state level?
6. How is progress toward meeting these goals measured?
7. Are agencies other than state agencies (e.g., Head Start, schools) actively recruited to assist with outreach?
8. If yes, are they reimbursed for their efforts? How is the reimbursement rate calculated?
9. Is the target population for outreach activities defined?
10. If yes, how is it selected?
11. How are outreach efforts linked to responses to notification?

Local Level
1. What is the ratio of outreach workers to eligible clients?
2. How large is an average caseload?
3. Are there target population priorities?
4. Who plans outreach activities?
5. There are some calculations which can be done to measure the impact of an outreach program, either state-wide or locally. These are:

A-9
Data Required

- Number of eligible persons in the area.
- Number and type of outreach contacts.
- Number of requests for service.
- Number of scheduled appointments.
- Number of broken appointments.
- Number of screenings.

Indicators*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of requests for service</td>
<td>Total number informed = Request yield</td>
</tr>
<tr>
<td>Number of scheduled appointments</td>
<td>Number requesting service = Scheduled appointment yield</td>
</tr>
<tr>
<td>Number of kept appointments</td>
<td>Number scheduled = Show rate (1 minus the show rate = the broken appointment rate)</td>
</tr>
<tr>
<td>Number of kept appointments</td>
<td>Number receiving any form of outreach service = Outreach yield</td>
</tr>
</tbody>
</table>

6. What is the nature of the initial contact? What information is given the client during this contact?

7. What is the nature of subsequent contacts? What is the maximum number of contacts? When would contact be resumed?

8. Are sufficient resources available to carry on an adequate outreach program, i.e., written materials, educational literature, A.V. materials for groups?

*There are no norms developed against which performance can be assessed. State administrators are urged to keep statistics for a period of time in order to establish baseline figures. It will be useful to compare performance in different sections of the state.

A-10
9. What techniques for education are used (e.g., media, publicity, general information to the public regarding prevention)?

10. Since all states are experiencing similar difficulties in implementing outreach services, is there anyone responsible for reviewing the literature or otherwise communicating with other states to see if more successful ideas are being developed and implemented elsewhere?
SCREENING

Resources
1. Are both public and private providers recognized as screening agents?
2. If one type is not recognized, what is the basis for this?
3. Are there adequate screening resources? Are they appropriately distributed?
4. How are private providers recruited?
5. How are providers monitored?
6. What is the state’s overall communication program with providers?
7. Does it have all the elements described in Chapter 6?
8. Is there a training program for screening providers?
9. Are nurse practitioners and physicians' assistants recognized as screening agents?
10. Are there screening contracts with other providers, e.g., HMOs, Head Start, neighborhood health centers?

Services
1. Does the screening package meet the federal requirements for EPSDT services?
2. Are immunizations provided during the screening?
3. How does the state provide guidance for the administration of optional tests (e.g., lead levels)?
4. What is the policy for claims payment when the screening form is incomplete?
5. Are provider claims for well-child care honored if they are billed on regular Medicaid forms?

A-12
6. If yes, what are the implications for the EPSDT program of this practice?

7. Has the state considered rejecting these claims and encouraging use of the screening form?

**Communication**

1. How is screening appointment scheduling linked to request for screening?

2. Are the time limit requirements observed?

3. What is the referral procedure for a positive screen?

4. Are the results of screening reported to the parent? Are they interpreted?

5. Do parents receive a copy of the screening form or some other record of screening?

6. Can other institutions -- schools and day care centers -- as well as referral providers receive adequate and appropriate information about screening results?

**Evaluation**

1. Are screening tests and procedures routinely reviewed for their currency and appropriateness?

2. What is the cost/screening?

3. What percent of the eligible population has been screened?

4. What is the immunization level of the eligible population?

5. For the EPSDT eligible population, what is the prevalence rate of visual impairments? Hearing impairments? Elevated lead levels? Nutritional problems? Growth and developmental problems?

6. Have cost benefit or cost-effectiveness studies been done for each screening category?
1. How are the screening efforts coordinated with the diagnosis and treatment resources?

2. Who makes the appointments for diagnosis and treatment?

3. How is this coordinated with patients' needs for transportation?

4. What is the average lag time between a positive screen and a follow-up visit?

5. How is the information concerning screening results forwarded to the provider?

6. What is the procedure for information feedback to the screening center? To the child's health record? To the case manager?

7. Do specialists accept referrals directly from the Health Department?

8. What is the cost/confirmed diagnosis?

9. What is the cost/case diagnosed and successfully treated?

10. What are the total program costs?

11. Have cost benefit studies been conducted?
CASE MANAGEMENT AND FOLLOW-UP

1. Draw a typical patient flow diagram from the point of outreach (or notification) to completion of treatment. Draw a parallel flow diagram for documents and paperwork. Note any areas where the system "breaks down" or does not have the capability to handle a possible occurrence.

2. Who is responsible for case management?

3. How does the state monitor case management?

4. Are there written procedures for case management?

5. What kind of training do the case managers receive?

6. What on-going training is provided to keep case managers updated?

7. Are cases triaged for types of care and urgency of care needed (e.g., high priority for diagnosis and treatment of positive lead screens)?

8. What follow-up is there for children with chronic problems?

9. Who discusses the need for additional care with the family (exit interview)?

10. Who identifies the appropriate provider(s) for a client's health needs?

11. Who makes the appointments for screening visits? For referrals?

12. Is there a follow-up procedure to ensure appointments are kept?

13. Is transportation offered for screening visits? Referral visits? Who arranges and provides transportation and supportive services?

14. What follow-up procedures are used to work with the family to get the child to care if the initial appointment has not been kept?

15. Who has the responsibility for assessing future needs of the child after the referral visit? Who is responsible for meeting these needs?

A-15
INFORMATION AND REPORTING

1. Draw an information flow diagram noting:
   - types of data collected,
   - collection points,
   - data flow to local and state level,
   - feedback to local level.

2. What reports are generated at the state level? Local level?

3. Have these reports been evaluated for their timeliness and utility?

4. What types of EPSDT reports are available:
   - federal,
   - statistical,
   - management,
   - tracking?

5. Is the tracking system automated?

6. How is eligibility data compiled? Used?

7. What is the turnaround time for eligibility information to reach the local level?

8. Is eligibility information appropriately protected?

9. Can eligibility information be manipulated—such as separated by age?

10. Is all pertinent EPSDT case finding information contained in local printouts?

11. Can the state distinguish between initial and periodic screens?

12. Are there any procedures to ensure that screening counts are not duplicated?

13. Is the state able to list all abnormal conditions identified in screening which require diagnosis and treatment?

14. Can the state determine from reports that treatment is under-way or on-going?
15. Where is the most complete file maintained? Centrally? Locally? Health? Welfare?

16. How much turnaround time is involved between visits and results in the health file?

17. What are the case managers' documentation responsibilities?

18. Is a list of providers available to case managers? To clients?
The Screening Resource Assessment Guide is intended to assist state and county EPSDT administrators in EPSDT program planning. The heart of the guide is a data collection form—a survey questionnaire which is designed to locate, quantify and describe actual and potential screening resources within a defined area. The manual also offers program administrators some guidance in conceptualizing and implementing an overall communications program with providers. Chapter 6 of this manual provides a more complete treatment of this subject. Conducting the survey may be the first opportunity for face-to-face communication between the EPSDT program representative and providers of screening services. With this in mind, considerable information has been offered to prepare survey staff to function effectively during their visits to providers.

This manual is designed to measure the actual screening capacity of providers at the local level. However, it also offers an opportunity to review the entire subsystem of provider resource development within the EPSDT program. The local survey is part of a complete planning cycle for EPSDT resource development. A state cycle might look like this:

- Set overall quantified program objectives.*
- Evaluate performance in meeting these objectives on a region by region or county by county basis.
- Identify areas with poor performance.
- Perform Local Screening Resource Assessment Survey.
- Analyze data.
- Set priorities for developing resources.

*For example, number screened/year; percent increase in screening; penetration rate; rate of completed diagnosis and treatment; target population emphasis, etc.
Design plan for developing resources.

Implement plan.

Evaluate plan.

Survey results will be much more useful if the survey is performed in the recommended sequence.

State program administrators will want to be involved in the selection of priority areas for survey activities. There are several conditions which might identify an area as appropriate for survey activity:

- Low overall screening penetration rate.
- Excessive time lag between request for service and actual screening appointment.
- High transportation costs (providers not accessible).
- Low ratio of Medicaid-participating providers to total provider population (especially when one or more of the conditions listed above is present).
- Noncompliance with one of the major program objectives (e.g., a low referral rate compared to the number of abnormal screening results).

No area should be considered static, however. Even an area that has many providers and meets the current demand can be affected by changing conditions, such as:

- expanded eligibility guidelines;
- influx of eligible population;
- providers leaving the area;
- the presence of migrant workers;
- providers leaving Medicaid program;
- lower levels of primary care activity (such as reduced funding of community health centers);
- hospital closing.

Selecting areas to survey and planning the provider communications program with county staff can be an opportunity for state administrators to exercise leadership and guidance in EPSDT program performance. Sharing some of the planning and implementation of the assessment ties local concerns and activities into overall state concerns and activities. However, the most critical impact of the state administrator is in designing the survey and possibly participating in the analysis of data. The data will provide a basis for planning and resource allocation.

It is suggested that this survey be conducted in areas...
where there is a lack of current information concerning the participating status of providers or when providers have not been approached about EPSDT in the past. This survey is a recruitment tool itself and it can provide information which is useful in designing a recruitment plan.

Survey Preparation

Conducting the survey offers EPSDT staff an opportunity to perform many functions. These functions include education, recruitment, communication, public relations, and support and encouragement. The field team conducting the survey will have an opportunity to receive feedback about the program from the providers. Surveyors should be versatile and skilled at anticipating concerns and responding to unexpected questions with poise. There is debate over whether persons with specific medical/health backgrounds perform provider surveys more effectively than lay persons who are trained for the interviewing tasks. This and other issues that may influence providers require explicit consideration. The surveyor should always view him/herself as a representative of the program in a public relations capacity. Careful consideration should be given to the possible impact of all types of communication with providers—written, telephone and face-to-face.

In order to conduct the survey effectively, workers will need a solid orientation to the program. Much material has been written about EPSDT. Persons who have had experience with the program (preferably at the local level) should be involved in selecting training material and preparing the survey staff. At a minimum, the survey staff should have working knowledge of the following topics:

1. federal and state program history;
2. program philosophy;
3. rules, regulations and reimbursement mechanisms;
4. responsibilities of the provider to EPSDT clients and to the EPSDT agency;
5. obligations of the EPSDT program to the health care provider;
6. concerns that providers may have about scheduling, referral, quality of care, etc.;
7. other health resources in the area;
8. assistance available to the provider from local, state or other resources.

It is recommended that survey staff carry copies of short educational articles summarizing these points and that these be given to providers for their review (perhaps in an advance mailing).
Literature should provide basic EPSDT information to providers. It should include a synopsis of the EPSDT program and answer these questions:

1. What is EPSDT?
2. When was it developed?
3. Which agencies and departments are responsible for the program?
4. Whom does the program serve?
5. What has been done in my region so far?
6. How were the screening services and periodicity schedules developed and/or selected?

In addition to screening, diagnostic and treatment services, it is essential for the provider to be aware of other responsibilities he/she has to the EPSDT eligibles and the EPSDT administrative body. With this information, the provider can make appropriate management decisions.

Providers should be informed of all the ramifications of the agreement with the EPSDT program, including state monitoring procedures. It also is essential that they be informed when any changes in program procedures or population characteristics occur.

Items which should be addressed include:

1. What is the potential demand for EPSDT services in the provider's district?
2. Which immediate patient load should the provider expect?
3. Which characteristics (age, sex) can the provider expect in patients?
4. How will they be notified of changes in the regulations? Screening tests? Periodicity schedules?
5. About which services should the provider inform the patient (transportation, day care, etc.)?
6. Which acceptable referral services are available for EPSDT eligibles?
7. What are the names of other EPSDT providers in the area?

Billing and reimbursement procedures directly affect providers and participation by providers effects the success of the program. Providers have financial obligations to themselves, their employees and their patients. They are concerned about cash flow in their practices. The state's reimbursement system should be explained clearly to non-participating providers. Questions which should be addressed include:
1. What are the regulations for becoming an EPSDT provider?
2. What is the claims processing procedure?
3. What is the average turnaround time for reimbursement?
4. What is the reimbursement rate for screening?
5. What is the recognized customary fee schedule when there is no fixed reimbursement rate for screening?
6. Are partially completed forms eligible for reimbursement?
7. How is eligibility of clients verified?
8. What are the procedures for appeal in disputed claims?

Some providers are eager to supply EPSDT services but are uncertain about how their existing practices may be affected or about the mechanisms involved in implementation. The EPSDT staff conducting this assessment should know where providers can turn for assistance if they experience difficulties providing EPSDT services. Other physicians usually are the most effective source for this information.

Providers should be informed of the EPSDT resource assessment before they are directly contacted by a surveyor to participate in the study. Some effective ways to inform them include:

1. announcements in the Medicaid bulletin or newsletter;
2. notices mailed with reimbursement checks;
3. announcements sent by mail;
4. addressing a specialty group at an association meeting (requested by EPSDT program representatives).

Announcements or presentations should include the following information:

1. **What is going to happen?** (For example, telephone call for an appointment, request to complete a questionnaire by mail, etc.)
2. **When?** (For example, within the next few days, sometime during the summer.)
3. **Who will contact them?** (If possible, name and phone number.)
4. **Why?** (What it is about.)
5. **What will be expected of them?** (How much time? Who should participate? Will facts and figures need to be prepared?)
6. **What will be covered in the survey?**
7. **What will be done with the information and who will review it?**
8. Will the information be handled confidentially?
9. Who may contact the provider if he has concerns and questions before the interview?

Collecting Data

Two primary ways of collecting information about health resources in an area are through published information sources and through direct personal contact (by letter, telephone or face-to-face). To use time effectively, the least costly and most appropriate method to acquire information should be used. The usefulness of the methods in the order given should be evaluated and face-to-face direct contact used only when it is specifically required and indicated. The survey should carefully select the types of information collected during interviews. One of the hidden "costs" of using direct face-to-face contact to excess is the danger of aggravating the provider by taking up valuable time with inappropriate questions. For instance, a hospital's telephone number can be obtained from the phone book and its bed-capacity from American Hospital Association directories. These types of questions need not be asked by the surveyor.

After the announcement bulletin has been sent, the EPSDT resource assessment staff should begin to outline its work strategy. First, a list must be developed which includes all providers who are or can be EPSDT providers. The following list of health care information sources was prepared to assist the state/regional EPSDT surveyors in their effort to locate those health care providers who could be a health resource for the EPSDT program.

The EPSDT surveyors are not required to contact all those sources listed. It is possible that one of the agencies mentioned will have all the information required for the purpose of this study. Try contacting the first few listed. If they do not have the information required, ask the agency to identify a more comprehensive source of information.

General sources:

1. State Social Services Department (Medical Services)
2. State Health Department
3. Health Systems Agency—state board and local agency
4. County Health Department
5. City Health Department
6. National, state and county physicians' associations
7. Local Blue Cross Agency
8. National and regional offices of HEW
9. State Health Regulatory Agencies
10. Local PSRO agency (Professional Standards Review Organization)
11. State, county and municipal planning agencies
12. Volunteer health organizations
13. Local community action projects

Printed Sources

1. Telephone directories
2. American Hospital Association—Annual Survey of Hospitals, Registered and Non-Registered
3. American Medical Association—Physician Master File
4. American Medical Association—Periodic Survey of Physicians Group Practice File

Based on information from these sources, complete the sample chart form on page B-9 which will give an overview of all the resources within a county. A separate listing of all the providers should be compiled. As the survey progresses, discrepancies may be found and the chart corrected.

The next step is to develop codes for different types of providers in preparation for plotting their location on county maps. Colored pins on a wall map work very well. If there are natural barriers like mountains, lakes, forests, etc., these should be drawn on the map. For urban centers, a detailed street map may be required to show the exact location of resources. The map is a visual graph of the concentration, types and locations of providers. This information can be compared with data about the size and distribution of the eligible population.

Large counties should be divided into regions and small counties should be aggregated in order to develop a survey area. Experience will dictate the area size and number of providers that can be handled comfortably by one surveyor. Based on figures the pharmaceutical industry uses for its "sales force" or "detail men," it seems reasonable to assume that one researcher could visit 70 providers in approximately 4 weeks if the average interview time was 30 minutes and 20 percent of working time was spent actually conducting interviews. The rest of the time would be spent traveling, waiting for the interview, telephone work, reports, office meetings and followup work. This calculation is offered as guidance only; each region or county will want to make decisions appropriate for that area and staff. A sample coded map of a divided county is provided on page B-10.

Before beginning the interviews or the resource assessment, EPSDT staff should become familiar with the assessed area's
EPSDT statistics. These basic statistics include the number of eligibles, the number screened, the number that still require screening and the number eligible for rescreening. Other relevant statistics would include ethnic or racial identity and special health-related customs which could effect the accessibility of the provider to an individual child and the total amount of care available to a specific group of children.

A work flow diagram like the one on page B-11 should be designed in order to avoid confusion, increase efficiency, monitor progress and ensure the completion of the assessment in the required time. This should be developed in a team setting with as many surveyors and their supervisors as possible. It should be a flexible document and altered as needs and experience dictate. In addition to the diagram, milestone, Gantt and P.E.R.T. charts are useful tools to use in planning work.

A sample interview outline, suitable for EPSDT participating or non-participating providers, follows. The basic outline can be used for:

- physicians in private practice;
- clinics;
- neighborhood health centers;
- hospital outpatient departments;
- health maintenance organizations (HMO);
- health departments.
<table>
<thead>
<tr>
<th>CODE</th>
<th>TYPE OF HEALTH CARE RESOURCE</th>
<th>HAS MEDICAID (EPSDT) #: PROVIDING SCREENING</th>
<th>HAS MEDICAID #: NOT PROVIDING SCREENING</th>
<th>NO MEDICAID #: POTENTIAL PROVIDERS OF SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health Dept/ Nursing Serv.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Private Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Neighborhood Health Centers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hospitals (Outpatients)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Health Maintenance Organization (HMO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Schools</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Day Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Instructions: Enter the number of each type of resource in blank space; enter totals in line 9.
<table>
<thead>
<tr>
<th>CODE</th>
<th>HEALTH CARE PROVIDER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲</td>
<td>County Health Department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Group Practice</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Single Private Provider</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Community Health Center</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health Maintenance Organization (HMO)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Osteopath</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Dentist</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Day Care (Provider)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>
SAMPLE WORK FLOW DIAGRAM

START

1. Studying Manual and Learning EPSDT
2. Collecting Information and Analyzing County
3. Preparing Information for Providers
4. Planning Itinerary
5. On-site Work in Counties (See next page for expansion of this phase)
6. Collating Data in Required Form
7. Participating in Data Analysis
8. Planning for Resource Development

FINISH

TIME FRAME IN MONTHS

1 2 3 4 5 6 7

B-11
# SURVEYOR'S PRELIMINARY CHECK-LIST

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarized self with EPSDT program and provider concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepared list of relevant health care resources by county</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divided county map into regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coded and located providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sent appropriate announcement bulletins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Familiarized self with EPSDT eligible population characteristics and location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish itinerary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developed proposed work flow schedule and timetable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B-12
SAMPLE SEQUENCE OF TASKS WITH ONE PROVIDER

Identify Provider from Information Source

Code and Locate on Map

Estimate Probable Time Range for Visit

Mail Survey Announcement Information

Schedule Appointment (Telephone?)

Drop Off Background Information and Introduce Self to Office Staff

Conduct Survey

Complete Report

Notify Welfare Office if Provider is Now Accepting EPSDT or Wishes More (or Fewer) Referrals

Initiate Action to Respond to Provider Requests (If Any are Generated)

Send Thank-You Letter

Report on Survey Results

Request Provider Involvement in On-Going Resource Development Committee (If Indicated)

If Provider Becomes EPSDT Provider as a Result of Survey, Follow-up with Telephone Call or Visit Within 30 Days to Discuss Experience with Program and Any Problems
<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
</table>
| 1 | Are you aware of the Early, Periodic Screening, Diagnosis and Treatment Program  
If no, offer a brief explanation and present written material.  
Officer to return at another time after provider has reviewed material.  
If yes, proceed.                                                                                                          | ( ) ( ) ( )  
YES NO                                                                                                                     |
| 2 | Do you participate in the Medicaid program?  
If no, got to #4.  
If yes, proceed.                                                                                                            | ( ) ( ) ( )  
YES NO                                                                                                                     |
GENERAL PROVIDER SURVEY OUTLINE

<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Do you use this form (show screening form) when delivering well-child services to Medicaid patients under 21 years? If yes, go to #6. If no, proceed.</td>
<td>( ) YES ( ) NO</td>
</tr>
</tbody>
</table>

NOTE: You may wish to use screening form as a checklist for services.

<table>
<thead>
<tr>
<th></th>
<th>Which of the following services do you generally offer young patients during a routine visit and who performs the test?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>a. Health History</td>
</tr>
<tr>
<td></td>
<td>b. Developmental Assessment</td>
</tr>
<tr>
<td></td>
<td>c. Physical Assessment</td>
</tr>
<tr>
<td></td>
<td>d. Nutritional Assessment</td>
</tr>
<tr>
<td></td>
<td>e. Dental Assessment</td>
</tr>
<tr>
<td></td>
<td>f. Blood Pressure</td>
</tr>
<tr>
<td></td>
<td>g. Hearing with Puretone Audiometer</td>
</tr>
<tr>
<td></td>
<td>h. Other Hearing Tests Specify</td>
</tr>
</tbody>
</table>

Laboratory Tests:

|   | i. Anemia Testing                                               | ( ) ( ) ( ) ( ) |
|   | j. Bacteriuria (Females)                                       | ( ) ( ) ( ) ( ) |
|   | k. Increased Lead Absorption                                    | ( ) ( ) ( ) ( ) |
|   | l. Sickle Cell                                                  | ( ) ( ) ( ) ( ) |
|   | m. Tuberculosis                                                 | ( ) ( ) ( ) ( ) |
|   | n. Labwork On-site                                             | ( ) ( ) ( ) ( ) |
|   | o. Labwork Off-site                                           | ( ) ( ) ( ) ( ) |
### GENERAL PROVIDER SURVEY OUTLINE

<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Are there specific reasons for your not participating in the EPSDT program?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Possible reasons:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Not participating in Medicaid program (Go to #6)</td>
<td>a. ( )</td>
</tr>
<tr>
<td></td>
<td>b. Reimbursement problems</td>
<td>b. ( )</td>
</tr>
<tr>
<td></td>
<td>c. No Medicaid patients</td>
<td>c. ( )</td>
</tr>
<tr>
<td></td>
<td>d. Patients have not requested EPSDT</td>
<td>d. ( )</td>
</tr>
<tr>
<td></td>
<td>e. Office (clinic) not designed for screening program</td>
<td>e. ( )</td>
</tr>
<tr>
<td></td>
<td>f. Cannot provide all required services</td>
<td>f. ( )</td>
</tr>
<tr>
<td></td>
<td>g. Children receive comparable services but not reported through Medicaid or EPSDT</td>
<td>g. ( )</td>
</tr>
<tr>
<td></td>
<td>h. Unable to accept new patients</td>
<td>h. ( )</td>
</tr>
<tr>
<td></td>
<td>i. Other (Specify)</td>
<td>i. ( )</td>
</tr>
<tr>
<td>6</td>
<td>Would you like additional information concerning Medicaid/EPSDT?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES NO</td>
</tr>
</tbody>
</table>

**NOTE TO INTERVIEWER:** This may signal the end of the interview with non-participating providers. You may elect to proceed with recruitment activity or note any required follow-up on follow-up sheet.

<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Are you providing diagnosis and/or treatment services for your Medical Assistance patients?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
<td>YES NO</td>
</tr>
<tr>
<td></td>
<td>Specify category of D and/or T</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>QUESTIONS</td>
<td>RESPONSES</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>8</td>
<td>Do you refer patients who have positive screening results? If yes, proceed. If no, ask how referral is handled.</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td>Referral Procedure:</td>
<td>YES NO</td>
</tr>
<tr>
<td>9</td>
<td>Are you having any difficulty with referral procedures?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td>10</td>
<td>What information do you usually receive about the patient's further care?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. None—go to #11.</td>
<td>a. ( )</td>
</tr>
<tr>
<td></td>
<td>b. Scheduled appointments</td>
<td>b. ( )</td>
</tr>
<tr>
<td></td>
<td>c. Kept appointment</td>
<td>c. ( )</td>
</tr>
<tr>
<td></td>
<td>d. Patient under continuous care</td>
<td>d. ( )</td>
</tr>
<tr>
<td></td>
<td>e. Further referral</td>
<td>e. ( )</td>
</tr>
<tr>
<td></td>
<td>f. Treatment complete</td>
<td>f. ( )</td>
</tr>
<tr>
<td>11</td>
<td>What information would you like to receive?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. None</td>
<td>a. ( )</td>
</tr>
<tr>
<td></td>
<td>b. Scheduled appointments</td>
<td>b. ( )</td>
</tr>
<tr>
<td></td>
<td>c. Kept appointment</td>
<td>c. ( )</td>
</tr>
<tr>
<td></td>
<td>d. Patient under continuous care</td>
<td>d. ( )</td>
</tr>
<tr>
<td></td>
<td>e. Further referral</td>
<td>e. ( )</td>
</tr>
<tr>
<td></td>
<td>f. Treatment complete</td>
<td>f. ( )</td>
</tr>
<tr>
<td>#</td>
<td>QUESTIONS</td>
<td>RESPONSES</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>12</td>
<td>What are your (clinic's) hours for EPSDT screening?</td>
<td>( ) Days Hrs. ___ to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( ) Evenings ___ to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( ) Weekends ___ to</td>
</tr>
<tr>
<td>13</td>
<td>Approximately how many EPSDT screens do you provide monthly?</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( ) Don't Know</td>
</tr>
<tr>
<td>14</td>
<td>How long does it take you to complete a screening?</td>
<td>Minutes/Individual</td>
</tr>
<tr>
<td>15</td>
<td>Can you estimate the number of additional complete EPSDT screens you could provide?</td>
<td>Number/Week</td>
</tr>
<tr>
<td>16</td>
<td>What is your present broken appointment rate for EPSDT?</td>
<td>Rate ___ %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( ) Don't Know</td>
</tr>
<tr>
<td>17</td>
<td>Are you willing to accept new patients who are eligible for Medical Assistance?</td>
<td>( ) ( ) YES NO</td>
</tr>
<tr>
<td>18</td>
<td>Would any modification in the EPSDT program encourage you to increase the number of EPSDT screenings?</td>
<td>( ) ( ) YES NO</td>
</tr>
<tr>
<td></td>
<td>If yes, proceed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, go to #21.</td>
<td></td>
</tr>
</tbody>
</table>
## GENERAL PROVIDER SURVEY OUTLINE

<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Which modifications would be most helpful to you?</td>
<td>Elaborate</td>
</tr>
<tr>
<td></td>
<td>Changes in:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Reimbursement rate</td>
<td>a. ( )__________</td>
</tr>
<tr>
<td></td>
<td>b. Forms design</td>
<td>b. ( )__________</td>
</tr>
<tr>
<td></td>
<td>c. Screening package requirements</td>
<td>c. ( )__________</td>
</tr>
<tr>
<td></td>
<td>d. Assuring appointments are not broken</td>
<td>d. ( )__________</td>
</tr>
<tr>
<td></td>
<td>e. Periodicity schedule</td>
<td>e. ( )__________</td>
</tr>
<tr>
<td></td>
<td>f. Other</td>
<td>f. ( )__________</td>
</tr>
<tr>
<td>20</td>
<td>Given these program changes, how many more EPSDT screening visits would you be willing to provide?</td>
<td>Number/Week________</td>
</tr>
</tbody>
</table>
**GENERAL PROVIDER SURVEY OUTLINE**

<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Aside from my visit, what have been your sources of information about EPSDT?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. TV, radio or other advertising media</td>
<td>a. ( )</td>
</tr>
<tr>
<td></td>
<td>b. Medical society publications and journals</td>
<td>b. ( )</td>
</tr>
<tr>
<td></td>
<td>c. State publications (mail, letters, bulletins, etc.)</td>
<td>c. ( )</td>
</tr>
<tr>
<td></td>
<td>d. Patients</td>
<td>d. ( )</td>
</tr>
<tr>
<td></td>
<td>e. Colleagues (verbal communication)</td>
<td>e. ( )</td>
</tr>
<tr>
<td></td>
<td>f. Other</td>
<td>f. ( )</td>
</tr>
<tr>
<td></td>
<td>Specify</td>
<td></td>
</tr>
</tbody>
</table>

| 22 | Would you like any assistance or further information about the program?  |           |
|    | If yes, go to follow-up sheet.                                            |           |
|    |                                                                         | YES | NO |
### HEALTH DEPARTMENT SURVEY OUTLINE

<table>
<thead>
<tr>
<th>Health Department</th>
<th>County</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Name of Administrator</td>
<td></td>
<td>Person Interviewed</td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composition: MDs</td>
<td>Nurse Practitioners</td>
<td>RNs</td>
</tr>
<tr>
<td>Interview Conducted by</td>
<td></td>
<td>Date</td>
</tr>
</tbody>
</table>

#### QUESTIONS

<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you providing EPSDT services to children?&lt;br&gt; If no, go to #9.</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES NO</td>
</tr>
<tr>
<td>2</td>
<td>Do you perform outreach services?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES NO</td>
</tr>
<tr>
<td>3</td>
<td>Do you have a contract or agreement with the local welfare agency to perform outreach and follow-up services?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES NO</td>
</tr>
<tr>
<td>4</td>
<td>How many EPSDT screenings are performed weekly at your clinic?</td>
<td>Number/Week</td>
</tr>
<tr>
<td>5</td>
<td>Does this clinic have the capacity to offer more EPSDT services?&lt;br&gt; If yes, go to #7.</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES NO</td>
</tr>
<tr>
<td>6</td>
<td>If no, what would be required to expand capacity?</td>
<td>Specify</td>
</tr>
<tr>
<td>#</td>
<td>QUESTIONS</td>
<td>RESPONSES</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>How many more screens/week could be handled?</td>
<td>Screens/Week</td>
</tr>
<tr>
<td>8</td>
<td>Does your clinic assume responsibility for referral?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>9</td>
<td>Are you having difficulty in referring your patients for diagnosis and/or treatment services?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>10</td>
<td>Would you like additional information about EPSDT?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>11</td>
<td>Aside from my visit, what have been your sources of information about EPSDT?</td>
<td>a. ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specify</td>
</tr>
<tr>
<td>12</td>
<td>Would you like any assistance or further information about the program?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td>If no, STOP.</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>If yes, go to follow-up sheet.</td>
<td></td>
</tr>
</tbody>
</table>
SCHOOL AND DAY CARE SURVEY OUTLINE

Center or School ___________________________ County ______ Region ______
Health Coordinator ___________________________ Title ______
Center or Address ____________________________
School Street ________________________________ City ______ Zip Code ______
Phone __________________
Person Interviewed ____________________________ Date __________________

Interview Conducted By ____________________________ Date __________________

NOTE: If the institution is a provider, some of the questions on the main survey form may be relevant.

<table>
<thead>
<tr>
<th>#</th>
<th>QUESTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How many EPSDT eligible children are enrolled in your school/center program and what are their ages?</td>
<td>Number __________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age: Infant ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preschool ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6-10 ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11-21 ( )</td>
</tr>
<tr>
<td>2</td>
<td>Are you providing health care screening services for your children?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES NO</td>
</tr>
<tr>
<td>3</td>
<td>Do you provide them directly, through contract, or through referral?</td>
<td>Direct ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contract ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral ( )</td>
</tr>
<tr>
<td>4</td>
<td>Does the EPSDT program meet the health and licensing requirements of your program?</td>
<td>( ) ( )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES NO</td>
</tr>
<tr>
<td>#</td>
<td>QUESTIONS</td>
<td>RESPONSES</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>5</td>
<td>Are you or are you willing to coordinate your health service efforts with those of the EPSDT program?</td>
<td>( ) ( ) YES NO</td>
</tr>
<tr>
<td></td>
<td>If yes, go to #6.</td>
<td></td>
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<tr>
<td></td>
<td>If no, what are your reasons for not using the EPSDT program?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Shortage of providers:</td>
<td>a. ( ) S ( ) D ( ) T ( )</td>
</tr>
<tr>
<td></td>
<td>Screening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Delay in receiving reimbursements</td>
<td>b. ( )</td>
</tr>
<tr>
<td></td>
<td>c. Lack of necessary screening equipment</td>
<td>c. ( )</td>
</tr>
<tr>
<td></td>
<td>d. Lack of necessary personnel</td>
<td>d. ( )</td>
</tr>
<tr>
<td></td>
<td>e. No Medical Assistance patients in the area</td>
<td>e. ( )</td>
</tr>
<tr>
<td></td>
<td>f. Children receiving similar services but not billed to EPSDT</td>
<td>f. ( )</td>
</tr>
<tr>
<td></td>
<td>g. Other</td>
<td>g. ( )</td>
</tr>
<tr>
<td>6</td>
<td>Do you have the capacity to serve additional children?</td>
<td>( ) ( ) YES NO</td>
</tr>
<tr>
<td></td>
<td>If no, go to #8.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>How many and with what limitations (e.g., age, geography)?</td>
<td>Number____ Limits____</td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>QUESTIONS</td>
<td>RESPONSES</td>
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<tr>
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<td>---------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>8</td>
<td>What is your referral procedure? (Please list any problems you have in making referrals.)</td>
<td>Referral Problems:</td>
</tr>
<tr>
<td></td>
<td>Referral Procedure:</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Would you like additional information about EPSDT? (Use follow-up sheet if necessary.)</td>
<td>( ) ( ) YES NO</td>
</tr>
</tbody>
</table>
Instructions for Follow-up Sheet

The follow-up sheet gives the surveyor an opportunity to record a quick assessment of the provider's attitude and to note any items which require follow-up. An example of required follow-up would be a physician requesting additional screening forms. Although these miscellaneous requests may not be tailored to the surveyor's responsibilities, the surveyor may be the only program representative whom the provider has personally met. Surveyors should try to handle these requests through their supervisors. If the request is for information or activities totally outside of surveyor responsibility, a letter or memo should be sent to the person most capable of handling the matter and the provider informed through a copy or separate note that his/her request or question has been referred. These sheets can be torn from the packet and filed separately according to "date needed." It is important to jot down a description of what finally happened under "disposition."

With some experience, surveyors will begin to see a pattern to the attitudes and additional requests which they encounter. It is important to keep communication open and maintain credibility by delivering what is promised or informing the provider when this cannot be done.
### FOLLOW-UP SHEET

**For EPSDT Regional Staff Use**

<table>
<thead>
<tr>
<th>County</th>
<th>Region</th>
<th>Interviewer</th>
</tr>
</thead>
</table>

#### 1. Name of provider interviewed

#### 2. Attitude of the person interviewed regarding EPSDT:
- ( ) Enthusiastic
- ( ) Receptive
- ( ) Neutral
- ( ) Negative

#### 3. Follow-up information on activities required or requested: ( ) Yes  ( ) No

<table>
<thead>
<tr>
<th>Specify:</th>
<th>What ___________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When__________________________________________</td>
</tr>
<tr>
<td></td>
<td>Resources needed to perform follow-up __________________________</td>
</tr>
<tr>
<td></td>
<td>Date needed____________________ Date completed____________</td>
</tr>
<tr>
<td></td>
<td>Disposition____________________________________</td>
</tr>
</tbody>
</table>

#### 4. Other comments:

#### 5. Recommendations for date and type of follow-up contact: