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wound —healer *n.*  
**health** (*helth*) *n.* [OE. *hæalth*] 1. physical and mental well-being; freedom from disease, etc. 2. condition of body or mind [*poor health*] 3. a person's health and happiness [*lost his health*] 4. soundness, as of a



**men-tal** (*men't'l*) *adj.* [*< L. mens, the mind*] 1. of, for, by, or in the mind [*mental patients*] 2. ill in mind [*mental patients*] 3. for the ill in mind —*men'tal-ly adv.*

# Why do we wait?

A Mental Health Report

# Executive Summary

## EPSDT: Mental Health Prevention and Early Intervention Services

Providing children, adolescents, and families the opportunity to access quality and accessible preventive and early intervention mental health care is fundamental for their health, safety, and success. Healthy children and adolescents have a better opportunity to live quality lives and have a positive impact on society. Conversely, unrecognized mental health concerns of children and adolescents may contribute to difficulties that adversely affect their lives, their families, and society. Research indicates that Medicaid-eligible children and adolescents encounter more mental health issues than the general population, which emphasizes the even greater need for effective preventive and early intervention mental health care for this population.

### Background

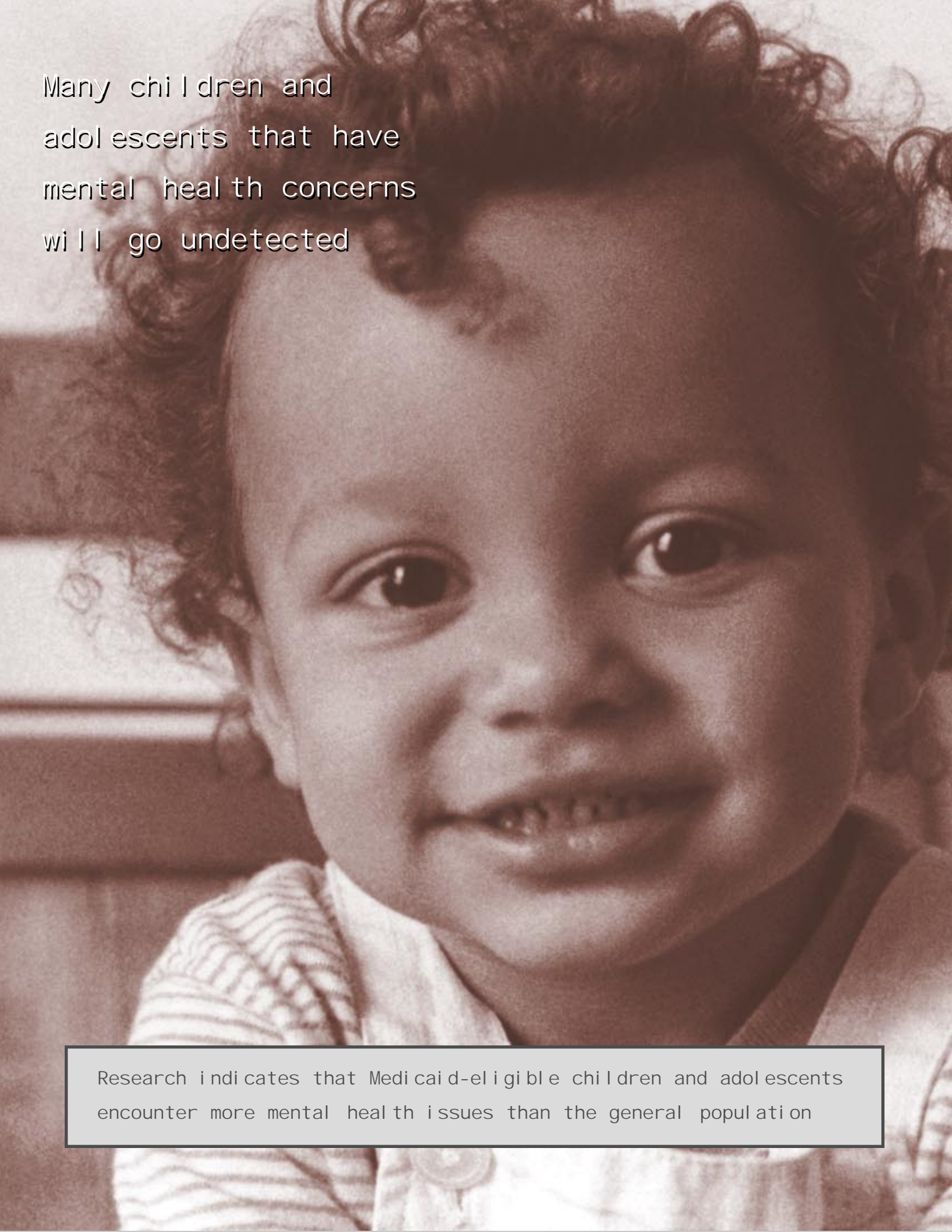
The federal government's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides Medicaid-eligible children and adolescents, birth to age 21, with preventive and early intervention health care services. The Minnesota Department of Human Services (DHS) is the responsible state agency for this program. This program's purpose is to inform and encourage families to have their children screened to detect any physical or mental health concerns by performing comprehensive periodic screening services. Once mental health concerns have been identified, the necessary treatments can be offered before overlying concerns negatively affect the children, adolescents, and their families.

This report focuses on administrative services and mental health-screening protocol. Administrative services provide the processes to inform children, adolescents, families, and health care providers of the benefits of the EPSDT program. This includes assisting families by scheduling appointments, offering transportation, and encouraging health care providers to provide EPSDT services. The mental health-screening protocol includes the administration of a mental health-screening and a comprehensive health history.

### The EPSDT Program


The EPSDT program operates under the following system. Families that are in need of financial assistance may apply for Medicaid at their local human service agency. During the application process, families are given information about the EPSDT program. This is a voluntary program, so families can decide if they want their children to receive preventive health screenings and other services such as immunizations and health consultation.

Generally, families that want their children to receive EPSDT screening services are referred to either their private medical clinics or public health clinics. Other screening locations may include schools, Head Start programs, and



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Research indicates that Medicaid-eligible children and adolescents encounter more mental health issues than the general population

A young woman with her hair in a bun, smiling and resting her chin on her hands. The image is a close-up portrait with a soft, warm tone. She is wearing a dark-colored top and has a gold bracelet on her right wrist.

[In] 1995 ... only 15 percent of the eligible population received an EPSDT screening. The federal requirement is 80 percent.

Once mental health concerns have been detected ... the necessary treatment can be provided

Women, Infants, and Children (WIC) sites. County social-service EPSDT coordinators are available to assist families with scheduling appointments, transportation and locating an EPSDT screening site.<sup>1</sup> Screening services are made available at 1, 2, 4, 6, 9, 15, 18, and 24 months and at 3, 4, 5, 6, 8, 10, 12, 14, 16, 18, and 20 years of age.<sup>2</sup>

The mental health-screening protocol of the EPSDT program includes a comprehensive health and developmental history screening, which includes an assessment of physical and mental health development.<sup>3</sup> This includes the completion of two vital functions: a comprehensive mental health screening and a comprehensive health history.

An effective mental health screening requires the use of standardized mental health-screening instruments. In order for a mental health-screening instrument to be truly effective in identifying evidence of mental health concerns, an instrument must possess the following qualities:

- Reliability • Validity • Sensitivity • Specificity
- Rapid administration • Use of multiple sources

A mental health screening may assess the areas of chemical use, social, emotional, and mental health status. This information is collected from a variety of sources that know the child or adolescent, such as the child's parents or other adults familiar with the child.

To effectively assess a child or adolescent for mental health concerns, a comprehensive health history must be completed in conjunction with the mental health screening. A quality and comprehensive health history involves the collection of the following information that is used to determine if a child or adolescent may have mental health concerns:

- Cognitive and school functioning
- Peer relations history
- Family relationship history
- Physical development and medical history
- Emotional development history

- Stressful circumstances history
- Family medical and mental health history

If the mental health screening and comprehensive health history are not fulfilled, many children and adolescents that have mental health concerns will go undetected and, consequently, they may not receive the necessary treatment to address their concerns.

## EPSDT Program Concerns

Because of the importance of preventive and early intervention mental health care, the Minnesota Office of Ombudsman for Mental Health and Mental Retardation has completed a review of the EPSDT program, which addresses concerns related to the performance of this program. The Ombudsman Office has concerns that this program is not effectively informing and reaching out to families and health care providers and, consequently, is not identifying the mental health concerns of Medicaid eligible children and adolescents. The EPSDT data used to monitor this program illustrates this concern.

For the year 1995, which is the most current available data from the DHS at the time of the study, only 15 percent of the eligible population received an EPSDT screening. The federal requirement is 80 percent. Additionally, no more than 4.6 percent of the children and adolescents screened received a mental health referral. This percentage indicates that the program is greatly deficient in identifying the mental health concerns of this population. Research indicates that 25 percent to possibly 30 percent of Medicaid-eligible children and adolescents experience mental health concerns.

## EPSDT Program Review

The agency's review of Minnesota's EPSDT program included interviewing, researching program requirements, and contracting with a child psychiatrist to assist in the clinical aspects of the mental health-screening protocol component. Through the agency's review, the following concerns were identified:

- There is great variability in the quality of

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<sup>1</sup>Minn. R. 9505.1730

<sup>2</sup>Minn. R. 9505.1727

<sup>3</sup>42 U.S.C. § 1396d(r)(1)(B) and HCFA, State Medicaid Manual § 5123.2(A).

- EPSDT outreach at the county level.
- Monitoring and evaluation of the local EPSDT outreach effort is lacking.
- Physician buy-in of the EPSDT program is questionable.

- Require all EPSDT-screening providers to obtain comprehensive health histories of Medicaid-eligible children and adolescents.
- Amend the Department of Human Services' current training contract with the Department of Health to include training on the use of standardized mental health-screening instruments and comprehensive health-history assessments.

Effective informing and outreach strategies are essential, so the benefits of this program can be fully utilized.

- Many screening providers do not use standardized mental health screening instruments and comprehensive health-history assessments.
- Generally, private clinics do not provide adequate time to perform a comprehensive screening.
- Alternative screening locations are not fully utilized.
- The data-collection system used to monitor the performance of this program is inadequate.

Thus, because preventive and early intervention mental health care is significant for children's and adolescent's quality of life, the agency has formulated recommendations intended to improve the administrative services and mental health-screening protocol components of the EPSDT program. The agency believes that although this program provides a valuable service to families, there are opportunities to improve the program's performance.

## EPSDT Program Recommendations

The Office of Ombudsman recommends that the DHS consider the following recommendations:

- Develop and implement a comprehensive, coordinated statewide outreach plan.
- Require all EPSDT-screening providers to use standardized mental health screening instruments, which are sensitive, valid, reliable, specific, rapidly administered, and use multiple sources.
- Explore the use of financial incentives and penalties to increase the use of standardized mental health-screening tools.

- Consider a pilot project to promote the use of standardized health-screening instruments and comprehensive health-history assessments at EPSDT-screening locations and to evaluate the results of their use.

## EPSDT Program Goals

The fundamental goal of the Office of Ombudsman's recommendations is to shape systemic change in how the EPSDT program is currently operating and performing. This report encourages the promotion of two focus areas for the improvement of the EPSDT program. First, to inform Medicaid-eligible children, adolescents, families, and health care providers of the valuable benefits of the EPSDT program. Effective informing and outreach strategies are essential, so the benefits of this program can be fully utilized by the nearly 368,000 eligible children and adolescents in Minnesota. Second, to institute a quality mental health-screening protocol, which is vital to accurately identify the mental health concerns of this population. Once mental health concerns have been detected at the early stages, the necessary treatment can be provided, and the prognosis for a healthful, safe, and quality life is more probable.

The collaborative efforts of state, county, and private health-care providers are necessary to make these systemic changes occur. The Office of Ombudsman encourages the promotion of the recommendations in this report and is optimistic that others will embrace the significant need for preventive and early intervention mental health care for Medicaid-eligible children, adolescents, and families of Minnesota.



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### *Preface*

The Minnesota State Office of Ombudsman for Mental Health and Mental Health Retardation is charged with the responsibility to respond to individual and system complaints concerning the care and treatment of persons with disabilities.

Why Do We Wait? is a report about concerns related to the mental health services of the state's Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program provides early intervention and prevention mental health services to Medical Assistance recipients age birth to twenty-one. These services are essential for the health and well being of many children, adolescents, and their families.

A function of the Ombudsman office is to inform the public about how Minnesota's care and treatment programs perform in providing services for disabled people when paid for with public dollars. The Ombudsman's report, Why Do We Wait? is a review of the state's mental health component of the EPSDT program. The report questions the program's effectiveness to successfully identify those children and adolescents that may have mental health issues, which is the intent of this federally mandated program. The report also offers recommendations designed to identify more children and adolescents with mental health problems so they can receive the needed treatment.

Minnesota must invest in early invention and prevention mental health services for Medicaid-eligible children and adolescents. Efforts to improve the process to identify those children and adolescents that have mental health problems not only benefits the recipients of this program, but it also benefits society overall. Research indicates that this population experiences more conditions that contribute to the development of mental health problems. Children and adolescents whom are identified with mental health problems at an early age and receive the appropriate treatment are better prepared to contribute to society. Consequently, this can reduce the cost of emergency, social, special education, and juvenile justice services.

Children and adolescents whom are identified with mental health problems at an early age and receive the appropriate treatment are better prepared to contribute to society.

As suggested by the title of this report, why do we wait to identify the mental health problems of this population when the EPSDT program is available to provide mental health prevention and early intervention services? I am hopeful that the Ombudsman's report will initiate discussion to work toward improving the mental health component of this program. Let's not wait; instead let's help the children, adolescents, and families of Minnesota today before it is too late!

Roberta Opheim  
Ombudsman

## I. INTRODUCTION

Untreated mental health problems result in significant dysfunction and high costs within various systems, including emergency medical care, special education, social services, and corrections.<sup>4</sup> Research indicates that many low-income children and adolescents have mental health problems that if not addressed will negatively affect their social and emotional development.<sup>5</sup> The majority of children and adolescents receiving Medicaid are from low-income families. As significant as the rates of psychopathology are for children and adolescents in the general population, the rates are even higher in the Medicaid population.<sup>6</sup>

The Minnesota Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program's low participation rate and low number of identified children and adolescents with mental health concerns are the primary reasons for the Office of Ombudsman for Mental Health and Mental Retardation to undertake this review. The low rates of the EPSDT program concern this agency because preventive and early-intervention health care services are vital for the health, safety, and success of Medicaid-eligible children and adolescents. This is illustrated in the EPSDT data the agency received from the Department of Human Services (DHS). In 1995, 368,032 children and adolescents were Medicaid-eligible, which entitled them to EPSDT services. Only 55,501 or 15 percent of this population received an EPSDT screening. Furthermore, no more than 4.6 percent of the 55,501 were referred or identified as in need of a mental health referral.

The EPSDT program offers prevention and treatment services to help low-income children and adolescents develop healthful lifestyles. EPSDT is a comprehensive preventive health care program that provides a package of physical and mental health services to Medicaid-eligible children and adolescents, from birth to age 21. The elements of the EPSDT program are as follows:

- **Early:** assess children's physical and mental health status early in life so prevention and treatment services can be made available.
- **Periodic:** assess children's physical and mental health status at recommended intervals to detect any untreated physical and mental health needs.
- **Screening:** detect any physical and mental health conditions that may require further attention.
- **Diagnostic:** determine the nature and cause of identified physical and mental health issues.
- **Treatment:** address physical and mental health needs.

Each of these components makes EPSDT the most comprehensive health care program available to Medicaid-eligible children and adolescents today.<sup>7</sup> This report focuses specifically on problems with Minnesota's EPSDT processes to effectively inform children, adolescents, families, and health care providers about the benefits of this program. It also discusses problems with the mental health-screening protocol to effectively identify mental health concerns of this population. The agency offers recommendations to improve the access and quality of services available through the EPSDT program.

The federal government's Health Care Financing Agency (HCFA) monitors the performance of states' EPSDT programs. State Medicaid programs are required to submit data to HCFA that show their states' compliance with the EPSDT program. States are required to screen 80 percent of EPSDT-eligible children and adolescents.<sup>8</sup> Minnesota has not achieved this requirement.<sup>9</sup>

The DHS administers and monitors the state's EPSDT program. In 1995, 15 percent of the 368,032 Medicaid-eligible children and adolescents received EPSDT screenings. Fifteen percent is well below the 80 percent federal requirement.

To learn and understand the mechanics of how the state's EPSDT program operates and functions, state, county, and private provider staff of EPSDT programs were interviewed. Additionally, the federal and state requirements were reviewed, and the agency contracted with a child psychiatrist to do an extensive literature review of the mental health-screening protocol and the statistical significance of mental health problems for Medicaid children and adolescents.

This report consists of four parts:

- Administrative services
- Mental health-screening protocol
- Data and treatment
- Proposed recommendations to improve the effectiveness of the state's administrative services and mental health-screening protocol of the EPSDT program.

The first area addressed is the administrative services component of the EPSDT program. This component of the program is designed to provide families with information about the program, reach out to families and providers, and support families through the health care system. The state and federal requirements, Minnesota's implementation of these activities, an analysis of the problems, and recommendations to improve this component of the EPSDT program are described.

<sup>4</sup>William Dikel, M.D., *The Status of The Mental Health Portion of EPSDT Screening In Minnesota: Problems and Possible Solutions* (Unpublished - Consulting Child and Adolescent Psychiatrist) [hereinafter W. Dikel's unpublished research].

<sup>5</sup>McLoyd, V. et al., *The Strain of Living Poor: Parenting, Social Support and Child Mental Health*, Children in poverty: Child development and public policy, 1994, pp. 105-135, and Offord, D., Child Psychiatric Prevalence and Perspectives, *Psychiatric Clinics of North America* Vol. 8, Vol. 4, December 1985, pp. 637-650.

<sup>6</sup>*Ibid.*

<sup>7</sup>H.R. Rep. No. 101-247, reprinted at 1989 U.S.C.C.A.N. 1906, 2124 ("EPSDT benefit is, in effect, the nation's largest preventive health program for children."), September 20, 1985.

<sup>8</sup>Health Care Financing Administration (HCFA), State Medicaid Manual § 5360(B).

<sup>9</sup>National Health Law Program, *Children's Health Under Medicaid - A National Review of Early and Periodic Screening, Diagnosis and Treatment*, August 1998.

The second area this report addresses is the requirements of a comprehensive mental health screening and descriptions and discussion of best practices used to effectively identify mental health concerns. This section provides an examination of problems with the state's mental health-screening protocol. It also provides a detailed and comprehensive description of an effective mental health-screening protocol, which is designed to identify a more accurate yield of mental health problems for this population.

Third, the report provides a limited discussion of the mental health treatment services and a critical analysis of the data and methodology used by the DHS to collect data. Although treatment is an important function of this program, this agency could not commit the necessary time and resources to complete a comprehensive review of this section. However, this section of the report does describe some concerns with the treatment component.

Fourth, the report provides recommendations to address the concerns identified through this agency's review of the EPSDT program. Recommendations include improving the informing and outreach processes, strengthening the mental health-screening protocol function, improving the data-collection system, and improving collaboration with health care providers and the DHS. A pilot project is also recommended. It would include the use of standardized mental health-screening tools and effective health history, and the collection of data to determine its effectiveness.

The Office of Ombudsman believes that the performance of the EPSDT program can greatly improve in its capacity to provide preventive and early intervention mental health care. Systematic changes must occur to improve the performance of this program. The agency believes its recommendations can contribute to making the EPSDT program more effective for children, adolescents, and their families.

## II. ADMINISTRATIVE SERVICES

One of the keys to a successful Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is ensuring that Medicaid-eligible children and adolescents are fully informed about the benefits of this program. Ensuring access to EPSDT preventive mental health services can only occur when families are aware that the program exists. The purpose of administrative services under EPSDT is to provide families with information about the program, reach out to families and providers, and support families through the health care system.

This section of the report describes administrative services, explains Minnesota's implementation of administrative services, and provides an in-depth analysis with proposed solutions.

Administrative services includes the following services:

- **Informing and Support Services:** Informing families about EPSDT services and assisting families to access these services.
- **Provider Outreach:** Recruiting and training providers for the EPSDT program.
- **Community Outreach:** Coordinating EPSDT services with related programs and targeting outreach to at-risk groups.

In Minnesota, administrative services, including informing, support services, and outreach, are the responsibility of local human service agencies.<sup>10</sup> Each county has an EPSDT coordinator, who coordinates all administrative services in his/her county. Local human service agencies are allowed by Minnesota rules to contract these services to other entities.<sup>11</sup> Many local human service agencies contract with local public health agencies in their counties. However, the initial informing of EPSDT generally remains the responsibility of local human service agencies. County financial workers of the local human service agencies perform this initial informing function during the public assistance-eligibility determination process.

Any contract for administrative services must be approved by the Department of Human Services (DHS).<sup>12</sup> The model contract developed by the DHS has five main objectives:

- Objective 1: "Inform families and/or children under 21 who are eligible for [EPSDT] services about the program."
- Objective 2: "Provide assistance for families and children to access [EPSDT] services."
- Objective 3: "Identify families and children who decline [EPSDT] services."
- Objective 4: "Coordinate [EPSDT] services with related programs."
- Objective 5: "Recruit and train local providers about the [EPSDT] program."<sup>13</sup>

Objectives one through three are the responsibilities of the EPSDT coordinator for informing and support services. Objectives four and five are the requirements for community and provider outreach.

Under each objective, activities that are required must be performed by each county coordinator. When drafting the contract, the county coordinator must describe the methods that will be used to complete each activity. The evaluation component of the contract consists of statistics that are collected annually, including the number of Medicaid-eligible children and adolescents, outreach contacts, families requesting support services, screenings completed, referrals made, provider contacts, collaborative activities, and written agreements.

<sup>10</sup>Minn. R. 9505.1727 - .1733 and Minn. R. 9505.1745.

<sup>11</sup>Minn. R. 9505.1748 (Including county public-health nursing service, a community health clinic, a Head Start agency, a community action agency, or a school district.), 1998.

<sup>12</sup>*Ibid.*

<sup>13</sup>MN Department of Human Services Bulletin, 1998 C&TC Administrative Services Contracts/Plans Are Due November 15, 1997 (#97-15-1), September 19, 1997.

## A. Informing and Support Services

Under federal law, states are required to inform all Medicaid-eligible children and adolescents under age 21 that EPSDT services are available.<sup>14</sup> States must provide “a combination of written and oral methods designed to inform effectively all EPSDT-eligible individuals (or their families) about the EPSDT program.”<sup>15</sup> The Health Care Financing Administration<sup>16</sup> (HCFA) State Medicaid Manual provides guidance on how informing activities should be implemented by states.<sup>17</sup> The manual suggests that a combination of face-to-face, oral and written informing activities is most productive. The informing should occur in clear and non-technical terms and include information about (1) the benefits of preventive health care, (2) the services available under EPSDT as well as where and how to obtain services, and (3) necessary transportation and scheduling assistance that is available.<sup>18</sup> Informing must occur within 60 days of the date eligibility is determined, and eligible individuals must be informed of whether the services are provided without cost.<sup>19</sup>

A written notice must be sent to families informing them of the child’s next periodic screening.<sup>20</sup> These notices must be sent at the following ages: 6 months, 1 year, 18 months, 2 years, 4 years, and every 3 years after age 4.<sup>21</sup> The local agency must send an annual notice to families whose children have never been screened informing them that the child is eligible for screening.<sup>22</sup>

States must also provide support services to EPSDT recipients, which include transportation and scheduling assistance. All EPSDT clinics must notify families that the local human services agencies can provide names and addresses of treatment providers and help with appointment scheduling and transportation.<sup>23</sup> Before each due date of a child’s periodic examination, families must be offered both transportation and scheduling assistance.<sup>24</sup>

### 1. Implementation

In most Minnesota counties, the initial informing of families about EPSDT services is the responsibility of county

financial-intake workers.<sup>25</sup> Depending on the type of public assistance for which a person is applying, there are two separate application processes. One process is the short-form process, which can only be used when applying for MinnesotaCare<sup>26</sup> and Medical Assistance. A person can fill out the short-form application and mail it to the county for processing. No interview with a county worker is necessary. Under the short-form process, the state fulfills its obligation to initially inform the client of EPSDT by attaching an EPSDT brochure to the form. The EPSDT brochure provides basic information regarding the benefits of the program.

Alternatively, the long-form process must be used if a person is applying for other public assistance beyond Medical Assistance and MinnesotaCare. If a person uses the long form, he or she must have an interview with a county financial worker. Under the long-form process, the state fulfills its obligation of initially informing the client of EPSDT by the intake worker giving a brochure and verbally explaining the service to the applicant.

Further, under the short- and long-form process, the applicants must decide whether they want any child in the family to receive a screening. If the applicant marks the form “no,” the EPSDT coordinator cannot provide additional information to the family until the child’s next scheduled periodic screening. However, if the applicant answers “yes” or “?”, additional outreach activities by the EPSDT coordinator are automatically triggered.

The computer tracking system, “Catch 2,” automatically generates an introductory letter and sends it to families that mark “yes” or “?” on the Medical Assistance application.<sup>27</sup> The introductory letter explains EPSDT services and offers support services to the family, including assistance in scheduling appointments and transportation for screenings and referrals. The counties interviewed also make follow-up telephone calls after sending the introductory letters and provide the families lists of local EPSDT providers. If the family asks for information or assistance not related to EPSDT, the coordinator will generally refer the person to other county programs. The “Catch 2” system also generates

<sup>14</sup>42 U.S.C. § 1396a(a)(43)(A)

<sup>15</sup>42 CFR § 441.56(a)(1).

<sup>16</sup>The Health Care Financing Administration of the United States Department of Health and Human Services is responsible for the administration of the Medicaid program at the federal level. HCFA promulgates regulations, which interpret the Medicaid statute and govern administration of the program. It also issues various guidelines that implement these regulations and statute. These guidelines are primarily in the State Medicaid Manual, *An Advocate’s Guide To The Medicaid Program*, National Health Law Program, July 1991.

<sup>17</sup>HCFA, State Medicaid Manual § 5121

<sup>18</sup>*Ibid.* § 5121(C).

<sup>19</sup>42 CFR § 441.56(a)(4); Minn. R. 9505.1727.

<sup>20</sup>Minn. R. 9505.1727.

<sup>21</sup>*Ibid.*

<sup>22</sup>*Ibid.*

<sup>23</sup>Minn. R. 9505.1730.

<sup>24</sup>*Ibid.*, HCFA, State Medicaid Manual § 5140(C).

<sup>25</sup>A county financial intake worker is the person responsible for collecting all financial and other information from families to determine eligibility for public assistance.

<sup>26</sup>MinnesotaCare is a state- and federally-funded program that primarily covers families with children whose income does not exceed 275 percent of the federal poverty guideline and adults without children whose income does not exceed 175 percent of the federal poverty guideline. The Minnesota Department of Human Services, *MinnesotaCare Health Care Reform Waiver, B1115 Waiver Amendment Request, Phase 2*, June 1998.

<sup>27</sup>The “Catch 2” system is a statewide standardized computer system that tracks all new eligible enrollees, all scheduled periodic screenings, and health plan/provider screening data. The Department of Human Services distributed the “Catch 2” system to all 87 counties in 1997.

reminder letters for recipients who have periodic screenings coming up. These reminder letters for upcoming periodic screenings are sent to participating and non-participating families. Some counties also follow up with telephone calls after sending the reminder letters.

In addition, the "Catch 2" system generates listings of any referrals made as a result of a screening.<sup>28</sup> After the referral is made, the EPSDT coordinator makes another offer of assistance with appointment scheduling and transportation for the referral. After the offer of assistance is completed, the coordinator does not have further contact with the family until the next periodic screening.

## 2. Analysis

Informing families about EPSDT during eligibility interviews seriously undermines the effectiveness of the program. "Adding EPSDT to the list of complex eligibility topics creates 'confusion, anxiety and information overload-inescapable by-products of an eligibility determination process.'"<sup>29</sup> Families requesting county assistance are often in crisis situations and are not ready to learn about preventive health care.

The county coordinators interviewed reported that training of financial intake workers has occurred, but they are still not convinced that informing has improved significantly, and they feel informing still varies greatly. Of greater concern are families who complete the Medical Assistance short forms. A brochure for EPSDT is attached to this form, but no person-to-person informing occurs. Under this method, families are even less likely to have full information about the program and are more likely to refuse EPSDT services. Regardless of the type of Medical Assistance form, initial informing should be conducted outside of the initial eligibility determinations. County coordinators who have a thorough knowledge of the program and preventive health care should inform the families.

Nationally, many states have taken EPSDT informing outside of the initial Medicaid enrollment process by contracting out the responsibility to maternal and child health agencies (such as state or local health departments), community groups, or private agencies.<sup>30</sup> Most of these state programs are characterized by person-to-person contact, not paperwork, to provide information.<sup>31</sup> In Minnesota, most of the informing and outreach activities are the responsibilities of the county coordinators, so it may not be a difficult transition for the coordinators to provide initial informing of the program along with their other informing and outreach duties.

Otter Tail County has already taken some initial steps to remove initial informing from the Medicaid-eligibility determination process. A member of the EPSDT coordinator's staff is stationed at the local human services office every day to speak to families who mark "yes" or "?" on the form. The financial intake workers are trained to encourage families to mark at least a "?" on the form, so the family can receive more information from the EPSDT coordinator stationed at the site. The Otter Tail County Coordinator reported that 50 percent of the families initially mark a "?," but after the face-to-face outreach, approximately 30 percent to 40 percent of the "?" are converted to a "yes" on the form. The Otter Tail County program has had some success in increasing family participation in the EPSDT program. However, it should be noted that if a family completes a short form, still no person-to-person informing occurs.

It should be noted that as of January 1999, the initial informing responsibility has been transferred to EPSDT county coordinators. This agency will continue to monitor the initial informing activities to ensure that families are adequately informed about the program.

## B. Provider Outreach

States are responsible to recruit and train local health care providers about the EPSDT program.<sup>32</sup> States are required to take advantage of all resources to deliver EPSDT services in order to ensure a broad health-care provider base to meet the needs of Medicaid-eligible children and adolescents.<sup>33</sup> Federal law prohibits states from limiting EPSDT health care providers to only those who are able to deliver all EPSDT services.<sup>34</sup>

### 1. Implementation

In Minnesota, EPSDT county coordinators are responsible for provider outreach. The outreach generally consists of providing information on the different components of a screening and providing technical assistance on billing issues. The coordinators also share information regarding training opportunities offered by the Minnesota Department of Health.

The Department of Human Services has taken some steps to increase provider compliance and address periodicity schedule issues. The DHS has implemented an incentive payment in the 1999 health plan contracts to increase provider participation and compliance. Also, in 1995 the DHS surveyed providers about barriers to the EPSDT

<sup>28</sup>The referral information is gathered from Box 24H on the HCFA 1500 form.

<sup>29</sup>Jane Perkins, National Health Law Program, and Susan F. Zinn, Texas Rural Legal Aid, *Toward A Healthy Future - Early and Periodic Screening, Diagnosis, and Treatment For Poor Children*, April 1995 (hereinafter *Toward A Healthy Future*), p.42, quoting National Governor's Association, *MCH Update State Coverage Of Pregnant Women And Children*, July 1992, pp. 16, 32.

<sup>30</sup>*Toward A Healthy Future*, *supra* n. 28, quoting National Governor's Association, *MCH Update State Coverage Of Pregnant Women And Children*, July 1992, Table 1.

<sup>31</sup>*Ibid.*, p.47.

<sup>32</sup>MN Department of Human Services Bulletin, *1998 C&TC Administrative Services Contracts/Plans Are Due November 15, 1997* (#97-15-1), September 15, 1997.

<sup>33</sup>HCFA, *State Medicaid Manual* § 5220(A).

<sup>34</sup>42 U.S.C. § 1396d(r).

program and convened an expert panel with the Minnesota Department of Health to discuss EPSDT screening components. An ongoing dialogue has resulted in continued updates to the EPSDT periodicity schedule.

## 2. Analysis

Some of the coordinators and health plan representatives interviewed shared concerns about the lack of interest by physicians in EPSDT and felt that without physician buy-in, the program would never work. The coordinators and health plan representatives indicated that many physicians felt the periodicity schedule<sup>35</sup> was too strict and, consequently, would not follow it. Other physicians just simply failed to follow the billing guidelines.<sup>36</sup> DHS staff indicated that physicians have little incentive to follow the billing guidelines for an EPSDT screening because the physician is paid for the specific components, regardless of whether it is a full screening.<sup>37</sup> Several coordinators indicated that reaching out to providers is their top priority.

The DHS must provide leadership and direction for increasing provider compliance with the EPSDT program. A theme throughout the agency's interviews is the lack of provider buy-in and compliance with the program. Some initial steps have been taken by DHS to address billing, provider compliance and periodic schedule concerns. However, significant concerns still remain regarding many of these issues. DHS must have a continuing dialogue with all stakeholders in the system to reach consensus on these issues.

## C. Community Outreach

Through community outreach, states must coordinate the EPSDT program with other agencies and programs, which includes WIC (a supplemental food program for Women, Infants, and Children), Maternal and Child Health Title V block grant programs, Head Start, and schools. States are also urged to target specific outreach activities to at-risk groups, such as mothers with babies, adolescents, newly eligible recipients, and those who have not used the program for over two years.<sup>38</sup> The manual encourages state flexibility, but the outreach activities must be effective in providing every EPSDT-eligible child or adolescent with basic information necessary to gain access to EPSDT services.<sup>39</sup>

The following provides a brief discussion of how different states have coordinated related agencies and programs with EPSDT, why coordination should occur, and how Minnesota has coordinated the related programs with EPSDT.

## 1. Women, Infants, and Children (WIC)

Coordination with the WIC program is required under EPSDT regulations.<sup>40</sup> EPSDT programs must give information about WIC and referrals to all Medicaid recipients who are pregnant women, postpartum women, breastfeeding women, and children under the age of 5.<sup>41</sup> Some states have developed mutual referral systems between the two programs. In addition to mutual referral systems, a few states are actively coordinating EPSDT and WIC by offering "one-stop shopping" for benefits, clarifying the importance of WIC in EPSDT-provider manuals, and establishing toll-free hot lines for information about the whole range of services.<sup>42</sup>

In Minnesota, coordination with WIC generally includes sharing EPSDT information and brochures with WIC staff and providing an EPSDT reminder in the WIC newsletter on a periodic basis. However, two counties interviewed provide more aggressive outreach. One county provides face-to-face outreach at WIC sites by standing in the WIC site lobby periodically and providing information on EPSDT, providing immunizations, and answering health-related questions. Another county has established a mutual referral system with the WIC program. At initial enrollment and at every WIC certification, families are asked about well-child care and are referred to EPSDT if on Medicaid. If the child receives a screening at the public health clinic, the child's EPSDT and WIC files are combined into one file.

## 2. Maternal Child Health (MCH)

EPSDT programs must coordinate services with Maternal Child Health (MCH) programs.<sup>43</sup> MCH programs are administered jointly by the federal and state governments.<sup>44</sup> States may use these grants for the following purposes:

1. Improving access to quality maternal and child health services to those with low income or who lack access to health services

<sup>35</sup>The "periodicity schedule" is a standardized schedule indicating the frequency that medical screenings must occur. The screens must be "provided at intervals which meet reasonable standards of medical . . . practice, as determined by the State after consultation with recognized medical . . . organizations involved in child health care." 42 U.S.C. § 1396d(r)(1)(A)(i) and HCFA, State Medicaid Manual § 5140(A).

<sup>36</sup>The problems surrounding provider compliance with the periodicity schedule did not include the mental health component. However, our agency realizes that for mental health screenings to occur, the program, as a whole, must work.

<sup>37</sup>It should be noted that some health plans provide incentives to providers for complete screenings. However, providers have indicated that the screening reimbursement rate along with the incentive equals the amount of the fee-for-service rate. One health plan responded by stating that the clinic's overall reimbursement for all services (the monthly capitated rate) is more than the reimbursement the providers would receive under fee-for-service.

<sup>38</sup>HCFA, State Medicaid Manual § 5121(A), 5121(B).

<sup>39</sup>HCFA, State Medicaid Manual § 5123.1(B).

<sup>40</sup>42 U.S.C. § 1786.

<sup>41</sup>42 U.S.C. § 1396a(a)(53); 42 C.F.R. § 431.635(c)(2).

<sup>42</sup>*Toward A Health Future*, supra n. 28, citing HCFA, *Medicaid National Summary Of Early And Periodic Screening, Diagnosis And Treatment (EPSDT) Program* (describing activities in Oregon, Washington, Wisconsin, and Wyoming), September 1993, pp. 22-29.

<sup>43</sup>HCFA, State Medicaid Manual § 5230.1.

<sup>44</sup>42 U.S.C. § 701; 42 C.F.R. § 51a.

2. Reducing infant mortality
3. Reducing preventable diseases and need for institutional services
4. Providing preventive and primary care
5. Providing rehabilitation and coordination of care services for children with special health-care needs.<sup>45</sup>

The EPSDT program and MCH programs must have a written agreement that provides maximum utilization of services available under the MCH programs and that utilizes MCH grantees to develop more effective use of Medicaid resources.<sup>46</sup> The goal of EPSDT-MCH agreements is to improve the health status of children by ensuring the provision of preventive services, health examinations, and the necessary treatment and follow-through care.<sup>47</sup>

Generally, in Minnesota, maternal and child health programs consist of home visits for at-risk mothers and children and pregnant teen/teen mother classes. EPSDT information is provided to families during the home visits and classes. One county indicated that in the past, their home-visiting nurses provided EPSDT screening during the home visits. However, the program had to be discontinued due to lack of funding.<sup>48</sup>

### 3. Head Start

Head Start programs provide “comprehensive health, educational, nutritional, social, and other services to economically disadvantaged children and their families.”<sup>49</sup> The EPSDT program should coordinate with Head Start since they share the same child health and developmental goals.<sup>50</sup> Approximately 50 percent of Head Start families are also Medicaid families.<sup>51</sup> Nationally, EPSDT programs have taken different approaches to coordinating with Head Start programs. In one state, Head Start providers receive orientation sessions on Medicaid eligibility and can assist parents with filing Medicaid applications and explain the benefits of EPSDT.<sup>52</sup>

In Minnesota, coordination with Head Start varies considerably. One county has very little contact with Head Start staff. The coordinator indicated that Head Start showed little interest in EPSDT, and the coordinator did not know whether the Head Start program had current EPSDT information. Through interviews, the reviewers learned that most counties provide EPSDT information to Head Start staff. However, two county coordinators interviewed stated

that the Head Start program actually provides part of the EPSDT screening. Head Start staff will provide the hearing, vision, and developmental screening and send this information to the child’s primary clinic for the clinic to complete the screening by providing the physical exam.

### 4. Schools

The HCFA manual provides that there is no single “best” way for schools to relate to EPSDT; however, it does provide that schools and EPSDT programs should be coordinated with services provided in the school.<sup>53</sup> “Schools can be a focal point from which to identify children with problems, to increase students’ access to both preventive and curative health services, and to ensure appropriate use of health care resources.”<sup>54</sup>

In Minnesota, coordination with schools generally includes providing EPSDT information to the school nursing staff. In Saint Paul, some of the schools actually provide EPSDT screenings in the school.

### 5. At-Risk Populations

The State Medicaid Manual urges states to target at-risk groups, such as mothers with babies, adolescents, newly eligible recipients, and those who have not used the program for over two years. One at-risk group that has been successfully targeted by some states is non-users of the EPSDT program.<sup>55</sup> Under a typical non-user outreach program, a “tickler system” is used to notify local human service agencies on a monthly basis of each child due for a screen in the following month. The county agency is responsible for tracking the children and identifying children who have missed screening appointments or did not show for follow-up care. Children who miss an appointment or follow-up care are referred to an outreach coordinator.

In Minnesota, the computer tracking system, “Catch 2,” automatically generates a monthly report indicating each child and adolescent that has a screening due the following month. However, we are not aware of any county following up on missed screening appointments or missed follow-up care. Ramsey County is currently considering targeting outreach to children under age 2 that have no identified screening in the “Catch 2” system, but it is not clear whether the outreach will include following up on missed appointments or missed follow-up care.

<sup>45</sup>42 U.S.C. § 701(a)(1).

<sup>46</sup>HCFA, State Medicaid Manual § 5230.1.

<sup>47</sup>*Ibid.*

<sup>48</sup>The home screening program was paid for through county funds, not Medical Assistance.

<sup>49</sup>42 U.S.C. § 9831(a).

<sup>50</sup>*Toward A Healthy Future*, *supra* n. 28, p. 134.

<sup>51</sup>*Ibid.*

<sup>52</sup>*Toward A Healthy Future*, *supra* n. 28, p. 135, citing National Governor’s Association, *Caring For Kids*. 1991, p.26.

<sup>53</sup>HCFA, State Medicaid Manual § 5230(2)(A).

<sup>54</sup>*Ibid.*

<sup>55</sup>National Health Law Program, *Children’s Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment*, August 1998; Colleen Bridger and Laura Kirby, *An Evaluation of the Health Check Program in North Carolina*, September 24, 1997, pp. 14-15; Joseph Tiang-Yau Liu, *Children’s Defense Fund, Increasing the Proportion of Children Receiving EPSDT Benefits: A South Carolina Case Study*, July 1990, pp. 11-14.

Some EPSDT coordinators have also considered other outreach activities that target particular at-risk groups. For example, the Northeast Regional Workgroup<sup>56</sup> is currently working on an outreach project that will target 11-13 year olds with an EPSDT promotion project. The workgroup will collect data and evaluate the program to see whether the program increased the number of screenings within the targeted age group. This is the first effort by this workgroup to target one group and evaluate the results. Another example of targeted outreach is Otter Tail County, which is currently working on a project that will target sixth graders. The Otter Tail county coordinator is working with the schools to coordinate a mailing to families about EPSDT.

## 6. Analysis

There is no comprehensive, coordinated statewide EPSDT outreach plan. With decentralized outreach, there is the potential of great variability in the quality of outreach by counties, and it was learned that there is variability at the county level.<sup>57</sup> For example, the coordination with the WIC program varied from providing EPSDT information in the local WIC newsletter to mutual referral lists between the programs and aggressive face-to-face outreach at WIC sites. A comprehensive, coordinated statewide outreach program could provide leadership and focus for local campaigns. A coordinated outreach program would allow DHS to gather information on the more effective county outreach strategies and facilitate replication of these strategies statewide. In October 1998, the DHS published its new EPSDT coordinator's handbook, which included a section on innovative ideas. However, no plan is in place to facilitate replication of these ideas.

A statewide outreach program could have the ability to bring together resources for larger outreach campaigns, such as media campaigns and targeted outreach projects that a single local agency may have difficulty doing alone. Currently, there are several EPSDT regional workgroups with representatives from counties and health plans, which could be utilized by the DHS in developing regional/statewide campaigns.<sup>58</sup> One outreach project that could be considered on a regional or statewide basis would be targeting non-users of EPSDT.<sup>59</sup>

A statewide program could also facilitate more effective outreach by establishing statewide outcomes for local outreach campaigns. The DHS' current contract is process based and requires county coordinators to describe the methods used to complete particular tasks, but does not require the coordinators to actually produce positive outcomes for the program. A September 19, 1997 DHS bulletin indicates that they would be moving to outcomes-

based contracting for EPSDT in 1999, but the reviewers have since learned the Department has ruled out this possibility. The Office of Ombudsman believes that the DHS must facilitate the development of outcome measures to ensure that all outreach and informing efforts are effective.

In addition, a statewide program could facilitate more effective outreach by establishing better monitoring and evaluation for local outreach campaigns. The monitoring and evaluation of outreach and informing activities consists only of collecting broad general data regarding the number of screens, referrals, informing contacts, collaborative activities, etc., but does not require an evaluation of whether specific outreach or informing activities actually increased the number of screenings. The Northeast Workgroup is currently working on an outreach project to target 11-13 year olds. Part of this project is an evaluation component to ascertain whether the targeted outreach actually increases awareness and the number of screenings that occur. The county coordinator interviewed from the Northeast Region indicated that this project is the first targeted effort with an evaluation component attempted in the area. DHS must provide more leadership, support, and encouragement to local outreach efforts in evaluating their outreach efforts.

## D. Summary

The goal of administrative services is for every family on Medicaid to know about the valuable benefits of EPSDT. The reviewers have identified several ways that the DHS can improve the administrative services component to meet this goal, including:

- Removing the initial informing process out of the eligibility determination process.
- Encouraging leadership and direction by the DHS on providers' buy-in and compliance issues.
- Establishing a comprehensive, coordinated statewide EPSDT outreach plan.

The Office of Ombudsman encourages the Department of Human Services and other stakeholders to actively promote these ideas for effective change to the EPSDT program.

## III. MENTAL HEALTH-SCREENING PROTOCOL

Prevention and early identification of mental health concerns is important for the well being of children and adolescents. It is important to note that the mental health concerns of Medicaid-eligible children and adolescents are

<sup>56</sup>The regional workgroups consist of representatives from counties, health plans, providers, and DHS. The workgroups' purpose is to discuss the current problems with how EPSDT is implemented and how it can be improved.

<sup>57</sup>HCFR, *Medicaid National Summary Of Early And Periodic Screening, Diagnosis And Treatment (EPSDT) Program* (noting problems with informing activities so "decentralized"), September 1993, p. 5.

<sup>58</sup>The Northeast Workgroup is currently working on a targeted outreach project for 11-13 year olds. The metro workgroup worked on a media campaign, but it has been denied by the Department of Human Services.

<sup>59</sup>Discussion under "At-Risk Populations" section.



considerably higher than the general population of children and adolescents. This section of the report provides:

- Collection of research that represents the remarkable prevalence of mental health concerns for Medicaid-eligible children and adolescents.
- Effective mental health-screening protocol, which includes the use of standardized mental health-screening tools and a comprehensive health history.
- Description of and problems with the Department of Human Service's and the Department of Health's screening tools.
- Examples of standardized mental health-screening tools.
- Descriptions of various locations that perform EPSDT screenings and the impact these locations have in identifying the mental health concerns of children and adolescents.

The following research illustrates the significant prevalence and therefore the need for strong preventive mental health measures for this population.<sup>60</sup>

Rowter and Goodyear noted that stressful life events increase the relative risk of psychiatric disorders by three to six times.<sup>61</sup> Rae-Grant noted that family problems and parental problems add to risk for mental disorders, including maternal psychiatric disorders and admission into care of a local authority.<sup>62</sup> Several of these factors are common in many children on Medicaid.<sup>63</sup> When two of the factors occur together, the level of risk of psychiatric disorders goes up by a factor of four. In addition, with the presence of more than two factors, the risk becomes even several times higher.<sup>64</sup>

Raadal reviewed 890 low-income children from among Seattle public school students, aged 5 through 11 years old.<sup>65</sup> Thirty-one percent of these children were noted to have evidence of behavioral problems that needed professional treatment, which is a significantly higher proportion than the 18 percent noted in the general population.<sup>66</sup> Zahner noted that in a study of 822 children, ages 6 to 11, in a metropolitan center when reports of parents and teachers were combined, 38.5 percent of the children were noted to be at risk of psychiatric disturbances.

Problems are even more significant in foster-care children on Medicaid. Stein noted that in a population of 248

foster-care children, ages 4 to 16 years, 41 percent to 62 percent of the children had psychiatric abnormalities.<sup>67</sup> Thompson and Fuhr found that 60 percent to 80 percent of their population of children, ages 6 to 18, had evidence of psychiatric abnormality based on the Child Behavior Checklist and other screening instruments.<sup>68</sup> Frank noted that of 50 children, ages 6 to 12 years, 79 percent to 91 percent were noted to be severely impaired.<sup>69</sup> Swire and Kavalier described 96 percent of 179 children, ages 1 to 15 years, as showing psychiatric impairment, with 35 percent being markedly to severely impaired.<sup>70</sup>

Children on Medicaid in homeless families are also noted to be significantly impaired. Zima noted that the vast majority (78 percent) of homeless children suffered depression, behavioral problems, or severe academic delays.<sup>71</sup>

This research illustrates the significant prevalence of mental health issues among low-income children and adolescents and the need for prevention and early identification. However, the DHS data indicates that only a small percentage of the children who received an EPSDT screening are being identified as having evidence of mental health concerns. In 1995, DHS data accounted for 55,501 children and adolescents that received an EPSDT screening, but no more than 4.6 percent were possibly referred for mental health concerns. Under the Fee-for-Service Program, 34,085 children and adolescents received an EPSDT screening, but only 1,825 or 5 percent were identified to have mental health problems. Health plans screened 21,416 children and adolescents, with no more than 702 or 3.3 percent possibly identified as having mental health problems.

Four areas were found that may contribute to this under-identification of mental health concerns in children and adolescents. These areas include:

- Ineffective mental health screenings.
- Ineffective health histories.
- Insufficient time allowed to conduct and complete a comprehensive screening and health history.
- Private medical clinics being the primary location for mental health screening.

<sup>60</sup>W. Dikel's unpublished research, supra n.4. (A significant portion of the following research was collected by the agency's consulting child psychiatrist.)

<sup>61</sup>Rowter, M., *Epidemiologic Longitudinal Strategies in Ca*; Goodyear, I. et al., *The Impact of Recent Undesirable Life Events on Psychiatric Disorders in Childhood and Adolescence*, British Journal of Psychiatry, 1987, pp. 151, 179-184.

<sup>62</sup>Rae-Grant, N. et al., *Risk, Protective Factors and the Prevalence of Behavioral and Emotional Disorders in Children and Adolescence*, AM.ACAD.Child/Adolesc. Psychiatry, 1989, pp. 28, 263-268.

<sup>63</sup>*Ibid.*

<sup>64</sup>Rutter, M., *Protective Factors in Children's Response to Stress and Disadvantage. Primary Prevention of Psychopathology: Social Competence in Children*, (Vol. 3).

<sup>65</sup>Raadal, M. et al., *Behavior Problems in 5 to 11 Year Old Children From Low Income Families*, J.AMA.ACAD.Child/Adolesc. Psychiatry, 1994, pp. 33, 7: 1017-1025.

<sup>66</sup>*Ibid.*

<sup>67</sup>Stein, E. et al., *Psychiatric Disorders of Children in care: Methodology and Demographics Correlates*, Canadian Journal of Psychiatry, 1994, pp. 39: 341-347.

<sup>68</sup>Thompson, A. and Fuhr, D., *Emotional Disturbance in Fifty Children in the Care of the child Welfare System*, Journal of Social Service Research, 1992, pp. 15: 95-122.

<sup>69</sup>Frank, G., *Treatment Needs of Children in Foster Care*, American Journal of Orthopsychiatry, 1980, pp. 50: 256-263.

<sup>70</sup>Swire, M. and Kavalier, F., *The Health Status of Foster Children*, Child Welfare, 1997, pp. 56:635-653.

<sup>71</sup>Zima et al., *Emotional/Behavioral Problems in Sheltered homeless children in Los Angeles County*, American Journal of Public Health, Vol. 84, #2, February 1994, pp. 260-264.

## A. Mental Health Screening

Health Care Financing Agency (HCFA) requires states to provide a comprehensive health and developmental history-screening program, which includes an assessment of physical and mental health development.<sup>72</sup> This information is obtained from a parent or other responsible adult who is familiar with the child's history.<sup>73</sup>

HCFA does not require screening providers to use any specific instruments to identify developmental problems, but they have established essential principles for providers to consider.<sup>74</sup> Key principles to consider include collecting information about a child's or adolescent's usual functioning patterns from a parent, teacher, or other familiar person.<sup>75</sup> In addition, screenings should be culturally sensitive and valid, and screening providers should consider and use all available information when determining expected developmental range.

Minnesota Rule 9505.1696 defines two types of clinics that provide EPSDT screenings. An "EPSDT clinic" is a facility supervised by a physician that provides EPSDT screenings.<sup>76</sup> Types of clinics that fit this definition would include community health clinics and private clinics. An "EPS clinic" is a nurse-supervised facility that is approved by the Minnesota Department of Health.<sup>77</sup> To be certified by the Department of Health, the clinic must have an EPS clinic coordinator, EPS-trained nurse, EPS laboratory assistant, EPS vision and hearing technician, and EPS clinic assistant.<sup>78</sup> Types of clinics that fit this definition would include public health clinics.

### 1. Physician-Supervised Clinics (EPSDT Clinics)

The Minnesota Department of Human Services EPSDT rule requires physician-supervised clinics to perform a health history and a developmental screen to assess for mental health problems as required by HCFA.<sup>79</sup> Sexual development, chemical use, social, emotional, and mental health status are the types of information screening providers must collect from the child's parent or other adults familiar with the child.<sup>80</sup> Physician-supervised clinics are not required to use standardized mental health-screening tools to assess for mental health problems. Physicians are permitted to use their professional judgements to assess for mental

health problems.<sup>81</sup>

Physician-supervised clinic staff were interviewed to learn how they conduct EPSDT mental health screenings for Medicaid-eligible children and adolescents. This included physicians, a nurse practitioner, registered nurses, and clinic managers. These clinics are located in the Metropolitan Area and Greater Minnesota. Great variability was found in how the practice of mental health assessments occurs across Minnesota.

Physician-supervised clinics did not use standardized mental health-screening tools, and some clinic staff used checklist-screening instruments. One physician that was interviewed asks the child and or parent three questions to determine evidence of mental health problems. The questions are "How are you eating?," "How are you sleeping?," and "Are you vomiting?" Another physician that was interviewed also uses no mental health-screening tools. The nurse practitioner that was interviewed uses a mental health-checklist instrument, but she is interested in more effective mental health-screening tools.

It is highly probable that some physicians may resist suggestions to use standardized mental health-screening tools. Nonetheless, many physicians who depend solely on their clinical judgements without using standardized tools are missing many children and adolescents that have mental health problems.

A study by Costello supports the premise that physicians who solely rely on clinical judgement fail to identify children with mental health problems.<sup>82</sup> Costello used the Child Behavior Checklist to identify the prevalence of psychiatric disorders in children, ages 7 to 11 years, visiting their primary care physician.<sup>83</sup> Twenty-four percent of the children were noted to have evidence of mental health problems.<sup>84</sup> However, only 3.6 percent of the children had received a mental health referral from their primary care physician.<sup>85</sup>

Costello also used the Child Behavior Checklist to identify the prevalence of mental health problems in children, ages 7 to 11 years, that had visited their pediatrician.<sup>86</sup> He found that 25 percent of the children had mental health problems.<sup>87</sup> In contrast, the children's

<sup>72</sup>42 U.S.C. § 1396d(r)(1)(B). HCFA, State Medicaid Manual § 5123(2)(A).

<sup>73</sup>HCFA, State Medicaid Manual § 5123.2(A)(1)(a).

<sup>74</sup>*Ibid.* § 5123.2(A)(1)(b).

<sup>75</sup>*Ibid.*

<sup>76</sup>Minn. R. 9505.1696, Subp. 8.

<sup>77</sup>Minn. R. 9505.1696, Subp. 6.

<sup>78</sup>Minn. R. 4615.1200.

<sup>79</sup>Minn. R. 9505.1718, Subp. 2.

<sup>80</sup>*Ibid.*

<sup>81</sup>Minn. R. 9505.1718, Subp.9.

<sup>82</sup>Costello, E. et al., *Psychiatric Disorders In Pediatric Primary Care*, Archives of General Psychiatry, Vol. 45, December 1998, pp. 1107-1116, and Costello, E. et al., *Psychopathology in Pediatric Primary Care: The New Hidden Morbidity*, Pediatrics Vol. 82, #3, September 1988, pp. 415-424.

<sup>83</sup>*Ibid.*, *Psychiatric Disorders In Pediatric Primary Care*, Archives of General Psychiatry, Vol. 45, December 1998, pp. 1107-1116.

<sup>84</sup>*Ibid.*

<sup>85</sup>*Ibid.*

<sup>86</sup>Costello, E. et al., *Psychopathology in Pediatric Primary Care: The New Hidden Morbidity*, Pediatrics Vol. 82, #3, 415-424, (September 1988).

<sup>87</sup>*Ibid.*

pediatricians did not identify 83 percent of these cases.<sup>88</sup> Costello was concerned about the low sensitivity (17 percent) of the pediatrician's identification of mental health problems in their patients.<sup>89</sup>

## 2. Nurse-Supervised Clinics (EPS Clinics)

The Minnesota Department of Health (MDH) EPSDT rule requires nurse-certified clinics to conduct a health history and developmental screen to assess mental health problems. These clinics are required to use a specific standardized screening tool, the Denver Developmental screening tool, or receive MDH approval to use an alternative standardized screening tool.<sup>90</sup>

Many of the nurse-supervised clinics that were interviewed used the screening instrument recommended by the MDH, along with various other mental health checklist-instruments. However, research indicates that the Denver Screening tool does not adequately screen for mental health problems (the problems of this tool will be discussed later in the report). The clinics that were interviewed were interested in screening tools that would more accurately identify the mental health problems of children and adolescents. All the practitioners that were interviewed expressed interest in and supported the use of more effective screening tools to detect evidence of mental health problems.

## 3. Elements of Effective Mental Health-Screening Tools

Screening tools are fundamental in identifying mental health problems in children and adolescents. Effective mental health-screening tools have certain qualities that make it possible for them to accurately identify evidence of mental health concerns in children and adolescents. The following is a list of such qualities that constitute an effective screening tool:

- Sensitivity
- Specificity
- Reliability
- Validity
- Rapid administration

- Multiple sources of information

The ideal screening tools are both sensitive and specific. Sensitivity refers to the ability of the screening tool to be sensitive enough to identify as many of the problems as are present.<sup>91</sup> Thus, 95 percent sensitivity would indicate that the tool identifies 95 percent of the individuals who have a disorder. Specificity means that if a disorder is identified, the individual actually has the disorder.<sup>92</sup> If the tool is overly sensitive and has low specificity, children will be identified who do not actually have a disorder.<sup>93</sup> However, screening tools need to be sensitive enough to not overlook children and adolescents that have mental health disorders.

Screening tools also need to be reliable and valid. Reliability refers to the issue of whether different raters will reach the same conclusions given the psychopathology.<sup>94</sup> Validity refers to whether the screening tool actually identifies the problem in question. Research indicates that for a tool to be reliable and valid, it needs to be tested on a large number of individuals with known diagnoses in order to ensure that the symptoms identified are of predictive value.

There are many standardized mental health-screening tools available that have demonstrated effectiveness in identifying evidence of mental health problems for children and adolescents.<sup>95</sup> However, given the time constraints of clinics and other sites performing EPSDT screenings, the screening tools must be able to be administered quickly and efficiently.<sup>96</sup>

The screening tool must also obtain information about the child or adolescent from multiple sources. Screening for mental health problems in children is more complex than for health problems.<sup>97</sup> This is because there are varying perceptions among different individuals about the child's or adolescent's problems, as well as different manifestations of these problems in various settings. For example, a child may have serious problems at school, whereas the child may only have mild problems in the home.

Kashami noted that parents are more likely than the child to report disruptive or externalizing behaviors, such as restlessness, inattention, impulsiveness, oppositionality, or aggression.<sup>98</sup> Conversely, children may be more likely to report anxious or depressive feelings and symptoms, including suicidal thoughts and acts, of which the parents may be unaware.<sup>99</sup> Verhulst compared the Teacher Rating Form (TRF) to the parent report on the Child Behavior Checklist (CBCL).<sup>100</sup> The authors noted that teachers'

<sup>88</sup> *Ibid.*

<sup>89</sup> *Ibid.*

<sup>90</sup> Minn. R. 4615.1100, Subp.3G.

<sup>91</sup> W. Dikel's unpublished research, *supra* n.4.

<sup>92</sup> *Ibid.*

<sup>93</sup> *Ibid.*

<sup>94</sup> *Ibid.*

<sup>95</sup> "Examples of Mental Health-Screening Tools" section.

<sup>96</sup> Bazelon Center for Mental Health Law, *Managed Mental Health Care Policy: #3 An Evaluation of State EPSDT Screening Tools*, June 1997.

<sup>97</sup> *Ibid.*

<sup>98</sup> G. Kashami et al., *Informant Variance: The Issue of Parent/Child Disagreement* J.AM.ACAD.ChildPsychiatry, 1985, pp. 24: 437-441.

<sup>99</sup> *Ibid.*

<sup>100</sup> F. Verhulst et al., *Differential Predicted Value of Parents' and Teachers' Reports of Children's Problem Behaviors: A Large Juvenile Study*, Journal of Abnormal Child Psychology, Vol. 22, No. 5, 1994.

information was equal to or somewhat better than parent information in predicting later signs of disturbance.<sup>101</sup> Zahner also used the TRF and the CBCL.<sup>102</sup> The authors identified a significant lack of overlap between parent reports and teacher reports in the clinical range of children identified as needing mental health services.<sup>103</sup>

Thus, screening for mental health concerns should ideally be done from a variety of sources, such as parents, teachers, and the child or adolescent. If this is not done, many significant mental health problems may go unidentified in this population.

#### 4. Examples of Mental Health-Screening Tools<sup>104</sup>

There are many standardized mental health-screening tools available that are used to identify mental health concerns of children and adolescents. Some tools will screen for specific concerns such as depression or attention deficit disorder. Others will screen for how the children or adolescents are generally functioning in their environments, instead of a specific diagnostic category.

The following is a list of assorted standardized mental health-screening tools used by mental health professionals. It is important to note that this list is not intended to represent any specific tool but merely provides some examples that illustrate the different types of tools used.

The Child Adolescent Functional Assessment Scale (CAFAS) and the Children's Global Assessment Scale (CGAS) are both scales that focus more on local psychological dysfunction than on specific diagnostic issues. The CGAS is a scale of adaptive functioning adapted from the Global Assessment Scales for Adults.<sup>105</sup> Endicott found that each ten points on the scale is accompanied by descriptions and examples of behavior and functional levels of children typical of that decile and the scores assigned on a continuum.<sup>106</sup> The psychometric characteristics of the CGAS have excellent reliability and validity and are instruments of considerable strength in providing a measure of impairment.

The CAFAS is a multi-dimensional measure of degree of impairment and functioning. Hodges and Wong found this tool to have significant validity and reliability, as well as to have value about poor social relationships, difficulties in school, and problems with the law.<sup>107</sup> This tool measures how youths present themselves in day-to-day functioning and identifies youths who may have behavioral, emotional, or substance abuse problems. It can be used to link student

needs with available services and can be used to assess change over time. This scale is suggested for ages 7 to 17. This scale is not administered, but a trained rater or clinician rates the youth. The scales take approximately ten minutes to fill out.

The Child Behavior Checklist (CBCL) is a frequently used screening tool that has been found effective in many studies. This tool is specific and sensitive and has forms to complete for both parents and teachers. This tool does not have validity scales.

The Behavior Assessment System for Children (BASC) is a screening tool frequently used by mental health professionals in both clinical and special education settings.<sup>108</sup> This tool has an advantage of both validity scales and ability to be administered to adolescents, parents, and teachers. The tool is more time consuming than the more simplified tools, but it yields a significant amount of clinical data in a number of realms of emotion and behavior.

The BASC has a number of scales rating externalizing problems, internalizing problems, and school problems. The externalizing problems include hyperactivity, aggression, and conduct problems. The internalizing problems include anxiety, depression, and somatization. School problems include attention problems and learning problems. There are also scales for atypicality, withdrawal, adaptability, social skills, leadership, and study skills. The BASC has a teacher rating form, a parent rating form, and a child rating form. There is also a preschool version of this screening form.

Personality Inventory for Children (PIC) is another screening tool that has the advantage of having a validity scale. This tool also provides information on a variety of realms. It can be computer-scored and yields valuable data about emotional and behavioral problems in children and adolescents.

There are more specific screening tests for different disorders such as Attention Deficit Hyperactivity Disorder and depression. The Attention Deficit Disorders Evaluation Scale (ADDES) is an example of a test that would help to clarify whether a child has Attention Deficit Hyperactivity Disorders. The Connor Rating Form identifies this problem as well.

#### 5. Minnesota State Screening Tools

This section of the report provides a description and analysis of the type of mental health-screening tools or guidelines that the Department of Human Services (DHS)

<sup>101</sup> *Ibid*

<sup>102</sup> G. Zahner et al., *Children's Mental Health Service Needs and Utilization Patterns in an Urban Community: An Epidemiologist Assessment*, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 31, No. 5, September 1992, pp. 951-960.

<sup>103</sup> *Ibid*.

<sup>104</sup> W. Dikel's unpublished research, *supra* n. 4. (Significant portions of the "Examples of Mental Health-Screening Tools" section is from Dr. Dikel's research.)

<sup>105</sup> Shaffer, D. et al., *A Children's Global Assessment Scale CGAS*, Archives of General Psychiatry, 1983, pp. 40: 1228-1231.

<sup>106</sup> Endicott, J. et al., *The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance*, Archives of General Psychiatry, 1976, pp. 33: 766-771.

<sup>107</sup> Hodges, K. and Wong, M., *Psychometric Care through the Multi-Dimensional Measure to Assess Impairment: A Child and Adolescent Functional Assessment Scale*, Journal of Child and Family Studies, Vol. 5, #4, 1996, pp. 445-467.

<sup>108</sup> *Ibid*.

and the Department of Health (MDH) offer EPSDT-screening providers. These screening tools or guidelines are used to identify the mental health concerns of Medicaid-eligible children and adolescents.

### a. Department of Human Services

Currently, the Department of Human Services (DHS) offers an "Instruction Manual Guidelines for Mental Health Referral" for EPSDT-screening providers. This manual was made available to EPSDT-screening providers in May 1991 and was developed to assist EPSDT-screening providers in completing the mental health-screening component of the EPSDT program. However, this document falls short of being an effective mental health instrument because it does not possess the necessary qualities that constitute a standardized mental health-screening tool.

The manual consists primarily of interview formats that collect information about possible mental health concerns of children and adolescents. However, it is not a standardized mental health-screening instrument. It is not valid, reliable, sensitive, or specific, which are essential qualities that an effective mental health-screening tool must possess if it is to be effective. If EPSDT-screening providers use only this tool, they will miss many children and adolescents that may have mental health concerns.

More recently, the DHS is recommending a modified version of the current Minnesota Student Survey for self-reporting mental health-screening of adolescents and the use of the Pediatric Symptom Checklist (PSCL) for screening children. This agency has concerns about the use of these screening tools to effectively detect evidence of the mental health concerns of children and adolescents, especially the modified version of the Minnesota Student Survey.

The Minnesota Student Survey is a self-report survey instrument developed by the Department of Children, Families, and Learning to collect information from adolescents about aspects of their lives and environment. This is not a mental health-screening instrument; however, the DHS would like to incorporate mental health-type questions into the survey. A problem with this instrument is that students anonymously complete the survey, and there is no available data that indicates how adolescents would complete the survey if they knew that the information would not be anonymous. Another concern is that no other people,

such as parents and teachers, evaluate the child or adolescent, which is an important element of an effective mental health-screening instrument.

The PSCL is a brief checklist generally completed by a parent that reviews various symptoms of mental health problems and psychosocial dysfunction.<sup>109</sup> This checklist has proven to be valid and reliable when compared to the CBCL.<sup>110</sup> The PSCL is as valid and reliable for children from economically disadvantaged and minority backgrounds as it is for middle- and upper middle-class populations.<sup>111</sup>

However, concerns have been raised about the sensitivity of this tool. Jalenek noted that the sensitivity of this tool was 95 percent in middle-class samples, but only 80 percent in lower-class samples.<sup>112</sup> This means that one of five children with mental health problems would be missed with this tool based on this sensitivity.

### b. Department of Health

The Minnesota Department of Health (MDH) requires nurse-supervised clinics to use the Denver Developmental screening tool.<sup>113</sup> This tool is for children from infancy to age 6 as part of EPSDT screening that measures development in four areas: growth, motor, language, fine motor-adaptive, and personal-social.<sup>114</sup> The Denver Developmental screening tool describes various developmental stages in each of these areas and allows the clinician to check the test items on whether the child has passed or not passed the items.<sup>115</sup> For example, if a child at 2 years is not walking backwards or running, this would indicate a developmental delay.<sup>116</sup> This is a very useful tool in defining whether a child may have developmental delays, gross-motor delays or fine-motor skills-adaptive functioning.<sup>117</sup>

However, the Denver Developmental tool is not an adequate tool for mental health screening. The Denver Developmental screening form would pick up the most severe mental health problems, but would miss a number of significant, moderate, or mild mental health difficulties.<sup>118</sup> There are no specific questions for learning problems in preschool or elementary school; difficulties in social interaction; conduct disorders; or general issues of social reciprocity, relatedness to others, organizational skills, psychomotor over-activity, impulsivity, and symptoms of depression and anxiety.<sup>119</sup>

The Denver screening tool is an appropriate tool for screening of gross-motor, language, and fine-motor-adaptive

<sup>109</sup> W. Dikel's unpublished research, *supra* n. 4.

<sup>110</sup> *Ibid.*

<sup>111</sup> Murphy, J. et al., *Screening for Psychosocial Dysfunction in Inner-city Children: Further Validation of the Pediatric Checklist*, *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 31(6), November 1992, pp. 1105-1111, and Murphy, J. et al., *The Family APGAR and Psycho-social Problems in Children: A Report from ASPN and PROS*, *General Family Practice*, 1998, 46 1, 54-54.

<sup>112</sup> Jalenek, M. et al., *The Pediatric Symptom Checklist, Support for use in Managed Care Environment* *Archives of Pediatrics and Adolescent Medicine*, July 1995, pp. (149) (7): 740-746.

<sup>113</sup> Minn. R. 4615.1100, Subp. 3G.

<sup>114</sup> W. Dikel's unpublished research, *supra* n. 4.

<sup>115</sup> *Ibid.*

<sup>116</sup> *Ibid.*

<sup>117</sup> *Ibid.*

<sup>118</sup> *Ibid.*

<sup>119</sup> *Ibid.*

skills, but should not be considered an adequate screening tool to identify mental health problems with appropriate sensitivity, specificity, reliability, and validity.<sup>120</sup> This is not a screening tool used by mental health professionals.<sup>121</sup>

## B. Health History<sup>122</sup>

Performing a comprehensive health history is an important function that should be completed to effectively identify mental health concerns. This section of the report gives a detailed account of the elements of a comprehensive health history that is used in conjunction with a mental health screening.

EPSDT-screening providers are required to obtain comprehensive health and mental health histories from children and adolescents. A screening tool will only identify problems noted at the time, but it will not differentiate between different types of abnormalities. In fact, the mental health history is often the most pertinent factor in making a mental health diagnosis. If the history is not obtained, mental health problems can frequently be missed even if valid and reliable screening tools are used.

The essential components of a comprehensive medical and mental health history as they would apply to children and adolescents who have mental health difficulties are as follows:

**Cognitive and school functioning** would be addressed beginning with early childhood, reviewing the child's pattern of cognitive strengths and weaknesses including verbal, attention and organizational skills. The educational history would address the social, emotional and intellectual aspects of school participation. It would also include the ability to separate from parents and to attend school regularly, interpersonal relationships with peers and teachers, motivation to learn, tolerance for frustration and delay of gratification, attitudes toward authority, and the ability to accept criticism.

**Peer relations history** includes the quality of the child's friendships, such as preferences of age and gender of friends, and any changes in the peer group. Social skills and participation and enjoyment of informal and organized peer activities would also be reviewed. In adolescents, the social history would include a capacity for intimate relationships, romantic interests, sexual activity, and any concerns over sexual orientation.

**Family relationship history** issues would include how the child has related to his individual family members and how the child fits into the overall family system. The impact of changes in family composition or relationships caused by death, birth of siblings, older siblings leaving the family, marital separation, parental divorce or remarriage, changes in

care-taking arrangements, custody or visitation, etc., is appropriate to review.

**Physical development and medical history** pertinent to mental health issues would include issues beginning with the child's conception, gestation, and delivery. Developmental history would include fine- and gross-motor development, toilet-training issues, eating behavior and attitudes, and sleep patterns. Stages of puberty maturation and physical growth including precocious development, as well as the child's feelings concerning them, should be noted. Systemic inquiry is important regarding medication; illness; hospitalization; surgeries; and serious injury, especially those involving the head; as well as the child's reactions to these events and their impact on his or her health and activities. In addition, a possible history of tics, difficulty with hearing or vision, and abnormal states or loss of consciousness should be reviewed. Speech and language problems in the history would also be relevant for the mental health history. This would include abnormalities in receptive and expressive language and speech articulation abnormalities.

**Emotional development history**, including temperament and mental state is also appropriate to review, such as issues of the child's personality; past and present mood; style of attachment and reaction to separations; anxieties; and adaptability to new, challenging, or frustrating situations. The history of possible periods of depression should be reviewed including questions about history of suicidal death, gestures, or attempts. The occurrence of distressing or impairing anxiety should be explored.

Also, the occurrence of unusual fears, excessive shyness or withdrawal, obsessive and compulsive symptoms and hallucinations, and delusion or difficulties in reality testing should be reviewed. The history of difficulties in regulating aggression needs to be reviewed. Development of conscience and values, which would include remorse for negative behaviors, would be appropriate to address.

The mental health history would also include details of the history of any current problems that may exist. These details would include the duration, frequency, and intensity of the problems; precipitants; circumstances in which these problems have occurred; and consequences, including associated distress, interference with social, family, cognitive, emotional, or academic functioning; and adverse impacts on the child's development. The history of behavior problems, including fire-setting, running away, destructiveness, stealing, lying, and aggression towards other is also pertinent for the mental health history.

**Stressful circumstances history**, including history of exposure to traumatic circumstances such as sexual or physical abuse; family substance abuse; family or community violence; or natural-disaster experiences needs to be addressed.

<sup>120</sup> *Ibid.*

<sup>121</sup> *Ibid.*

<sup>122</sup> W. Dikel's unpublished research, *supra* n. 4. (Significant portions of the "Health History" section is from Dr. Dikel's report.)

In addition, prior psychiatric treatment needs to be noted, including a view of prior psychiatric, psychological, or educational evaluations or interventions that may have been sought for any of the difficulties noted. This would include treatment provided by primary care physicians.

Also, a history of involvement in the juvenile justice, child welfare system, or institutional care, needs to be addressed in the mental health history.

**Family medical and mental health history** must also be reviewed, including history of psychotic or affective disorders, suicidal behaviors, anxiety disorders, tics, obsessive-compulsive disorders, alcohol and substance abuse, attention-deficit hyperactivity disorders, learning and developmental disabilities and delays, anti-social behavioral disorders, or metabolic and neurologic disorders.

### C. Insufficient Time for Screening

EPSDT-mental health screenings occur at private and public health clinics, community sites, and schools. In Minnesota, private and public health clinics are the primary locations where screenings are performed. The agency found through its review and research that there is a difference in the amount of time given to complete a mental health screening and health history among EPSDT-screening providers.

In addition to a comprehensive mental health-screening, an EPSDT well-child examination includes a comprehensive physical-health assessment that includes an unclothed physical exam, required immunizations, laboratory tests, and health education.<sup>123</sup> Through our interviews, we discovered that physician-supervised clinics scheduled, on average, 20 minutes to complete an EPSDT screening. This short time frame is inadequate time to complete a comprehensive screening. Clinic staff reported that the mental health-screening received less attention from physicians because of the need to complete the physical exam and immunizations.

On the other hand, time is not a contributing factor for nurse-supervised clinics to complete a mental health screening. Nurse-supervised clinic staff stated that the hour to an hour-and-half time they allot for an EPSDT exam is adequate to complete the screening. This also includes the physical exam, required immunizations, laboratory tests, health education consultation, and mental health-screening.

A factor that may contribute to the limited time allotted by physician-supervised clinics is the reimbursement rate for

screenings. The DHS contracts with health plans to perform EPSDT screenings for Medicaid-eligible children and adolescents. The contracted health plan then contracts with clinics and other providers to perform EPSDT screenings. Providers stated that the reimbursement rate for screenings under managed care is considerably lower than the rate provided under fee-for-service. Health plans responded by stating that incentives beyond the base rate are given to providers who have completed EPSDT screenings. However, providers have indicated that the screening reimbursement rate, along with the incentive, only equals the fee-for-service rate, and therefore is not truly an incentive. Health plans responded to this comment by stating that the providers' overall reimbursement for all services is higher than the reimbursement providers would receive under fee for service.

The factors causing inadequate time to perform comprehensive screenings are unclear. However, because of the limited time scheduled for EPSDT screening, a barrier is created for the use of effective mental health-screening protocols. Therefore, the DHS, health plans, and providers need to work together to resolve this issue, which may include a higher level of funding specifically for incentives to providers to administer comprehensive EPSDT screenings.

### D. Screening Locations

Mental health-screenings occur primarily at physician- and nurse-supervised clinics with physician-supervised clinics performing the majority of EPSDT screenings.<sup>124</sup> The primary philosophy of the EPSDT program is to provide preventive health screenings at community medical clinics.<sup>125</sup> Families are encouraged to develop relationships with their community clinics to avoid fragmentation or duplication of services.<sup>126</sup>

However, there are significant barriers to effective mental health screenings occurring in medical clinic settings. First, it has been reported that physicians do not support EPSDT well-child screenings.<sup>127</sup> Specifically, physicians feel that annual well-child screenings are not useful in detecting problems and prefer to incorporate screenings into a surveillance protocol during sick-child visits.<sup>128</sup> Also, there is insufficient time to complete a comprehensive mental health-screening in the time allotted by physician-supervised clinics for an EPSDT well-child exam.<sup>129</sup> In addition, clinics that receive capitated rates may hesitate to commit resources to perform a comprehensive mental health history and mental health screening because it may not be cost effective.<sup>130</sup> Further, clinics that receive capitated rates may have financial

<sup>123</sup>HCFA, State Medicaid Manual § 5123.2.

<sup>124</sup>Letter from Genie Potosky, Child and Teen Checkups (EPSDT) Program Coordinator, The Department of Human Services (on file with authors) (hereinafter *Letter from Genie Potosky*), November 20, 1997.

<sup>125</sup>HCFA, State Medicaid Manual § 5220(A).

<sup>126</sup>*Ibid.*

<sup>127</sup>Department of Human Services, Demonstration Project for Persons with Disabilities, *Services Delivery Standards*, June 8, 1998, Letter from James R. Moore, MD., Co-chair of the Committee on Children with Disabilities American Academy of Pediatrics, Minnesota Chapter to Gary Cox, Minnesota Department of Human Services ("EPSDT has never been enthusiastically embraced by child health professionals in Minnesota . . .").

<sup>128</sup>*Ibid.*

<sup>129</sup>"Insufficient Time for Screening" section of this report.

<sup>130</sup>*Ibid.*

disincentives to identify mental health problems because the cost of treatment may negatively affect their capitation.<sup>131</sup> Last, many low-income families face multiple stressors in their lives, including lack of child care for siblings, which makes it difficult to bring a child to a health screening.

Children and adolescents may be hesitant to discuss mental health problems in a clinic setting with a physician they rarely see. Further, clinic staff interviewed indicated that adolescents, in particular, are just not being seen for EPSDT screenings.<sup>132</sup> Another barrier is that a variety of sources are rarely used in mental health screening. For example, it would be unusual for medical clinics to obtain teacher information about a child or adolescent that provides valuable information to help in detecting evidence of mental health problems.

Performing EPSDT screenings in locations such as schools and other community sites may alleviate the barriers to screening in medical clinics. In fact, a number of states have expanded the sites where screenings are performed to meet the needs of Medicaid-eligible children and adolescents.<sup>133</sup> EPSDT screenings should be available in locations, such as WIC sites, Head Start Programs, schools, and family homes, that are accommodating to families so they can access the EPSDT-screening program.

### 1. Women, Infants, and Children (WIC)

WIC programs provide supplemental food and nutrition education at no cost to low-income families. The program addresses the special risk that low-income women and their children face with “respect to their physical and mental health by reason of poor or inadequate nutrition or health care or both.” Coordination between EPSDT and WIC makes good sense, particularly given the increased health risks that hunger and malnutrition cause in children.<sup>135</sup>

States are required to coordinate EPSDT and WIC services, but states rarely use WIC sites to deliver EPSDT-screening services. These programs could benefit from each other’s resources; however, in Minnesota, we are not aware of WIC sites that provide EPSDT screenings. They should be considered because of the benefits in coordination and increased screening rates.

### 2. Head Start

Head Start programs provide “comprehensive health, educational, nutritional, social, and other services to economically disadvantaged children and their families.”<sup>136</sup> The programs must ensure that children receive comprehensive health services, and “promote preventive health services and early intervention.”<sup>137</sup> Furthermore, Head Start programs must identify mental health problems and promptly intervene to resolve them, as well as to prevent them.<sup>138</sup> Families would benefit if Head Start and EPSDT coordinated their services because both programs have similar goals, and about 50 percent of the families that receive Head Start services are eligible for Medicaid.<sup>139</sup>

HCFA urges states to coordinate Head Start and EPSDT services since both programs share the “same child health and development goals.”<sup>140</sup> Although Head Start programs are a logical location to deliver EPSDT-screening services, this type of coordination is rare.<sup>141</sup> However, in Minnesota two county coordinators indicated that the Head Start program actually provides part of the EPSDT screening. Head Start staff will provide the hearing, vision, and developmental screening and send this information to the child’s primary clinic for the clinic to complete the screening by providing the physical exam. Also, Itasca County’s Mental Health Department provides screening at Head Start programs, but county funds pay for the screening, not Medicaid funds.<sup>142</sup> This agency encourages the expansion of screenings at Head Start programs statewide.

### 3. Schools

There are many advantages to performing mental health screenings in school. First, participation rates will increase because children and adolescents are readily accessible for screenings since they spend the majority of their days at school. Studies have shown that school-based providers and clinics facilitate on-time appointments.<sup>143</sup> Second, teachers can participate by providing information about each student, which greatly helps when assessing mental health problems. Collecting student information from teachers is important because teachers spend a great deal of time with students and become familiar with them. In addition,

<sup>131</sup> *Ibid.*

<sup>132</sup> In 1995 and 1996, participation rates for 15-20 year olds in Minnesota was 13 percent and 18 percent respectively, while the total averages for all ages for 1995 and 1996 were 17 percent and 27 percent respectively.

<sup>133</sup> National Health Law Program, *Children’s Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment*, August 1998, citing Jane Perkins, *Adolescent Health in North Carolina*, Adolescent Health Care in Transition: Medicaid, Managed Care and Health Care Reform, 1998, (available from National Center for Youth Law, San Francisco, Ca. and HCFA, *Child Care & Medicaid: Partners for Healthy Children*, undated, pp. 14, 18-19.

<sup>134</sup> 42 U.S.C. § 1786(a).

<sup>135</sup> *Toward A Healthy Future*, *supra* n. 28, at 128.

<sup>136</sup> 42 U.S.C. § 9831(a)

<sup>137</sup> *Toward A Healthy Future*, *supra* n. 28, p. 135.

<sup>138</sup> *Ibid.*

<sup>139</sup> *Ibid.*

<sup>140</sup> HCFA, State Medicaid Manual § 5230.2(B).

<sup>141</sup> *Toward A Healthy Future*, *supra* n. 28, p. 135.

<sup>142</sup> Interview with Pat Cortez, Itasca County.

<sup>143</sup> *Toward A Healthy Future*, *supra* n. 28, p. 142.



effective mental health screening includes information from a variety of adults that know each child and adolescent. Third, school environments may be more relaxed and comfortable than medical clinics.

In addition, school mental health-screening services are important to adolescents because this group tends not to be linked with health care services. This is reflected in the low EPSDT-screening rates for this population.<sup>144</sup> Schools can play a critical role in linking children and adolescents with health care services in the community.

A Colorado study found that adolescents who had access to a school-based health center were screened for high-risk behaviors at a higher rate than those who did not have the same access.<sup>145</sup> The study also found that adolescents who had access to a school-based health center were greater than ten times more likely to make a mental health or substance abuse visit.<sup>146</sup>

The study concludes that school-based health centers seem to have a synergistic effect for adolescents enrolled in managed care by providing comprehensive health supervision and primary health and mental health care and in reducing after-hours visits.<sup>147</sup> School-based health centers are particularly successful in providing access to and treatment for mental health problems and substance abuse.<sup>148</sup>

Many schools nationwide provide EPSDT screening at school-based programs and school-based clinics.<sup>149</sup> The state of Maryland has developed a system where Medicaid-eligible children and adolescents are offered EPSDT screening at school-based clinics.<sup>150</sup> Baltimore City has targeted high-school children and middle-school children since the program's inception, but has now shifted resources to elementary schools to provide preventive care earlier in children's lives.<sup>151</sup>

The state of Maryland has developed a model for providing EPSDT screening in schools. Medicaid-eligible students that are enrolled in health plans can receive EPSDT screening at school instead of a clinic setting. If a child receives health care coverage through a Medicaid HMO arrangement, the school is required to obtain prior authorization from the health plan before the school can perform an EPSDT screening.<sup>152</sup> Once prior authorization is obtained and the school completes the screening, the school is reimbursed by the health plan for the screening services.<sup>153</sup> This type of

arrangement provides more opportunities for students to receive screening services.

In Minnesota, a school must enroll as a Minnesota Health Care Programs (MHCP) provider with the DHS for Medicaid to pay for screening services. As an MHCP provider, the school would submit a claim to the DHS for eligible screening services provided to eligible children and adolescents. The school must follow the EPSDT program and billing guidelines to receive reimbursement for the screening services. If the school is within a county that has managed care, such as Prepaid Medical Assistance Program (PMAP) or MinnesotaCare, the school must be a part of the health plan's provider network to seek reimbursement for screening services. The school would submit a claim to the health plan for eligible screening services provided to eligible children and adolescents.

The DHS has indicated that it is aware of only one school district that provides EPSDT screening services: St. Paul Schools. However, the DHS also indicated that EPSDT services may occur in more schools but may be performed and billed by another provider. A school may contract with a health care provider to provide screenings in the school.

A St. Paul School District representative that provides EPSDT screenings to kindergartners and third graders in schools was interviewed for this report. This representative reported that schools are an excellent place to provide screenings. Their program has been successful in connecting with parents and providing them with information about the benefits of preventive health care. Having access to students gives teachers opportunities to know the students and their families, which is helpful information to have when performing EPSDT screenings.

However, the St. Paul School District representative reported that some health plans will not contract with the district to provide EPSDT screenings in her schools. Some health plans will only provide screenings at "full-service clinics," which are clinics that provide the full spectrum of medical services. The St. Paul School District utilizes a team of nurses to provide EPSDT screenings throughout the school district, but they do not provide other medical services. Many schools do not have full-service school-based clinics to provide a full spectrum of medical services as required by some health plans.

<sup>144</sup>In 1995 and 1996, participation rates for 15-20 year olds in Minnesota was 13 percent and 18 percent respectively, while the total averages for all ages for 1995 and 1996 were 17 percent and 27 percent respectively.

<sup>145</sup>D.W. Kaplan et al., University of Colorado School of Medicine, *Managed Care and School Based Health Centers. Use of Health Services*. Archives of Pediatrics & Adolescent Medicine, January 1998, pp. 152(1): 25-33.

<sup>146</sup>*Ibid.*

<sup>147</sup>*Ibid.*

<sup>148</sup>*Ibid.*

<sup>149</sup>National Health Law Program, Children's Health Under Medicaid: *A National Review of Early and Periodic Screening, Diagnosis and Treatment*, August 1998, citing HCFA, *Medicaid National Summary of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program 12*, September 1993 and HCFA, *Child Care & Medicaid: Partners for Healthy Children 14* (undated).

<sup>150</sup>Telephone Interview with Bernice Rosenthal, Baltimore City Health Department, December 1998 and Health Care Financing Administration, U.S. Department of Health and Human Services, *EPSDT: A Guide For Education Programs*, September 1992, p. 20.

<sup>151</sup>*Ibid.*

<sup>152</sup>*Ibid.*

<sup>153</sup>*Ibid.*

In addition to the full-service clinic barrier, other barriers that may inhibit schools from providing screenings are access to confidential health care data, lack of qualified medical personnel, and coordination of screenings services with the child's primary medical clinic. However, these barriers can be overcome by a strong, coordinated effort between schools, the DHS, and health plans.

For EPSDT screenings to happen in schools, the DHS must provide technical assistance to schools on confidentiality issues, specifically on how to determine if a student is Medicaid-eligible without breaching confidentiality. Also, the DHS must provide assistance on the various options for providing EPSDT services, even if the school does not employ qualified medical personnel. For example, a school can contract with a health care provider to perform screening services. Further, if the school has appropriate personnel to provide part of the screenings, the school may submit this screening information to the child's primary-care clinic to complete the remaining components of the screening.

In addition, the DHS must work closely with schools to ensure coordination between the school and the child's primary clinic. Finally, health plans must be more flexible to allow schools to become screening providers.

Due to the many benefits of providing EPSDT screenings in schools, the Office of Ombudsman strongly encourages schools, the DHS, and health plans to work together to develop the most effective and efficient means of accomplishing school-based mental-health screening.

#### **4. Mobile Screening**

Otter Tail County Public Health had used a mobile EPSDT screening approach to provide screenings. The county found that families responded positively to this approach, but limited funding discontinued the mobile program. This type of user-friendly approach should be explored because of Otter Tail County's success.

### **E. Summary**

There are many opportunities to improve the quality and accessibility of Minnesota's EPSDT mental health-screening protocol. This report has identified three notable areas that contribute to the under-identification of mental health problems for Medicaid-eligible children and adolescents. Unless changes are made in these three areas, many children and adolescents may continue to struggle with mental health problems throughout their lives.

First, screening providers should use effective mental health-screening tools and comprehensive health histories. This will greatly increase the identification of mental health problems for children and adolescents. Second, screening providers need more time so they can truly perform a comprehensive mental health-screening. Third, alternative screenings

locations should be considered to increase participation rates and give families more choices. These locations include WIC sites, Head Start programs, and schools.

Effective mental health-screening is good preventive and early intervention mental health care. However, because of the current barriers this report has identified, the EPSDT mental health-screening protocol is failing to identify those children and adolescents that have mental health problems. The Office of Ombudsman encourages the DHS and other stakeholders to actively promote public policy that incorporates the ideas presented in this section of the report for effective change.

## **IV. TREATMENT**

The provision of diagnostic and treatment services under the EPSDT program is an area of concern, but this report does not fully address this issue. Because mental health-screening services are the focus of this report, the review process was structured to address the essential elements related to screening services. However, it was discovered through interviews that Medicaid-eligible children and adolescents may not receive the necessary mental health diagnostic or treatment services as identified in the screening process.

The EPSDT program requires states to provide diagnostic and treatment services as identified by the screening process for Medicaid-eligible children and adolescents.<sup>154</sup> Currently, Minnesota's package of services provides for an array of mental health diagnostic and treatment services. However, Minnesota does not include residential treatment services as a covered service. This issue is currently being discussed at the state and county levels to determine if this service should be included as a Medicaid-covered service.

It was learned through interviews that access to quality mental health treatment services is a concern. Concerns expressed include limited number of providers and hours of treatment available, extensive waiting lists for treatment, and limited or no culturally competent providers. Because of these issues, Medicaid-eligible recipients have difficulty accessing quality mental health diagnoses and treatment services once identified through the screening process.

## **V. DATA COLLECTION**

This section of the report describes the problems with the Department of Human Service's (DHS) EPSDT data-collection system and provides an overview of the EPSDT data collected by the reviewers. The reviewers were interested in obtaining data that illustrates the performance of the mental health component of this program. Specifically, the data requested included calendar year 1995 through the most current year available on the number of Medicaid-eligible children and adolescents, the number who received mental health screenings, and the number who were identified with mental health issues through the screening process.

<sup>154</sup>42 U.S.C. § 1396d(a)(4)(B) and HCFA, State Medicaid Manual § 5124(B).

Throughout this report, 1995 data was utilized because the DHS was unable to provide complete and accurate health plan-data for any proceeding years. More current data, including 1996 and 1997 is not available because of technical difficulties as indicated by the DHS. Furthermore, it should be noted that the DHS expressed concerns about the 1995 data as well. Approximately 10 percent to 15 percent of the claims for 1995 are not valid.<sup>155</sup> Further, the billing format changed for EPSDT in 1994, and training was not initiated until October 1994. The DHS indicated that the 1995 data predates most of the training, and therefore many coding errors occurred.<sup>156</sup>

In addition, the DHS was unable to provide complete and accurate health plan-mental health referral data. Health plans use an alpha coding system on provider claim forms to identify referrals for the EPSDT program. When a screening provider makes a referral, a referral code must be placed on the claim form indicating the type of referral made. There are four possible codes that relate to mental health services. These codes are “schools,” “mental health centers,” “psychologist,” and “yourself,” which means a referral back to the screening provider.

There are two primary concerns with this referral system. First, it is not clear how many referrals to “schools” and “yourself” are actually related to mental health. For example, a primary care physician or pediatrician can treat children with certain mental health disorders, such as Attention Deficit Disorder, so the physician would mark “yourself” as the referral code on the claim form. However, a physician or pediatrician can also treat many physical disorders as well, which would also be considered a referral to “yourself.” Similarly, a referral to the child’s school could be for any number of health-related issues.

The second concern is that the list of referral codes does not include a referral code for psychiatrist and other mental health professionals. The referral codes “mental health center” and “psychologist” do not adequately cover all the mental health referrals that could be made from an EPSDT screening.

The DHS data-collection system for the EPSDT program is inadequate to effectively monitor the program. Specifically, DHS needs more current data and more specific data regarding mental health referrals to adequately monitor the mental health component. It is the Office of

Ombudsman’s hope that the DHS will perform a comprehensive review of their data-collection system and methodology in collecting this data.

The following is a complete overview of the 1995 data received from the DHS. The DHS provided 1995 health plan and fee-for-service data that indicated there were 368,032 Medicaid-eligible children and adolescents (this includes MinnesotaCare).<sup>157</sup> Of the 368,032 Medicaid-eligible children and adolescents, only 15 percent (55,501) of children and adolescents received an EPSDT screening.<sup>158</sup>

The fee-for-service data indicated that 34,085 children and adolescents received EPSDT screenings.<sup>159</sup> Of the 34,085, 5.3 percent (1825) of children and adolescents were referred for mental health issues.<sup>160</sup>

The health plan data indicated that 21,416 Medicaid-eligible children and adolescents received EPSDT screenings.<sup>161</sup> Of the 21,416 receiving EPSDT screenings, 793 children and adolescents were referred for further assessment for mental and/or physical conditions.<sup>162</sup> Of the 793 referrals, 702 were possibly be related to mental health issues.<sup>163</sup> This means no more than 3.3 percent of the children and adolescents were referred for mental health issues. Of the 702 possible mental health referrals, two were referrals to schools and 700 were referrals to “yourself,” which means a referral back to the screening provider.<sup>164</sup> There were zero referrals reported to mental health centers and psychologists.<sup>165</sup>

The total number of possible mental health referrals by health plans and fee-for-service is 2527. This number represents only 4.6 percent of the total number of children and adolescents that were screened. Further, this represents less than 1 percent of the total number of Medicaid- and MinnesotaCare-eligible children and adolescents (368,032). However, it is important to note that an additional 13,285 children and adolescents under fee-for-service received mental health evaluations without going through EPSDT screenings.<sup>166</sup> These numbers are not reflected in the percentages of mental health referrals that occurred within the EPSDT program. Furthermore, this agency did not receive health plan data that indicates the number of mental health evaluations that occurred without going through the EPSDT screening program.

<sup>155</sup>Letter from Vicki Kunerth, Acting Director, Performance Measurement and Quality Improvement, Department of Human Services (letter on file with authors) (hereinafter *Letter from Vicki Kunerth*), July 31, 1998.

<sup>156</sup>*Ibid.*

<sup>157</sup>Telephone call with Karen Peed, Department of Human Services, December 1998 and *Letter from Vicki Kunerth*, *supra* n.154 and *Letter from Genie Potosky*, *supra* n. 133.

<sup>158</sup>*Ibid.* and *Letter from Vicki Kunerth*, *supra* n. 154.

<sup>159</sup>*Letter from Genie Potosky*, *supra* n. 133.

<sup>160</sup>*Ibid.*

<sup>161</sup>*Letter from Vicki Kunerth*, *supra* n. 154.

<sup>162</sup>*Ibid.*

<sup>163</sup>*Ibid.*

<sup>164</sup>*Ibid.*

<sup>165</sup>*Ibid.*

<sup>166</sup>*Letter from Genie Potosky*, *supra* n. 133.

## VI. CONCLUSION

The two primary goals of this Office of Ombudsman report are to improve the administrative services and mental health-screening protocol components of the EPSDT program. EPSDT is critically important to low-income children and adolescents because prevention and early intervention is key to a successful outcome for children with mental health issues. In this report the reviewers specifically reviewed the administrative services requirements, mental health-screening protocol, data collection, and mental health treatment services.

The first goal of this report is to improve the administrative services component. For children and adolescents to benefit from EPSDT, they must know that the program exists. The purpose of the administrative services component is to provide families with information about the program, reach out to families and providers, and support families through the health care system.

Through this agency's review, two ways to improve this component of the EPSDT program were identified. First, the Department of Human Services must provide a comprehensive, coordinated statewide outreach plan. This statewide outreach program could assist in decreasing the variability in the quality of outreach, facilitate the establishment of outcomes and better monitoring methods, and bring together resources for larger outreach campaigns. Further, the statewide program would provide leadership and direction in resolving the issues surrounding provider compliance.

Second, the Department of Human Services must improve the initial informing process by taking it out of the initial Medical Assistance enrollment process and allowing county coordinators to initially inform families. County coordinators have a much better understanding of EPSDT and preventive health care, and with readily available information and direct access to support services, families are more likely to utilize EPSDT services. As of January 1999, initial informing was transferred from the county intake workers to the EPSDT county coordinators. This agency will continue to monitor initial informing activities to ensure families are adequately informed.

The second goal of this report is to improve the mental health-screening protocol for the EPSDT program. Research indicates that there is a significant percentage of children and adolescents who have mental health problems, and this percentage is even higher in the Medicaid population. Department of Human Services data indicates that the state's EPSDT program is doing a poor job in identifying children and adolescents with mental health concerns. The reviewers identified several ways to improve the mental health-screening protocol for the EPSDT program.

First, a comprehensive mental health history combined with a reliable, valid, sensitive, and specific screening tool, which gathers information from a variety of sources must be utilized. This would help ensure identifying the vast majority of the children and adolescents who require services. Second,

screening providers must be allowed more time to perform a truly comprehensive screening, which includes a comprehensive mental health-screening. Third, alternative screening sites, such as Head Start, schools, and WIC sites, should be considered to increase participation rates and give families more choices.

The Office of Ombudsman also identified two other areas of concern: treatment services and data collection. Treatment services are not intended to be a primary focus of this report. However, this report describes concerns raised by various interviewees about Medicaid reimbursement for residential services and concerns regarding the availability of quality mental health-treatment services. Also, the Department of Human Services' data-collection system raised concerns. This section of the report describes the concerns this agency has with the Department of Human Services' ability to provide complete and accurate EPSDT mental-health data from health plans.

The state, counties, and health plans must work collaboratively to ensure that children and adolescents receive EPSDT prevention and early intervention screening services. EPSDT can play a key role in ensuring that prevention and early intervention services become a part of the full array of mental health services available. The Ombudsman Office's strongly recommends that the EPSDT screening process will become an integral part of Minnesota's mental-health care system for Medicaid-eligible children and adolescents.

## VII. RECOMMENDATIONS

The Ombudsman Office's review of the state's EPSDT program has identified many concerns that contribute to the poor performance of this program. Thus, the reviewers have formulated recommendations designed to increase the rate of identifying Medicaid-eligible children and adolescents that have mental health concerns. The recommendations are fundamentally developed from the information collected through interviews, consultation, and research.

The recommendations range from statewide changes to a specific proposal and are organized into three categories. These categories include outreach, mental health-screening protocol, and a pilot project proposal. Listed below are the recommendations the Ombudsman Office offers the Department of Human Services.

### A. Outreach

The Ombudsman Office recommends the Department of Human Services develop and implement a comprehensive, coordinated statewide outreach plan that establishes the following elements:

1. Replication of effective county outreach strategies statewide
2. Measurable outcomes for local outreach campaigns
3. Better monitoring and evaluation of local outreach campaigns

4. Larger outreach projects bringing together resources from the state, county, and health plan levels

The Ombudsman Office recommends the Department of Human Services create a task force or utilize the current regional workgroups to review the provider-compliance issues. All stakeholders in the system should participate, including DHS staff, providers, county coordinators, health plans, consumers, and advocates.

## **B. Mental Health-Screening Protocol**

The Ombudsman Office recommends the Department of Human Services require all EPSDT-screening providers to use standardized mental health-screening instruments, which are sensitive, valid, reliable, specific, rapidly administered, and use multiple sources. The agency recommends that Minnesota Rule 9505.1718 be amended to include the use of standardized mental health-screening tools.

The Ombudsman Office recommends the Department of Human Services explore the use of financial incentives and penalties to increase the use of standardized mental health-screening tools.

The Ombudsman Office recommends the Department of Human Services require all EPSDT screening providers obtain a comprehensive health history of Medicaid-eligible children and adolescents, which includes the elements listed in this report.

The Ombudsman Office recommends the Department of Human Services amend their current training contract with the Department of Health to include training on the use of standardized mental health-screening instruments and comprehensive health history assessments.

## **C. Pilot Project Proposal**

One goal of this report is to explore opportunities to increase the rate of screening to identify evidence of mental health problems for Medicaid-eligible children and adolescents. This agency proposes a pilot project to promote the use of standardized mental health-screening instruments

and comprehensive health history assessments at EPSDT-screening locations.

The parameters of the project are to establish the use of standardized mental health-screening instruments and comprehensive health history assessments at selected EPSDT-screening locations. Screening locations should include a private clinic, a public health clinic, and an alternative site such as a school, a Headstart, or a WIC site.

In addition, screening providers should provide an evaluation component to determine the effectiveness of implementing comprehensive mental health-screening protocol. Each selected screening provider should develop outcome indicators and collect data to measure their results. The Department of Human Services should provide technical assistance to selected screening providers in developing an effective mental health-screening protocol, outcome indicators, data collection systems, and other areas of need.

The Department of Human Services and the contracted health plans should explore opportunities to reimburse alternative screening providers who perform comprehensive mental health screenings. Screening providers would receive reimbursement if they use standardized mental health-screening tools and comprehensive health history assessments. The agency realizes there are concerns about the sharing of information at alternative locations. The DHS must work with these sites to protect all eligible children's and adolescent's data-privacy rights. Performing mental health screening at alternative locations gives parents and their children more opportunity to receive mental health screenings.

## **VIII. SUMMARY**

The Ombudsman Office's recommendations are intended to improve the outcome of the EPSDT program to better serve Medicaid-eligible children and adolescents. By improving outreach, the mental health-screening protocol and data-collection components of this program, more children and adolescents will be identified earlier for mental health concerns. This agency believes this is the goal of preventive and early intervention mental health care.

## IX. DHS RESPONSE



Minnesota Department of Human Services

March 16, 1999

Roberta Opheim, Ombudsman  
Office of the Ombudsman For  
Mental Health and Mental Retardation  
Metro Square Building  
121 7<sup>th</sup> Place East, Suite 420  
St. Paul, MN 55101-3506

Dear Ms. Opheim:

Thank you for your letter regarding the Ombudsman's office review on EPSDT services which addresses program activities in general as well as mental health screening in particular. The Department of Human Services (DHS) commends the Ombudsman's office for its concern for the mental health needs of children enrolled in Minnesota's Health Care Programs (MHC<sup>2</sup>) such as Medical Assistance and MinnesotaCare. DHS also has a strong interest in ensuring that children receive the mental health screening, assessment and treatment they need in order to develop to their fullest potential.

The Ombudsman's office and DHS have the same goals in providing services to children. I am concerned, however, that the report does not portray Minnesota's EPSDT program accurately.

The report does not thoroughly discuss the factors contributing to Minnesota's Child and Teen Checkups Program (C&TC) participation rate. (C&TC is Minnesota's name for the federal EPSDT program.) Rather, the report oversimplifies the issue and inaccurately concludes that the program is not effectively informing and reaching out to families and health care providers. The major issues that Minnesota and other states encounter when working to improve the participation rate are: 1) enrollee participation in the program is voluntary and 2) providers do not consistently code C&TC visits as such when they bill though they provided C&TC services and made appropriate referrals.

Many states report a higher participation rate than Minnesota, though few attain the federal goal of 80%. While this may appear to indicate better performance, the differences have a lot more to do with how states calculate their rate than what services children actually do or do not receive.

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In Minnesota, DHS very conservatively counts only comprehensive visits to assure that children enrolled do not receive an incomplete screening. Many visits other states would count in their participation rate are not figured into Minnesota's because they do not include a complete screening. It is precisely because DHS counts only those services that meet this high standard consistent with federal specifications that Minnesota's rate is lower. Also Minnesota does not require that an EPSDT screening be received prior to receiving assessment, diagnosis or treatment of health care or mental health services.

Particularly damaging to the report's usefulness is that the terms "mental health screening" and "mental health assessment" are used interchangeably throughout the document. Screening is a brief procedure designed to identify children who may need to receive diagnosis or assessment. Assessment involves professional determination of a diagnosis or the factors contributing to the problem and the assets and resources of the individual family. Using these two concepts interchangeably, the report fails to provide a meaningful dialogue on the standards to which one might expect a C&TC screening visit to adhere.

Many of the statistics used or calculated are misleading, and in some cases simply inaccurate. The 1995 participation rate cited is not the most recent available (17% in 1995 versus 24% in 1997) -- the 1997 rate has been available since April 1998. Nor is there any mention of the trend of improvement these two figures represent.

Unfortunately, the recommendations section is particularly misleading as the large majority of the recommendations are projects that have already occurred or are currently underway. Information about our activities was provided to Ombudsman's office staff. Representing these activities as recommendations misleads the public to believe Minnesota is not responsive to the issues raised by the report.

Finally, the report does not describe how the interviews with various providers of the C&TC program were conducted, or with whom. Quotes from an individual provider, county staff person, or health plan representative are held up as indicative of the pervasive opinion with no other data or information source to support the statements. There is no discussion of how many or which counties, providers, or health plans were interviewed, how ubiquitous the represented sentiments were among that group, or the nature of the questions asked. Yet these anecdotal remarks are characterized as the norm upon which action should be taken. This represents selective fact finding and is inappropriate to portray as research upon which policy should be based.

Below are some of the more salient examples of our concerns, discussed under the following headings: 1) reports and statistics, 2) mental health screening tools, and 3) recommendations.

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#### Report statistics, participation rate and statement of facts/problems

- The report claims that only 4.6% of children who received a C&TC visit in 1995 received a referral for further mental health assessment. The report would appear to consider this number lower than it should be, however, no appropriate or expected number is suggested. More importantly, the report also neglects to mention that approximately 60,000 children, or 20% of the overall MHCP population, received mental health services in 1995. Many of these children may not have received a referral at the time they received a well-child screening because: 1) the child already had an established relationship with a mental health provider and was receiving assessment or treatment, 2) they may have received an assessment prior to their enrollment in the program, 3) or they may have received a screening and/or assessment done at another visit which was not a C&TC screening, all of which would mean the child was receiving appropriate screening and treatment, but did not appear as a C&TC screening referral statistic.
- The report states that families are not adequately informed about the benefits of EPSDT screening services. Children/families receive letters, phone calls, or both each time a child is due for a screening. Families also receive home visits at which they are encouraged to make appropriate appointments for C&TC screenings. Assistance is offered to all families to locate a provider, arrange for transportation, and provide other assistance the family may need in order to make a screening visit possible. To conduct these one-on-one outreach activities, all 87 counties use CATCH II, a free computer tracking software package developed by DHS. CATCH II aides counties in informing and assisting families in getting EPSDT appointments and referrals through generating reminder letters, tracking services children have received, and prompting county staff on contacts that need to be made. This software has been showcased in a number of other states as an innovative tool for providing timely outreach and follow-up services to families. In addition, the C&TC brochure, which describes the screening program and provides information about benefits of the program, is widely distributed and available in eight languages.
- The report cites a number of articles that document the prevalence of "behavioral problems" or "mental health issues" in children generally or Medicaid children specifically. It would appear that these comparisons are given in an attempt to quantify what should be happening with regard to C&TC screening and/or treatment. However, "behavioral problems" and "mental health issues" are much broader concepts than the actual prevalence of mental health diagnosis in a population.



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### Screening Tool

- While the report discredits the current mental health screening tool developed by DHS and the Minnesota Department of Health (MDH), the report suggests no alternative screening tool. DHS has contacted a number of states and numerous mental health professionals from Minnesota and elsewhere in search of a mental health screening tool they could recommend for use in a C&TC screening. It is because DHS could find no recommended screening tool that the referenced 1991 screening tool was developed. DHS has received a grant from the National Institute of Health to develop and test a mental health screening tool for children. This information was provided to the Ombudsman's office by DHS staff.
- The section of the report which claims to give examples of mental health screening tools, in fact, reviews assessment tools with the exception of the Pediatric Symptom Checklist, which the report then goes on to discredit as unreliable. Lengthy speciality assessment tools are inappropriate for use in a health screening and, therefore, irrelevant to the discussion of a C&TC screening visit or referral rates.
- The tools listed in the report are assessment tools and these tools lack reliability with the range of ethnic groups represented in Minnesota. It should be noted that over the last two years, DHS has provided extensive training for the provider community and counties on the use of the Child Adolescent Functional Assessment Scale (CAFAS) as a standardized assessment tool for use when a child is in need of assessment.

### Recommendations

Recommendations are typically meant to suggest courses of action not currently taken. DHS is concerned that this report presents ideas already implemented or in process as suggestions for the future, leading the general public to believe that DHS is not currently taking such action. The bullet points below detail the specific recommendations and information provided to Ombudsman's office staff.

- The report suggests counties should share ideas. In October 1998, DHS published its C&TC Coordinator's Handbook, which included a section on innovative ideas. The Handbook was developed after meetings with county coordinators from around the state. DHS staff also holds regional meetings from one to three times per year to share information from state staff and among county coordinators in a continuing effort to improve outreach and follow-up activities.

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- The report suggests developing measurable outcomes. For some time, counties have been required to submit monitoring and evaluation plans. They also report annually on meeting outreach and follow-up objectives.
- The report suggests informing newly eligible families about the C&TC program should be done by C&TC coordinators instead of county intake workers. DHS has already implemented this approach in its 1999 contracts with counties
- The report points out that local media campaigns have proven ineffective. Work groups have already met and begun work on plans to conduct a uniform statewide information campaign through the local county outreach efforts
- The report recommends that the EPSDT program work with Head Start. This already occurs at both the state and county level. Since 1996, DHS and MDH have worked with state Head Start and early childhood screening staff to encourage community collaboration for early childhood screening. Along with a letter encouraging cooperation, screening documentation forms were designed and distributed to all Head Start sites, early childhood screening agencies and county EPSDT coordinators. This dissemination was followed by six regional meetings in 1997. DHS and the Department of Children, Families and Learning staff continue working together to increase the number of Head Start agencies enrolled as providers and to provide information about Medical Assistance and MinnesotaCare Programs' availability at Head Start sites.

In addition to state-sponsored efforts, county C&TC coordinators already collaborate and coordinate with a number of other community agencies and programs including Head Start, public schools, parenting and pregnant teen programs, the Minnesota Visiting Nurse Association, and migrant health. County coordinators and staff also take advantage of community events such as health fairs, county fairs, opportunities to speak to community groups and writing articles for local publications.

- The report incorrectly states that county C&TC coordinators are responsible for providing technical assistance on billing and that they are solely responsible for provider outreach. Billing and coding are addressed by DHS and health plan provider customer service phone and training staff. A good deal of provider outreach is conducted under contract with MDH and by DHS training staff
- The report indicates that DHS must provide leadership and direction for increasing provider compliance with the EPSDT program. DHS has implemented an incentive payment in the 1999 health plan contracts to increase provider participation and compliance. In addition, DHS convened an expert panel several years ago to provide input on screening components, produced the first two editions of a provider information guide, revised the billing format at

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providers' request, and contracts with MDH to provide a variety of provider trainings throughout the state. Last year, DHS chose as one of our 1999 external quality review studies C&TC screening services.

- The report indicates that DHS has not addressed the issues of provider buy-in or periodic schedule issues. The following are examples of the type of work conducted to address these issues:
  - 1) The Periodicity schedule for C&TC visits — in 1995 DIIS surveyed providers about barriers to the C&TC program and convened an expert panel with MDH to discuss C&TC screening components and outreach. Since that time, an ongoing dialogue has resulted in continued updates to the C&TC periodicity schedule and the components included in a C&TC visit to the extent changes can be made within the framework of federal law.
  - 2) Provider buy-in — A group of county coordinators and health plan representatives has recently completed work on a provider outreach curriculum that will be available to all county coordinators. The work is the result of a group of county coordinators and health plan representatives who are dedicated to increasing provider buy-in and participation. The group convened a meeting with approximately sixty providers.
  - 3) Provider training — MDH, under contract with DHS to train providers and increase provider participation, had an article published in the December 1998 issue of the Minnesota Academy of Pediatricians newsletter (*The Minnesota Pediatrician*) explaining the merits of the C&TC program.

The one recommendation that is conspicuously absent from the report but would have been helpful to DHS is the identification of a useful mental health screening (not assessment) tool that could be recommended to providers conducting EPSDT screenings.

### Treatment

- The report claims that generally, private clinics do not provide adequate time to perform a comprehensive screening, although this information is anecdotal and the claim is not backed by any form of documentation. We have had no complaints to our Ombudsmans' staff or information from county coordinators to this effect, although we have received complaints about the length of time spent by some public health nursing clinics to screen a child.

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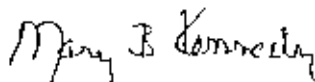
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- The report also indicates that alternative screening locations are not fully utilized. It is unclear what background documentation was used to arrive at this conclusion. County C&TC coordinators are required to provide eligible families/individuals with a list of screening providers if requested. And many counties send staff to clinics and Women, Infants and Children Supplemental Nutrition (WIC) programs and other sites in their area in an effort to be conveniently available for C&TC eligible enrollees. It is true that many families prefer to receive all well child care through their primary care physician.
- The report recommends requiring all C&TC screening providers to obtain a comprehensive health history of Medicaid eligible children and adolescents. A comprehensive health history is already a requirement of a C&TC screening.

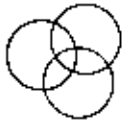
In summary, the intentions and goals of the Ombudsman's office and DHS are clearly the same. Every eligible child should receive a comprehensive C&TC screening at the appropriate time, and it is to include a screening for potential mental health service needs. DHS is disappointed, however, to see that the program and its activities were not always accurately represented in the Ombudsman's office report.

DHS would welcome any constructive information and suggestions to improve mental health screening services for Medical Assistance and MinnesotaCare children. DHS anticipates an ongoing dialogue and collaborative work with the mental health advocacy community and mental health, pediatric, and general practice providers as we continue to address the mental health needs of children in Minnesota Health Care Programs.

Sincerely,



Mary B. Kennedy, Medicaid Director  
Assistant Commissioner Health Care

**IX. OMBUDSMAN RESPONSE TO DHS**

STATE OF MINNESOTA  
**OFFICE OF THE OMBUDSMAN FOR  
 MENTAL HEALTH AND MENTAL RETARDATION**

121 7th Place E. Ste 420, Metro Square Building, St. Paul, MN 55101-2117  
 612-296-3848 or Toll Free 1-800-657-3506  
 TTY/Voice - Minnesota Relay Service 1-800-627-3529

April 26, 1999

Mary Kennedy  
 Department of Human Services  
 444 Lafayette Road  
 St. Paul, Minnesota 55155

Dear Ms. Kennedy:

Thank you for responding to the Ombudsman's office report of the state's EPSDT program. I commend your agency's effort in making changes to improve the delivery of EPSDT services for Minnesota children and families. In addition, I appreciate the Department of Human Services commitment to continued dialogue and collaborative work to improve mental health screening services for Medical Assistance and MinnesotaCare children.

We have made changes to our report that include your agency's activities in addressing some of the concerns in the report. However, many of the report's recommendations were not mentioned in your letter, so I would like to emphasize them and address some of our concerns with your letter. I am primarily concerned that your letter emphasizes the process of your initiatives rather than their effectiveness through performance data.

I have organized my comments in three sections: methodology, informing and outreach, and mental health screening. Dr. Dikel, who is the consultant the agency contracted with, also has had an opportunity to review your response and his letter is attached. Many of his comments are included in this letter.

Methodology

Your letter questions the methodology used in the report. The following is a listing of counties, providers, health plans, and agencies that we interviewed for this report in 1998:

1. Ramsey County Coordinator-a member of the Metro Area workgroup.
2. Hennepin County Coordinator-a member of the Metro Area workgroup.
3. Blue Earth County Coordinator
4. Blue Earth County Public Health Clinic
5. Otter Tail County Coordinator
6. Otter Tail County Public Health Clinic
7. Itasca County Coordinator-a member of the Northeast workgroup.



an equal opportunity employer

8. Department of Human Services-EPSDT coordinator, Medicaid Director, and PMQI Director and staff.
9. Department of Children, Families and Learning-Early Childhood Screening Coordinator.
10. Department of Health-EPSDT Director and staff.
11. HealthPartners
12. Allina
13. UCare
14. East Metro Clinics Group-includes ten clinics in the East Metro area.
15. Fergus Falls Medical Group-including a nurse and doctor.
16. Perham Clinic-clinic manager who represented Merit Care system in northwest region.
17. Grand Rapids Clinic-including a nurse, nurse practitioner, and doctor. Information was provided that encompassed the Grand Rapids Clinic system that includes 13-14 doctors and 5 nurse practitioners.
18. Deer River Clinic-including a nurse and clinic manager. This clinic is part of the Duluth Clinic system that provides medical services for the northeast region.
19. St. Paul Public Schools representative
20. Minnesota Disability Law Center

The information gathered from these sources fully supports the agency's recommendations. First, the information gathered supports our position that outreach activities are not being measured to indicate whether these activities are successful. Your letter provides information about outreach activities that are occurring, but the issue is the effectiveness of these activities, not the process. Second, the information gathered supports our position that EPSDT screening providers generally do not use effective mental health screening tools. This is further supported by the Department of Human Services data regarding the low number of mental health referrals. Also, the stakeholders interviewed indicated that mental health screening was not a priority in comparison to the other EPSDT screening components.

#### Informing and Outreach

Your letter of response indicates several initiatives that have been implemented to improve informing and outreach components including:

- A new innovative idea section in the EPSDT Coordinator's handbook.
- Several examples of initiatives to improve provider compliance and buy in and periodic schedule issues.
- Efforts to increase the use of Head Start sites as screening locations.
- Taking the initial informing out of the eligibility determination process and transferring the duties to county coordinators.

We commend the Department of Human Services in implementing these changes to improve the EPSDT program. We have made specific changes to the report to reflect these initiatives.

However, we still have concerns with the outreach and informing components. We believe the primary mechanisms to improving Minnesota's EPSDT participation rate is outreach and informing. Since the program is voluntary, the outreach and informing activities must be effective in convincing families and providers that preventive screening is important and worthwhile. We urge the Department of Human Services to not only review the informing and outreach process but continually evaluate the effectiveness of these activities.

We are specifically concerned that the EPSDT county contracts continue to be process based and only require county coordinators to describe methods used to complete particular tasks. Coordinators should be required to produce positive outcomes for the program. The report recommends that the Department of Human Services provide measurable outcomes for counties, and our hope is that the Department will follow through with this recommendation.

Concern also remains that the Department of Human Services has not developed a plan to facilitate replication of the innovative ideas in the coordinator handbook. Providing ideas in a handbook will not ensure that the innovations will be utilized throughout the state. Another concern is provider compliance and buy-in and periodic schedule issues. Despite efforts made by the Department of Human Services, problems with these issues remain. Continuing dialogue with counties, health plans, advocates, and other stakeholders is necessary to improve these areas.

#### Mental Health Screening

The fundamental issue the report addresses is the following: Does Minnesota's EPSDT program adequately identify the mental health problems of Medicaid-eligible children and adolescents? Dr. Dikel states that "given base rates of mental health problems in that population, and given the low rate of identification in EPSDT screening, two possibilities exist. One is that the children have been identified elsewhere and that the screening was not necessary. The other is that many of the children and adolescents are eventually identified, often well into the deteriorating course of their mental health problems, and that this could have been prevented to a large extent with adequate screening." Dr. Dikel further states that "given data regarding the sensitivity of doctors' ability to identify mental health problems (footnotes 82, 83), given the time needed to obtain the required comprehensive mental health history compared to the time of a typical entire EPSDT screen, and given the lack of screening tools, I would assume that the latter is true."

Also, in 1995, 20% of the overall MHCP population received mental health services, which suggests that only a small percentage of mental health problems are identified through the EPSDT program. Dr. Dikel suggests that "in order to analyze this issue it would be necessary to discover at what point in the development of their mental health problems they were first seen for mental health treatment." He further states that the "key word in EPSDT is early." The longer children go untreated, the more severe problems become and the cost to provide treatment becomes much more expensive.

Dr. Dikel further suggests that analysis is necessary "to discover whether at the time of the EPSDT screening of young children a high percentage of them are already being treated. If, in fact the age of the first treatment turns out frequently to be a significant amount of time after the disorders develop, and if the disorders had not been identified at the time of screening, then the 20% figure would suggest treatment that is not in line with early intervention and prevention services."

The Ombudsman Office agrees with Dr. Dikel's summary. If the rate of mental health problems is significantly higher for the Medicaid population, and the identification rate in EPSDT screens is very low, DHS should demonstrate that children and adolescents are being identified by other means in a timely manner. However, if this is not the case, then the DHS and the EPSDT screening program is failing to provide adequate mental health early intervention services.

The report provides recommendations to improve the effectiveness of the EPSDT mental health screening protocol, which includes the use of standardized screening tools and comprehensive health histories. The following information clarifies and supports these recommendations.

The Ombudsman Office's report addresses concerns related to the DHS proposed screening tool, which is a modified version of the current Minnesota Student Survey. First, the proposed tool is not meant to be an overall-screening instrument for mental health issues, and second, an effective screening tool collects information from other sources than the child to have appropriate sensitivity. The Pediatric Symptom Checklist is another tool the DHS is considering. Sensitivity is a concern with the Pediatric Symptom Checklist screening tool as cited in research, which is different from reliability and is discussed in the report. The research cited in the report indicates that one of five children of lower socioeconomic who had mental health problems would be missed if using the Pediatric Symptom Checklist.

The Ombudsman Office's report does not recommend a specific screening tool. Instead, the report provides the essential elements that constitute an effective mental health-screening tool. Screening tools that do not possess these elements will fail to effectively identify mental health problems. The report also provides examples of screening tools. Dr. Ken Winters, Ph. D, a University of Minnesota expert, describes the tools listed in the report as screening tools. Furthermore, Dr. Dikel has worked with a number of mental health professionals who have found the tools described in the report as helpful in identifying mental health problems in children from many different ethnic groups.

One of the screening tools mentioned in the report is the CAFAS tool. This tool is not designed to assess any type of mental health problem a child may experience, but it is designed to assess the child's level of functioning. The CAFAS is not a diagnostic assessment tool. There are many effective mental health screening tools available, and the Ombudsman Office believes that EPSDT screening providers should choose the tool that fits their environment.

Another recommendation is that EPSDT screening providers complete comprehensive health histories that include the elements listed in the report. This is an important function when screening for evidence of mental health problems.

Based on your letter, the following issues also need to be clarified:

- Only the effectiveness of EPSDT mental health screening is discussed in the report. We do not discuss concerns or issues related to the diagnostic component of the EPSDT program.
- The term mental health assessment protocol refers to the combination of a mental health screening and a comprehensive health history. To avoid confusion, the mental health assessment protocol will be changed to mental health screening protocol.
- Data used in this report includes 1995 fee-for-service and health plan data, which is the data available at the time of our request to the DHS.
- Research is included in the report to represent the significant degree of mental health problems in the Medicaid population. These citations illustrate the prevalence of psychiatric disorders for the general and the Medicaid population of children and adolescents.



I commend the strategies and activities that DHS has demonstrated to improve the delivery of EPSDT screening services. Many more opportunities exist to provide effective mental health screening, which I have discussed and are included in our report. I extend to you the opportunity to meet with us to discuss our report. The EPSDT program can help many Minnesota families receive effective mental health early intervention and prevention services. Let's work together to make this happen.

Sincerely,



Roberta Opheim  
Ombudsman

cc: Michael O'Keefe, Commissioner  
Pam Perri Weaver, Governor's Office

## X. LETTER FROM DR. DIKEL

March 17, 1999

Bill Wyss  
Office of the Ombudsman for  
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Dear Bill,

I read with great interest Ms Kennedy's response to concerns that were raised by your office about the mental health component of EPSDT screening. As a number of the criticisms concerned the issues raised in my consultation on this matter, I feel that it is appropriate for me to respond to her letter. I appreciate that DHS is making the commitment to have the same goals as the Ombudsman's office-namely advocacy for high quality mental health services that include thorough mental health screening, and appropriate mental health referrals when appropriate.

Ms. Kennedy notes that your report cites the prevalence of "behavioral problems" or "mental health issues", stating that it would appear that these comparisons are given in an attempt to quantify what should be happening with regard to C&TC screening and/or treatment. She notes that these are much broader concepts than the actual prevalence of mental health diagnoses in a population. Although my literature review did include some studies that discussed behavioral problems and mental health issues, there were numerous studies that cited the prevalence of psychiatric disorders.

E.g. for the general population:

- reference 9: (21.4% DSMUIR disorders in preschoolers)
- reference 12: (prevalence of psychiatric disorders from 17.6-22%)
- reference 20: (almost one fourth of the adolescents met criteria for at least one psychiatric disorder by age 14)
- reference 22: (22% qualified for one or more psychiatric diagnoses)

and for the Medicaid population

- reference 30: (26.4% of the population studied had clear evidence of psychiatric impairment)
- reference 36: (41%-62% of the children in foster care had psychiatric abnormalities)

Frankly, I am puzzled by the criticism of statements describing behavioral problems and mental health issues, as they were in the context of the citing of numerous references that make an overwhelming argument about the significant degree of mental health problems in the Medicaid population.

Ms. Kennedy cites that 20% of the overall MHCP population received mental health services in 1995, and notes that many children are identified as having mental health problems outside of the EPSDT screen. In fact, the data clearly indicates that only a very small percentage of the mental health problems are identified in EPSDT screening. The issue that Ms. Kennedy raises is a valid one, as it suggests that these children and adolescents receive mental health treatment anyway. In order to analyze this issue, it would be necessary to discover at what point in the development of their mental health problems they were first seen for mental health treatment.

The key word is "early". If 20% of the Medicaid population were being treated for high lead levels, but many or even most of them had several years of lead poisoning prior to treatment, then the public health implications would be obvious. The same is true for mental health problems, in that the longer that they go untreated, the more severe they become, the more impairment that they cause and the harder and more expensive they are to treat. Ms. Kennedy could do a further analysis in order to discover whether, at the time of the EPSDT screenings

of young children a high percentage of them are already being treated. If, in fact, the age of the first treatment turns out frequently to be a significant amount of time after the disorders develop, and if the disorders had not been identified at the time of screening, then the 20% figure would suggest treatment that is not in line with early intervention and prevention services.

When I consulted to the MA division of DHS in 1995, I was told that 1% children and adolescents receiving fee for service MA were using up 25% of the budget, with 98% of these funds being spent on hospitalization and personal care attendants. Six percent were using up 80% of the funds. If in fact many of these high cost interventions could have been prevented if there had been earlier screening when the problems had not been as severe, the money saved could be directed towards payment for more effective mental health screening.

Ms. Kennedy refers to a screening tool being developed by DHS, and being tested under an NIH grant. If this is the tool discussed by Pat Harrison, she told us that the student survey was not meant to be an overall screening tool for mental health issues. Also, a screening tool needs to gather information from other sources than the child or adolescent, in order to have appropriate sensitivity.

Ms. Kennedy alleges that the report discredits the Pediatric Symptom Checklist as being unreliable. In my memo, I did not note any problems regarding its reliability or validity. I cited a source (#60) that noted problems with the sensitivity of the test, noting that one out of five children of lower socioeconomic status who had mental health problems would be missed by this screening tool.

Ms. Kennedy notes that the tools described in my memo are "assessment tools" and not screening tools. Many mental health professionals would disagree with this, and in fact, these tools were described as screening tools by Ken Winters, Ph D, a University of Minnesota expert on screening tools. A separate issue is whether these are time consuming. I discussed the option of using a two step screen, for example using a functional assessment tool for the first step, and a more time consuming tool only for the individuals who clearly had evidence of dysfunction. I would point out that a screening tool, if adequately sensitive, would identify some individuals who ultimately do not have mental health problems, in order to not miss those who do. The use of a second, more thorough tool could screen out individuals who might not require a full mental health assessment.

I would be interested in reviewing references that state that the tools that I described lack reliability with the range of ethnic groups represented in Minnesota. I have worked with a number of mental health professionals who have found these tools to be very helpful in identifying mental health problems in children from many ethnic groups. The CAFAS is a tool that is not designed to assess the type of mental health problems being experienced, but is rather an assessment of functioning.

In my opinion, the major issue can be defined simply: "Are mental health problems experienced by children and adolescents who receive Medicaid being identified adequately by EPSDT screening?" Given the base rates of mental health problems in that population, and given the low rate of identification in EPSDT screening, two possibilities exist. One is that the children have been identified elsewhere and that the screening was not necessary. The other is that many of the children and adolescents are eventually identified, often well into the deteriorating course of their mental health problems, and that this could have been prevented to a large extent with adequate screening. Given research data regarding the sensitivity of doctors' ability to identify mental health problems (reference 48), given the time needed to obtain the required comprehensive mental health history compared to the time of a typical entire EPSDT screen, and given the lack of use of any standardized, reliable, valid, sensitive and specific screening tools, I would assume that the latter is true. Data analysis of types of service interventions, ages at which services are first initiated, etc., could help clarify this issue.

The papers that you could not find that were referenced were probable references quoted in other papers. I will fax the list to the medical library in order to obtain the papers.

In my opinion, Ms. Kennedy's response does not answer the key issues raised about EPSDT. If there is a significantly high rate of mental health problems in this population, and a very low rate of identification in EPSDT screens, then it is incumbent upon DHS to demonstrate that the children are identified by other means in a timely manner. If this is not the case, then the screening is failing to provide the service for which it is designed, and this would require a corrective action plan. Data analysis could clarify this issue, and I would urge the Ombudsman's office to seek clarification of this issue.

Please feel free to contact me if you have any questions.

Sincerely,



William Dikel, M.D.



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**This information will be made available in  
alternative format, for example, large print,  
Braille, cassette tape, upon request.**

**Issued under the authority of Roberta  
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and Mental Retardation**