Increased Professional Provider Participation in State and Local EPSDT Programs

FINAL REPORT

AMERICAN ACADEMY OF PEDIATRICS

Contract No. SRS-500-75-0029

Increased Professional Provider Participation in State and Local EPSDT Programs

MEDICAL SERVICES ADMINISTRATION
SOCIAL AND REHABILITATION SERVICES
DHEW

Evanston, Illinois
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1. INTRODUCTION

In December 1972 the Executive Board of the American Academy of Pediatrics issued a policy statement on the Early and Periodic Screening, Diagnosis and Treatment program. This statement was supportive of the program and encouraged active involvement of the membership. The Academy through its Head Start contract identified a pediatrician in each of the Department of Health, Education and Welfare regions to serve as a liaison to the regional Social and Rehabilitation Service offices. SRS contracted with the Academy for the development of an EPSDT screening manual and subsequently a manual on administration, diagnostic and treatment services. Perhaps most significant was the appointment by the Executive Board of a Committee on EPSDT which developed a frequent, open dialogue with the Medical Services Administration.

In 1975 the Medical Services Administration awarded the American Academy of Pediatrics a contract to determine ways and means of enlisting increased interest, support and effective participation of professional health care providers in the implementation of EPSDT. Dr. Richard W. Olmsted, Associate Executive Director of the Academy and Acting Director of the Department of Community Services, assumed the position of Project Director with Dr. Robert A. Tidwell assuming the position of Medical Director. They, along with a Board appointed ad hoc advisory committee to the project, were responsible for the execution of the contractual activities documented in this report.

II.
FINDINGS AND RECOMMENDATIONS

One. We now have a viable AAP EPSDT organization in each state. Our recent contacts with the Academy of Family Practice and American Osteopathic Society lead us to believe that they will become a part of our state EPSDT effort, resulting in a strong primary care oriented Advisory Committee.

Two. Our association with the Academy of Family Practice and the American Osteopathic Society will require constant nurturing in order for them to maintain a degree of enthusiasm necessary for a strong state EPSDT Advisory Committee.

Three. Regional Medical Consultants have cut through the red tape and are in most instances known and respected by their counterparts in the Regional MSA Office. This liaison needs to be maintained not only for the welfare of both parties but so that the state EPSDT individual or Advisory Committee has an "open door" to the first level of the federal agency responsible for EPSDT implementation by his state.

Four. Regional meetings and regional task forces. Only the meetings in Atlanta and Kansas City were MSA-EPSDT oriented. The other meetings had a Head Start orientation as it relates to EPSDT as well as MSA-EPSDT.

The Regions IV and VII were most successful (on paper). It remains to be seen if recommendations were indeed carried out. The report from Region IV indicates that such was the case, but this needs further documentation.

This type of get together should be continued if for no other reason than to show the cooperation that exists between the AAP and MSA.

Task forces, where they have been properly oriented, have been very successful. This needs to be enlarged upon and established in all regions.

Five. Inadequate fees, slow payment and paper work. Although these problems are all under the jurisdiction of the state, their solution to the satisfaction of the provider, be he private or public, can only be solved by a strong Advisory Committee with involvement of the regional people for the national picture.

Six. Missed appointments. This is a problem irrespective of mode of delivery of services, i.e. - private, health department clinic, mobile unit, etc. This, like other problems, needs a national pooling of effort in order to ascertain the best methodology of dealing with the problem. The Regional MSA people could assist in this by feeding data into Washington for advice and consent as to procedures most successful in solving the dilemma.

Seven. Private physicians not allowed to screen. In many instances, this is the result of an attitudinal hang-up by the state implementing agency. This can and must be solved by the regional MSA people in conjunction with the state providers. In some instances there are not enough private providers to accomplish the needed screening. In these instances the health departments, nurse practitioners, public health nurses, etc. must be hired to do the job. In no instances must a private practitioner be denied the opportunity to become involved, nor must barriers such as lower fees (than paid other screeners) be placed in his way. Some solution must be developed to solve the problem of repeat screening by various agencies and practitioners in order to reduce the reduplication and needless expenditure of public funds.

Eight. No follow-through, inadequate records, over-diagnosis, inappropriate screening. These, like the missed appointments, are universal and occur irrespective of the locale of screening. The complication of information from the states through the regional coordinators (AAP and MSA) as to their methodology of dealing with these problems could result in some solutions. In many instances neighboring states have no idea what's going on next door, and learn of these things only through the Regional Office or regional meetings as spoken of in number four.

The ideal record should be developed and distributed as a guide for future changes.

Too many screeners accept the AAP-MSA Screening Guide and the Denver Developmental as how things should be done. An educational program is needed to overcome these misconceptions.

Nine. There is a need for an educational service to the Departments of Social Service in some states, just as there is a need to not only encourage but demand a better outreach effort. Many eligibles are not being reached through ineffective, inefficient and improper outreach, just as the educational material is ineffective, etc., because the idea of education is foreign to the Social Service Department and they as a result are not prepared to mount an effective educational program.

This could be corrected through a training and technical assistance program.

Ten. At times there seems to be a total lack of communication from the top down. Complementary program people do not communicate with one another in Washington, the region or in the state. There is a great duplication of effort at all levels which could be held to a minimum if there was greater and more detailed communication. This will never happen at the state level until there is evidence of it occurring at the top. There needs to be in-depth discussion of all the programs including the proposed "Maternal and Child Health Program of 1976", and their relationship to one another, how they can be made to operate more efficiently both from the standpoint of money and personnel, and how they can compliment one another rather than the constant show of suspicion and jealousy that now exists.

RECOMMENDATIONS

A grant proposal will be presented in a few weeks, based on the above findings. This proposal will offer plans to resolve some of the dilemmas of the program as well as offer solutions to some of the problems.

III.

METHODOLOGY

In conjunction with the recommendations put forth in the report on "Professional Health Provider Participation" by the AMA's Committees on Health Care of the Poor, the American Academy of Pediatrics sought to establish liaison arrangements with representatives of other National Professional Health Care Organizations to promote their knowledge of, and participation in, EPSDT.

Forty-nine identified Health Care Organizations received a personal letter from the Project Medical Director with a brief questionnaire designed to ascertain the status of EPSDT within the organization. The questionnaire sought information relative to existing EPSDT committes, state, regional, or chapter EPSDT committees, or, in the event such committees did not exist, the name of the president or executive secretary of regional or state chapters. The data obtained from the questionnaires resulted in the development of an "EPSDT Directory." The EPSDT Directory became a comprehensive resource in the identification of EPSDT knowledgeable contacts. Arranged by state, the Directory lists key AAP EPSDT resource consultants, SRS-MSA regional and state staff, state agency EPSDT staff and contacts in national health care organizations. Distribution was logged to permit necessary updating.

The questionnaire to the Professional Health Care Organizations met with the following response:

		Percent of Total
Number of questionnaires mailed	49	-
Number returned	35	71%
Number of organizations with an EPSDT Committee	12	34%*
Number with state EPSDT Committees	4	11%*

* of those responding

It was anticipated that this initial communication would help stimulate the growth of liaison relationships through which the Academy could inform Professional Health Care Organizations of EPSDT program developments, arrange for the inclusion of EPSDT on their national meeting agendas, and include reports on EPSDT in their national journals. Follow-up letters and telephone communications were made to those organizations manifesting an interest in the project, with a concentrated emphasis on those of a primary care nature. A copy of Dr. Keith Weikel's address delivered at the Academy of Pediatrics' annual meeting in Washington, D.C. in October 1975 entitled "EPSDT - A Blueprint for National Health" along with an offer from the Academy to provide any resource assistance went to all forty-nine organizations. Despite intense follow-up efforts, the Academy met with minimal success. Of the thirty-five National Professional Health Care Organizations responding:

	Percent of Total	
19	54%	confined their communication to the return of the questionnaire
11	31%	expressed an interest in receiving future mailings and/or a polite receptivity to the idea of working with the Academy
5	14%	responded with positive action*

*Positive action describes activity in which an organization engaged as a result of the Academy's effort. Examples include such activities as giving consideration to the inclusion of EPSDT into committee functions, dissemination of Dr. Weikel's aforementioned address and copies of the EPSDT Directory to organization members, and the identification of a person to serve as a liaison with the Academy project.

Through the communication with the National Professional Health Care Organizations provided a fair indication of EPSDT significance within organizations, progress

was unsatisfactory in terms of receiving requests for EPSDT informational materials, invitations to deliver EPSDT presentations, and participation by other than Academy physicians at state and regional meetings.

To supplement the growth of liaison relationships with National Professional Health Care Organizations, the Academy simultaneously conducted similar activities with State Medical Societies and Academy State Chapters.

State Medical Societies

To determine the degree of EPSDT involvement, a letter from the Project Medical Director and a brief two-item questionnaire were directed to all fifty-one State Medical Societies. The level of response was not satisfactory:

		Percent of Total
Number of questionnaires mailed to State Medical Societies	51	-
Number of questionnaires returned	37	73%
Number indicating EPSDT committees	22	59%
Number with a local (county) EPSDT committee	1	1%*

* of those responding

Ten State Medical Societies reported the absence of an EPSDT committee, however, five indicated an interest in incorporating EPSDT into other named committees. A copy of Dr. Keith Weikel's address was sent to all (51) Medical Societies. In some instances Regional Academy Medical Consultants were able to involve State Medical Society representatives in state and/or regional meetings.

The data collected from the Medical Society questionnaires contributed to the analysis of EPSDT by state, covered in Section VI of this report.

AAP State Chapters

In August 1973 there were sixteen Academy State Chapters with named EPSDT committee responsibility.

With the award of the MSA contract, an immediate effort was launched to identify an individual or committee in each state Academy chapter who would be responsible for promoting EPSDT in his/her state. A questionnaire was disseminated to all fifty-five Academy Chapter Chairmen to indicate the priority of EPSDT within each chapter.

		Percent of Total
Number of questionnaires mailed	55	-
Number of questionnaires returned	52	95%
Number with EPSDT committees	40	77%*

* of those responding

The remaining 23% are in the process of developing an EPSDT committee or are a part of the State Medical Society's EPSDT (or Title XIX) committee.

In view of the lack of response from other National Professional Health Care Organizations, it was evident that the Academy State Chapter was the most effective vehicle to facilitate an extensive exploration of the level of EPSDT provider participation in each of the states.

A regional network of knowledgeable consultants was favored as the method best capable of facilitating the expression of provider concerns to the state and region, with the consultant serving as the "go-between". In each of the ten DHEW regions, a fellow of the American Academy of Pediatrics was identified and designated to establish strong regional liaisons with SRS/MSA. The consultants had diverse backgrounds with their basic association with EPSDT coming from the Academy's Medical Consultation Service to Project Head Start and the EPSDT collaborative effort. In many instances the DHEW-EPSDT regional staff were uncertain as to the degree of co-operation called for in the contract until two key communications from the Commissioner of SRS, were sent to the Regional Offices. It should be noted that effectiveness under the methodology set forth in the MSA-EPSDT contract required a more aggressive, outgoing personality than needed for effective performance under the Head Start EPSDT collaborative effort. Under Head Start, the Regional Medical Consultants-EPSDT were "invited in" to address specific, previously identified problems or situations. Under the MSA methodology, they were required to initiate contacts and actions in a totally foreign atmosphere -- namely, the HEW regional organization.

Once they overcame these hurdles, most of the Regional Medical Consultants developed firm, viable relationships with the state and regional SRS/MSA staff. Once these liaisons were established, the Regional Medical Consultants were able to branch off into administrative problem-solving on behalf of the provider community.

The third item in Table XII, AAP facilitated regional meetings, was accomplished in five HEW Regions; I, II, IV, VI and VII. Though having the common goal of increased involvement by providers in EPSDT, each meeting was "customized" to accommodate the widely varying methods and attitudes of each state, as well as the resources made available by the regions. These meetings are extremely cost effective. An average of approximately ten EPSDT knowledgeable physician providers participated in each meeting.

IV.
ANALYSIS

A recommendation passed at a quarterly meeting of the ad hoc Advisory Committee resulted in an expansion of the Objective and Operating Plan. An evaluation methodology was developed to provide specific state data to allow for the identification of problems by state. Two questionnaires were developed; one was disseminated to the single state agency administrators, the other to the AAP Chapter EPSDT chairmen. The questionnaire to the single state agency administrators solicited information on the status of private provider participation in EPSDT including the attitude displayed by the private provider sector toward the program. A complete tabulation and analysis of these questionnaires is presented in Attachment A.

The questionnaire to the AAP chapter EPSDT chairmen sought information on areas which private providers viewed as barriers and on the level of communication between private providers and the single state agency administrators. A tabulation and analysis of the chapter questionnaire responses is given in Attachment B.

An Assessment of Provider Status by State

With the data made available by the questionnaires, each state was placed into one of three categories: positive assessment, negative assessment, or conflicting assessment. (See Table I.) Positive assessment indicates states in which both the AAP chapter and the single state agency assessed private provider participation in EPSDT at a high level and supportive. Conversely, negative assessment indicates states in which both the AAP chapter and the single state agency assessed private provider participation in EPSDT as minimal. In this regard single state agencies often characterized the private providers' attitudes as antagonistic, uncooperative or passive with the AAP chapter validating this observation by citing barriers which were viewed as preventing effective participation. Conflicting assessment is a category in which the single state agency either portrayed the private provider as active while the AAP chapter reported significant problems with private provider participation, or the single state agency tended to gloss over or bypass private provider participation and extol the success of

the program. In either case the single state agency and the AAP chapter were in disagreement over the status of private provider participation and the status of EPSDT. Of 42 states yielding a complete set of data, 18 (43%) were evaluated as positive assessment states; 13 (31%) were evaluated as negative assessment states and 11 (26%) were judged as conflicting assessment states. Thus 24 (57%) of the states reporting were found, on the basis of the assessment, to be in need of supportive private provider participation.

Positive Assessment: Identification of Significant Factors

In order to differentiate a positive assessment state from a negative or conflicting assessment state, three factors were isolated and tested for relational significance. (See Table II.) Sufficient communication with state administrators, private provider input into the planning and implementation of EPSDT and private providers participating in EPS were identified most frequently in the questionnaires as factors which related to the status of private provider participation. Of the 18 states in this category, 11 (67%) reported satisfactory communication, 9 (50%) reported provider input into the planning and/or implementation of EPSDT, and 14 (78%) reported private providers are included in EPS. Of the 18, 16 (89%) identify at least one of the above factors, 12 (67%) identify two of the above factors, and 7 (39%) identify all three of the above factors. In order to further look at relationships in determining a positive assessment state, it is necessary to test the factors in negative and conflicting assessment states. (See Tables III and IV.)

The same three factors tested in negative and conflicting assessment states yield a radically different result. Of the 12 negative assessment states, only 2 (17%) report sufficient communication, 2 (17%) report provider input into the planning or implementation of EPSDT, and 4 (34%) report private provider participation in EPS. Of the 12, 5 (42%) identify one of the above factors, 2 (17%) identify two of the above factors and just 1 (9%) identifies all three of the above factors. Contrasting the factors as they appear in the positive assessment states with their appearance in the negative and conflicting assessment

states leads to the conclusion that in appropriate order, private provider participation in EPS, sufficient communication with state administrators, and provider input into the planning and/or implementation of EPSDT contribute heavily to the success of private provider participation in EPSDT.

Positive Assessment and "EPSDT States"

"EPSDT states" are those states in which all phases of EPSDT are receiving equal consideration as opposed to "EPS states" which concentrate on screening. The questionnaire to the AAP chapter EPSDT chairmen requested they classify their state as EPS or EPSDT. Of the 39 states responding to this request, 22 (57%) characterized their states as EPS while 17 (44%) characterized their states as EPSDT. When the 18 positive assessment states are isolated and tested for EPSDT status, 12 (67%) qualify as EPSDT states. Whereas, with the 12 negative assessment states, 4 (33%) qualify as EPSDT states. Only 1 (10%) of the 10 conflicting assessment states qualifies as EPSDT. (See Tables V - VII.)

A relationship does exist between positive assessment states and "EPSDT states." Thus states in which private providers participate in EPS, and where good communication exists with state administrators, and where private providers have had input into EPSDT are more likely to be comprehensive "EPSDT states."

"EPSDT States" Provider Composition

The last section made reference to the point that states in which private providers participate in EPS are more likely to be comprehensive EPSDT states. To further test the validity of such a statement, it is necessary to determine the composition of providers within the aforementioned "EPSDT states," to discover if in "EPSDT states" the majority of EPS includes private providers. (See Tables VIII-IX.) Of the 17 "EPSDT states" 5 (29%) report EPS is done primarily through public providers, 8 (47%) report EPS is done primarily through private providers, and 4 (24%) report EPS is delivered through both sources. Thus a total of 13 (76%) "EPSDT states" report the inclusion of private providers in EPS; a

level which indicates a strong relationship between comprehensive "EPSDT states" and private provider participation in EPS. When "EPS states" are tested for provider composition, the level of private provider participation is much lower. Of the 22 "EPS states" 14 (64%) report EPS is done primarily through public providers, 0 (0%) report EPS is done primarily through private providers, and only 8 (36%) report EPS is provided through both sources. Thus 8 (36%) of the states characterized as "EPS" involve the private sector in screening. This quickly leads to the conclusion that a state has a greater potential of providing comprehensive EPSDT services if the private sector is participating in EPS. The questionnaire respondents characterizing their states as "EPSDT" frequently attributed the successful linkage to a situation in which the private provider performs a screen and if diagnostic or treatment services are indicated, they can be initiated on the spot.

What Are the Barriers to Successful Private Provider Participation in EPSDT?

The categories of negative and conflicting assessment states have been discussed. Studies demonstrated the factors contributing to states characterized as positive assessment states. It is now necessary to identify those factors which appear to impede effective private provider participation in EPSDT in the negative and conflicting assessment states. (See Table X.) In order of frequency, of the 23 states, 18 (78%) report insufficient communication with state administrators, 14 (61%) report lack of physician familiarity with EPSDT, 13 (57%) report inadequate or delay in payment with fees, 11 (48%) report physicians are not allowed or encouraged to participate in EPSDT and only 7 (30%) report forms are too complex or not designed to document the child's health. The order of frequency is of significance. In the past, forms and fees have been labeled as the major deterrent. This study indicates insufficient communication with state administrators is the foremost deterrent with forms and fees falling into the background. The questionnaires frequently indicated that if sufficient communication did exist inadequate fees would not prevent private providers from participating. It must be noted what is meant

by insufficient communications. In some states this alludes to a situation in which there has been no dialogue between the private sector and state administrators. However, more often, the states report there has been communication but the quality of communication is found lacking. The private providers want the opportunity to provide medical input into the planning and implementation of EPSDT. Private providers want and need to play a significant role in the decision-making process. The majority have been, to date, bypassed in this process.

Potential Problem Analysis

From available data, fourteen factors were identified and judged to be potential problems which are affecting or could affect the quality of EPSDT within any given state. (See Table XI) The factors cited in order of frequency are:

Factors	Number of States
Appointments not kept	35
Insufficient physician distribution	29
Insufficient communication	28
Lack of provider input	28
Linkage incomplete	26
Covert/overt barriers present	26
Duplication of services	23
Fees unacceptable	22
No equivalency	22
Physicians excluded from EPS	21
Negative provider attitude	18
Physicians not familiar with EPSDT	15
Inadequate outreach	14
Forms unacceptable	9

Using the above data, it is possible to develop a rough ranking of the states based on the frequency with which the factors are present in each state. Though in reality some factors may have a more significant impact on the EPSDT program, no attempt has been made to assign any one factor a greater or lesser value.

Number of factors present, by states:

1	VT
2	NE, SD
3	CA, MT, NY, OK
4	ID, ME, ND, WA
5	GA, HI, OR
6	DC, IN, IA, MN, MS, RI, VT
7	AK, AR, MO, NV, NH, OH, PA, IN
8	CO, FL, IL, MI, NJ, WY
9	AL, MD, NC, WV, WI
10	KY, NM, VA
11	DE, KS, LA, TX
12	SC
13	
14	

All states are represented in the ranking save Connecticut and Georgia on which there is incomplete data. For a complete assessment of EPSDT by state refer to Table XI.

TABLE I - An Assessment of Provider Status by State

SURVEY EVALUATION	STATES	Positive Assessments	Negative Assessments	Conflicting Assessments
	Alabama	0	+	0
	Alaska	0	+	0
	Arkansas	0	0	+
	California*	z	z	z
	Colorado *	+	0	0
	Connecticut	z	z	z
	Delaware	0	+	0
	D.C.	z	z	z
	Florida	0	+	0
	Georgia	z	z	z
	Hawaii	z	z	z
	Idaho	+	0	0
	Illinois	+	0	0
	Indiana	z	z	z
	Iowa	0	0	+
	Kansas	0	0	+
	Kentucky	0	+	0
	Louisiana *	0	0	+
	Maine	+	0	0
	Maryland *	0	+	0
	Massachusetts	+	0	0
	Michigan	+	0	0
	Minnesota	0	+	0
	Mississippi	+	0	0
	Missouri	0	0	+
	Montana	z	z	z
	Nebraska	+	0	0
	Nevada	+	0	0
	New Hampshire	0	0	+
	New Jersey	0	0	+
	New Mexico	0	0	+
	New York	+	0	0
	North Carolina	+	0	0
	North Dakota *	0	0	+
	Ohio	0	+	0
	Oklahoma	+	0	0
	Oregon	+	0	0
	Pennsylvania *	+	0	0
	Rhode Island	+	0	0
	South Carolina	0	+	0
	South Dakota	+	0	0
	Tennessee	+	0	0
	Texas	0	0	+
	Utah	0	+	0
	Vermont	+	0	0
	Virginia	0	+	0
	Washington *	0	+	0
	West Virginia	z	z	z
	Wisconsin	0	0	+
	Wyoming	0	+	0

z = data incomplete
+ = yes
0 = no

TABLE II POSITIVE ASSESSMENT: IDENTIFICATION OF SIGNIFICANT FACTORS

	Colorado	Idaho	Illinois	Maine	Massachusetts	Michigan	Mississippi	Nebraska	Nevada	New York	North Carolina	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Dakota	Tennessee	Vermont
Sufficient Communication with State Administrators	0	+	0	+	+	0	+	+	+	+	0	+	0	+	0	+	0	+
Provider Input into the Program	0	0	0	+	+	+	+	+	+	+	0	0	0	+	0	+	0	+
Private Providers Included in EPS	+	+	+	+	+	0	0	+	0	+	+	+	+	+	+	+	0	+
State Advisory Committee	+	z	z	z	+	z	z	z	z	0	+	z	z	0	z	z	0	z

TABLE III NEGATIVE ASSESSMENT: IDENTIFICATION OF COMPARATIVE FACTORS

	Alabama	Alaska	Delaware	Florida	Kentucky	Maryland	Minnesota	Ohio	S.Carolina	Utah	Virginia	Washington	Wyoming
Sufficient Communication with State Administrators	0	0	0	+	0	0	0	0	0	z	0	+	0
Provider Input into the Program	0	0	0	0	0	0	0	+	0	z	0	+	0
Private Providers Included in EPS	0	0	0	0	0	0	+	+	0	+	0	+	0
State Advisory Committee	z	z	0	z	+	+	+	+	z	z	z	z	z

+ = yes
0 = no
z = data incomplete

TABLE IV CONFLICTING ASSESSMENT: IDENTIFICATION OF COMPARATIVE FACTORS

	Arkansas	Iowa	Kansas	Louisiana	Missouri	New Hampshire	New Jersey	New Mexico	N. Dakota	Texas	Wisconsin
Sufficient Communications with State Administrators	0	0	0	0	0	+	0	0	0	0	+
Provider Input into the Program	0	0	0	0	0	+	0	0	0	+	0
Private Providers Included in EPS	0	+	0	0	+	+	+	0	+	0	0
State Advisory Committee	z	z	z	0	z	z	z	z	0	+	0

+ = yes
0 = no
z = data incomplete

TABLE V POSITIVE ASSESSMENT AND "EPSDT" STATES

	Colorado	Idaho	Illinois	Maine	Massachusetts	Michigan	Mississippi	Nebraska	Nevada	New York	N.Carolina	Oklahoma	Oregon	Pennsylvania	Rhode Island	S. Dakota	Tennessee	Vermont
Reports as an "EPSDT" State	0	0	+	0	+	0	+	+	0	+	+	+	+	0	+	+	+	+

TABLE VI NEGATIVE ASSESSMENT AND "EPSDT" STATES

	Alabama	Alaska	Delaware	Florida	Kentucky	Maryland	Minnesota	Ohio	S.Carolina	Utah	Virginia	Washington	Wyoming
Reports as an "EPSDT" STATE	0	0	0	0	+	+	0	+	0	+	0	NC	0

TABLE VII CONFLICTING ASSESSMENT AND "EPSDT" STATES

	Arkansas	Iowa	Kansas	Louisiana	Missouri	New Hampshire	New Jersey	New Mexico	N.Dakota	Texas	Wisconsin
Reports as an "EPSDT" State	0	0	0	0	0	0	0	0	NC	0	+

+ = yes
0 = no
NC = No comment

TABLE VIII "EPSDT STATES" PROVIDER COMPOSITION

	Illinois	Kentucky	Massachusetts	Maryland	Mississippi	Nebraska	New York	North Carolina	Ohio	Oklahoma	Oregon	Rhode Island	South Dakota	Tennessee	Utah	Vermont	Wisconsin
EPS Primarily through Public Providers	0	+	0	+	+	0	0	0	0	0	0	0	0	+	0	0	+
EPS Primarily through Private Providers	+	0	0	0	0	+	+	0	0	+	0	+	+	0	+	+	0
EPS through Public and Private Providers	0	0	+	0	0	0	0	+	+	0	+	0	0	0	0	0	0

+ = yes
0 = no

TABLE IX "EPS STATES" PROVIDER COMPOSITION

	Alabama	Alaska	Arkansas	Colorado	Delaware	Florida	Iowa	Kansas	Louisiana	Maine	Michigan	Minnesota	Missouri	Nevada	New Hampshire	New Jersey	New Mexico	Pennsylvania	South Carolina	Texas	Virginia	Wyoming
EPS Primarily through Public Providers	+	+	+	0	+	+	0	+	+	0	+	0	0	+	0	0	+	0	+	+	+	+
EPS Primarily through Private Providers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
EPS through Public and Private Providers	0	0	0	+	0	0	+	0	0	+	0	+	+	0	+	+	0	+	0	0	0	0

+ = yes
0 = no

TABLE X Negative and Conflicting Assessment: Identification of Significant Factors

OBSTACLES / STATE	Alabama	Alaska	Arkansas	Delaware	Florida	Iowa	Kansas	Kentucky	Maryland	Minnesota	Missouri	New Hampshire	New Jersey	New Mexico	N. Dakota	Ohio	S. Carolina	Texas	Utah	Virginia	Washington	Wisconsin	Wyoming
Lack of M.D. Familiarity with EPSDT	+	+	0	+	+	0	+	+	+	0	+	0	+	0	+	+	+	+	0	0	0	+	0
Insufficient Communication with State Administrators	+	+	+	+	0	+	+	+	+	+	+	0	+	+	+	+	+	+	+	0	0	0	+
Forms too Complex or Fail to Document Child's Health	NC	0	0	+	NC	0	+	0	+	0	0	0	+	+	NC	0	0	0	+	NC	0	+	0
Delay or Inadequate Fees	NC	+	+	0	NC	+	+	+	+	0	+	NC	+	NC	NC	0	+	+	+	NC	+	0	+
M.D.'s Not Allowed or Encouraged to do EPS.	+	0	0	+	+	0	0	0	+	+	0	0	+	+	0	0	+	+	0	+	0	+	0

+ = yes
0 = no
NC = not certain

Table XI An Assessment of EPSDT by State

	AL	AK	AR	CA *	CO	CT	DE	DC*	FL	GA	HI *	ID	IL	IN **	IA	KS	KY	LA	ME	MD	MA *	MI	MN	MS	MO
Provider Input	o	o	o	+	o	z	o	z	o	z	z	o	o	z	o	o	o	o	+	o	+	+	o	+	o
State Advisory Committee	o	z	z	+	+	+	o	o	o	z	+	o	z	z	o	o	+	z	o	o	+	+	z	o	o
Sufficient Communication	o	o	o	+	o	z	o	+	+	z	o	+	o	z	o	o	o	o	+	o	+	o	o	+	o
Physicians Included in EPS	o	o	o	+	+	z	o	o	o	o	+	+	+	+	+	o	o	o	+	o	+	o	+	o	+
State Medical Assn. Involvement	z	z	+	+	+	z	z	z	z	z	+	+	+	z	z	z	z	z	+	+	+	+	+	z	z
Covert/Overt Barriers Absent	o	+	o	o	o	z	o	o	o	z	o	o	+	z	+	o	+	+	o	o	z	+	+	o	z
Physicians Familiar with EPSDT	o	+	+	+	+	z	o	+	o	z	+	+	+	z	+	o	o	o	+	o	z	+	+	+	o
Positive Provider Attitude	o	o	+	+	+	z	o	z	o	+	z	+	+	+	+	+	o	o	+	o	z	+	o	o	+
Total Linkage	o	o	o	o	o	z	o	+	o	z	o	o	+	z	o	o	+	o	o	+	+	o	o	+	o
Equivalency	uc	z	o	+	+	z	o	o	uc	+	+	+	o	z	+	+	o	o	+	+	z	o	+	o	+
Fees Acceptable	+	o	o	+	+	z	uc	o	o	z	o	+	o	z	o	o	o	o	+	o	z	o	+	+	o
Forms Acceptable	uc	+	uc	+	+	z	o	+	uc	z	+	+	o	z	+	o	+	uc	+	o	z	+	+	+	+
Minimal Duplication	+	z	+	uc	o	z	o	z	uc	+	z	+	+	z	+	+	o	o	o	o	z	o	o	+	o
Appointments Maintained	o	+	+	+	o	z	o	o	uc	z	o	o	o	z	o	o	o	o	uc	uc	z	o	o	o	+
Outreach Sufficient	uc	+	+	z	o	z	uc	+	+	z	z	z	o	z	z	o	z	+	o	+	z	+	+	o	+
Physician Distribution Sufficient	o	o	+	o	o	z	+	o	o	o	+	+	o	z	o	o	o	o	+	o	z	o	+	z	o

z - data incomplete
+ - yes
o - no
uc - uncertain
nc - no comment
* - chapter sole source of data

Table XI An Assessment of EPSDT by State

	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	[illegible]	WV	WI	WY
rovider Input	z	+	+	+	o	o	+	o	o	+	o	o	+	o	o	+	o	+	z	+	o	+	o	o	o
tate Advisory Committee	z	o	z	z	+	z	+	+	+	o	z	z	+	z	o	z	+	+	z	z	o	[illegible]	o	z	z
ufficient Communication	+	+	+	+	o	o	+	o	o	o	+	o	+	o	o	+	o	o	uc	+	o	+	o	+	o
hysicians Included in EPS	o	+	o	+	+	o	+	+	+	+	+	+	+	+	o	+	o	o	+	+	o	+	+	o	o
tate Medical Assn. Involvement	+	+	z	z	z	+	z	+	+	+	z	z	+	z	z	+	z	+	z	z	z	+	z	+	z
overt/Overt Barriers Absent	o	+	o	o	o	o	+	o	uc	+	+	o	+	+	o	+	+	o	z	+	o	nc	o	o	o
hysicians Familiar with EPSDT	+	+	+	+	o	+	+	+	o	o	+	+	+	+	o	+	+	o	+	+	+	+	o	o	+
ositive Provider Attitude	+	+	+	o	+	o	+	o	+	o	+	+	+	+	z	+	o	+	+	+	o	o	+	o	o
otal Linkage	+	+	o	o	o	o	+	+	uc	+	+	+	o	+	o	+	+	o	+	+	o	nc	o	+	o
quivalency	+	o	+	o	+	o	+	o	uc	+	o	+	o	o	o	o	o	o	+	+	o	+	o	o	uc
ees Acceptable	+	+	+	z	o	uc	+	o	uc	+	+	+	+	o	o	+	+	o	o	+	uc	nc	o	o	o
orms Acceptable	+	+	+	+	o	o	+	+	uc	+	+	+	o	+	o	+	+	+	o	+	uc	nc	+	+	+
inimal Duplication	+	o	o	o	+	+	o	o	uc	o	uc	o	o	o	o	+	+	o	o	+	o	o	+	+	+
ppointments Maintained	o	+	o	o	o	o	o	o	uc	o	o	o	o	o	o	+	o	o	o	o	o	o	o	o	+
utreach Sufficient	+	+	o	o	+	o	+	+	+	o	+	+	o	+	+	+	o	o	o	+	uc	uc	uc	o	z
hysician Distribution Sufficient	+	+	o	z	+	+	o	o	o	o	+	+	o	+	o	o	+	o	o	+	o	o	o	+	o

z - data incomplete

uc - uncertain

Table XII Analysis of Regional Medical Consultant Activity

	I	II	III	IV	V	VI	VII	VIII	IX	X
Meeting or contact with Regional Commissioner SRS or Associate Regional Commissioner	+			+	+	+		+	+	+
Meeting/ongoing communication with MSA Regional EPSDT Coordinator and/or MSA Regional EPSDT staff	+	+	+	+	+	+		+	+	+
AAP facilitated regional meeting	+	+		+	+	+	+			
Participated in DHEW facilitated regional meeting	+		+		+	+			+	
Participating on Regional Interagency Task Force for EPSDT					+	+		+	+	+
Meeting/ongoing communication with Single State Agency Administrator and/or State EPSDT contact	+	+	+	+	fee schedule	form simplification		+	fee structure	+
Meeting/ongoing communication with State Health Department EPSDT staff	+	+	express provider concerns		+	screening contracts	+		EPS provisions	+

Question number	Yes	No	Uncertain	Comments
6. Fees a barrier	22	21	5	6. Of the 23 respondents citing a problem with payment, 16 relate to payment falling below the usual and customary fee, 3 relate to a lag in reimbursement ranging from 60 days to 12 months, and 6 relate to problems with both a lag and insufficient reimbursement. The majority of chapters suggest the development of a more realistic fee schedule. At least four chapters are currently engaged in meeting with legislators to address this need.
7. Other problems	23	20	5	7. Other barriers identified in order of frequency were: 1) limiting physician participation to diagnosis and treatment; 2) state unable/unwilling to understand and/or work with professional providers; 3) inadequate screening delivered through health departments.
8. Maldistribution	27	20	1	8. Suggestions offered to relieve problems with limited supply and/or maldistribution of providers concentrate on the possible services of PNP's and PNA's under the supervision of a physician. An intensified effort through social service agencies to provide recipients with transportation is the second most favored suggestion.
9. FPSDT vs. EPS	22	20	6	9. Chapters which report states concentrating on the full EPSDT program most often attribute the linkage and followup mechanisms to full physician involvement. With the physicians providing screening along with diagnostic and treatment services, the risk of losing clients in the referral process is minimized. A few responses indicate that an installation of a computerized billing system has resulted in an effective mechanism.
10. Outreach a barrier	14	26	8	10. Responses indicating outreach as a barrier to effective implementation did not focus on the degree to which it impaired the EPSDT program. Where low outreach activity is identified, lack of dollars and insufficient social services agency manpower are cited as the contributing factors. Two chapters specifically report that social service manpower did not increase with the inclusion of EPSDT responsibilities. One chapter stressed that the EPSDT target group is being "outreached" by several agencies.

ATTACHMENT 5

STATE CHAPTER EPSDT QUESTIONNAIRE - SUMMARY OF REPLIES

Question number	Yes	No	Uncertain	Comments
1. Familiarity with EPSDT	33	15	0	1. Of the 33 affirmative responses, 22 appeared to exclusively reflect the pediatric community. Frequently identified methods used to familiarize physicians with EPSDT are: AAP chapter meetings and bulletins, state/local agency mailings, and state/county medical association meetings and publications. Lack of familiarity is attributed to state agency neglect in effectively involving professional providers in the administration and implementation of EPSDT.
2. Sufficient communications	17	28	4	2. The majority of suggestions for improving communication indicated that 1) the state should allow professional providers to become , actively involved in an advisory capacity with the administration of EPSDT and 2) the state could take some initiative and send representatives to meetings of professional provider groups. It should be noted that several chapters are in the process of establishing or increasing communication with the state.
3. Appointment problem	32	9	7	3. Of the 32 chapters reporting appointment problems, 30 indicate that both screening and diagnostic/treatment appointments are affected. Two chapters report the problem is confined to screening appointments. Primary suggestions are 1) an increase in recipient health education, 2) an increase in social service manpower, and 3) allowing physicians to participate in screening as well as in diagnostic and treatment services.
4. Forms a barrier	11	31	7	4. Note that only 23% of the respondents are reporting forms a barrier. The affirmative responses to barriers created by forms lacked specificity. These answers tended to indicate that the problem is excessive detail and general complexity. (Suggestions for simplification focus on allowing physicians to assist the state in condensing the forms into a single page.) Chapters are in the process of working with the state to simplify forms.
5. Equivalency accepted	24	19	5	5. The affirmative responses indicate the option to determine equivalency rests with the physician. The physicians are provided with forms on which they may indicate an equivalent screen

Question number	Yes	No	Not certain	Comments
6. Services duplication problem	19	22	4	5. Public school health programs, physician medical examinations, and well-child conferences are cited as examples of services which are duplicating EPSDT. Suggested solutions focus on the need to have OMB spell out equivalency and for state initiated tracing mechanisms. States which cite little difficulty with duplication attribute the success over a broad spectrum which ranges from total service through primary care physicians to the exclusion of primary care physicians from EPS.
7.Other comments				7. Additional comments cover a broad area. There is only one distinguishable theme; a concern that rigid federal requirements sacrifice quality for quantity.

ATTACHMENT

STATE IMPLEMENTING AGENCY EPSDT QUESTIONNAIRE

Question number				Comments
1. Physicians' attitude	Passive 14	Cooperative 25	Combination 6	1. Many states identify screening as a critical factor in determining physician attitude - both passive and cooprrative. To a lesser degree physician involvement with the state in the planning and implementation of EPSDT is identified as influencing a cooperative attitude.
2. Physician shortage	Yes 30	No 15		2. Most states indicate rural areas experience a shortage of physicians. Some states report the use of physician extenders, health departments and mobile teams to serve these areas. Greater emphasis is placed on the lack of primary care providers versus specialists.
3. M.D.'s see Medicaid clients	Problem 8	No problem 34	Not certain 3	3. The states reporting problems in obtaining sufficient Medicaid providers identify fee schedules and high client case-loads as deterrents.
4. M.D.'s see Medicaid clients but not EPSDT	Problem 8	No problem 34	Not certain 3	4. The majority of states indicate physicians do not make any distinction between Medicaid and EPSDT. Those who participate in Medicaid participate in EPSDT. A few states indicate physicians participating in Medicaid refuse EPSDT clients because of inadequate fee schedule and/or the necessity to work with local health departments.
5. Informing techniques	Yes 43	No 1	Not certain 1	5. States generally report physicians are informed of EPSDT through letters combined with personal contact. Personal contact includes local agencies meeting individually with physicians, state representation at professional provider meetings, and the establishment of a liaison position with medical societies. Few states appear to have adopted a uniform procedure.

HEW Region I
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30
RECEIVED
JUL 12 1976

July 9, 1976

Mr. Jack Hoppock
American Academy of Pediatrics
Box 1034
Evanston, Illinois 60204

Dear Mr. Hoppock:

Thank you for agreeing to accept this late report from your Region I EPSDT Consultant. I understand you will forward it to MSA as an addendum to your national report.

My perception of the New England situation agrees for the most part with the state reports you have received. By and large health care for the poor is going well, but its documentation - a questionable goal - is fuzzy. Continuity of care (the "medical home") is threatened both by inappropriate demands for documentation and by arbitrary, capricious, and discriminatory under-funding. As was observed in the far west, the problem with EPSDT is "Fees and forms, forms and fees, fees and forms, etc."

In Maine strong and effective medical leadership has helped the state cooperate with the physician community in attaining mutually desirable goals. Tensions between physicians, the home health agencies and the public health nursing community - aggravated by widely discrepant state reimbursement - have relaxed considerably. A proper balance between responsibilities for outreach and care is being attained.

In New Hampshire a sensitive academician is EPSDT chairman. He sees the multi-problem poor as requiring extensive supporting social programs. New Hampshire, the only state still without a broad-based tax, does not share this social philosophy - at least at the gubernational level. Dr. Joseph Baldwin, who skillfully administers the state's EPSDT program, is a pediatrician himself. Without Dr. Baldwin's understanding of the problems of pediatrics New Hampshire's program could easily falter. His Child Health Assurance Program (CHAP) and his attempts at establishing an "equivalency" report are noteworthy. The New Hampshire reimbursement program, however, pays for preventive services at a lesser rate than for therapeutic services. Its computer digests reimbursement vouchers only if they are either preventive or therapeutic. Computers and bureaucracies in New Hampshire as elsewhere have difficulty in understanding that screening, diagnosis and treatment are concurrent processes in any comprehensive child health program.

Vermont's effective outreach program is a credit to the close relationship between the Chapter's EPSDT Chairman (who is also recognized as spokesman by the State Medical Society) and the health professionals directing the state's program. The recent abritrary action by the state temporarily to cut back Medicaid payments by 3% below the 1968 profile on which physicians had been paid for eight years was, however, discriminatory. ~~During~~ After an eight year span ~~when during which~~ all costs had risen considerably the state in 1976 arbitrarily selected health care for the poor as a service for which it would pay less. The $8.00 per visit payment previously in effect for a limited office visit was cut $.24 to $7.76. The administrative headache of processing this $.24 cut per visit had a punitive impact upon providers exceeding the magnitude of the cut itself. One wonders why the State's providers of road salt and concrete or secretarial services were not cut 3% in payments as well.

A long festering suit against Vermont has counterproductive potential. In a "res ipsa loquitur" manner, a low income group is demanding that the state produce data that it is complying with EPSDT. Absence of this data, the plaintiff contends, means non-compliance. Efforts to find each Vermont child a "medical home" will be frustrated if the State is forced to establish screening clinics in order to generate the data demanded by the plantiff. The interests of the poor would be better served if the plaintiff group would itself aid in the outreach program which brings Medicaid children into the mainstream of health care.

If Vermont has fiscal problems with a 3% payment cut, Massachusetts' 30% cut is ten-fold worse. The EPSDT "Blueprint for National Health Insurance" is indeed flawed. How can any government, state or federal, expect the enthusiastic participation of health care providers when it defaults by $.30 on every dollar?

In Rhode Island and in Connecticut the dialogue between providers and states is improving. Rhode Island's exhaustive (and invasive-of-privacy) reporting form may be changed. Connecticut has been set back a bit by the illness of a key state official.

In summary, headway is being made. Commitment to the concept of the "medical home" is incomplete. Fees and forms, forms and fees impede progress. Not until the poor are integrated into our health care system will their needs be met. "Separate but equal" has never ~~been~~ resulted in equality. The poor deserve equality in health care.

Sincerely,

James R. Hughes

James R. Hughes, M.D.

JRH/sept

HEW Region II

New York

The major emphasis has been placed on screening and there has been an effort to attempt to get the children and parents involved with an ongoing relationship with one provider, either a private practitioner or a clinic. There has been a generally favorable response to the value of having the New York State Ad Hoc Advisory Committee from the State Chapter of the American Academy of Pediatrics involved in the development of CHAP and in recruiting physicians' participation in the program. This has taken place in conjunction with the AAP chapter endorsement of the EPSDT program.

There have been some physician complaints about the level of Medicaid fees and of the claims for CHAP services. There have been reported in certain counties with a high population to physician ratio that the doctors are refusing to participate in EPSDT due to their lack of time, staff, laboratory back-up, etc. In areas that are rural there occurs a concentration of doctors in major towns and this also contributes to poor accessibility for rural families.

According to the current estimates, approximately 10% of doctors in New York City and somewhat less than 40% of doctors in the entire state participate in Medicaid and therefore are potentially working in EPSDT. It should be noted that more primary care physicians may participate in CHAP than regularly work vis Medicaid due to the reimbursement schedule for the CHAP exams through the composite fees.

The responsibility of informing the physicians is with the local Departments of Social Services and this information includes an explanation about CHAP, standards of care, sample of forms and instructions. In some counties the Medicaid Medical Director or Commissioner for Social Services has spoken to county medical societies and elsewhere, CHAP staff people have visited practitioners to acquaint them with the objectives of the program and of administrative matters.

The AAP representatives have worked out a simplified form with the state and county Health and Social Services group and this form is not complicated and easy to use.

New York State allows a Head Start or preschool examination to be equivalent to a "screening exam" and if the parent of a CHAP eligible child indicates that the child is under care, a form is sent for the provider to complete in return for which service there is a $15 fee.

There appears to be no major problem in payment of CHAP services with the standard fee of $21.20 considered by most adequate for the screening exam. However, in regard to the ongoing responsibility for follow-up, the Medicaid fees for some providers represent about half of the usual and customary fees. This is $7.50 for general practitioners and $12 for a pediatrician as compared with twice this for their usual fee for services. There are other formulae for calculation of the clinic fees and reimbursement schedule.

The problem of maldistribution of providers that exists in certain areas may possibly be relieved with the employment of pediatric nurse practitioners who clearly can accomplish all of the necessary screening procedures. The problem following the long delays in payment of Medicaid fees has been dealt with and seems corrected, although there is general agreement that there are not sufficient funds for outreach workers.

The physicians in New York have been informed by announcements in the State Medical Journal and State Medical Society Newsletter and in the AAP Newsletters as well as during AAP Chapter meetings and hospital meetings where CHAP has been discussed. There is a CHAP committee, as you must know, in each AAP Chapter and a pediatrician has been designated to promote the program and to relate to the Department of Social Services. However, this is not done in each county at the local level although it seems to be a useful managerial step.

There is need for continual attention to CHAP in order for it to function and for it to bring the individual pediatrician and other providers into the program. This can be facilitated via the AAP and through contact with the Department of Social Services at the local level.

One need identified is the problem which seems to be universal having to do with broken appointments, plaguing both the individual practitioners and the clinic providers. There must be additional outreach workers relating to this problem and some of the work of local Health Departments in conjunction with local Departments

of Social Services would be to visit the families who break appointments. At the recruitment interviews the importance of keeping any appointments made can be emphasized as part of dealing with an educational problem. This obviously relates to both screening and follow-up examinations.

Some providers feel that the State and County professional societies must take a more active role in their responsibility of convincing the individual doctors of their personal responsibility to provide public service.

There is a tracking system for follow-up appointments, linking families after the screening examinations with the treatment facilities. The CHAP program is still concentrating on the preschool child and just starting to work with the school children.

New Jersey

There is a well described computerized program for keeping track of Medicaid eligible families in New Jersey and this seems to be in place and working fairly well. However, it must be pointed out that different regions in this state function and relate to the EPSDT program in different ways. That is to say there is a variable response across this state ranging from total commitment on the part of the providers to active and organized antagonism and boycott. Factors that must influence the practitioners' participation are multiple. In some locations, the placement of the practice in a particular area is a factor with physicians in Ocean County, for example, reluctant to participate in any "government" program, whereas neighborhing counties have active participation.

The type and size and success of the practice influence a physician's willingness or unwillingness to work with EPSDT. The extremely busy solo practitioner is not anxious to accept new patients for screening. In summary, it seems that there has been a development of a more favorable attitude. As of last July, it was calculated that there was only 21% of participating potential among the pediatricians, generalists and family practitioners. However, all of the providers were involved with the diagnosis and treatment portion of EPSDT. This breakdown indicates that the program is considered as representing separate and more or less isolated components, rather than considering it as a whole package.

On the whole, most counties in New Jersey are considered to have adequate or better than average coverage of Medicaid recipients. However, since there was a 10% reduction in Medicaid physicians' fees, there was some decrease in the number of EPSDT providers. In some counties, Middlesex for example, there was a definite provider problem with eight physicians dropping out of the program and Ocean County continues to denounce the EPSDT. Overall, about 75% of the total number of licensed physicians in New Jersey participate in the Medicaid program.

Despite the local problems mentioned above in particular counties, the state claims that all recipients have been able to obtain care and there seems to be a difference between those who provide both screening and follow-up services and the group who may only provide follow-up services and who refuse to become involved in the screening of school children.

The providers are informed about EPSDT through a variety of sources including publication and descriptions in the Journals of the Medical Society of New Jersey and the New Jersey Osteopathic Association. There are Medical Assistance Program Newsletters sent to all participating private practitioners, to directors of pediatric clinics of participating hospitals and to all approved independent clinics. There are medical consultants employed in the local Medical Assistance Offices through New Jersey who have conducted personal contact with physicians to explain EPSDT, to solicit a commitment for program participation and to clarify any questions. These consultants have spoken at some county medical and state medical society meetings to promote EPSDT and answer questions.

The State Medical Assistance Agency has established a Child Health Care Advisory Committee composed of physicians from the State Pediatric Society, Family Practice Specialty and Osteopathic Association, as well as physicians in various practice settings in the state. This group provides a bilateral flow of information between the state agency and providers.

With the computerized system in place, there is less duplication of services if the family attends one clinic or goes to a particular provider. That is to say, there is a tracking system to indicate the child is under care and receiving adequate coverage with a particular

physician, at a Child Care Conference, Neighborhood Health Center, Head Start Center or elsewhere. If a payment claim is received by the EPSDT system, the child's name will not appear on a list for the outreach worker. However, if a client forgets, loses or does not wish to keep an appointment, or does not indicate that the child is under adequate care, then there may be duplication of services. Also, some families "shop around" for services and this appears to be unavoidable duplication.

There have been efforts to coordinate the EPSDT services with the Head Start programs and through an examination of paid forms it can be determined if certain outreach efforts can be avoided. The school system has been surveyed and New Jersey is trying to cope with the problem of coordinating their 28 million dollars spent annually for school health services with the Federal programs such as EPSDT in order to avoid an identical and parallel system for eligible school children.

To be balanced, this report must include comments from the others who represent the dissenting point of view. It is the opinion of some providers that New Jersey's Medicaid Administration has interpreted EPSDT "as a nuisance, a waste of time, and interference with State Health care and an evil that might go away if ignored." Hence, this group feels that New Jersey has delayed its promotion of EPSDT and provided as little services as possible. They continue to mention that very little in the way of public information or public relations have been provided, explaining that the state feels that the fewer physicians familiar with EPSDT, the less cooperation possible and the cheaper the state's costs.

The objection is not related to the quantity of information about EPSDT provided, but the quality is poor in the communication of descriptions of EPSDT. The comment has been made that "the nearer the health services approach the private practice mode of health care delivery, the better appointments are kept; and the more impersonal and institutional is the provider, the less interested and faithful is the recipient of EPSDT."

A suggestion was made for a better form with the possibility of a uniform form for both health evaluation and reimbursement that could be standardized for the country. Another objection was made in regard to the periodic well child visits being counted as EPSDT examinations, and the charge

made that through state regulations providers are submitting "bogus" EPSDT examination forms without fully appreciating the entire program and how the screening fits into the entire preventive program. There was an objection about the "arbitrary 10% cut for examinations and 40% cut in laboratory examinations" which served to have EPSDT "alienate and lose" a number of cooperating physicians.

The remark that since the basic concept of EPSDT is to bring the child into the "mainstream of medical care," it is essential that private practitioners be encouraged to participate and join in the EPSDT program as contrasted to the "Medicaid mills and hospitals." It seems that there is a definite opposition on the part of some New Jersey providers to the state Medicaid Administration and I have seen this but have no idea how this serious conflict can be avoided. It strongly resembles "party politics" and there are certain very strong representatives in this opposition group.

At a recent meeting (April 2, 1976) of the New Jersey EPSDT Task Force, it was pointed out that despite a concerted effort directed at recruitment of the school children, age group 6 - 15 years, more children in this age group were being screened. This was assumed to be the result of the efforts of the caseworkers who are concerning themselves with the siblings of the preschool age group. There is activity in the area of coordinating the EPSDT program with services provided through school health systems. There is interest in avoiding duplication, establishing the necessary linkages and in maintaining confidentiality of records.

One of the problems identified is in securing clarification on the percentage necessary in a given school district of Medicaid eligible children in order to have all of the school district's children screened under EPSDT. This problem has been part of the New York City discussion of similar services and deserves an answer from the Federal agencies.

Finally, something should be mentioned about the monitoring of EPSDT examination conducted in Health Department facilities. Having seen some of these reports, I personally have grave doubts as to the comprehensiveness of the

examinations being conducted. Certain parts of the examination must be done very hurriedly because there are major discrepancies which were obvious and apparent to me and must have been picked up by the monitoring teams. I have not seen reports about this, but if monitoring goes beyond the clearing of claim forms and goes into the specific findings then I would suspect that similar observations would emerge as to very poor quality of the EPSDT examinations. I also would like to indicate that I have worked with Pediatric Nurse Practitioners and Physicians' Assistants and found them to be without exception extremely thorough and comprehensive in their examinations and often much superior to physicians doing the same sort of screening.

I hope that the above provides some additional information and that you receive this not too late for your purposes. In closing I would like to add my personal regards to you and to the staff in Evanston.

HEW REGION III

The answers to your questionnaire from state officials and from state Academy of Pediatric Committee Chairmen is a story of great irony. Each writer can produce only a fraction of the picture. Each state conducted its own little experiement in nature. None of the writers are able to compare their state program with a realistic goal achieved through a series of objectives inherent in the legislation. Reading all the material in one sitting makes me intensely aware of my own limitations as well as the frailties which I see in others.

From this review I see a basic underlying flaw in the legislation. It calls for the development of a state plan which includes participation of health and welfare departments as well as private providers with an unproven negative form of motivating cooperation between these parties in the form of penalties drawn against federal welfare subsidies. The costs of producing a model program were monumental while the penalties were relatively trifling. These penalties were felt most by the Title XIX recipients; they were applauded by persons who sought to diminish welfare programs and possibly reinforce efforts to obstruct a state's EPSDT program.

The regional office which was expected to provide expert advice was also expected to advise st ates of nonconformance. These regional offices had many severe reorganizations and changes in staff. In my experience I was accepted by the Philadelphia office when I first introduced myself. With each attempt on my part to work with the regional office or to gain information I was received less cordially; I received less help and I had greater despair for accomplishing anything with the regional office. My frequent requests to participate in regional office staff visits to individual state programs was met with the lame excuse "you cannot come unless you have been invited by the state office". Needless to say I was never invited by a state office to any visit by staff from the regional office inspite of a close working relationship with the director of MCH of the state of Virginia and with the chief of the EPSDT program in the state of Pennsylvania.

Each state has strength and limitations which are not evident in your questionnaire survey.

Pennsylvania

Dr. Irving Wolman is one of the strongest leaders in developing EPSDT programs in the five states for which I am responsible. The State Department of Welfare seems to be committed to producing a meaningful program. For them Dr. Wolman has identified six subjects which would respond to various kinds of work and which would advance the development of this program.

The development of Pennsylvania's program has been stormy in part due to the great participation of all parties in the planning and early organization which ironically produced much competitive feeling and anger.

Their statistics would show a marked sudden improvement if the children who received screening, diagnostic, and treatment services through the health department were added to the statistics collected by the Department of Welfare. I believe Dr. Wolman will solve this incompleteness of reporting in the not too distant future.

The respondent from the state chpater is clearly not as well informed as earlier state chapter chairmen. This reflects a breaking-off of the state chapter from planning activities after proposals by Dr. Fred North and others were not wholeheartedly accepted. The state chapter might reassess their position with the help of pediatricians who are currently active on Dr. Wolman's council.

Virginia

The EPSDT program in Virginia has documented its progress elsewhere. Their statistics show the proportion of eligible children who have received EPSDT for each county in the state. The proportion of children who have received treatment or identified problems is also presented. The statistics show that this is a nicely designed effective program. In my judgment it is largely the result of the work of Dr. Patricia Hunt.

By putting together published statistics with the comments of Dr. Hays and my conversation with Dr. Patricia Hunt we may conclude that pediatricians are not active in the screening and immunizing elements of the program. They do accept selected children for treatment. It is clear that the Virginia State Plan does not promote the activity of private practicing physicians in periodic screening. Dr. Hays states, "Providers are apparently unwilling to provide all examinations and immunizations to eligible recipients

for the established reimbursement rate". This means that the reimbursement rate is too low to attract physicians. I still have a question whether or not physicians are even asked to provide screening procedures for the state plan.

West Virginia

In my only work with the West Virginia EPSDT Project I have raised the question as to whether the proportion of families eligible for Title XIX assistance have ever applied for or are receiving this assistance. I believe that families who are eligible often do not receive assistance because their geographic location does not permit them to get to the welfare department and the welfare department does not get to them. In addition families needing assistance are too proud to ask for it. Another form of pride sometimes prevents social services personnel reaching out to families who they do not see as deserving public assistance.

Delaware

Dr. Diane Kittridge is new to Delaware and to Public Health. She asked for consultation and for a chance to give greater information. With her activity she may have more impact on planning in the Department of Social Services than the chairman of the EPSDT Chapter Committee.

Delaware's public health services to children are highly centralized. They have not achieved traditions of active participation by practicing pediatricians in planning or policy formation. Dr. Kittridge's arrival gives the Chapter of the Academy a new opportunity to reapproach the Delaware State Health Department and the Delaware State Department of Social Services through Dr. Kittridge.

Maryland

Harry Bass' statement is a masterpiece of irony. He states "some physicians have expressed a desire to contract directly with the state to provide screening services and this arrangement is being worked out". This statement means that Dr. Karl Green has threatened to sue the state of Maryland for failing to meet federal regulations which require that physicians be notified of EPSDT programs and that physicians be eligible to be providers. In spite of Karl Green's offorts to become a provider as of January 1976 there was no method by which the state of Maryland could directly reimburse any physician as a provider. Since then it is now policy that Baltimore City and County Health Departments may arrange with individual physicians for reimbursement at a rate of payment lower than the reimbursement received by the health department for the same services.

The Maryland State Health Department has been in administrative turmoil and has shown no leadership. EPSDT was obscured from view from being renamed as a computer program entitled "Child Health Screening Information System". Public health nurses and county health departments did not even know that C.H.S.I.S., in fact, stood for EPSDT. As a physician eligible to provide services to children eligible for Medicaid, I can state that there was no announcement of EPSDT to Title XIX providers. To my knowledge there has been no announcement made by the division of Maternal and Child Health to the pediatricians or general practitioners of the state of Maryland concerning EPSDT. This is a very ironic definition of passiveness as used by Mr. Bass.

The Medical Liaison Committee of the State Medical Society has only been involved very recently. By working with the state medical society the program is almost assured that there will be little impact at the county level since the county medical societies deal directly with the county health departments which for a long time were the sole authorized providers for EPSDT.

"Methods to prevent duplication by the schools and EPSDT providers have been explored". In my experience this exploration is largely at the level of the conference table and is usually mentioned as a deterrent to program development. At the time of the writing to Mr. Bass there was no method to enumerate those children who had received the equivalent of EPSDT screening programs through children and Youth Projects.

REGIONAL MEDICAL CONSULTANT ANALYSIS

HEW REGION V

Illinois

The Department of Public Aid has the responsibility for total administration of the EPSDT Program. The DPA has the responsibility for outreach to recipients and follow-up and payment to providers for diagnosis and treatment. The DPA has a contract with the Department of Public Health (DPH) to provide screening and referral services. The DPH staff has responsibility for recruiting and monitoring the screening providers and submitting reports to the program progress and operation through DPA. DPA has prior approval authority regarding information issued by the DPH relative to the EPSDT (Medicheck) policies and procedures; communicates information to recipients with respect to the availability of EPSDT services; conducts an outreach program; and develops and implements policies and procedures.

The DPA has contracted with the DPH to provide screening services. DPH lists 412 private physicians participating in Medicheck, 338 dentists, 5 private clinics and 10 public clinics.

Providers are informed of the program requirements through the Medicheck Policy and Procedures Manual and the Regional Public Health Medicheck Coordinators who are responsible for informing, encouraging and assisting providers and potential providers.

Monitoring of services rendered by providers is done by the DPH review of screening invoices on a sample basis and a complete review of computer rejects. This is to assure that services claimed for reimbursement have been provided.

Conceptually, the Illinois Medicheck program is one of the most sophisticated in the nation. The screening package is comprehensive and complete and has been approved by both the Illinois Pediatric Coordinating Council and the State Medical Society. The program was planned to maximize the available resources and provide for continuous and comprehensive care in a workable framework. Conceptually, it provides for the provision of a "medical home" and the maximum utilization of other community resources such

as mental health facilities, crippled children services, special education diagnostic services, special education classes, etc.

The same doctors, dentists, and clinics that provide Medicaid services are the providers for treatment of EPSDT referrals. When a physician or dentist provides a screening, and indications are that the child needs immediate diagnosis and treatment, such are expected to be provided by him if within his area of competence, or referred to specialist if indicated. The few Medicheck "screening only" providers are required to have resources available to provide diagnostic and treatment services.

The State has established follow-up procedures, placing responsibility with the service worker who must contact the recipient within 45 days.

Basically the physicians in the state are all familiar with EPSDT as a result of an early initiative by the Department of Public Health with the cooperation and assistance of the Illinois Chapter of the AAP and the State Medical Society. The providers have noted dissatisfaction with the complexity of the form to be completed, and the reimbursement of approximately 60% of usual and customary fees for the service. The equivalency examinations are permitted as long as the Medicheck form for the given age is completed. The identified barriers for successful provider participation are the usual low fees and regulatory red tape.

The Illinois Medicheck Program has several major problems, none of which could not be overcome without too much difficulty.

Political expediency has necessitated a low pitch approach to spending of Title XIX funds. Since EPSDT is a fairly new program, it has been given fairly low priority. Likewise, although originally under administration of a public health pediatrician, the present administrative procedure had been dictated by bureaucrats who are experienced primarily in the income eligibility determination arena. Service workers are not performing the follow-up functions as described by the state, and organized outreach has left much to be desired. Since most of the eligible population reside in areas served by neighborhood health centers and hospital outpatient departments with much higher

pre-negotiated rates per visit than the Medicheck Program payment scale permits, many eligible encounters are not documented on the Medicaid form on a strictly monitary basis. Thus, there are probably many more individuals receiving this service than has been documented.

The attitude of the provider, especially the pediatricians, has been very commendable. Since the model is built on the private practitioner providing all services within his competency, the Illinois Program, if given proper DPW and DPH support and priority, could be a model program.

INDIANA

The Indiana EPSDT Program is administered by the Indiana Department of Public Welfare. There are no agreements between this agency and other public or private agencies. There are six Public Assistant Consultants who work directly with the 92 counties in all areas of the Medicaid Program. These consultants as well as other State Office personnel are available to the counties for assistance.

Letters are mailed or given to each recipient at the time of determination of eligibility. The State has not prepared a brochure or other informational material on the program. It uses its Medicaid brochure, which list EPSDT as one of its services.

The caseworker is the individual designated to give specific information to the recipient, and make a health assessment of persons under 21 who are already receiving financial assistance in addition to maki health assessments of all newly eligible as soon as the eligibility determination is made.

The State Agency provides each county with a listing of Medicaid providers by specialty in their geographic area. If a recipient does not have a physician, the counties use the listing for referrals. The primary providers in the state are the private. Most recipients have a Medicaid provider on a continuous basis.

Indiana does not have a screening package per se, and has taken the position that the practitioners should be given the responsibility for performing whatever tests and examinations his professional judgment deems necessary for the individual child. Since the State Agency uses all Medicaid certified practitioners in clinics in providing EPSDT services, no special agreement in relation to the program has been made.

The periodicity for reassessment by the caseworker is specified as yearly from ages 0 to 6 and every two years from ages 6 to 21.

There are no uniform standards established for referring recipients for further diagnosis and treatment. Treatment can be secured from the physicians, specialists, hospitals, or medical centers. The counties are not normally notified by the providers when recipients are referred for further diagnosis and treatment unless prior authorization is required. County officials stated that there were sufficient providers for physical, hearing, visual and dental service.

Medicaid providers are responsible for diagnosis and treatment. Caseworkers make referrals to the doctors when the caseworkers determine it is indicated. It is the family who must "feel" there is a health problem and a need for treatment. There is no systematic method of followup in relation to treatment.

The AAP questionnaire to the State EPSDT Administrator contains very little additional information. They did note, however, that the physicians' attitudes were cooperative and concerned. They also note that a large percentage of the state physicians participate in

the Medicaid program. Physicians refuse to see Medicaid patients to only a minimal extent.

The AAP questionnaire to the Indiana Chapter was never answered.

Since Indiana was one of the two states in Region V who were penalized for noncompliance to the EPSDT Program, I originally made them number one priority for assistance. However, the identified EPSDT Committee Chairman was most difficult to contact, and when I finally contacted him, I learned that he had been replaced. I then contacted the new chairman who had not had much time to evaluate the situation. The next contact was made with the Indiana State AAP Chapter Chairman. It was learned from him that the AAP Chapter in Indiana is essentially the pediatric section of the State Medical Society. This presented a most untenable situation, since the State Medical Society had evidently not given its sanction, approval and support to the EPSDT Program. When the possibility of arranging for a meeting with the AAP and State Medical Society members and the AAP EPSDT administrator, and Regional Consultants, was suggested, the answer was, "Don't call us, we'll call you." No further contact has been made.

MICHIGAN

Michigan has one of the better EPSDT programs in the nation. It is exceptionally good, with the Department of Social Services contracting with the individual County Health Department for screening purposes. The private providers perform the definitive diagnosis and treatment of the referrals from the screening. Categorical as well as medical needy individuals up to age 21 are included with

a re-screening schedule of 6 months, 1, 3, 5, 8, 11, 14, 17 and 20 years.

There is an EPSDT interagency management by objective system to monitor the operation and development of the program.

The County Social Service Department vary with their outreach activity and with the communication with the Health Department. There is good evidence that effective outreach decreases the "no shows" in screening and increases the followup for definitive diagnosis and treatment. Although the state is concentrating on its screening efforts, the definitive diagnosis and treatment aspects are functioning fairly well. There is a sufficient number of providers in a sophisticated enough system to insure that all definitive diagnosis and treatment occurs within 60 days. Approximately 70% of the referral forms are returned by the providers and there is a need for better coordination between the local Health Department and the provider to return the form and return it early. The approximately 40% "no shows" are followed with repeated contact from the Department of Social Service until the screening is performed. The practice of routing the applicant to the local Health Department Centers for screening (instead of to private providers) simplifies and minimizes efforts required to follow up on the "no shows." The questionnaires completed by the State AAP and the State DSS were pretty much in agreement. R. Kirk, M.D., Program Director, Child Health Division, of the Michigan Department of Public Health, completed the AAP questionnaire.

There is a communication problem between the professional health provider and the Department of Social Services, but a better relationship between the provider and the Department of Public Health.

I personally can't understand why they do not permit the Head Start and Preschool examinations to count for a periodic EPSDT visit.

All components of the screening package have been separately identified by the Department of Public Health. They have screened a very large number of children with a high referral rate. The 116 screening centers have a total maximum capacity rate of 20,000 spots per month for which the DSS is responsible for keeping filled. The DSS claims that about 1/2 of the eligible children have already been screened. "No shows" are a problem and they are refining their procedure to assure followup and treatment of abnormal screening results.

The cost is $22.91 per screen and the total state budget for the EPSDT program is $3.6 million - 7% is figured for administrative cost. The involved state agency believes that the local centers are better able to provide a more comprehensive screening service than could be provided in many local medical physician's offices.

This is one of the better and more successful programs in the nation. The Department of Public Health screening centers appear to be doing their job satisfactorily and there is probably better communication between the primary care provider and the involved state agencies than is the usual situation. The major state administrators are sophisticated and apparently trained public health professionals.

MINNESOTA

The EPSDT Program in Minnesota is run by the Department of Public Welfare. There are two forms of the EPS components: nurse physical assessment or physician physical examination. The more commonly used nurse physical assessment requires a followup agreement for definitive diagnosis and treatment. However, there is physician opposition to this part of the program. A rather complete medical and laboratory package is required.

EPS is not limited to Title XIX children only. In fact, less than 50% of the children are eligible for Title XIX. Screening is available on an annual basis. There is no specific periodicity with respect to age. The referral rate from the nurse physical assessment program was approximately 50% in the quarter ending December 19, 197[illegible] The County is responsible for followup and definitive diagnosis and therapy.

A review by the HEW Region V MSA representative revealed that Minnesota did not meet the informing requirement for the July to September 1975 quarter. There is also not much evidence that the state had been insisting that the County Welfare Departments follow through with its directive to implement EPSDT. The state could not provide assurance that the counties were implementing the EPSDT program.

The AAP questionnaire to the state DPW revealed that not all of the physicians were well informed about the program, especially the difference between screening and a regular physical examination.

There was supposedly no physician shortage, but transportation was the main problem in the rural area. Since all of the Title XIX children are eligible to receive physical examination under the regular Medical Assistance Program, there was some reluctance from the part of physicians to become involved in a separate EPSDT program.

There is a serious duplication of service problem which is attempting to remedy. Since the school health examination, and Head Start Program examinations, Community Clinic evaluations, Indian and Migrant Program examinations, all qualify for the comprehensive screening program as required for EPSDT, there is a need for integration of all of these programs with the EPSDT.

Dr. W. Wilder, representing the AAP, raised some serious issues which resulted in a meeting on March 31, involving the providers represented by AAP and the CHF. According to the MSA Director of the EPSDT Program, Ms. Bea Moore, the individual patient can use his personal physician even though the state has set up a screening clinic. The state must provide the physician with information on required procedures, and must pay the physician according to state-established fees. The state also set the standards relative to the quality of the providers. It was also decided at this meeting that the AAP would work very closely with the Child Health Care Committee of the Minnesota State Medical Society on informing and recruiting providers, and the AAP Pediatric State Chapter Chairman would assume responsibility for leadership in working closely with the state.

According to statistics, there is a 50% referral rate from the

nurse physical assessment program. That certainly suggests a carefu analysis of the reasons for referral and brings up the question that to why screen at all with that high a referral rate. I trust that by now there has also been a periodicity with respect to age guidelines. Since there was a stated need for cooperation between the state and the public and private providers, the March 31 meeting should be a step in the right direction to solve this problem. The state still seems concerned about provider accountability and assurance that all components of the EPSDT are completed. One would anticipate that the state professional regulatory agency could assume responsibility for certification of the involved professionals, and that the DPW could include a question on their EPSDT statement forms to be completed by the provider acknowledging that all components of the assessment for examination had been completed.

The private providers have accepted the program of screening by the local health department. However, there is some question as to the cost effectiveness of this approach.

OHIO

The EPSDT Program in Ohio is in the Department of Public Welfare. However, the Department of Public Health certifies the Ambulatory Health Care Centers and is responsible for resource development. Both AFDC and SSI recipients are eligible. The social service staff from the DPW follows up, on request, for screening services or on those eligible who have not replied to forms.

The screening package consists of a history and physical examination

obvious physical defect and heart. Optional tests are hemoglobin, hematocrit, screening for blood, urinalysis, sickle cell screen, and chest x-ray. These tests are performed at ages 1, 4, 7, 11 and 16 years. The recipient may use their local medical doctor or physician from a state list. Other providers include hospital outpatient departments, ambulatory health care centers, and health departments and clinics. Definitive diagnosis and treatment is performed by Title XIX participating physicians, dentists and clinics. The screening facility may perform the definitive diagnosis and treatment themselves or must have a formalized agreement with a back up facility. A computer print-out alerts the County Welfare Department for followup. This component is monitored and confirmed by the state. The local county staff is knowledgeable in the location of specialized providers in urban centers or neighboring counties when there are not enough local providers in the immediate vicinity to provide the definitive diagnosis and treatment services.

Implementation began late in 1974, and there has not been much encouragement by the state to the county to implement the program.

The Medicaid Management Information System has had many problems and delay in payments to providers resulting in a not too pleasant relationship between the state and the providers. Likewise, some counties do not have a good relationship with the state and this has handicapped implementation at the county level.

In the 50% of the counties visited by the HEW-MSA-EPSDT representatives, the providers mentioned the need for clarification of

information and other assistance from the state.

Each county has developed a system to actively follow up on referrals, once the screening invoice is received and a need for referrals known.

There is a mixed attitude among the providers concerning the program. The negativism is directed toward Medicaid and the billing and payment problems. The State Medical Association has formally endorsed the program, but has done little to encourage involvement.

The rural areas have benefited from the development of new health department clinics to fill the gap. This has provided for more efficient use of available physician manpower.

One of the primary sources for the hesitancy for providers to participate in the EPSDT Program is a special reporting form. However, the physician can bill and be paid for an equivalent EPSDT exam on the regular Medicaid invoice. There has also been some covert opposition due to concern of the value of preventive services.

Although Head Start and Child Development Center examinations are acceptable, an attempt to retrieve these equivalent exams will probably not be very fruitful. There has been less duplication of services than was expected; few screening exams are as comprehensive as the EPSDT exam.

In general, many more physicians are willing to participate in the definitive diagnosis and treatment than in the screening. Payment is generous for screening, and usually adequate for treatment. The

problem is delayed payment, because the screening form is not completed correctly. The screen payment is so generous, in fact, that some providers are abusing the program. These problems can be overcome by the use of better judgment by the claims examiners in delaying the payment and by better instructions for filling out the claims and perhaps even simplifying the forms.

One of the main problems has been the lack of medical input into the administration of the program, plus a general lack of administration of the program. There has apparently been some apathy at the state level. A standing advisory committee was recommended, but Welfare has refused to appoint and pay for it. A small committee, meeting monthly could assist with provider relations and support, assist with monitoring the program, assist with judging of claims that seem unreasonable, advise on screening test, and advise on facilities for treatment.

The overall program, although slow in starting, is making steady progress. It has the potential for being one of the better programs in the nation. There appears to be a definite need for more communication and informing of other professional providers in addition to the pediatrician.

WISCONSIN

The status of the EPSDT provider participation in Wisconsin is somewhat difficult to ascertain since the program is functioning unevenly. The Counties need encouragement by the State to offer the necessary services to effectively reach the eligible population. There is some

problem in determining the responsible person for coordination in a County Welfare office; there is the need for County assistance with outreach; some problems still exist with the notification of new applicants; and there is some difficulty with the cooperation of the County Health Department in some counties.

According to information received from the Wisconsin Department of Health and Social Services which administers the program, the physici provider attitudes vary from passive to somewhat antagonistic since the screening programs are mostly done outside of physicians' office. There is a physician shortage in the rural areas, and many physicians object to completing the EPSDT billing forms and prefer to use the shorter Medicaid billing forms. The state notes that each screening agency has at least one physician on the EPSDT Advisory and Review Committee. This physician is allegedly reporting the EPSDT activiti to the County Medical Society. According to the State questionnaire, there is not much duplication of EPSDT and other services, and Head Start is using the EPSDT screening. Very few physicians are doing audiometric examinations, and there is a shortage of dentists willing to serve Title XIX patients. The state notes that EPSDT offered an excellent health education benefit and also an opportunity to deve knowledge useful for screening if National Health Insurance is implemented.

According to the AAP questionnaire, there is very little physician input, since the pediatrician doesn't understand the program, and the family practitioner has less information. However, there is good communication between the health profession and the State EPSDT

Administrators. According to the AAP, the main problems are "no shows" and outreach. There is much program overlap, basically duplication with what could already be obtained from ADP. The providers believe that there is no physician shortage problem, but there are too many forms to be completed. The state does not permit Head Start, Preschool, and periodic well-child visits to be equivalent to a screen.

The provider questionnaire states that the physicians are willing to provide the entire program in the office, but the State Administrators won't permit it. They note that screening by non-physicians is too expensive. The most provocative statement is "do health care and stop worrying about statistics."

The Division of Health was designated by the Department of Health and Social Services for implementation of EPSDT. This is done mainly by a non-physician screen by local public health agencies under contract with local county boards and the state Title XIX agency. The followup and definitive diagnosis and tratment are performed by the private physicians and dentist, clinics, and possible outpatient departments which are certified for Title XIX service. However, there is apparently abundant interagency referrals, and followup information by the Health Department is needed. The screening starts at 6 months of age and the screening intervals appear much too long. There is no mention of mental health evaluation in the screening package. Some of the statistics which I reviewed were most interesting: At the Green Bay Free Clinic there were 350 children screened and 175 referrals. In Milwaukee County there were 1067 children screened and 439 referred for diagnosis and treatment. This certainly justifies

the providers' concern regarding the cost of screening.

It appears that Wisconsin is moving along slowly and unevenly with a mixed degree of provider participation. Since it is apparently the state's desire to have a non-physicians' screening program, the administrators have the challenge of quality surveillance of any screening programs, equivalent programs definition and acception, and professional provider education, incentive, and commitment for handling the referrals for definitive diagnosis and treatment.

I personally, as a pediatrician, have very serious concern for an initial visit deferred until 6 months of age and the long intervals between screening - especially growth and development and immunizations.

ROBERT COHEN, M.D.

HEW REGION VI

OKLAHOMA

This is the only state in the Region utilizing private physicians for screening, diagnosis and treatment, and this is done generally in the physician's office. Both the state agency and the chapter spokesman feel that there has been adequate physician participation because most physicians are accepting Medicaid patients. I do not know what percentage of the providers are pediatricians as opposed to family practitioners and other disciplines. The chapter reports that payment schedules are in line with usual and customary fees and are satisfactory with providers. Failure to keep appointments is a problem for the initial evaluation but follow through for treatment is generally good since treatment is started at conclusion of the screening if indicated. One question that has been raised about the Oklahoma program is that an insufficient number of eligible children are being seen since statistics available do not clearly distinguish first appointments from followup visits.

ARKANSAS

There is a basic disagreement between the chapter and state agency as to the success of the program in this state. Pediatricians in this state have been apprised of the program but feel that they have not been adequately involved in formulating plans to reach the goals of EPSDT. The pediatricians also think the mechanics for reimbursemen are too cumbersome and cause unacceptable delays in payment for servi The EPSDT Program Coordinators I have talked with from Arkansas report that there was good cooperation with private providers when the progr was initiated, but some of the more faithful providers have dropped

out because of these problems with payment. Adequate communication between the state agency doing the screening and the private providers doing diagnosis and treatment seems to be one of the major problems in Arkansas.

NEW MEXICO

As the question has indicated, there is great disagreement between the state health department and the state chapter in regard to the success of the entire EPSDT Program. Again, communication is a definite problem. As far as I can ascertain, the complaint of the chapter spokesman that pediatricians have not been adequately involve in planning and executing the program is valid. My contacts with EPSDT Coordinators indicate that finding private providers for diagnosis and treatment is a real problem in New Mexico. Of course, the lack of medical facilities in the large, partially settled areas of this state is a major factor in this problem. In summary, there is a great feeling of distrust and lack of communication between private pediatricians and the state health department in New Mexico.

LOUISIANA

Unfortunately, I have had little input regarding EPSDT in this state. I have met with some of the EPSDT Coordinators, and some of these dedicated people were having difficulty finding providers for diagnos and treatment, particularly in dental services. One of the main factors has been an insufficient amount of state funds to provide for these services.

TEXAS

Pediatricians in this state have had good rapport and communication with the Department of Health Resources, the state agency responsible for administration of the program and for doing the majority of the screening. This has been accomplished through a committee of pediatricians appointed by the Texas Chapter and the Texas Pediatric Society to work with the EPSDT Coordinators of the state agency. In general, providers for diagnosis and treatment have been adequate, but some quality providers have dropped out because of low fee schedules for services and because of the relatively large number of appointment failures. The Department of Public Welfare has recently instituted some changes for case finding and follow through which hopefully will alleviate the problem of missed appointments. Recent increases in fees allowed for such services has helped, but this is still a problem area. Some private providers have expressed a desire to be involved in the screening as well as diagnosis and treatment, and we have talked with the Department of Health Resources in regard to this. To date, no changes have been made because of the existing contracts between the Department of Health Resources and local health departments doing the screening. The majority of providers for diagnosis and treatment are not pediatricians. This is primarily because of geographic factors as pediatricians are generally not located in sparsely settled rural areas or in the lower socio-economic areas of the large cities.

After serving as EPSDT Coordinator for this Region for almost one year and being involved with the Texas program for over two years, I have mixed feelings regarding the success of EPSDT. Undoubtedly,

a significant number of children have received quality medical and dental care which probably would not have been provided them previously. Certainly a lot of long present physical defects have been corrected. Hopefully, some of these families are learning the importance of preventive medicine as opposed to crisis care. However, I feel the goal of getting these children and their families into the mainstream of private medicine and out of the emergency rooms or outpatient clinics of the city hospitals is not being accomplished in most areas. This is probably one of the penalties paid for supposedly more efficient and less expensive mass screening as it currently is being done in most of the states. I think more pediatricians would be willing to provide total care for these children if they had more involvement in the planning and implementation of the program and if reimbursement were more in line with usual and customary fees.

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I would like to state that I have found that the quality of screening done by the nurses or physicians' assistants has been consistently good and that the screening teams are generally trying to do a good job. I have also been very impressed with the abilities and dedication of the local EPSDT Coordinators I have been privileged to meet. Undoubtedly, these people would welcome more input from the pediatric community.

The most frustrating aspect of the assignment has been, "...I detect an undercurrent of misunderstanding and distrust flowing between the higher levels of agencies responsible for EPSDT and private

physicians and vice versa. I would not attempt to blame either side entirely for this feeling, as I am sure fault lies on both sides. However, if the goals of EPSDT are to be met, this problem must be overcome. Perhaps more open communication between the agencies and medical organizations can help solve this problem."

STEPHEN MADDOX, M.D.

HEW REGION VII

IOWA, KANSAS, MISSOURI, NEBRASKA

Generally, the survey showed a number of completed answers which was almost 100%. Responders identified a wide range of professional concerns. Responses indicated significant involvement in the EPSDT program both in development and implementation to its present level.

Relevant comment is that the AAP Chapter Chairmen's responses reflect provider experience and viewpoints of pediatricians. It seems their responses are both positive and negative. Their comments were with candor and in depth. It is my opinion their responses reflect professional concern and knowledge of contemporary methodolo systems and innovation as it relates to comprehehsive health care of children by dedicated individuals of demonstrated capability. It is equally important to note the replies to the State Agency questionnaires. It would be my opinion the answers were by employees of state agencies assigned responsibility for EPSDT administration, e.g., a state Division of Social Services, Welfare or Health. The replies indicate professional capability and concern.

In reference to the technical assistance provided previously and the evaluative assessment of effective achievement of contract objectives, the following summary of questionnaires is forwarded. Identified are areas where change may be positively effectuated. Areas such as communication and linkage are noted so that you may systematically consider them as you appraise current project status and more definitively evaluate it. Other problems are also identifi which are in need of being addressed and overcome in the future by

utilizing appropriately developed technical assistance in indicated areas to reinforce positives noted and eliminate negatives.

Chapters' responses indicated positive awareness and familiarity with EPSDT goals in the states of Nebraska and Iowa. There was negative awareness in Kansas and Missouri.

Chapters' responses regarding communication between state EPSDT providers and administrators indicates a positive reply by Nebraska and negatives from states of Missouri, Kansas and Iowa.

Chapter responses indicated a major failure to keep appointments for EPSDT in Iowa and Kansas. There was no indication of significant appointment failure in Missouri or Nebraska.

Responses indicated acceptance of the forms and records used in all states of this region. There were no suggestions for improvement received. This probably indicates resignation to the inevitable rather than "acceptance."

Chapter responses indicate "equivalency" concept is allowable in Kansas, Iowa and Missouri and is accomplished by obtaining and submitting properly an appropriate form which is technically difficult.

The responses to question regarding payment problems indicated no problem in Nebraska which pays usual and customary. Problems were indicated in Iowa where lower than usual and customary fees are paid. Missouri indicates significantly lower payments than usual. Kansas

utilized two systems, one being usual and customary.

Responses indicated there is a lack of participating providers in the state of Iowa and suggests an alternative in Nurse Practitioners. Kansas and Missouri list administrative barriers as their foremost concern. Nebraska indicates 90% of 21,000 screens performed as conducted by physicians.

Regarding professional providers (manpower) availability and distribution indicates rurality as the principal identified factor in Kansas, Missouri, Iowa and Nebraska. Usage of nurses in Iowa and transportation was a suggested solution in Missouri.

Chapter responses identified Kansas, Missouri and Iowa as concentrating on screening EPS. Nebraska had a large percentage of physicians who perform the complete EPSDT program. The child's caseworker is relied on for linkage in instances of referral. County Health Department nurses perform screening in their dominions; nurse practitioners do screening along with other paraprofessionals in urban Missouri locations.

Outreach is performed statewide in Nebraska under auspices of Welfare Office. Missouri operates similarly. Chapter in Iowa did not comment. Kansas enclosed communications indicating reduction of operating funds for an outreach program conducted in that state by County Welfare agency. St. Louis Head Start conducts an outreach and Kansas City, Missouri, expects to initiate an outreach effort soon, reportedly.

Other comments: Chapter presidents in Kansas and Missouri also attached letters indicating existence of problems along with proposed solutions or actions being initiated to remedy the specific difficulties. Favorable outcomes of the indicated activity should ensure improvement in accessibility and availability of needed health serives, the four states of this region noted.

State Agency Questionnaire Analysis

In reference to the question relating to physician attitude and cooperation, the administrator response in Nebraska indicated "excellent." Kansas replied, "variable." Missouri "acceptive" and Iowa "generally cooperative."

Relating to physician manpower, Nebraska indicated ten or twelve counties lack physicians and dentists. A shortage of physicians in northern and southern Missouri counties is stated. Thirty counties in Iowa utilize nurse screening providers. Kansas has seven counties with one or less physicians, and County Health Departments provide nurse screening for EPS throughout the state.

In reply to the question regarding physician refusal to see Medicaid patients, administrators in all states in this region indicated no problem of this type. Iowa, Nebraska and Missouri indicated there are a few physicians who have refused to add to their existing patient clientele.

Replies regarding physician willingness to see Medicaid but not EPSDT indicated availability of and willingness to participate by physicians in all states.

The question seeking to determine the method of informing physicians concerning EPSDT was answered by administrators indicating Kansas uses a statewide letter; Nebraska utilizes letters, pamphlets and bulletins; Iowa disseminates a handbook; and Missouri uses letters to vendors.

Regarding duplication of services, replies indicated a problem previously existed in Nebraska, but currently has been minimized by client questioning and isolation and information concentration to high risk recipients. Missouri acknowledges some duplication of services exists and lists Head Start as an example of payment duplication. Iowa uses utilization review and Kansas believes duplication minimal.

Other comments included indicated that Kansas has difficulty with physicians' reporting on screening referrals. Missouri notes screening is accomplished at intake and periodically at times of reinvestigation. Caseworkers and large health centers are used to control screening forms.

The foregoing comprises the summarization and analysis of Region VII EPSDT questionnaire data and recommendations. The information contained, when combined with data and recommendations from other regions, should enable comparison and evaluation of the nationwide EPSDT technical assistance endeavor. It should also assist you in identifying the strengths existing in the methodology currently utilized as indicated in the replies of the provider and state administrators and the recommendations derived from consolidation of the regional replies.

LEWIS N. BASS, M.D.

HEW REGION VIII

I am writing, as per your request, a summary of the previous years EPSDT effort from my vantage point as Regional Coordinator. My remarks will be to the point, many of them are only of my personal opinion and should not be construed to reflect other opinions.

My main functions were to achieve liaison with Regional SRS and MSA, and to try and have pediatrician input into the Regional Office's decisions and decision making. I have not met personally with either state AAP EPSDT representatives (except for Colorado) or with the various state personnel responsible for implementation of EPSDT. This was a shortcoming.

I have read the comments you forwarded to me from the state AAP EPSDT representatives, and will comment on each state then discuss my viewpoint on the regional-level situation.

Colorado: has a good program which has been enhanced by meeting of AAP state representatives with the State Health Department Social Service Director. As stated in the comments, there exists a lack of Social Service's understanding of what screening means. To wit, I heard they wanted to screen for emotional disorders - a concept that was aptly and appropriately rebutted by AAP representatives. The provider cooperation has been good and reimbursement acceptable.

North Dakota: has a better plan on paper than exists in practice. The screening component is highly variable in quality, as many of the providers are rural practitioners who are understandably preoccupied with acute care. Inadequate liaison with the state health department was previously listed in the reports.

South Dakota: is unique for there are no state-wide Health Department facilities, and the private practitioners have undertaken mostly all of the EPSDT burden. From what I've heard no comprehens

screening exists, for it's all included in the physical examinations.

Wyoming: remains very conservative, a ruggedly individualistic physician (and patient) population. As per the report, considerable and justifiable, concern over reimbursement exists.

Utah: has a good EPSDT plan, however, its requirements for eligibility are quite stiff. There is good provider cooperation.

Montana: suffers from the fact that, for the most part, physicians were not included in writing the state plan. There is extensive use of mobile vans for screening (a concept I abhor), and the vans screen and the physicians diagnosis and treat. Service-wise, they are providing needed care, but where is the medical "home" for the child? In addition, there is poor tracking of the children identified by the mobile van screen as having problems.

Regionwide: I am opinionated. Unfortunately, I have very few solutions, but a lot of questions and, as I see them, unresolved problems.

(1) I see little in the way of governmental commitment to EPSDT. I'm sure it exists, I just don't see it. There is no one who ramrods the effort and the bureaucracy is stifling. I don't really think anyone is in control. Whenever it comes to making a decision, there are so many different agencies to consider, that I don't know what happens. We need a dictator to implement EPSDT.

(2) Primary focus by MSA on administrative matters and not on health care. The year was spent, quoting MSA, as "putting the pieces together" (whatever that means) and "rearranging the pieces" (whatever that means). Being in compliance is a "joke". It's cheaper for a state to take the penalty than to implement the program, and with all of the rules and regulations, they probably should. The linkage

of LPS and DT and quality of care was not of foremost concern, compliance with administrative guidelines was predominant.

(3) "Task force folly". Over twenty people attended the first regional task force meeting; the last one consisted of a "chat" between the regional MSA Director and myself. We agreed to have a meeting in North Dakota with all necessary parties invited, but, of course it was cancelled because "all the pieces weren't as yet in order". Let's face it EPSDT is not regarded as high priority.

(4) EPS vs. DT: The linkage between screening and diagnosis and treatment needs to be resolved.

(5) Follow-up: Who knows?

(6) "Rent-a-Screen" or Mobile Vans: How does this create a medical home for the children? Who monitors the quality of their work? In summary, to me, mass screenings do little to enhance parental concern or to stimulate parents to improve their child's health status. To me, mass screening is a medical tease.

(7) The outreach workers who informs eligibles about EPSDT is frequently the least sophisticated member of the team. If they don't truly understand EPSDT, how can they be effective when imparting information?

(8) It appears that county health departments can do essentially what they want.

HEW REGION IX

ARIZONA

As yet Medicaid does not exist in Arizona, so EPSDT is not functioning. It is hoped at this time that Medicaid will commence in July as well as an active EPSDT program. The EPSDT program is ready to go now, primarily due to input from the State Department of Health with Arizona Medical Association and American Academy of Pediatrics' support. The committee has been functioning and meeting on a regular basis at the State Department of Health in an attempt to work out guidelines for EPSDT. It is primarily an Arizona Medical Association committee, but has much American Academy of Pediatrics' participation. The committee has worked out its guidelines as fully as possible at this point and the program is ready to go. There has been a pilot project which has been functioning for the past six months and this has been quite successful. It is being used as the model for the fully functioning EPSDT program if it is implemented by the Executive Department of the State of Arizona.

The program consists of screening primarily to be done by health aides. The health aides will be supervised by pediatric nurse practitioners who in turn will be supervised by pediatricians. It is intended to use private pediatricians wherever they are interested. However, for Arizona it is felt that this will not be very feasible. The pediatricians cannot do outreach or do followup to see that children with potential defects do receive further diagnostic studies. The program has not been universally embraced but each American Academy of Pediatrics meeting has had time devoted for a discussion of the status

of EPSDT as of that time. The Academy is also working with the Arizona Medical Association in conducting a series of seminars in community colleges in Arizona to teach health aides in a three- to four-month period of time so that they can do the necessary screening.

Charges, if and when the program becomes functional, should not present any problem since they are to be set at the 75th percentile of usual, customary and reasonable fees. Diagnosing and referring defects found also should not be any problem since the program as currently envisioned will require any possible defects to be seen by a physician involved in screening before a referral for diagnosis can be made. The referral will be physician to physician. It is hoped this will facilitate the ongoing care of children. There do not appear to be problems with the forms the State has devised for this program, although until the program begins to function, one cannot be sure of this. The program as currently envisioned does not serve as a strong basis for bringing children into the mainstream of medical care, but appears to be rather a probably effective means of giving some screening care to almost all children within the State. The chief stumbling block remains implementation of the Medicaid concept in the State of Arizona, this being the only state in the United States that has yet to start this program.

NEVADA

In Nevada, EPSDT has started functioning as a nurse-administered program under the direction of the State Welfare Department. Screening is done using a relatively simple form with a varying fee structure

from one group performing screening to another. There is essentiall no physician participation. This is because there are so few pedia tricians in the State that they feel they do not have time for this type of program. They essentially provide minimal preventive servic and are almost entirely involved in an illness-oriented type practic In addition to the lack of adequate numbers of pediatricians, there is a relatively low financial return from the program and thus no incentive for pediatric participation. Also, pediatricians are loath since their practices are too large already, to bring more children into their offices for ongoing care.

There are Academy people who are assigned the role of AAP representatives and this report is based partially on discussions with the Academy's representative in Nevada, but representation is more in name than in fact. It would appear that the only physician input into the program within the State of Nevada is through general practitioners in Reno who give advice to the Chief of the Medical Care Service Section of the Welfare Department. It would appear, however, that they also do not participate extensively in this progra

Thus, the program, although providing some screening, does not get children into the mainstream of medical care and at this point it cannot be determined how many children in whom potential defects are found will receive the necessary followup, diagnostic and therapeutic care.

HAWAII

The EPSDT screening program in Hawaii has failed to function until

quite recently due to an inadequate fee structure, complex forms and a welfare orientation. The Hawaii Chapter of the American Academy of Pediatrics has been very interested in trying to make the EPSDT program an effective one that will bring children into the mainstream of medical care. They have felt that many children were probably already covered through welfare, Head Start and private care, but that the program was not well organized and one could have no way of determining how many children were falling through the cracks. In order to make the program an effective one in which pediatricians could participate, the Academy went over the heads of the line officers in the Welfare Department to the Head of the Department of Welfare, the Governor, and key members of the legislatu They were able to accomplish a number of things by doing this. First an advisory committee was established concerning EPSDT and on it were two members of the Academy, one of whom was from the School of Medicine of the University of Hawaii and one directly representing the Academy, the Director of the Department of Health and the Directo of the Social Service Department of Hawaii. There were ex officio members representing Head Start, dentists and others interested in the program. Through efforts of the Academy and this committee, the fee structure was upgraded to a level where Medicaid will not pay the 75th percentile of usual, customary and reasonable fees and budgeted $4,000,000 more for this purpose starting in July 1976. Also within the program a designation was made that a full-time EPSD coordinator would be established in the program. This would take it out of the line Medicaid program and make it a separate and more effective agency with its own administrator. The person to assume this role is to be appointed shortly.

The regulations governing this program are quite simple. Forms, although lengthy, should not be a barrier to provider participation. Followup, diagnosis and referral also should be no problem since there will be an adequate fee structure now to cover these studies. The Academy has taken a stand supporting provider participation now that the program has been established in a way that they feel will effectively bring children into the mainstream of medical care.

Since all these changes will be occurring shortly, the belief that the program will be successful and that many pediatricians will participate still is a supposition and not fact.

CALIFORNIA

EPSDT in California has, until this point, been a failure. Initial attempts at implementation were markedly underfunded paying fees of less than half of the usual Medicaid fees in this State. Because of this, and a cumbersome bureaucracy, there was minimal private provider participation and indeed counties and county clinics failed to perform screening since it would have been a financial loss to them also. Outreach and followup were under the Department of Social Welfare while the medical aspects of the examination have been under the Department of Health. This fragmentation has resulted in a disjointed and uncoordinated program. Establishing regulations for the program was left to an administrator who was a relative novice to the State Department of Health and therefore had much difficulty establishing appropriate regulations for such a vast undertaking. The program became markedly over-regulated which again was a discouragi

factor in gaining provider participation. Recently, due to continued Academy efforts, changes have been proposed which, if enacted, should ensure pediatric participation.

1) Working with Academy representatives the State has agreed to a shorter, simplified form. Effort is being expended in gaining State approval of further shortening.

2) The State has tentatively agreed to a realistic fee structure with an additional bounty for physicians who agree to provide ongoing care to children they screen.

3) Simplification of the regulations has been proposed and will be further discussed in future meetings with Health Department personnel.

4) The law has been changed to read that in all instances the usual source of health care will provide screening whenever possible. The Academy has agreed to support member participation in screening if the proposed changes reach fruition.

BIRT HARVEY, M.D.

HEW REGION X

Washington - High percentage of private practitioners and clinics involved in total package of screening, diagnosis and treatment. Many patients seen under Title XIX who are receiving equivalent care but because of extra forms are not being reported under EPSDT. A recent grant to the state under Title X for outreach has produced in some instances overwhelming results. In one county appointments for screening are backed up to September. This has caused some anxiety in the state and Regional Offices but will probably resolve itself.

Some counties in the state are not doing an adequate job from the screening standpoint (an equivalency program would solve this). The State Medical Society is trying to resolve the county problems.

There is still some complaint relative to the fee structure. The state has recently developed a new computer system - which are no better than the old system - still leave a lot to be desired as far as adequate reporting - follow through etc is concerned.

At the moment the state is on the verge of "non compliance" because of their failure to adequately rectify some of the aforementioned problems.

Oregon - There is a money problem in this state - compounded by the failure of the legislature to understand the nature of the program and the importance of preventative care.

There is some fumbling from time to time from the medical profession. These fires are temporarily smothered but seem to flare anew with each procedural change.

Most physicians are involved in Title XIX altho they may not be reporting such as EPSDT encounters.

There is an advisory committee to the implementing agency but I'm not sure just how strong they are when it comes to making changes. I believe the state would benefit from more across the table dialogue with a strong advisory committee.

Idaho - The state is trying to accommodate the private practitioner and thereby involve him in EPSDT. The idea of paying the practitione for "Preventative Health Care" is foreign to the Health Department i.e. they pay only for sickness. This issue has been or is being resolved, the State Chapter of the AAP has gone on record as wanting to be involved and in the major cities this is being car out to a limited degree. The Health Department teams through use of mobile vans still travel the "out back" as they have done in the past.

Alaska

An Enigma!