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EVALUATION OF THE NEW YORK STATE CHILD HEALTH ASSURANCE PROGRAM

VOLUME II OF II

15

Presented to:

The Assistant Regional Director for Planning and Evaluation
Department of Health, Education, and Welfare
Region II

Information
Resource
Center

MACRO SYSTEMS, INC.

October, 1976

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APPENDIX A

BIBLIOGRAPHY

BIBLIOGRAPHY

Over 120 documents, books, and articles were read and are reflected in this report. A comprehensive index of all sources used for this report follows in Exhibit A-1. Many of these articles are annotated and are so identified in the exhibit. The annotations follow the exhibit and are arranged by topic into the following headings:

- 100 Health Screening
- 200 Preventive Health Care and Pediatric Health Screening
- 300 Child Health Screening Program
- 400 EPSDT
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SELECTED ANNOTATED MATERIALS RELATING TO CHILD HEALTH SCREENING

100 Garfield, Sidney R.
MULTIPHASIC HEALTH TESTING AND MEDICAL CARE AS A RIGHT
New England Journal of Medicine 283(20): 1087-1089, 12 November 1970

Although no long-term evidence exists that the course of disease is influenced by multiphasic health testing, this is largely irrelevant. Such programs are essential for other very important reasons. The existing and spreading concept of medical care as a right, with its elimination of personally paid fees, is creating a demand for periodic health checkups and health appraisals. This demand cannot be met by traditional methods totally involving the physician without great waste of doctor time. Multiphasic health testing can help separate the entry mix of patients into the well, the asymptomatic sick, and the sick. This separation makes possible optimum use of physicians' services, which can be devoted to the area where they are most needed: the care of the sick. (Journal

Comment: In the context of a health maintenance organization such as Kaiser Permanente, with which the author is associated, the multiphasic exam serves as a point of initial patient contact, establishes a medical baseline for future encounters, and meets the consumer's demand to be assured of health as well as cured of ailments. Arguments dismissing the multiphasic exam for its small yield of significant findings in asymptomatic individuals fail to consider these other important functions. Dr. Garfield's point is well taken: in the context of a comprehensive care program, the multiphasic exam may serve multiple purposes, not easily comprehended in plumbline cost-benefit analyses. As a corollary, however, it might be argued that the unplumbed advantages of multiphasic screening diminish or disappear outside the comprehensive health care context.

101 Spitzer, Walter O. and Brown, Bruce P.
UNANSWERED QUESTIONS ABOUT THE PERIODIC HEALTH EXAMINATIO
Annals of Internal Medicine 83(2): 257-[illegible], August 1975

The authors question the value of the periodic health examination of asymptomatic individuals. Persuaded that health professionals now tend to "oversell prevention to overestimate their ability to deal effectively with detected disease, and to overvalue the benefit of their care to patients," Spitzer and Brown discuss a series of questions designed to raise the practice of periodic health examination as an issue in the consciousness of health professionals.

Question One--"What conditions, risk factors, or diseases can reasonably be found in a preclinical state whose natural outcome can be altered or palliated in a way that benefits the patient or society?"

Answer--Very few. Only seven targets are considered appropriate for the preclinical detection of disease or disorder among children:

(1) rhesus incompatibility with the mother, (2) phenylketonuria, (3) congenital dislocation of the hip, (4) some congenital heart defects, (5) hearing impairment, (6) amblyopia, and (7) smoking.

Question Two--"Is a periodic lifetime health examination program, with aggressive initiative by the health providers and with high compliance by the patients associated with improved health status for the population?"

Answer--Very little in the way of findings may be marshalled to answer this question positively. The Kaiser-Permanente group is beginning to report randomized, controlled trials with modestly significant statistical differences in favor of the periodic health exam. The authors question the clinical and practical significance of these findings outside the context of a comprehensive care plan employing rigorous call-back procedures.

Question Three--"Are asymptomatic persons who solicit a periodic health examination different in health status from persons on whom the checkup is imposed?"

Answer--The authors could find only one reference illuminating this question. In the Family Doctor, Wolfe and Bayley report the yield of significant findings among asymptomatic individuals at 11 percent against 38 percent among symptomatic persons in a sample of 3,203 health examinations completed by family doctors.

Question Four--"Should a health services system make provision for periodic health examinations of all citizens of a state throughout life?"

Answer--The authors consider such a provision economically infeasible and socially inappropriate until the benefits from a health examination become more certain.

Question Five--"Which are the minimally required components of an effective program of periodic health examinations?"

Answer--Physicians still do not know what to include in the health exam of asymptomatic individuals. Although common wisdom maintains that certain subgroups--infants and the elderly--may profit from periodic checkups, an evaluation of 6,668 well-baby exams has revealed that only 130 of these uncovered clinically significant abnormalities and, of these, less than half could benefit from early intervention. Moreover, although the American Academy of Pediatrics has recommended a total of 10 well-baby visits during the first year of life, studies conducted in Rochester, New York, found that an abbreviated, three-visit schedule compared favorably with the higher frequency schedule. In brief,

available evidence does not support absolute decisions about what should be included in the health exam, who should conduct it, what subgroups might profit most from exams, or how often such exams should be conducted.

Question Six--"What ethical issues must be considered when implementing a program of periodic health examinations?"

Answer--Screening or well-person examination is a presumptive effort that holds the promise of (1) identifying abnormalities and (2) referring afflicted patients to adequate and available sources of care. If this promise is not realized, then screening becomes an issue of medical ethics. The authors recommend that the World Health Organization criteria for the validation of screening programs be applied to the issue of well-person examinations.

Question Seven--"Is the absence of definitive evidence about the value of the periodic health examination sufficient justification to abandon the practice?"

Answer--Such a recommendation cannot be made comfortably until more evidence is accumulated.

The authors conclude that neither evangelical advocacy nor wholesale dismissal f the health examination is appropriate at this time. In the area of child health, ey recommend that the following practices be continued until demonstrated valueless: (1) history-taking and physical evaluation of all new patients to stablish a medical baseline; (2) screening for PKU, congenital dislocation of the hip, and congenital heart defects; (3) not more than six or fewer than nree well-baby visits during the first year of life; (4) vision and hearing tests n the second and fourth years; (5) well-child checkups as often as needed to maintain contact with and knowledge of the patient. Beyond these practices, the uthors recommend that health professionals remain "alert to increases in incidence and prevalence of health problems" and "institute prescriptive screening or target diseases that might arise and for which intervention may be beneficial.

omment--Although not focused on the screening of asymptomatic children, this article raises seven questions that should remain live in the minds of EPSDT program officials. The authors' exploration of these questions already aises troublesome doubts about the conduct, content, periodicity, and context f EPSDT screening as figured forth in the SRS/American Academy of Pediatrics guidelines.

102 Knox, E. G.
MULTIPHASIC SCREENING
Lancet: 1434-1436, 14 December 1974

Knox notes a lack of "interest in primary health objectives" in the pages of reports emanating from multiphasic screening programs. His evaluation of the research and statistics finds little support for the notion that multiphasic screening may contribute to positive medical outcome. Unconvinced, Knox warns against the temptation for program expansion held out by low marginal costs and encourages the medical profession to evaluate each screening component before adopting it into the panoply. Given the available evidence, Knox is forced to conclude that "multiphasic health screening procedures appear to be of little value in medical practice at the present time, particularly in respect of individuals who are apparently well and who are not in hospital."

103 Holland, W. W.
TAKING STOCK
Lancet: 1494-1497, 21 December 1974

In this summary article, Holland repeats the criteria that should apply in the development of screening programs and concludes the Lancet series on screening for disease with the following remarks.

"The purpose of this series of articles on screening was "to reappraise the evidence and to determine what attitude should be adopted to screening today." The evidence is largely negative, and all too often the investigations required have simply not been done. However, it may be worth reflecting at this point that screening has probably been assessed more critically than any other area of medical practice. Those with critical minds might with profit explore other areas to see how they meet Cochrane's criteria of effectiveness.

"As a whole, the series leaves the impression that total population screening is hard to justify for any condition, save P.K.U. Selective screening, on the other hand, has a useful place in health care, but a great deal of work remains to be done.

"The first major area for attention is systematic, stringent, and unemotional evaluation of the various screening procedures for introduction. It is essential for unequivocal evidence to be presented before an experimental project is introduced into routine medical practice.

"Secondly, we must improve our skill in interpreting abnormal findings and decide, on reliable evidence, whether multiple tests are really more effective, more economical to the health service, and more beneficial to the patient, rather than merely more convenient to the organization of an individual laboratory or clinic.

"Thirdly, we must develop methods of identifying high-risk individuals and of persuading them to attend for screening. Selective rather than mass screening is both a more effective and economical use of scarce resources. In this context, it may also be helpful to differentiate between four different forms of screening: (1) Screening for individuals with risk factors, such as obesity and cigarette smoking, which predispose to illness but are not themselves alerting symptoms. (2) Screening for conditions, such as raised blood-pressure, that are the early signs of a disease. (3) Identification of individuals with abnormalities in whom preventive action must be taken. (4) Identification of individuals who could benefit from surveillance and continuing care (e.g., those with visual or hearing loss where the disease process is irreversible but its effects can often be alleviated).

"The fourth area for development concerns the problem of convincing these high-risk individuals to adhere to effective methods of prevention such as anti-hypertensive medication, weight reduction, and ceasing to smoke. And in this context, primary prevention in the form of identification (and correction) of the influences that encourage people to smoke, overeat, and lead sedentary lives may be much more effective than identifying individuals in the early stages of disease.

"There are clearly two objectives that can be discerned from all the topics raised in this series--screening to prevent disease and screening to treat disease. I would like to end by emphasizing a third objective that has tended to be forgotten ...d that is screening for conditions that are beyond prevention or curative treat...nt, but which nevertheless can be alleviated or improved. In the middle-aged ...d elderly, for example, simple tests for vision and hearing, and tests to identify ...ople in need of chiropody or walking aids, may be far more effective than more ...mplex biochemical and laboratory-oriented procedures in improving the quality ... life."

200 Thompson, Hugh C.
PREVENTIVE SERVICES FOR CHILDREN
Pediatric Clinics of North America 16(4): 947-955, November 1969

In this monograph, Dr. Thompson underlines the importance of some preventive pediatric health practices and questions the significance of others. Among questionable elements are: (1) the periodicity of well-baby and well-child visits, (2) the location for immunization programs, and (3) the delegation of screening responsibilities to allied health personnel. Although confirming the importance of intellectual, emotional, and social development in the context of child health, Dr. Thompson cannot fully endorse available screens for these targets and suggests that we lack resources for treating the majority of children who might be identified by these screens. Again, although recognizing the comprehensive care setting as the most appealing and efficacious setting for preventive services, Dr. Thompson remarks that these settings have not been widely available to the less privileged. At the time of writing, the Neighborhood Health Center seemed to afford greatest promise for the provision of pediatric health care by persons familiar with the fabric of family circumstances in which the child is involved.

201 Bailey, Edward N., et al.
SCREENING IN PEDIATRIC PRACTICE
Pediatric Clinics of North America 21(1): 123-165, February 1974

This group of authors, all senior residents in the Department of Pediatrics at the University of Rochester School of Medicine and Dentistry, discuss a number of targets for screening, portray the controversy surrounding each screen, and develop screening recommendations. The authors begin and end with familiar admonition and advice: recommendations must be modified to suit local needs and resources; screening without follow-up is useless to the patient. The recommendations developed by the group are reflected in Exhibit A-2, following this page, drawn directly from the article.

EXHIBIT A-2

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

RECOMMENDATIONS FOR PEDIATRIC SCREENING

	Newborn	Under One Year	One to Five Years	School Entry	Elementary School	Adolescence
Growth	Height, weight, head circumference	Height, weight, head circumference	Height, weight, head circumference	Height, weight	Height, weight	Height, weight
Metabolic Disease	PKU, galactosemia	--	--	--	--	--
Vision	Blink, pupillary response to light, red reflex	Hirschberg test	Hirschberg test, cover test, Allen cards	Hirschberg test, cover test, Snellen chart	--	Snellen chart
Hearing	--	Hardy test	VASC	Pure tone audiometry	Pure tone audiometry	--
Cardiac Disease	Palpation of pulses, auscultation	Auscultation	Auscultation	Auscultation	--	Auscultation
Atherosclerosis	--	--	Serum cholesterol and triglyceride*	--	--	--
Hypertension	--	--	Blood pressure	Blood pressure	Blood pressure	Blood pressure
Tuberculosis	--	--	Mantoux or Multiple Puncture Test*	Mantoux or Multiple Puncture Test*	--	Mantoux or Multiple Puncture Test*
Anemia	Hematocrit or hemoglobin	Hematocrit or hemoglobin	--	--	--	Hematocrit or hemoglobin
Sickle-Cell Anemia	Hemoglobin electrophoresis*	--	--	--	--	Sickle prep or Sickledex*
Thalassemia	--	Hematocrit peripheral smear*	--	--	--	Hematocrit peripheral smear*
G-6-PD Deficiency	Spot test or dye test*	--	--	--	--	--
Lead Poisoning	--	Blood lead*	Blood lead*	--	--	--
Bacteriuria	--	--	Urinalysis and culture (girls)	--	--	--
Proteinuria	--	--	Dipstick	--	Dipstick	Dipstick
Congenital Hip Dislocation	Barlow's test, Ortolani's test	Bilateral abduction	--	--	--	--
Development	--	--	Denver Developmental Screening Test (DDST)*	--	DDST, Draw-a-Person, Ammon's Quick Test*	--
Behavior	--	Checklist	Checklist	--	--	--
Vision and Reading	--	--	Speech milestones	--	Pupil rating scale, reading paragraphs	--

* High-risk populations only

This lengthy monograph is richly referenced with some 300 citations categorized by screening target, e.g., hearing, growth, metabolic disease, vision, hypertension.

202 Rogers, K. D.
SCREENING IN PEDIATRIC PRACTICE: REVIEW AND COMMENTARY
Pediatric Clinics of North America 21(1): 167-174, February 1974

In this review and commentary, Dr. Rogers emphasizes the limitations of screening as a contributor to improved health status and suggests what measures must be taken to advance the art. Considering first the rationale for screening, Dr. Rogers notes that its presumed benefits rest on two assumptions: (1) that many diseases, whoever their victims, have natural histories involving stages that may be subject to effective intervention, and (2) that certain physiological indicators can often distinguish the diseased from the nondiseased among asymptomatic populations.

The balance of Dr. Roger's critique questions these two assumptions. His discussion includes a number of basic definitions well worth repeating:

- Natural History of Disease
  - Prepathogenic Period: Precedes the origin of specific disease within the host. Certain factors--genetic, social, environmental, anatomical- may render certain individuals at relatively high risk of contracting some diseases or developing some conditions. Screening during this period focuses on these risk factors.
  - Preclinical Period: Involves initial development phases, when the disease or condition has not yet manifested itself clinically. During this period, telling alterations in bodily functions may sometimes be picked up by screening.
  - Clinical Period: Frank signs and symptoms of disease develop during this period.
  - Postclinical Period: The denouement of disease in death, recovery, or permanent loss of structure or function.
- Levels of Prevention
  - Primary: Instituted in the prepathogenic period, primary prevention deters disease from ever occuring or dramatically modifies factors contributing to high risk.
  - Secondary: Aborts or ameliorates the natural history of a disease or condition.

- Limitations of Screening

  - Screening Positivity: May be indicated by the absolute presence of certain findings, by a statistical definition of normality, or by the presence of an attribute assumed to occur more often in the diseased than the nondiseased. Unfortunately, as Dr. Rogers notes, statistical abnormality is not necessarily related to biological abnormality; moreover, cut-off points in a distribution of values may make arbitrary and inaccurate distinctions between the "diseased" and the "nondiseased". Accordingly, the choice of cut-off points for the screening components of any particular program must consider the economic and health consequences of both false-negatives and false-positives.

  - Insensitive Tests: Fail to pick up diseased persons.

  - Nonspecific Tests: Falsely identify the nondiseased as diseased.

Given the uncertain natural histories of most diseases, the variable history of a disease within individual hosts, the lack of sensitivity and specificity among available screens, the questionable effectiveness of early intervention in preventing or ameliorating many diseases or conditions, and the common absence of adequate follow-up resources and methods, Dr. Rogers recommends that the health community place major emphasis on gathering substantial knowledge of disease prognosticators as a basis for developing finer screening instruments and procedures. Significantly, Rogers maintains that many of the tests currently mandated by some health laws and regulations--routine urinalysis, tuberculin test, chest x-ray, serologic tests for syphilis, height and weight in school-age children, auscultation of the lungs, abdominal palpation, and rectal examination--have very low effectiveness in discovering new cases among the asymptomatic.

Comment: Although Dr. Rogers encourages skepticism about the medical benefits of screening, his review and commentary considers the application of screens to the general, pediatric population, not the high-risk Medicaid group. Accordingly, his skepticism should be tempered in the context of EPSDT screening.

203 Holt, K. S.
INFANCY AND CHILDHOOD
Lancet: 1057-1060, 2 November 1974

The author notes that current enthusiasm for screening in early infancy and childhood is often uncritical and but poorly supported by available data on health benefits. As yet, few screening procedures for childhood diseases and disorders are sensitive, specific, quick, or cheap enough to warrant their wide adoption.

Not considering anemia, bacteriuria, congenital metabolic disorders, or tuberculosis--dealt with in other articles of the Lancet series--Holt identifies the following diseases and disorders as candidates for screening, albeit with some reservations: (1) Congenital hip instability--Given a shortage of personnel equipped to conduct reliable exams, screening for this disorder may require a focus on high risk groups; (2) Cardiovascular disease--Warning against the dangers of reporting cardiac nondisease, Holt still recommends that screening for cardiovascular disease be part of the school entry exam; (3) Infestation--The high prevalence of scabies in the United Kingdom warrants that British school children be examined routinely for infestation of the skin and hair; (4) Muscular Dystrophy--Given a relatively low prevalence in the United Kingdom, only the siblings of known victims should be screened; (5) Strabismus--The disorder is common, the screen relatively simple, and the damage from failure to intervene may be significant; accordingly, Holt recommends that children be screened routinely for strabismus as early as three years of age; (6) Development--Although delays in development may be highly significant, the content of developmental exams, their timing, and the personnel appropriate for conducting them remain disputed issues. Screening for abnormalities in physical growth--e.g., short stature--have proved largely unproductive; (7) Hearing--Simple hearing tests may be performed at six and nine months of age; exams for the hearing of speech sounds are recommended at between two and three and one-half years of age; since it is not easy to reach or administer tests to this age group, audiometric examinations should be conducted again on school entry and at least three more times during the school years; (8) Vision--Almost all children are screened at school entry and all should be screened for vision impairment on an annual basis thereafter; (9) Behavior--The dangers of mislabeling are so great that the author thinks more harm than good may be done by available screening techniques; (10) Language--Since language disorders are often transitory, very early screening may be wasteful; (11) Learning disabilities--Existing screens are unsatisfactory; identification may be destructive when not accurate or when not coupled with sufficient resources for remediation; and (12) Clumsiness--Screens are inadequate and the danger of stigmatization great.

204 Frankenburg, William K.
SELECTION OF DISEASES AND TESTS IN PEDIATRIC SCREENING
Pediatrics: 54(5): 612-616, November 1974

Dr. Frankenburg here promulgates the criteria for selecting screening targets and techniques that he and Dr. North included in A Guide to Screening EPSDT: Medicaid. The items to be considered in selection include:

- Screening Target
  - Importance Of The Problem: Only those diseases or conditions with significant impact on morbidity or mortality should be screened.

- Prevalence: As a rule of thumb, only relatively prevalent conditions can be screened economically.

- Accepted Criteria For Diagnosis: The screening program must define indicators for distinguishing diseased from nondiseased subjects; a disease presenting no reliable early indicators is unsuitable for inclusion in a screening program.

- Treatable Or Controllable: If nothing can be done to reverse, retard, or eliminate the condition or to support the family in coping with it, then there is little value in screening.

- Advantage To Earlier Treatment: If early intervention is no more efficacious than treatment following the frank presentation of symptoms, there is little value in screening for the condition.

- Duration Of "Screening Time": Screening should occur after the point at which reliable indicators may first suggest disease but before the point at which remedial measures are no longer effective. The screening times for various conditions vary widely and should influence the schedule and periodicity of screening components.

- Availability Of Diagnostic And Treatment Resources: Facilities should be available to diagnose and treat subjects flowing through the screening process, especially when such a process is publicly initiated and supported.

- Program Cost: The expense of screening should be offset by savings in cost and human suffering.

Screening Tests

- Acceptability: Patients, parents, and screening personnel must accept the test and physicians consider it valid or valuable.

- Reliability: The screen should measure consistently the function or structure it is designed to assess.

- Validity: Within limits, positive and negative findings should be consistent with the actual presence or absence of disease. A test is sensitive to the degree that it picks up diseased subjects and specific to the degree that it identifies nondiseased subjects as normals. A screen with a low sensitivity will produce a relatively high number of false-negatives; a screen with a low specificity will produce a high number of false-positives.

Dr. Frankenburg encourages program officials to consider the direct and indirect costs (costs of false-positives, false-negatives, time and inconvenience of parents and children, transportation) when assaying the benefit of a screening program or individual screening components. Improving the validity of a screen or an entire program is an obvious way to economize; such improvement may involve: (1) manipulating the cut-off points for screening scales to increase either sensitivity or specificity, as needed; (2) increasing reliability of instruments and/or the competence of personnel; (3) selecting a better test, if available; (4) using more than one screen for the same target; and (5) rescreening with the same test.

Dr. Frankenburg concludes this discussion of criteria and program costs with the caveat that programs ignoring the principles for selecting targets, selecting screens, and weighing costs against benefits are likely to waste resources, harm some subjects, and do little good for others.

205 Scriver, Charles R.
PKU AND BEYOND: WHEN DO COSTS EXCEED BENEFITS?
Pediatrics 54(5): 616-618, November 1974

Dr. Scriver explores concepts of cost in the context of screening for genetic disease. The economic analysis of health programs emphasizes the concept of cost avoidance, e.g., how much is saved by screening and treating PKU (measured by weighing the costs of caring for the projected number of untreated victims against the costs of screening the target population). Scriver notes that this economic model ignores benefits and costs that cannot be described easily in dollars. The concept of marginal cost, i.e., the cost of new equipment and new materials required for expansion, may be invoked by program officials wishing to add new screens to existing operations. A screening program may alter the cost balance by focusing the panoply of screens or individual screening components on "at risk" populations. As also mentioned by Frankenburg, costs may be affected by the validity and reliability of the screens. Low-specificity increases costs by producing false-positives for follow-up. Low-sensitivity increases overall medical costs by producing false-negatives who may not benefit from early interventions. Against short-term costs of screening and treatment must be weighed long-term genetic costs to the species. Dr. Scriver favors intervention and treatment, even at the possible expense of an increasing pool of deleterious genes.

206 Allen, C. M. and Shinefield, H. R.
AUTOMATED MULTIPHASIC SCREENING
Pediatrics 54(5): 621-625, November 1974

From our experience with automated multiphasic health tests in more than 20,000 children, we have formed the following tentative conclusions. Multiphasic testing, combining a group of tests for administration at a single session,

is less costly in time and inconvenience to the patient and provides more useful information to the evaluating and treating physician than does an uncoordinated set of individual tests.

Automation of instruments, use of nonprofessional testers, and computer processing of data can markedly reduce the usual cost of acquiring standard data provided that: (1) there is a large number of persons from which standardized data are to be acquired; (2) the acquisition of the data can be scheduled so that specialized equipment and personnel are fully utilized; (3) automated equipment is used only when there is a real advantage over manual equipment.

These potential benefits of automated multiphasic testing are severely limited by: (1) the lack of knowledge and agreement about what standard information is useful for improving the health care of children; and (2) the problems involved in ensuring appropriate follow-up examinations.

Our purpose in presenting these conclusions is not to support or condemn automated multiphasic testing or screening, but rather to point out that a number of unsolved problems exist. They will not be solved unless all who engage in automated multiphasic screening, or any kind of screening, arrange their testing and data keeping procedures so that the new knowledge necessary for evaluating programs and resolving unsolved problems can be gained. Until we have such knowledge, we must be modest and tenatative in our claims that automated multiphasic screening can contribute positively to the health care of children. (Authors' summary)

Comment: The authors are associated with the Kaiser-Permanente Medical Center in California, which administered more than 20,000 multiphasic exams between 1967 and the time this article was written. From other reports of this program, it may be comfortably assumed that multiphasic testing was initiated as much to establish norms and develop screening criteria as to contribute to the health status of the particular population undergoing screening. Thus, the authors' cautions. They are especially skeptical of the benefits of multiphasic screening applied to "Medicaid-eligible children who have no regular source of health care..."

207 Kunin, Calvin M.
CURRENT STATUS OF SCREENING CHILDREN FOR URINARY TRACT INFECTIONS
Pediatrics 54(5): 619-621, November 1974

Dr. Kunin suggests that the morbidity from urinary tract infection is sufficient to warrant screening, that the screens available for detecting bacteriuria are sufficiently economical and simple, but that the health care resources may not be sufficient or sufficiently committed to the treatment of victims. Accordingly, national screening programs should observe the following priorities: (1) educate

physicians to provide care for symptomatic patients; (2) screen children in office practice for urinary tract infection; (3) for purposes of mass screening, select low cost but reliable tests; (4) develop a system for diagnosis and referral; (5) assure patients the opportunity for consultation with competent urologists.

Although A Guide to Screening, EPSDT: Medicaid refers to Dr. Kunin's work, the Guide fails to convey the degree of caution that Dr. Kunin includes in this article. Kunin warns communitues against screening for bacteriuria in the absence of a protocol that should include: (1) definition of target population, screening methods, and criteria for identifying only significant, persistent bacteriuria, (2) a data system allowing easy retrieval and accurate, timely documentation of diagnosis and therapy for each case; (3) quality control of services rendered, be they diagnostic, pharmaceutical, or surgical; (4) consumer education; (5) fiscal support sufficient to assure every child appropriate treatment.

208 Moriarty, Richard W.
SCREENING TO PREVENT LEAD POISONING
Pediatrics 54(5): 626-628, November 1974

Dr. Moriarty is critical of the Surgeon General's Report of 1970 which codified preventive measures against lead poisoning. First, in the absence of strong clinical evidence, the Surgeon General's Report specifies certain blood-lead levels as indicative of risk, poisoning, or acute reaction. Second, blood-lead level--the recommended screen--may not be the best indicator of risk; e.g., some investigators now maintain that the free erythrocyte protoporphyrin level may better indicate risk. Third, and again in the absence of strong clinical support, the Report recommends treatment for asymptomatic individuals with high blood-lead levels, though chelation therapy is itself painful and expensive. Fourth, the Report identifies dilapidated housing as the chief environmental culprit even though lead absorption has been shown common in one community and rare in another community, both with similar housing conditions.

Dr. Moriarty concludes with a caveat that may apply to all screening components: "...every screening program must be modest and tentative in its claims and must be carried out in a way that data from its activities can contribute to the resolution of the controversies."

209 Edwards, Phyllis Q.
TUBERCULIN TESTING OF CHILDREN
Pediatrics 54(5): 628-629, November 1974

The changing epidemiology of tuberculosis suggests that routine testing of all children may be unnecessary. The low prevalence of the disease, the relatively low specificity of routine screens, and the short screening time suggest alternatives to wholesale periodic screening. Alternatives include identification

of high risk groups through the prevalence of new clinical cases and through periodic epidemiologic surveys of older school-age children and the identification of high risk individuals through clinical signs and medical history.

Comment: The Medicaid population would, by most accounts, be considered at relatively high risk. Nevertheless, the demise of the tuberculin test as an economical and efficient screen for the majority of the population suggests the importance of subjecting screening components to continual evaluation.

210 North, A. Frederick
SCREENING IN CHILD HEALTH CARE: WHERE ARE WE NOW AND WHERE ARE WE GOING?
Pediatrics 54(5): 631-640, November 1974

Using the criteria developed by Frankenburg, Dr. North summarizes the state-of-the-art of child screening for some 22 childhood disorders and diseases. Exhibit A-3 on the following page, drawn directly from the article, clearly and concisely reflects pediatric opinion about the usefulness of available tests for the medical entities commonly subject to screening. The exhibit may serve program officials not only as a summary but also as a dummy form useful for the continuing evaluation of screening components.

In addition to this summary of disease entities subject to screening, Dr. North provides a helpful summary of tentative screening recommendations, listing screening tests, interview questions, and physical examination items in conjunction with the approximate age at which they should be administered. Again, the tabular summary, Exhibit A-4, following Exhibit A-3, is included in its entirety since it provides a convenient catalogue of current opinion as well as a dummy form useful for the continual updating of screening periodicity recommendations.

It should be noted that Dr. North offers recommendations as tentative--i.e., hypotheses subject to modification. Continuing investigation of the predictors of disease, the natural history of disease entities, their prevalence, incidence, and distribution--all are expected to modify and supplement current screening recommendations.

In Dr. North's view, certain extra-medical considerations will also contribute to directions in the administration of screening. Salient among these trends in program administration are: (1) the demise of single-disease screening programs; (2) the integration of screening with medical care; (3) the standardization and wide dissemination of screening schedules that may be applied practically to large population subsets; (4) parent participation in a system of child health supervision that is less paternalistic and more instructive than heretofore; and (5) improved screening technology.

EXHIBIT A-3

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

USEFULNESS OF SCREENING TESTS*

	Importance	Prevalence	Diagnostic Criteria	Effective Treatment	Early Treatment More Effective	Adequate Screening Time	Adequate Treatment Resources	Effective Screening Test	Acceptable Direct Costs	Acceptable Cost Of False Positives	Acceptable Cost Of False Negatives
Phenylketonuria	+	+	+	+	+	+	+	+	+	+	+
Galactosemia	+	+	+	+	+	+	+	+	+	+	+
Other inborn errors of metabolism	+	+/-	+/-	+/-	+/-	+	+	+	+/-	?	+
Anemia	+	+	+	+	+	+	+	+	+	+	+
Sickle-cell diseases	+	+	+	+	+	+	?	+	+	+	+
Hemoglobin S and C traits	?	+	+	?	+	+	?	+	+	+	+
Bacteriuria	+(?)	+	+	+	?	+	+	+	+	+	+
Impaired hearing	+	+	+	+	+	+	+	+	+	?	?
Impaired vision	+	+	+/-	+	?	+	+	+	+	?	+
Deviant physical growth	+	+	?	+/-	?	+	+	+/-	+	?	?
Deviant psychomotor development	+	+	?	+/-	?	+	?	+	?	?	?
Glucosuria	+	0	+	+	0	0	+	+	+	?	?
Albuminuria	?	+	?	?	0	?	?	+	+	0	+
Cystic fibrosis	+	+/-	+	+	?	+	+	?	?	?	+
High blood pressure	?	?	0	?	?	+	?	+/-	+	0	+
Hypercholesterolemia	?	?	?	?	?	+	?	+	?	?	+
Deviant behavior	+	+	?	?	?	+	0	?	?	?	?
Intestinal parasites	?	+	+	+	?	+	+	?	0	?	?
Dental diseases	+	+	+	+	+	+	+	+/-	0	+	0
Lead absorption	?	?	+/-	?	+	+	+	+/-	+/-	?	?
Tuberculosis	+	0	+	+	+	+	+	+	+	0	+
Occult stool blood	?	+	?	?	?	+	+	+	+	0	?

* Key: +, problem or test appears to meet this criterion; +/-, problem or test appears to partially meet this criterion; 0, problem or test appears to fail this criterion; ? evidence appears insufficient for judgment.

EXHIBIT A-4

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

SUMMARY OF TENTATIVE SCREENING RECOMMENDATIONS

Screening Tests	Approximate Age of Evaluation												
	NB	2 mo	4 mo	6 mo	9 mo	12 mo	18 mo	2 yr	4 yr	6 yr	9 yr	12 yr	15 yr
PKU and galactosemia (a)	+	=	=										
Anemia	+	=	=	=	=	+	=	=	=	=		▲	=
Sickle cell diseases (b) (c)	+	=	=	=	=							▲	+
Hemoglobin S and C traits (c) (d)													
Bacteriuria (girls only)									+	+	+	–	+
Hearing					(e)				+(f)	+(f)	+	–	
Vision									+	–	+	–	+
Physical growth	+	+	=	+	=	+	=	+	+	–	+	▲	+
Psychomotor development					+	=	=	=	+				
Lead absorbtion (high risk only)						+(g)	+(g)	+(g)	+				
Tuberculosis (high risk only)						+			+			–	
Interview Questions													
Illness or medication in pregnancy	+	=	=										
Family history of genetic disease	+	=	=	=	=	=	=	=	=				
Abnormalities of delivery	+	=	=										
Social and economic factors affecting health and health care	+	=	=	=	=	+	=	+	+	=			
Mother's perception of child as "easy-difficult"–"good-bad"	+	+	+	+	+	+	+	+	+	–	+	–	
Psychomotor development		+	+	+	+	+	+	+	+	–			
Language development			+	+	+	–	+	+	+	–			
Evidence of sight and hearing		+	+	+	+	+	+	+	+				
Relationships with peers and sibs					+	+	+	+	+	–	+	–	+
Exposure to lead				+	+	–	+	+	+				
Exposure to tuberculosis	+	=	=	+	+	+	+	+	+	+	+	–	+
Feeding or eating patterns		+	+	+	+	+	+	+				+	+
Bowel movement patterns		+	+	+	+	+	+	+	+				
Allergic symptoms					+	–	+	+	+	–	–	–	+
Seizure-like symptoms			+	+	+	–	+	+	+	–	+	–	+
Lower urinary tract symptoms		+	+	+	+	+	+	+	+	–	+	–	+
School progress									+	–	+	–	+
Dental care								+	+	–	+	–	+
Sexual behavior												–	+
Drug, alcohol, tobacco use											+	–	+
Child's perception of self												–	+
Immunization status		+	+	+	+	+	+	+	+	–	+	–	+
Physical Examination Items													
Cardiorespiratory signs	+	=											
Gastrointestinal obstruction	+												
Visible congenital anomalies	+	=	=										
Hip dislocation	+	=	=	+	=	=							
Vision and hearing behavior	+	+	+	+	+	+	+	+	+				
Neuromotor development	+	+	+	+	+	+	+	+	+	+	+		
Mother-child interaction		+	+	+	+	+	+	+	+	+	+	+	
Strabismus			+	+	+	+	+	+	+	+			
Serous otitis					+	+	+	+	+	+	+		
Scoliosis											+	–	+
Breast development											+	+	+
Genital development	+	=	=	=	=	+	=	=			+	+	+
Acne, Eczema, and other skin	+	+	+	+	+	+	+	+	+	+	+	–	+

\+ Do at this age.
= Do at this age if not done at previous scheduled age.

(a) Other inborn errors may be added with the development of adequate testing and follow-up services.
(b) Screening should only take place when excellent comprehensive care can be given to all positives.
(c) Only persons with African, Mediterranean, and certain Latin-American ancestry need be tested.
(d) Testing should take place only with informed consent and when skilled counseling can be ensured.
(e) Testing with calibrated noisemakers may be added at 9 or 12 months if skills and resources permit.
(f) Hearing should be tested yearly from ages 4 to 8.
(g) Lead testing should be performed two to three times yearly for children living in high-risk environments.

New technologies for screening also raise serious ethical, social, and economic questions, e.g., should we use all the techniques in the screening armamentarium? Certain categories for possible screening--fetal screening, infant-mother relations, the child rearing environment, speech, and adult risk factors--involve sensitive subjects that may be inadequately and uneconomically addressed by existing or newly developed screens. By implication, Dr. North suggests that program officials may be tempted to screen in these areas before adequate cost-benefit analysis is available and advises against such precocity. In the context of increased pressure for screening of children, Dr. North recommends several priorities for program officials: (1) Program operators must be aware of the limits of current knowledge and technology and should include only those screens that have been proved beneficial or have the "highest probability of substantial benefits in relation to cost;" (2) screening program design should include a continuing evaluation component; (3) programs should accumulate longitudinal data on children to assist the medical profession in further elaboration and refinement of screening recommendations.

In a final recapitulation section, Dr. North notes that early detection has not fulfilled the promise of improved health status and suggests that this failure may be attributed, in part, to programs that have failed to operate under the principles enunciated in the Pediatrics symposium; they are: (1) Screening must be linked to treatment opportunities; (2) tests employed and problems screened must meet established criteria; (3) programs should avoid mislabeling the nondiseased or stigmatizing the diseased; (4) screening should be an alert or early warning system, not a substitute for primary care; (5) the existence and availability of a simple screening device does not alone justify its use; (6) the comprehensive health care setting offers the greatest potential for linking screening to effective intervention; (7) a central administration for testing and follow-up contributes to economy and effectiveness; (8) again, screening and its components must be evaluated continually.

211 Massachusetts Department of Public Health
COST-BENEFIT ANALYSIS OF NEWBORN SCREENING FOR METABOLIC DISORDERS
New England Journal of Medicine 291(6): 1414-1416, 26 December 1974

This report of screening and treatment for metabolic disorders in Massachusetts supports the finding of an earlier New York State study: all costs considered, "a substantial net savings results from routine screening for metabolic disorders in the newborn." The total cost for specimen collection during Fiscal Year 1972-1973 was $155,130; the cost for testing these specimens was $200,971; the cost for evaluating and treating PKU for one-year was established at $68,187; the total cost for evaluating and treating metabolic disorders other than PKU was $35,750. Accordingly, the total for screening and treatment components equalled $460,638. Against this actual cost of identifying and treating afflicted children, the authors project the costs that were avoided through early intervention, with

institutionalization costs for victims of PKU estimated at $648,240 and at $162,060 for the cohort suffering from other metabolic disorders. The cost for evaluating and hospitalizing these children is set at $15,000. On balance, the authors estimate a savings of $363,662 for Fiscal Year 1972-73 realized by the early identification and treatment of metabolic disorders.

212 Frankenburg, William K., Dick, Nathan P., and Carland, James
DEVELOPMENT OF PRESCHOOL-AGED CHILDREN OF DIFFERENT SOCIAL AND ETHNIC GROUPS: IMPLICATIONS FOR DEVELOPMENTAL SCREENING
The Journal of Pediatrics 87(1): 125-132, July 1975

The intellectual and social climate surrounding this study was characterized by severe criticism of developmental and intelligence tests being applied to minority children. The authors' results suggest that the instruments in question were not prejudiced against ethnic minorities.

The developmental status of 1,180 children representing a cross section of Denver's ethnic and parental occupational groups was compared with that of 1,035 children (349 Anglo, 354 Spanish surname, and 352 Black) whose parents were unskilled workers. The children varied in age from 2 weeks to 6.4 years were evaluated with the Denver developmental screening test. Comparisons made in developmental achievements as reflected by individual item differences for Anglo children from unskilled families with Anglos from cross-sectional families. A second comparison of Anglo, Spanish, and Black children in unskilled sample was also made. The first analysis comparing 910 children from the cross-sectional sample with 349 Anglo children from unskilled families demonstrated significant differences ($p<0.05$) for 39 of 105 items. Below 20 months of age, children of the unskilled sample were more advanced, whereas after 20 months of age, the children of the cross-sectional sample were advanced in all test sectors except for items in the personal-social sector. Comparisons of Anglo, Black, and Spanish surname children from the unskilled families showed fewer differences in rates of development. (Journal)

Findings of the present study suggest that there might be a higher frequency of questionable DDST findings when screening low SES children who are above 2 years of age. Because of these results, one might ask whether local norms, or those for low SES children, might be more appropriate to screen low SES children. The answer to that question depends upon what one is attempting to identify. If the purpose of screening is to move up the time of diagnosis and treatment to an earlier stage in the disease or handicapping process, the screening would have not only concurrent, but more importantly, predictive validity. For the most part, local norms are useful in determining how well a child does in relation to others in the same locale. Such comparisons may or may not be useful when one is attempting to predict performance when the child is merged

with others from divergent backgrounds. The revised DDST scoring method has been designed to agree closely with national norms on such criterion measures as the revised Bayley scales of infant development and the Stanford Binet. More recently, Camp and associates demonstrated that the DDST with its cross-section norms administered to 4- and 5-year old children of low-income families did predict which children were destined to have problems in school 3 and 4 years later. It is well recognized that an unusually high percentage of low SES children have less facility in language skills when they enter school, and it has often been suggested that this deficit plays a major role in school failure. The present study suggests that the low SES children begin to fall behind in their language and adaptive skills starting at 2 years of age. A positive approach to helping these low SES children to succeed in school would be to identify children with such deficiencies as early as possible and to provide extra language activities to prevent later school failure. Local screening norms based upon children of low-income families would tend to gloss over these deficiencies and thus preclude efforts in preventing school failure. Consequently, we recommend when screening for developmental problems that one employ the DDST cross-sectional norms and the revised DDST scoring method, since these have demonstrable concurrent and predictive validity." (Authors' summary)

213 Phillips, Carol F.
CHILDREN OUT OF STEP WITH IMMUNIZATION
Pediatrics 55(6): 877-881, June 1975

From the many studies cited, several points can be seen: (1) Diphtheria and tetanus are good immunizing agents which produce long-term immunity. (2) A series of two diphtheria-tetanus plus a booster one year later is adequate for basic immunization. (3) Two injections of pertussis at least 60 days apart produce levels of agglutinin that are equal to the amount produced by three jections. (4) Prolonged time between the injections of the basic series of diphtheria-tetanus does not interfere with the final immunity. There is no need to "restart" a DPT series. (5) After the basic series and booster a DT every ten years is adequate to preserve immunity. (6) A series of two trivalent oral polio doses eight weeks apart and a booster one year later is adequate for basic immunization. (7) Live viral vaccines can be given together, and, if desired, oral polio, smallpox, measles, and mumps can be given simultaneously.

For a child over the age of one year who has had no immunizations, the following schedule could be utilized. First visit: DPT (or DT), trivalent polio, tine test, two months later: DPT (or DT), trivalent polio, measles; and one year later: DT, trivalent polio. If desired, mumps and rubella can also be given at the time of the second visit. With current information available, it is now possible for us, as physicians, to adequately immunize in three visits the child who is out of step with immunization. (Author's summary)

214 Gorman, Pearl S., et al.
PREVENTIVE AND EPISODIC HEALTH CARE OF INNER-CITY CHILDREN
Submitted for publication to Pediatrics
For further information contact the author at the Health Services Research and Development Center, the Johns Hopkins Medical Institutions, 624 North Broadway, Baltimore, Maryland 21205

This paper examined preventive and episodic care among children in an inner-city population. Source of care and, for children three through five years of age, enrollment in day care programs were examined for their effect on securing care under a variety of situations. This analysis was part of a larger study of the health behavior and experiences of three sample populations living in 12 census tracts surounding The Johns Hopkins Hospital. The data are based, for this analysis, on information reported on behalf of children by adult members of their households. A later phase of this study will involve data obtained from medical records of children reported to have asthma or ear infections, and will provide an opportunity for testing the validity of reported prevalence and aspects of the process of care for these entities.

The data showed that while the majority of children school age and older had had multiple immunizations, only about half the children under age six had. There were higher proportions of children aged three through five with multiple immunizations among those enrolled in day care.

Next to immunizations, the highest percentages of children receiving care [illegible]ge who reported earaches. Care for an undifferentiated episode of illness showed no pattern of relationship to the various factors examined. Substantial proportions of the children in the sample populations were not receiving preventive care in the form of a well-child examination within the last [illegible]. Further, there were sizeable proportions who had not seen a [illegible]ner for any reason for over a year. There was some indication that within the newer group practice type of facility, higher proportions of children were receiving some type of preventive care. A moderately high proportion of asthmatic children aged 6-17, similarly, were not under regular care for this condition although the East Baltimore Medical Plan had the highest proportion under regular care. These findings suggest that while children will receive care for acute discomfort and to meet the requirements of day care and school, other kinds of preventive care or monitoring of an ongoing condition command much less attention. How this pattern compares with different [illegible]conomic groups and what the implications are of such differential use on ultimate outcome raise questions for future inquiry. (Author's summary)

215 Dawson, Peter, et al.
YIELDS AND COSTS OF SCREENING CHILDREN IN HEALTH CENTERS
Presented at the American Public Health Association Annual Meeting, 19 November 1975

The authors report the results and costs of pediatric screening conducted by health aides stationed at two neighborhood health centers, one small health care satellite, and the pediatric clinic of a university hospital. The performance of this group is then compared to the results of a special project that employed four health aides to conduct home-based screening. The facility-based aides used tone audiometry, the Denver Developmental Screening Test, the Denver Articulation Screening Test, tests of visual acuity, and tests for strabismus. The home aides conducted this same set and also inspected children for severe dental caries, took immunization histories, and urine samples. Moreover, the home aides rescreened children with abnormal findings before referring them to neighborhood health centers for diagnosis and treatment, and they also took great pains to encourage parents to visit the centers for needed follow up. The tables below present the findings of both the health center and housing project studies.

Table 1
TESTS DONE AND OUTCOMES

	Health Centers	Housing Projects	
	4 Tests	4 Tests	All 7 Tests
Tests done	3,183	2,177	3,602
Abnormal Tests	302 (9%)	146 (7%)	354 (10%)
Tests resulting in clinic visits for diagnosis	132 (44%)	82 (56%)	222 (63%)
Tests resulting in decision that treatment was required	86 (65%)	40 (49%)	172 (77%)

4 tests: vision, hearing, articulation, development
7 tests: plus immunization, dental caries, bacteruria

Table 2
ANNUAL COST OF ONE SCREENING AIDE

	Health Centers (Average)	Home Project
Direct	$ 7,022	$6,227
Indirect	3,915	2,946
Total	$10,937	$9,173

Table 3
COST PER TEST

	Health Centers	Housing Projects	
	4 Tests	4 Tests	All 7 Tests
Total cost (direct and indirect) during period of study	$9,139	$9,700	$11,501
Tests done	3,183	2,177	3,602
Cost per test	$2.87	$4.46	$3.19

4 tests: vision, hearing, articulation, development
7 tests: plus immunization, dental caries, bacteruria

Table 4
COST PER ABNORMAL TEST RESULT

	Health Centers	Housing Projects	
	4 Tests	4 Tests	All 7 Tests
Total cost	$9,139	$9,700	$11,501
Abnormal test results	302	146	354
Cost per abnormal test result	$30	$66	$32

4 tests: vision, hearing, articulation, development
7 tests: plus immunization, dental caries, bacteruria

Table 5
COST PER TEST THAT RESULTED IN
DECISION THAT TREATMENT WAS REQUIRED

	Health Centers	Housing Projects	
	4 Tests	4 Tests	All 7 Tests
Total cost	$9,139	$9,700	$11,501
Tests resulting in decision that treatment required	86	40	172
Cost per test that resulted in decision that treatment was required	$106	$242	$67

4 tests: vision, hearing, articulation, development
7 tests: plus immunization, dental caries, bacteruria

In conclusion, the authors emphasize that evaluation of screening programs must consider not only process (number of tests done) but outcome (number of tests resulting in decision that treatment is required). But most important, the yield of the program will be increased if abnormal findings are followed aggressively. Although slightly more expensive per test, home screening may be needed to reach children in poverty areas.

300 Butler, Allan M., et al.
PEDIATRIC NURSE PRACTITIONERS AND SCREENING PHYSICAL EXAMINATIONS
Clinical Pediatrics 8(11): 624-628, November 1969

The authors report favorably on a Head Start screening program that employed specially trained nurse practitioners to conduct physical examinations. Unanswered questions remain: does a single screening session give satisfactory return on the effort; specifically, is screening valuable outside the context of comprehensive patient care?

301 Hunter, Gertrude Teixeria
SCREENING TESTS FOR HEAD START CHILDREN
Pediatric Clinics of North America 18(1): 159-168, February 1971

Dr. Hunter describes the screening model employed by the Head Start Program to evaluate vision, hearing, and physical growth and to identify cases of anemia, urinary tract infection, and tuberculosis among preschool children. To lend specificity to the discussion, she focuses on activities in Detroit, Michigan; here, Head Start screening involved a medical history and physical examination as well as the above mentioned screens carried out by a health team composed of six specially trained health workers and practical nurses under the supervision of a public health nurse and a physician coordinator. Given the advantage of established locations for screening, the Detroit team was able to evaluate some 1,500 children in two months.

The results of a Bureau of Census national sample of Head Start children, Exhibit A-5, following this page, suggest that low-income populations may benefit more from screening than the general pediatric population.

Dr. Hunter registers dissatisfaction with the scope of screening services that were provided the children and recommends the inclusion of improved screens for speech problems, psychological disturbance, and developmental anomolies.

302 Allen, Constance M., Metz, Richard J., and Shinefield, Henry R.
TEST DEVELOPMENT IN THE PEDIATRIC MULTIPHASIC PROGRAM
Pediatric Clinics of North America 18(1): 169-178, February 1971

This report out of Kaiser-Permanente (San Francisco) describes the development and use of psychological tests within a pediatric, multiphasic screening program. In the authors' view, three major objectives justify the inclusion of individual screening components: (1) detection of chronic complications of acute disease; (2) detection of abnormalities predisposing children to acute conditions; and (3) detection of chronic occult conditions that might be contravened or ameliorated through early intervention. The Kaiser program had a

EXHIBIT A-5

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

RESULTS OF SCREENING TESTS PROVIDED TO PROJECT HEAD START CHILDREN BY MID-PROGRAM TERM

	Full Year 1967-1968	Summer 1968
Tuberculin Test		
Children who received TB test during program	57 %	54 %
Children not tested during program due to recent test	7	8
Children with positive results (tested in program and recently tested)	1.9	2.2
Blood Test For Anemia		
Children who received blood test	52	58
Type of blood test received:	(100)	(100)
Hemoglobin	49	52
Hematocrit	28	26
Both	17	12
Unknown	6	10
Tested children with results indicating anemia	14.9	10.7
Screening Test For Hearing		
Children who received test for hearing	49	64
Tested children with abnormal results	3.9	4.8
Screening Test For Vision		
Children who received test for vision	57	72
Tested children with abnormal results	7.3%	8.6%

Source: Data collected by the Bureau of the Census on a 5 percent sample of Project Head Start children in full year and 1 percent sample in summer programs.

fourth objective, perhaps its most dominant: to establish normal values based on the screening of large numbers of presumably healthy children. Armed with more precise normal values, the investigators hoped to develop finer screens.

Certainly, as the authors note, the prevalence of psychological and learning disorders warrants that these be targeted for screening. The screens either developed or employed at Kaiser (behavior inventory, Rutgers drawing test, Peabody Picture Vocabulary Test, Columbia Mental Maturity Scale, reading section of the Wide Range Achievement Test) were between 70 and 78 percent sensitive and between 92 and 94 percent specific. At the time of writing, the psychological phase of the screening program was yielding 7 percent new cases for follow-up. Nevertheless, the authors warn that the value of the program can only be "determined longitudinally, as detection leads to intervention and, hopefully, improved performance in school and social activities." In addition, long-term follow-up of screened populations must be accompanied by the development of a data bank large and reliable enough to support a variety of necessary evaluative analyses.

303 Allen, Constance M. and Shinefield, Henry R.
PEDIATRIC MULTIPHASIC PROGRAM: PRELIMINARY DESCRIPTION
American Journal Diseases of Children 118: 469-472, September 1969

A pediatric multiphasic program, conducted by San Francisco Kaiser-Permanente Medical Group, combines into a single health service the following three separate elements: (1) a group of screening tests, or phases, administered by nurses or nurse's aides; (2) computer processing and storage of results of these tests; and (3) a physician's examination approximately one month after the tests are performed. The purpose of the program includes: (1) evaluation of this type of examination in the delivery of medical care to children, (2) establishment and verification of new normal values, and (3) an opportunity for developing a variety of longitudinal clinical research studies. Over 5,000 children between 5 and 15 years of age have already been tested; younger children will soon be included in this program. (Authors' summary)

Comment: In their concluding comment, the authors note that the multiphasic screening program, composed of 21 elements, was not expected to uncover many cases of occult disease. As a later report by Shinefield and Allen (Pediatrics 54(5) November 74) makes plain, automated, multiphasic screening has not yet proven a significant contributor to child health and should not be considered ripe for wide implementation.

04 Thores, A. and Philion, J.
A PRESCHOOL SCREENING PROGRAM ON CENTRAL VANCOUVER ISLAND: A TWO-YEAR FOLLOW-UP
Canadian Journal of Public Health 65: 385-387, September/October 1974

The authors report findings of a follow-up on a preventive health initiative that tested 1,087 preschool children or 67 percent of the target population for hearing, vision, general health, and developmental problems. After two years, 25 of the 109 children referred for follow-up diagnosis/therapy had visited the nurse or doctor for the condition in question and 67 were undergoing or had completed therapy or intensive surveillance. Only four of the 67 had had previous attention for the problem identified through screening.

The authors note that their findings are comparable to those of a more extensive evaluation of a far more extensive screening program conducted in Scandanavia; the Scandanavian study, it should be noted, was one of the few published evaluations available to the authors for comparison. Screening in the Vancouver programs was conducted first by lay volunteers, with suspect cases referred to public health nurses for rescreening. Percentages of children considered suspect were considerably reduced by the rescreening. Over-referral rates were 6.94 percent for vision; 2.35 percent for hearing; and 1.10 percent for general health problems. The authors consider program acceptance high, particularly for a community unfamiliar with preventive health practices, and anticipate even greater response upon the establishment of necessary follow-up facilities.

400 Foltz, Anne-Marie and Brown, Donna
STATE RESPONSE TO FEDERAL POLICY: CHILDREN, EPSDT, AND THE MEDICAID MUDDLE
Medical Care XIII(8): 630-642, August 1975

The implementation in Connecticut of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), a program of comprehensive medical care for needy children, illustrates the complexities engendered by federally mandated state-administered health programs. The EPSDT amendments to Title V and Title XIX (Medicaid) were ambiguous on four major issues: administrative responsibility, costs, eligibility, and scope of services. The problems experienced by federal, regional, state, and local administrators in resolving these issues illustrate the weaknesses inherent in federal-state relations, and the contrasting roles health and welfare agencies under Medicaid have played in the development of health policy.

Connecticut may represent maximum limits to state performance in carrying out EPSDT because it is a rich state, ranking high in medical resources and in the provision of Medicaid services. During the first year of implementation of EPSDT, the program had little impact: less than 5 percent of eligible children were served. State policies, which contravened federal policy, precluded effective resolution of the legislative ambiguities; no new services were added, the organization of health services remained unchanged and fragmented; and the State Health Department played only a limited role. (Journal)

401 Foltz, Anne-Marie
THE DEVELOPMENT OF AMBIGUOUS FEDERAL POLICY: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)
Milbank Memorial Fund Quarterly 35-64, Winter 1975

This paper examines why Congress's first major program for comprehensive health care to needy children took five years to begin even partial operation. An examination of the 1967 program's legislative history reveals that Congress paid little attention to EPSDT's implications; it was left ambiguous whether health (Title V) or welfare (Title XIX) would administer; costs were never clearly stated; eligibility and scope of services to be provided were left vague. Despite pressure from welfare rights interest groups, these ambiguities delayed the preparation of regulation and guidelines which never did succeed in resolving the question of overlapping jurisdiction and costs. In addition, many states' resistance to paying for the program further held up implementation.

The paper concludes that: (1) Congress's and HEW's unwillingness to face up to the real costs of health programs threatens long-term public and state support for such programs; (2) division of responsibility between health and welfare

lessens the impact of a program; (3) grant-in-aid programs give states the power to distort the intent of federal health policies; and (4) where states fail to implement such policies, initiatives may pass to consumer advocacy groups. (Journal)

402 Kirk, Thomas R. and Rice, R. Gerald
EPSDT--ONE QUARTER MILLION SCREENINGS IN MICHIGAN
Presented at the American Public Health Association Annual Meeting, 19 November 1975

Since the spring of 1973, Michigan has screened more than 300,000 of its approximately 440,000 Medicaid-eligible children. The Department of Social Services contracted the Department of Health to undertake the screening and referral components of the EPSDT program; in turn, State Health subcontracted local health departments to conduct the actual screenings. In combination, 72 teams composed of a nurse, two technicians, and a clerk screen about 10,000 clients a month, referring more than half for diagnosis and treatment. Referrals are made most often for dental care (27 percent) and next, for immunization (26 percent). "No show's" run high for screening and at moderate levels for diagnosis and treatment. With more aggressive local clinical follow up, the program finds that approximately 65 percent of children referred receive diagnosis and treatment and, presumably, this mode will be pursued. The estimated cost per child screened is $26. Differentiated yields of the program (i.e., cost and benefits of components elements) have yet to be determined.

According the the authors, response to the program has been hearty. Providers receiving referrals include: private physicians (25 percent); dentists (32 percent); local health departments (22 percent); outpatient clinics (9 percent); crippled children clinics (1 percent); and "other" (11 percent).

The distribution of Michigan's eligible children by age group, the screening goal for each group, and the number of children actually screened are highly suggestive statistics that go both uninterpreted and unexplained in the text:

Age Group	Eligible Population	Target	Actual
0-5	121,126	60,563	61,237
6-12	159,261	79,631	60,394
13-21	220,283	110,142	34,132

It should be noted that Michigan's response to EPSDT represents a form that has received considerable criticism from the medical community, objections being that the establishment of separate screening facilities undermines comprehensive care, produces an unconscionable number of false positives, and does little to assure that those screened are then diagnosed and treated.

500 Wallace, Helen M. and Goldstein, Hyman
CHILD HEALTH CARE IN THE UNITED STATES: EXPENDITURES AND EXTENT OF COVERAGE WITH SELECTED COMPREHENSIVE SERVICES
Pediatrics 55(2): 176-181, February 1975

This paper summarizes pertinent data on national health expenditures for children and youth. In Fiscal Year 1972, the average expenditure per child per year for health care from all sources in the United States was $147 for children and youth under 19 years of age, an amount 15 percent above that for the children and youth projects ($128 per child per year). The extent of coverage of children and youth, even those in high-priority groups, is still very restricted. Some implications are suggested for future planning for the use of existing funds currently available for the health care of children and youth. (Journal)

Comment: It should be noted that average annual expenditures for Medicaid children ran at $301.87 in 1971 or about $174 more than the average spent on enrollees at Child and Youth Projects in general. The authors suggest that children may be better and more economically served in comprehensive health care settings, such as Child and Youth, than in the open health care market. They recommend that Medicaid funds be channeled into the development, expansion, and strengthening of existing comprehensive care programs.

501 Rabin, David L. and Schach, Elisabeth
MEDICAID, MORBIDITY, AND PHYSICIAN USE
Medical Care XIII(1): 68-78, January 1975

Medicaid programs which provide services for low-income persons who have high medical needs have been criticized for high costs and have raised questions about overuse of physician services. A Baltimore SMSA household interview of use of health services permitted comparison of use of physician and preventive services controlled for morbidity by Medicaid recipients and two other income groups. Medicaid recipients were sickest and had higher physician use. They were more likely to have visits suggested by a physician, to be asked to return, and to be given injections. Physician visit rates were higher for each morbidity category, particularly for Medicaid healthy, who also used more preventive services in two weeks. Higher use of services by Medicaid recipients is accounted for by higher morbidity and increased need and demand for preventive services. Constraints on the use of physician services now most directly affect use of preventive services by those of low income without Medicaid benefits in the Baltimore SMSA. (Journal)

502 Pratt, Lois
THE RELATIONSHIP OF SOCIOECONOMIC STATUS TO HEALTH
American Journal of Public Health 61(2): 281-292, February 1971

Crediting the existence of a direct relationship between diminished health and low socioeconomic standing, the author attempted to refine this connection through a survey of 401 women, all with children between 9 and 13, all with husbands in residence, and all living in a Northern New Jersey city. The most striking revelation of the study was that women from lower socioeconomic groups with good health practices were not significantly disadvantaged in health level when compared to more affluent women. The personal health practices in question included personal care, behavior (sleep, exercise, elimination, dental hygiene, smoking, and alcohol consumption); use of professional health services (quality in use of preventive, specialized, and episodic care); level of health knowledge; and amount of health equipment in the home.

Based on the study findings, the author recommends that health programs: (1) focus on highly specific health practices rather than abstract health principles; (2) emphasize the importance of exercise as well as nutrition; (3) reinforce the sound health practices that are found in concentration among low-income women.

503 Brown, Howard J.
DELIVERY OF PERSONAL HEALTH SERVICES AND MEDICAL SERVICES FOR THE POOR
Milbank Memorial Fund Quarterly 46: 203-223, January 1968

The author, a consultant to the Office of Economic Opportunity at the time of writing, explores the literature of health care needs, describes existing models for delivery of care, and proposes the elements that must be included in a plan for the delivery of health services to the poor. He maintains that no existing models of care can be adopted to meet the needs of the impoverished, and takes great pains to explode what he considers a mythic connection between private practice and quality medical care. Private practice is also considered unsuitable as a resource for the care of the impoverished because private providers are absenting themselves from low-income neighborhoods, urban as well as rural. In contrast, the emergency rooms and clinics of large urban hospitals deserve considerable support and should assume a central role in delivery to the poor since these are the locations that the poor choose to frequent in increasing numbers and for an increasing range of problems. (It should be noted that in 1968, when this article was written, the growing use of emergency rooms for noncritical care was widely indicated and plans were proposed for diverting the poor from these favored sites. Thus, the author

held a rather novel view of the problem, one that seems to hold considerable logistic merit, but one that has not widely influenced the development of services under public health programs.)

Brown notes in particular that the provisions of Medicare legislation will not help the poor appreciably because the poor have never been able to negotiate the fee-for-service system on which the program is based. Although he has not worked out an exact mechanism for the effective delivery of health services to the poor, Brown contends that consumer involvement is the most powerful, potential method for offsetting the self-interest of the professions and inadequate financing by government.

Clearly, Brown speaks here as a man of the 60's, deeply touched by the temper of that time. Yet the evidence he marshalls against private practice as the optimal location of services for the poor and the case he makes for the expansion of hospital clinics still deserves a careful hearing.

504 Lefcowitz, Myron J.
POVERTY AND HEALTH: A REEXAMINATION
Inquiry X: 3-13, March 1974

Survey data generated by the National Center for Health Statistics (NCHS) are commonly cited to support the belief that poverty leads to less medical care and diminished health. After reexamining NCHS data, Lefcowitz suggests that these connections are less direct than has been assumed. Specifically, "when education is taken into account in analyzing the income-health relationship, the correlation is considerably diminished, usually to the point of disappearance." Lefcowitz acknowledges the high correlation between income and education and so admits that health programs directed toward the poor would probably capture a large portion of the medically impoverished population. Still, this admission does not undercut his main point: policymakers who would promote improved health standards must consider structural as much or even more than financial barriers to access; to succeed in their mission, they must explore and address the conditions that lead to poor patterns of utilization.

The implications for EPSDT are plain. The program does recognize that patterns of utilization are determined by structural as well as financial barriers to access, thus the emphasis on outreach. Unfortunately, EPSDT outreach has fallen far short of what would be required to alter deeply engrained patterns of health and sickness behavior.

505 Weaver, Jerry L. and Inui, Lloyd T.
INFORMATION ABOUT HEALTH CARE PROVIDERS AMONG URBAN LOW-INCOME MINORITIES
Inquiry XII: 330-343, December 1975

The purpose of the reported study was to determine the kind and level of health care information possessed by low-income respondents from selected ethnic groups--Anglos under age 65, Anglos over 65, Blacks, Filipinos, and Japanese. The researchers hypothesized that ethnicity, not socioeconomic status, is the dominant variable explaining provider preference and source of information about health care. The five samples (with between 64 and 189 cases in each) contained similar distributions of major socioeconomic and demographic attributes. All respondents were asked to indicate where they would recommend that a friend or family member go to get treatment for each of five separate needs: (1) badly cut leg; (2) typhoid shot or small pox innoculation; (3) emotional upset or chronic nervousness; (4) advice about a pregnancy problem; and (5) information about venereal disease.

The researchers noted a clear divergence between reliance on private as opposed to public providers, with the under 65, Anglo, Black, and Filipino groups recommending public health clinics and emergency rooms more consistently than the Japanese and elderly Anglos. The authors believe that structural barriers contribute much to the marked preference for or avoidance of the various providers. Specifically, Blacks at all income levels show a disproportionate favoring of public clinics and institutions where, it is assumed, they suffer less from feelings of social distance. The absence of physicians [illegible] in urban ghettos is also cited in explanation.

The findings of this study have implications for the development of health care services directed at poverty populations. First, the categorical programs received little notice among respondents, suggesting a need for more or different forms of outreach. Since different ethnic groups and different age groups gain health care information from different sources, outreach must first identify and then tap existing linkages between dominant and communal services. In conclusion, the authors warn that "knowledge about providers who remain racist, inhumane, discriminatory, inaccessible, and prohibitively expensive will do little to change prevailing utilization patterns or improve health and well-being. Structural reform and community education are prerequisites to improvement.

600 Warner, Morton M.
LOWER SOCIOECONOMIC GROUPS AND PREVENTIVE PUBLIC HEALTH PROGRAMS: A PROBLEM OF COMMUNICATION EFFECTIVENESS
Canadian Journal of Public Health 64: 562-573, November/December 1973

This article deals with the problems that arise when preventive health care programs developed by middle-class minds are conveyed by middle-class professionals to the lower classes. An important variable in the transmission of public health messages is that of social distance, which has here been isolated for consideration.

A study was undertaken of 96 families in the Mt. Pleasant area of Vancouver wherein the effectiveness of various public health professionals in communicating to lower socioeconomic groups was examined. The effectiveness of newspapers, health articles, and television was also assessed.

The paper takes note of the fact that the position of the individual receiving public health messages is far from static. He is influenced by the subject of the message, the personality of the sender of the message, and by many extraneous sources, such as neighbors and relatives. In addition, barriers such as language, age, sex, and values act as roadblocks in the receiving of messages.

By pointing out the problems of the association of preventive health programs with middle-classness, this study suggests methods for better communication through reduction of the factor of social distance. (Journal)

Comment: Although respondents reported a marked social distance between themselves and public health nurses, they reported that the message these nurses purveyed had influenced their preventive health behavior, directing them toward fluoridation, regular dental checkups, immunization, and prenatal classes. Apparently social distance did not create impermeable barriers in an audience prepared to perceive a message as intrinsically important.

601 Freymann, John Gordon
MEDICINE'S GREAT SCHISM: PREVENTION VS CURE: AN HISTORICAL INTERPRETATION
Medical Care XIII(7): 525-536, July 1975

All societies, primitive and advanced, demand therapeutic services, but a society must develop sophisticated prerequisities before it can support preventive services. This discordance in the origins of curative medicine and of public health does not explain why a schism between them still persists. This gap should be closed since medicine has cured most curable diseases and the residue of chronic conditions is best handled by preventing them or detecting them before they become medical crises. Reasons for persistence of the schism include: early concentration of public health on environmental sanitation to the

exclusion of medicine; identification of public health with governmental bureaucracy; linking care of the poor with tight-fisted welfarism; existence of two separate educational systems; the view of doctors, who are activists by nature, toward the excitement of cure; the custom of paying only for active therapy; and the orientation of the Hippocratic ethic toward individuals. (Journal)

602 Nader, Philip R.
THE SCHOOL HEALTH SERVICE: MAKING PRIMARY CARE EFFECTIVE
Pediatric Clinics of North America 21(1): 57-73, February 1974

Dr. Nader recommends more consistent and cooperative interaction between the schools and health agencies and providers serving children. He reports models for interaction designed to assure links between the screening function and the provider of first-line health care. For instance, the presence of health personnel in the school and their participation in school life may serve as a measure of primary prevention, promoting a more salubrious environment for health maintenance and flourishing. Their knowledge of students' needs may forge strong links between individual students and sources of required secondary prevention; given a knowledge of the curative interventions undertaken, health personnel may assist in the student's return to health--tertiary prevention.

For the most part, Dr. Nader's presentation of models for interaction is more anecdotal than conceptual, painting a picture charactered with interdisciplinary teams composed of nurses, psychologists, social workers, etc. Having adumbrated the concepts of primary, secondary, and tertiary prevention, he expatiates on the considerations that must figure in development of a coordinated school service--geography, available resources, training for school health personnel, and methods of implementation.

603 Schoenwetter, Charles D.
THE SCHOOL HEALTH SERVICE: REVIEW AND COMMENTARY
Pediatric Clinics of North America 21(1): 75-80, February 1974

A discursive review and commentary of Dr. Nader's monograph on the school health service, this article includes significant observations if not precise recommendations. First, Dr. Schoenwetter observes that until quite recently, education adopted a medical-model approach to school health, wherein the "different" child is defined as the problem, diagnosed, and hopefully cured or improved. Now, to the author's approval, education and medicine are beginning to consider the interacting conditions that promote child health. Second, although physicians see children from birth onward and thus may contribute significantly to school health programs, they should not assume the dominant position on interdisciplinary school health teams. Like most observers, Dr. Schoenwetter warns that available screens are neither specific nor sensitive enough to yield reliable, categorical results and urges school physicians to attend to the teacher's observations about a given child. He endorses the

location of screening programs in the schools because: schools are appropriately placed in the community; they are excellent loci for maintaining data banks; and they provide physicians access to large numbers of normal children, such children as are often missed in the secondary and tertiary centers where doctors do their training.

Dr. Schoenwetter notes that the problems identified in this environment of normalcy are commonly referred to the physician's office. Better to his mind would be a physician's visit to the child's school and classroom, where the teacher's knowledge of the child might eliminate duplicative testing and the interactional context might inform the physician's subsequent treatment. He praises a Washington, D. C., health and educational diagnostic system devised by Ozer and Richardson, featuring a diagnostic team of teacher, physician or nurse, and psychoeducational counselor.

In effect, the sum of Dr. Schoenwetter's observations portray the school as the most appropriate agent for screening and the physician with other professionals as resources.

Comment: Since grants for school health projects are becoming more and more competitive and since screening under EPSDT may not necessarily support the school as a location for preventive services, it may become more and more difficult to consummate the recommended "marriage" between education and medicine.

304 Novick, Lloyd F.; Mustalish, Anthony; and Eidsvold, Gary
CONVERTING CHILD HEALTH STATIONS TO PEDIATRIC TREATMENT CENTERS
Medical Care XIII(9): 744-752, September 1975

Nineteen child health stations in New York City have added treatment services to their traditional role of well-child supervision with the objective of increasing the access of children living in underserved areas to integrated preventive and therapeutic care. The conversion process was studied at nine pediatric treatment centers (PTC) in upper Manhattan and the South Bronx. The Department of Health accomplished the conversion by adding full-time pediatricians, on-premises laboratory capability, prepackaged pharmacies, and informal arrangements with local hospitals. The proportion of patient visits at the PTC's for sick care ranged from 11 to 57 percent and varied with the length of time the unit had been in operation. Personnel cost per visit was $16. Six child health stations were compared before and after conversion to PTC's. Registration increased 5 percent, visits increased 50 percent, and personnel costs increased 150 percent. Review of 600 patient visits revealed that the majority of illness visits were for minor conditions, notably upper respiratory infections. Interviews of 600 parents at three PTC's revealed that approximately one-fourth regarded the PTC as a usual source of care. Increased access and continuity

of child health services have been accomplished by these conversions. Adding treatment services to child health stations is a satisfactory alternative to the overcrowded hospital-based pediatric facility. (Journal)

Comment: This study did not attempt to evaluate medical outcome under the new system of comprehensive care established by adding therapeutic services to an existing program of preventive services. Instead, process measures were indicators of success, serving to demonstrate the desire for this organization of care among members of the target population. High utilization of these resources suggests that EPSDT might well build ento existing programs providing either preventive services or episodic care. Either way, the desired integration of preventive, therapeutic, and maintenance services might be accomplished.

605 Becker, Marshall H., Drachman, Robert H., and Kirscht, John P.
CONTINUITY OF PEDIATRICIAN: NEW SUPPORT FOR AN OLD SHIBBOLETH
The Journal of Pediatrics 84(4): 599-605, April 1974

Although continuity of pediatrician has great intellectual and emotional appeal, there is little evidence that continuity itself contributes to improved medical outcome. The authors' experimental design "permitted comparison of ambulatory pediatric care in a traditional comprehensive clinic with similar care in an experimental clinic emphasizing continuity of physician. The results of a survey of all staff and a sample of patients' mothers indicated that provision of pediatric continuity yields higher staff and client satisfaction, better patient practitioner relationships, and greater efficiency."

The authors imply that the greater satisfaction afforded by physician continuity may promote patient compliance with recommended therapies. Moreover, since staff satisfaction was universally higher under the physician continuity system, it is likely that physicians might participate more willingly in clinics proffering such patient-physician relationships. They recommend that continuity be a goal of all pediatric clinics.

606 Breslau, Naomi, et al.
COMPREHENSIVE PEDIATRIC CARE: THE PATIENT VIEWPOINT
Medical Care XIII(7): 562-569, July 1975

Two meanings of the term comprehensive care are delineated. The first refers to a wide scope of health services, the second to a humanistic approach to the patient. Findings from a sample of patients from one pediatric practice suggest that the two meanings constitute two independent variables with respect to patient expectations.

Patient responses to questions regarding their expectations of the pediatrician revealed a tendency to hold a traditional disease orientation. Comprehensive care as a broad scope of health services that included mother guidance in child rearing is not a common goal for mothers utilizing the pediatric practice under study. On the other hand, a comprehensive approach by the pediatrician is a standard shared by most respondents in the sample; high priority is accorded the pattern of the personal physician with whom a patient forms a continuous doctor-patient relationship which instills in the patient trust that the physician's recommendations are based on thorough knowledge of the patient as an individual. (Journal)

607 Pless, I. B.
THE CHANGING FACE OF PRIMARY PEDIATRICS
Pediatric Clinics of North America 21(1): 223-244, February 1974

Once overburdened by patients, pediatricians must now face the possibility of dwindling practices. Birthrates are falling; infectious disease is declining; the varieties of health specialists, superspecialists, and paraprofessionals are multiplying; and the renaissance of the family physician, a strong competitor, is now gaining support. Accordingly, pediatricians must define their place in the delivery of health care to children and describe the special contribution that they make to child health. Pless suggests that two rudimentary questions should guide this definition: First, what can the "primary" pediatrician do for the child that no one else can do or do as well; and, second, if there is, in fact, less work for the pediatrician of the kind that he has traditionally undertaken, what new roles and functions should be assume?

Dr. Pless suggests a number of possible responses to these questions. First, pediatrics might follow a spiralling path downward to ever narrower subspecialties or pediatricians might direct their unleased time to the exploration of relatively uncharted areas of practice--preventive medicine, social medicine, service in medically needy areas, service split between suburban and urban environments, expansion of their age range to include not only infants and children but adolescents and even young families, and expansion of primary care to include service to the underserved minorities, the socially and economically deprived, and children suffering developmental, behavioral, or social distress.

Throughout, Dr. Pless encourages the profession to admit that many tasks of the pediatrician are delegable and should be given over to less highly trained persons. He openly favors a response to the pediatrician's dilemma that moves away from superspecialization toward the expansion of primary care to include preventive service, community involvement, health education, behavioral and social problems. If heeded, Dr. Pless's suggestion for remodeling the practice of pediatrics might encourage wider professional commitment to such programs as EPSDT.

608 Amberg, Richard H.
WHO WILL MEET OUR CHILDREN'S HEALTH NEEDS?
Chicago Daily News, 5 September 1975

In a series of articles on the inadequacies of existing child health care, Amberg reviews recent proposals for improving the situation, including:

- Mini national health insurance for children under six, with employers required to cover the children of their employees and neighborhood health centers expanded to aid poor and near-poor children
- A public fund to offset medical bills for children under six accompanied by fund providing loans for the establishment of additional neighborhood health centers by physicians, hospitals, medical schools, and community groups
- Expansion of the existing network of comprehensive care programs through increases in Medicaid funding
- Channeling of funds for episodic care into health maintenance organizations and other prepaid plans
- A free-standing national health service for every child and expectant mother providing a full range of prenatal, postnatal, pediatric, and support services
- Deployment of mobile units into underserved areas to screen, diagnose, and provide free treatment for all children and expectant mothers, regardless of income (included in the proposed Child and Maternal Health Care Extension Act)
- Extend financial assistance to states and localities for the upgrading and expansion of comprehensive family services, including health care, screening for handicaps, prenatal care, in-home and center-based day care, health education, and nutrition programs (proposed Child Health and Family Services Act of 1975)

700 General Accounting Office/Report to the Congress
IMPROVEMENTS NEEDED TO SPEED IMPLEMENTATION OF MEDICAID'S EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM
9 January 1975

At the request of Senator Randolph H. Metcalfe, the General Accounting Office (GAO) reviewed the status of EPSDT implementation through a survey of eight states--Alabama, Idaho, Illinois, Massachusetts, Oregon, Rhode Island, Washington, and Wisconsin. GAO found that, as of June 30, 1973:

- HEW had failed to monitor compliance issues and force adherence to regulations.
- Outreach efforts varied widely among the states and among localities within states; screening rates were directly related to the breadth and intensity of outreach.
- States were making inadequate use of allied health professionals even when private resources did not seem equal to the task of screening eligible children.
- None of the states had achieved their self-established schedules for the performance of screening.
- Most of the programs lacked mechanisms for determining whether those children referred for diagnosis and treatment actually received the services.

Although the above inadequacies were widely shared, performance varied markedly. In general, state and local programs that recognized EPSDT as an opportunity to improve health services for Medicaid children had also and expectedly found ways to overcome many of the administrative impediments to effective outreach and case management. In contrast, states that saw EPSDT mainly as an unnecessary and burdensome flourish had taken few if any steps to implement the program. They maintained that their existing Medicaid services were comprehensive enough to do the job of EPSDT, reported that most of their children were under appropriate care, and balked at the multiplication of reporting forms and mechanisms that would be required to satisfy EPSDT regulations.

Accepting the possibility that many unscreened children might be receiving appropriate care, GAO maintained that the states cannot effectively direct their EPSDT efforts until they determine what services eligible children are receiving from other programs or providers.

In conclusion, GAO recommended a number of improvements that would be needed to speed implementation of the program, all of them directed to the Administrator of the Social and Rehabilitation Service (SRS) and most of them casting SRS in a helping role:

- Develop criteria for determining children who are under appropriate care and focus screening on the unattended remainder of the eligible population.
- Encourage states to use other outreach techniques in addition to or in lieu of the simple written notification.
- Encourage and help states to use allied health workers, particularly for screening in physician-poor areas.
- Encourage and help states to devise methods for ensuring that screenings are updated periodically.
- Monitor state progress in meeting screening schedules.
- Require states to establish procedures for ensuring that those children who need diagnosis and treatment receive the services.

responded to these findings and recommendations by describing the actions epartment was already taking to remedy admitted shortcomings. GAO ed satisfied enough with HEW's response to recommend that, as of January 75, no further Congressional action need be considered.

Weinberger, Caspar W.
TEXT OF SPEECH PREPARED FOR AN EPSDT CONFERENCE
Washington, D.C., 9 August 1974

s item is included to serve as an example of the oversights common in offi- l rhetoric. These are understandable, pardonable, since the podium cannot he weight of detailed analysis. And yet, if taken too seriously, if removed their original context and quoted to a different perhaps less informed ce, such official remarks may perpetuate unfounded assumptions and ions.

ollowing list includes some, but not all, of the assumptions that were con- d in Caspar W. Weinberger's remarks before an EPSDT Conference, held ugust 9, 1974. Obviously, some are more solidly grounded than others, all are presented with the same degree of rhetorical certitude and thus danger:

- Needy children receive piecemeal care or no care at all.
- A governmental program is capable of bringing these children into the mainstream of medical care.
- There is a mainstream of care capable of and willing to accommodate these children.
- Many diseases can be detected and treated early before they develop into handicapping conditions.
- The nation's poor children can profit immeasurably from preventive health services.
- The United States spends far too much money on curative services.
- If we spent more money on preventive care, we could gradually reduce expenditures for curative care.
- Proper medical attention is not usually a poor family's first priority.
- Poor children do not visit the doctor enough.
- Preventive health services for most poor children are simply nonexistent.
- The best way to reduce the incidence of illness is to prevent it, and the next best way is to diagnose and treat it early.
- The medical technology for prevention and early case finding is available.
- Needy and sickly children are almost synonymous.
- Through EPSDT, poor children can be assisted to realize a lifetime of achievement.
- Without EPSDT, eligibles would be unlikely to receive the services the program provides.
- It is possible to gain the effective support of established medical organizations.
- Many children have never been introduced to the medical system.

- Medicaid children, who make up half of the Medicaid population, should be claiming more than 20 percent of Medicaid dollars that are now spent on their care.

- EPSDT is designed to assure that services are actually available and accessible to Medicaid children.

Many of the assumptions included in Mr. Weinberger's remarks have prompted scores of contradictory, inconclusive studies. Clearly, the assumptions propounded in official language cannot be adopted at the operational level until they are tested.

Unfortunately, as is clear from the hearings of the Subcommittee on Oversight and Investigations, many Congressmen have adopted these assumptions uncritically and may use them to support certain misguided recommendations for the further development of the EPSDT program.

702 House Subcommittee on Oversight and Investigations
GETTING READY FOR NATIONAL HEALTH INSURANCE:
SHORTCHANGING CHILDREN
Transcript of hearings on the role of government in preventive health programs that primarily affect children, 7 and 8 October 1975

This is perhaps the most telling document in the entire EPSDT canon. In miniature, it reflects the majority of problems associated with the program and demonstrates with some drama how very difficult it is to develop effective social [illegible] through the legislative process. Clearly, most of the Committee members came to the hearings with the preconception that EPSDT, as conceived, was a "good" that had not materialized. All wanted to "get clear on" why implementation of this worthy initiative had been delayed for so many years; many latched on to figures about the cost of preventable disease, making this their hobbyhorse throughout the proceedings. Those who were captivated by the numbers game did not seem to understand the perilous assumptions on which they were operating--that the EPSDT program could, in fact, have prevented or ameliorated these preventable or remediable ailments; that money spent on preventive health care will automatically reduce money expended on curative services. No one seemed to notice that the ailing children brought before the gathering to demonstrate the horrible morbidity that might be prevented by a fully formed EPSDT program had, in fact, been in considerable contact with the medical community. They had been screened, their problems were recognized, but--in most cases--their parents were not powerful enough to negotiate responsible treatment from the medical community.

Given their preconceptions, most Committee members heard the testimony with glaring selectivity. Those medical professionals who cut their criticisms deeply into the conceptual fabric of EPSDT were not accorded the degree of attention they deserved, at least not by most members. In other cases, public witnesses sluffed off the most trenchant questions of Committee members. For instance, when Representative Sharp asked whether EPSDT could do the job we need to do or whether we should be drawing up a new program, he was scarcely noticed. His plea for an experimental approach to health service delivery also went unheeded.

In the end, at least as evidenced by the transcript the Committee ended where it had begun, still convinced that EPSDT was well-designed to address a critical problem and was a program that simply could not and would not be denied their utmost support. At this writing, the Subcommittee has not yet submitted its report to the President but is expected to do so within the next eight weeks.

CASE REPORT:
CHEMUNG COUNTY

APPENDIX B

CASE REPORT: CHEMUNG COUNTY

Site Visits
December, 1976
May, 1976

CASE REPORT: CHEMUNG COUNTY

1. INTRODUCTION TO CHEMUNG COUNTY

Chemung County was selected as representative of an upstate urban county without a large city. Several characteristics of the Child Health Assurance Program (CHAP) made it an attractive candidate for inclusion in the study. Most important, Chemung's CHAP program is administered by a private contractor; early indications were that the County had a well-trained and highly motivated staff with strong support by the Commissioner of the County Department of Social Services (DSS), and cooperative relations with local providers. Although the rate of implementation[1/] was somewhat slow, the positive features of the County made it an appealing case study.

(1) Chemung County Is One Of Two Counties In The State Where The Major Responsibility For Implementation Of CHAP Rests With A Contractor

The Chemung County DSS has contracted with the Comprehensive Interdisciplinary Developmental Services, Inc. (CIDS), to administer CHAP. CIDS ("Kids" with a "C") is an Appalachian Regional Commission (ARC) funded program which provides services to 23,000 children aged zero to six in a three-county area.[2/] Since May, 1972,[3/] CIDS has conducted a program of screening and assessment in the health, education, psychological, and social areas. In addition, CIDS was responsible for operating the earlier Early and Periodic Screening, Diagnosis, and Treatment EPSDT) program in Chemung County. The success of this earlier relationship and the attractive financial arrangement offered by CIDS lead DSS to negotiate a formal agreement under CHAP. Currently, CIDS is responsible for most client- and provider-oriented functions associated with CHAP operations, such as contacting families who request examinations and tracing the care provided. DSS provides a full-time Coordinator for liaison and is responsible for many of the administrative functions required under EPSDT, primarily: notification, initial contact at intake and recertification, completion of the request

1/ Less than 35 percent of those children eligible for the first half of the calendar year were under adequate care (includes those identified in appropriate medical supervision and those who received initial screening).

2/ As part of their overall charter, CIDS also services children in Steuben and Schuyler Counties, although CIDS has no agreement with those counties to provide CHAP services.

3/ CIDS was recently assured funding for Fiscal Year 1976-1977 and has tentative commitments for funding during Fiscal Year 1977-1978.

form (DSS-2400), preparation of monthly statistical reports (DSS-2404), and payment of provider claims.

(2) Chemung County Is A Small And Sparsely Populated County With Adequate Provider Resources

Chemung County is a relatively small county of 415 square miles with a total population of 102,000. In 1970, an estimated 40,000 persons were under the age of 19. The median family income is $9,376 (1969). In 1972[4/] 5,500 persons in the county were on public assistance (PA); 9,000 persons (9 percent) received Medicaid; and in 1975, approximately 4,712 children were eligible for CHAP.

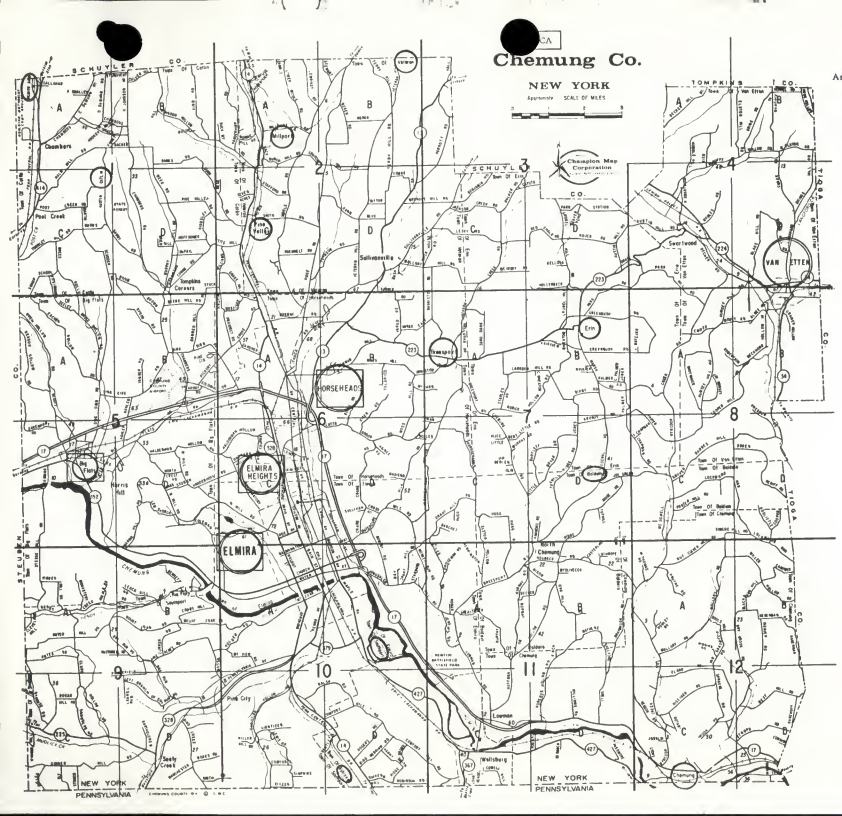
Chemung County has adequate provider resources. There are two hospitals with a combined capacity of 602 beds, a modern psychiatric center, and a County Health Center which includes a 200-bed infirmary for patients requiring nursing-level care. Another 176 nursing home beds are provided through the Elcor Nursing Home, also in Chemung County. Over 150 physicians and 40 dentists representing most specialties practice in the County, mostly in the Elmira area. Twelve pediatricians and five family physicians currently participate in CHAP. The pediatricians practice as part of two Elmira-based groups. Most dentists in the County participate in Medicaid and have indicated a willingness to receive CHAP referrals. Exhibit B-I, following this page, shows the geographic distribution of the CHAP-eligible children and providers in the County.

Initially, CHAP anticipated negotiating agreements with all providers. Their early experience, however, of using only two pediatric group practices as the major providers of periodic examinations, has lead the County to discount the necessity of provider agreements and DSS does not expect to negotiate agreements with these two group practices or with other providers. However, DSS will negotiate provider agreements with CHAP providers upon their request.

DSS has taken several steps to encourage provider participation in the program. Dr. Robert Huddle, DSS Medical Director, plays a key role as liaison with the provider community. In addition, CHAP got off to a good start in Chemung County with a formal orientation for providers who seem generally sympathetic to the goals of and need for CHAP. It is interesting to note that the formal presentation prepared by the CHAP Coordinator was quickly abandoned in favor of a question and answer session. The consensus at the conclusion of this meeting

4/ Chemung County Chamber of Commerce.

Chemung Co.



Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DISTRIBUTION OF CHAP-ELIGIBLE CHILDREN AND PROVIDERS IN CHEMUNG COUNTY

CHAP Children--Jan. to Nov., 1975

Elmira:	Southside	615
	Balance of City	1,738
Horseheads		377
Chemung		250
Southport		250
Elmira Heights		377
Van Etten		100
Ashland		75
Baldwin		50
Big Flats		35
Beaver Dam		25
Breesport		25
Catlin		25
Erin		25
Millport		25
Pine Valley		25
Veteran		25

Provider Population

	Physicians	Dentists
Elmira	83	32
Elmira Heights	--	1
Horseheads	8	5
Corning	2	--
Johnson City	--	1
Ithaca	--	1
Big Flats	1	1

JOHNSON CITY

was that the more informal format was more informative and conducive to good provider/CHAP relations.

2. THE CHEMUNG COUNTY CHAP PLAN WAS PRIMARILY DRAFTED BY CIDS ON THE BASIS OF ITS PRIOR EPSDT EXPERIENCE

At the request of the Commissioner, CIDS took major responsibility for drafting the CHAP plan. The Administrator of CIDS, John Shannon, Ph.D., assisted by his administrative assistant and the CHAP Coordinator, assumed most of this responsibility. He based the plan not only on his past experience but also on Bulletin 190. Dr. Shannon viewed Bulletin 190 as a valuable tool providing guidelines which changed the old EPSDT program in two major respects:

- It added a more sophisticated tracking and monitoring system to assure better continuity of care
- It more clearly charged the program with serving children from ages 7 to 21[5/]

Commissioner William Liddle reviewed the plan and approved it based on the following considerations:

- CIDS had done a good job carrying out the EPSDT program for children aged zero to six. The CIDS staff was well trained and, as an organization, CIDS was singularly committed to providing health and social services to children. The addition of children aged 7 to 21 was not expected to present a problem.
- CIDS offered to carry out CHAP for a contract fee of $50,000 per year. An analysis by DSS indicated that the cost would be substantially higher if carried out by Department staff.
- Chemung is a politically conservative County whose legislator--Senator William Smith--presides as Chairman of the State's Senate Committee on Welfare. In the face of the fiscal uncertainty threatening the State, the committee and its county equivalent have recently grown cautious of any increases in social service programs. At the time CHAP was to be implemented, the Commissioner believed it would be more expedient for program implementation to negotiate a contract with CIDS than to obtain an increase in DSS staff positions.

5/ There was some confusion in Chemung County as to the source of the requirement that these older children be included. The original Chemung program, effective 1971, included children of all ages, but the States, and therefore the counties, were permitted initially to concentrate on serving the younger population and phase in the 7-21 age group by 1974.

The plan is extremely well written and detailed. Its main features are summarized in Exhibit B-II, following this page.

3. THE CONTRACT AGREEMENT WITH CIDS PROVIDES CHEMUNG COUNTY WITH A WELL-TRAINED, ENTHUSIASTIC STAFF; INTERORGANIZATION COORDINATION IS FACILITATED BY A FULL-TIME DSS CHAP COORDINATOR

Operating any public program under contract can be a complex business. This is true if reporting and fiscal responsibilities span two organizations, but even more difficult when interdependent programmatic responsibilities are also lodged in both. Chemung County DSS and CIDS have established an organizational linkage which operates very smoothly. Symbolically, the program is referred to in Chemung as CHAP/CIDS, an acronym that will be adopted for the balance of this report. Exhibit B-III, following Exhibit B-II, is an organization chart which graphically depicts the relationship between the two agencies. This relationship is elaborated in the paragraphs below.

(1) Two Coordinators Perform The Essential Liaison Between DSS and CIDS

The roles of CHAP/CIDS coordinator experienced a major shift during 1975. Mr. Richard Farr originally filled the position and was responsible for the early implementation of the program. Late in 1975 his employment with DSS was terminated as the result of a staffing cut. CIDS hired him to work 75 percent time as Coordinator at that time; DSS assigned Ms. Terry Brophy to the position vacated by Mr. Farr.

The two CHAP/CIDS Coordinators share the following responsibilities:

- Maintaining liaison between DSS and provider community
- Supervising and training CHAP staff in the administrative operations of CHAP
- Assessing client status, including appropriate care in consultation with the CIDS pediatric nurse practitioner, if necessary
- Providing information on current federal program regulations and requirements

EXHIBIT B-II(1)

Chemung County

SUMMARY COMPARATIVE ANALYSIS OF CHAP: PLANNED VERSUS REQUIRED VERSUS ACTUAL: CHEMUNG COUNTY

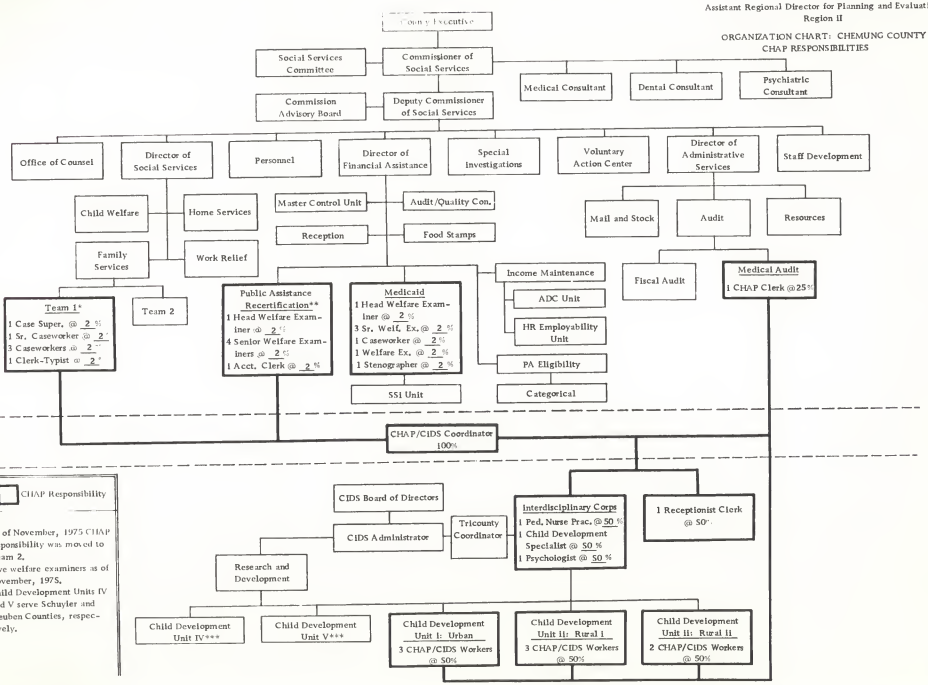
	PLAN	ACTUAL
Outreach — Provider	Will prepare a resource list to assist CHAP/CIDS workers in channeling workers to proper sources	A list of providers is given to clients if they do not have their own physician
	Agreements will be signed with all providers who do CHAP examinations	It is not felt that agreements are necessary due to a positive relationship with providers
Outreach — Community	Presentations describing CHAP services and importance of early preventive care will be made to community organizations and schools	Presentations made to community physicians as part of an initial orientation
		Presentations made to local Child Development Task Force and to local Hospital Administrators
	Informal information sessions with day care/Headstart parents, PTA, churches, volunteer groups	
Identifying Eligible Children	Identified at intake or recertification	MA patients identified at intake; PA at recertification
	Some children identified through referral from CIDS comprehensive clinics and other agencies	Some children identified through referral from CIDS comprehensive clinics
Informing Clients Of Availability Of Services	Advised at recertification or intake of available services	Advised at recertification or intake of available services
	DSS 2400 completed at intake	DSS 2400 completed at intake and recertification
	Home visits or telephone contact is made for every client who accepts services	Home visits or phone calls are made for every client who accepts CHAP services
	Clients not under appropriate care who refuse CHAP services are seen at recertification	Clients not under appropriate care who refuse CHAP services are seen at recertification and encouraged to participate in the program. Clients continuously refusing services will be visited by the caseworker and/or the Pediatric Nurse Practitioner to further explain services.
	Flyers and pamphlets distributed throughout County	Materials on CHAP are only provided to clients at public assistance recertification and at Medicaid intake and recertification
	Insert in Cooperative Extension monthly mailing	
	Spot announcements on radio and television	
Determining Those Under Appropriate Care	CHAP/CIDS Coordinator reviews DSS 2400 and mails DSS 2402 with letter of explanation if client identifies personal physician	CHAP/CIDS Coordinator reviews DSS 2400 and mails DSS 2402 with letter of explanation if client identified personal physician
	Medical payment record for each client is reviewed to determine if vision, speech, hearing, and developmental exams have been included in the comprehensive examination	Medical payment record for each client is reviewed to determine if vision, speech, hearing, and developmental exams have been included in the comprehensive examination

	PLAN	ACTUAL
Periodic Examinations	CHAP/CIDS workers will actually schedule most appointments	CHAP/CIDS workers actually schedule most appointments
	Transportation will be offered	Transportation is offered
	Written reminders will be sent	Written reminders are sent
	Will use special CHAP examination clinics and local pediatric groups	CHAP/CIDS sponsors a special "initiation" clinic at various locations in the County. The clinic is headed by a pediatric nurse practitioner and designed to introduce clients to the provider setting, overcoming fear and reluctance on the part of the client
[illegible]	Case conferences will be held on all children with indicated need for follow up to review, assess and make recommendations on the case when appropriate; interagency case conferences will be held to avoid duplicate or conflicting treatment plans	Case conferences are held on all children with indicated need for follow up to review, assess and make recommendations on the case when appropriate; interagency case conferences will be held to avoid duplicate or conflicting treatment plans
	All cases needing follow-up care will be discussed with the parent by letter or in person	If the physician requests assistance in discussing a case with the client, the CHAP unit will provide it
	Cases will be checked after two months to determine whether a bill for follow up has been received. If not, case will be followed with the provider	Cases are checked after two months to determine whether a bill for follow up has been received. If not, case will be followed with the provider.
	Client control file will include all client history information, health status report, follow-up recommendations, progress notes	Individual Unit file does include all client history information, health status report, follow-up recommendations, progress notes. The Master Control file located in the CHAP Coordinator's office contains the individual tracking form (DSS-2401).
	Each child assigned to specific case worker on basis of geographic location	Each child is assigned to specific case worker on basis of geographic location
	If the child has no provider and uses the CHAP clinic every effort will be made to integrate the child into the practice of a private practitioner	If the child has no provider and uses the CHAP clinic every effort is made to integrate the child into the practice of a private practitioner
	If eligibility lapses copies of health records will be forwarded to the child's health provider and referrals are made to other community agencies	CHAP/CIDS calls the provider to determine whether his records are complete. If not, copies of the child's records are forwarded for his file

EXHIBIT B-III

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

ORGANIZATION CHART: CHEMUNG COUNTY
CHAP RESPONSIBILITIES



- Preparing statistical reports required to meet federal reporting requirements

- Providing assistance to the CIDS Director to maximize provider participation in the CHAP/CIDS program and to coordinate personnel and staff training functions

Organizationally, Mr. Farr reports to the Director of CIDS and Ms. Brophy is responsible to the Family Services Division under the Director of Social Services.

(2) Several Other DSS Workers Are Involved With CHAP

In addition to the CHAP/CIDS Coordinators employed by DSS there are several other DSS staff members with a role in the operation of the CHAP/CIDS program:

- The Medicaid intake workers and PA recertification workers are responsible for informing CHAP/CIDS clients of exact services and for providing assistance for completion of the client request form (DSS-2400).

- A CHAP/CIDS clerk conducts a medical claims search. A DSS medical audit clerk assists in the preparation of monthly statistical reports.

- DSS Child Welfare Unit handles casework for foster care children, but, CHAP/CIDS maintains tracking and reporting responsibility for all foster care children. This is essentially a paperwork function.

- The DSS Medical Director, Dr. Robert Huddle, continues to serve in an advisory capacity to CHAP. He consults on medical cases and acts as liaison to the provider community.

(3) CIDS Staff Is Composed Of Paraprofessional And Professional Staff Committed To Early Detection Of Developmental Disabilities

CHAP/CIDS workers employed by CIDS are divided into two rural and one urban Child Development Units. This organization can be seen in Exhibit B-III, referenced above. The six workers in these three units spend approximately 50 percent of their time working with the CHAP program. The CHAP/CIDS workers are well trained and enthusiastic:

- All have (or are currently working towards) at least associate degrees representing a variety of human services disciplines
- Two weeks of intensive training are provided to all CIDS staff on interviewing techniques, developmental tests, outreach, referral, and follow up
- Continuing in-service education is provided on a bimonthly basis by community specialists in areas such as speech pathology, psychiatry, and nursing

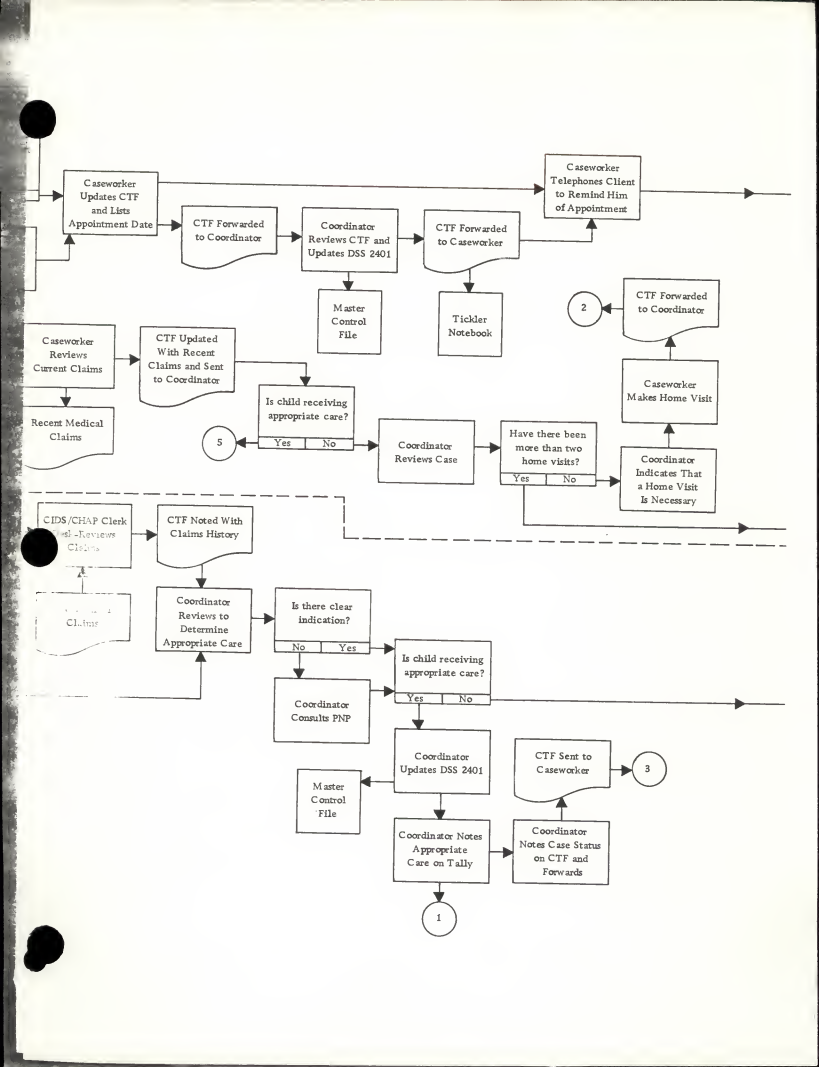
Ironically, CIDS Director Dr. Shannon reports that initially the quality of the staff caused some implementation problems. More specificially, during early stages of program development, staff occasionally manifested overzealousness with clients and public agencies offering community services. This tended to alienate clients and providers and frustrate CHAP/CIDS workers. Staff meetings provided an important forum for airing these problems and teaching staff members that the interests of clients were best served when they learned to relate on a less evangelical basis.

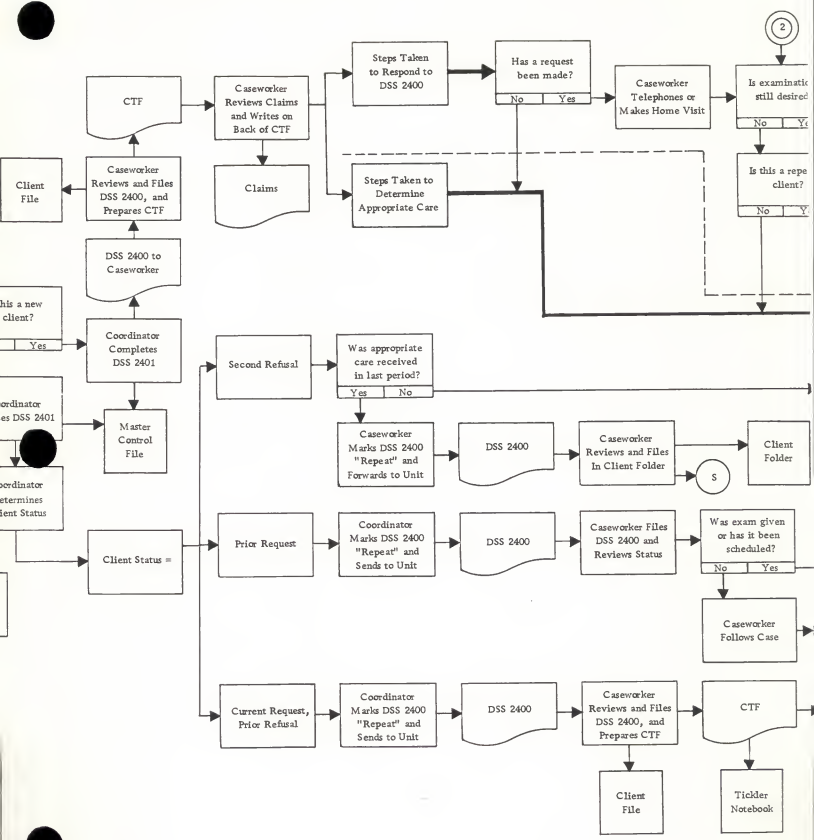
The CHAP/CIDS program also benefits from interaction with the CIDS interdisciplinary core comprised of one pediatric nurse practitioner, one child development specialist, and one psychologist. This specialized core participates in case conferences and in determining which children are under appropriate care.

4. CHEMUNG COUNTY APPEARS TO HAVE A STRONG CHAP/CIDS PROGRAM THAT EMPHASIZES HOME VISITS AND CONTINUITY OF CARE

The CHAP/CIDS program in Chemung County reflects the personal commitment of Commissioner Liddle and Dr. Shannon to the concepts underlying CHAP. The administrative functions of CHAP/CIDS are not complicated unduly by the need for close coordination between the two organizations. Exhibit B-II, referenced earlier, summarizes the actual CHAP/CIDS operations--contrasting them to planned activities. There are few major deviations from the plan and the program operates relatively smoothly. The flow chart in Exhibit B-IV, following this page, describes primary administrative functions in detail, including:

- Outreach
- Identification of eligible children
- Client notification
- Determination of appropriate care
- Follow up
- Ongoing case management


Caseworker Updates CTF and Lists Appointment Date
CTF Forwarded to Coordinator
Coordinator Reviews CTF and Updates DSS 2401
CTF Forwarded to Caseworker
Caseworker Telephones Client to Remind Him of Appointment
Master Control File
Tickler Notebook
2
CTF Forwarded to Coordinator
Caseworker Reviews Current Claims
CTF Updated With Recent Claims and Sent to Coordinator
Recent Medical Claims
Is child receiving appropriate care?
Yes
No
5
Coordinator Reviews Case
Have there been more than two home visits?
Yes
No
Caseworker Makes Home Visit
Coordinator Indicates That a Home Visit Is Necessary
CIDS/CHAP Clerk
CTF Noted With Claims History
Coordinator Reviews to Determine Appropriate Care
Is there clear indication?
No
Yes
Is child receiving appropriate care?
Yes
No
Coordinator Consults PNP
Coordinator Updates DSS 2401
Master Control File
CTF Sent to Caseworker
3
Coordinator Notes Appropriate Care on Tally
Coordinator Notes Case Status on CTF and Forwards
1


CTF
Caseworker Reviews Claims and Writes on Back of CTF
Claims
Steps Taken to Respond to DSS 2400
Has a request been made?
No
Yes
Caseworker Telephones or Makes Home Visit
Is examinatic still desired
No
Ye
2
Is this a repe client?
No
Y
Steps Taken to Determine Appropriate Care
Client File
Caseworker Reviews and Files DSS 2400, and Prepares CTF
DSS 2400 to Caseworker
his a new client?
Yes
Coordinator Completes DSS 2401
ordinator es DSS 2401
Master Control File
oordinator etermines ient Status
Client Status =
Second Refusal
Was appropriate care received in last period?
Yes
No
Caseworker Marks DSS 2400 "Repeat" and Forwards to Unit
DSS 2400
Caseworker Reviews and Files In Client Folder
S
Client Folder
Prior Request
Coordinator Marks DSS 2400 "Repeat" and Sends to Unit
DSS 2400
Caseworker Files DSS 2400 and Reviews Status
Was exam given or has it been scheduled?
No
Yes
Caseworker Follows Case
Current Request, Prior Refusal
Coordinator Marks DSS 2400 "Repeat" and Sends to Unit
DSS 2400
Caseworker Reviews and Files DSS 2400, and Prepares CTF
CTF
Client File
Tickler Notebook

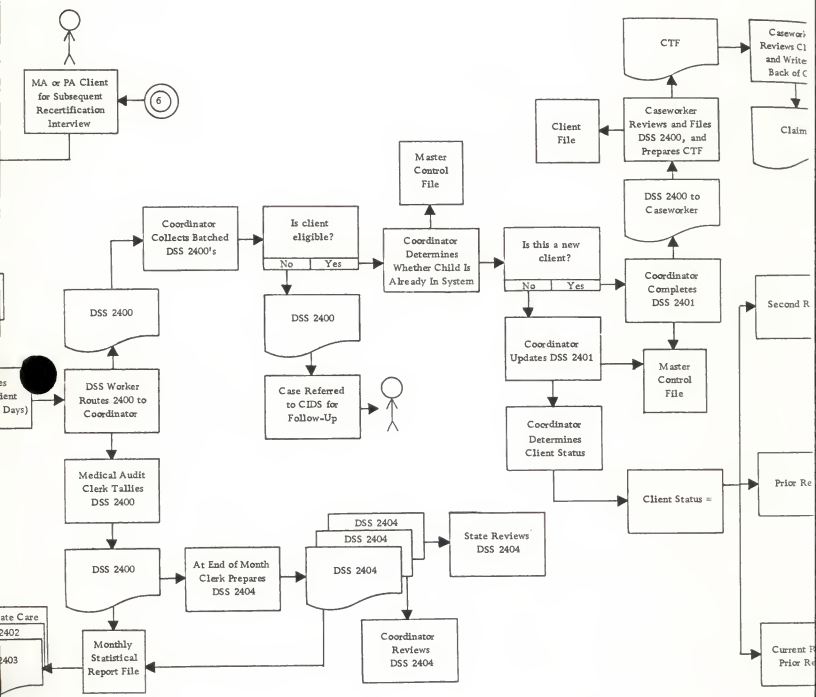
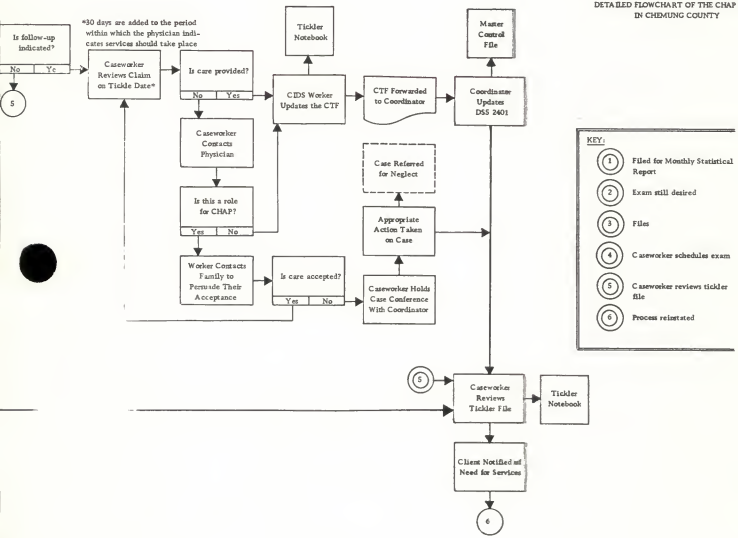
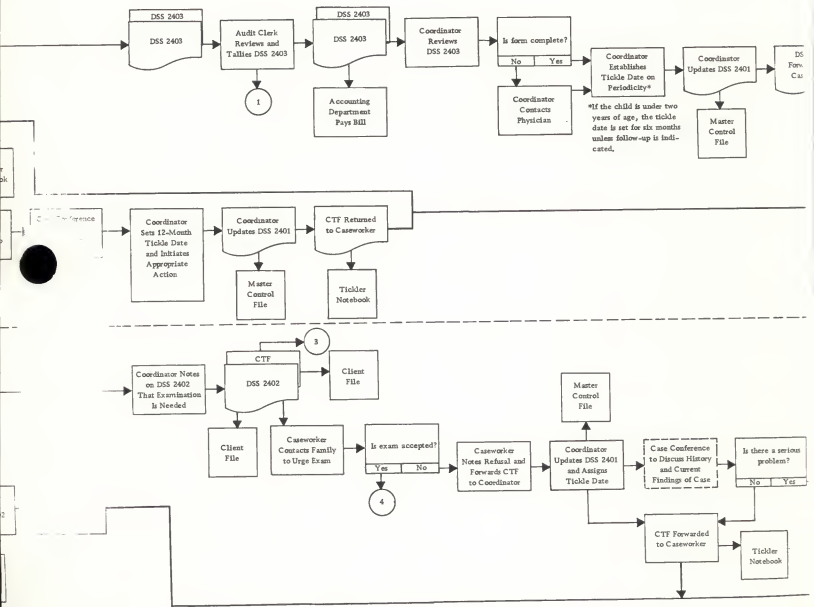

MA or PA Client for Subsequent Recertification Interview
6
Coordinator Collects Batched DSS 2400's
Is client eligible?
No
Yes
Master Control File
Coordinator Determines Whether Child Is Already In System
Is this a new client?
No
Yes
DSS 2400 to Caseworker
Caseworker Reviews and Files DSS 2400, and Prepares CTF
Client File
CTF
Caseworker Reviews Cl and Write Back of C
Claim
Coordinator Completes DSS 2401
Second R
Coordinator Updates DSS 2401
Master Control File
Coordinator Determines Client Status
Client Status =
Prior Re
DSS 2400
DSS Worker Routes 2400 to Coordinator
Medical Audit Clerk Tallies DSS 2400
DSS 2400
Case Referred to CDS for Follow-Up
DSS 2400
At End of Month Clerk Prepares DSS 2404
DSS 2404
DSS 2404
DSS 2404
State Reviews DSS 2404
Coordinator Reviews DSS 2404
Monthly Statistical Report File
Current P
Prior Re

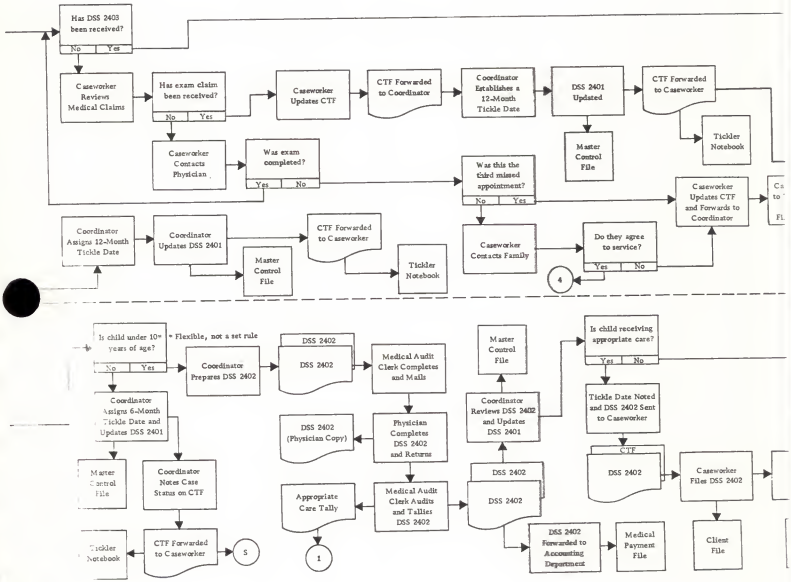
EXHIBIT B-IV

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DETAILED FLOWCHART OF THE CHAP PROCESS
IN CHEMUNG COUNTY




DSS 2403
DSS 2403
Audit Clerk Reviews and Tallies DSS 2403
1
DSS 2403
DSS 2403
Accounting Department Pays Bill
Coordinator Reviews DSS 2403
Is form complete?
No
Yes
Coordinator Contacts Physician
Coordinator Establishes Tickle Date on Periodicity*
Coordinator Updates DSS 2401
Master Control File
*If the child is under two years of age, the tickle date is set for six months unless follow-up is indicated,
Coordinator Sets 12-Month Tickle Date and Initiates Appropriate Action
Coordinator Updates DSS 2401
Master Control File
CTF Returned to Caseworker
Tickler Notebook
3
CTF
DSS 2402
Client File
Coordinator Notes on DSS 2402 That Examination Is Needed
Client File
Caseworker Contacts Family to Urge Exam
Is exam accepted?
Yes
No
4
Caseworker Notes Refusal and Forwards CTF to Coordinator
Coordinator Updates DSS 2401 and Assigns Tickle Date
Master Control File
Case Conference to Discuss History and Current Findings of Case
Is there a serious problem?
No
Yes
CTF Forwarded to Caseworker
Tickler Notebook


Has DSS 2403 been received?
No
Yes
Caseworker Reviews Medical Claims
Has exam claim been received?
No
Yes
Caseworker Updates CTF
CTF Forwarded to Coordinator
Coordinator Establishes a 12-Month Tickle Date
DSS 2401 Updated
CTF Forwarded to Caseworker
Master Control File
Tickler Notebook
Caseworker Contacts Physician
Was exam completed?
Yes
No
Was this the 6/dd missed appointment?
No
Yes
Caseworker Updates CTF and Forwards to Coordinator
Coordinator Assigns 12-Month Tickle Date
Coordinator Updates DSS 2401
Master Control File
CTF Forwarded to Caseworker
Tickler Notebook
Caseworker Contacts Family
Do they agree to service?
Yes
No
4
Is child under 10* years of age?
No
Yes
* Flexible, not a set rule
Coordinator Prepares DSS 2402
DSS 2402
DSS 2402
Medical Audit Clerk Completes and Mails
Coordinator Assigns 6-Month Tickle Date and Updates DSS 2401
Master Control File
Coordinator Notes Case Status on CTF
DSS 2402 (Physician Copy)
Physician Completes DSS 2402 and Returns
Medical Audit Clerk Audits and Tallies DSS 2402
Appropriate Care Tally
1
Tickler Notebook
CTF Forwarded to Caseworker
5
Master Control File
Coordinator Reviews DSS 2402 and Updates DSS 2401
DSS 2402
DSS 2402
Is child receiving appropriate care?
Yes
No
Tickle Date Noted and DSS 2402 Sent to Caseworker
CTF
DSS 2402
Caseworker Files DSS 2402
Client File
DSS 2402 Forwarded to Accounting Department
Medical Payment File

Salient features of the Chemung County CHAP/CIDS operation are discussed below.

(1) There Is No General CHAP Community Outreach Program, But A Good Provider Relations Program

The CIDS in Chemung County has an active community outreach program which indirectly influences CHAP clients. The CHAP/CIDS program itself has not sponsored general media campaigns for several reasons:

- They feel that the client population is adequately reached through established DSS systems
- It is feared that advertising might backfire by attracting ineligible persons to the program and arousing community antagonism to the program
- Face-to-face client contact is believed to be the most effective means of reaching the eligible population

The CHAP and CIDS Coordinators and the DSS Medical Consultant are in regular communication, however, with local providers to promote the program and foster their participation.

(2) Children Are Routinely Identified During The Intake And Recertification Periods

Clients are first informed of the CHAP program by DSS welfare examiners--PA clients at recertification and MA only clients at initial intake and recertification. There are two reasons for addressing these two populations differently:

- The MA client is involved with DSS for primarily medical reasons. It is, therefore, more likely that this population will be responsive to a health-oriented program at the time of initial application.
- The PA client, on the other hand, is concerned at intake with a range of acute problems, many of which are not health related. DSS believes that once the presenting problems of the PA client have been attended to, the client may be more interested in CHAP. In addition, the PA intake routine is more complex than that for MA, and CHAP is an unnecessary addition to an already complex and time-consuming interview.

CHAP/CIDS services are explained and the request form completed each time an MA or PA client reports to the DSS interview (recertification interview and intake interview, respectively), because there is no single way to determine whether or not a previous request was completed. Consequently, this procedure may be repeated several times for some clients. This duplication is somewhat inefficient, as shown in Exhibit B-IV, but it does serve as a means of quality control and staff supervision since a suitable replacement has been developed.

The process of completing the DSS-2400 at each interview does decrease the possibility that potential CHAP/CIDS clients are missed. All request forms are collected at DSS and forwarded weekly to the Coordinators. The Coordinators then review the request form against the DSS-2401 forms in the master control file to determine whether the client has previously been introduced into the system. From this point, no duplication of activities occurs. All subsequent action depends on the client's previous status vis-a-vis CHAP/CIDS.

(3) All Clients Are Notified Of CHAP/CIDS Service Annually By Mail But Face-To-Face Interviews Are Stressed On The Effective Means Of Client Notification

As required by Federal and State regulations, CHAP/CIDS notifies all clients annually by mail that health examinations and follow-up services are available. However, the program relies heavily upon the intake and recertification interviews to introduce the CHAP/CIDS message and upon home visits and telephone contacts to expand and reinforce the message.

Home visits are made to each client who requests services and to certain clients who refuse--particularly clients who do not appear to be under appropriate care or who are quite young. The CHAP/CIDS workers are competent to explain the medical components of the CHAP examination and satisfy a basic health education function.

(4) CHAP/CIDS Exercises County Priorities In Determining Those Children Who Are Under Appropriate Care

In recognition of the budgetary constraints under which DSS operates, CHAP/CIDS places a priority on children under 10 years of age. All children are served adequately within the parameters of Federal and State regulations, but refusals from young children are given more vigorous attention to assure they receive appropriate attention.

CHAP/CIDS believes that this population is at higher risk and, consequently, that the cost effectiveness of reaching these children is greater.

CHAP/CIDS uses two methods to identify children under appropriate care:

- The medical payment record of each child identified for the CHAP/CIDS program is searched to determine a medical history. This activity is carried out by a clerical staff member. The CHAP/CIDS Coordinator reviews the medical history against the criteria for appropriate care in Bulletin 190. They exercise some judgment in making the final determination.[6/] In cases where the medical status of the child is unclear from the record, the CIDS pediatric nurse practitioner is consulted. All children who refuse services but cannot be determined from the payment record to be under appropriate care are "tickled" for six months. At this time, the payment record is reviewed and the client is contacted if the need for an examination continues.

- The Child Health Care Status Report, DSS-2402, is used sparingly--primarily for children under 10--to determine children under appropriate care. The major drawback to using this method results from a peculiarity of Chemung County. All pediatricians in the county practice in two groups based in Elmira. Consequently, the total paperwork burden of completing the verification forms falls on two offices. To avoid antagonizing the pediatricians, no more than two forms per day are generally sent to each provider group.[7/] Interestingly, while there is little complaint about the amount of paperwork or the fees paid for other CHAP/CIDS-related services, providers react less favorably to the verification procedure. Early in CHAP/CIDS, the Coordinator entertained the idea that each child under appropriate care could be "tickled" once a year using the DSS-2402. Unfortunately, this would create an administrative burden for the two provider groups in so far as the majority of the children are served by those two practices and the idea was abandoned. Moreover, Bulletin 190 limits the use of the DSS-2402 to one time per client.

6/ For example, if the record shows that three out of four siblings are under appropriate care it might be inferred that the family has a provider and that the fourth child--should he need care--has easy access to a physician. The fourth child's medical history and health status is reviewed thoroughly.

7/ As a result of recent discussions with the providers, CHAP/CIDS is now able to send DSS-2402 in a more timely manner.

The determination of appropriate care is made for all children regardless of whether they request an examination.

- Theoretically, a client who requests services but is under continuing care is contacted to re-explain the CHAP concept and assure the client that there is no need for an examination at that time. In practice, however, the appointment for an examination may already be made before the record search can be completed. This results because the home visit (immediate response to request) takes place simultaneously with the record search.

- If the client refuses care, it is important that the CHAP/CIDS worker has a reasonable medical history for each child as a basis for subsequent discussions with the client.

(5) CHAP/CIDS Examinations Are Conducted Primarily By Two Elmira-Based Pediatric Group Practices

Up to this point, this report has focused primarily on paper flow and administrative procedures. Once a request for service is received by CHAP/CIDS workers, the real "client contact", the chief strength of Chemung County's program, comes into play. Each client who requests service is contacted by a CHAP/CIDS worker by phone or in the client's home who offers assistance in arranging appointments of transportation. The CHAP/CIDS workers appear to be fairly diligent in their efforts to contact families and often make several visits or phone calls to each client. Three interesting points about the periodic examinations should be noted:

- The primary providers for CHAP/CIDS examinations are two pediatric group practices in Elmira. The CHAP/CIDS staff has a good working relationship with these two groups and can easily set appointments for the majority of the CHAP/CIDS children.

- Because it is possible for CHAP/CIDS workers to actually make most of the appointments for examinations, it is relatively easy to call clients one day in advance to remind them of the appointments. This limits the number of "no shows" which, in turn, increases provider willingness to participate in the program.

- Early in its development, CHAP/CIDS considered an interesting experimental clinic which would initiate clients into the regular provider setting. The clinic was to be held at various sites throughout the County by the CIDS pediatric nurse practitioner who would escort the client through the examination, explaining office procedures and providing basic health education. CHAP/CIDS believed that this approach would help dispel some of the fears that many clients have about providers and health examinations. Unfortunately, the clinic was never initiated, although CIDS interest in the project continues.

(6) Tracking Children With Conditions For Follow-Up Care Is Accomplished Through The Medical Payments System, And Aggressive Follow Up Is Used To Assure That Children Receive Needed Care

As in other counties, tracking of CHAP clients is documented on the client tracking form, DSS-2401. This form is housed in the master control file maintained by the CIDS Coordinator. Chemung County also uses a modified version of DSS-2401--the Chemung Tracking Form (CTF). The CTF contains, on one side, a quarter of the information on the DSS-2401; essentially, there is one series of questions for each time the client enters the system. The benefit of this modified form is twofold:

- The back of the form can be used to record the client medical assistance payment history, consolidating much of the important data about each child on a single form.

- The form is used for interoffice communications while the master document--DSS-2401--is securely centralized in the Coordinator's office.

Nonetheless, the system is essentially dependent upon (and hampered by) the provider claims to determine whether necessary follow-up care has been received. In many cases, CHAP/CIDS workers may believe that necessary follow-up care has not been received when, instead, the bill has simply not been received. In such cases, unnecessary work--contacting the provider or the client--may go into establishing the client's true status.

- CHAP/CIDS workers will contact the examining physician to determine what role, if any, should be played in contacting the family to urge care. When necessary, the CHAP/CIDS workers will counsel the family concerning the need for care and facilitate the appointment.

- In instances where caseworkers are unsuccessful in bringing clients in need of services into the program, the pediatric nurse practitioner on the CIDS staff will be consulted and requested to make a home visit.

- In rare instances, a case may be referred to the medical neglect unit for aggressive follow-up.

Tracking and follow-up activities are complicated for the rural areas of Chemung County where many clients do not have telephones, which is another reason why so much reliance is placed on home visits. although they often report that a home visit is unproductive--the client being absent from the home.

At present, CHAP/CIDS is able to meet the work requirements. They do believe, however, that the staff has come close to its limit in handling the case load. As the program matures and more eligible children request services, the program may begin to experience a staffing pinch.

CHAP/CIDS Maintains Individual Client Folders As Well As A Central Tracking File

The record and file system of the CHAP/CIDS program revolves around the master control file (DSS-2401) maintained by the Coordinator. The CTF is used for communication between the Coordinator and the three CHAP/CIDS Units to which clients are assigned on the basis of their location in the County. Initially each Unit developed its own system of files, client folders, and tickler systems but recently these systems were made more uniform.[8/] A review of these record systems indicates that the Chemung tracking forms are used more for communication between the Coordinator and the Units than as a central repository of information about the child's progress. The difficulties with the record and case management system are elaborated in section five of this report but two important features of the case management in Chemung County are noteworthy:

[8/] The file structure was changed during the Spring of 1976 so that all Units operated in a similar manner.

- Continuity of care is greatly enhanced in Chemung because of the linkage of DSS to CIDS. More specifically, children in "mid stream" of CHAP/CIDS, whose eligibility lapses, can be followed by CIDS workers. Although CIDS cannot pay for services, it can often make referrals or otherwise facilitate appropriate continuation of each case. Indeed, many case folders for children whose cases had been closed contained the notation "referred to CIDS."

- Similarly, CIDS provides a range of developmental services which are not so integral a part of most CHAP plans. There is strong feeling in Chemung County that the discovery and treatment of developmental disorders holds promise of greater cost benefits and many of the County's children gain from these services. Although this is not strictly CHAP related, it is often difficult to determine where one program begins and the other ends.

In summary, it appears that Chemung County has established the procedures necessary to support CHAP/CIDS and is largely in compliance with Bulletin 190. Nonetheless, they have experienced a number of difficulties in administering CHAP, some stemming from factors inherent to EPSDT others from the administrative complexities of Medicaid itself. These difficulties can be viewed in both quantitative and qualitative terms and are discussed in the two major sections below.

A. A STATISTICAL AND COST EVALUATION OF CHEMUNG CHAP/CIDS REVEALS DIFFICULTIES OF EVALUATING PROGRAM SUCCESS

The original plan for the case study envisioned a detailed and extensive review of Medicaid claims that would support a statistical and cost analysis of the program. This approach proved somewhat naive as to the time required to complete such an "audit" and also as to the value of the data that might be extracted from the payment system. The data available from the claims are difficult to access and lack specificity that is necessary to really determine case status.[2/]

For these reasons, this exhaustive analysis was abandoned in favor of a record review which assisted the analysis of existing routinely reported data and shed light on the difficulties of the CHAP/CIDS interface with the claims system.

2/ For example, a child screened with conditions reported needing follow-up in the area "genito-urinary" may return to have this condition care for and, at the same time, be treated for acute bronchitis. This latter condition is the more likely to be reported on the claims which makes no reference to CHAP follow-up.

(1) Statistically, Chemung County CHAP/CIDS Has Not Done Exceptionally Well Although This Level Of Analysis Is Painfully Misleading

Statistical evaluation of the CHAP/CIDS is extremely difficult; it can be done only with a clear understanding of the limitations of the available data and suffers from the lack of agreed upon criteria for measuring "success." There are two possible standards against which current performance can be assessed:

- Past Performance In Chemung County--During 1974, the EPSDT program was carried out under an informal agreement with CIDS but was of reduced scope--in terms of target population (it addressed primarily the 0-6 age group)[10] and in terms of staff resources committed to the program. Data are available only on the number of examinations which took place during CY74 (as opposed to the number of children) and reveal that 435 examinations took place. This compares to 661 examinations[11] for CY75. Although it does reflect an increase in output, the questions must be rasied as to whether the magnitude of the increase in resources committed justifies an increase in examinations of 52 percent.[12]

- Experience In Other Counties--Although many of the data provided monthly by the counties are suspect, the number of screening examinations reported is generally viewed with confidence. For all its administrative sophistication, Chemung CHAP/CIDS provided screening examinations to slightly over 10 percent of its target population[13]. In comparison, 35 upstate counties (exclusive of the big six counties[14]) matched or bettered this performance.[15]

10/ Although, interestingly, 40 percent of the examinations were provided to children over six.

11/ Initial examinations were provided to 518 children.

12/ Moreover, the CHAP/CIDS program identified 1665 children (26 percent of the case load) as being under inappropriate care. No such activities were conducted during 1974, no data were collected, and, consequently, no comparison can be made.

13/ Based on the projected dynamic case load of 6,466. Obviously, the denominator used to calculate the percentage of children screened has a great influence on the resulting ratio. There is some concern that the dynamic case load is not the appropriate measure of the number of children who come in contact with CHAP/CIDS, and to the extent that it is in err, the percentage of children screened is in err.

14/ Erie, Monroe, Nassau, Onondaga, Suffolk, and Westchester.

15/ Based on data reported on DSS-2404 and the projected dynamic case load.

Even these "simple statistics" do not reflect the entire picture, particularly to the extent that they do not include the number of children under appropriate care--another measure of program penetration. It goes without saying that these statistics do not speak to the quality of the service. There are several other measures, shown in Exhibit B-V, following this page, which shed some light on the parameters of CHAP/CIDS performance but even they do not tell the entire story. Rather than allow the data to speak for themselves, the following insights are offered:

- Target Population--The overriding difficulty in assessing the program is that many of the statistics depend on the "target population" for a denominator. Chemung County could be assessed on the basis of three separate figures, each with some claim of defining "target population."

  - The static case load figure estimated in Bulletin 190, 4700. This figure is highly suspect in that it was developed several years ago and did not take into consideration the on-again-off-again nature of the EPSDT eligible population.

  - The dynamic case load figure computed by MSI on the basis of client eligibility data reported routinely by Chemung County DSS to the State. On the basis of this estimate, which considers the revolving nature of the case load, Chemung County's target population for 1975 was 6,466.

  - The actual count of records in the CHAP/CIDS system, equal to 3,709 for 1975. It is clear that some children are not referred to CHAP/CIDS from DSS, and, thus, that this figure understates the size of the target population to some extent.

  The dilemma, then, is deciding which figure to use in program evaluation. Based on the dynamic case load, Bulletin 190 and the actual count of records, the percentage of the "target population" screened ranged from 10 percent, 11 percent, to 13 percent, respectively. When viewing CHAP/CIDS in comparison to its county peers, it is reasonable to base the analysis on the dynamic case load, insofar as the dynamic case load for each county was developed in the same manner. On the other hand, it is unreasonable to judge CIDS alone on the basis of a target

EXHIBIT B-V

Assistant Regional Director for Planning and Evaluation
Department of Health, Education, and Welfare, Region II

CHAP/CIDS PERFORMANCE MEASURES 1975:
CHEMUNG COUNTY

Indicator	Measure	CY 1975	
		#	%
Outreach	Number of Requests / Target Population	898 1/ / 6,466	14%
Follow Through	Number of Examinations / Number of Requests	518 / 898	58%
Penetration	Number of Examinations / Target Population	616 / 6,466	10%
Penetration	Examinations + Appr. Care / Target Population	616 + 1,665 / 6,466	36%

1/ Developed by MSI based on Medicaid eligibility data reported monthly/quarterly by the County.

population about which it had only partial knowledge. This would argue for evaluating CIDS on the basis of the number of client records it currently has on file.

- Outreach--The relationship between number of requests and target population can be used as a rough indicator of the effort engaged by CHAP/CIDS (in this case, DSS recertification workers not otherwise involved in CHAP/CIDS) to encourage client participation. This percentage must be considered in light of the fact that some clients are confused about the voluntary nature of the examination, believing it to be related in some way to their eligibility for other services. Moreover, recertification workers report that most clients [16] who refuse examinations (75 percent of all clients offered services refuse) have a family doctor already. Consequently, a community with adequate if not abundant provider resources may be penalized in this analysis for not soliciting requests from clients who are not in need of care.

- Penetration--Without belaboring the points raised above about the difficulties assessing the adequacy of the number of examinations provided, a few words must be said about the number of children determined to be under appropriate care. Chemung County has adopted a conservative approach to determining whether children are under appropriate care. [17] When there are inadequate data to make a firm decision, the child is placed in a tickler file for six months (contrast the one-year tickler status for children deemed under medical supervision) for a redetermination. Consequently, a sizable number of children were not reported in 1975 to be under appropriate care, nor is CHAP/CIDS' interaction with them reported in any measure or fashion.

Exhibit B-V, following page 15, does not tabulate the number and types of conditions identified for follow-up, nor does it address the critical question of how many children who needed follow-up care actually received it. Information about follow-up care received is not routinely tabulated. Therefore, the decision was made prior to the second visit to Chemung County not to do comprehensive client and claim record search.

16/ 3709 offers less 898 requests = 2400 refusals, or 75 percent. As a note of interest, the level of "refusals" reported monthly was not considered in the evaluation scheme because we believed it would be merely the complement of the number of requests. Such is not the case in Chemung where only eight refusals were noted. Refusals were tallied only when a client who initially made a request subsequently refused after repeated home visits.

17/ This approach evolves partially from the feeling that it makes good sense from clinical and cost-effectiveness perspectives and partially because of recent agitation over an alleged case of child abuse in which a DSS caseworker is held liable.

Nonetheless, MSI did review the client tracking system to gain a better understanding of the client tracking system (DSS-2401) and to get a general idea of the problems experienced by CHAP/CIDS in trying to case manage. In addition, we reviewed case folders to determine what additional information was available about each case. A number of noteworthy findings deserve comment.

- It Is Impossible To Determine How Many Children Are In Need Of Follow-Up Care--There is a large discrepancy between the number of children reported in the monthly statistical reports to the State (DSS-2404) to require follow-up care and the number identifiable through the client tracking system--reports being 309 (equal to 59 percent of those screened) and 158 (equal to 30 percent of those screened). This large difference is partially explained by the procedure used by Chemung County to tally responses for the monthly statistical report--the medical audit clerk simply tallies items as she scans the bill and, being untrained in CHAP/CIDS operations, does not use any discretion or attempt to interpret the often incomprehensible or ambiguous notes from the physician. The CHAP/CIDS Coordinators on the other hand, can use more judgment in transferring information from the provider claim (DSS-2403) to the tracking form (DSS-2401). However, it seems unlikely that a discrepancy of this size is due solely to this factor. It is more reasonable that during the time-consuming administrative process of updating the tracking forms, some children slip through the cracks. These findings cast doubt on the value of the data report which proports to count the number of children with conditions requiring follow-up care. A similar situation probably exists in many counties.

- It Is Difficult, If Not Impossible, To Tell If A Child Received Follow-Up Care--Because of CHAP/CIDS' advantageous relationship with two pediatric provider groups, it is not surprising that in the cases of two-thirds (101) of the children identified on the tracking form to be in need of additional care, the provider indicated that he would make the referral or provide the follow-up care. However, the review of 30 child records raised some questions about CHAP's ability to track a child's progress through the entire EPSDT cycle. For instance, although there was evidence that CHAP/CIDS workers searched medical claims within a reasonable time after the examination noted a need for follow-up care, it was rare that a claim was filed in the child's folder. [18/]

[18/] If there are no claims after a reasonable time, CHAP calls the physician to determine if care was received. If not, the parent is contacted to urge follow up.

In only six cases out of 30 reviewed was there definitive evidence that the follow up had occurred. This characterizes the difficulty that CHAP staff experiences in trying to fulfill its case management responsibilities.

. The Data Do Not Reflect The Severity Or Nature Of The Disorders Identified During The Screening Examination--Eventually, the EPSDT program must come to grips with the question of true program impact--What is the significance of disorders being "discovered" by periodic examinations? To date, the data routinely collected about conditions identified only suggest the general area of the problem; they do not pretend to suggest the severity; nor do they indicate whether the condition was likely to cure itself, can be treated at all, or likely to have been discovered through other channels or by routine care. Thus these data do not intend to comment on the need for the program in any clinical sense. Yet they do not even accurately portray what they are intended to reflect. Not only are the numbers of children suspect (as discussed above), but they do not even indicate with certainty that a condition exists. For example:

- If a provider indicates that a test for anemia or sickle cell anemia was conducted, he does not necessarily indicate what the test results were, i.e., whether the condition exists. Nonetheless, under the current reporting scheme, it is highly likely that the "condition" anemia will be reported.

- If the child is due for routine immunizations and receives them at the time of the CHAP examination, the provider will indicate, and CHAP/CIDS will report, "immunizations" under conditions discovered.

To the extent that these routinely collected data are used as surrogate measures of the need for the program, they must be used with extreme caution.

(2) The Costs Of The CHAP Administration And Screening Were About $87,000

There are three important elements of cost that must be considered in determining the total cost of CHAP:

. Administrative costs which total $69,398 are comprised of two major elements:

- The cost of the contract with CIDS ($52,018). In 1975, the total actual and budgeted costs were equal, with only slight reallocation among line items. The budget is shown in Exhibit B-VI, following this page.

- The costs of staff members whose salaries are borne directly by DSS. The components of these costs ($17,380) are shown in Exhibit B-VII, following Exhibit B-VI. Initially, the methodology called for detailed allocation of DSS recertification worker time to CHAP-related activities. This time appears to be so slight--and by no means incremental--that it could almost be disregarded entirely. No attempt was made to apportion overhead cost because it is so minimal as to be inconsequential.

- The costs of screening examinations reported monthly on the DSS-2404 is equal to $14,094.

- The costs of diagnosis and treatment were not determined. Thus two of the three program elements total approximately $87,000. This is equal to approximately $13.00 per child estimated to be part of the CHAP case load.

CHEMUNG COUNTY CHAP IS PROFESSIONALLY RUN AND BEGINNING TO EVOLVE INTO A PROGRAM THAT REFLECTS THE PRIORITIES AND RESOURCES OF THE COUNTY

The level of "client penetration" (as measured by percent screened r under appropriate care) is undeniably higher in some counties than in Chemung. To the extent that this measure provides an indicator of ive success of CHAP, Chemung County might be encouraged to take a close look at ways in which it can better reach its target population. The dilemma in such a comparative analysis, of course, is the difficulty in ring both input and output. For example:

- Output Measure--The restraint exercised by Chemung in determining children under appropriate care--which should be viewed to their credit--may actually discredit them when the figure "percent of children under appropriate care" is considered only quantitatively.

- Input Measures--Even if it is true that relatively fewer children are examined, it is difficult to judge the impact on these children of the home visit (and concomitant health education) and the benefit of an examination in a pediatric clinic rather than a general practitioner's office.[19/]

19/ Many counties have the luxury of employing primarily pediatricians, but others must rely on general practitioners and other specialists to share, if not carry, the load. A longitudinal assessment of CHAP effectiveness would, of necessity, consider this variable.

EXHIBIT B-VI

Assistant Regional Director for Planning and Evaluation
Department of Health, Education, and Welfare, Region II

COST OF CHAP/CIDS CONTRACT: CY 1975

	Actual	Budgeted
Professional Salaries		
. 6 Child Development Aides @ 50%, @ $5,500	16,500	16,500
. 1 Psychologist @ 50%, @ $13,500	6,750	6,750
. 1 Pediatric Nurse Practitioner @ 50%, @ $12,400	6,200	6,200
. 1 Child Development Specialist @ 50%, @ $13,500	6,750	6,750
Clerical		
. 1 Receptionist Typist @ 50%, @ $5,700	2,550	2,550
Fringe Benefits At 16%	6,200	6,200
Other		
. Travel	1,568	5,568
. Administrative Costs	4,000	0
. Telephone	1,500	1,500
Total	52,018	52,018

Note: No overhead was assigned because the rent to CIDS is free from the Elmira Psychiatric Institute.

EXHIBIT B-VII

Assistant Regional Director for Planning and Evaluation
Department of Health, Education, and Welfare, Region II

COSTS OF DSS RECERTIFICATION WORKERS
ALLOCATED TO CHAP

Costs At DSS 1/

- Public Assistance Recertification

  5 Workers @ 2% — $880

- Medicaid

  4 Workers @ 2% — $700

- Medical Audit

  1 Worker @25% — $3,800

- CHAP Coordinator

  1 Worker @ 100% — $12,000

1/ These costs and estimates relate to the current situation at DSS rather than that in CY 1975; however, there is not considered a significant difference between last and the current year insofar as the responsibilities of these workers are concerned.

These questions are intriguing to be sure, but the solutions are beyond the scope or capacity of this study. There are a number of other important, more operational issues that are brought more clearly into focus by the CHAP in Chemung.

(1) The Program Is Evolving To Better Accommodate Chemung County Needs, But May Be Flirting With Several Compliance-Related Issues

It is not fair to say of the Chemung CHAP/CIDS program that its staff is overly concerned about the compliance penalty. They simply assume that because the program is constructed around Bulletin 190 and has experienced no particular or severe difficulties, it is adequate to meet minimum federal requirements. There are, however, a number of aspects of the program that would probably be handled differently if the staff had more latitude within their interpretation of the compliance constraints. Many of the procedures the CHAP staff believes necessary for or prohibited by compliance may be misconceptions and to that extent lead them to activities that may be unnecessary. The MSI site visit team did not place itself in the role of interpreter of the compliance regulations but, rather, suggested that where questions exist they be taken up with the State or HEW Regional Office staff directly. From the perspective of CHAP/CIDS, there are some practices currently in effect, and others under consideration, which may raise or be constrained by compliance issues.

The major difficulty in operating results from maintaining the "master control file" (DSS-2401). Although this form, per se, is not required for the compliance audits, CHAP/CIDS has established it primarily for that purpose. While it does have some other, more operational uses,[20/] these functions could be accomplished in a less tedious fashion if the master control file was dispensed with. Moreover, the system is duplicative of, but not as complete as, the family case records maintained by case workers and, ironically, might prove to be as of little value to the audit process as it was to our search of the case history.

20/ E.g., determine status of case vis a vis appropriate care, home visits, examinations, follow-up.

Beyond this, Chemung CHAP/CIDS staff is unfamiliar with the particulars of the audit protocol or the criteria against which they would be judged, having never been audited. Although they believe that CHAP/CIDS would continue if the penalty were removed as an incentive, this view is tempered by:

- Lack of confidence that such would be the case in most other counties; even in Chemung County, the political forces might be brought to bear against the program. The County Department of Social Services has already experienced some cuts in staffing and there are no assurances that CHAP/CIDS is immune to these pressures.

- The feeling that the program in Chemung would be quite different and more effective in the absence of strictly prescriptive EPSDT and State regulations.

In keeping with this latter point, CHAP/CIDS has already taken a number of steps (most of which were not in effect during CY 1975 but are of sufficient interest to be reported here) to streamline their program and make it more relevant to the needs and priorities of the County. These modifications would probably be pursued with more enthusiasm and vigor if the County had assurances from the State or Region that they are acceptable within the meaning of EPSDT or Bulletin 190 requirements.

- Appropriate Care--The determination of children under appropriate care would be made more flexible. On the one hand, CHAP/CIDS is able to rely on the professional judgment of the pediatric nurse practitioner to make decisions on questionable cases. On the other hand, CHAP/CIDS believes that the criteria should allow for determinations on the basis of the family, rather than the individual child, emphasizing the concept of the "medical family."

- Age--The program as it exists in Chemung already has a means of emphasizing the younger eligible children (those children under 10). Given leeway, the program would concentrate more directly (but not exclusively) on the younger children, probably those under 10 or 12.

- Periodicity Schedule--The periodicity schedule would be modified in at least two ways. First, they would, at the advice of the physician, skip the 23- to 25-month examination for infants. This would also reduce the difficult problems that arise when the CHAP/CIDS workers are giving advice or reminders to parents that are in conflict with those given by the physician. Secondly, they would "tickle"

families rather than individuals, except in the case of very small children. This would reduce the number of home visits necessary and also hold down the number of times the parent must make appointments and arrange transportation.

- Provider Participation--A curious, but alarming situation appears to be emerging in Chemung County; some providers are reniging on activities traditionally assumed by them, such as arranging follow-up appointments, sending reminder letters, and so on. When questioned, several providers responded that these were no longer their responsibilities but those of DSS. It is the feeling of CHAP/CIDS that the program should not usurp the traditional responsibilities of the provider community and, also, should not encourage the development of practices by which providers discriminate between Medicaid and non-Medicaid clients.

Consequently, CHAP/CIDS is looking for more opportunities to rely on the existing provider system without being liable themselves and for ways of holding the physician more accountable (not in the legal sense of the word) for the agreements that have been struck regarding CHAP/CIDS services. 21/

(2) Chemung County CHAP Organization Demonstrates That A Linkage With An Outside Agency Is A Viable Strategy For Carrying Out The Program

One of the original reasons for selecting Chemung County as a participant in this study was interest in the linkage with the CIDS. The linkage has been strengthened since 1975, when the original DSS-employed CHAP/CIDS Coordinator became a full-time staff member of CIDS (75 percent time commitment to CHAP) and was replaced by a DSS worker who spends 100 percent of her time on CHAP. Although there appears to be some confusion about the respective roles of the two "CHAP Coordinators," the addition of the extra person has eased the administrative details of the program and strengthened communications between the two agencies. Several comments that relate more to the generic concept of linkages can be made on the basis of the experience in Chemung County.

- Although confidentiality of information regarding Medicaid eligibility has been considered a barrier to creation of linkages, it has presented no problem in Chemung. Chemung County construes the blanket waiver form that is a routine part of the Medicaid eligibility process to be ade-

21/ No provider agreements have been written in Chemung County; the process of writing such an agreement might provide the opportunity to clarify precisely what the providers and DSS/CIDS feels are the appropriate roles for all parties concerned; this is not felt to be necessary at this time.

quate permission that communication between DSS and CIDS is acceptable. They have experienced no difficulties in misuse of information or in complaints by clients.

The reimbursement rate to the County for services provided under contract is less than that which would be available if the same "medical" personnel were employed directly. This serves only as a slight thorn in the fiscal side of the County at this point and the benefits of the arrangement far outweigh the relatively greater expense. It is unclear, however, whether this would continue to be the case if the financial crunch became more severe.

Most of the client contact, e.g., setting appointments and arranging transportation, home visits, follow up on examinations, and diagnosis/treatment needs, is conducted primarily by the staff at CIDS. It has been suggested that one advantage of such a linkage is the fact that workers are removed from the welfare environment and, consequently, can be more enthusiastic, if not more effective. Nonetheless, the initiation point for clients is the recertification process and, to this extent, CHAP/CIDS can be only as effective in outreach as the recertification workers[22] in explaining the program and generating requests. Unfortunately, it is clear from discussions with the recertification staff that there is little interest in or understanding of CHAP. Most workers consider it "just another form" and a "wasteful program." The reasons for these feelings are complicated, involving at least two elements:

- Most recertification workers report that clients appear to have physicians or, at least, their children are examined in the schools. There was no understanding by the recertification workers of the differences between the school and the CHAP examinations or the need for CHAP examinations in general.

- During the site visit, there was considerable speculation about which (not whether) recertification workers would be terminated from County employment as part of the cutback in expenditures. Consequently, there was understandable resentment and "venting" intruding in the interviews which may have painted a more dismal

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CHAP/CIDS notes that if a child appears to be in need of care and did not make a request, the parent is contacted by CHAP/CIDS, thus muting the impact of this difficulty somewhat.

picture than routinely exists. One thing which did come through the interviews clearly, however, was the feeling of the recertification workers that CHAP no longer was a priority program in the County. These attitudes cannot help but be represented to the clients and have a detrimental impact on the program. As long as EPSDT remains a welfare/medical assistance-related program, it seems inescapable that part of the burden for client outreach will fall on the eligibility and recertification workers.

In summary, the experience in Chemung suggests that the contracted approach to conducting the CHAP/EPSDT program is feasible, although nothing definitive can be said about its relative cost-effectivness. It must be remembered that Chemung County is rich in provider resources and it may well be that the environment of cooperation which predates the CHAP/CIDS linkage is a critical element in the success of this particular arrangement. And to reiterate, it seems clear that the indispensible element in the success of this linkage is the personal leadership and commitment to the success of the project supplied by the Commissioner of the Department of Social Services and the Director of CIDS.

(3) There Is Some Question About Whether The EPSDT Program Is The Most Appropriate Model For Improving The Health Care Status Of Children In Chemung County

Among the four counties that participated in this evaluation it appears that Chemung County is the most committed to the concept of serving children with comprehensive preventive and treatment services. Ironically, it is also the County in which the most critical questioning of the clinical value of the program is occurring. This observation is supported primarily by anecdotal evidence.

- Several respondents believed that the $50- to $60,000 being spent for CHAP might be more effectively spent on a program with a more well-defined target population. This is not to say that they do not believe that CHAP is of value, but simply not as important or promising as other programs that might be designed given an equal amount of resources.

- The statistics which reflect the number of children referred for additional diagnosis and treatment are viewed with considerable skepticism. Many conditions are either not "conditions" (in the sense that they are minor, self-correcting, or

could be predicted reasonably well without an examination) or they are not discoveries (in the sense that at least one, if not multiple, service agencies, e.g., Head Start, other elements of DSS or CIDS, the schools, the public health nurses are already involved in the case). Consequently, several respondents question whether there would be a serious consequence if the notification and tracking elements of EPSDT were eliminated.

(4) There Are A Number Of Ways In Which The CHAP/CIDS Program Might Enhance Its Operations

It is difficult to identify any serious problems with the way the CHAP/CIDS program operates. Several of the administrative areas in which obvious corrections or adjustments are necessary are already under consideration by the staff (e.g., discontinuing the master control file). Changes which get more directly to the service aspect of the program (e.g., targeting more specifically on younger age groups) are also being discussed. We would only suggest that such discussions might be facilitated by including representatives from the State or Region, to clarify the attitudes and official postures at those levels.

There are, however, several recommendations that emerge from our analysis of the situation:

- The morale of the recertification workers in general and their attitude towards CHAP, in particular, has the potential of seriously and negatively impacting the CHAP/CIDS program. The feeling is pervasive among these workers that CHAP is no longer a priority and this attitude is reflected in their performance in the program. DSS migh consider reemphasizing the priority that CHAP represents and reorienting these workers to both the administrative and clinical aspects of the program.

- The site visit team experienced some difficulty interpreting the contents of files. It is entirely possible that the CHAP workers know the details of each case and that they are simply not documented in the files. It might be valuable for the Coordinators to review the file system as we did, to determine whether voids in documentation reflect gaps in care or merely inadequacy of file systems.

In summary, we believe that Chemung County has demonstrated good faith and diligence in implementing CHAP. The County's general attention to the health of children and the cooperative attitudes of the County and CIDS staffs make Chemung County a fertile testing ground for some of the recommendations that we put forth in the larger report of this evaluation study.

CASE REPORT:
HERKIMER COUNTY

APPENDIX C

CASE REPORT: HERKIMER COUNTY

Site Visits
November, 1975
April, 1976

CASE REPORT: HERKIMER COUNTY

INTRODUCTION TO HERKIMER COUNTY

Herkimer is a large (1,435 square miles), sparsely populated (67,633) county, located in the middle of the State. The median family income is $9,460, with almost 30 percent of the population earning less than $7,000. Approximately one third of Herkimer's population is under the age of 21 (23,120), and of these children, about 2,400 (10 percent) are eligible for CHAP (static case load).[1] Herkimer has limited medical resources: 45 physicians representing most specialties, three clinics, three hospitals, and 25 dentists. Exhibit C-I, following this page, shows the geographic distribution of Herkimer County's CHAP-eligible population and medical resources.)

During the site selection process, Herkimer County emerged as a promising candidate for study. From all evidence available to the study team, it appeared that conditions in Herkimer had been particularly favorable for the implementation of CHAP:

- The county had established services for children and the elderly as priorities and had already recognized the shortcomings of the existing EPSDT program as a tool for meeting its own objectives.
- The county reported remarkable provider cooperation with both Medicaid and CHAP. Although sometimes reluctant to take new patients, all local physicians participate in Medicaid. At the time of site selection, the agency had signed agreements with 25 of the 45 private providers, two of three local hospitals, and a number of clinics.
- Early statistical analysis (September, 1975) indicated good progress under CHAP, with 31 percent of the eligible children being reported as "under appropriate care."[2]

1/ "Static" case load is the number of children eligible at a particular time. "Dynamic" case load is the number who are eligible at some time during the year.

2/ "Medical care" defined as those who received initial screening plus those identified in appropriate care.

EXHIBIT C-1

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DISTRIBUTION OF PROVIDERS AND CHAP
CHILDREN: HERKIMER COUNTY

Notes:

1. The clinics are informal arrangements more akin to group practices; all physicians operative in this manner have signed agreements with CHAP.
2. All providers in the county participate in Medicaid and are thus available for follow-up care.
3. Several physicians maintain more than one office and thus are counted as more than one location on the map.

CLIENT KEY:

- < 10
- 10-50
- 51-100
- 101-150
- 151 and Over

Number of families as of November, 1975

PROVIDER KEY: *

P = Physician
D = Dentist
H = Hospital
C = Clinic

*If parenthesized, indicates provider agreement

- Herkimer was the only county that reported a detailed plan for formal linkage with a school district. This plan, developed with the support of an Albany Regional Medical Program (ARMP) grant, evidenced that the county had gone well beyond a mere mandated and token interest in CHAP to expend energy and in the design of program strategies.

Given these salutary findings, Herkimer was included in the study as a representative of the rural counties.

1. UNDER THE CLEAR DIRECTION OF THE COMMISSIONER OF SOCIAL SERVICES, THE CHAP PLAN IN HERKIMER COUNTY REPLACED A MARGINAL EPSDT PROGRAM

The EPSDT program in Herkimer County had been but marginally successful. The county never established a clear and commited center of responsibility for EPSDT operations. Instead, services workers were obliged to conduct the program in the course of their normal contact with clients. EPSDT was even further compromised by a negative response among local providers; in general, community physicians objected to EPSDT's emphasis on "screening" as opposed to comprehensive care and were skeptical about the program's capacity to enhance child health. Under these circumstances, the county was forced to conduct EPSDT screenings through a clinic established in Herkimer County Hospital specifically for this purpose. Over the course of a year, the clinic was operated serially by a physician coaxed out of retirement, a local physician, and a doctor who had been persuaded to relocate his practice by Herkimer's active recruitment committee.

The unfavorable conditions surrounding EPSDT operations were reflected in program statistics: during CY74, the program screened only some 200 children.

As mentioned, Herkimer County concurred wholeheartedly with the transcendent goal of EPSDT--to improve health among poor children, but had never embraced EPSDT as a fitting vehicle for pursuit of this goal. The county's Commissioner of Social Service, Michael J. Bush, serves as a member of the State's Local Commissioner's Medical Advisory Committee and favored the overall reform of the program. Accordingly, in spite of its rather bad experience with EPSDT, Herkimer was prepared to recognize CHAP as a fresh start, not simply a new name for the failed EPSDT program. Bulletin 190 was well received by the Department and viewed as leverage for the county to proceed with a plan that it might well have launched on its own initiative.

The county did not institute a particularly formal planning process. The Commissioner consulted briefly with the Department of Health in Albany, but

wrote the plan essentially by himself, without seeking further assistance from the Regional Health Department. The original plan for Herkimer is abstracted in Exhibit C-II, following this page.

Once the plan was written, implementation proceeded rather smoothly. The Commissioner encountered no resistance from the county legislature, which readily granted use of CETA funds for a full-time CHAP position. In December, 1974, the Commissioner hired Ms. Joan Johnson (B.S. in education and graduate study in health education) as CHAP Coordinator.

Using the original CHAP plan as a point of departure, Ms. Johnson and the Commissioner made several early efforts to advance the process of program implementation.

- The Commissioner and Ms. Johnson met with the medical staff of each of the county's three hospitals to describe the program, particularly to emphasize its comprehensiveness and to encourage their participation.

- Ms. Johnson met with each physician individually to negotiate a provider agreement.

- CHAP sponsored a training session for physicians' secretaries to introduce them to the program and explain the use of its associated forms.

- Similarly, CHAP and the Staff Development Coordinator sponsored an orientation session for DSS employees who were to be involved in CHAP.

- The Commissioner met with the County Dental Society to explore the conditions under which dentists might participate in the program. (The Society appeared willing to cooperate, and Mr. Bush is now awaiting direction from the State regarding the dental aspects of the CHAP program.)

As indicated, these early initiatives promoted a high level of provider participation and inspired excellent support from the agency staff and from the community at large.

2. HERKIMER COUNTY HAS ESTABLISHED A SEPARATE CHAP UNIT WITH A FULL-TIME COORDINATOR

Joan Johnson, CHAP Coordinator, was the architect of her position and is personally responsible for the following:

EXHIBIT C-11(1)

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation, Region 11

SUMMARY COMPARATIVE ANALYSIS OF CHAP: PLANNED VERSUS REQUIRED VERSUS ACTUAL: HERKIMER COUNTY

CHAP Function	Original Plan	Revised Plan	Actual Plan
Outreach — Provider	• No difficulty anticipated	• No difficulty anticipated • 30 physicians and 3 hospitals have signed agreements	• Meetings with all physicians and dentists in county • Training session for the office staffs of all physicians • Agreements for screening with 29 physicians; and 3 hospitals to do laboratory work
Outreach — Community	• Press releases to audio-visual media • Pamphlets, talks to local groups	• Press releases to audio-visual media • Pamphlets, talks to local groups	• Four newspaper articles • Plans to address Chamber of Commerce, et al • Held meeting of all school nurses
Identifying eligible children	• Through active MA/PA caseload and new applications • Referrals from community service agencies, providers, etc. • Newborns from income maintenance	• Through active MA/PA caseload and new applications • Referrals from community service agencies, providers, etc. • Newborns from income maintenance • Individual file for each child initiated with DSS 2401 and 3 x 5 card	• CHAP unit notified by telephone distribution center of all opening cases • CHAP coordinator reviews MA/PA printouts and change sheet as well as hospital admissions forms for newborns
Informing clients of availability of services	• Copy of letter mailed to all families eligible on December 31, 1974, and opening cases thereafter • Face to face interview at application and recertification	• Copy of letter mailed on January 28, 1975 to all open families • All newly opened cases receive the letter. – PA clients receive notification from eligibility workers – MA clients receive notice with letter of opening.	• Copy of letter mailed on January 28 • All newly opened cases receive the letter. – PA clients receive notification from eligibility workers. – MA clients receive notice with letter of opening.
Determining those under appropriate care	• Indicated by parent on DSS 2400 and verified by MA record • Verified by DSS 2402 if necessary	• Indicated by parent on DSS 2400 and verified by MA record • Verified by DSS 2402 if necessary	• Indicated by parent on DSS 2400 and verified by MA record • Verified by DSS 2402 if necessary

N/A: Not Addressed

EXHIBIT C-11(2)

CHAP Function	Original Plan	Revised Plan	Actual Plan
Periodic examinations	• Transportation will be arranged • List of medical providers provided and appointments scheduled if necessary	• Transportation is arranged as necessary but "...the client is asked to make every attempt to arrange for his own transportation since this may create a sense of responsibility for medical care." • List of providers is available or appointments made by CHAP	• Assistance with transportation and appointments is provided but clients are encouraged to take responsibility. • List of medical providers available • Appointments often later than 60 days because of client convenience
Diagnosis and treatment (follow-up care)	• Referrals to Public Health of all children with positive sickle cell or lead tests, also referrals to handicapped children and mental health • Other follow-up responsibility of parent or CHAP unit; appointment made within 60 days and reminder sent 3 days prior to appointment. • Appointments verified; "No Shows" tickled for recertification interview	• DSS 2403 reviewed for indication of follow-up conditions • Scheduled by provider, parent, or CHAP	• All services under State plan are available although dental care is not stressed. • Transportation provided if necessary • Referrals made frequently by provider. Alternately, CHAP provides a list of provider or makes the appointment. • Appointments frequently beyond 60-day limit at client/provider discretion • No positive sickle cell tests to date; no lead tests conducted • Negotiating with handicapped children for referrals • "No shows" seen by CHAP worker at recertification. Services workers used in recalcitrant cases
Ongoing [illegible] management	• Once a child has received an examination, CHAP unit will be responsible for on-going medical supervision using DSS 2401	• Three main tickler files - Periodicity - Annual - Recertification Interview	• Three main tickler files - Periodicity - Annual - Recertification Interview • Record of who needs follow-up compared monthly to billing forms • Most clients seen routinely at recertification

[illegible] Addressed

- The monthly report DSS 2404 and the quarterly report
- Interviewing clients
- Making referrals, arranging transportation, making appointments
- Collecting existing health records and establishing CHAP case records
- Reviewing Medical Payment records
- Pursuing follow-up and record information
- Cooperating with Public Health and State Health Department and others as necessary
- Assuring that clients are notified about CHAP services

Ms. Johnson is assisted by a clerk who is assigned to the CHAP Unit 50 percent and charged with responsibility for:

- Making referrals and arranging transportation
- Collecting existing health records and data and reviewing these records
- Typing, filing, and recording information
- Mailing notification letters
- Interviewing clients (only in an emergency)

A number of people filled this clerical position during 1975, which resulted in some loss of continuity and efficiency in administrative matters, but not to the detriment of the client-CHAP relationship.

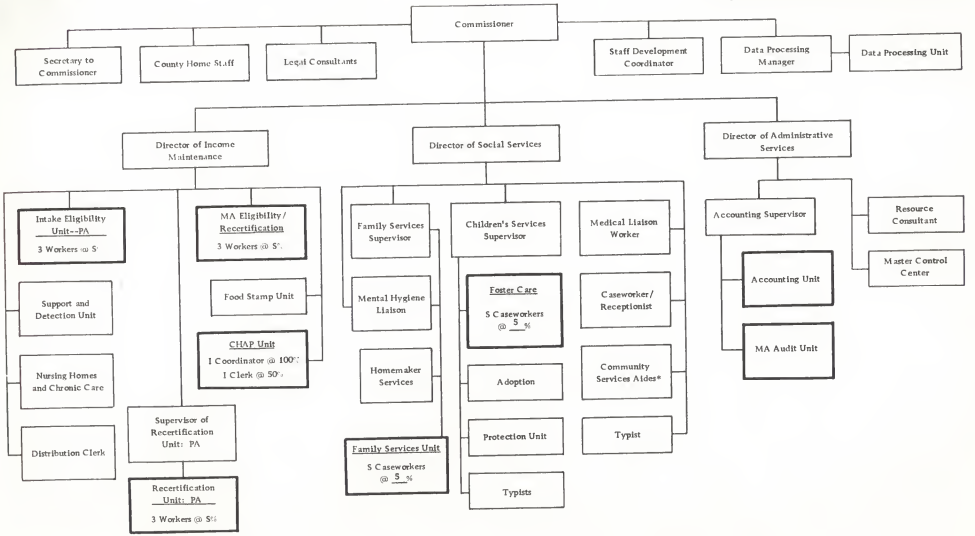
Exhibit C-III, following this page, presents an organization chart of the Herkimer County DSS and highlights those units with CHAP responsibility. Specifically:

- Income Maintenance recertification and eligibility workers complete the DSS 2400, explain CHAP to clients, and refer questions to the CHAP Coordinator.

EXHIBIT C-III

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

ORGANIZATION CHART: HERKIMER COUNTY DEPARTMENT OF SOCIAL SERVICES--CHAP RESPONSIBILITIES



Note: *Previously involved in the EPSDT Clinic

KEY: ☐ CHAP Responsibility

- Services workers (caseworkers and community services aides), upon referral from the CHAP Unit, contact clients to determine why indicated follow-up has not been received and to encourage clients to avail their children of CHAP services.

- Accounting personnel review and pay bills.

This organizational structure and the small size of the agency and its case load make it feasible for Ms. Johnson to oversee the CHAP functions carried out in other units. The agency has recently implemented a client flow process designed to minimize the time required for services workers to usher clients to the CHAP Unit.

3. THE CHAP APPEARS TO OPERATE SMOOTHLY WITH AN EMPHASIS ON ENCOURAGING CLIENT RESPONSIBILITY FOR CARE

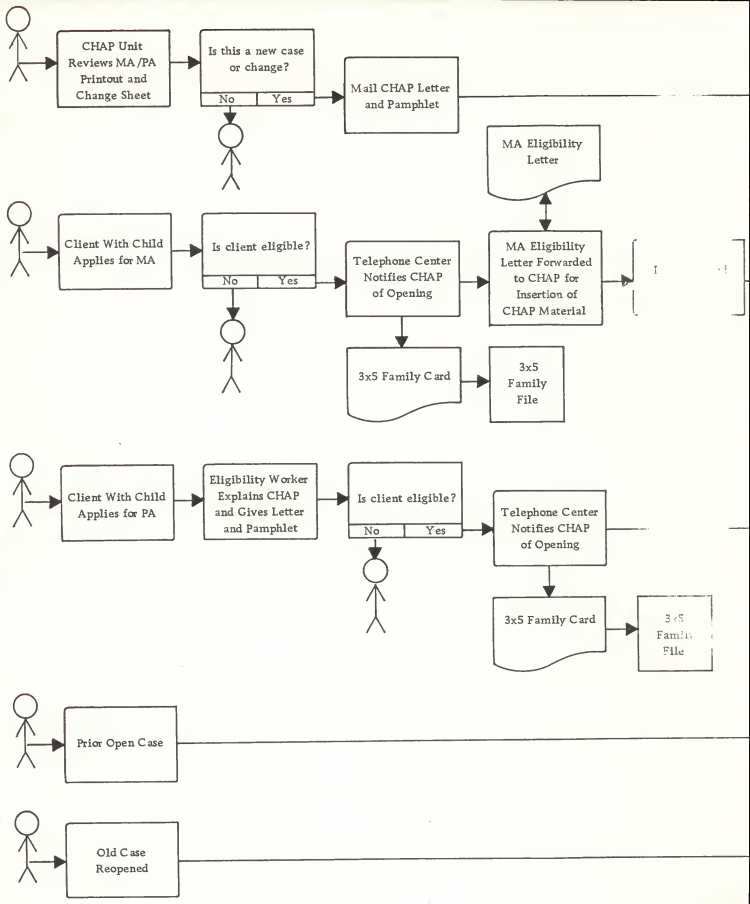
Exhibit C-II arrays the major features of the actual CHAP operations against those originally planned. There were no significant deviations from the plan. The flow chart in Exhibit C-IV, following this page, describes in detail the following operations of the CHAP--identifying eligible children; informing clients of availability of services; determining those under appropriate care; periodic examination, diagnosis, and treatment; and ongoing case management These CHAP elements are highlighted in the paragraphs below.

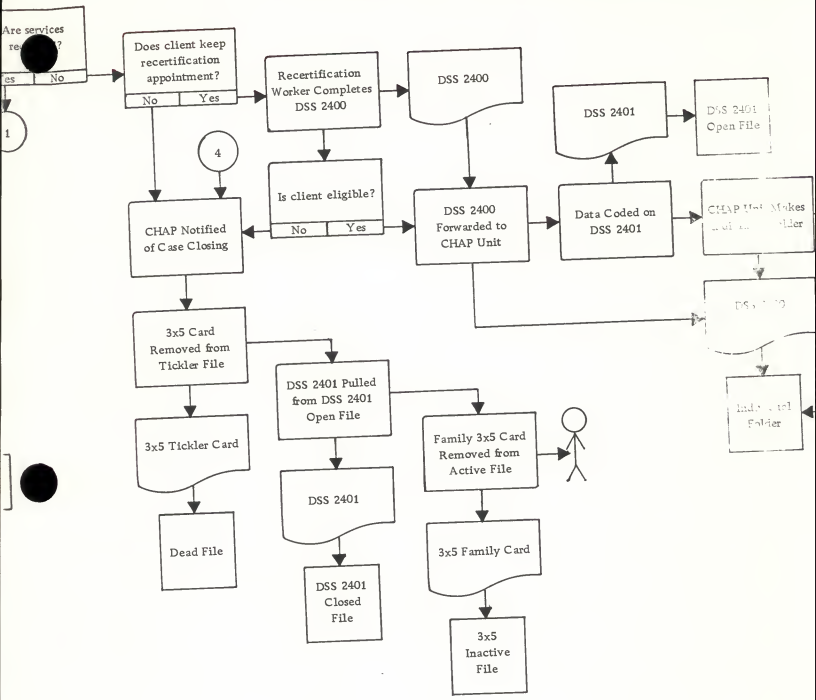
(1) The CHAP Coordinator Uses Several Approaches To Be Certain That No Eligible Children Are Overlooked

The telephone distribution center notifies CHAP periodically of all openings (and closings) of cases with children under 21 and provides the unit with a 3 x 5 card with the family case number and names. In addition to this routine procedure, the CHAP Coordinator monthly reviews MA and PA records, the change sheet, and hospital admissions reports of newborns to update the list of eligible children.

(2) Clients Are Informed Of The Existence Of CHAP At Intake But The Thrust Of CHAP's Efforts Is Directed To Clients At Recertification And Beyond

When the program began, notices were mailed to each family. In addition, two articles appeared in the Department's Newsletter which is distributed to all clients. Now PA clients are given the CHAP form letter and pamphlet upon application; MA clients receive this material with their eligibility notification letter.


CHAP Unit Reviews MA/PA Printout and Change Sheet
Is this a new case or change?
No
Yes
Mail CHAP Letter and Pamphlet
MA Eligibility Letter
Client With Child Applies for MA
Is client eligible?
No
Yes
Telephone Center Notifies CHAP of Opening
MA Eligibility Letter Forwarded to CHAP for Insertion of CHAP Material
3x5 Family Card
3x5 Family File
Client With Child Applies for PA
Eligibility Worker Explains CHAP and Gives Letter and Pamphlet
Is client eligible?
No
Yes
Telephone Center Notifies CHAP of Opening
3x5 Family Card
Prior Open Case
Old Case Reopened


Are services
No
1
Does client keep recertification appointment?
No
Yes
Recertification Worker Completes DSS 2400
DSS 2400
DSS 2401
DSS 2401 Open File
4
Is client eligible?
No
Yes
CHAP Notified of Case Closing
DSS 2400 Forwarded to CHAP Unit
Data Coded on DSS 2401
3x5 Card Removed from Tickler File
DSS 2401 Pulled from DSS 2401 Open File
Family 3x5 Card Removed from Active File
3x5 Tickler Card
Dead File
DSS 2401
DSS 2401 Closed File
3x5 Family Card
3x5 Inactive File

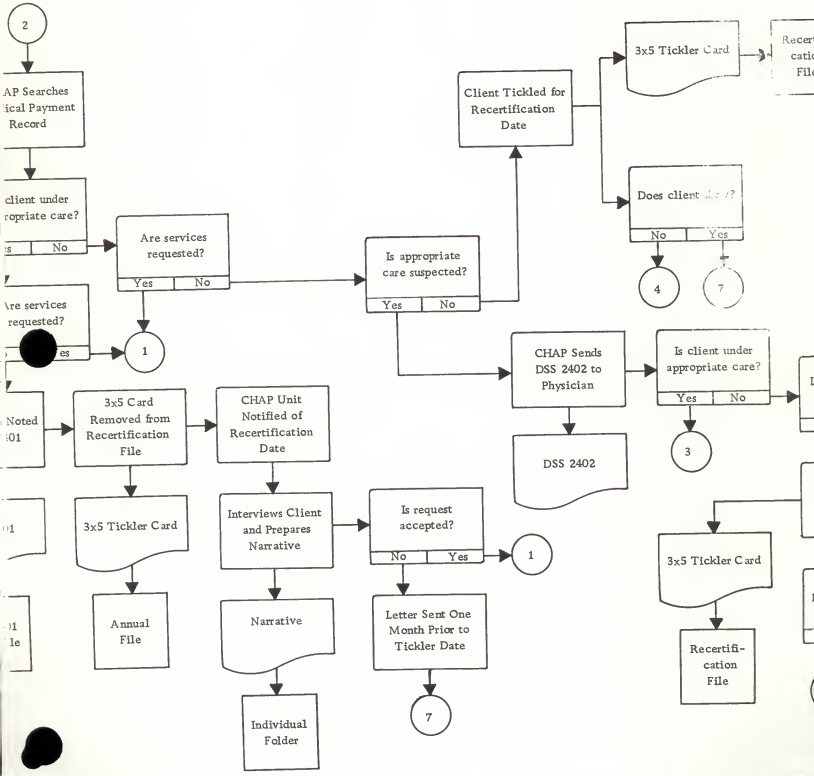
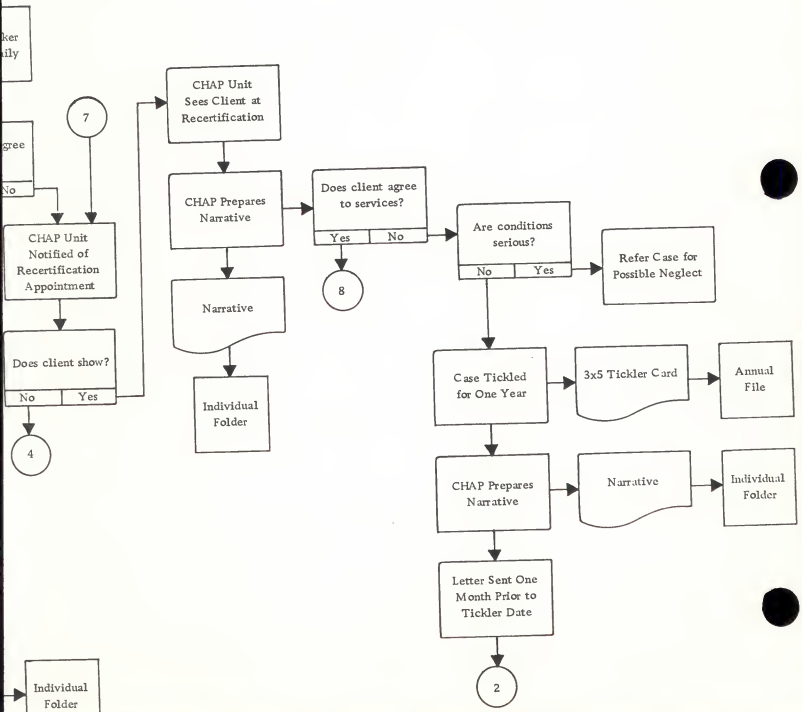
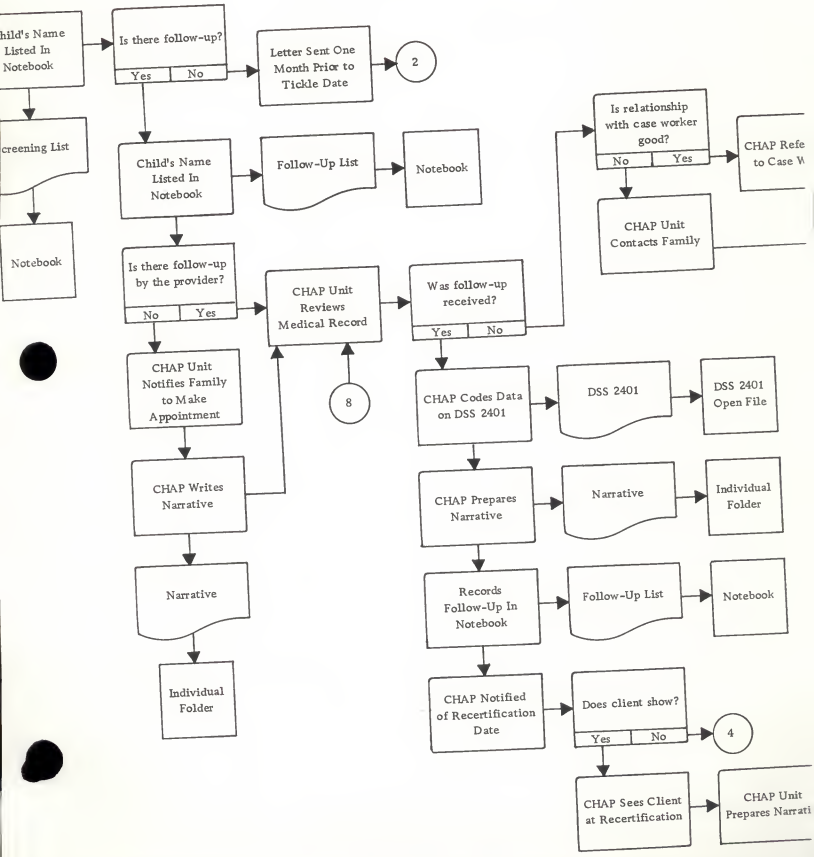

2
AP Searches
ical Payment
Record
client under
ropriate care?
s
No
Are services
requested?
Yes
No
re services
requested?
es
1
Noted
:01
3x5 Card
Removed from
Recertification
File
CHAP Unit
Notified of
Recertification
Date
01
3x5 Tickler Card
Annual
File
Interviews Client
and Prepares
Narrative
Narrative
Individual
Folder
Is request
accepted?
No
Yes
1
Letter Sent One
Month Prior to
Tickler Date
7
Client Tickled for
Recertification
Date
3x5 Tickler Card
Recert
catio
File
Does client
No
Yes
4
7
Is appropriate
care suspected?
Yes
No
CHAP Sends
DSS 2402 to
Physician
DSS 2402
Is client under
appropriate care?
Yes
No
3
3x5 Tickler Card
Recertifi-
cation
File

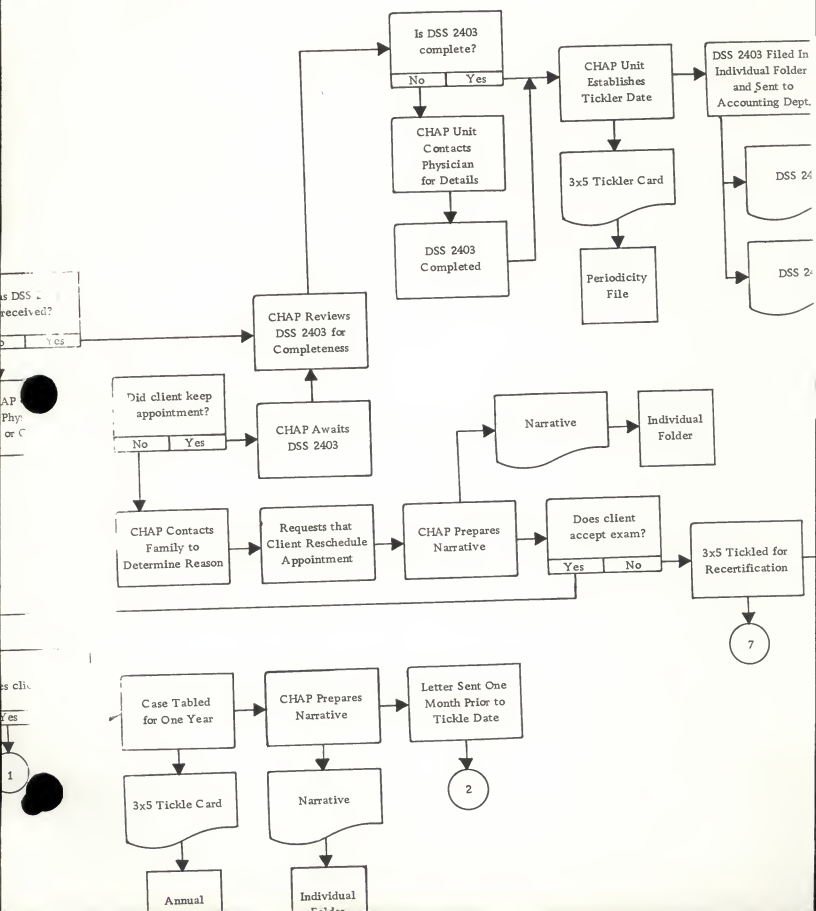
EXHIBIT C-IV

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DETAILED FLOWCHART OF THE CHAP PROCESS
IN HERKIMER COUNTY




hild's Name Listed In Notebook
Is there follow-up?
Yes
No
Letter Sent One Month Prior to Tickle Date
2
creening List
Notebook
Child's Name Listed In Notebook
Follow-Up List
Notebook
Is relationship with case worker good?
No
Yes
CHAP Refe to Case W
CHAP Unit Contacts Family
Is there follow-up by the provider?
No
Yes
CHAP Unit Reviews Medical Record
Was follow-up received?
Yes
No
CHAP Unit Notifies Family to Make Appointment
8
CHAP Codes Data on DSS 2401
DSS 2401
DSS 2401 Open File
CHAP Writes Narrative
CHAP Prepares Narrative
Narrative
Individual Folder
Narrative
Records Follow-Up In Notebook
Follow-Up List
Notebook
Individual Folder
CHAP Notified of Recertification Date
Does client show?
Yes
No
4
CHAP Sees Client at Recertification
CHAP Unit Prepares Narrati


Is DSS 2403 complete?
No
Yes
CHAP Unit Establishes Tickler Date
DSS 2403 Filed In Individual Folder and Sent to Accounting Dept.
CHAP Unit Contacts Physician for Details
3x5 Tickler Card
DSS 24
DSS 2403 Completed
Periodicity File
DSS 24
CHAP Reviews DSS 2403 for Completeness
Did client keep appointment?
No
Yes
CHAP Awaits DSS 2403
Narrative
Individual Folder
CHAP Contacts Family to Determine Reason
Requests that Client Reschedule Appointment
CHAP Prepares Narrative
Does client accept exam?
Yes
No
3x5 Tickled for Recertification
7
Case Tabled for One Year
CHAP Prepares Narrative
Letter Sent One Month Prior to Tickle Date
3x5 Tickle Card
Narrative
2
Annual
Individual

Face-to-face notification occurs at recertification. The CHAP Unit has elected to postpone the intensive introduction to CHAP until the first recertification day (90 days for PA and six months for MA). They believe that because the applicant is under stress and exposed to so much new material, adding CHAP at that point would be ineffectual.

In addition to the individual client notification, CHAP has received local newspaper coverage on four occasions, in response to press releases issued by the Department. No other efforts to raise community awareness have been undertaken, although it is hoped that awareness of CHAP by the general community (as opposed to the Medicaid community only) might promote the concept of CHAP-equivalent examinations for all children.

(3) The CHAP Coordinator Searches The Medical Record Of Each Child To Determine Whether The Child Is Under Appropriate Care

The CHAP Coordinator reviews the medical payment record for each child to determine whether he is under appropriate care. She has experienced little difficulty using the criteria suggested in Bulletin 190 although it is a tedious, manual process.

DSS-2402 is rarely used to determine appropriate care. Early experience with the form indicated:

- A physician's concept of "continuing care" may be out of line with that used as a basis for CHAP. For example, a physician could check "yes" and simultaneously state that the child was last seen in 1970. In such cases, the child is not considered under care and is followed accordingly.

- Most clients who refuse an examination and are not found to be under appropriate care by a search of the payment record can be persuaded of the value of an examination at the face-to-face interview. If this is the case, CHAP considers the $5.00 spent on the DSS-2402 wasted.

(4) Periodic Examinations Are Conducted Almost Entirely In Private Physician's Offices

As noted above, the provider resources in Herkimer County are thin. Nonetheless, services workers report that most clients have a family physician and many seem relieved to know that this doctor can be used for CHAP purposes as well. Even if the family physician is not under a provider agreement, the CHAP Unit does not discourage use of that physician because to do so would violate the the concept of continuity

of care. CHAP will make appointments (or provide a list of cooperating physicians) and arrange transportation if necessary, but prefers to explore the alternatives with the client and allow the client to take responsibility, if possible.

Although CHAP and MA/PA workers report that this approach to scheduling examinations does not stunt client participation, it does make client tracking somewhat complicated insofar as CHAP usually does not know whether an examination has taken place until a DSS-2403 has been received. Physicians vary in the promptness with which bills are submitted and thus the documentation of screening is often delayed, putting the program in jeopardy from a penalty compliance point of view. Also, the latitude allowed the client in establishing his/her own appointment at his/her convenience (convenience used somewhat lightly here, because often serious obstacles prevent timely attention to the examination), sometimes results in examinations taking place more than two months from the first recertification (acceptance/request) date.

Herkimer County's extensive use of private physicians helps to reinforce the physician/patient relationship and to develop patterns of continuous care. The Commissioner pointed out that, while this arrangement is advantageous and far preferable to the old EPSDT clinic, he does not object to the clinic approach per se, hence the county's interest in the school clinic experiment with ARMP. The major apparent hazard in the clinic system is the breakdown in the follow-up and referral functions.

Services team workers indicated that clients are often confused about the difference between the school health examination or newborn discharge examination and the CHAP examination, viewing the latter as superfluous in some cases. These workers are not familiar enough with health aspects of CHAP to answer such questions; throughout the year, CHAP Coordinator considered a seminar for the workers to address the basics of preventive health care which underlie CHAP but no progress has been made to date.

Several services team workers also commented that clients are receiving uneven examinations with (as might be expected) some physicians making more comprehensive and thoughtful examinations than others. Clients have been heard to complain that the physician barely looked at the child and provided little or no feedback to the parent unless a condition for follow up was discovered. The extent of the problem (if there is one) cannot be estimated.

(5) Tracking Follow Up Care Is The Most Burdensome Administrative Aspect Of CHAP

Because the majority of CHAP examinations are carried out under provider agreements, the clients are most often referred for follow up directly by the physician. Consequently, CHAP does not generally know when or with whom follow up is scheduled. This procedure makes CHAP dependent upon the provider bill for information about the follow up visits. This is a difficult process because the provider bill rarely notes that the encounter was CHAP related. To circumvent this problem somewhat, the CHAP Unit reviews each 2403 and records the name and conditions of each client indicated for follow up. Every month, the CHAP Coordinator reviews the MA records and bills of each client to identify follow up care. The same time-lapse problems that confound speedy documentation of screening examinations plague this process. The CHAP Coordinator has considered establishing a procedure whereby she would list the children who require follow up and distribute the list to services workers monthly so that they become aware of care received (during the normal course of their contact with a family) and they can feed the information to the CHAP Unit. Although this procedure would enhance the ability of the services workers to be responsive to a client's total services needs as well as improve CHAP's ability to document that care is received, no action has been taken.

In addition, foster care workers are responsible for the medical care of foster children. However, there are several differences between foster care workers' and the services team's roles:

- Foster care workers have frequent and close contact with the foster mothers and therefore progress on the CHAP schedule is easy to assess. The foster care mothers have no "free choice" insofar as a medical examination is a requirement under the foster care program and cooperation is reportedly high.

- Foster care workers have a better line of communication with and a more cooperative attitude toward the CHAP than do the services workers. There is some evidence that the services workers feel slighted in having had the health care of their clients shifted to CHAP, although there is also evidence that the health care aspects were minimal prior to CHAP.

(6) Ongoing Case Management Is Accomplished With A Number Of Files And Periodic Review Of All Payment Records

The CHAP Unit has established a number of manual files to facilitate tracking and timely reminders on the basis of the periodicity schedule:

- Three tickler files: (a) periodicity (for children who have received an examination), (b) recertification (for children who have not received an examination or who are delinquent in obtaining follow up care), and (c) annual (for children under appropriate care or whose cases have been tabled for a year)
- A notebook listing all children who have received an exam with conditions for follow up (if any) described
- The DSS-2401 file in which open and closed files are maintained
- An index of families with CHAP children filed for easy cross reference with the family case number
- The individual client record which contains the 2400, 2402 (if any), 2403, and narrative reports on client interviews

Each month the CHAP Coordinator reviews the medical payment record to determine what care has been provided to CHAP-eligible children, particularly those requiring follow up care, and updates the child's record.

4. IN 1975 HERKIMER COUNTY CHAP ASSURED THAT ALMOST 50 PERCENT OF THE ELIGIBLE CHILDREN RECEIVED APPROPRIATE MEDICAL CARE

There are no quantified objectives--county specific or otherwise--against which Herkimer's CHAP performance in 1975 can be measured; over three (3.3) times as many children received screening examinations in 1975 as did in 1974 (384 v. 263). The cost (exclusive of administrative costs) was slightly less than three times more although this is probably more a reflection of the change in the CHAP rate than "cost effectiveness" of the program. In any case, it appears that Herkimer County made a significant investment in implementing CHAP in 1975 with a good measure of success. Exhibit C-V, following this page, summarizes the major measures of CHAP effectiveness:

- OUTREACH--Almost one half--47 percent--of the clients who came through intake or recertification during CY 1975 made a request for a CHAP examination. To a certain extent, however, this high rate reflects misunderstanding by clients

EXHIBIT C-V

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

CHAP PERFORMANCE MEASURES:
HERKIMER COUNTY

Indicator	Measure	CY 1975
Outreach	Number of Requests / Dynamic Population*	1,801 / 3,839 = 47%
Follow-Through	Number of Examinations / Number of Requests	864 / 1,801 = 48%
Penetration	Number Screened / Dynamic Population	864 / 3,839 = 23%
Penetration	Number Screened and Number Under Appropriate Care / Dynamic Population	864 + 952 / 3,839 = 47%
Follow Up**	Number Receiving Follow Up / Number Requiring Follow Up	93 / 141 = 66%

Notes: * Actual count during year
** For period January to September, and numerator includes only children for whom a specific report of follow up is available--see Exhibit C-VI for further details.

of the nature of the "request;" apparently many believe, despite assurances from eligibility workers that the request is wholly voluntary, that it is somewhat obligatory or at least easier to sign than not.

FOLLOW-THROUGH--Only half (48 percent) of the requests made are followed by an examination. That 52 percent did result in an examination can be explained by one of several reasons:

- Many clients make half-hearted requests, never intending to pursue examination.

- CHAP believes that clients should take a major responsibility for arranging the examination (although, as noted above, a list of providers and transportation is offered); evidently, many clients do not bother.

- An initial request is made on the DSS-2400 and presented to an intake worker; CHAP does not become involved until six months later, at recertification. Consequently, sufficient time has not passed to allow claims to be posted for some clients who perhaps made a request in months October, November, and December of 1975, have recently received an examination, and have returned for recertification. The effect of this time lag is to depress the measure of CHAP "follow through" and put the County in jeopardy on a penalty compliance issue.

PENETRATION--Judging from both measures of program penetration, Herkimer has performed reasonably well. Although no target levels have been established to define success, Herkimer County screened a higher percentage of its target population than the majority of States, being matched by one State (New Mexico)[3/] and surpassed by only 13.[4/] No comparable data exist for comparison of the number of children under appropriate care.[5/]

3/ HSM 646 (9-72) (Formerly PHS 446); Fiscal Year 1975 National Statistical Summary of EPSDT; first 10 months data.

4/ Ibid. Tennessee, Arkansas, Louisiana, Oklahoma, Texas, Iowa, Kansas, Colorado, North Dakota, Nevada, Alaska, Oregon and Washington.

5/ Of course, similar data exist for the other counties in New York, but these data have yet to be validated before confident comparisons can be made.

FOLLOW-UP [6]--Determination of which children received follow-up care was a complicated and frustrating task for a number of reasons:

- Many cases are closed before the follow-up is provided. This does not necessarily imply that follow-up care was not received but, rather, that it was not paid for under Medicaid and, consequently is not part of the Medicaid payment record.

- Often CHAP examinations "discover" conditions which are preexisting and under treatment (or for which there is no treatment); nonetheless, the physician often indicates that the child has abnormal conditions, artificially padding the number of children reported as needing further attention. Unfortunately, it is impossible to determine exactly how often or in which cases this occurs.

- Not infrequently, follow-up is provided in a free clinic (i.e., immunization clinic), or under a court ordered support arrangement, by parent or by private insurance In some cases, the CHAP Coordinator is able to ascertain from the parents that care was received (although not in a timely manner, the absence of a follow-up claim being discussed with the client at a subsequent recertification period--usually six months hence) but there is no bill to validate the date, extent or cost of care.

Exhibit C-VI, following this page, provides details about the follow-up activities for children requiring such additional care. Because there is a time lag which distorts the data for up to five months, the data are separated into two groups--(1) January to September and (2) October through December--on the assumption that the performance during the last three months will eventually match that of the first three quarters.[7] As seen in the Exhibit, during the first three quarters 12 percent of the children did not get CHAP follow-up care (assuming that CHAP is not held liable for children in closed cases or for monitoring conditions which were preexisting and under treatment). This jumped to 30 percent in the last three months of the year. Further analysis of these case revealed:

6/ In surveying to obtain these data, no attempt was made to determine whether the follow-up occurred within 60 days of the examination.

7/ Moreover, Herkimer County did not pay any provider claims during the last quarter because of a failure in accounting equipment; these problems do not effect adversely the other statistics reported above.

EXHIBIT C-VI

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

OUTCOMES FOR CHILDREN WHO
REQUIRED FOLLOW-UP CARE

Descriptor	Total Year		January to December		October to December	
	Number	Percent	Number	Percent	Number	Percent
Total Number of Children With Conditions Requiring Follow-Up Care	198	100%	141	100%	57	100%
Children Who Received Follow-Up Care:						
. Bills Available	105	53%	87	61%	19	33%
. Bills Not Available	19	10	6	5	13	23
Children Who Did Not Receive Follow-Up Care	35	18%	18	12%	17	30%
Other:						
. Preexisting Condition	18	9%	15	11%	3	5%
. Case Closed	20	10	15	11	5	9

- The reasons why follow up care did not occur vary, as shown in Exhibit C-VII, following this page. The cases outstanding during the first three quarters, for the most part, do not reflect badly on CHAP with only six for which there is no explanation; conversely, there is good reason to expect that at least half of the cases outstanding in the last three months will receive the needed care.

- The conditions for which follow-up care was required is shown in Exhibit C-VIII, following Exhibit C-VII. As seen there were a large number of conditions reported related to vision, anemia, immunizations, ears, dental, cardio-pulmonary, conditions of the skin. It is difficult to assess the severity (from the provider perspective) or urgency (from the patient perspective); for example "ears" might mean simple ear wax or threatened permanent deafness. It is, therefore, impossible to guess the consequences to a child who does not receive follow-up. Although there are no startling trends, it does appear that clients and providers were less successful in attending conditions related to dental needs than any other. This is consistent with the general lack of emphasis on dental (contrast medical) care in Medicaid and CHAP Statewide and suggests an area where more attention should be focused.

- The ages of children who did not receive follow-up care are shown in Exhibit C-IX, following Exhibit C-VIII. The tendency to obtain follow care appears to decrease as the children age.

CHAP COSTS REPRESENTED LESS THAN ONE PERCENT OF THE MEDICAID BUDGET FOR CY 1975

The total cost of Medicaid in Herkimer County[8/] in 1975 was $4,287,891.[9/] f this sum, $34,200 can be attributed to the CHAP program. There are three ..ements of this cost:

Federal, State and local match.

$3,902,787 payments for Medical Assistance plus 62 percent of the following administrative costs: Medical irector, Salaries, Equipment, Contractual Expenses, Data Processing, and Staff Development. 62 percent is the elationship between medical assistance payments and total payments for services.

EXHIBIT C-VII

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

REASONS FOR FAILURE TO OBTAIN
FOLLOW-UP CARE

Reason	Number of "No-Shows" for Months: January to September	October to November	Total
Referrals	8	2	10
Eligibility Turnover*	2	--	2
Death	1	--	1
False Positive	1	--	1
..nts Agreed to Schedule, But No Bill Received to Date	--	7	7
No Explanation	6	8	14
Total	18	17	35

* Case is not closed currently but was closed shortly after the examination and prior to receipt of ..llow-up care; it is not known whether follow-up care was received from the private sector ..ring the lapse in eligibility.

EXHIBIT C-VIII

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

CHILDREN WHO DID NOT RECEIVE FOLLOW-UP CARE, BY CONDITION

Condition	Number of Children With Condition Reported	Number of Children With Condition Reported Who Did Not Receive Follow-Up Care*	Percent of Children Who Did Not Receive Follow-Up Care
History, Growth, and Development	11	2	18%
Vision	15	2	13
Hearing	7	1	14
Anemia	18	4	22
Urinalysis	1	1	100
Immunizations	21	6	29
Eyes	11	2	18
Ears	24	1	4
Dental	21	10	48
Cardiopulmonary	22	1	5
Musculoskeletal	9	1	11
Neurological	3	1	33
Conditions of the Skin	23	4	17
Other	14	1	7

Note: * Does not equal number of children because some children were reported as having more than a single condition

EXHIBIT C-IX

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

CHILDREN WHO DID NOT RECEIVE
FOLLOW-UP CARE, BY AGE

Age	Number of Children With Referable Condition Requiring Follow-Up Care	Children With Referable Condition Who Did Not Receive Follow-Up Care	
		Number	Percent
0 - 1	30	3	10%
1 - 6	62	9	14
6 - 21	106	23	21
Total	198	35	

- Administrative Cost--The costs of direct labor, as seen in Exhibit C-X, following this page, were $15,185. There are no other significant administrative costs to be allocated to CHAP.

- Screening Examination And Child Health Care Status Report (DSS-2402) Cost--As reported by Herkimer, during the 12-month period $15,919.95 was spent on examinations and $125.00 on the DSS 2402.

- Cost Of Diagnosis And Treatment Identifiable As CHAP Related--A search of the medical payment records reveals that at least $2,971.95 was spent on CHAP-related follow-up care. Two important points must be made:

  - Exhibit C-XI, following Exhibit C-X, shows the breakdown of these expenditures by the first three and last quarters. It appears that relatively less follow-up was paid for in response to examinations which took place late in the year, but this is probably not the case. It is more likely that the year-end transactions have not been billed or added into the claims file.

  - For the reason suggested above, and because of the difficulties in matching payment claims to CHAP records, the amount shown as follow-up care must be considered the minimum amount. In other words, at least $2,971 was spent.

C. THE CHAP PROGRAM IN HERKIMER COUNTY OPERATES AS EFFECTIVELY AS POSSIBLE: ANY SHORTCOMINGS IN THE PROGRAM ITSELF REFLECT BASIC PROBLEMS WITH EPSDT, RATHER THAN ITS PARTICULAR IMPLEMENTATION IN HERKIMER

The initial progress of the CHAP in Herkimer County appears to be the singular result of the personal commitment of Commissioner Bush. As a participant on New York State's Department of Social Services Medical Advisory Committee, he was persuaded that CHAP was in harmony with the County's own priorities for services to children and the aged. The impetus of his original commitment has been reflected by the enthusiastic administration of the CHAP plan by Coordinator Joan Johnson. Two other factors provided fertile ground for the development of CHAP in Herkimer County:

EXHIBIT C-X

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

ADMINISTRATIVE COSTS: HERKIMER COUNTY, 1975

Direct Labor Cost	Total
CHAP Coordinator (100%)	$ 8,008
CHAP Clerk (50%)	2,808
Public Assistance Recertification Workers (3 welfare examiners @ 5%)	1,117
Public Assistance Eligibility Workers (3 welfare examiners @ 2%)	447
Medical Assistance Eligibility Recertification Workers (3 welfare examiners @ 5%)	1,117
Child Welfare Workers (5 caseworkers @ 2%)	844
Family Services Workers (5 caseworkers @ 2%)	844
Total Administrative Costs	$ 15,185

EXHIBIT C-XI

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

SERVICE COST OF CHAP IN CY 1975:
HERKIMER COUNTY

Expenditure	Costs for Period: January to September	October to December	Annual Total
Screening: Examination	$ 11,845.89	$ 4,074.06	$ 15,919.95
DSS 2402	125.00	--	125.00
Cost of Treatment and Diagnosis	2,393.64	578.31	2,971.95
Annual Total	$ 14,364.53	$ 14,652.37	$ 19,016.90

- A willingness on the part of the county legislature to fund the position of a full-time CHAP Coordinator. It appears that there will be no difficulty in continuing to fund this position when the CETA funds under which it is supported are reappropriated by the county legislature.

- A favorable attitude among the county's physicians for a screening program with a strong follow-up component. Although the physician community has not been organized in overt and public support of the program, they have participated with relatively little complaint; the high level of follow up care received indicates that Herkimer is justified in its assumption that providers will typically assume this responsibility.

The following sections discuss some of the most important conclusions that can be suggested about the EPSDT program in general based upon the experience in Herkimer County.

(1) The Experiment With The School System Did Not Provide An Adequate Test Of The Concept Of Linkages

Herkimer County was originally selected as a case study partly on the basis that it planned a demonstration project with the Herkimer County Central School District (HCSD). According to the plan, which was to be funded by a combination of Albany Regional Medical Program (ARMP) funds and Medicaid, children in grades K, 1, 3, 7, and 10 were to receive a CHAP equivalent examination by the school physician; information obtained from school examinations was to be shared with DSS, and, in turn, DSS was to alert HCSD of children in the relevant grades who were (became) eligible or who had a CHAP examination from a private physician or clinic.

The project was plagued from the onset of implementation by personality difficulties and lack of communication, although all parties agree that the approach to providing care to children through the schools is sound. Essentially, the school district did not realize the amount of resources it would take to fulfill its commitment. As of April, only 16 examinations of the possible 86 had been completed. By June 1976, however, all 86 children received examinations; 55 through the schools.

Although the project was not a successful test of the potential for a CHAP linkage with the school system, it did shed light on a number of factors considered to be barriers to such linkages:

Dual Standards Of Care--One difficult decisions that must be made when considering linkages with the school system is whether or not services should be made available to all students or only to the Medicaid-eligible population. The argument that this is not a serious barrier rests on the assumption that parents are not aware of or concerned about the health-related activities carried out in school. This was not born out in HCSD. Although HCSD did include all children in the relevant age groups, there was considerable interest on the part of parents of children in other grades (as well as parents of children in other school districts) about the comprehensive examination. This indicates that public concern about the equity of services does exist and is a force that must be considered; it does not, however, shed light on the strength of the reaction, particularly if the inequity is based on criteria of welfare eligibility, rather than residence or grade level.

Confidentiality--There is considerable concern about the ability of cooperating agencies to maintain confidentiality of patient status as Medicaid eligible. HCSD and DSS feel quite confident that they are not violating either the spirit or the letter of the law insofar as information regarding CHAP eligibility is limited to the school nurse, the physician, the secretary, and the school psychologist--the analogues of those privy to such information in any providers' office. Under no circumstances are teachers informed of CHAP eligibility. It is impossible to state with surety whether these precautions are, indeed, adequate to absolve DSS of the liability for breach of confidentiality; there is much variation in interpretation of the confidentiality requirements which state merely that disclosure of names can only be made "...within the administration of the plan." Whether the school's role in CHAP falls within this rubric can, ultimately, be judged only in court; it is reasonable to assume, however, that the steps taken by the HCSD and DSS to be discrete will significantly lessen the possibility that the issue is brought to open complaint.

Funding--It is a long standing tenet of Medicaid that services provided free to some members of the general population may not be reimbursed under the Medicaid program as these constitute available resources. Consequently, when the new ARMP funds expire at the end of the one year demonstration period, the program will probably terminate. The several alternatives that exist do not appear likely:

- The parents of all children will be charged for the service, making Medicaid equally liable for reimbursement on behalf of CHAP eligibles.

- The routine school health examination will continue free of charge for all students, with the additional services which constitute the CHAP equivalent being rendered through the school only to CHAP students and billed to Medicaid.

There is little enthusiasm for either option and it appears that the program will be discontinued.

(2) The Date Problems Which Plague CHAP Operations Continue To Be Enormous Despite Recent Implementation Of A Computerized Billing System

As discussed elsewhere in this report, CHAP is almost solely dependent for information about client health status on the provider claim forms. The operational difficulties which arise from this dependency exist at two levels:

- Screening--The CHAP Unit must await the DSS 2403 form to determine whether an examination has occurred as scheduled. Earlier attempts to persuade clients to return stamped post cards indicating whether and when the examination took place met with failure and have been abandoned. Because the CHAP bills are delivered directly to the Coordinator prior to being audited and paid, the delay is minimized but can never be avoided altogether. Moreover, the CHAP Unit is unable to determine from the bill (1) the nature and severity of the disorder requiring follow up, if any, and (2) when or if the provider has arranged for appropriate follow-up activities. These difficulties do not cripple the program, only complicate its operation.

- Follow-Up Care--While the data problems involved in the screening process are a nuisance, the data problems encountered in determining whether follow-up care occurred are enormous. This occurs for several reasons:

- It is very difficult to establish whether some conditions "discovered" by the CHAP examination have been well known and under treatment for a long period of time. In such cases, it is difficult to measure CHAP's responsibility for follow-up or to allocate costs to the follow-up component of CHAP.

- It is often impossible to match the condition reported on the DSS-2403 with other medical encounters experienced by the child: (1) the codes available on the MA 21 are very vague and, often, only the shortest diagnosis or procedure is coded, obliterating all detail, (2) not infrequently, the bill for "follow-up" care arrived prior to the bill for the screening examination. The survey by which MSI identified diagnosis and treatment costs demonstrates that something can be learned from the payment records, but that it is not a perfect source of information about the health status or needs of the CHAP children. Moreover, this information is collectable only at considerable expense--measured primarily in time invested monthly by the CHAP Coordinator who must review each bill.

These difficulties will not be markedly reduced by the recently installed computerized payment system. The computer will be able to identify all children under 21 and, possibly to keep a running count of the dynamic case load. It will be able to sort all children who received a CHAP examination although the CHAP Unit will probably continue to review each DSS-2403 as it is received, to ensure timeliness and record conditions requiring follow up. The system may eventually also point out the data on all children under 21 who required follow-up care; this may reduce the coordinator's task in searching the claims for relevant subsequent medical attention, although two factors reduce the potential benefit: (1) the printouts will not allow as timely a review as will searching the bills, and (2) the difficulty in matching conditions with subsequent care may be exacerbated to the extent that codes become more cryptic. At a minimum the computer can indicate the children for whom no bill was received and consequently for whom no more intense analysis of the bill is productive. There is also hope that the computer can be used in place of the tickler system to notify CHAP when an examination is due under the periodicity schedule, although this is not likely to occur for over a year.

To their credit, Herkimer has done a considerably good job of data analysis above and beyond the minimal reporting requirements of the State, although this is a totally manual process. The CHAP Coordinator knows, for example, the dynamic case load of children eligible for CHAP throughout the year and prepares quarterly and annual summary statistical and cost reports.

(3) Although The Program Is Embraced Enthusiastically, There Is Some Question As To Whether It Is The Best Approach To Meeting The Objectives Of CHAP/EPSDT

From the outset, Herkimer County has been enthusiastic about the EPSDT program, viewing it as consonant with its own objectives and priorities. This enthusiasm is not without its qualifications, however. Although there is no quarreling with the need for improved health care programs for children, there are some questions about whether a program of periodic examinations is the best vehicle for reaching this goal. For example:

- A review of the medical payment records for children who received a CHAP examination revealed that they are frequent users of medical care, with many children having as many as 30 encounters per year. This may indicate that CHAP is not reaching the true target population of underserved children and that health education regarding appropriate utilization of medical services is necessary for children with suspiciously frequent medical care use.

- It is possible that because those who receive CHAP examinations are frequent users, that the underusers (priority targets for CHAP) are not being reached.

- Not only are many recipients of CHAP examinations frequent users of medical services, they tend to use multiple sources of care. An objective of CHAP is to stimulate continuity of care; a cursory review of patient claims does not reveal such a trend. [10/]

- Although provider participation has been adequate, there is not powerful commitment to or understanding of the program in the provider community, indicating that it is not considered a clinical imperative. The question can even be raised as to what role that the relatively attractive reimbursement rate plays in provider participation.

10/ A definitive review of the claims for this purpose would require a match between type of provider and nature the disorder; this was beyond our scope.

In summary, the program as presently operated will continue to be Herkimer's response to its concern about the health care of children. However, this is at least as much a function of the lack of alternatives (legally funded under Medicaid) as it is to a wholehearted belief that CHAP is the most effective vehicle possible.

(4) Although Health Education Remains An Implicit Objective Of CHAP, The Program Has Made Little Progress In This Direction

It is a firmly held belief of the CHAP coordinator and the philosophy that influences program administration, that an informed clientele is the key to a successful CHAP. This is reflected in the continuing insistence that clients make their own appointments and find their own transportation if possible.

The CHAP coordinator is well versed in the basic concepts of health education and does spend a good deal of her time in face-to-face discussions with the client. She reports anecdotal evidence that some clients are "getting the message," although whether they are the ones in most serious need of the message is unclear. Nonetheless, CHAP does not currently have a strong health education component. The intake and recertification workers who have the initial contact with the client are not well informed about health education and there is even a strong feeling at CHAP that the school health system as currently operated, is more pro forma than effective. Consequently, the interest in health education is unsupported by any meaningful financial training commitment, and, moreover, suffers to a certain extent from lack of information about the state of the art.

(5) The Possibility Of Compliance Monitoring And Penalty Assessment Does Not Seriously Influence The Daily Operations Of Herkimer's CHAP

It is difficult to measure the impact that the penalty compliance program has had on CHAP in Herkimer County. This is true for several reasons:

- The county has not been audited; consequently, the staff does not understand fully the procedures that constitute the audit and are unable to judge accurately whether their program would be found acceptable, although it is difficult for them to believe that their good faith efforts would not be adequate.

- From what they do know about the audit procedure and the criteria upon which counties are judged, they conclude that some of the measures are unreasonable and arbitrary. For

example, they do not believe (1) in the efficacy of written notification, (2) that they should be held liable for follow up within 60 days if the physician specifically indicates that follow up should take place within six months, (3) that any county will ever be able to respond to all requests, (4) that CHAP can ever know about all the examinations that take place (some at free clinics, some incorrectly billed), (5) that it is possible to determine with precision whether or to what extent follow-up care was received (again, because some is rendered in free clinics, some unidentifiable as CHAP-related), and so on.

Because the Herkimer CHAP has not had direct experience with the compliance procedures or the Regional Office staff, and because they have received little explanation or elaboration of the regulations, they remain in the dark about how the penalty might possibly be assessed against their program. They are unable to "pretest" their program for compliance because they do not know how various elements of their CHAP will be interpreted by the Regional assessment team. To this extent, CHAP operates in a manner consistent with the commitment of the DSS to offering screening and medical care to children and without much regard for the penalty.

Moreover, the program's continued existence as a priority within DSS does not rest on continuation of the penalty. This feeling may not, however, be shared in the politically and fiscally conservative county as a whole. The fate of CHAP is unclear if it suddenly was no longer "mandatory." There is already a strong cost containment sentiment evidenced in county response to the Title XX program to provide good care within the minimum framework required, and the scope of Title XIX is also being questioned.

On a larger, more theoretical level, however, it can be assumed that without the rigid prescription of the EPSDT program concept implied in the Federal regulations and explicit in the State Bulletin 190, Herkimer County might--given equal funds--have implemented a far different program in response to its priority on child health. The program may have targeted more directly on the hard core medically underserved, may have invested more directly in health education (perhaps community wide), may have centered its attention on children under six, or perhaps focused on dental problems or a few other disorders of more demonstrated cost benefit. There is interest expressed in "what's being done in other areas"--models that might be useful to Herkimer County in enhancing its program and it is likely that more innovation and a more tailored program could have developed.

In addition, discussions with the CHAP Coordinator revealed that there would be a good response to compliance monitoring on the basis of quantifiable objectives assuming that standards are set with clear recognition of attainable rather than optimal levels of performance. This implies also that the intent and definition of each measure can be clearly agreed upon by all parties well in advance of the evaluation period.

(6) There Are A Number Of Ways In Which The Herkimer County Might Enhance Its Ability To Reach EPSDT Objectives

The CHAP in Herkimer County is basically sound, the strongest of the four counties which participated in this evaluation. It was developed an adequate (if tedious) case management system which is hampered but not crippled by its reliance upon the claims system and workable only because of the small size of the client load. It is difficult to suggest ways that this system, given the administrative requirements imposed, can be improved. However, there are a number of recommendations that emerge from the analysis of Herkimer's CHAP--several which are exploratory rather than operational in nature, some which suggest roles for New York State or the Regional Office:

- To reach the hard core underusers of medical care, CHAP should identify those children who have not received any medical attention for over a year and invest considerable effort in reaching them with the CHAP message. Two considerations must be made in identifying such children: (1) Does the case have a long enough and continuous medical payment history to tell whether the child has received care?, and (2) Do the siblings have the same pattern of underutilization or is there evidence that the family has access to the medical community?

- A more focused review of medical claims to determine where extreme and inappropriate use of multiple providers (especially the more costly providers) is occuring. A health education effort might help reduce this misuse and complement two important CHAP objectives: long- and short-range cost effectiveness, and establishing continuous provider, patient relationships.

- As Herkimer initiates its computerized payment system, it may be possible to incorporate features existing and tested in other counties which aid CHAP administration, and, thus avoid reinventing the wheel. In addition, because the system is new and flexible, an opportunity exists to try models that

do not mesh with existing systems in other longer-established counties. The State or the Region might be a valuable source of technical assistance or, at least, facilitate communication between Herkimer CHAP and other counties whose experiences are revelant.

With respect to the health education aspect of CHAP, a number of assists are possible:

- The recertification and intake workers who introduce the clients to CHAP are not well informed about the nature of well-child care and its possible benefits. A program of health education for the de facto health educators might heighten program impact.

- Although the CHAP Coordinator has graduate training in health education, she could benefit from information about health education models in other small, rural counties that might be transferred to Herkimer's CHAP.

It appears that there are a significant number of referrals related to dental care and that a proportionally larger number of these cases go without care. A more focused emphasis from the State might help ameliorate this situation.

ATTACHMENT I

DESCRIPTION OF THE CHAP
LINKAGE WITH THE HERKIMER
CENTRAL SCHOOL DISTRICT

DESCRIPTION OF THE CHAP
LINKAGE WITH THE HERKIMER
CENTRAL SCHOOL DISTRICT

The Herkimer Central School District (HCSD) encompasses six schools:

- St. Francis*, grades K through 8
- Tugar, grades K through 2 and two special education classes
- East Herkimer, grades K through 6
- Bills, grades K through 2 and 4 through 6
- Foley, grades 7 and 8
- Herkimer High School, grades 9 through 12

All schools in the district, based on the CHAP periodicity schedule, have at least one grade that requires participation in the program. Approximately 800 children are expected to be examined during this experimental year.

1. PLANNING THE SCHOOL/CHAP LINKAGE TOOK SEVERAL MONTHS AND WAS CARRIED OUT BY REPRESENTATIVES OF THE DEPARTMENT OF SOCIAL SERVICES (DSS) AND THE HERKIMER CENTRAL SCHOOL DISTRICT (HCSD)

The initial impetus for the linkage with the school system came from Mr. Michael Bush, Commissioner of DSS. As a past president of the School Board, Mr. Bush felt reasonably sure that the school district might respond favorably to the idea of providing CHAP equivalent examinations through existing mechanisms in the schools. He was fortunate in having a close working relationship with Mr. Donald Putterman, Superintendent of HCSD and the plan was eagerly accepted.

Mr. Bush also broached the idea that Albany Regional Medical Program (ARMP) might be willing to finance the experiment. The major responsibility for writing the plan was assigned to Ms. Kathy Carleson, school psychologist for HCSD. Representatives of the State and County DSS were closely involved throughout the planning process, particularly in:

* Parochial school

- Determining the exact scope of the examination to ensure conformance with CHAP requirements
- Establishing procedures for information sharing.

Exhibit I, following this page, details the chronology of the planning process.

The plan was approved in October, 1975 and formally signed in November of that year.

Exhibit II, following Exhibit I, details the planned budget for the project.

2. AS PROPOSED, THE MECHANICS OF THE LINKAGE APPEAR TO BE EFFICIENT

Considerable groundwork was laid, to assure adequate communications and efficient use of medical resources. The project was expected to operate as follows:

- A notice is sent to each family, informing them that an examination is required and offering the opportunity for the family to make its own arrangements through a family physician. Two interesting points regarding this notice:
  - The child is provided with a memo to alert the parents an important notice is coming through the mail
  - The parents are requested to contact the school if they do not want their children to participate. The letter is sent several times to ensure that each family receives notification, however, inertia or apathy is working in the best interests of program cooperation.
- HCSD receives a list of all children who are eligible for CHAP from DSS. The list further indicates which children have received a recent examination, thus enabling HCSD to avoid duplicating services.
- A secretary funded under the ARMP grant is responsible for maintaining all records and, prior to the examination, completes the administrative sections of the DSS 2403 for all children who are CHAP eligible.
- Prior to the examination, the school health nurse talks to each class about the value of the examination and what they can expect.

EXHIBIT I

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

PLANNING SCHEDULE

July, 1975	Mr. Bush approached the HCSD with the idea of a linkage between school and CHAP examinations.
July-August, 1975	Ms. Carleson prepared the ARMP grant and submitted it for review.
August-September, 1975	Laboratory services contract negotiated with the Herkimer Hospital.
October, 1975	Notification from ARMP that award had been made.
November, 1975	Formal agreement reached between ARMP and HCSD.
January, 1976	Meeting between DSS and HCSD in which the details of the CHAP examination were agreed upon.
January, 1976	Lab work, histories, and physicals began in the first school.
February, 1976	Examinations began.

EXHIBIT II

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

PROPOSED BUDGET

	Budget Item	ARMP Funds	HCSD Funds
a)	Salary/Wages		
	1 - doctor	750	3500
	2 - nurses	0	3600
	3 - dental hygienist	0	3600
	4 - secretary	1000	0
	5 - director	0	1000
b)	Equipment - built-in	0	(100%)
c)	Equipment - moveable	0	(100%)
d)	Construction	0	0
e)	Consultants	0	0
f)	Supplies	250	0(?)
g)	Travel	150	0
h)	Rent	0	0
	Alterations	0	0
	Publications	0	0
	Contractual (laboratory)	7295	0
	Communications	50	0(?)
	Computer	0	0
	Other	505	0
	Direct cost to ARMP.....	10,000	
	Grant related income.....	0	
	Local funds.....		at least.. $11,700
	Other funds.....	0	

- Laboratory work, hearing and vision, dental examination are provided by a hygienist, and the child's history is recorded on the child's record before the physician examination.
- The physician reviews the assembled data on the child and completes the balance of the examination, noting conditions for follow-up, if any.
- The DSS 2403 is forwarded to DSS where the bill is paid. Indicated follow-up for these children is handled by the CHAP coordinator.
- Follow-up for all other children with abnormal conditions is the responsibility of the school nurse.
- Families of children with all conditions indicated normal are sent a letter assuring them of the normalcy of the examination.

3. PROGRESS UNDER THE DEMONSTRATION PROJECT WAS DISAPPOINTING BECAUSE OF PERSONALITY DIFFICULTIES AND POOR COMMUNICATION

Early in the summer of 1975, Dr. Michael Solomon accepted the position of school physician, the position required that he perform 650 to 700 routine school health examinations, as the plan to cooperate with CHAP had not been embarked upon. Subsequent to that appointment, a number of events took place which lead to Dr. Solomon's resignation. An interview with Dr. Solomon revealed the following:

- Dr. Solomon believes he is unable to complete the CHAP equivalent examination for the school for a number of reasons:
  - He expected to begin the examinations in October, 1975, but no examinations were permitted until February. At that time, Dr. Solomon determined that he could not neglect his private practice to the extent necessary to complete the examinations by May.
  - The number of examinations increased from 700 to 800 and the scope of the examination increased, particularly with the addition of laboratory tests. Consequently, Dr. Solomon does not consider the fee ($4,250 plus CHAP reimbursement for approximately 125 children) adequate

- Dr. Solomon was dissatisfied with the communications between himself and the school system throughout the planning period. As the key doctor, he believed he should have been more deeply involved in negotiating the grant with ARMP at an earlier stage.

Interviews were also held with Mr. Putterman and Ms. Carleson. They believe that:

- Dr. Solomon was adequately involved in the planning process witness his attendance at several meetings between New York State DSS and the HCSD.
- The increased comprehensiveness of the examination does not significantly increase the length of physician time required to conduct the examination because
  - The laboratory history, hearing, vision, and dental examinations are completed before he arrives. Children are ushered through the examination process without delay.
  - All the administrative paperwork is completed for the physician.
- That the fee is adequate particularly in light of the additional billings available from Medicaid.

On February 10, the HCSD Board accepted Dr. Solomon's resignation as [illegible]l physician and authorized a contract with Dr. Chang-il Cho, the local pediatrician. Although Dr. Cho expressed confidence that he could complete all required examinations within time and budgetary constraints, only 20 CHAP children had been examined through the school as of April, 1976. By June 1976, however, all children received examinations. Of 86 CHAP eligible children, 55 received examinations in the schools.

TWO MAJOR ISSUES ARE RAISED BY THE HERKIMER EXPERIMENT

There are two important issues focused by the experimental linkage between DSS and HCSD--two of which apparently have kept other counties from attempting such a cooperative effort:

- Confidentiality--How can the identity of Medicaid eligible children be kept confidential? HCSD and DSS feel quite confident that they are not violating either the spirit or the letter of the law as information regarding CHAP eligibility

is limited to the school nurse, the physician, the secretary, and the school psychologist. Under no circumstances are teachers informed of CHAP eligibility. As a matter of fact, it is impossible to determine whether confidentiality is violated or, if indeed, CHAP's relationship with the school falls within ". . .the administration of the plan" restrictions on disclosure. They are taking reasonable precautions, however, and do not expect parental complaints.

- Funding--Herkimer County was fortunate in receiving a $10,000 grant from ARMP. Unfortunately, ARMP's grant authority will change at the end of this year leaving Herkimer without a source of funds. Although the school is searching for alternative grant monies, they are not overly optimistic at this point. A possible strategy involves asking parents of all children to pay for the laboratory examination--the most costly deviation from the routine school physical--thereby allowing HCSD to bill Medicaid for these services as well.

The grant requires that HCSD conduct an evaluation that will determine, among other things:

- Whether a larger proportion of children received a comprehensive examination from the school physician than in years past
- Whether there was less duplication of examinations than previously
- Whether, as anticipated, children's medical needs will be better monitored through an efficient recording and reporting system

It is unclear whether or how this evaluation will be conducted. It appears, however, that the promise offered by such a linkage did not materialize in the demonstration.

ATTACHMENT II

RESPONDENTS FOR SITE VISIT II: HERKIMER COUNTY

ATTACHMENT II

Assistant Regional Director for
Planning and Evaluation
Department of Health, Education, and Welfare
Region II

RESPONDENTS: HERKIMER COUNTY

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2. Fran Bernstein
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3. Cathy Carleson
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4. Dr. Theresa Chun
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5. Judy Meagher
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6. Donald Putterman
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8. John Symons
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CASE REPORT:
NASSAU COUNTY

APPENDIX D

CASE REPORT: NASSAU COUNTY

Site Visits
November, 1975
June, 1976

CASE REPORT: NASSAU COUNTY

I. INTRODUCTION TO NASSAU COUNTY

Nassau County was selected as a representative of the large counties suburban to New York City. As a class, these counties face particular challenges in implementing Medicaid and its component programs and, collectively, are responsible for providing Child Health Assurance Plan (CHAP) services to 10 percent of the State's children. Several factors recommended Nassau County as an interesting case study:

- After being found out of penalty compliance for the first quarter of CY 1975, the County made a remarkable turnaround. A large number of children are now under adequate care and, at the time of site selection, it appeared that "...if the County sustained this performance, all children would be under (adequate) care by July, 1975." 1/

- The County appeared to have planned a comprehensive program with linkages to the Head Start Program and the County Health Department. Moreover, Nassau is abundant with provider resources and has been successful in establishing a strong provider network for CHAP.

- Organizationally, Nassau County presents an interesting picture. Part of the CHAP responsibilities are carried out in the County's several satellite offices; within the main office in Mineola, the County has allocated considerable resources to a large, separate CHAP Unit. Early evidence indicates a strong commitment to the objectives of CHAP on the part of the Unit staff.

1/ "Recommendations for Alternative Site Selections: The Evaluation of New York State's Child Health Assurance Program," October 3, 1975, page 4.

(1) Nassau County Is A Heavily Populated Community Suburban To New York City

Nassau County is a densely populated area of 298 square miles [2] on Long Island, bordering New York City. The estimated population for 1975 is 1,432,328.[2] This population is described as:

- Comprised of 7 percent under the age of five and 38 percent under the age of 19.[2] The projected CHAP case load is 27,000 (static)[3] and upwards of 44,000 (dynamic)

- Having a median family income of $14,632.[2] Approximately 5.4 percent[4] of the County's population is presumed eligible for Medicaid

Nassau County is abundant with medical resources and reports a very high provider participation rate. Exhibit D-I, following this page, lists the providers currently participating under Medicaid generally and under CHAP specifically. Exhibit D-II, following Exhibit D-I, shows the geographic distribution of the CHAP providers.

(2) Early And Periodic Screening, Diagnosis, And Treatment (EPSDT) In Nassau County Emphasized Screening For Children With Known Health Problems Who Were Followed By Services Workers, Volunteers, And The County Health Department

Prior to the full-scale implementation of CHAP, the County Health Department was largely responsible for the care and follow-up of Medicaid children. While the program concentrated more strongly on the younger Medicaid population, there is considerable feeling within the County that the Health Department was doing a "CHAP comparable" job of assuring adequate health care for its children.

During 1973 and 1974, the EPSDT program assumed part of this responsibility but continued to rely on the Health Department and the faith that the County's providers were taking care to ensure follow-up

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e cited in this section are from the County Data Book.

static" case load is the number of children eligible at a particular time. "Dynamic" case load is the who are eligible at some time during the year.

ea Resource File, Health Resources Administration, HEW; New York State Statistical Yearbook, 1974.

EXHIBIT D-I

Department of Health, Education,
and Welfare
Assistant Regional Director for
Planning and Evaluation, Region II

PROVIDERS: NASSAU COUNTY

MEDICAID PROVIDERS

- 526 pediatricians
- 1,100 general practitioners
- 115 family practice specialists
- 1,000 internists
- Nine outpatient clinics
- Four Department of Health clinics
- North Shore Hospital *
- Nassau County Medical Center

CHAP PROVIDERS

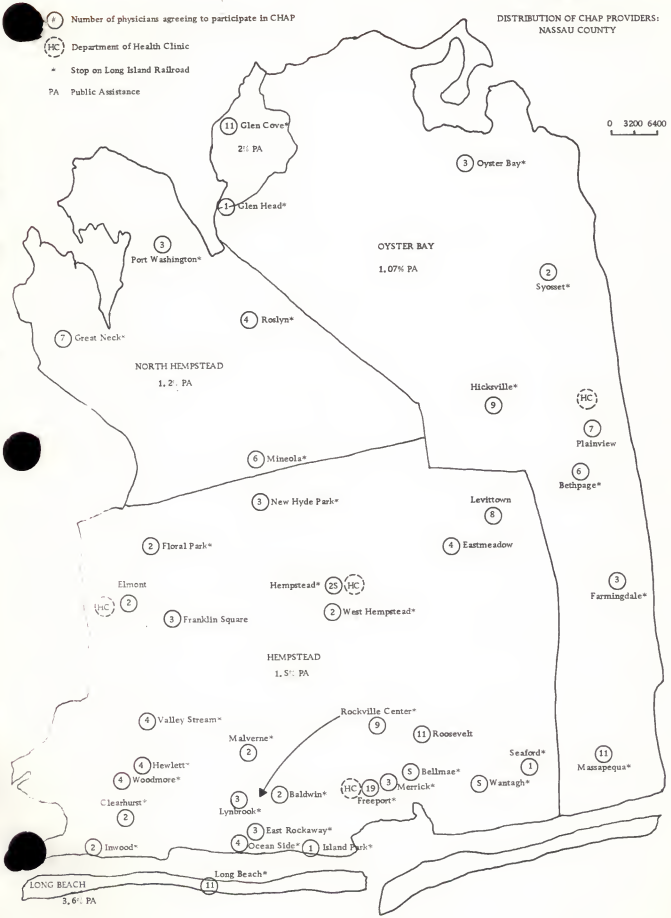
- 116 pediatricians
- 95 general practitioners
- One family practice specialist
- 20 internists
- One preventive medicine specialist
- Four Department of Health clinics
- North Shore Hospital
- Nassau County Medical Center

* There are many other hospitals which participate in Medicaid but not in CHAP.

EXHIBIT D-11

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DISTRIBUTION OF CHAP PROVIDERS:
NASSAU COUNTY



and continuity, per the State Medical Handbook. EPSDT concentrated its efforts on clients who both indicated a desire for screening and suspected their child might have a health problem. An EPSDT Medical Control Unit, consisting of three clerks, was responsible for the administrative aspects of CHAP and the outreach and follow-up requirements were met by services workers and community volunteers.

2. IN PREPARING ITS COMPREHENSIVE CHAP PLAN, NASSAU COUNTY BECAME CONCERNED ABOUT THE FISCAL AND ADMINISTRATIVE IMPLICATIONS OF THE PROGRAM

Nassau County operates one of the largest Medicaid programs in the State; its CHAP case load of 44,000 is the fifth largest in the State.[5/] Consequently, the promulgation of any program as potentially far-reaching as CHAP is met with due administrative constraint. Early planning indicated that a CHAP Unit of at least 15 full-time staff members (either centralized in the CHAP Unit or measured as equivalent in the Services Bureau) would be required to carry out CHAP. It was the strong feeling throughout the County that the essential objective of CHAP--assuring that children were receiving adequate medical care--was already being carried out well by the existing system. There was no objection in the County to the philosophy underlying CHAP but, rather, a strong objection to establishing an administrative program that was designed to document these efforts.

Moreover, the County quickly realized that full-scale implementation of CHAP would require at least a year of start-up time and would necessitate the development of some rather complex, integrated programs to accommodate Nassau's Medical Assistance Payment System (MAPS).

Consequently, the County began inquiry throughout the State and particularly in Albany as to the possibility of curtailing or modifying some of the more administratively burdensome CHAP requirements. In the meantime, Nassau County developed its CHAP plan and prepared for a phased implementation.

(1) The Initial CHAP Plan Was Developed Almost Solely By The Department Of Social Services And Addressed The Need For Phased Implementation

The original Nassau County CHAP plan contemplated several major aspects which apparently (although not explicitly stated in the plan) were intended merely to phase CHAP in to the point where a more

5/ Fifth to New York City and Suffolk, Westchester and Erie Counties. Based on the dynamic case load developed by MSL.

reasonable estimate of the level of effort could be made and to allow time to garner the necessary resources. In addition, the County entertained some hopes that:

- The requirements of Bulletin 190 which they viewed as excessive could be muted, thereby lessening the resources required for compliance
- The State could be prevailed upon to provide more specific guidance, particularly respecting the interface between the payment system and CHAP[6/]

Specifically, the plan suggests that Nassau's CHAP would be carried out by the Medical Control Unit established under EPSDT; the Unit was to be renamed but not significantly enlarged. Rather, the increased CHAP responsibilities would be shared by "...Caseworkers in Family Bureau, Welfare Examiners in Public Assistance and Medical Assistance, ...Training Specialists in Staff Development, and Management Analysts of Systems Computer Programs."[7/] Other aspects of the plan are abstracted in Exhibit D-III, following this page.

Although not specifically addressed in the plan, volunteer student nurses were expected to contribute their efforts to the early CHAP outreach and follow-up activities. These nurses were expected to supplement the program but never to substitute for a full-time CHAP staff. The experience with these nursing students led many in Nassau County to feel that organizing volunteers was not worthwhile, although several respondents were quick to point out that the students were conscientious and highly motivated.[8/]

Nassau County experimented with one other interesting method for phasing in CHAP. Believing that the "fell swoop" start-up of a program with a potential case load of over 27,000 was unrealistic, Nassau identified all children under the age of six for whom no medical payments had been made. These children--characterized by young age and lack of

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6/ Several respondents believed that the State should promulgate all new programs in three distinct ways--one each to address the peculiarities of New York City and the "big three" suburban counties, the larger upstate counties, and the rural counties.

7/ Nassau County Department of Social Services, CHAP Plan, February 4, 1975.

8/ They feel it is difficult for volunteers to become quickly or well-integrated into CHAP and, to that extent, continuity of program administration suffers.

EXHIBIT D-III(1)

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

SUMMARY COMPARATIVE ANALYSIS OF CHAP:
PLANNED VERSUS REQUIRED VERSUS ACTUAL:
NASSAU COUNTY

CHAP Function	Planned	Actual
Outreach: Provider	. Pediatric Society of Nassau County provided CHAP with a roster of pediatricians who agreed to participate (updated for CHAP) . Health Department will meet with Pediatric Society in January to explain program and encourage participation. . Periodic meetings with pediatricians and internists will be held to encourage understanding and acceptance of CHAP. . County Health Department provides CHAP examinations	. Memorandum to all providers in county . Pediatric Society of Nassau County provided CHAP with a roster of pediatricians who agreed to participate (updated for CHAP) . County Health Department provides CHAP examinations . Agreements signed with the Health Department, Nassau Co-Medical Center, and North Shore Hospital
Community	. Posters, signs, and pamphlets will be visibly displayed in the Department's waiting and interviewing rooms . Enlist aid of community agencies and health personnel to disseminate information about CHAP	. Posters, signs, and pamphlets were visibly displayed in the Department's waiting and interviewing rooms . Expect to design and distribute bold, more engaging posters for distribution to the centers of care and other community gathering places . Health Fair used as vehicle for CHAP and health education
Identifying Eligible Children	. Caseload will be identified through computer runs . Initially, CHAP will identify and give priority attention to children under six years of age who have had no recent medical care . Subsequently, older children in need of medical care will be identified	. After being found out of compliance for emphasizing children under the age of six for particular emphasis, the CHAP now identifies all children as they become eligible (make application)
Informing Clients of Availability of Services	. Personal contact will be held at point of application and recertification	. Mailing to all families annually . Interview at application to explain CHAP and complete DSS 2400 . In future will have a face-to-face interview at recertification
Determining Those Under Appropriate Care	. Computer programs can produce individual medical records showing type and frequency of medical care . Guidelines will have to be set for what is considered appropriate care	. Computer programs which produce individual medical records of all children proved so massive as to be impractical . DSS 2402 is sent to physicians when DSS 2400 indicates a provider and refuses the offer of services . Temporarily, CHAP unit receives copies of encounter forms for all children who receive an examination from the Health Department
Periodic Examination	. CHAP Medical Control Unit issues authorization for care and maintains records and controls	. Prior authorization and CHAP information is sent to all clients making a valid request for a CHAP examination . Client asked to inform CHAP unit of date of appointment and folder placed on file to await results of examination . 60-day period counted from time CHAP unit receives bona fide request (vis. after eligibility has been established) rather than from date DSS 2400 completed

CHAP Function	Planned	Actual
Diagnosis and Treatment (Follow-Up Care)	. CHAP Medical Control Unit refers cases requiring services and follow-up to other agencies within the Department . Follow-up and referral to be done by services worker, public health nurses, and a network of volunteer student nurses	. The CHAP Medical Control Unit has expanded its responsibility taking over the tracking and follow-up functions as well as the administrative control . Physician is expected to make referrals for all conditions found. If he fails to do so, the case is referred to the public health nurses, when appropriate . The DSS 2400 series forms are used
Ongoing Case Management		. Complicated and serious cases identified by screening are followed closely over time to watch progress of the patient . CHAP unit maintains two tickler files--periodicity and annual notification . CHAP workers each assigned particular cases to monitor

medical care[9/]--were concentrated on as the target population of risk. It was the clear intention of Nassau to phase in all other age groups by the end of 1975.

(2) In Mid-1975 Nassau County Launched Its Current Approach To CHAP

The early efforts under the CHAP plan described above were, as anticipated by the County, inadequate to bring Nassau into satisfactory compliance with Department of Health, Education, and Welfare (HEW) regulations and the County was found penalty liable on two counts:

- Failure to arrange for screening, diagnosis, and treatment within 60 days of request for service
- Failure to serve all eligible children, particularly those over six years of age

The impetus of this finding (which was, of course, vigorously objected to by Nassau) and a number of other factors led to the development of a large, separate CHAP Unit:

- A meeting between the County Executives and the State was held with the primary purpose of determining to what extent, if any, Bulletin 190 mandated services beyond those in the federal regulations. Satisfied that the State was not greatly inflating the federal program, Nassau County prepared to make the necessary commitment to implementing Bulletin 190.
- The County was faced with a staffing freeze which would have made gearing-up the CHAP Unit quite difficult had not a number of staff members become available from other units.

This mid-year shuffling led to the development of a large CHAP Unit. The staff of this Unit was oriented during a six-week training

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9/ These criteria for lack of medical care did not conform to the ones suggested in Bulletin 190. Nassau believes that a serious programming effort is required to retrieve such data from the payment system. One interesting finding from using the payment system to determine appropriate medical care (by either set of criteria) is that children who are newly eligible for Medicaid and consequently have not had time to use the program all appear to be medically underserved insofar as any care rendered is not recorded in MAPS.

course (two hours a week for each of six weeks) stressing group dynamics, team building, referral technique, and so on. The training course was conducted by the Department's staff development branch; a sequal was held in the winter of 1976 and addressed the health components of CHAP in addition to reinforcing the team building concept. The organization and activities of this Unit are described in the balance of this report.

3. NASSAU COUNTY HAS NOW ESTABLISHED A LARGE, SEPARATE CHAP UNIT WHICH IS RESPONSIBLE FOR ALMOST ALL CHAP FUNCTIONS

As discussed above, Nassau County realized early that a staff of about 15 would be necessary to assure that CHAP responsibilities were carried out. Over the course of the first six months under CHAP it became clear to the County that these responsibilities should be lodged in a Unit with singular attention to CHAP, thereby reducing the conflicting priorities that often arose when services workers had CHAP as well as general casework and crisis intervention to contend with. The CHAP Unit now consists of 18 members with a reporting responsibility to the Director of Medical Services. Key members of the team are:

- Director Of Medical Services--Grace R. Charnow, ACSW, had the lead role in developing the CHAP plan and establishing the CHAP Medical Control Unit. For the second half of 1975, Ms. Charnow was on leave of absence; her CHAP responsibilities were assumed by Joseph Reiher, ACSW, Assistant Director of Medical Services, who continues in this role despite Ms. Charnow's recent return. This change in responsibility resulted in a temporary, but not serious, loss of continuity in the development of the CHAP Unit.

- CHAP Supervisor--Makoto H. Hill, ACSW, was involved in EPSDT and CHAP at the services level until June of 1975 when she was transferred to supervise the CHAP Medical Control Unit. She is responsible for client and clerical staff.

- CHAP Clerical Services Supervisor--Blanche Pannizzo has been with the Department since 1965. In 1973, she helped form the EPSDT Control Unit and has provided invaluable continuity to the development of the CHAP Medical Control Unit.

The balance of the staff is divided between clerical and client activities. With respect to the latter, five caseworkers and seven community service aides

are responsible for essentially the same functions (notifying clients of the availability of screening examinations, making home visits, and so on) despite their divergent levels of training and expertise. The complaint is heard that the Unit is short on competent clerical staff; the additional assistance offered by Public Works Program (PWP) volunteers is viewed as somewhat counter-productive because these workers are transient and, hence, not well integrated into the Unit.

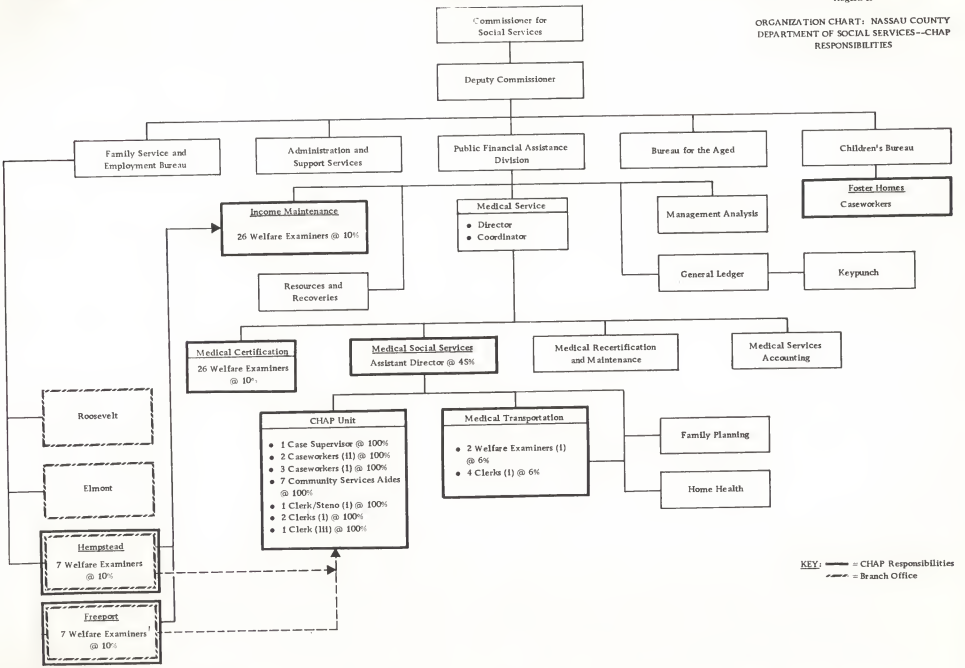
Exhibit D-IV, following this page, shows the organization of the Nassau County Department of Social Services as it existed during the second half of 1975. The exhibit also highlights organizational units with CHAP responsibilities and indicates the estimated staff commitment to CHAP activities. Specifically:

- The CHAP Unit is located under the Office of the Assistant Director of Medical Social Services and is responsible for:
  - Issuing prior authorizations for examinations and sending written notifications to each family with eligible children
  - Assisting in arranging appointments or transportation
  - Following each child to be sure that the appropriate care is received and timely notices sent to assure that families understand the need for examinations on the basis of the periodicity schedule
  - Completing all required statistical reports
  - Approving medical claims for screening examinations
- The Medical Transportation Unit, also under the supervision of the Assistant Director of Medical Social Services, authorizes transportation and arranges for pick-up times.
- The Income Maintenance Welfare Examiners (both in the main office at Mineola and two local offices in Freeport and Hempstead) are responsible for explaining CHAP to all families with children at the eligibility determination interview and assisting the Public Assistance client in completing DSS 2400.
- Similarly, Welfare Examiners in the Medical Certification Unit introduce Medical Assistance clients to CHAP and assist with the completion of DSS 2400.

EXHIBIT [redacted]

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

ORGANIZATION CHART: NASSAU COUNTY
DEPARTMENT OF SOCIAL SERVICES--CHAP
RESPONSIBILITIES



4. OPERATION OF NASSAU COUNTY'S CHAP IS PLAGUED BY THE VOLUME OF PAPERWORK REQUIRED TO FOLLOW A LARGE CASE LOAD AND INEVITABLE TIME LAG IN SUBMISSION AND PROCESSING OF PROVIDER BILLS

The operation carried out by Nassau County's CHAP Unit is very complex, although not unnecessarily so. The flowchart, Exhibit D-V,[10/] following this page, describes in detail the operations of CHAP and shows that the major reason for the complexity is the numerous outcomes of each client encounter--request versus refusal, receipt of provider bill versus no bill, appropriate versus lack of appropriate care, and so on. Exhibit D-III, referred to earlier, summarizes the CHAP elements--identifying eligible children, informing clients of the availability of services, determining those children who are under appropriate care, assuring periodic examinations and appropriate diagnosis and treatment, and ongoing case management. These CHAP elements are highlighted in the paragraphs below.

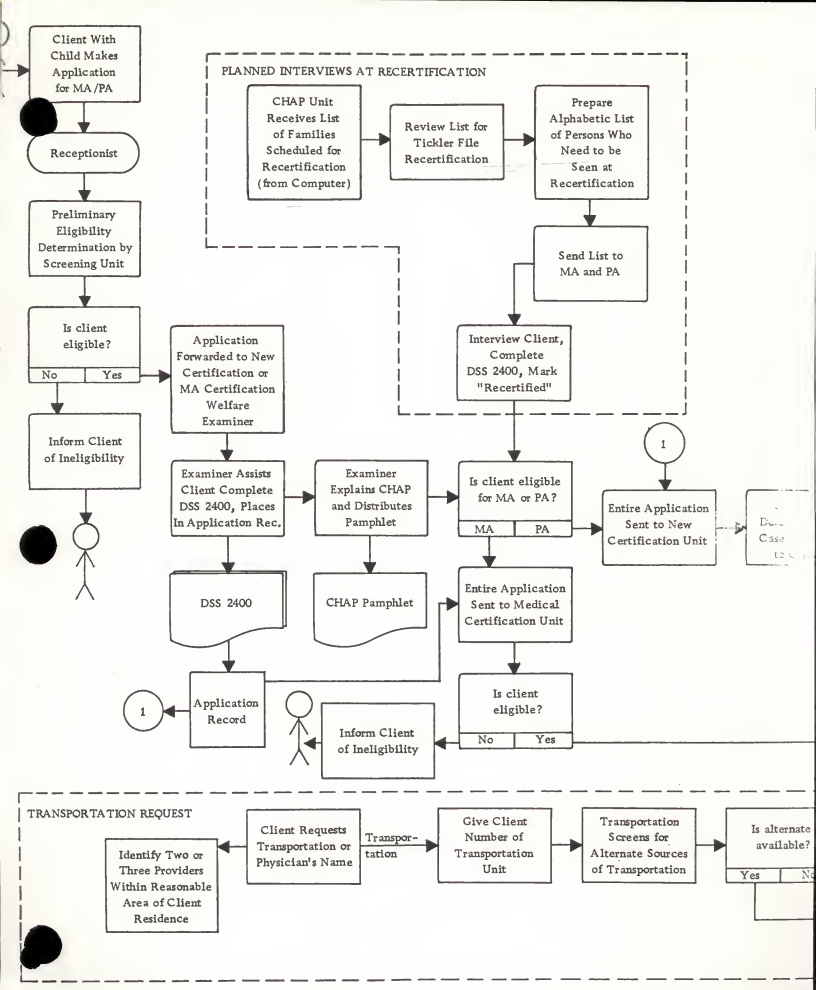
(1) The CHAP Unit Is Notified Of All Opened Cases With Children Under 21 And Uses A CRT To Validate Eligibility

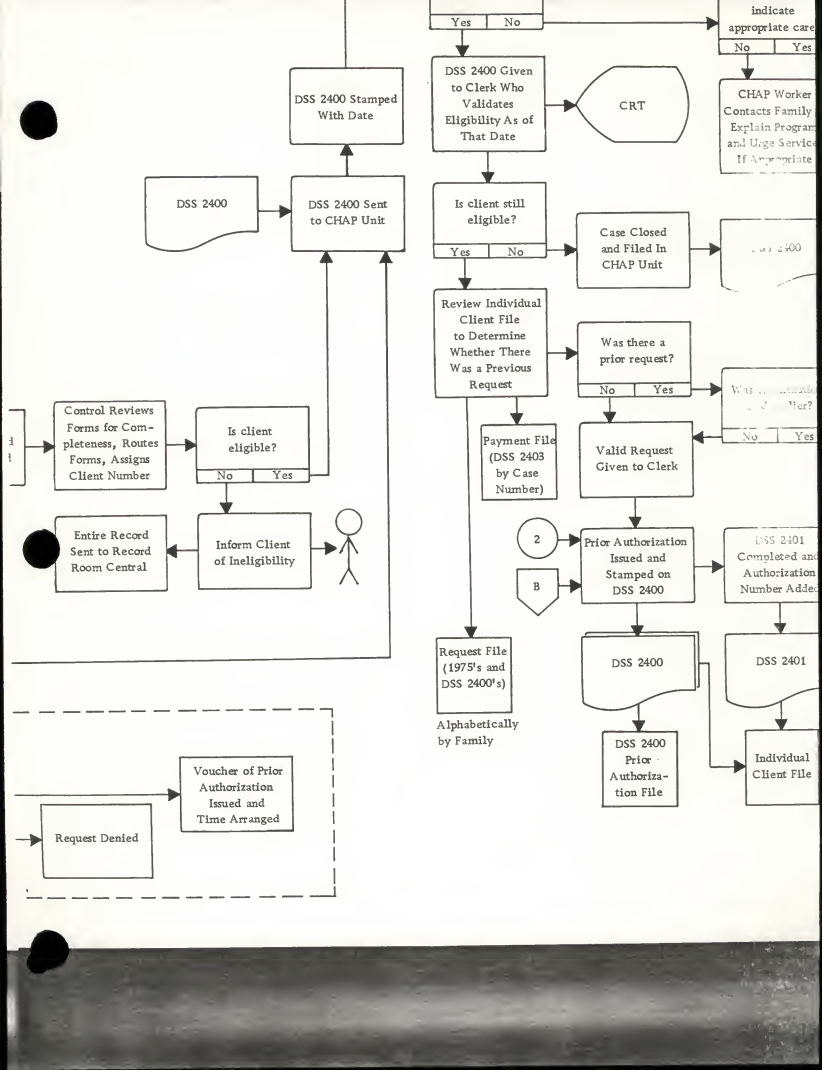
Initially, children were identified for CHAP only as they were certified eligible for Medical or Public Assistance and completed the request for services (DSS 2400). These names were forwarded to the CHAP Unit after eligibility was established (a period of four to six weeks); thereafter, any child's eligibility status could be verified with the CRT located in the CHAP Unit. Recently, however, the CHAP Unit has established several additional procedures for identifying eligible children:

- CHAP workers search the DSS 505 (claim forms) to identify all children who have had a well child visit; these children and their siblings are added to the CHAP rolls if not part of the identified case load.

- The CHAP Unit has recently keypunched all tracking forms (DSS 2401) and will soon be able to run this list against the DSS 606 (eligibility file) to identify additions (and, by the way, to identify case closings, thus keeping their records current).

10/ The section on the foster care children is expected to change in the near future.


Client With Child Makes Application for MA/PA
Receptionist
Preliminary Eligibility Determination by Screening Unit
Is client eligible?
No
Yes
Inform Client of Ineligibility
Application Forwarded to New Certification or MA Certification Welfare Examiner
Examiner Assists Client Complete DSS 2400, Places In Application Rec.
Examiner Explains CHAP and Distributes Pamphlet
DSS 2400
CHAP Pamphlet
PLANNED INTERVIEWS AT RECERTIFICATION
CHAP Unit Receives List of Families Scheduled for Recertification (from Computer)
Review List for Tickler File Recertification
Prepare Alphabetic List of Persons Who Need to be Seen at Recertification
Send List to MA and PA
Interview Client, Complete DSS 2400, Mark "Recertified"
Is client eligible for MA or PA?
MA
PA
1
Entire Application Sent to New Certification Unit
Entire Application Sent to Medical Certification Unit
Is client eligible?
No
Yes
Inform Client of Ineligibility
1
Application Record
TRANSPORTATION REQUEST
Identify Two or Three Providers Within Reasonable Area of Client Residence
Client Requests Transportation or Physician's Name
Transportation
Give Client Number of Transportation Unit
Transportation Screens for Alternate Sources of Transportation
Is alternate available?
Yes


Yes
No
indicate appropriate care
No
Yes
DSS 2400 Stamped With Date
DSS 2400 Given to Clerk Who Validates Eligibility As of That Date
CRT
CHAP Worker Contacts Family Explain Program and Urge Service If Appropriate
DSS 2400
DSS 2400 Sent to CHAP Unit
Is client still eligible?
Yes
No
Case Closed and Filed In CHAP Unit
Review Individual Client File to Determine Whether There Was a Previous Request
Was there a prior request?
No
Yes
Control Reviews Forms for Completeness, Routes Forms, Assigns Client Number
Is client eligible?
No
Yes
Payment File (DSS 2403 by Case Number)
Valid Request Given to Clerk
No
Yes
Entire Record Sent to Record Room Central
Inform Client of Ineligibility
2
B
Prior Authorization Issued and Stamped on DSS 2400
DSS 2401 Completed and Authorization Number Added
Request File (1975's and DSS 2400's)
Alphabetically by Family
DSS 2400
DSS 2401
DSS 2400 Prior Authorization File
Individual Client File
Voucher of Prior Authorization Issued and Time Arranged
Request Denied

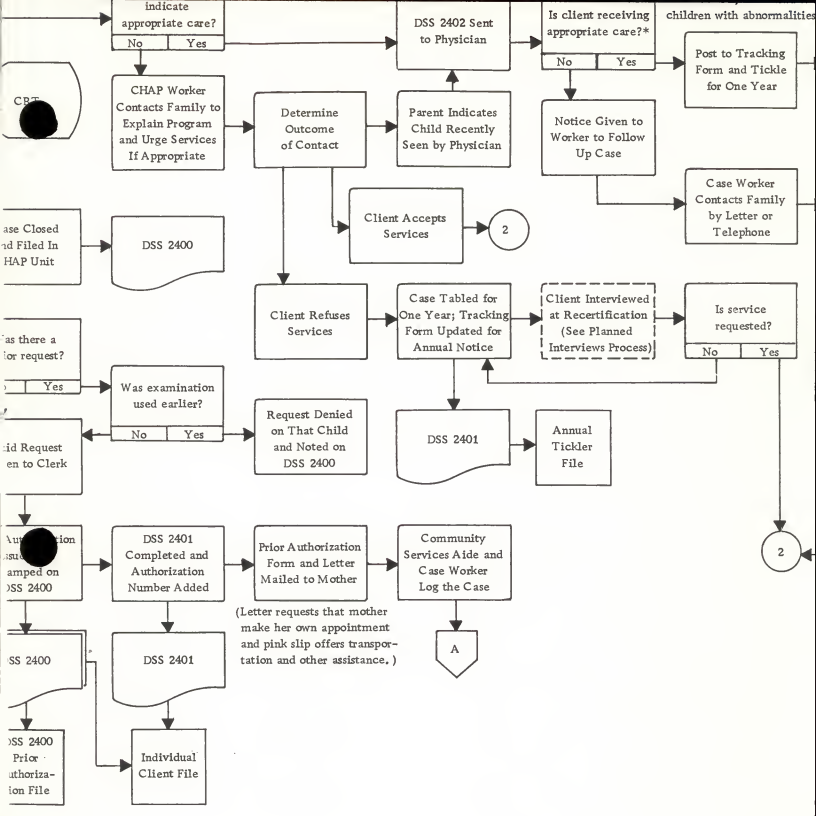
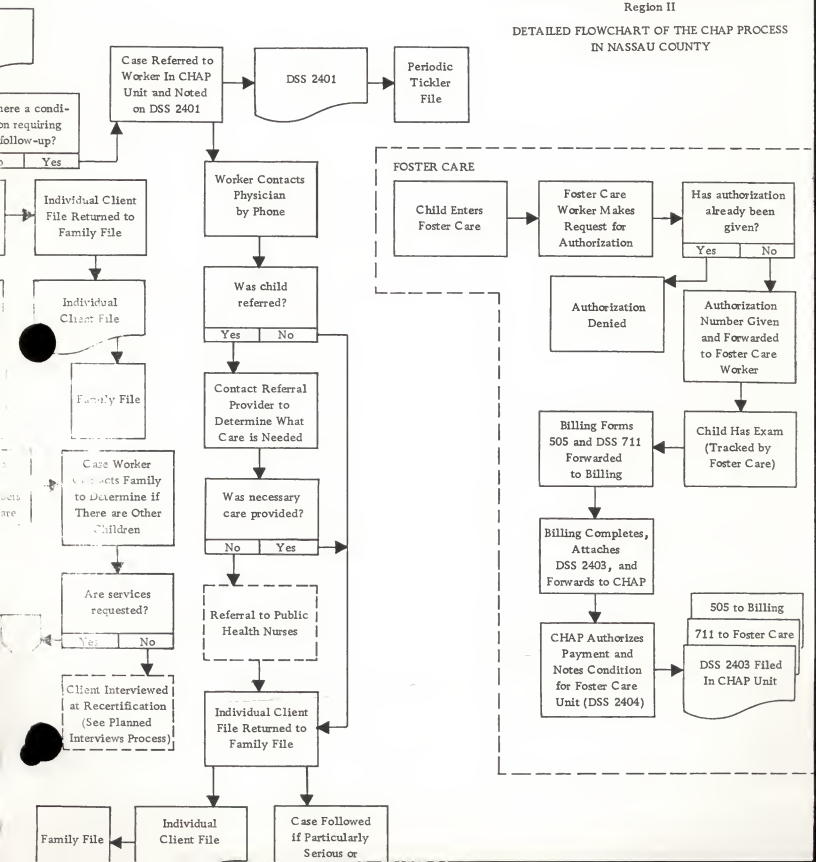
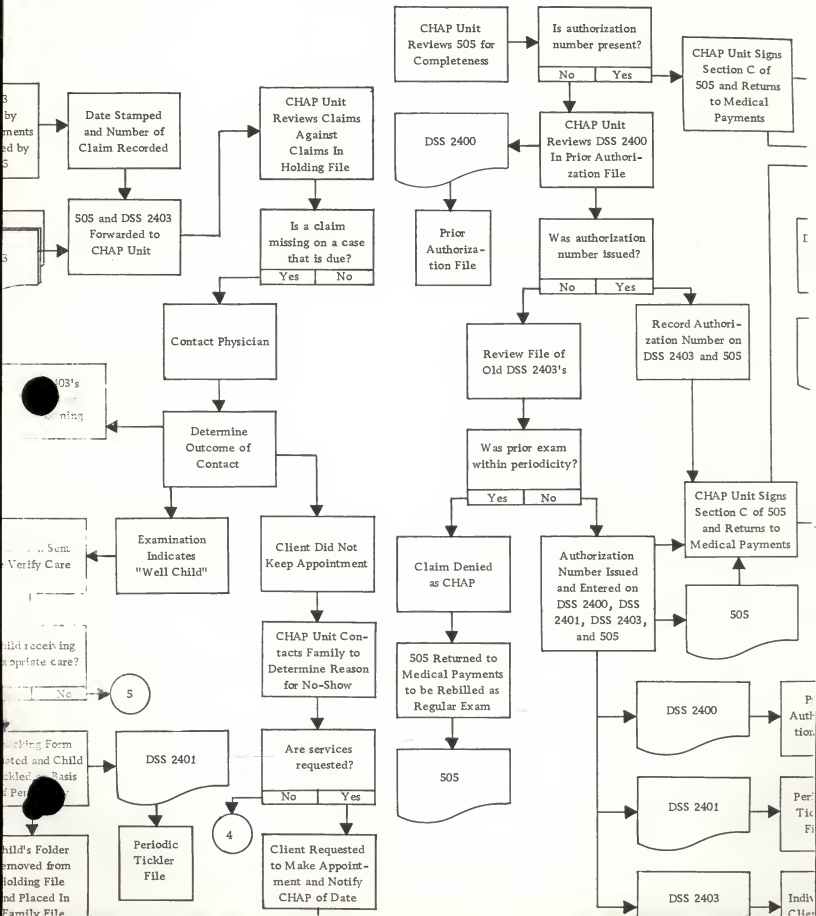

indicate appropriate care?
No
Yes
DSS 2402 Sent to Physician
Is client receiving appropriate care?*
No
Yes
children with abnormalities
Post to Tracking Form and Tickle for One Year
CHAP Worker Contacts Family to Explain Program and Urge Services If Appropriate
Determine Outcome of Contact
Parent Indicates Child Recently Seen by Physician
Notice Given to Worker to Follow Up Case
Case Worker Contacts Family by Letter or Telephone
Client Accepts Services
2
DSS 2400
Client Refuses Services
Case Tabled for One Year; Tracking Form Updated for Annual Notice
Client Interviewed at Recertification (See Planned Interviews Process)
Is service requested?
No
Yes
Was examination used earlier?
No
Yes
Request Denied on That Child and Noted on DSS 2400
DSS 2401
Annual Tickler File
DSS 2401 Completed and Authorization Number Added
Prior Authorization Form and Letter Mailed to Mother
Community Services Aide and Case Worker Log the Case
(Letter requests that mother make her own appointment and pink slip offers transportation and other assistance.)
A
DSS 2401
Individual Client File

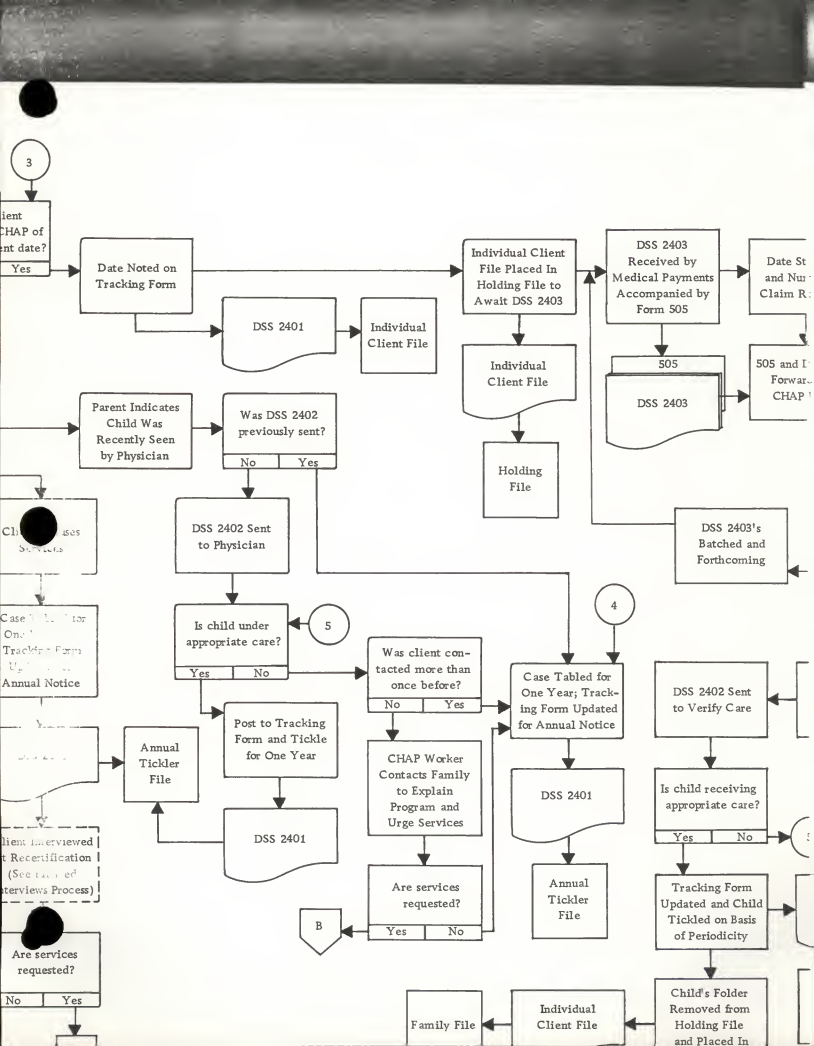
EXHIBIT D-V

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DETAILED FLOWCHART OF THE CHAP PROCESS
IN NASSAU COUNTY




CHAP Unit Reviews 505 for Completeness
Is authorization number present?
No
Yes
CHAP Unit Signs Section C of 505 and Returns to Medical Payments
DSS 2400
CHAP Unit Reviews DSS 2400 In Prior Authorization File
Prior Authorization File
Was authorization number issued?
No
Yes
Record Authorization Number on DSS 2403 and 505
Review File of Old DSS 2403's
Was prior exam within periodicity?
Yes
No
CHAP Unit Signs Section C of 505 and Returns to Medical Payments
Claim Denied as CHAP
Authorization Number Issued and Entered on DSS 2400, DSS 2401, DSS 2403, and 505
505
505 Returned to Medical Payments to be Rebilled as Regular Exam
505
DSS 2400
DSS 2401
DSS 2403
Date Stamped and Number of Claim Recorded
505 and DSS 2403 Forwarded to CHAP Unit
CHAP Unit Reviews Claims Against Claims In Holding File
Is a claim missing on a case that is due?
Yes
No
Contact Physician
Determine Outcome of Contact
Examination Indicates "Well Child"
Client Did Not Keep Appointment
CHAP Unit Contacts Family to Determine Reason for No-Show
Are services requested?
No
Yes
DSS 2401
Periodic Tickler File
Client Requested to Make Appointment and Notify CHAP of Date
5
4


3
Yes
Date Noted on Tracking Form
DSS 2401
Individual Client File
Individual Client File Placed In Holding File to Await DSS 2403
Individual Client File
Holding File
DSS 2403 Received by Medical Payments Accompanied by Form 505
505
DSS 2403
Parent Indicates Child Was Recently Seen by Physician
Was DSS 2402 previously sent?
No
Yes
DSS 2402 Sent to Physician
DSS 2403's Batched and Forthcoming
Annual Notice
Is child under appropriate care?
5
Yes
No
Was client contacted more than once before?
No
Yes
Post to Tracking Form and Tickle for One Year
Annual Tickler File
DSS 2401
CHAP Worker Contacts Family to Explain Program and Urge Services
Are services requested?
Yes
No
B
4
Case Tabled for One Year; Tracking Form Updated for Annual Notice
DSS 2401
Annual Tickler File
DSS 2402 Sent to Verify Care
Is child receiving appropriate care?
Yes
No
Tracking Form Updated and Child Tickled on Basis of Periodicity
Are services requested?
No
Yes
Child's Folder Removed from Holding File and Placed In
Individual Client File
Family File

- The Department of Health routinely photocopies and shares with CHAP their encounter forms for children believed to be Medicaid eligible, thus identifying additional cases for CHAP.

- The CHAP Unit is alerted to newborns by receipt of the bill for delivery; although this is a reliable system that rarely overlooks newborns, the lag in claims often means that the child may be several months old before the birth is discovered, and thus already delinquent on the periodicity schedule.

(2) All Clients Are Notified Of CHAP Services Annually By Mail And Incoming Clients Are Approached At The New Certification Interview

As a minimum, Federal regulations require that EPSDT services be offered to each child in writing once a year. Nassau has no difficulty meeting this requirement once a year and simply generates a computer list of all families with children under 21 to whom a letter is mailed. The first mass mailing to over 22,000 clients resulted in 339 requests (response rate of 1.5 percent).

It is the strong recommendation of Bulletin 190 and the feeling of Nassau County that face-to-face contact is by far the more effective means of reaching clients. During 1975, the program used welfare examiners to inform all families of CHAP at the new certification interview and to assist them in completing the DSS 2400. Recently, however, the CHAP Unit has experimented with stationing its own workers in the recertification area to interview the Medical Assistance clients at this time. (Public Assistance clients are recertified in their homes and thus this arrangement is not feasible for them.) The Unit is pleased with the apparent success of this approach and is considering using the Information Referral and Resource Specialists (IRRS) to supplement this outreach effort; such workers are currently assisting family planning outreach efforts and, if valuable, the lessons will be applied to CHAP.

CHAP workers are particularly anxious to effect this new policy because they have long questioned whether the new certification period was the most propitious for introducing CHAP. Public Assistance clients particularly are under a great deal of stress during the first eligibility interview and are likely to acquiesce in completing DSS-2400 to the implicit expectation that they request services. To the extent

that this takes place, the real message of CHAP is lost and CHAP workers may spend time needlessly pursuing clients who never had any intention of utilizing the services.

(3) After Its Initial Attempt To Identify And Emphasize Children Who Were Not Under Appropriate Care, Nassau Has Found It Infeasible To Make Such Determinations

The purpose of identifying children under appropriate care is, effectively, to remove the less needy children from daily concern of the CHAP Unit, putting them on a tickler basis of one year. This frees the Unit to concentrate on children who are not so fortunate and, theoretically, increase the overall cost effectiveness of the program. This objective is in line with Nassau's very strong belief that CHAP should experiment with new approaches to identifying the "hard core" medically underserved (estimated by some respondents to be 5 to 10 percent of the Medicaid children). As noted above, Nassau's phased approach to CHAP employed a medical record search to identify children under appropriate care. The initial attempt to use the criteria in Bulletin 190 proved impractical, insofar as the criteria could not easily be matched with the codes contained in the medical payment record. Consequently, during 1975, children were identified as under appropriate care in three ways, none of which really served the purpose of alleviating the CHAP case load significantly:

- When a parent refuses CHAP services but indicates that the child has a physician, a DSS 2402 is sent to the physician for verification.

- Periodically (and only temporarily, this program to be phased out) the CHAP Unit receives from the Department of Health copies of the encounter forms for all children who received an examination at a Health Department clinic. These children are matched against the CHAP case load to identify the CHAP eligibles who have received attention.

- If the DSS 2403 is returned indicating the child will be under the physician's continuing care, these children are considered to be under appropriate care.

Because it was the strong feeling in Nassau County that most of its children were receiving appropriate and adequate care, they pursued the course of establishing systems for identifying children under appropriate care and during 1976 the focus of the program has changed

significantly. The emphasis is no longer solely on providing screenings but rather on identifying as many children as possible under continuing care. This is done in a number of ways: the Child Health Care Status Report (DSS 2402); the indication on the screening claim form (DSS 2403) that the child is in the continuing care of the physician; a search (manual) of the medical history of selected children who are suspected of having received well child examinations; and reliance of the photocopies of children served by the Department of Health. Soon, however, a breakthrough is expected in CHAP's ability to identify children under appropriate care. The Department of Health has developed the Management and Analysis Information System (MAIS) which feeds from the Medical Assistance Payments System (MAPS) of DSS and possibly will identify automatically the children receiving appropriate care per the requirements of Bulletin 190. Discussions are currently in progress and, if the system works as well as it might, will be of great assistance to CHAP administration. If the situation is as suspected by the County, remove a large percentage of the case load from continuous consideration, allowing CHAP to focus on the more at-risk elements in the target population. This posture is also responsive to the County's fears that, if anything, there is overutilization of services in Nassau County.

(4) The Majority Of Periodic Examinations Are Conducted By The County's Private Pediatricians Supplemented By Four Health Department Clinics

Nassau's CHAP is able to respond fairly quickly to requests for examinations after the bona fide request reaches the Unit. Because of the delay in processing applications, it is often four to six weeks after the DSS 2400 has been completed (vis., after a request has been made) that the CHAP Unit receives notice of the opened case. The 60-day time period within which requests must be honored is counted from the time the request is received by the CHAP Unit. Discussions with the HEW audit team indicate that this is an acceptable procedure.

After a request for screening has been received, the CHAP Unit issues an authorization for payment; this mechanism assures that the higher rate available for CHAP examinations is not over-utilized by physicians.[11/] The letter which is mailed to the client with the authorization form indicates that assistance in locating a provider is available. Only

11/ Bulletin 190 requires that "... any provider that performs more than one examination per year for a child should claim for the second and succeeding examinations at that provider's usual fee or rate of reimbursement." (page 55).

rarely does the CHAP Unit actually make the appointment, but it does offer a list of providers if necessary. Instead, the Unit requests that the client make the appointment and notify the CHAP Unit within seven days, giving the CHAP Unit sufficient time to meet the 60-day compliance requirements if the client does not respond immediately. Occasionally, the CHAP Unit makes home visits to families who have not used their authorization within several weeks and who have failed to respond to written or telephone communication. This happens in approximately 35 percent of the requests, particularly those which result from the intake procedure. CHAP staff does not believe that the intake is very effective for explaining CHAP or for instructing the client on the procedure for using the authorization and, consequently, considerable effort is undertaken to assure that clients receive their examinations. The Unit makes approximately 200 to 300 home visits per month, although many of these relate to the follow up or diagnosis and treatment needs of clients who have received the examination.

Transportation, if no alternatives are available, is arranged through the Transportation Unit. During the months of September, October, and November, 1975, there were 409 requests for transportation related to CHAP (409 out of 6,514 requests, or 6 percent). Child care does not seem to be a problem, as it has yet to be requested or cited as a cause for a missed appointment. Follow up to assure that a screening examination has taken place is done by reviewing the DSS 2403. Unfortunately, physicians often withhold the bill for batching and submission may be delayed for several weeks (average four). Nassau has established procedures to quickly route bills to the CHAP Unit, thereby avoiding any internal delays in verifying CHAP examinations and identifying children in need of follow-up care.

Because the CHAP Unit is dependent on these bills (incidentally, the standard Nassau Form 505 is used for billing purposes and the DSS 2403 merely attached) for information about client health status, the CHAP staff takes on a curious and cumbersome accounting function:

- The Prior Authorization Number on each DSS 2403 must be validated by CHAP before being paid by accounting.

- When a claim for a CHAP examination is submitted without an authorization number, it is the CHAP Unit's responsibility to determine the status of the case (i.e., has the child exhausted his allowable screenings based on the periodicity schedule or was an authorization number issued but simply omitted from the claim?) and validate or reject the claim.

In case of a rejection, the claim is returned to the physician for rebilling at a normal office visit rate. Otherwise, a "prior" authorization number is issued giving CHAP credit for a completed examination.

Foster care children are examined/treated through a separate process and remain the responsibility of foster care workers. CHAP's only connection with foster children is issuing a prior authorization for the examination and counting these children in the monthly statistical reports. The situation vis a vis foster care children is greatly simplified by the fact that foster children must have an examination; free choice--and therefore, the possible outcomes of the client encounter--is limited by the requirements incumbent upon the foster care mother.

Although the County remains primarily dependent upon private providers, it has increasingly tended to refer children to the Department of Health feeling quite certain that these children will be under continuing care. However it is doubtful that the basic reliance on private providers will erode, considering the wealth of private providers in Nassau County.

(5) Cases Indicating The Need For Follow-Up Care Are Referred To A CHAP Case Worker For Individual Attention

In reviewing the DSS-2403 claim form, CHAP workers take note of all conditions indicated for follow up. The examining physician is contacted to determine whether the child will be in his continuing care[12/] or whether a referral was made. If so, and the case does not involve serious conditions, it is filed for tickling based on the periodicity schedule. If the case is of a more serious nature, it is handled in one of several ways, depending largely on the discretion of the CHAP worker:

- The case is referred to the public health nurses at the Department of Health when lead poisoning or severe conditions are indicated
- The family is contacted by phone or in a home visit to explain the need for additional care, and to arrange an appointment or transportation

The CHAP workers report considerable success in persuading the clients to obtain follow-up care through a home visit. Also, the home visit is an opportunity for case finding for other service agencies--protection services, housing, and other general assistance. Often,

12/ In some cases, where the provider indicates on the DSS-2403 that the child is under continuing care, this step is omitted. CHAP staff receive consultation from Peter Roody, M.D., Local Medical Director and a pediatrician. As a result of these consultations, Dr. Roody has often made suggestions regarding procedures, referrals, and in appropriate situations, has contacted physicians regarding the problem of the child under care.

the CHAP workers report the conditions found in the home have more serious implications for the child's health than do the conditions found in the examination.

Ideally, CHAP would like to be able to track follow-up care for all children with the aid of the computer, but so far this technique has proven infeasible for three reasons:

- The time lag in submission of provider claims and processing of bills
- The fact that providers have no billing code by which to indicate that the services performed are CHAP-related. In fact, the provider may not know that the services are CHAP-related.
- The multitude of other claims that may be submitted for the examined child as a result of non-CHAP-related, episodic care

(6) Ongoing Case Management Is Carried Out By Assigning Each Child To A Specific Worker

The children on the case load are assigned to specific workers based on geographic distributuion. Clients are given the name of a specific worker to contact in case of difficulty with the program, thereby reducing the feeling of fragmentation on the part of the client. Unless there are unusually complex or serious health difficulties, no routine contact between CHAP and the client takes place between required examination periods.

The filing system in which each child's progress is marked and followed is a complex one, in terms of sheer volume alone. There was a marked improvement in this system between the first and second site visits (December, 1975 and June, 1976, respectively). The staff now believes that the system works for them rather than the other way around. Nonetheless, the concept of a single case file for each child has proven infeasible and information on each child may be located in at least three places at once:

- The DSS-2400, stamped with the Prior Authorization Number, is filed alphabetically by family name. This file must be maintained separately to validate claims for CHAP examinations.

- The individual child folder which may contain DSS-2400 (copy), DSS-2402, DSS-2403, and medical history and narrative reports. This file may be found either in:
  - The main file in which both opened and closed files are routinely stored
  - The individual worker's file, if action is taking place on the case
- The tickler file, which contains the DSS 2401, is filed numerically by date. Originally, the cases were filed alphabetically but this proved error prone and did lead to confusion in cases where children in the same family had different last names. Periodically, the DSS 2401 must be removed from the tickler file when a new examination is due. The case worker maintains the 2401 until the examination has occurred. The tickler file is an adequate control and has replaced the various "lists" used early in the program such as separate calendars for scheduled appointments and lists of children requiring follow-up care.

In summary, Nassau County appears to have a strong program. The staff is enthusiastic about the program despite the early difficulties experienced in gaining support for the program and attaining a staff. Staff at all levels are keenly aware of the penalties issues and complain about (but are effective in) the level of administration required to conduct the program, but also are able to have more client contact than many other programs.

5. A STATISTICAL AND COST EVALUATION OF NASSAU COUNTY CHAP REVEALS DIFFICULTIES OF EVALUATING PROGRAM SUCCESS

The original plan for the case study envisioned a detailed and extensive review of Medicaid claims that would support a statistical evaluation of the program. This approach proved somewhat naive as to the time required to complete such an "audit" and also as to the value of the data that might be extracted from the payment system. The data available from the claims are difficult to access and lack specificity that is necessary to really determine case status. [13/]

13/ For example, a child screened with conditions reported needing follow up in the area "genito-uninary" may return to have this condition cared for and, at the same time, be treated for acute bronchitis. This latter condition is the more likely to be reported on the claims which makes no reference to CHAP follow up.

For these reasons, this exhaustive analysis was abandoned in favor of a review and clarification of routinely reported statistical data. In addition, MSI reviewed budget data neceessary to determine the administrative costs of CHAP.

(1) Statistically, Nassau County CHAP's Performance Fell Short Of EPSDT's Achievements In 1974, Although This Level Of Analysis Is Very Misleading

Statistical evaluation of CHAP is extremely difficult; it can be done only with a clear understanding of the limitations of the available data and suffers from the lack of clearly specified objectives. Although there are no widely agreed upon criteria for measuring "success," there are two possible standards against which current performance can be assessed:

- Past Performance In Nassau County--During 1974, the EPSDT program was staffed by three clerical workers and focused primarily on screening. During 1974, EPSDT provided 6,258 screening examinations. In 1975, only 4,124 children were screened, a reduction of 22 percent. However, the two programs (1974 versus 1975) differed significantly, making comparison between years misleading:

  - The 1975 CHAP program added considerably more staff and became involved in the diagnosis and treatment and outreach aspects of the program.

  - During 1975, CHAP began to document that children were under appropriate care rather than indiscriminately providing examinations to all children making requests; 3,825 children were verified under appropriate care.

- Experience In Other Counties--Nassau County provided screening examination to 9 percent of its eligible children; 36 districts bettered this performance. Among the large districts to which Nassau can be more reasonably compared, Nassau County performed well--the average percent of target population examined by the largest nine districts[14/] was 6 percent; only Onondaga examined a larger percent (10) of its target population.

14/ New York City, Erie, Suffolk, Nassau, Westchester, Monroe, Onondaga, Oneida, and Albany.

But these "simple" statistics do not reflect the entire picture. They do not include the number of children under appropriate care--another measure of program penetration. Nor do these statistics speak to the quality of the service. There are several other measures, shown in Exhibit D-VI, following this page, which shed some light on the parameters of CHAP performance, but even they do not tell the entire story. Rather than allow the data to speak for themselves, the following insights are offered:

- Target Population--The overriding difficulty in assessing the program is that many of the statistics depend on the "target population" for a denominator. Nassau County has long been critical of the target population figure suggested by Bulletin 190, equal to 35,876. They have estimated that as many as 60,000 children may pass through Medicaid eligibility in a year; MSI's estimated "dynamic case load" is equal to 44,028.[15/] The difficulty for evaluating CHAP performance is patent. Depending on which target population (or denominator) is used, the portrait is vastly different.

- Outreach--The relationship between number of requests and target population can be used as a rough indicator of the level and success of the CHAP efforts to encourage client participation. The level of requests is at least partially inflated by requests from clients who are confused about the voluntary nature of the examination, believing it to be related in some way to their eligibility for other services. Moreover, the statistic does not measure the "appropriateness" of the request. It may be that many clients who refuse examinations should refuse because they have a family doctor already. Consequently, a community with adequate if not abundant provider resources may suffer from comparison with a district without such resources where the level of outreach should be higher.

- Penetration--Without belaboring the points raised above about the difficulties in assessing the adequacy of the number of examinations provided, a few words must be said about the number of children determined to be under appropriate care. During 1975, Nassau County experienced considerable difficulty determining children under appropriate care. Among the largest districts, only two found fewer children under appropriate care than did Nassau. It is quite likely, however,

15/ The methodology for calculating this population is discussed in detail in Chapter II.

EXHIBIT D-VI

Assistant Regional Director for Planning and Evaluation
Department of Health, Education, and Welfare, Region II

CHAP'S PERFORMANCE MEASURES 1975:
NASSAU COUNTY

Indicator	Measure	CY 1975 #	%
Outreach	Number of Requests / Target Population	10,468 / 44,028	24%
Follow Through	Number of Examinations / Number of Requests	4,857 / 10,468	46%
Penetration	Number of Examinations / Target Population	4,857 / 44,028	11%
Penetration	Examinations + Appr. Care / Target Population	4,857 + 3,825 / 44,028	20%

Developed by MSI based on Medicaid eligibility data reported monthly/quarterly by the County.

that many more children are under appropriate care and simply not verified as such. It will be important to watch Nassau's progress in this area over the next year as MAIS is implemented.

Exhibit D-VI, following page D(17), does not tabulate the number and types of conditions identified for follow up, nor does it address the critical question of how many children who needed follow-up care actually received it. Although information about follow-up care received is not routinely tabulated (the decision not to do a comprehensive client and claim record search was made prior to the second site visit), a review of random records indicated that CHAP usually has a fairly adequate system for following (tickling) cases which they determine to be in need of additional CHAP assistance.

(2) The Costs Of The CHAP Administration And Screening Were About $322,346 In 1975

There are three important categories of cost that must be considered in determining the total cost of CHAP:

- Administrative costs are summarized in Exhibit D-VII, following this page. For 1975, these costs can be broken into two groups:

  - The direct labor and fringe benefit charges in the CHAP Unit were equal to approximately $155,841.

  - The labor and fringe benefit charges from other Units (e.g., intake and recertification) were equal to approximately $62,630.

  No other costs were allocated to the administration of CHAP. Combined, the administrative costs of CHAP equalled $218,471 or 6.1 percent of total Medicaid administrative costs.

- The costs of screening examinations and the Child Health Care Status Report (DSS 2402) were equal to $102,008 and $1,865, respectively, for a total of $103,873. Compared to the Medical Assistance payments of 1975--$96,585,752--EPSDT screening costs are relatively insignificant, less than 0.1 percent.

- The costs of diagnosis and treatment which were not determined

EXHIBIT D-VII

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

TOTAL MEDICAL ASSISTANCE EXPENDITURES AND CHAP COSTS, 1975: NASSAU COUNTY

MEDICAL ASSISTANCE EXPENDITURES

		Total
Staff Costs	$ 2,645,674	
Fringe Benefits (34.11%)	902,439	
Administrative Overhead*	--	
Medical Assistance Payments	96,585,752	
Total Medical Assistance Expenditures		$ 100,133,865

CHAP COSTS

1. DIRECT LABOR

(1) CHAP Unit

. 1 Caseworker Supervisor @ 100% for 7.5 months	$ 12,596	
. 2 Caseworkers (II) @ 100% for 6 months	14,920	
. 3 Caseworkers (I) @ 100% for 6 months	19,867	
. 1 Caseworker (I) @ 100% for 4 months	4,337	
. 7 Community Service Aides @ 100% for 6 months	30,028	
. 1 Clerk/Stenographer (I) @ 100% for 6 months	4,550	
. 1 Clerk (III) @ 100% for 6 months	12,638	
. 2 Clerks (I) @ 100% for 12 months	17,268	
Total CHAP Unit		$ 116,204

(2) Non-CHAP Unit

Medical Social Services--1 Assistant Director @ 45% **	$ 9,785	
Medical Transportation--2 Welfare Examiners (I) @ 6%	1,254	
. Medical Transportation--4 Clerks (I) @ 6%	1,980	
. Medical Certification--29 Welfare Examiners (I) @ 5%	14,682	
Income Maintenance--40 Welfare Examiners @ 5%	19,000	
Total Non-CHAP Unit		46,701
. Total Staff Costs		$ 162,905
. Benefits (34.11%)		55,566
. Total Direct Labor Costs		$ 218,471
2. MEDICAL EXAMINATIONS		102,010
3. DSS 2402		1,865
TOTAL CHAP COSTS (Exclusive of Diagnosis and Treatment)		$ 322,346

* All overhead is traditionally charged to Public Assistance, but soon will be allocated to MA and PA, raising the cost of CHAP in subsequent years.

** 45 during start-up year; currently estimated to be 15%

In summary, CHAP is a relatively inexpensive aspect of the Medicaid program. The administrative component was more costly than the cost of providing services ($218,471 compared to $103,873, or 188 percent), but the administrative and screening costs of CHAP equalled about 0.3 percent of the County's total Medicaid budget.

6. THE CHAP PROGRAM IN NASSAU COUNTY MADE NOTICEABLE IMPROVEMENTS BETWEEN THE FIRST AND SECOND YEARS OF OPERATION

The administrative improvements in the CHAP program in Nassau County between the first and second site visits were very clear:

- The Assistant Director of Medical Social Services, who has overall responsibility for CHAP, weathered his transition into this role and now, although spending far less time on CHAP (approximately 15 percent compared to 45 percent for the start-up year) is more familiar with the program and making many experimental attempts to improve its effectiveness.

- The program is far better able to identify children under appropriate care and this ability will be increased even more dramatically when the MAIS is implemented. If, as they have long suspected, a majority of the children in Nassau County are under appropriate care, the work load of the CHAP Unit will be reduced and the quality of CHAP's response to the underserved will be improved.

- The staff moral is high, partly as a result of two group training sessions. The first session, held early in the group's life (July, 1975), lasted for five weeks (three hours a week) and stressed team building and group dynamics. The second session, initiated by requests from the workers themselves, lasted for six weeks and again focused on techniques for improving team effectiveness, task and problem solving, referral sources for medical and social problems, and so on. This second session had also some focus on medical terminology and health problems of children, although this was not the major agenda of the training effort. A third session is planned for early 1977 to address more squarely the health needs of children and techniques for health education. This session will be carried out primarily through a series of guest speakers.

The record-keeping system and file system of the CHAP Unit have been streamlined and all staff are familiar with the systems. In addition, CHAP is preparing for the first time to keypunch some client information to assist in the identification (but not the tracking) process. Yet, despite these growing successes, CHAP in Nassau County is still troubled by a number of key issues that--while not more troublesome in Nassau than in other counties--assume a larger significance merely because of the large case load affected by the operations in Nassau.

(1) Health Education Remains An Elusive Goal Of CHAP

The CHAP staff in Nassau County is at least as professional and well trained as those in the other three counties studied. Moreover, they have more client contact (particularly through home visits) than do two of the other counties. Nonetheless, CHAP believes that it does not provide enough in the way of health education and probably makes little impact on the patterns of health care usage beyond the single examnation or treatment which inspires that particular visit. CHAP staff is unable to provide more than information about the availability of care and the general philosophy that well child care is important. The Department of Health is credited with greater success in providing health education than DSS. Currently, the health education efforts of the Health Department center around the Public Health Nurses (who, [illegible] training, are dedicated to health education) and written and audio-visual materials. The target population of this effort includes about 8,000 children, of whom only about 20 percent are CHAP eligible. In general, the state-of-the-art of health education is so poor and so elusive that neither DSS nor DOH can do a very effective job.

(2) Outreach And Case Finding Are Still Believed Ineffective In Reaching The Most Hard-Core Underutilizers Or The Children At Greatest Risk

A recurring complaint by the CHAP staff is that the outreach procedures imposed by the Federal and State requirements must be addressed to every child in the target population leaving the County little flexibility in designing (within the same level of available resources) an outreach program that would reach the truly needy and underserved. Until recently, initial outreach was conducted only through the annual written message (known to be highly ineffective) and through brief verbal descriptions of the program offered at intake. The latter is conducted by the Medicaid or Public Assistance intake or eligibility workers who understandably lack the expertise and commitment to the

program and its imposition of another step in an already tedious, complex determination protocol. Recognizing that this is a rather unpropitious time for reaching clients, CHAP is considering:

- Employing specialists (IRRS)[16/] to assist at the intake process
- Reaching the Medical Assistance[17/] clients during recertification, stationing a CHAP staff member at the recertification room for face-to-face discussions with the clients.

In addition, the CHAP caseworkers report that the home visits are lucrative opportunities for finding cases in need of other services (not specifically CHAP services) and that they are often in a position to make referrals to other workers in DSS. While it is certainly reasonable that cases identified through this means be referred for collateral service, the CHAP home visits certainly are not the most efficient means of case finding of this type, discoveries being more or less random or accidental.

Thus, it is undeniable that some children in need are being served by CHAP. But there is still the concern in Nassau that the hard core underserved children at greater risk are not being identified or persuaded to participate in the program. The program is unable to focus its attention or energies on finding these children because of what they believe to be the restrictive policies of the Federal and State governments and their fears of being found penalty liable.

(3) The Threat Of A Compliance Penalty Continues To Have A Serious Effect On The CHAP Program In Nassau County

Being one of the first counties to be found out of compliance (and to remedy the situation), Nassau has always been keenly aware of the penalty provisions and has shaped its program carefully to avoid penalties in the future. Even so doing, the program staff admits candidly that the sheer size of the case load almost guarantees that some children "slip through the cracks" despite their tight system of controls. Caseworkers are required to use discretion in deciding which children

16/ As noted above on page D(9), the family planning division has had early success with the Information and Resource Referral Specialists and CHAP is considering use of the same professionals.

17/ Public Assistance recertification is conducted in the clients' homes and therefore these clients cannot benefit from this new procedure.

to follow aggressively and this arbitrary process might result in differences of opinion for which the County might be held liable given a repeat penalty compliance vist.

To this extent, and because of the loss of flexibility in the program which results from the County's interpretation of the Federal requirements, the penalty can be viewed as a detriment to the program. On the other hand, it is quite clear that CHAP, as currently structured, would quickly vanish from Nassau County if the penalty provision were dropped. This is not to suggest that the County might not continue with a similar or different program designed to serve the health needs of children, but such a program would probably not be based on providing comprehensive screening examinations nor would it address all children in the Medicaid target population with equal vigor. Several options have been considered:

- Similar to the way in which Nassau County initially launched CHAP, the program might identify, through the medical payment record, the youngest and most underserved children (or perhaps those with the most inappropriate patterns of use, e.g., multiple-provider usage) and focus their attentions on bringing these children into appropriate care.

- A program similar to that operated by Handicapped Children but designed to serve a less seriously disabled population might be initiated by referrals from physicians, school nurses, service workers in other parts of the department, and so on. The responsibilities of this program could be aggressive follow up and patient advocacy, not case finding. The rationale for such a program derives from CHAP's belief that DSS does not discover anything new and that any child in the community who has a serious condition is already known to at least one agency--thus the missing link is treatment, not identification. This approach also presumes that the subtle but potentially damaging conditions (such as hearing loss and developmental disorders) are at least as well identified through existing sources, such as the schools and the Department of Health Clinics and Projects.

(4) Nassau County Has Been Largely Uninterested In Developing Linkages Between CHAP And Other Community Agencies, Preferring To Focus Its Program In The Private Pediatrician Network

Of the four counties studied, Nassau has been the least active in pursuing the possibilities of linkages with existing community resources.

Linkages have been considered relatively unnecessary, the strong and abundant pediatric resources in Nassau County being viewed as the best means of implementing the program at the time of the initial site visit (November, 1975), 116 out of the County's 526 pediatricians had agreed to participate in CHAP. A recent survey of pediatricians in the Brooklyn, Queens, Nassau, and Suffolk Counties area showed that close to half of the respondents currently do not accept CHAP patients into their practices; the primary reasons for refusing to do so were: (1) full practices (in other words, the physician accepts no new patients), (2) the rate for the CHAP examination (although Nassau is one of the few counties which employs the maximum CHAP rates (approximately) $21.00 and $36.00 for private and institutional providers, respectively), and (3) the general bother which dealing with Medicaid (not specifically CHAP) entails.

The Health Department and DSS have established no linkage beyond their normal relationship which predates CHAP. The Department of Health services about 8,000 children with comprehensive care and of these approximately 20 percent are estimated to be CHAP eligible. The Department of Health simply bills Medicaid for services provided; it does not increase its level of care to CHAP children, does not change the composition of its target population, does not intensify outreach or referral efforts, or otherwise change its routine to interface more with CHAP.

In summary, Nassau County appears to have developed a sound CHAP program, with an adequate and competent staff. As the program intensifies its efforts to identify children under appropriate care, it should experience greater success in the coming reporting periods.

CASE REPORT:
ONONDAGA COUNTY

APPENDIX E

CASE REPORT: ONONDAGA COUNTY

Subsequent to the final site visit, Onondaga County CHAP reported changes in several administrative procedures. Although MSI did not verify these changes, they are described in footnotes to this report.

Site Visits

December, 1975/January, 1976/
May, 1976

CASE REPORT: ONONDAGA COUNTY

1. INTRODUCTION TO ONONDAGA COUNTY

Onondaga County was selected as representative of an upstate county incorporating a major metropolitan area, and also as a county distinguished by Department of Social Services (DSS) plans to establish effective linkages between the CHAP program and other community organizations. Information gathered for initial site selection revealed that early discussions had been held with County Health Department and Head Start officials to explore the possible nature of these linkages. Another important reason for the selection of the Onondaga CHAP program was evidence of historically low provider participation in Medicaid, which appeared to be affecting CHAP implementation.

(1) Onondaga Is A Large County With The Major Portion Of Population Concentrated In The City Of Syracuse

More than one-third of Onondaga's 484,863 people[1/] live in the City of Syracuse, where 1975 population was estimated at 190,400. The remaining population is scattered in 19 towns and villages across an area of 794 square miles. In 1970, 183,902[1/] County residents were under the age of 19; of these, 42,080 were under four. (Recent statistics indicate that Syracuse is experiencing a declining birth rate.[1/]) Onondaga also can be described as:

- Having a median income of $10,836 county-wide. The median income within the densely populated City of Syracuse is significantly lower at $6,023.

- Including 35,000 recipients of Public Assistance, of whom 8,000 are recipients of Medicaid only.

Onondaga County has abundant medical resources--991 resident physicians, resulting in a physician to population ratio of 1:486, and 278 dentists. Exhibit E-I, following this page, depicts the geographic distribution of provider resources in the County. Despite ample

1/ New York Office of Planning Services.

EXHIBIT E-1

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DISTRIBUTION OF CHAP PROVIDERS:
ONONDAGA COUNTY

Baldwinsville	6D/1GP (medical center)
Brewerton	1D
Camillus	5D/5P
Cazenovia	1D
Cicero	1D
DeWitt	4D/1GP
Fayetteville	20D/2GP
Jamesville	1D
Liverpool	9D/2GP
Marcellus	2D
Mattydale	3D/1FP
Minoa	1D/1GP
Skaneateles	6D/1GP
Solvay	3D
Syracuse	146D/31GP/16P/3FP

KEY: D = Dentist
FP = Family Planner
GP = General Practitioner
P = Pediatrician

professional manpower, the County has suffered from low provider participation in the CHAP program. Exhibit E-II, following this page, lists providers currently participating in Medicaid generally and in CHAP specifically. As can be seen from the exhibit, less than 25 percent of the County's medical providers participate in Medicaid.

Dentists in Onondaga are typically unaware of CHAP as separate from Medicaid and offer little resistance to participation in either program. Approximately 128 dentists currently participate in both programs.

(2) Prior To CHAP, The Early Periodic, Screening, Diagnosis, And Treatment (EPSDT) Program Was Implemented By The Onondaga County DSS On A Limited Basis

The EPSDT program began in Onondaga in 1972 and was phased out by the end of 1974 with the advent of CHAP. Administered by the DSS Medical Payments Division, EPSDT screened a total of 2,267 children from 0 to 21 years of age during its three years of operations. Records of these screenings show that participation in EPSDT peaked in April of 1973, when 1,600 screenings were conducted, and declined dramatically in 1974, when only 667 screenings occurred.

Unfortunately, duplicative efforts were made under the Onondaga EPSDT program by DSS Income Maintenance Division workers and a Medical Payments clerk. Nearly identical letters were sent to clients offering them EPSDT services and supplying a list of five providers, one being the client's own physician. The only difference between the two was that Income Maintenance workers asked clients to bring the EPSDT letter to the recertification interview for further explanation and then forwarded acceptances or refusals to the Medical Payments clerk. The Medical Payments clerk, on the other hand, merely referred clients to a DSS telephone number for the same purpose. Understandably, this procedure generated little response. In effect, no meaningful effort, e.g., intensive outreach, was ever made to include clients in the EPSDT program.

In Onondaga, EPSDT was widely viewed as a poorly structured and possibly unnecessary program. Since many officials believed that Onondaga children were already under appropriate care, limited resources were allocated for EPSDT staffing and operations.

EXHIBIT E-II

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

MEDICAID AND CHAP PROVIDERS:
ONONDAGA COUNTY

MEDICAID PROVIDERS

48	Pediatricians
60	General Practitioners
11	Family Practice Specialists
128	Internists
247	
6	Outpatient Clinic*
25	Health Department Clinics
209	Dentists

CHAP PROVIDERS

16	Pediatricians
22	General Practitioners
2	Family Practice Specialists
40	
2	Outpatient Clinics
209	Dentists

* CHAP clients are referred to two outpatient clinics. However, the additional four clinics operating as Medicaid providers would be willing to provide CHAP services.

2. THE CHAP PLAN FOR ONONDAGA COUNTY WAS DEVELOPED IN A SHORT TIME AND RESPONDED LITERALLY TO BULLETIN 190

The CHAP plan for Onondaga County was written by the DSS Income Maintenance staff, in consultation with the Deputy Commissioner of Health. Plan development was undertaken by Commissioner Lascaris following a series of State-sponsored meetings in Albany and Elmira on CHAP administration. CHAP administrators in Onondaga believed that initial assistance by the State was inadequate because it did not consider local, political, and economic forces that might inhibit CHAP implementation. Specifically, CHAP, like EPSDT, was viewed as an additional and costly administrative burden in a County where the DSS already was responsible for the largest expenditure of public funds. As discussed earlier, inadequate provider participation in Medicaid (and any related program) was also considered a major obstacle.

Negative attitudes toward Medicaid had intensified prior to CHAP, when the legislature cut established provider fee schedules. One small group of specialists was dismayed by this action and sent letters to Medicaid clients, terminating future services. Other factions in the medical community thereupon called a meeting of the Medical Society, in which an untenable situation was improved through informal agreements to participate in Medicaid. Nevtheless, even physicians who agreed to participate in Medicaid maintain generally that fees, particularly for follow-up by specialists, are too low. They believe also that Onondaga was adequately served prior to EPSDT and CHAP.

In the face of this controversy over increasing DSS expenditures and negative provider attitudes, little time was spent preparing the Onondaga CHAP plan. As a result, the plan lacks detail, though it promises to carry out the guidelines proposed in Bulletin 190 and generally describes CHAP implementation procedures for the County. Exhibit E-III, following this page, presents a summary of Onondaga's planned and actual CHAP program.

Onondaga County DSS officials believed that the kind of planning required by the State would not be very useful in a complex political environment. Because of this persuasion, they focused their planning on activities designed to improve provider attitudes and prepare DSS staff for the CHAP program. These activities included:

- Meetings with such provider groups as the Medical Society and the American Academy of Pediatrics
- Working with the Deputy Commissioner of Health to define CHAP operations for Onondaga County

EXHIBIT E-III(1)

Department of Health, Education, and Welfare
Assistant Regional Director for
Planning and Evaluation
Region II

SUMMARY COMPARATIVE ANALYSIS OF CHAP
PLANNED VERSUS ACTUAL

PLANNED	ACTUAL
OUTREACH:	
Provider--	• Several meetings with pediatric groups to explain program and encourage participation
General Community--	
• Community organizations such as Health Department, Well-Child Clinics, neighborhood activity centers, schools, Head Start, Day Care Centers, Clinics, etc., will be contacted to disseminate appropriate information about the program.	• DSS has an informal agreement with the Health Department to participate in outreach and follow-up activities for CHAP. • Organizations representing Day Care Centers, Foster Care, Family Medical, Family Planning, and Head Start have been contacted.
IDENTIFYING ELIGIBLE CHILDREN:	
• Eligible children over one year of age will be identified on a yearly basis: children under one identified more frequently.	• Eligible children identified at each recertification period
• Data processing will provide the CHAP Unit monthly with a printout of PA cases with children. A separate printout of MA only cases with children will be provided.	• Planned computer program to alert CHAP Unit to new or unborn children on the case load • PA emergency clients are identified at intake
NOTIFYING ELIGIBLE CHILDREN:	
• Income maintenance will mail out CHAP notices at the time of recertification and will give the notice to applicants.	• Clients receive the DSS 2400 and CHAP materials with their eligibility notice
• CHAP pamphlet and letter will be distributed at the eligibility interview.	
• Face-to-face interview with head of each household by CHAP worker	• Recertification workers introduce program and escort client to CHAP worker who explains program.
IDENTIFYING CHILDREN UNDER APPROPRIATE CARE:	
• Data processing provides a list of all clinic, physician, hospital care, and other care given during the prior 12 months.	• Medical payments printout is used to determine children under appropriate care. Criteria in Bulletin 190 are used.

PLANNED	ACTUAL
• DSS 2402 will be used in cases where parent believes child is under appropriate care.	• DSS 2402 is used in cases where parent believes child is under appropriate care, when physician is non-Medicaid provider; and when the child is identified as having attended a well-child clinic sponsored by the Health Department.
PERIODIC EXAMINATIONS:	• CHAP schedules almost all appointments (90%).
	• Transportation provided if necessary.
	• Reminder notices and phone calls are sent to client prior to appointment date.
	• DSS 2408 not used for billing purposes. CHAP clerk must transcribe data onto billing form DSS 376.
FOLLOW-UP CARE:	
• DSS 2401 is used for tracking.	• DSS 2401 is used for limited tracking.
• Manual system early in program but plan to develop a computer system to identify children under appropriate care, notify CHAP Unit that recertification interview is required, track appointments.	• Computer programs were requested, but have not been made available.
• Children under one year will get special treatment.	
• Health Department will provide follow-up care.	• Health Department provides some follow-up. CHAP receives supplemental case information from the Medical Rehabilitation Division on handicapped children.
?OING CASE MANAGEMENT:	
• A separate file folder will be maintained on each child.	• File folders are maintained by family.
• Foster care children are followed by foster workers.	• Follow-up appointments are scheduled by CHAP when indicated on the DSS 2403 billing form.

- Preparation of an information package to explain CHAP objectives to providers

- Meetings with Income Maintenance workers to discuss staff responsibilities for CHAP

Despite these efforts, CHAP program start-up in Onondaga was slow. For example, identification of children to participate in CHAP was scheduled to begin in January of 1975 but did not get under way until March of that year. One cause of the delay was the time needed to mobilize and train the staff necessary for program administration; although some staff personnel were available in January, they were not sufficiently trained to start full operations until three months later. Another factor was provider resistance. This problem was manifested in the refusal of some Onondaga physicians to provide CHAP services to more than two children from any family during the same appointment. According to these providers, a high rate of "no-shows" justified this decision. Section 5 of this report, concerned with CHAP operations, examines efforts to minimize client no-shows and thus reduce the negative provider attitudes towards CHAP clients.

Dentists in Onondaga, however, do not appear to share the physician community's reluctance to participate in CHAP, even though CHAP fees for them again are lower than those charged private patients. As stated earlier, this is primarily because dentists do not distinguish CHAP from Medicaid programs. As a result, a sufficient number of dentists provide services to CHAP clients. It was suggested that the dentists in Onondaga are highly competitive and, therefore, more willing providers.

PLANNING IN ONONDAGA HAS INCLUDED EFFORTS TO ESTABLISH EFFECTIVE LINKAGES WITH COMMUNITY ORGANIZATIONS FOR CHAP OUTREACH AND FOLLOW-UP

As proposed in the Onondaga CHAP plan, the DSS has pursued linkages with the school system and Head Start.[2/] The scope of these planned linkages was ambitious, but progress to date has been disappointing:

- The Head Start program in Syracuse sponsors a program of screening for enrolled children regardless of Medicaid eligibility. The envisioned linkage would have (1) shared information between CHAP and Head Start to avoid duplication and (2) referred the older siblings of Head Start

[2/] As discussed in the following section, the plan also mentioned linkages with the Health Department.

enrollees to CHAP for an examination. The linkage has been discouraged by fears of confidentiality violation and by lack of motivation for either party to pursue the linkage. In addition, P.E.A.C.E.,[3/] the organization which administers Head Start, owns a fleet of vehicles that is used to transport children for various purposes, including those requiring follow-up care to the source of care. At one time it appeared that this transportation service might have assisted CHAP-examined children to obtain care, but this, too, has failed to materialize, except in a few isolated instances.

- The school system and CHAP have flirted with the idea of linkages, but again the experience has been disappointing. The plan involved using school nurses to make referrals to CHAP and to assist with follow-up referrals and tracking after the examination. Virtually no progress has been made in this regard. Two reasons were cited: (1) concerns about confidentiality of data, and (2) the Medical Director of the Syracuse School District complained that CHAP failed to observe accepted protocol in dealing with the school nurses.

4. THE CHAP PROGRAM IS ADMINISTERED BY A SEPARATE CHAP UNIT THAT HAS EXPERIENCED MANY STAFF CHANGES AND SPLIT STAFF COMMITMENT

Despite the autonomy suggested by existence of a separate CHAP Unit, the Onondaga program has had continuous staffing problems and is dependent on minimal assistance from DSS Income Maintenance and Health Department staff. At the outset, staffing resources were extremely scarce. The original Coordinator was shifted from the DSS WIN program to administer CHAP, and three Comprehensive Employment and Training Act (CETA) workers were made available to the program. CHAP administrators have said that without CETA, CHAP might never have gotten off the ground. Unfortunately, although the CHAP staff expanded during 1975, professional personnel time often was split between CHAP and other programs, or experienced workers were shifted out of the unit to higher priority assignments. The situation has not improved in 1976.

The consequences of the current organizational and staffing patterns include:

3/ People's Equal Action for Community Effort, a local Community Action Plan (CAP) agency.

- A lack of program continuity
- Slow program implementation
- A need for continual training of replacement staff

Exhibit E-IV, following this page, depicts the organization of the Onondaga County Department of Social Services, highlighting the divisions responsible for CHAP activities. The organization chart also shows estimates of some DSS staff commitments to CHAP.

(1) The Onondaga CHAP Staff Performs Most Administrative Functions Associated With The CHAP Program, But Experiences A High Staff Turnover

In 1975, the Onondaga CHAP Unit was operated by a 10-member team composed of professional, paraprofessional, and administrative support staff. Official staff positions were defined as follows:

- One coordinator (Grade B Supervisor)
- One supervisor (Senior Caseworker)
- Two examiners (one Examiner I, one Examiner II)
- Three CETA workers
- One clerk (Senior Clerk)
- One typist

Two graduate students of social work from the University of Syracuse supplemented the CHAP staff an estimated eight months during the year. This was helpful, but these students have graduated and are not expected to be replaced. As evident in Exhibit E-IV, commitment of professional time to CHAP has been limited; the Coordinator was able to devote only 40 percent of her time to CHAP and one of the two examiners only 20 percent to CHAP.

From the outset, however, CHAP has experienced considerable staff turnover and the situation has not improved in 1976. At the time of the last site visit to Onondaga in May, 1976, the CHAP Unit has:

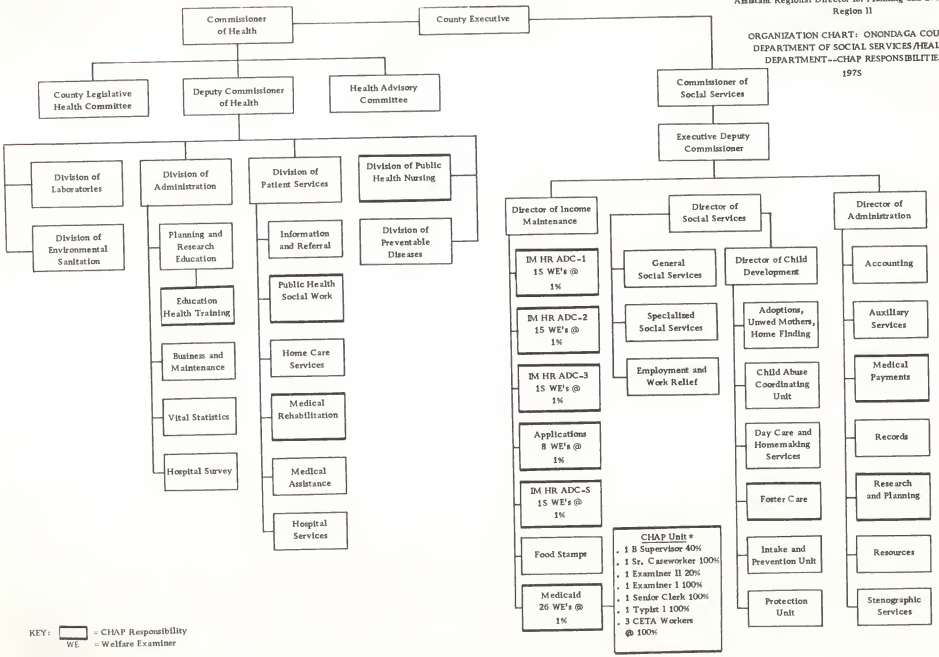
- Lost its experienced Coordinator, who was replaced by the CHAP supervisor; the transition was sudden and the new Coordinator did not have the benefit of the experience gained during program start up

- Lost its experienced, full-time examiner

EXHIBIT E-IV

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

ORGANIZATION CHART: ONONDAGA COUNTY
DEPARTMENT OF SOCIAL SERVICES/HEALTH
DEPARTMENT--CHAP RESPONSIBILITIES
1975



KEY: ☐ = CHAP Responsibility
WE = Welfare Examiner

* In 1975 all these workers were assigned to CHAP; currently, the Unit is staffed by only the Sr. Caseworker, Examiner II, Clerk, Typist, and two CETA workers.

- Lost a CETA worker who is not expected to be replaced
- Lost the graduate students

Consequently, the constant turnover within the CHAP Unit that was noted during the first site visit continues to have a major impact on program continuity since additional staff training is required (but not received) and program implementation is slowed by inexperienced workers. The Unit has responded with all the visible signs of low morale, limited enthusiasm, and, in some cases, a lack of understanding of the basic goals and objectives of the program.

Given these staffing problems, client contact through home visits is currently limited. Inexperienced CHAP workers are not allowed to conduct outreach or follow-up, and those qualified for these functions do not have time to perform them. CHAP client contact is sustained, however, through interviews at DSS and in telephone conversations. Understandably, such limited client contact may foster an administrative focus on the part of CHAP staff.

The following people have played key roles in the implementation and operation of CHAP:

- Original CHAP Coordinator--Roberta Celemin worked with the DSS Commissioner during the early stages of CHAP development. Prior to her involvement with CHAP, Ms. Celemin had nine years experience with DSS. Currently, she is working towards a Master in Social Work degree. During 1975, her responsibilities were divided between CHAP and the Food Stamp program; she now devotes her full energy to Food Stamps.

- Current CHAP Coordinator--Beverly Batty, after five years experience in the Income Maintenance Division of DSS, joined the CHAP Unit in October, 1975. Originally, she performed as CHAP supervisor, assisting Ms. Celemin. She now has overall responsibility for the program.

- Senior Clerk--Mary Dwyer has worked with DSS for the past 25 years. Ms. Dwyer has extensive knowledge of administrative functions related to CHAP. Because of her earlier experience in the Medical Payments Division, she has been given responsibiity for auditing CHAP claims, as well as making and following up on appointments for screening examinations.

(2) The CHAP Unit Is Dependent Upon Other Units Within DSS And The Health Department

The CHAP Unit, located in the DSS Division of Income Maintenance, has primary responsibility for these program functions:

- Explain CHAP services
- Assist in arranging appointments and transportation
- Track children through the medical payments system to identify children under appropriate care
- Audit and approve medical claims and prepare Standard Medicaid Billing (Form DSS-376), used in addition to the CHAP Periodic Child Health Examination and Claim (Form DSS-2403)
- Complete statistical reports

A functional conflict is evident. Although CHAP is a service program, its staff spends a considerable amount of time in performing two accounting functions: (1) prior authorizing CHAP examinations, and (2) auditing medical claims and transcribing billing information from the CHAP claim form (DSS-2403) to the standard billing form (DSS-376). These activities have a definite negative influence on the attitude of the workers toward the service nature of the program.

Even though the CHAP program is based in a separate Unit, it is dependent upon other units within DSS and the Health Department. Unfortunately, these linkages have not proven very effective:

- Health Department--The Health Department is located in the same building with DSS, and the Deputy Commissioner of Health also works for DSS as Medical Director. Three Health Department divisions have coordinated responsibilities with CHAP:
  - Public Health Nursing--An agreement drafted in September, 1975 was recently signed, delineating the respective roles of DSS and the PHN's. The agreement states broadly that public health

nurses will assist DSS in "Identifying the Medicaid population and informing eligible families and providers of the program's benefits." It specifies further that the public health nurses will assume an active role in providing outreach services to eligible clients who have not responded to DSS inquiries and in providing follow up on cases where appointments were missed.

The agreement does not indicate that two specific public health nurses will provide these services, but rather indicates that all nurses will be expected to incorporate the CHAP message into their routine case work. The Department of Health expects reimbursement of approximately $35,000 per year for providing this service. CHAP has no way of monitoring how well or how often these services are provided.

In addition to outreach, a two-way referral system was envisioned. To date, however, few referrals have been made. For example, a major cooperative effort has been planned to identify and reach high-risk children,[4/] but difficulties with the medical payment system and communication problems between DSS and the Health Department have stymied this effort. It remains unclear how this identification and referral can be conducted on a timely, ongoing basis.

- Education And Training--This Division, also located within the Health Department, was involved in the early implementation of CHAP. Although Division staff were included in early training sessions concerning CHAP operations, health education has not been effectively coordinated with the CHAP program. The Director of Health Education believes that she is no longer up to date with CHAP operations but expressed a willingness to become more involved. To date, there has been no follow up on a brief introduction to CHAP provided early in 1975, nor has there been any effort to develop a basic health education package for CHAP staff.

4/ Children under one year of age with no history of medical claims.

- Division Of Medical Rehabilitation--Medical Rehabilitation Division represents the only Health Department entity that is coordinated systematically with CHAP. The DSS-2403 provider claim is regularly forwarded to Medical Rehabilitation staff in all cases of children with handicapping conditions. The public health social worker reviews case files to determine whether a previous record exists. A written report is then forwarded to the CHAP Unit indicating whether additional follow-up is required. This procedure has proven relatively successful: (1) CHAP has access to additional medical history information in some cases, and (2) the CHAP examination may serve as a case finding mechanism for children eligible for the Medical Rehabilitation program.

Department Of Social Services--Within the Department of Social Services, two units besides the CHAP Unit are involved in CHAP-related functions:

- Foster Care--The Foster Care Division, under the Director of Social Services, operates quite independently of CHAP. An agency pediatrician provides examinations at the child welfare station weekly, after which CHAP forms are completed and forwarded to the CHAP Unit. Foster Care workers alone handle the scheduling for examinations, but occasionally the CHAP Unit will become involved in scheduling appointments for follow-up care. All Foster Care children are examined at least annually, a policy which predates implementation of the CHAP program. The primary difference between the old Foster Care health program and the CHAP program is that it takes the Foster Care workers at least an additional day per month to complete the paperwork required by CHAP.

- Income Maintenance Zones--Within DSS, the Zones include most of the agency's examiners responsible for recertification of Medicaid and Public Assistance clients. As discussed in more detail below, our interviews with the Zone staff indicate that the attitude towards CHAP is negative, and possibly damaging to the program's outreach and notification functions.

OPERATION OF ONONDAGA COUNTY'S CHAP PROGRAM IS ENCUMBERED BY ADMINISTRATIVE DUPLICATION AND LIMITED RESOURCES FOR CLIENT TRACKING

CHAP operations in Onondaga County are centered around the six-month and annual recertification periods for Public Assistance and Medicaid recipients, respectively. Given a conveniently captive audience, the CHAP Unit conducts most client interviews, schedules appointments, determines appropriate care, and completes other administrative tasks at these times. CHAP's activities are somewhat duplicative, however, because the Unit does not screen out individual Public Assistance clients who have already been integrated into the CHAP system. Although computer printouts are produced for all persons who require recertification, the printout fails to distinguish those who need CHAP services from those up to date with CHAP examinations or under appropriate care. Consequently, CHAP staff engage in a repetitive interviewing process and then perform an internal file search to determine whether the child has already been initiated into the Onondaga CHAP system.[5/]

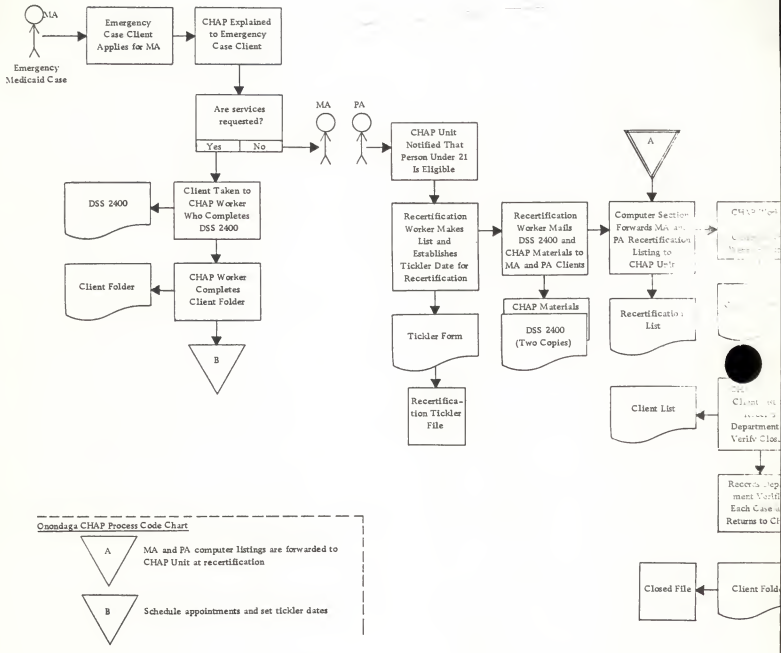
The flowchart, Exhibit E-V, following this page, describes the detailed operations of CHAP and specific procedures for: (1) identifying children; (2) informing clients of the availability of services; (3) determining appropriate care; and (4) assuring periodic examinations, appropriate diagnosis and treatment, and ongoing care management. These CHAP elements are highlighted in the paragraphs below.

(1) The CHAP Unit Is Notified Of All Open Cases Of Children Under 21 Prior To Each Recertification Period

To ensure that all eligibles are seen by CHAP workers, a medical payment history is produced each month for all Medicaid and Public Assistance clients under 21 who are scheduled for recertification. CHAP workers then check the medical payment history against CHAP client files to assure that all those currently enrolled in CHAP have been accounted for and to determine whether a case was closed or accidentally omitted. All CHAP files on clients scheduled for recertification must be retrieved and taken to the recertification area prior to CHAP interviews. The CHAP Unit employs a number of measures to assure that no children are missed:

- CHAP workers develop a list of children whose names do not appear in the medical payment history, but for whom a CHAP file was located for a matched recertification period.

5/ In October, 1976, subsequent to the final site visit, it was reported to MSI that computer printouts are now being produced which identify explicitly, using Bulletin 190 criteria, all persons scheduled for recertification who are not under appropriate care.


MA
Emergency Case Client Applies for MA
CHAP Explained to Emergency Case Client
Emergency Medicaid Case
Are services requested?
Yes
No
MA
PA
CHAP Unit Notified That Person Under 21 Is Eligible
A
DSS 2400
Client Taken to CHAP Worker Who Completes DSS 2400
Client Folder
CHAP Worker Completes Client Folder
B
Recertification Worker Makes List and Establishes Tickler Date for Recertification
Recertification Worker Mails DSS 2400 and CHAP Materials to MA and PA Clients
Computer Section Forwards MA and PA Recertification Listing to CHAP Unit
CHAP Materials
DSS 2400 (Two Copies)
Recertification List
Tickler Form
Recertification Tickler File
Client List
Department Verify Clos
Closed File
Client Fold
Onondaga CHAP Process Code Chart
A
MA and PA computer listings are forwarded to CHAP Unit at recertification
B
Schedule appointments and set tickler dates

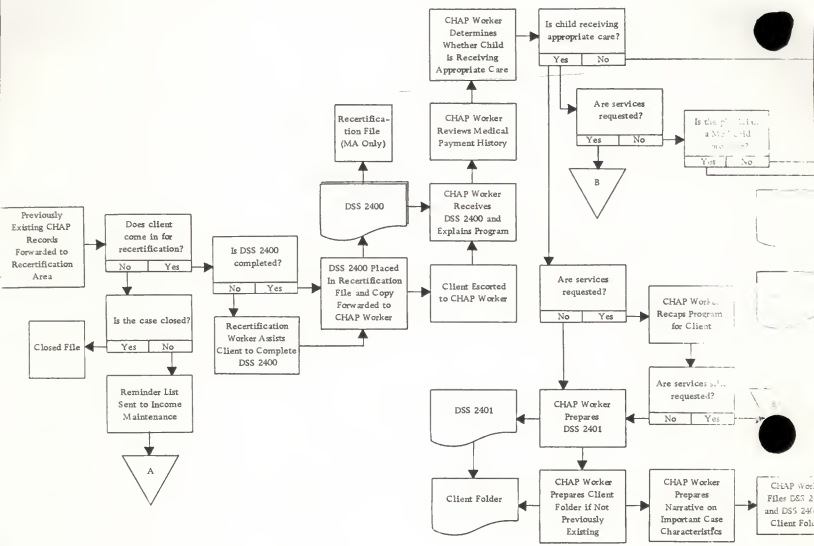
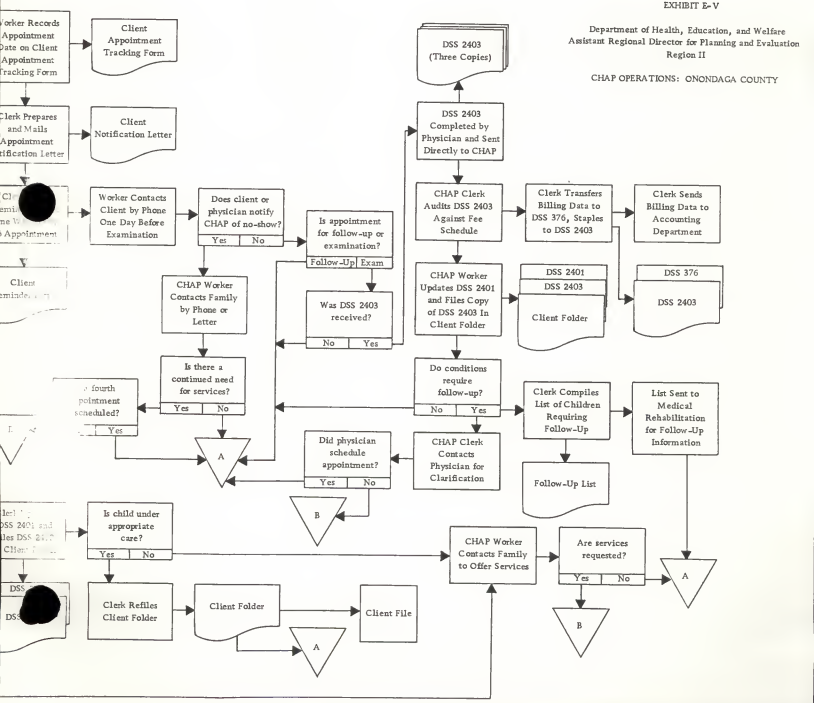
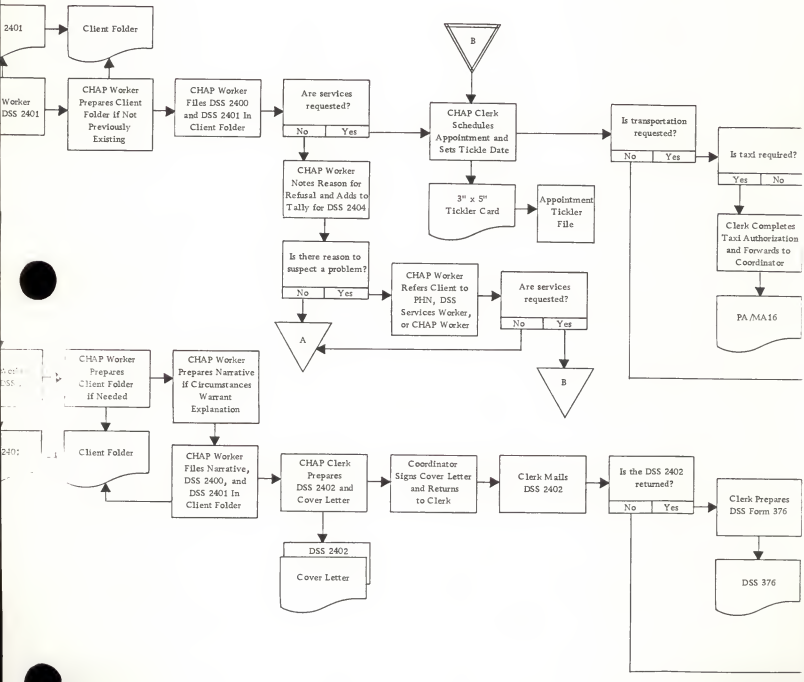

Previously Existing CHAP Records Forwarded to Recertification Area
Does client come in for recertification?
No
Yes
Is the case closed?
Yes
No
Closed File
Reminder List Sent to Income Maintenance
A
Is DSS 2400 completed?
No
Yes
Recertification Worker Assists Client to Complete DSS 2400
DSS 2400 Placed In Recertification File and Copy Forwarded to CHAP Worker
Recertification File (MA Only)
DSS 2400
CHAP Worker Determines Whether Child Is Receiving Appropriate Care
CHAP Worker Reviews Medical Payment History
CHAP Worker Receives DSS 2400 and Explains Program
Client Escorted to CHAP Worker
Is child receiving appropriate care?
Yes
No
Are services requested?
Yes
No
B
Are services requested?
No
Yes
CHAP Worker Recaps Program for Client
Are services requested?
No
Yes
CHAP Worker Prepares DSS 2401
DSS 2401
Client Folder
CHAP Worker Prepares Client Folder if Not Previously Existing
CHAP Worker Prepares Narrative on Important Case Characteristics

EXHIBIT E- V

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

CHAP OPERATIONS: ONONDAGA COUNTY




2401
Client Folder
Worker
DSS 2401
CHAP Worker Prepares Client Folder if Not Previously Existing
CHAP Worker Files DSS 2400 and DSS 2401 In Client Folder
Are services requested?
No
Yes
B
CHAP Clerk Schedules Appointment and Sets Tickle Date
CHAP Worker Notes Reason for Refusal and Adds to Tally for DSS 2404
3" x 5" Tickler Card
Appointment Tickler File
Is transportation requested?
No
Yes
Is taxi required?
Yes
No
Clerk Completes Taxi Authorization and Forwards to Coordinator
PA/MA16
Is there reason to suspect a problem?
No
Yes
CHAP Worker Refers Client to PHN, DSS Services Worker, or CHAP Worker
Are services requested?
No
Yes
A
B
CHAP Worker Prepares Client Folder if Needed
CHAP Worker Prepares Narrative if Circumstances Warrant Explanation
Client Folder
CHAP Worker Files Narrative, DSS 2400, and DSS 2401 In Client Folder
CHAP Clerk Prepares DSS 2402 and Cover Letter
Coordinator Signs Cover Letter and Returns to Clerk
Clerk Mails DSS 2402
Is the DSS 2402 returned?
No
Yes
Clerk Prepares DSS Form 376
DSS 2402
Cover Letter
DSS 376

- The list of CHAP clients who do not appear on the monthly medical payment history is submitted to the Records Division where cases are identified as either "open" or "closed." The Records Division notifies the CHAP Unit of current client status.

- Based on information provided by the Records Division, the CHAP Unit assumes that clients whose cases are active will appear for recertification. Inactive cases are placed in the "closed" file.

- Periodically, names appearing on the medical payment history cannot be identified in the active CHAP files. In such cases, the CHAP worker reviews the "closed" file to determine whether a client's case has been reopened or whether the additional name represents a new case.

All active CHAP case files and the medical payment history for a given recertification period are taken to the recertification area in DSS where they are accessible to CHAP workers conducting the interviews that follow recertification. Unfortunately, DSS recertification workers do not distinguish clients who need to be seen by CHAP workers from those who do not, which means that, by design, virtually all clients must be referred to the assigned CHAP Unit area.

A more serious problem, however, is the recertification workers' attitude toward CHAP. Apparently, many of the recertification workers refuse to refer clients to the CHAP Unit, seriously limiting the client identification and notification process. In fact, in the spring of 1976, it was estimated that as many as 50 percent of the potential CHAP clients were not being referred during the recertification period.

This situation apparently exists because recertification workers believe that CHAP does not correspond to or complement their primary function--income maintenance--which is already an excessively complex and time-consuming task. The perception that CHAP is not germaine to DSS responsibilities and is "paternalistic" may be explained, in part, by two reasons: (1) recertification workers lack sufficient programmatic information to develop an interest in and commitment to CHAP and have neither the health background or education to become convinced of the relevance of the program, and (2) their interaction with clients convinces them that most clients are under the appropriate care of a family physician already.

In response to this problem, the CHAP Coordinator is working more closely with the recertification workers to reestablish and improve inter-unit communication.[6/]

(2) Clients Receive Written Notification Prior To Recertification As Well As A Personal Explanation Of CHAP Services

DSS recertification workers mail a letter explaining CHAP services and the DSS-2400, Request for Family Health Care Services to all eligible CHAP clients prior to the assigned recertification date. Since Public Assistance recipients are recertified every six months, and Medicaid recipients annually, these mailings assure that Onondaga meets the annual notification schedule established in Bulletin 190. The mailings are also convenient because CHAP materials are sent in conjunction with a complete recertification package. Instructions are not, however, included for completion of the DSS-2400, Request for Family Health Care Services. More important, the main problem with this method of notification is that the client may mistakenly assume that CHAP is, in some way, tied to the overall recertification process. Presumably, any such false assumptions will be eliminated when CHAP services are explained to the client by a CHAP worker following the recertification interview.

In some instances, clients may be notified of CHAP services by a public health nurse working for the Health Department. Another variation of the typical notification process occurs when a client becomes eligible for Medicaid on an emergency basis. In such cases, he is informed about CHAP immediately.

(3) Medicaid Payment Records Are The Primary Means Used To Identify Children Under Appropriate Care

Following the recertification interview, Medicaid and Public Assistance clients are taken to a nearby CHAP worker who reviews both the CHAP file, if one exists, and the medical payment history to determine whether the child is under appropriate care. Standards for periodicity established in Bulletin 190 are used as criteria for identifying children under appropriate care. There are, however, a number of problems associated with the use of the medical histories presented in the DSS payment record:

- Monthly recertification listings provide a medical history only for a one-year period so it is impossible to determine whether older children are receiving care within the periodicity schedule.

6/ Subsequent to the site visit, it was reported to MSI that Onondaga has recently initiated a feedback mechanism to alert recertification workers of the status of each client who makes a request.

- Examinations provided by non-Medicaid physicians or at well-child clinics do not appear on the payment record.

- Public Assistance clients, seen twice a year for bi-annual recertification requirements, are frequently counted twice as "under appropriate care" by CHAP workers. These distorted accounts are subsequently included in the DSS-2404, Statistical Report on Children Receiving Periodic Health Examinations.

- Time lags created by late billing by physicians also distort client medical histories.

In Onondaga, the health care status of clients who indicate that they are under the care of a non-Medicaid physician and who also refuse CHAP services is verified through the use of the DSS-2402, Child Health Care Status Report, which is mailed to the client's physician. Clients who refuse CHAP services because they are under the care of a Medicaid physician are simply followed up at the next recertification.

(4) Careful Planning Is Exercised By The CHAP Unit In Scheduling Appointments With Onondaga Providers

Onondaga CHAP workers invest considerable time and effort in scheduling appointments with local providers to ensure that the appointments are not missed. Typically, appointments are scheduled and transportation requirements determined following the recertification interview. Appointment information is recorded on a 3" x 5" card and filed in a tickler system, the only one maintained by the CHAP Unit since all other files are organized according to the recertification schedule. An initial letter notifying the client of the appointment date is then promptly mailed to the client. This notification is followed one week prior to the examination by a reminder letter, which includes a taxi voucher or bus tokens, if requested. CHAP workers also maintain a separate schedule of client appointments and telephone clients one day before the examination. The CHAP Unit offers to reschedule appointments for clients who cancel and will often notify the physician of any cancellation. These efforts are sustained for two important reasons:

- To exercise a measure of control over appointments, thus reducing the 25 percent no-show rate claimed by Onondaga providers

- To provide necessary support services to ensure that clients receive regular care

The Onondaga program also recognizes that scheduling appointments affords CHAP an opportunity to remain in contact with the physician. Once an appointment is made, the CHAP Unit, unless otherwise notified by the physician's office, must wait to receive a DSS-2403, Periodic Child Health Examination Report and Claim Form to determine whether the appointment has been kept.

Appointments for foster care children are arranged by the Children's Division of DSS, which holds their own clinics every Tuesday to provide placement and annual physicals to foster care children. As in other counties, foster parents are required to assure regular health care to their children. Nevertheless, the CHAP Unit will schedule follow-up appointments if conditions for additional care are identified on the DSS-2403. The CHAP Unit also retains a DSS-2401, Individual Tracking Form, along with the DSS-2403 for these clients.

(5) The CHAP Unit Identifies Any Need For Follow-Up And Obtains Supplemental Information When Necessary

Typically, the CHAP Unit identifies the need for follow-up through a review of the DSS-2403, Periodic Health Examination and Claim Form. Information on required follow-up is often confusing since the form is designed so that procedures performed and follow-up required are noted in the same column. Other problems, such as lack of clarity about action to be taken by CHAP or illegible handwriting, frequently require that CHAP contact the physician for additional information. Once it is established that the child needs follow-up care, CHAP determines whether the provider has indicated a willingness to provide the care or make the referral. The provider makes a referral in about 90 percent of the cases; for the remaining 10 percent, CHAP arranges the follow-up care.

As a matter of course, the CHAP Unit sends a copy of the DSS-2403 to the Medical Rehabilitation Division of the Health Department to obtain supplemental information on follow-up requirements for children with handicapping conditions. Upon a physician's recommendation, Onondaga's CHAP Unit will notify public health nursing that a home visit is required as part of the follow-up effort.

During 1975, CHAP staff did not take additional steps to assure that the necessary care was received until the following recertification period when the medical payment history was reviewed and discussed with the parent. Throughout 1975, this information was seldom recorded in the child's file and, consequently, Onondaga had no means of identifying

children who continued to require care. Currently, CHAP is experimenting with a system to determine whether care has been received by children for whom CHAP made appointments for additional diagnosis and/or treatment.

(6) Ongoing Case Management

To reduce paper volume, the Onondaga CHAP program organizes client files by family, rather than by individual child. These files, maintained in alphabetical order within an assigned recertification period, are supposed to contain:

- DSS-2400, Request for Family Health Services
- DSS-2401, Internal Tracking Form
- DSS-2403, Periodic Child Health Examination and Claim Form
- Case narratives, originally prepared for those who accept CHAP services and now prepared for all families who are interviewed

A review of many of these files revealed gaps in required records.

As indicated earlier in this report, the DSS-2402, Child Health Care Status Report is sent only to non-Medicaid physicians identified as providers by clients who decline CHAP services. All client files are located in the CHAP Unit except when being used for reference by CHAP workers conducting post-recertification interviews. "Open" and "closed" CHAP files for Public Assistance recipients, Medicaid recipients, and Foster Care children are maintained separately.

The CHAP Unit has had difficulty keeping track of client files. For example, duplicate files are sometimes developed if a worker fails to review the "closed" file before starting a new client folder. Occasionally, files or documents are lost despite the existence of "charge to" cards designed to replace any file that is removed and to identify the user.

CHAP operations are also controlled by the use of the:

- 3" x 5" Index Card File--Maintained for each child and used to track CHAP examinations; the card also identifies other family members so that their files may be accesssed.
- CHAP Appointment Calendars--Maintained by workers responsible for calling clients one day prior to examinations.

Forms, such as the DSS-2401, Individual Tracking Form are continuously reviewed by the CHAP Unit, but problems related to incompletion persist. The CHAP Unit has reorganized client files several times in attempts to minimize some of these problems, but continues to experience difficulty. These problems are discussed more fully in the section which follows.

6. STATISTICAL MEASURES OFFER A LIMITED PERSPECTIVE ON PROGRAM EFFECTIVENESS

Meaningful statistical indicators of CHAP performance are difficult to develop due to limitations in the availability and quality of data. In addition, the analyst lacks quantified objectives and accepted standards by which to measure performance. Although a persuasive argument might be advanced in favor of abandoning or discounting statistical analysis under these conditions, the statistics, nevertheless, are presented. The presentation of the figures along with discussion of their theoretical shortcomings and the opportunities for error occurring in their capture should, however, offer some limited perspective on program performance and, simultaneously, will illustrate the difficulties and limitations inherent in evaluating this program on the basis of currently existing statistics.

Available quantitative bases for evaluation include:

- Past Performance In Onondaga County--In 1974, under EPSDT, 699 children were screened, as compared to 2,549 screened under CHAP in 1975. This represents a 274 percent increase in screening examinations. Because EPSDT costs were not differentiated from the overall Medical Assistance budget, cost comparisons cannot be made.

- Experience In Other Counties--Onondaga County screened 2,599 children or 10 percent of their case load.[7/] Onondaga ranks 32nd among all 58 districts and first among the six large districts in percentage screened. In absolute terms--number screened, Onondaga ranks seventh among all of the districts and fifth among the six large districts.

7/ Case load, or dynamic population figures were developed by MSI based on eligibility data reported monthly/quarterly by the County.

(1) Routine Statistics Indicate That Onondaga County Reached Approximately Thirty Percent Of Its Target Population

Exhibit E-VI, following this page, offers some other statistical indicators of program performance. Explanation of the intentions and limitations of these measures follows below:

- Outreach--The relationship between the number of requests and the target population is an indicator of DSS's effort to encourage client participation. The figure indicates that requests for screenings were made on behalf of 21 percent of the target population.

  In Onondaga County, requests for CHAP examinations come almost totally from persons channeled into the CHAP Unit by Income Maintenance workers at recertification. Thus, the figure might be viewed as a reflection of the effectiveness of these face-to-face interviews with eligibles as a means of encouraging program participation. Given these circumstances, however, some of the requests may represent a misunderstanding on the part of the clients. The request figure may be inflated by instances of clients who believe that participation in the CHAP program is linked to their eligibility for other benefits. It is also likely that the same client made more or less automatic requests at the six-month recertification period, further inflating the figure of 21 percent.

- Responsiveness--Less than half of the requests for screenings, 45 percent, were followed by examinations. The screenings figure, tallied monthly on the basis of the number of DSS-2403 received, is assumed to be fairly reliable. Instances of requests not being followed by examinations may result from circumstances other than CHAP failure to make the necessary arrangements. The ratio may be distorted (1) by clients who fail to appear at screening appointments, (2) by instances of eligibility turnover, (3) by various kinds of nongenuine requests,[8/] including those made by persons believing that a request to participate in the CHAP program is linked to eligibility for other benefits, and (4) by requests made for children who have already received a CHAP examination earlier in the year.

- Penetration--The initial penetration measure indicates that 10 percent of the case load in Onondaga County received a screening examination. The second measure, intended to

8/ For example, at the end of 1974 (reported in January or February, 1975) EPSDT offered services to all clients in preparation for the transition to CHAP. Many of these "requestees" contacted subsequently by CHAP, declined

EXHIBIT E-VI

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

CHAP PERFORMANCE MEASURES: ONONDAGA COUNTY

Indicator	Measure	CY 1975
Outreach	$\frac{\text{Number of Requests}}{\text{Dynamic Population}}$	$\frac{5690}{26030} = 21\%$
Responsiveness	$\frac{\text{Number of Examinations}}{\text{Number of Requests}}$	$\frac{2549}{5690} = 45\%$
Penetration	$\frac{\text{Number Screened}}{\text{Dynamic Population}}$	$\frac{2549}{26030} = 10\%$
Penetration	$\frac{\text{Number Screened and Under Appropriate Care}}{\text{Dynamic Population}}$	$\frac{2549 + 5372}{26030} = 30\%$
Penetration	$\frac{\text{Number Screened and (Under Appropriate Care} \div 2)}{\text{Dynamic Population}}$	$\frac{2549 + 2686}{26030} = 20\%$

more correctly reflect the number of cases reached by the program, includes the number of cases under appropriate care in the numerator. On this basis, Onondaga reached 30 percent of its target population. The reader should be aware of a flaw in the counting of clients under appropriate care. Public Assistance cases are recertified twice a year and many clients determined under appropriate care twice a year--hence, some double counting occurs.

Among the limitations of these routinely reported statistics is the fact that none address the critical question of how well the program assures treatment of children with diseases and disorders. To examine the issue of follow up, MSI conducted a study of 25 percent of the cases in which need for follow-up care was identified. The methodology and findings are discussed below.

(2) A Special Study Of Children With Conditions Discovered During The CHAP Examination Indicates That Fifty-Five Percent Of The Children Received At Least Some Follow-Up Care

With the objective of studying the nature and costs of follow-up care, the following methodology was devised:

- Step 1: Draw Sample--Randomly select 84 cases (25 percent) with conditions for follow up from chronological stacks of DSS-2403 forms[9/]
- Step 2: Identify CHAP-Related Medical Charges--Cross compare information on the tracking form with the medical payment records to locate charges for follow-up care
- Step 3: Examine Case Folders--Review case information to obtain additional information on the status of the case (client refused, case closed, etc.)

The results of this study are summarized in Exhibit E-VII, following this page, and show that:

- The medical payment record provides evidence that 55 percent of the children received some follow-up care.
- Review of the case folders provided explanations for why 26 percent of the children did not receive follow-up care.

9/ It should be noted that all sample cases were drawn from examinations rendered from July to December, due to the fact that the DSS-2403 forms from the earlier part of the year were lost.

EXHIBIT E-VII

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DISPOSITION OF 84 CASES REQUIRING
FOLLOW-UP DIAGNOSIS AND TREATMENT

	Number	Percent
Cases which Medical Payment System indicates at least partial follow-up	47*	55%
Cases requiring dental care but with no follow-up	8*	10
Cases for which inadequate time has elapsed for follow-up to be recorded	4	5
Cases which were closed	9	11
Cases involving preexisting conditions assumed to be under care or untreatable	5	4
Explanation	13	15
Total Cases	86*	100%

* Two of these children required and received different attention but did not get their dental needs met and counted twice. The unduplicated count is 84.

- For only 15 percent of the cases was there no explanation for the lack of follow-up care. Exhibit E-VIII, following this page, summarizes the details of these cases (15 children).

  - Apparently the young children (under one year old) are more likely to receive follow-up care than the older children.

  - The conditions for which follow up was not obtained show no particular pattern.

These statistics on follow up should be reviewed with the understanding that CHAP is involved directly only in about 10 percent of the cases. When the physician indicates that he will keep the child under his continuing care, CHAP has no further involvement in the case. Moreover, the CHAP Unit does not arrange dental appointments.

- CHAP rarely arranges more than one follow-up appointment per condition.

- If the condition falls into one of the more than 100 categories that are covered under State Aid, the case is forwarded to the Medical Rehabilitation Unit and no further action is taken on the case by the CHAP Unit.

CHAP has no procedure for verifying that the patients have kept their follow-up appointments.[10/]

(3) The Statistical Analysis Revealed Problems In CHAP Administration And Reporting

The process of drawing a sample and reviewing records was very illuminating. In general, it can be said that the client records were disorganized. DSS-2403 forms for several months were lost completely and about one-third of the case files needed for our review could not be located in the appropriate place. More specifically, the following problems were identified:

- DSS-2403--Due to poor quality carbon copies, illegible handwriting, and a lack of uniformity in the way client identification numbers are arrayed, it is often difficult even to obtain the child's name and identification number (key to

10/ Subsequent to the site visit, it was reported to MSI that as of September, 1976, a system has been implemented whereby CHAP contacts each physician on the day following appointments. The date of the scheduled follow-up is ascertained by one of three methods: (1) the DSS-2403 indicates a date, (2) CHAP calls the examining physician to determine the date, or (3) CHAP schedules the appointment.

EXHIBIT E-VIII

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

DETAILS ON CASES FOR WHICH THERE IS NO
EVIDENCE OF FOLLOW-UP AND NO EXPLANATION

	Number of Children
Age 0 - 1	0
1 - 6	7
6 - 21	6

Conditions for Follow-Up

3 Skin
2 Anemia
2 Urinalysis
2 Hernia
1 Vision
1 Cardiopulmonary
1 Mouth and throat
1 Lead poisoning
1 History growth and development
1 Mild speech delay
1 Tonsillectomy

accessing information from the records system or responding appropriately to the child's needs) from the top of the form. This hampered our review and surely hampers CHAP administration as well.

Interpretation of the bottom portion of the form, which describes the child's state of health and indicates the need, if any for follow up, involves some subjectivity. In selecting our sample, we assumed that when a provider indicated that not all conditions were normal, it would indicate a need for follow up. It is unclear whether, in fact, it does. For example:

- It is unclear whether check marks beside the names of the laboratory tests indicate that tests are needed or that they were given.

- It is often unclear whether scribblings beside the name of a medical category indicate the name of a disorder or provider. Where a provider name is indicated, it is often unclear whether an appointment has been made or needs to be made.

Certainly, such uncertainty results in CHAP missing some children who need care and attending some who do not.

- DSS-2401--The tracking forms (DSS-2401) prove to be of little value in identifying occasions requiring or receiving follow-up care. For purposes of completing the tracking forms, the phrase "need for follow-up" is interpreted by the staff to mean instances where CHAP has a continuing responsibility as opposed to identified need for medical follow up. Thus, in cases where a need for follow-up is indicated on the DSS-2403 forms and the provider has indicated that the patient will be under his continuing care or that he has made a direct referral, the tracking forms are marked as having "no conditions for follow-up."

- The Medical Payments Record--The medical payment record is the only source[11/] of information about follow-up care. There are several problems with this approach:

11/ Theoretically, the child or the provider could be questioned, but this is a costly and time-consuming option.

- The cryptic procedure and diagnostic codes on the medical payment records are difficult to relate to the nonspecific medical categories on the DSS-2403 forms, especially "History, Growth, and Development" and "Other."

- There is a three-month time lag in the updating of the medical records. Some follow-up charges which have been incurred may not yet appear in the payment record.

- A child who receives care from other than a Medicaid source (closed case, free clinic) will have no record of follow-up care.

Thus, for the purposes of this study, and more seriously for routine CHAP administration, it is not possible to ascertain reliably, on an individual basis, whether adequate follow-up care was received where needed. The CHAP Unit is unable to determine on a timely basis whether follow-up care was received. In spite of this inadequacy, it does appear that many children are receiving medical follow-up at the initiation of their physician or their parents.

CHAP COSTS REPRESENT LESS THAN ONE PERCENT OF THE MEDICAL ASSISTANCE BUDGET

The total Medical Assistance budget for Onondaga County in 1975 was $39,955,455. Of this sum, $163,676 can be attributed to CHAP. There are two main elements of the cost:

- Administrative Costs--The cost of direct labor and overhead, summarized in Exhibit E-IX, following this page, was $86,259. No labor costs from the Department of Health were included because, in 1975, no payments were made under interagency agreement. The original cost estimating methodology anticipated a sophisticated procedure for allocating the costs of the recertification workers salaries to CHAP. Upon closer examination, however, the amount of the recertification workers time was found to be so minimal that a blanket 1 percent was used to apportion the time to CHAP.

- Service Costs--The three elements included in service costs are (1) cost of screening examinations, (2) cost of the Child Health Status Report (DSS-2402), and (3) costs of diagnosis

EXHIBIT E-IX

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

ADMINISTRATIVE COSTS OF CHAP

ADMINISTRATIVE COSTS, DSS

• Direct Labor, DSS		
- Income Maintenance Zones		
68 Examiner I @ 1%	$ 4,973	
Fringe benefits @ 21%	1,044	
		$ 6,017
- Foster Care		
1 Typist II @ 15%	1,144	
Fringe benefits @ 21%	240	
		1,384
- CHAP Unit		
1 B Supervisor @ 40%	5,010	
1 Sr. Caseworker @ 100% (3 months)	2,673	
1 Examiner II @ 100% (8 months)	5,610	
20% (1 month)	141	
2 Examiner I @ 100% (7 months FTE)	4,331	
1 Senior clerk @ 100% (11 months)	8,051	
1 Typist I @ 100% (10 months)	5,820	
3 CETA Community service aides @ 100%	17,151	
	48,787	
Fringe benefits @ 21%	10,245	
		59,032
- Medical Assistance		
26 Examiner I @ 1%	1,857	
Fringe benefits @ 21%	389	
		2,246
TOTAL DIRECT LABOR		$68,679
• Other Administrative Costs		
Training	Insignificant	
Travel	Insignificant	
Supplies	Undifferentiated	
Overhead	$ 17,580*	
TOTAL ADMINISTRATIVE COSTS, DSS		$86,259

* 586 sq. ft. usable space @ $2.50/ft./mo.--Accounting Department figures.

and treatment. These are summarized in Exhibit E-X, following this page, and the following observations are offered:

- The costs for the screening examinations and the Child Health Status Reports are routinely reported on the DSS-2404 forms and are considered to be fairly reliable.

- The $4,820 reportedly spent for the Health Status Report is lower than might be expected because Onondaga has elected to use the form only to establish appropriate care status for clients having non-Medicaid physicians.

- The figure for the cost of diagnosis and treatment was derived by multiplying the costs identified in the 25 percent sampling by four. It should be noted that this figure represents the lower limit of the potential cost of diagnosis and treatment under CHAP for two reasons: (1) the number of examinations reportedly identifying conditions for diagnosis and treatment is suspiciously low in Onondaga compared to other districts, and (2) some children did not get the necessary care; moreover, for those children who received some care, it is impossible to determine whether the entire treatment regime was completed.

THE ONONDAGA CHAP PROGRAM NEEDS TO BE STRENGTHENED IN SEVERAL RESPECTS

Although Onondaga County compares favorably with other counties in viously discussed quantitative performance measures, it does not fare as well when considered in the light of the following qualitative aspects:

- Experience, training, and enthusiasm of the staff

- Efficiency of file systems, reporting mechanisms, and other procedures designed to ensure that requests are honored and referrals are made

- Scope of the program, including the degree to which the program can identify eligible children and the level and kind of resources devoted to notification, outreach, and case management

EXHIBIT E-X

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

SERVICE COSTS OF CHAP: SCREENING, CHILD HEALTH CARE STATUS REPORT, AND DIAGNOSIS AND TREATMENT: 1975 1/

. Screening examination	$61,093
. Child health care status reports	4,820
. Diagnosis and treatment	11,504 2/
TOTAL	$77,417

1/ Source DSS 2404.

2/ ($2,876.11) x (4) = ($11,504.00) where $2,876.11 was the cost of diagnosis and treatment in a 25 percent sample.

Of the four counties examined intensively, Onondaga has the least favorable service staff to clerical staff ratio (1.6:1 compared to 12.5:1, 3.25:1, and 2:1 in Chemung, Nassau, and Herkimer Counties, respectively). It also has the highest case load to staff member ratio (5,005 compared to 958, 2,559, and 2,589 in Chemung, Herkimer, and Nassau, respectively). Onondaga County, working with the staff most limited in health background, invested less in training than two other counties. The training that did occur related primarily to the processes involved with EPSDT, was not goal-directed, and did not relate to health education. Not surprisingly, the Onondaga Unit appears to be fairly unenthusiastic about CHAP.

The scope of Onondaga's CHAP is the most narrow of the four counties studied. The CHAP staff makes little investment in outreach--none in the home; CHAP is dependent upon recertification workers to identify and refer eligibles, a process which has not worked effectively. The file system is inadequate; and there are no procedures to ensure follow-up care is received when needed.[12/]

The apparent paradox of the Onondaga County program, which appears relatively "successful" from a quantitative perspective, yet not so successful from a qualitative perspective, suggests two possible explanations. First, the statistical performance measures may not be valid indicators of success, i.e., it is possible to screen great numbers of children without having a high quality program. Second, the internal operations of the CHAP Unit may have little bearing on the success of the program. Conditions outside the CHAP Unit (i.e., physician attitudes and availability or district education levels) may have a greater impact on getting children to the physician than the workings of the CHAP Unit itself.

The conclusions and recommendations that follow suggest opportunities for improvement in the Onondaga CHAP program.

(1) Compliance Testing Has Served As A Two-Edged Sword, Forcing Program Implementation But Acting As A Disincentive For Program Improvement

In Onondaga County, where there is little enthusiasm for the CHAP program, either in the County legislature or in the Department of Social Services, it is doubtful that the program would have been implemented at all if there had not been the threat of the penalty assessment. Early in 1975, the County was found to be in compliance. Since then it has been assumed throughout DSS that the program continues to be in compliance although most DSS personnel do not understand and are

12/ Subsequent to the site visit, it was reported to MSI that procedures to ensure follow-up had been recently implemented.

not aware of the points on which compliance is measured. Thus, it is doubtful that compliance continues to serve as a source of pressure to perform.

With respect to specific points of compliance, the CHAP program experiences little difficulty in scheduling the initial examination within 60 days of the request. CHAP does find it difficult, however, to meet the requirements of the periodicity schedule for subsequent examinations or to ensure follow-up care within 60 days of the request, particularly if these time limits are in conflict with those preferred by the physician. As an example of the process orientation that CHAP has adopted, CHAP has limited its responsibility for follow-up care to making appointments for the few clients (about 10 percent) who are not indicated to be under the care of a provider. CHAP makes no attempt, however, to identify for the other 90 percent of the children whether the follow-up care is received; in fact, CHAP staff indicate on the client tracking form that there are no conditions for follow up.

Thus, compliance served as the initial spur to get the program off the ground; ironically, the grace period between compliance audits has served as a disincentive for the program to maintain its level of performance or undertake new initiatives for program improvement.

(2) Providers Continue To Be Antagonistic Towards Medicaid Generally And Apathetic Towards CHAP Specifically

Subsequent to the initial adverse reaction to CHAP, providers adopted a fairly apathetic posture towards the program. Central to the provider attitude, of course, is the Medicaid rate structure, which is widely considered lower than the actual cost of services. Provider objections center on at least the following:

- School examinations should be upgraded and provided to all children, replacing CHAP altogether. The Department of Social Services and Health Department are considered too bureaucratic and inefficient to establish and maintain such a program, whereas the school system has more or less continuous contact with these children and thus a better opportunity to meet their ongoing health needs.

- Immunizations are the most pressing health needs of children under 12; CHAP resources could be more cost effectively used if focused on this health need.

- Preschool children should be the focus of CHAP; many pediatricians do not themselves accommodate so large an age range as CHAP and many believe that resources could be more effectively used if focused on the younger Medicaid children.

Although the specifics of these problems reflect State or Federal policy and so are beyond Onondaga's control, it is clear that DSS should take some steps to enhance its provider relationships. The low level of children with referrable conditions in Onondaga might indicate that physicians are doing superficial examinations and this situation should be explored with the providers themselves. The CHAP Unit cannot make these overtures alone. Assistance is required from higher within DSS, perhaps the Medical Director, or from the Health Department.

(3) The CHAP Data System Is Inadequate

Many of the deficiencies in the Onondaga data system arise from circumstances beyond the control of the CHAP Unit. As discussed earlier, major deficiencies exist in the forms used to document CHAP. In addition, CHAP is troubled by incorrect and incomplete printouts on which it relies for case histories and for determining whether cases are open or closed. These problems are compounded by the condition of the CHAP manual files.

Several attempts have been made to improve the filing system, but the staff continues to experience difficulty in accessing and locating files. The files are complex and idiosyncratic partly because of the recertification schedules and partly because of time delays caused by the billing turnaround.

Initially, efforts should be made to (1) simplify the file structure and to assure that all persons doing the filing share the same understanding of how the files are organized, and (2) train staff in the proper procedures for completing CHAP forms. In the long run, however, due to the size of the case load, further computer support will be necessary to adequately meet the information needs of the CHAP in Onondaga.

(4) Linkages Have Been Stifled By Concern About The Confidentiality Of Data And By Lack Of Communication And Motivation

One of the most promising aspects of the Onondaga CHAP was the early initiative to create linkages with a number of local community agencies and with the Health Department. These linkages, however, have yet to develop to their potential for a number of reasons:

- The County, as well as the potential linkage agencies, fear that the identity and medical records of the children will be subject to violations of confidentiality. Interestingly, the linkage with the Health Department does not create this problem, because the public health nurses have enough rapport with their clients to ask them about their status (they do not, however, access all Medicaid clients, nor are Medicaid clients their sole or even primary target group).

- There is a considerable tendency of the organizations involved to defend their organizational authority. There are no clear financial incentives to the potential linkage agencies (with the exception of the Health Department) and, consequently, the agencies are not motivated to communicate well or frequently.

It did appear that the potential for a linkage with the Health Department was enormous. DSS should explore the possibility of turning the entire CHAP program over to the Health Department. Under such an arrangement, DSS would keep only the payment function. The advantages of this approach are several. The public health nurses already represent a powerful force in the community to promote well-child care and teach the fundamentals of good health education. For years, the public health nurses have referred families to Department-sponsored well-child and dental clinics, and, to this extent, the additional work they are charged with under their agreement with DSS is not really incremental. Moreover, the public health nurses lack the welfare stigma that apparently mutes client enthusiasm for the program and, instead, they are fairly zealous in spreading the CHAP message.

(5) The Management And Staffing Of CHAP Should Be Strengthened

As discussed earlier, the management and staffing situation in the CHAP Unit has eroded steadily during the past year. Not only has the number of staff dwindled, but the staff has become increasingly unenthusiastic and apathetic about CHAP. This is understandable in light of the operational environment. The overall atmosphere at DSS is not supportive of CHAP; the staff finds few sources of encouragement. The value of the CHAP Unit is widely questioned in other units amid a Department-wide drive for budget cutting and staff trimming. The comment is often made in the neighboring medical payments unit that the number of staff committed to CHAP seems out of proportion to medical payments as a whole. The CHAP Unit of about five staff members is compared disparingly to the single medical payments clerk who operated EPSDT.

The tasks involved in carrying out CHAP in Onondaga are inherently unrewarding, and the activities seem far removed from the goals of CHAP; there is no sense of accomplishment in the repetitive day-to-day activities. The staff members lack background in health and apparently have not been sufficiently "sold" on the merits of CHAP and the value of their role. Under these conditions, it seems fairly unlikely that the staff would spontaneously internalize CHAP goals as their own and undertake their tasks zealously as a mission to assure child health.

An infusion of direction and enthusiasm, from all quarters in DSS, is needed to improve the operations and attitudes of CHAP staff and to generate more support for CHAP within DSS and from other County agencies. The following are a few suggestions for providing tangible demonstrations of leadership that should improve CHAP:

- Assure appropriate and stable staffing of the CHAP Unit
- Conduct continuous workshops for all staff associated with CHAP, including recertification workers and Health Department staff, on overall EPSDT goals and how these goals can be accomplished through the combined efforts of each individual
- Redefine roles of personnel in the CHAP Unit with a focus on improving job satisfaction and fixing responsibility for specific tasks
- Establish uniform procedures and set expectations for performance of CHAP functions
- Increase supervision by managers and policymakers at various levels of the work performed by staff associated with CHAP functions

In addition, increased client contact might serve a double benefit--increasing the impact of the CHAP message on clients and making the CHAP function more meaningful to CHAP staff. To the contrary, however, it appears that Onondaga's CHAP will be deemphasized in the future. CHAP workers have been instructed to disengage CHAP from the recertification process and discontinue face-to-face contacts. Soon, all clients will be done through the mail or over the telephone. This will most likely cause a drastic reduction in the number of requests and, hence, examinations and follow-up encounters.

TABULATED RESPONSES TO THE STATEWIDE QUESTIONNAIRE ADMINISTERED BY THE NEW YORK STATE DEPARTMENT OF SOCIAL RESOURCES

APPENDIX F

TABULATED RESPONSES TO THE STATEWIDE CHAP QUESTIONNAIRE ADMINISTERED BY THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

TABULATED RESPONSES TO THE STATEWIDE CHAP QUESTIONNAIRE ADMINISTERED BY THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

During the summer of 1976, New York State Department of Social Services distributed a questionnaire to all districts (except the four case study counties) to gain further insight into CHAP operation statewide. One hundred percent response was achieved.

The following exhibits tabulate the responses to the questionnaire. In most cases the questions are repeated verbatim. In some instances, however, elaboration or clarification is provided in BOLD FACED TYPE to distinguish it from entries on the survey instrument itself. Throughout the body of the report these findings are referenced to support or expand upon the observations from four counties.

EXHIBIT F-1(1)

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

SUMMARY OF RESPONSES TO SURVEY INSTRUMENT

Survey Instrument	Response (* = Correct Answer)
SECTION I: STATISTICAL DATA FOR CY 75	
The following section is concerned with validating and clarifying certain data elements reported by your agency for CY 75. The data entered below were tallied for the year from the DSS 2404 forms received for January to December, 1975. Please review these data carefully and comment as to their accuracy and meaning.	
1. You reported _____ requests for examinations (DSS 2404-I-D). In using this number we are interested in the number of requests made by an unduplicated number of individuals during the course of 1975. Moreover, we are interested in the number of requests made by each individual that are "timely" within the meaning of the periodicity schedule. Please answer the following questions:	
a. Does this figure include requests which were made more or less routinely (for example, at each recertification period) without regard for whether the child had an examination recently?	Yes--43 *No--57
b. If a parent makes a request on behalf of several children, is the request counted:	Once for the parent--7 *Once for each child--93*
c. Does this figure include children who are under appropriate care and requested an examination?	Yes--62* *No--35 No answer--3
d. Can we rely on this figure to reflect the number of children on whose behalf a timely request for an examination was made during 1975?	Yes--83 No, more accurate figure provided--9* No, no more accurate figure provided--4* No answer--4
NUMBER OF DISTRICTS REPORTING OPTIMAL METHOD OF CALCULATING REQUESTS (i.e., No to "a;" Once for each child to "b;" and No to "c"): 22	
2. You reported _____ children under continuing care (DSS 2402-I-A). In using this number we are interested in the unduplicated number of children who were found under appropriate care during 1975 who did not also receive a CHAP examination. Please answer the following questions:	
a. Does this number include children whose medical status was determined by a search of medical payment records?	*Yes--63 No--35 No answer--2
b. Does this figure include children for whom a DSS 2402 (Child Health Status Report) was returned?	*Yes--89 No--11
c. Does this figure include children who were reported on the DSS 2403 (Report and Claim) to be in a physician's continuing care?	Yes--33 *No--67
d. Does this figure include children who were reported by their parents on the DSS 2400 as being under appropriate medical care, but was not subsequently verified?	Yes--7 *No--93
e. What other types of children are included in this figure?	9 of the districts include such children as those in institutions, those enrolled in the physically handicapped program, and so on

Survey Instrument	Response (* = Correct Answer)
f. Can we rely on this figure to represent the unduplicated number of children who were determined (by whatever means) to be under appropriate care and who did not receive an examination?	Yes--71% No, more accurate figure provided--21% No, no more accurate figure provided--4% No answer--4%

NUMBER OF DISTRICTS REPORTING OPTIMUM METHOD OF CALCULATING CHILDREN UNDER APPROPRIATE CARE (i.e., Yes to "a" and "b;" No to "c" and "d"): 28%

3. You reported _____ children screened who required additional diagnosis and treatment (DSS 2404-II-C). We are interested in knowing how many of these children actually are known to have received the appropriate additional care. Please answer the following questions:	
a. Do you have any records which indicate how many of these children received the appropriate diagnosis and treatment?	Yes--20% No--80%
b. How many children received diagnosis and treatment?	Between 100 and 14% (See Exhibit F-II for details)
d. Do you have any indication of the cost of follow-up care?	Yes--0% No--100%
e. If a physician indicates that the child has not seen a dentist for over one year, what action does your agency take?	• If the provider indicates that the child will be under his continuing care, we do nothing further--22% • If the provider does not indicate that the child will be under his continuing care, we contact the parent to arrange for the dental appointment--20% • Regardless of whether the provider indicates that the child will be under his continuing care, we do nothing further--7% • Regardless of whether the provider indicates that the child will be under his continuing care, we contact the parent to arrange for the dental appointment--56% (Many districts responded positively to a number of these options and thus the answers do not total 100%.)
f. If a physician does not indicate anything in the "dental" category, what action does your agency take?	Takes some action--31% Takes no action--50% No answer--19%

SECTION II: ORGANIZATION AND STAFFING	
1. What training opportunities and/or materials (if any) have been offered to CHAP staff or CHAP affiliated county workers?	• Columbia University workshops--85% • Training manuals developed by the local district--13% • Bulletin 190--98% • Other--39%
2. a. Does any person have responsibility to serve as CHAP Coordinator and oversee CHAP activities performed throughout the agency?	Yes--94% No--4% No answer--2%
b. What is the salary of the CHAP Coordinator (base annual)?	Average upstate--$9,607 Average suburban counties and New York City--$16,772
c. What percent of the CHAP Coordinator's time is devoted to CHAP?	Average upstate--63% Average suburban counties and New York City--86% (Note: 28% of the districts have a full-time Coordinator and 11% of the districts did not respond to the question.)
d. What is the educational background of the CHAP Coordinator?	Advanced degree--4% Four years of college--52% Some college--28% Other training--11% No answer--5%

NUMBER OF DISTRICTS WHICH REPORTED CHAP COORDINATOR BACKGROUND IN: HEALTH EDUCATION--2% HEALTH--22% EDUCATION--26% SOCIAL WORK--7%

Survey Instrument	Response (* = Correct Answer)
e. Is the CHAP Coordinator position funded by CETA?	Yes--5% No--95%
3. Do you have a separate CHAP unit?	Yes--78% No--22%
4. How many staff (exclusive of the CHAP Coordinator) are in the separate unit?	

RATIO OF CHAP STAFF TO DYNAMIC CASELOAD (Service Workers: Clerical Workers): AVERAGE UPSTATE-- 1:4,071 AVERAGE LARGE COUNTIES AND NEW YORK CITY-- 1:13,310 (See Exhibit V-11 for details)

RATIO OF SERVICE TO CLERICAL WORKERS (Service Workers:Clerical Workers): AVERAGE UPSTATE-- 1:0.54 AVERAGE LARGE COUNTIES AND NEW YORK CITY--1:1.36 (See Exhibit V-12 for details)

5. Is the CHAP unit responsible directly to:	• Medical Assistance Division--19% • Social Services Division--22% • Assistance Payments/Income Maintenance Division--4% • Commissioner's Office--33% • Other--9% • No answer--13%

SECTION III: PROGRAM LINKAGES

1. Is there a local health department in your county?	Yes--65% No--35%

OF THE 35 DISTRICTS WHICH REPORT A LOCAL HEALTH DEPARTMENT: THE NUMBER WHICH REPORT A CHAP-RELATED LINKAGE--24%
OF THESE, THE NUMBER WITH A WRITTEN AGREEMENT--15%

2. Are there any existing or planned linkages with other than the health department in the community (e.g., schools, Head Start, regional department of health)?	Head Start--37% Schools--21% Physically handicapped children--11% Other--31% No linkages existing or planned--37%

SECTION IV: CHAP PROCESSES

1. Are clients informed of CHAP during home visits?	Yes--48% No--52%
2. Identify the actions usually taken by your agency to assure periodic CHAP examination appointments are made.	• Clients are usually expected to make their own appointments--59% • Appointments are usually made for clients--17% • Clients are usually called to remind them of appointments--20% • Notices are usually sent to remind clients of appointments--41% • Transportation is usually provided, if necessary--81% • Day care or babysitting services are usually provided, if needed--7% • No answer or conflicting answers--11%
3. How are periodic examinations followed up to determine whether the examination was kept and to determine the need for diagnosis and treatment?	• Wait until bill (DSS 2403) is submitted by provider--63% • Wait a specified period of time, e.g., 30 days, to review bill (DSS 2403), and if bill not received within time frame then follow up with physician--35% • Direct contact with physician immediately after exam date--13% • Direct contact with client immediately after exam date--13% • Ask client at next recertification or periodicity schedule date--26%

Survey Instrument

4. Please discuss any problems you have had determining whether the periodic examinations have occurred.

5. Please describe how you determine whether children are under appropriate medical supervision.

6. a. When diagnosis and treatment is required, how do you determine that the care has taken place?

b. Please discuss any problems you have had determining whether required diagnosis and treatment care has been received.

7. When are home visits conducted in your CHAP process?

SECTION V: PROVIDER PARTICIPATION

1. How many providers furnish periodic examinations (screening) and diagnostic and treatment care in the CHAP program?

2. a. Briefly describe the position/attitudes of most providers with regard to CHAP.

Response (* = Correct Answer)

30% answers such as: "Need computer support" "Patients don't have phones" "Forms aren't being returned" "Insufficient staff"

- Criteria: Bulletin 190--81% Other--13% No answer--9%
- When:
  - . At or following initial intake--13%
  - . At or following first recertification period--11%
  - . At or following every recertification period--43%
  - . At the appropriate time based on the periodicity schedule--19%
  - . Once a year (MA and PA clients)--11%
  - . Combination of the above--43%
- How:
  - . Using the medical claims file--65%
  - . Using the DSS 2402--81%
  - . By asking the patient--31%
  - . Other--11%

- It is usually assumed that the physician/provider will provide follow-up care as needed--54%
- Health Department or Public Health Nurses track client to assure care is received--15%
- DSS Agency staff reviews Medicaid claims to match encounters with treatment needs--63%
- DSS Agency staff contacts physician to determine whether care was received--20%
- DSS Agency staff contacts client to determine whether care was received--72%
- Other--15%

TIME LAG IN BILLING--18% TIME-CONSUMING--6% INSUFFICIENT STAFF--6%
CASES CLOSE--2% NO-SHOWS--2% PROBLEM WITH DSS 2403--4%

- Never--13%
- For all clients right after initial intake--11%
- For all clients right after recertification--7%
- For only those clients who request periodic exam--2%
- For only those clients who refuse periodic exam--20%
- For only those clients who fail to keep an appointment for a periodic examination--19%
- For only those clients who require follow-up care--22%
- For only those clients who fail to keep an appointment for follow-up care--22%
- Other or combination of the above--62%

RESPONSES INSUFFICIENT FOR TABULATION

	Physicians	Dentists	Hospitals/Clinics
• Participate enthusiastically	22%	15%	24%
• Participate without complaint	70	80	5
• Participate but object to paperwork	31	19	17
• Participate but object to fee	9	17	4
• Participate but complain about no-show rate	22	13	9
• Participate but do not support the concept of CHAP	13	7	2
• Participate in CHAP but not in Medicaid	--	11	--
• Participate in Medicaid but not in CHAP	17	5	11

Survey Instrument

b. Briefly describe any problems you have had with the provider community.

3. Who in your agency serves as liaison with the provider community?

SECTION VI: DATA SYSTEMS

1. Does your agency currently have an automated Medicaid claims payment system?

3. Does your agency, within the next year, plan to automate any CHAP functions that are currently performed manually?

Response (* = Correct Answer)

25% of the respondents complained about a sparsity of providers in the community

Commissioner--24% Medical Director/Physician--28% CHAP Coordinator--72% Other--22%
No one--4%

- Identifying all Medicaid-eligibles under 21--20%
- Periodically sending written notification to all ADC cases--6%
- Printing identifying information on DSS forms--7%
- Reviewing the claims to determine if client is under appropriate care as per State Bulletin 190--7%
- Determining whether periodic examination was conducted--7%
- Identifying children requiring diagnosis or treatment based on the results reported on DSS 2403--4%
- Determining whether follow-up care, as identified in the periodic exam, was conducted--4%
- Identifying those children who are in need of a periodic examination (based on State periodicity schedule)--4%
- Auditing provider bills--7%
- Preparing provider checks--9%
- Identifying closed cases so that client files are kept current--13%

Yes--76% No--10% Possibly--4% No answer--10%

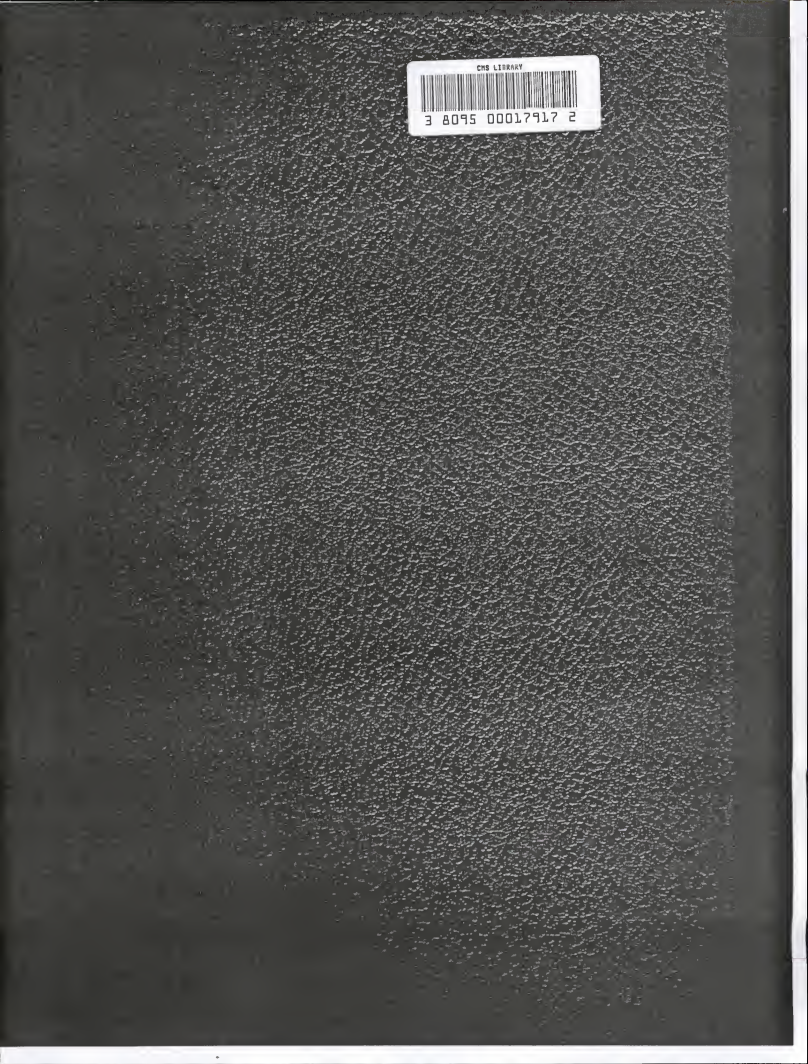
EXHIBIT F-II

Department of Health, Education, and Welfare
Assistant Regional Director for Planning and Evaluation
Region II

PERCENT OF CHILDREN RECEIVING DIAGNOSIS AND TREATMENT-1975 *

District	Number of Examinations Which Resulted In Referral for Diagnosis and Treatment	Number of Children Reported to Have Received Diagnosis and Treatment	Percent*
Cayuga	192	135	70%
Chenango	417	58	14
Fulton	187	187	100
Greene	262	262	100
Hamilton	9	5	56
Oneida	499	499	100
Ostego	526	288	55
Lawrence	348	289	83
Schuyler	32	28	88
Wayne	57	57	100

Note: * It is not technically correct to compare these two numbers as one represents "children" and the other "examinations." However, since it is unlikely that very many of the examinations which resulted in a referral involved the same child more than once, this calculation represents the rough percentage of children receiving adequate follow-up care.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