State Leadership Workshops on Improving EPSDT through Medicaid and Title V Collaboration

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State Leadership Workshops on Improving EPSDT Programs through Medicaid and Title V Collaboration

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I. Introduction

Technical assistance to States, supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB), was provided through "*State Leadership Workshops on Improving EPSDT through Title V and Medicaid Collaboration"* (hereafter referred to as Workshops or State Leadership Workshops). This report describes the substantive results of three series of Workshops (Series I in 2006, Series II in 2007-08, and Series III in 2009).

The goal of the Workshops was to provide technical assistance to States in order to foster successful coordination between State MCH and Medicaid agencies regarding the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, with the aim of increasing the number of eligible children receiving screening, diagnosis, and necessary treatment services. EPSDT is the child health component of Medicaid. Federal statutes and regulations require that children under age 21 who are eligible for and enrolled in Medicaid be entitled to EPSDT benefits and that States cover a broad list of prevention and treatment services. At the same time, States have responsibility for key implementation decisions, including determination of provider qualifications, payment levels, benefit definitions, and data reporting requirements. State Title V programs have an important role to play in successful implementation of EPSDT.

Conducted in fourteen jurisdictions — Alaska, Arkansas, Colorado, Illinois,[*] Iowa, Maine, Michigan, Ohio, Nevada, Puerto Rico, Tennessee, Virginia, Washington State, and Wyoming — these State Leadership Workshops were specifically tailored to assist each State in focusing on and addressing current questions and challenges they have identified and in advancing child health policy and system development based on State-identified priorities.

This report presents background on the relationship of the Medicaid EPSDT and the Title V programs and summarizes key themes and promising practices that emerged from these fourteen State Leadership Workshops. More detailed information about each State's priorities and recommended action steps is also included. This report concludes with some "lessons learned" about opportunities to improve EPSDT in other States.

II. Background on EPSDT

The History of EPSDT and Title V

EPSDT was enacted in 1967 to build on the vision of President Johnson and the Congress in order "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected." To create the program, both Title XIX (Medicaid) and Title V (Maternal and Child Health) portions of the Social Security Act were amended. The preventive purpose of the program was core.

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[*] The Illinois Workshop was supported by The Ounce of Prevention Fund, not by HRSA/MCHB funding; however, it used the same methods and techniques developed in this project.

> *"The way in which EPSDT is understood today bears only a partial resemblance to its actual legislative roots. The original EPSDT amendments (which were contained in the 1967 Social Security Act) were principally a revision of the Title V Maternal and Child Health and Crippled Children's program (as it was then known). The Johnson Administration's vision for the program … was what we might term today "public health."* (Rosenbaum, 2003)

The sweeping vision of EPSDT has never been achieved, however, in part because of State implementation challenges. As reported in various studies, implementation of EPSDT did not go smoothly from the beginning. (Foltz, 1972; Foltz and Brown, 1977; Children's Defense Fund, 1977; Rosenbaum and Johnson, 1986)

> *"The EPSDT amendments to Title V and Title XIX (Medicaid) were ambiguous on four major issues: administrative responsibility, costs, eligibility, and scope of services. The problems experienced by federal, regional, State, and local administrators in resolving these issues illustrate the weaknesses inherent in federal-State relations, and the contrasting roles health and welfare agencies under Medicaid have played in the development of health policy. During the first year of implementation of EPSDT [in Connecticut]... State policies, which contravened federal policy, precluded effective resolution of the legislative ambiguities; no new services were added, the organization of health services remained unchanged and fragmented, and the State Health Department played only a limited role."* (Foltz and Brown, 1975)

During the late 1970s, Federal and State implementation slowed even further until judicial action, including decisions from the Supreme Court, established EPSDT as a unique preventive program obligation of State Medicaid agencies. With the focus on enforcement of Medicaid and EPSDT benefits as entitlements, the Title V amendments were largely forgotten. By 1980, State Medicaid agencies were directly responsible for what had begun 15 years before as a program with health care finance and public health components. (Rosenbaum, 2003; Rosenbaum and Wise, 2007)

Implementation challenges continued through the 1980s, and State EPSDT benefits varied widely. While Medicaid agencies functioned efficiently as payers, many did not have the capacity to provide the required EPSDT outreach, informing, transportation, and case management in an effective manner. By 1989, Congress adopted major amendments to EPSDT. This legislation sought to address critical weaknesses that had plagued the program, including: 1) inadequate periodic visit schedules that did not meet pediatric care standards; 2) failure to cover treatment services for diagnosed conditions; 3) limits on provider participation; and 4) billing for well-child visits that did not meet the EPSDT standard for screening. (Sardell and Johnson, 1989; Peters, 2006)

In theory, EPSDT guarantees children coverage for the full range of screening, diagnostic, and medically necessary treatment services. In practice, however, most States participation rates fell short of the 80 percent performance benchmark set in 1989 under the last major Federal law changes to the program. (Johnson, 2006; Johnson, Kaye, and Rosenthal, 2009) Participation rates measure the proportion of children who had at least one EPSDT comprehensive well-child (screening) visit in a year. Another measure of State performance is screening ratios which are adjusted for expected number of visits based on a child's age and months of enrollment in a year.

In addition, data reported by States regarding referrals for further diagnostic evaluation or treatment as a result of an EPSDT screen show low rates. Several factors may contribute to these low referral rates. Recent State demonstration projects indicate that many pediatric primary care providers do not use age appropriate or sensitive tools for early childhood developmental screening. (Kaye, 2008; Johnson, Kaye, and Rosenthal, 2009) In addition, more detailed State studies (e.g., using audits and record reviews) indicate that low rates may reflect both low numbers of referrals and inadequate provider reporting.

Reviews of the EPSDT program suggest that implementation challenges continue and that many children do not receive the screening, diagnosis, and treatment services to which they are entitled. (Richardson et al, 1995; Gavin et al, 1998; Copeland and Wexler, 2000; Perkins, 2005; Cohen-Ross, 2005; Pittard et al, 2007) For example, the U.S. Government Accountability Office found that only about 20 percent of young children in Medicaid received the required screening for lead poisoning or dental visits. (U.S. GAO, 2001) In 2004, a Federal court found that Illinois had failed to deliver equal and adequate health care services to children entitled under Medicaid and EPSDT. Factors cited for this failure included: "1) no established, uniform procedures to effectively inform families, 2) written notices and information materials not adequately tailored to families with low literacy levels or poor English skills, 3) insufficient oral informing to supplement written material, and 4) insufficient utilization of outreach and case management activities to capture those who fall through the cracks." (Quote from Cook County judgment)

EPSDT Today

The potential impact of EPSDT policy and program implementation has grown substantially, as Congress and the States expanded eligibility over the past two decades. (Rosenbaum and Wise, 2007; Schor et al, 2007) Today, Medicaid is a leading purchaser of pediatric care. It provides health coverage for one out of every five U.S. children, including more than one third of births and one third of children ages 1-5 years. (Kaiser, 2005a) The program is important to both low-income White and minority children, covering an estimated 80 percent of poor Black children under age 6. (Dorn et al., 2005)

Financing health care and related services through EPSDT also comes at a relatively low cost because children are generally healthy and have lower average health care costs than adults and senior citizens. Thus, while children comprise half of all enrollees, they account for only 17 percent of expenditures in Medicaid. (Kaiser, 2009)

Medicaid can be effective in improving access to care; with Medicaid, low-income children's access to health care is similar to that of non-poor, privately insured children. Yet implementation challenges continue to result in underutilization of services or failures to address child health problems identified.

Over the past 30 years, Federal EPSDT law has been amended and State efforts evolved to meet the standards of pediatric care and the special physical, emotional, and developmental needs of low-income children. Yet among officials, providers, and families in many States, there is a fundamental lack of understanding about what exactly EPSDT entails; in essence, it is the child health benefit package of Medicaid. People without this understanding of the program tend to focus on its separate components, with a majority understanding only the screening component.

As described by the Centers for Medicare and Medicaid Services (CMS): "*The EPSDT program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources.*" (www.cms.gov) The first component involves coverage of and payment for "medical assistance" services. The second is linked to a series of administrative obligations: informing; supportive services to ensure that care is secured (e.g. transportation, case management); and reporting.

Over the past 15 years, Medicaid has been transformed into a purchaser of commercially-oriented managed care coverage plans. (Rosenbaum et al, 1998, 1999, 2001, 2008; Berman et al, 2005) An increasing number of children receive health coverage and services through Medicaid or CHIP managed care arrangements. Overall, more than half of all Medicaid beneficiaries are enrolled in some form of managed care in all States and the District of Columbia, except Alaska and Wyoming.

Among Medicaid beneficiaries, children are the group most likely to be required by State rules to enroll in managed care. Children are more likely than beneficiary groups such as the elderly, pregnant women, and adults with disabilities to be included in mandatory managed care enrollment rules under Medicaid.

In theory, the preventive approach of EPSDT should fit well with managed care. As Medicaid managed care approaches were created, State agencies and MCOs faced difficulties in developing contract provisions that address the full scope of EPSDT. State contracts with managed care organizations (MCOs) may not cover the full package of EPSDT benefits (e.g., dental care, mental health, or services for children with special health care needs may be outside the main contract). Many MCOs are not positioned to accept the duty to provide both the health care and administrative assistance required by EPSDT (e.g., transportation, case management). (Rosenbaum et al., 1999) Moreover, some MCOs have data collection and reporting approaches quite unlike the EPSDT reporting requirements. With experience, State Medicaid managed care contracts for EPSDT services have improved over the past decade, but challenges in implementation continue.

Many, both inside and outside government, have called for efforts to modernize and otherwise improve the operational approach to providing EPSDT.

> "*To strengthen the federal role in ensuring the delivery of EPSDT services and to bring greater visibility to ways that States can better serve children in Medicaid, we recommend that the Administrator of CMS: work with States to develop criteria and time frames for consistently assessing and improving EPSDT reporting and the provision of services, including requiring that States develop improvement plans as appropriate for achieving the EPSDT goal of providing health services to children in Medicaid; and develop a mechanism for sharing information among States on successful State, plan, and provider practices for reaching children in Medicaid.*" (GAO, 2001)

> "*…despite the fact that (a) Medicaid has been transformed in the interim into a purchaser of commercially-oriented managed care insurance products with complex implications for program administration, and (b) EPSDT has undergone a dramatic restructuring from a coverage perspective as a result of amendments enacted in 1989… there has been no officially sanctioned, multi-partner effort to translate EPSDT in its*

> *entirety into the world of managed care purchasing or operationalize the EPSDT components in a modern health system context. The benefit package is invaluable and needs to be conceptualized to operate in a manner that is consistent with managed care. The administrative functions need to be updated to take modern delivery arrangements – not 1967 – into account.*" (Rosenbaum, 2003)

Opportunities for modernizing EPSDT have been defined under a joint project of the Center for Health Care Strategies and the George Washington University. (Rosenbaum et al., 2008) In addition, some State Medicaid agencies are looking for ways to improve program operations. (Pelletier, 2006) The EPSDT Workshops undertaken in this project are an approach for States to examine their EPSDT programs in the context of the child health system and begin an interagency discussion of how to achieve greater performance and efficiency.

Potential Impact of the Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contained substantial amendments to the Medicaid program, with many provisions that could affect the eligibility, enrollment, and benefits of low-income children and families. The DRA offers to States, through the Family Opportunity Act provisions, an option to enroll children with severe disabilities from low- and middle-income families as an alternative to out-of-home placement. Also, DRA permits, at State option, changes in Medicaid cost-sharing (premiums and co-payments) and benefit packages.

Notably, the new section 1937 of the Social Security Act (SSA) (as added by the DRA) permits States to provide Medicaid benefits to children (and adults) through benchmark coverage or benchmark equivalent coverage. If a State chooses to exercise this option, children under 19 must continue to receive EPSDT benefits. In a letter to Medicaid directors, CMS services also clarified that: The new law does not in any way give a State the flexibility to fail to provide the EPSDT services required by subparagraph (A) (ii) of section 1937(a) (1). In the case of children under 19, wrap-around or additional benefits that a State could choose to provide under subparagraph (C) of section 1937 (a) (1) must be a benefit in addition to benchmark coverage and the EPSDT services that the State is already required to provide under subparagraph (A) of that section.

The DRA also contains provisions which are not optional for States. First and foremost, in a provision that took effect in July 2006, States are now required to secure documentation of citizenship at the time of enrollment and re-enrollment into Medicaid. These provisions can have an effect on all children, but may be particularly disruptive to the enrollment process for newborns, children in the child welfare system, and children born to immigrant parents. Second, in provisions that were effective in January 2007, the DRA clarified the definition of Medicaid case management and targeted case management, as well as excluding some case management activities from Medicaid reimbursement. Since many States have used Medicaid case management or targeted case management financing for services such as home visiting, care coordination for children with special health care needs, early intervention, mental health, medical home, and child welfare, this change in law may affect Medicaid, Title V, and an array of other children's programs.

EPSDT and Title V Collaboration

EPSDT and Title V have been linked from the beginning both in purpose and in legislative intent, as Congress envisioned that Title V agencies would identify children in need of care and the Medicaid program would finance the needed services. (Rosenbaum and Johnson, 1986) Table I illustrates how this inter-relationship continues to this day. In 2008, for example, 49.3 percent of pregnant women, 44.6 percent of infants, and 35.5 percent of Children with Special Health Care Needs (CSHCN) served in State Title V programs were Medicaid beneficiaries.

Over the history of the programs, Congress has added a number of requirements to Title V calling for collaboration with Medicaid.

Currently, Federal law requires that Title V programs:

- assist with EPSDT coordination (42 USC Section 705(a)(5)(F)(i));
- establish coordination agreements with their State Medicaid programs (42 USC Section 705(a)(5)(F)(ii));
- provide a toll-free number for families seeking Title V or Medicaid providers (42 USC Section 705(a)(5)(E));
- provide outreach and facilitate enrollment of Medicaid eligible children and pregnant women (42 USC Section 705(a)(5)(F)(iv));
- share data collection responsibilities (particularly related to infant mortality reduction and Medicaid) (Pub. L. 101-239, Section 6507); and
- provide services for CSHCN and disabilities not covered by Medicaid (42 USC Section 701(a)(1)(C)).

Over and above statutory requirements, Title V also has long played a role in implementing and improving EPSDT programs and policy. A recent review of State MCH-Medicaid interagency agreements found that, while State strategies vary widely, most go well beyond the Federal legislative requirements. (http://mchb.hrsa.gov/IAA/) State child health leaders have adopted innovations and remedies to improve screening, diagnostic, and treatment rates, including: jointly develop protocols for care and recruit/train providers, outreach or care coordination to Medicaid child beneficiaries provided by Title V, and reimbursement methodologies for payment of Title V direct care services developed by Medicaid. Many opportunities exist for continued improvement through collaboration and coordination.

Table 1. Populations Served by Title V by Source of Health Coverage, FY 2008

	Number Served in Title V (Total = 40, 299,062)	Primary Source of Health Coverage				
		Medicaid (Title XIX)	CHIP (Title XXI)	Private/ Other	Uninsured	Unknown
Pregnant Women	2,560,280	49.3%	0.3%	23.3%	5.3%	17.8%
Infants < 1 year	4,119,899	44.6%	0.5%	21.8%	5.0%	22.7%
Children 1-22 years	29,015,882	38.0%	3.8%	21.7%	6.2%	26.7%
CSHCN	1,844,973	35.5%	3.5%	21.9%	3.9%	33.1%
Others	2,758,028	30.9%	0.5%	23.4%	26.4%	16.3%

Data may include actual counts or estimates as reported by States in their Title V Block Grant FY 2008 Annual Report and FY 2010 Application; Form 07).
Source: Title V Information System (TVIS) https://perfdata.hrsa.gov/MCHB/TVISReports/default.aspx

III. State Leadership Workshops on EPSDT

Project and Workshop Design

Given the aforementioned background and context, the State Leadership Workshops on EPSDT were developed to assist States who are experiencing persistent challenges in implementation of EPSDT, as well as to inform current public administrators from Medicaid and Title V Programs. The desired outcome of the Workshop project overall was to support States in their efforts to improve child health policy and system development based on State-identified priorities.

The approach to EPSDT Workshop design was built on experience with a prior Workshop series in 2004 focused on managed care and child health in five States (Connecticut, Kansas, Pennsylvania, Ohio, and Wisconsin).[†] Lessons learned from these previous Workshops were applied to a new and revised Workshop series on EPSDT.

Several factors were identified that can serve as potential predictors of success for this type of technical assistance effort. Specifically Workshops were more likely to succeed if a State:

- expressed interest for (i.e., requests or volunteers) a technical assistance Workshop;
- had its own "catalyzer" – a State official or advocate with the authority and/or credibility to bring the concerned leaders to the table;
- had an independent facilitator;
- met a "threshold" test of being able to organize a Workshop planning committee that accurately reflects core constituencies;
- focused the Workshop around finding "common ground"; and
- maximized participation by senior executive-branch officials.

The EPSDT State Leadership Workshop design was purposeful and structured across all 14 jurisdictions. The design was guided by principles of the original User Liaison Program (ULP).[‡] The core of the approach was to rely on State officials to guide the content and discussions of the ULP Workshops. In essence, the policymakers set the priorities for learning and action. Careful planning, elimination of research and program jargon, high quality presentations, and expert facilitation were additional characteristics of the ULP Workshops. (Fox and Greenfield, 2006) By engaging Robert Fordham as a senior advisor, Johnson Group Consulting was able to apply the lessons learned from ULP to the EPSDT Workshop series. Accordingly, the Workshop approach was modified.

[†] See: *Advanced Leadership Workshops on Fiscally Sound Medicaid and SCHIP Managed Care Contracts for State Title V Maternal and Child Health Agencies and Local Health Departments* http://www.hrsa.gov/childhealthmccontracts/default.htm Also see: http://www.hrsa.gov/epsdt/

[‡] The User Liaison Program was developed by Robert Fordham and colleagues at what was then the National Center for Health Services Research, now known as the Agency for HealthCare Research and Quality.

Three series of EPSDT-focused Workshops were conducted. Six States participated in Series I in 2006, 5 States and Puerto Rico in Series II in 2007-08, and 2 States in Series III in 2009 for a total of fourteen (14) Workshops.[§]

The development of each Workshop involved collaboration among Federal agency staff, project contract staff, and State planning committee members.

- The role of HRSA/MCHB was to: 1) award a contract to a private firm judged to have appropriate expertise to conduct the Workshops, 2) promote the Workshops to State Maternal and Child Health leaders (e.g., through posting on the MCHB Web site, distribution of brochures), and 3) attend the Workshops.
- Participating States were asked to: 1) convene a planning group, 2) identify topics for the agenda, 3) encourage attendance at the Workshop, 4) send invitations to key leaders, and 4) secure meeting space, audiovisual equipment, and food, if desired.
- The primary role of the contract staff (Johnson Group Consulting) was to provide technical assistance in the course of planning and conduct the Workshops, including content knowledge and on-site presentation and facilitation. Additional facilitation was provided for the Alaska Workshop by Mark Gibson of the Oregon Health Sciences University. Neva Kaye of the National Academy of State Health Policy was co-facilitator of the Workshops in Arkansas, Maine, and Puerto Rico. Dr. Edward Schor of the Commonwealth Fund made presentations at the Washington State Workshop.

Selection of States

States requested this specific technical assistance with a brief, two-page application. (See Appendix D.) Each State's application was used to guide decisions and process. The application questions sought to give information about the engagement of program leaders, the nature of the issues for which the technical assistance was requested, and the general level of collaboration between Medicaid and Title V. (See Appendix D.)

For each series, several criteria were used to select from the group of States that expressed interest in hosting a State Leadership Workshop. Program performance, policy options, and current initiatives were reviewed for each State. (See Appendix B.) Ultimately, the States selected for each series varied in geographic location, size of the population served, administrative structures for Medicaid and public health, Title V budget, and EPSDT performance.

One aspect of EPSDT performance is the adequacy of the periodic visit schedule (also known as a periodicity schedule). Table 2 shows the periodic visit schedules applicable in these States for 2007. While some States have updated their schedules since that time (often based on release of an update of the AAP Bright Futures guidelines), this chart illustrates the variations among Workshop States. For example, in the case of toddlers from ages 1 and 2 years, nine States (AK, CO, IL, IA, ME, MI, NV, VA, and WY) covered four EPSDT comprehensive well-child periodic visits or two per year. Three States (AR, OH, and TN) covered three visits across these 2 years of life, and Washington covered two visits or one per year. Similar variations are shown for

[§] In 2009, two additional Workshops were conducted in Vermont and Colorado using the same general approach but were used to pilot a system mapping tool that is a product of the overall project.

older children and adolescents. For example, annual visits are recommended for high school students ages 15-18 years in seven States (AR, CO, ME, MI, OH, TN, and WY), while others cover visits every other year. Visit schedules for infants the first year of life vary somewhat based on how the State counts the newborn visit that might be provided in a birthing hospital.

Table 2. State EPSDT Periodic Visit Schedules, 2007

State	**AK**	**AR**	**CO**	**IL**	**IA**	**ME**	**MI**	**NV**	**OH**	**TN**	**VA**	**WA**	**WY**
Infant <1 (1 year)	5	6	6	9	6	9	5	5	6	5	6	5	7
Toddler 1-2 (2 years)	4	3	4	4	4	4	4	4	3	3	4	2	4
Preschool 3-5 (3 years)	3	2	3	3	3	3	3	3	3	3	3	3	3
Elementary School 6-9 (4 years)	2	2	2	2	2	2	2	2	4	2	2	3	2
Middle School 10-14 (5 years)	3	5	5	3	3	5	4	3	5	5	3	2	5
High School 15-18 (4 years)	2	4	4	2	2	4	4	2	4	4	2	2	4
Youth 19-20 (2 years)	1	2	2	1	1	2	2	1	2	2	1	1	2

Medicaid program data for selected States is shown in Table 3. Variations in coverage and program penetration reflect Medicaid income eligibility levels for children, the size of the child population, size of the population over age 65, birthrates, and poverty levels. For example, Maine's eligibility levels for adults and children were higher than those of Nevada. As a result, compared to Maine, Nevada has a higher proportion of uninsured children and a lower percentage of children covered by Medicaid. At the same time children are a smaller proportion of all Medicaid beneficiaries because Maine covers more non-elderly adults.

Table 3. Medicaid Program Data, Selected States

	Uninsured Children 0-18*	Children as a Percent of All Medicaid Beneficiaries*		Percent of all children covered by Medicaid*	Percent of poor children covered by Medicaid*	Percent of all births financed by Medicaid**	Percent of all Medicaid beneficiaries in managed care***
	Uninsured	**Children**	**Expenditures**				
Alaska	13%	60.8%	32.4%	22%	52%	55.1%	0%
Arkansas	8%	56.1%	26.7%	45%	78%	51.7%	80%
Colorado	13%	58.8%	21.8%	16%	44%	37.3%	96%
Illinois	7%	52.5%	17.8%	29%	70%	39.9%	55%
Iowa	5%	48.7%	15.4%	25%	68%	28.1%	82%
Maine	6%	40.3%	22.0%	34%	79%	47.0%	63%
Michigan	6%	56.1%	15.1%	29%	73%	35.3%	88%
Ohio	7%	50.9%	15.0%	27%	67%	32.1%	72%
Nevada	17%	58.5%	23.4%	16%	38%	32.2%	83%
Tennessee	10%	47.9%	20.3%	35%	75%	46.2%	100%
Virginia	9%	54.6%	22.0%	20%	58%	27.6%	63%
Washington	7%	53.8%	18.3%	26%	65%	45.6%	89%
Wyoming	9%	65.9%	26.9%	23%	60%	46.0%	0%
Puerto Rico	#	#	#	#	#	#	97%

Notes for Table 3:
* State data for 2007-2008 except Nevada for 2005; ** Data for births in 2003 except Nevada for 2002 and Virginia data are for State fiscal year; *** Data for 2008.
# Comparative data are not routinely reported for Puerto Rico
Source: Kaiser Family Foundation. Based on the Current Population Survey (CPS); More information at http://www.statehealthfacts.kff.org/methodology Used with permission from State Health Facts.

Appendix C provides more comparative information on the EPSDT in selected States. The table in Appendix C offers an overview of EPSDT program performance for the selected States, based on Federal fiscal year (FFY) 2007 data submitted to CMS. The graph in Appendix C shows the selected States' participation rates, that is, the percent of children enrolled in Medicaid for the year who received at least one EPSDT screening visit. The participation rate reflects how many children participated in EPSDT and does not reflect differences in the periodicity schedule by age (e.g., five visits for infants) or for duration of coverage (e.g., a child may have been enrolled in Medicaid for only for 8 months during the year). In contrast, the screening ratio shows the proportion of eligible children receiving screens adjusted for enrollment duration and age-specific periodicity schedules. The variations by State reflect differences in both the adequacy of data reporting and collection efforts, as well as EPSDT program performance (e.g., continuity of enrollment, use of managed care, effectiveness of outreach and informing, provider participation, and accessibility of pediatric primary care providers participating in Medicaid).

Workshop Planning and Process

After a State was selected, State leaders were asked to respond to additional questions in order to provide information about the relationships between Title V, Medicaid, and other agencies. The responses to these questions helped project staff understand the general organization and structure of key child health programs. (See Appendix D.) State leaders also were encouraged to send organizational charts and background documents related to their child health programs and initiatives.

To begin their planning, each State convened a planning committee of five to six individuals, including, at a minimum, executive branch leaders from Medicaid and Title V agencies. Through conference calls, each planning committee identified topics for the agenda, developed the list of invitees, and provided background information about their State's unique challenges and opportunities. The planning committee discussions guided the invitational process; that is the invitees were selected based on their relationship to the agenda topics.

For Series II, a sample Workshop agenda was offered at the beginning of the planning process. In all States, the planning committee developed and approved their Workshop agenda. (See agendas in Appendix E.)

States were encouraged to identify an area of importance in child health that might be addressed through better coordination and collaboration. The purpose was not to create new projects but to use the Workshop process to advance their ongoing work. The focus was on short-term (12-18 month), cross-sector changes and activities that would have a positive impact on child health.

Each Workshop had a mixture of short didactic presentations, group discussions led by an expert facilitator, and group problem solving. The main activity was full-group, 90-minute discussions, supported by seating in a hollow square arrangement. These discussions were open ended and not intended to be structured "brainstorming"; however, their effect was to generate new ideas and strategies to overcome ongoing challenges and breakdown interagency barriers.

The primary learning objectives for Workshop participants were: a) to improve skills for effectively managing the reciprocal obligations between Title V and Medicaid agencies with

regard to EPSDT; and b) to increase knowledge of available tools and strategies to improve child health services. More specifically, the aim of this set of Workshops was to increase Workshop participants' understanding of and knowledge about how to:

- Strengthen Title V and Medicaid partnerships to improve EPSDT and child health.
- Effectively promote quality child health services through EPSDT, Title V, and other public programs.
- Use information from the EPSDT Web module (http://www.hrsa.gov/EPSDT) and the pediatric purchasing specifications and related tools and materials.
- Promote quality in pediatric primary care, including use of pediatric purchasing specifications to improve managed care contracts.
- Use care coordination and case management to support providers and families.
- Inform and engage families in EPSDT and other child health services.
- Effectively monitor the performance of EPSDT.

The essential, core participants for these EPSDT Workshops were senior leadership from State Medicaid and Title V Maternal and Child Health/Children with Special Health Care Needs Programs. HRSA did not approve a State's participation unless the senior leadership from these three units of government was committed to participation. In half of the Workshops, commissioners of health, Medicaid directors, or umbrella health and human service agency commissioners attended the Workshop. Depending on each State's priorities, Workshops also included representatives from other State agencies (e.g., Children's Health Insurance Programs - CHIP, Part C Early Intervention, Child Welfare, Mental Health, WIC, Developmental Disabilities, Oral Health, Adolescent Health, or Education), as well as from local city/county public health programs. Representatives from State legislatures, Governor's offices, and so-called "children's cabinets" were included, as appropriate. In addition to governmental officials, State Workshop planners invited private sector partners, such as health care providers, academic experts, health plans, and families and their advocates, as appropriate. Provider organizations typically included the State Chapter of the American Academy of Pediatrics and/or American Academy of Family Physicians, as well as school nursing, public health, and primary care associations.

At the end of a Workshop, the participating State leaders were given an opportunity to prioritize the main issues raised in the discussion. Using some of the methods from a "concept mapping" technique (Trochim et al., 2003), the group ranked statements based on potential impact (importance) and feasibility. These rankings were plotted to show those with the highest expected impact and feasibility. The group thus identified three to five priority areas for action and assigned individuals to follow up on each priority. (Each State's priorities are discussed in Section IV of this report.)

Workshop Participants

Required participants from government were key leadership from:

- State Medicaid agencies
- Title V Maternal and Child Health (MCH) programs
- Title V Children with Special Health Care Needs(CSHCN) programs

Senior government leaders concerned with health were also important participants, including:

- Commissioners of Health/Public Health,
- Medicaid directors,
- "Umbrella" Health and Human Service Agency commissioners,
- State legislators,
- Governor's office staff, and
- "Children's cabinet" staff.

Depending on each State's priorities, representatives from other State agencies and units of government attended, including but not limited to:

- Adolescent Health,
- Child care/Early Care and Education,
- Child Welfare,
- Children's Health Insurance Programs (CHIP),
- Developmental Disabilities,
- Early Intervention or Special Education,
- Education,
- Mental Health,
- Minority Health,
- Oral Health,
- Public Health Nursing,
- Supplemental Nutrition Program for Women, Infants, and Children (WIC),
- and/or
- Local city/county public health programs.

Families and their advocates were involved, including representatives from:

- Family Voices,
- Voices for Children or other State-based child advocacy organization, and/or
- Federation for Families.

Key representatives from the private sector, such as:

- Health care providers, particularly representatives of the State Chapter of the American Academy of Pediatrics and/or the American Academy of Family Physicians, as well as school nursing, public health, community health centers, and primary care associations. Representatives from Children's Hospitals and Hospital Associations were included in a few Workshops.
- Academic experts from university-based programs and projects,
- Child health quality improvement projects, and/or
- Health plans, particularly Medicaid managed care organizations.

Foundations and other charities were represented at some Workshops and provided funding or facilities for a number of the meetings.

Factors in the Success of the Workshop Model

The success of these Workshops, as reflected in the participant evaluations and State actions, depended heavily upon three main factors. First, convening a public-private, interagency group of senior-level leaders who could discuss and envision the whole child health system, not just their program. Second, having an outside facilitator with content knowledge who could add information and offer technical assistance through the whole Workshop as the discussion advanced. Third, it was essential that State leaders had an opportunity to focus on their priorities and action steps.

Convening an appropriate group of State-level child health leaders was a critical element of success. Participants needed to have a perspective on larger child health and health systems issues. These Workshops were intended to involve senior leaders from government, providers who are leaders among their peers, parents who can speak for themselves and advocate for the concerns of other families. Our experience suggests that having too many participants who only know the realities of their own, smaller projects or practices did not lead to a productive discussion or to subsequent State action. In addition, the model for the Workshops called for having cross-agency participation. At least Title V and Medicaid agencies were to be represented. Having education, child welfare, human services, and others involved as appropriate was of benefit to the discussions. The group also needed to involve both public and private sector leaders (somehow government only groups seemed to generated fewer new ideas). Guides for effective meetings indicate that a "hollow-square" group discussion is most effective with no more than 30 people, and these Workshop experiences supported this rule.

The Workshop design called for having a facilitator with broad knowledge of child health and Medicaid issues. The facilitator not only managed the discussion but also shared knowledge about topics, offered specific examples of lessons learned in other States, and generally provided technical assistance through the discussion. This built on the Federal "User Liaison Program" and similar projects using a combined facilitator/technical assistance role. (Fox and Greenfield, 2006) Without knowledge of the broad issues in child health and Medicaid, the facilitator would not be able to advance the discussion of the group effectively.

And, last but not least, the success of the Workshops depended on their being guided by State leaders' priorities. From the start of agenda development in the planning phase through selection of priorities at the end of the Workshop, State leaders made the decisions about what would be discussed and what actions would be taken. In the process, Title V and Medicaid staff members concerned with child health developed the overall topic and the discussion questions for the agenda. These were guided by their current projects, challenges, and opportunities. Through the group discussions, Workshop participants were able to voice their views about obstacles and potential solutions to improving child health. By the end of the Workshop, a set of interagency, consensus priorities were generated that called for action in the coming 6, 12, or 18 months. (See discussion of priorities below.) Together, these elements of the process enabled State leaders in most Workshops to advance collaboration and integration that could improve the child health system and outcomes.

Evaluation

Summary of Workshop evaluation results

Overall, the evaluations of 11 State Leaderships Workshops were positive. No evaluations are available from the Iowa and Colorado Workshops in 2006, and Nevada's Workshop evaluation had somewhat different, non-comparable questions. A summary of the written evaluations follows.

- In total for the 11 States, 9 out of 10 people rated the Workshops to be excellent or good.
- Most respondents felt the Workshop met the stated objective, and virtually all strongly agreed that the Workshop addressed topics of importance.
- The clarity, level of technical detail, and thoroughness of the overview presentation were viewed as "just right" by 8 out of 10 participants.
- The level of interaction received high "positive" marks – nearly 90 percent. While most participants believed strongly that the discussions reflected cross-sector perspectives, there was variation by State (80-100 percent).

These evaluation results have two limitations. First, as is typical of Workshop evaluations, only about half to three-quarters of participants completed the evaluation form. Overall, only half of participants' perspectives are represented here. Second, these evaluations reflect the immediate responses of Workshop participants. It was not feasible to study the longer term impact of the Workshop on State policy, programs, and collaborative efforts across all 11 States. At the same time, a majority of States have subsequently reported that they made program and policy changes based on the priorities for action set at their Workshops.

Modifications based on Workshop Evaluations

Based on the 2006 evaluation responses and other feedback from State Workshop planners, Johnson Group modified the approach for the 2007-08 Workshop series. Specifically, the process was changed to:

1. Clarify and emphasize that this is a technical assistance Workshop, not just a State meeting.
2. Encourage State planners to invite senior officials.
3. Provide a sample agenda or key topics from which planning groups could begin agenda development.
4. Develop and provide a more uniform package of materials.
5. Give more emphasis to the role of Title V MCH and CSHCN programs.
6. Assure adequate time for State prioritization of topics and planning for next steps at the end of each Workshop.

Each of these changes was implemented on a consistent basis throughout the 2007-08 Workshop series. These changes improved evaluation scores and reported satisfaction of State Workshop planners.

Evaluation Results Summary Table

(Scale 1-5, with 5 being strongly agree or excellent)

	Question	***AK***	***AR***	***IL***	***ME***	***MI***	***NV***	***PR***	***TN***	***VI***	***WA***	***WY***	Average
Fit with needs													
1	Met Workshop objectives	4.2	4.4	4.7	4.5	4.7	4.1	4.9	4.5	4.3	4.1	4.7	**4.5**
2	Addressed important topics	4.7	4.8	4.8	4.6	5.0	na	4.9	4.8	4.5	4.4	4.8	**4.7**
3	Provided information for participants	4.2	4.6	4.7	4.6	4.8	3.9	5.0	4.3	4.3	4.0	4.8	**4.5**
4	Provided information useful for improving child health in state	4.2	4.6	4.6	4.8	4.9	na	4.8	4.4	4.1	3.9	4.7	**4.5**
Overview presentation													
5	Clarity	4.4	4.6	4.5	5.0	4.9	4.8	4.9	4.3	4.6	3.4	4.5	**4.5**
6	Appropriateness	4.2	4.7	4.6	5.0	5.0	4.8	5.0	4.5	4.6	4.0	4.7	**4.7**
7	Thoroughness	4.0	4.7	4.6	4.6	4.9	4.8	5.0	4.6	4.5	4.2	4.6	**4.6**
Group discussions													
8a	Were interactive and inclusive	4.6	5.0	4.9	4.6	5.0	4.9	5.0	5.0	5.0	4.9	4.8	**4.9**
8b	Reflected cross-sector perspectives	2.8	5.0	4.9	4.5	5.0	na	5.0	4.9	5.0	3.9	5.0	**4.6**
8c	Generated practical recommendations	3.2	5.0	4.9	4.3	5.0	na	5.0	4.8	4.9	4.4	4.6	**4.6**
Overall													
9	Overall Workshop rating (Excellent, Good, Fair or Poor)	4.2	4.6	4.7	4.6	4.9	4.9	5.0	4.5	4.5	4.4	4.7	**4.6**
Percent evaluating		*45*	*59*	*35*	*44*	*48*	*65*	*54*	*71*	*70*	*80*	*44*	**56%**

III. Summary of Key Content Areas for the Workshops

While each Workshop was customized to meet the needs of the individual States, there was overlap in the subject areas covered in the Workshops. Each planning group was provided with a sample agenda and given an opportunity to develop the core questions that would guide discussion. (See agendas in Appendix E.) These questions reflected overall system concerns, as well as specific issues of concern such as parent informing, medical homes, or case management.

Each Workshop discussion included a "mapping" exercise. Participants were asked to describe how community systems interface, who has accountability of care coordination and case management, and what funds are being used to finance these supports. These group discussions identified and illustrated current challenges and opportunities. As a result of Workshops in these 14 States, HRSA/MCHB has contracted for development of a tool that can be used by other States as a discussion guide and approach to child health systems mapping. This tool was vetted in a pre-conference session of the Association of Maternal and Child Health Programs and piloted in Vermont and Colorado in fall 2009.

Overall, based on the mapping and agenda questions, child health leaders in each Workshop were able to advance discussion of key issues. Several key themes and some ideas on promising practices emerged from these State Workshops. Concerns about special populations, particularly children birth to six and adolescents, were widely expressed. In addition, a variety of administration and coordination topics were commonly discussed across the States. The discussion below provides a summary of the common or often discussed issues grouped into three categories: a) administration and collaboration, b) operations of EPSDT, and c) special populations or service areas.

Administration and Collaboration Issues

Improving the quality and effectiveness of child health services depends heavily on the administrative structures that support programs and on collaboration between agencies, providers, and families. One of the major results of these Workshops was to give States an opportunity to discuss administrative and collaboration issues among a public-private and interagency group of leaders. These types of discussions are fundamental to current efforts in quality improvement, care coordination/case management, medical home, and information technology.

- *Provider capacity and participation*: Urban and rural medically underserved areas exist across the country, and the distribution and supply of pediatric providers is uneven in every State. Even where pediatric providers are available, many choose not to participate in Medicaid or participate on a limited basis. These challenges were discussed in each of the 11 Workshops. Strategies discussed for improving provider capacity and participation included increased reimbursement, telemedicine, and so-called "academic detailing" to deliver additional training and support.

- *Care coordination and case management*: Care coordination, particularly for CSHCN, and case management financed by Medicaid are approaches widely used to support families, improve care, and contain costs. Currently, every State uses these approaches in some way and uses the terms interchangeably. During every Workshop, concerns were raised about the structure or financing of care coordination/case management. Strategies discussed included: reviewing existing arrangements, creating EPSDT case management positions, using technology to improve linkages, better aligning personnel and needs.
- *Quality improvement*: Improving health quality is a leading topic of discussion in health policy and practice. The Institute of Medicine has written extensively on approaches for improving quality. For children, a number of States which did not host Workshops have special child health quality improvements. The experiences reported by the National Initiative for Child Health Quality (NICHQ), Vermont Child Health Improvement Program (VCHIP), Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ), and Vermont-Oxford Network each provide examples of how such a practice collaborative might effect change. Workshop participants saw opportunities to create their own quality improvement collaboratives or use data in other quality improvement efforts.
- *Implementation of the medical home concept:* For more than a decade, the American Academy of Pediatrics and HRSA/MCHB have called for increased use of the pediatric medical home concept, particularly for CSHCN. Most States have at least a medical home pilot project. These Workshops identified challenges in implementing the medical home concept, emphasizing the lack of fiscal incentives and of clear operational definitions.
- *Child health data and information systems*: At a time when health information technology and electronic medical records are being widely discussed, it is not surprising that all of these States saw opportunities to use these tools to improve EPSDT. Only Wyoming, however, had an active project that was seen as having the potential to affect EPSDT program administration in the near future. States also saw opportunities to make better use of integrated child health databases and to use Title V funding to support such efforts.
- *Title V – Medicaid administrative agreements/memoranda of understanding*: Many of the interagency relationships between Title V and Medicaid are defined in required administrative agreements. The Workshop participants appeared to have limited knowledge of what was defined in their State's agreements or the potential uses of such agreements. A new resource prepared for HRSA/MCHB may provide new insights to States concerned with this topic. http://mchb.hrsa.gov/IAA/

EPSDT Operational Issues

Improving EPSDT is a key role for Medicaid and Title V agencies. States have the responsibility for setting a recommended visit schedule, conducting family outreach and

informing, developing effective managed care contract arrangements, and assisting families in securing services. These issues were part of the discussions in each of these Workshops.

- *Periodic visit schedules and standards of care*: Each State has responsibility for setting schedules for periodic screening — known as "periodicity schedules" — for medical (including physical and mental health) dental, vision, and hearing services. These services must be provided at intervals that meet reasonable standards of medical practice. With the release in October 2007 of the new American Academy of Pediatrics guidelines — Bright Futures — states have given attention to improving and updating periodic visit schedules. (See for example, Johnson, Kaye, Cullen, and May, 2009.)
- *Family outreach and informing:* Conducting outreach and informing related to EPSDT is a required State responsibility. Child health leaders in these Workshops emphasized the weaknesses of current methods (e.g., informing at the time of Medicaid eligibility intake, annual letters to families). Interagency collaboration and increased use of public health agencies was seen as a major opportunity make improvements in this area.
- *Referral and treatment process:* Each of these State Workshops concluded that too few mechanisms exist to support families and primary care providers when an EPSDT comprehensive well-child visit identifies a problem that requires further referral for diagnosis and treatment services. Most States also noted that no standardized forms are available to document such referrals. (Maine does have such an approach.) Improved use of staff in local health departments, referral and feedback forms, and use of telephone and Internet technology were identified as important means to support the referral process. (For more information, see Johnson and Rosenthal, 2009.)
- *Managed care arrangements:* In each of these States except Alaska and Wyoming, managed care is the dominant approach to covering children in Medicaid. In some States more than 80 percent of Medicaid beneficiaries are enrolled in managed care. A variety of approaches to maximize managed care have been adopted by States; however, inadequate linkages to safety net providers and challenges in serving children with special health care needs were noted.
- *Deficit Reduction Act reforms:* Since the DRA affected eligibility, family cost sharing (i.e., premiums and co-payments), case management, and benefits, States discussed the potential impact of these changes in Federal law. None of these States had adopted changes in eligibility, cost sharing or benefits for children. The case management provisions, which affect an array of child health services, were a topic of interest and discussion.

Special Populations or Service Areas

Unique child and family needs, specialization in medical practice, and dedicated public program funding lead State officials to focus on special populations or service areas. The following 5 were areas of particular importance to Workshop participants in these 14 States.

- *Early childhood development services*: While child health professionals agree about the importance of early childhood development services, financing child development services through Medicaid is not simple. One reason is that, despite overlaps between EPSDT and early child development services content, the current Federal guidance does not specifically define "child development services" (Perkins, 2005; Johnson, 2003) A second reason is that Medicaid was designed to finance health care, while child development services often are provided by education or social service agencies. Third, each State has flexibility to make rules about which providers are qualified. Finally, because some child development services also are funded by other public programs (e.g., early intervention, mental health, or children with special health care needs), it may be difficult to understand which eligibility rules apply and who should pay for what services. The Arkansas, Illinois, Michigan, and Puerto Rico Workshops had a special focus on early childhood and their Assuring Better Child Health and Development (ABCD) projects.
- *Mental health and/or early childhood mental health*: Many children experience social-emotional and behavioral challenges that go undetected and interfere with their overall development, school success, and long-term mental health. Medicaid plays a particularly important role in addressing the developmental, behavioral and emotional needs of young children, covering 40 percent of U.S. infants (under age one) and an estimated one third of children ages 1-6 years. The EPSDT benefit provides coverage for a comprehensive array of preventive services that are designed to ensure health and development of children. This includes history and screening for mental health concerns. Approaches are being tested by five State Medicaid agencies through ABCD II pilot projects, and under State children's mental health grants from the Substance Abuse and Mental Health Services Administration. The Colorado Workshop in 2006 focused primarily on early childhood mental health, and mental health issues were discussed in most other State Workshops.
- *Children with special health care needs*: CSHCN are defined as children under 21 who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, and require health and related services of a type or amount beyond that which is required by children generally. (HRSA/MCHB). Such children may have a variety of conditions, but all have a need for specialized health care services, care plans, and care coordination. CSHCN account for an estimated 76 percent of total Medicaid expenditures for children, even though they represent less than 25-30 percent of the population. For pediatricians, the standard of care for children with special health care needs is that of a "medical home" – an approach to providing care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally competent. CSHCN issues were discussed in every Workshop.
- *Infants and toddlers in Part C Early Intervention*: Part C of the Individuals with Disabilities Education Act (IDEA) authorizes each State to operate an early intervention program for infants and toddlers, with or at risk for developmental delays and disabilities. Current policy and fiscal structures do not make it easy to provide early intervention to young children who show early signs of delay or environmental

risk factors, but whose conditions do not reach a diagnosable level. No one State agency has designated responsibility nor is there any clear funding stream. Under EPSDT, Medicaid can play a particularly central role, but in most States, interagency relationships are not strong. Similarly, Part C has the option of including infants and toddlers at risk of delays in its eligibility criteria, but only a small number of States have used this provision.

- *Adolescent health*: EPSDT screening rates and use of adolescent health services are low across the country. A variety of approaches have been recommended to improve use of adolescent health services, particularly by low-income and at-risk teens. School-based and school-linked services are one such strategy. More efficient use of visits for sports physicals, immunizations, and pregnancy tests has been recommended. In particular, several States saw the use of limited "sports physicals" as a barrier and disincentive for families to seek a comprehensive EPSDT well-child visit. Changing school requirements was a recommended strategy and already achieved in some areas. Quality improvement practice collaboratives are another approach (recently used with success in Vermont). The Tennessee Workshop had adolescent health as a primary focus.

Some child health topics received less attention than expected. The following are notably examples.

- *School Health:* School health is an important strategy for providing care, assessing risks, and linking to other services. Moreover, the CMS issued draft guidance related to Medicaid and school health financing during the project period. Yet, school health was not a primary agenda topic for any Workshop and emerged as a primary topic of discussion in only two States. This issue may have been seen as remote from the larger overall discussion of EPSDT and/or State officials may not have wanted to use an interagency meeting to tackle a sensitive topic under CMS review.
- *Immunization*: Childhood immunization has long been a linchpin of child health. It is the most effective preventive intervention and has led to dramatically reduced disease incidence. Evidence also suggests that a majority of parents are motivated by the offer of immunizations to seek child health services and bring their children for well-child visits. Immunizations also are important and unique enough to have their own financing strategy through the Vaccines for Children program. Yet, immunization services were not a primary agenda topic for any Workshop and emerged as primary topic of discussion only in Puerto Rico. This may be evidence of success in the 10 other States that hosted Workshops or may reflect the fact that States have separate meetings on that topic.
- *Oral health*: Dental caries is the single most common chronic disease of childhood, affecting five to seven times as many children as asthma. Approximately one quarter of US children – mainly poor, minority, and special health needs children – experience 80 percent of all decayed teeth. Federal EPSDT rules require dental coverage and a distinct dental periodicity schedule requirement under Medicaid EPSDT for well-child dental services, and call for direct referral to a dentist starting at age 1. More can and should be done through EPSDT to reduce the disproportionate burden of dental disease. Yet while oral health was a topic raised as

a concern by many planning groups, it was not a primary agenda topic for any Workshop and emerged as a primary topic of discussion in only two States (i.e., Wyoming and Maine). This likely reflects the fact that States have separate meetings on this topic, including more dental providers and advocates.

IV. State-by-State Summary of Workshop Discussions and Priorities for Action

Alaska

Alaska's EPSDT program extended to more than 87,000 children in 2005, including children covered by Medicaid and the Denali KidCare (the Children's Health Insurance Program – CHIP). Studies suggest that only about half of eligible children receive expected well-child and comprehensive screening, and even fewer have the benefit of effective referrals and follow up diagnostic and treatment services. In 2005-06, Alaska Medicaid covered 27 percent of children under age 18 — the same as the national average.

On May 23-24, 2006, more than 30 Alaska leaders representing key initiatives and agencies concerned with child health and development gathered to discuss opportunities to improve the health of all of Alaskan children. Participants included key staff from four State agencies, representing Medicaid and public health (e.g., early childhood comprehensive systems, behavioral/mental health, dental care, immunization, public health nursing, and children with special health care needs). In addition, representatives from non-State groups such as the Academy of Pediatrics, Alaskan Native tribal organizations, federally qualified health centers/Primary Care Association, and March of Dimes were active Workshop participants.

Speaking at the start of the meeting, Jerry Fuller, Director of Medicaid, and Richard Mandsager, Director of the Division of Public Health, stressed the importance of focusing on ways to improve the health of all Alaskan children, not just responding to Federal rules. The remainder of the first day of the Workshop was used for discussions of barriers and opportunities to improve child health among all of Alaska's children.

The majority of the meeting was divided into four segments that focused on questions related to: 1) achieving the standards of care and using quality improvement strategies, 2) assuring effective outreach and informing of families, and 3) monitoring child health care and outcomes, and 4) early childhood development. Barriers identified during the group's discussions included: the challenge of meeting the needs of children in frontier and urban settings, lack of medical providers in many areas of the State, families' lack of health literacy, and fragmented children's services. Based on extensive discussions held over the day and one-half meeting and through three rounds of voting, Alaska State leaders supported the five priority action areas below.

- **Improve data integration.** By increasing interagency data sharing, building on MMIS, EPSDT subsystem, and immunization registry data capacity expansions, and creating an integrated child health database similar to those developed in some other States.
- **Strengthen the network of community care coordinators.** By building on existing system capacity and pilot projects (e.g., tribal services, early childhood mental health), including case management opportunities, and using a system of care approach.
- **Implement a quality initiative related to EPSDT screens**. By reviewing adequacy of periodicity schedule, promoting better use of interperiodic screening, developing a dental

visit schedule, improving protocols for developmental screening, and investigating potential for pediatric practice collaboratives.

- **Develop a parent-focused initiative to boost parent informing and engagement.** By using revised parent informing materials (e.g., birthday card), implementing community-based information and education strategies, linking to family support and advocacy organizations, and focusing particularly on needs of families with young children and adolescents.
- **Support cross system training.** By strengthening public-private partnerships, securing departmental upper level "buy-in" (children's policy committee), and implementing one cross-training project or pilot project focused on early childhood development.

Arkansas

Arkansas' EPSDT program covers more than 400,000 children each year. (This includes children covered under a CHIP Medicaid expansion.) In 2005-06, Arkansas covered 39 percent of children under the age 18 — well above the national average of 27 percent.

The Arkansas Workshop was held on November 27-28, 2007. Workshop participants included staff from: the Departments of Human Services (e.g., Division of Medical Services/Medicaid, Division of Child Care and Early Childhood Education); Education; Mental Health, and Health (e.g., Family Health Branch, Office of Minority Health, and Division of Developmental Disabilities). Other participants represented the perspectives of local county public health agencies, behavioral health plans, early childhood programs (e.g., Head Start), and federally qualified health centers. Others appeared on behalf of organizations such as the Academy of Pediatrics, and Family Voices. Staff and leaders from the State's ABCD project, early childhood comprehensive systems initiative, and providers who have piloted developmental screening strategies also participated. Staff from the Foundation for Medical Care, Center for Health Improvement, and Arkansas Advocates for Children represented additional private sector health leadership.

Speaking at the start of the meeting, Paul Halverson, MD, Director of the Arkansas Department of Health, described the importance of Federal-State partnerships in improving health and the value of learning from other States' experience. With high morbidity and mortality rates, prevention and early intervention are priorities for the Department of Health.

The meeting was focused on early childhood health and development, including EPSDT and the Assuring Better Child Health and Development (ABCD) project. The majority of the meeting was divided into segments that focused on three specific agenda topics that had been identified by the planning committee: 1) building community systems, 2) assuring quality, and 3) maximizing the efficiency and effectiveness of services through improved collaborative effort.

Barriers were identified during the group's discussions. For example, an assessment of EPSDT in Arkansas (Arkansas Advocates for Children and Families, 2006) concluded that possible causes of low participation rates for screening visits include: billing practices, missed opportunities in clinical practice, parent knowledge of importance of well-child visits, and

limited numbers of children with a medical home. In terms of capacity for follow-up and treatment, several concerns were identified. In some regions, few pediatric providers are available. As in other States, specialty providers are less available in rural areas. Families have to travel considerable distances in some cases to get to an appropriate specialty provider. Dental capacity has improved, but there is more to be done. Mental health services capacity for children is considered a problem and improving capacity is a priority for the multiple State agencies and private sector advocates.

Opportunities also were highlighted. The State has taken steps to improve the use and quality of EPSDT comprehensive well-child screening visits, particularly through a pilot project, which was implemented by the Arkansas Foundation for Medical Care and involved 69 clinical sites with more than 160 physicians. The Arkansas Medicaid agency has created incentives for providers to be a medical home or a primary care provider for children using a per-member, per-month primary care case management fee. In addition, work in the ABCD pilot sites is helping to advance effective strategies for developmental screening of young children (birth to 5) in pediatric primary care.

The group adopted a clear vision for improving early childhood health and development. The consensus was that: *All children birth to 5 should receive objective developmental screening as part of comprehensive well-child examinations (otherwise known as EPSDT screens) in the context of a medical home.* Based on the Workshop discussions, Arkansas leaders identified opportunities to build from existing efforts or as necessary next steps to improve EPSDT and child health. Through extensive discussion and three rounds of prioritization, the group consensus supported several priority actions. These included the following.

- **Increase EPSDT care coordination capacity to support families and providers.** By creating a workgroup to review and plan for improved care coordination/case management efforts. Such a review would study the: current and past use of care coordination in local health departments, use of existing care coordinators (e.g., those working with CSHCN), care coordination efforts of medical home providers and the implications of Deficit Reduction Act changes in Medicaid law and definitions of case management. State leaders also will investigate how Arkansas' 211 telephone service lines are used and how the Connecticut "Help Me Grow" program maximized their "warm line" capacity. One goal is development of a network of early childhood health consultants/care coordinators who would work with families, health providers, and early care and education providers.
- **Plan for future use of fiscal incentives for EPSDT screen providers.** By studying the impact of current fiscal incentives; securing input from medical societies (AAP, AAFP), primary care association, and other professional organizations; focusing on incentives for developmental screening; and reviewing other States' experience with pay-for-performance approaches. From these efforts, the State would develop a plan for modified incentives for the next fiscal year. One objective is ongoing monitoring to determine the impact of fiscal incentives and make adaptations as necessary. Another objective is to cross-fertilize lessons learned from ABCD and EPSDT pilots, then design "next generation" learning collaborative applying fiscal incentives.

- **Mandate use of developmental screening tools**. Positioning for such a mandate calls for implementing the ABCD project (i.e., completing work with the pilot practices, collecting data), making necessary regulatory and policy changes to facilitate widespread use of objective developmental screening (e.g., clarify benefit definitions, recommend developmental screening tools, promote use of appropriate billing codes), advancing statewide training and support based on lessons learned from pilots, and identifying "champions" who can speak about their experience and encourage others to make changes in practice. Achieving the objective to mandate use of objective developmental screening tools will also require advocacy for additional financing from Medicaid and other payers and programs.

Colorado

Colorado's EPSDT program covered more than 340,000 children in 2005. (This figure may include some individuals eligible for EPSDT under a State Children's Health Insurance Program.) In 2005-06, Colorado Medicaid covered 21 percent of children under age 18 — well under the national average of 27 percent.

The Colorado Workshop was held on May 12, 2006. Workshop participants included staff from: the Departments of Health Care Policy and Financing (Medicaid); Education; Mental Health, and Health (e.g., children with special health care needs, early childhood comprehensive systems). Other participants represented the perspectives of local county public health agencies, behavioral health plans, early childhood programs (e.g., Head Start), and federally qualified health centers. Others appeared on behalf of organizations such as the Academy of Pediatrics, Federation of Families, Family Voices, and Smart Start. Staff from the State's early childhood mental health initiative, Project Bloom, and providers who have piloted developmental screening strategies also participated.

The agenda and group discussion focused particularly on opportunities to improve and sustain efforts to promote early childhood mental health and development through increased collaboration, building on existing initiatives. The first topic of discussion was: Maximizing the potential of EPSDT to foster early childhood development. The group exchanged views about how to better use opportunities to offer effective developmental screening and referrals for children birth to five through EPSDT, and how EPSDT screening, diagnosis, and treatment services can be used to foster healthy mental development. The second topic was: Using EPSDT in the context of early childhood systems development, with discussion focused on opportunities for collaboration among State agencies, such as EPSDT, Part C Early Intervention, CSHCN, Project Bloom, medical home, and other programs serving young children. The State has invested in: a multi-year project focused on early childhood mental health, a decade of efforts to improve early childhood services, a medical home pilot program, and community-level EPSDT coordinators. While each of these initiatives has strengths upon which to build, sustaining current effort will require partnerships and resources.

After extensive discussion and three rounds of prioritization, the group consensus supported several priority actions. These included the following.

- **Improve knowledge and practices of pediatric primary care providers.** By using a train-the-trainer approach, working with pediatricians committed to the medical home concept, and creating pilot projects and learning collaboratives.
- **Adopt a "no-wrong-door" approach.** By learning about promising practices in other States, creating a workgroup, building on the medical home concept, and advancing with the Early Childhood and School Readiness Commission.
- **Strengthen social-emotional services in the Part C Early Intervention Program.** By clarifying what Medicaid may finance, preparing and disseminating a document for providers, training service coordinators, adding members to interagency coordinating council to provide wider perspectives on this topic, and monitoring performance.
- **Promote a family-centered care coordination approach.** By identifying duplication/ overlap, clarifying definitions, removing administrative barriers to coordination, and aligning with no-wrong-door approach (e.g., assign primary service coordinators, build team protocols, and/or designate a lead or overarching coordinator).
- **Improve access to services for young children at risk for mental and behavioral health conditions but without diagnosis.** By determining specific problems to be addressed, developing a local pilot project, informing providers about opportunities to use mechanisms such as interperiodic screening to monitor a child's conditions, and clarifying when different providers should do diagnostic evaluations.
- **Augment and improve the early childhood mental health workforce.** By using more in-service training methods (e.g., reflective supervision, mentoring), encouraging use of early childhood specialists at mental health centers, and offering more early childhood professional training opportunities.

Illinois

The State's All Kids program provides publicly subsidized health coverage for all uninsured children, regardless of family income. In 2007, more than 1.4 million children under age 21 were eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) child health care benefits in Illinois. Illinois finances health care for approximately half of births and over one half million children under age 5 in its programs.

Children's publicly subsidized health coverage focuses on providing benefits in the context of a medical home. Mandatory managed care enrollment began in 2006, and program participants must enroll with a primary care case management provider or managed care organization (depending on area of residence). Provider payments and pay-for-performance incentives are structured to support the medical home and preventive care.

The Illinois State Leadership Workshop was held on June 25-26, 2008. The meeting was hosted by the Ounce of Prevention Fund. Workshop participants included State agency staff from the Department of Healthcare and Family Services (HFS), Department of Human Services (DHS), and Department of Children and Family Services (DCFS), as well as the Office of the Governor. These individuals represented perspectives of programs including: Medicaid, Title V Maternal

and Child Health/Children with Special Health Care Needs, Oral Health, Children's Mental Health, Part C Early Intervention, and Child Welfare. Other participants included local county public health leaders and representatives from children's hospitals. Representatives attended on behalf of organizations such as the Illinois Academy of Pediatrics, Illinois Academy of Family Physicians, Illinois Hospital Association, Illinois Primary Healthcare Association, and the American Dental Association. Families and their advocates were represented by Voices for Illinois Children, the Illinois Maternal and Child Health Coalition, the Ounce of Prevention Fund, and others. (See Appendix A for list of participants.)

The first day began with two overview presentations. Kay Johnson, as facilitator/consultant for this Workshop, provided an overview of Medicaid, EPSDT, and Title V policies, including the legal requirements and practical opportunities for improving child health through collaborative, interagency action. Deborah Saunders, of HFS-Maternal and Child Health, provided an overview of current Medicaid/EPSDT policy and special initiatives in Illinois.

The meeting was focused on early childhood health and development, particularly mental health and dental health and ensuring the benefits of EPSDT as related to specialty services for these two areas. The majority of the meeting was divided into segments that focused on four specific agenda topics that had been identified by the planning committee: 1) building community systems of family support, care coordination, and case management; 2) assuring screening benefits; 3) assuring diagnosis and treatment benefits; and 4) cross system collaboration to improve the health of young children.

Illinois Medicaid is aiming to ensure a medical home for each child enrolled, regardless of eligibility category (Medicaid, CHIP, All Kids – State funded). Medicaid's pediatric primary care case management (PCCM) program was recently implemented to improve continuity and quality of primary and preventive care. Families are required to use the PCCM program, Illinois Health Connect, across the State, except in Cook County or seven other downstate rural counties, where they may select a managed care organization (MCO). As of June 2008, over 5.3 million medical homes had enrolled 1.7 million individuals, of which about 173,000 are enrolled in an MCO and the remainder is enrolled in the PCCM program.

Improving system connections at the community-level is a key challenge, particularly for young children who are served at different ages in multiple systems of early care and education, health, and family support. The group used a "system mapping" exercise to stimulate discussion about how community service systems interface. Workshop participants discussed recent improvements, unmet needs, and model programs from other States. Illinois has made great advances in early childhood screening for developmental risks and problems, including physical, social-emotional, and other development. While further improvements are needed, many pediatric primary care providers are using recommended, objective developmental screening tools. (See discussion below for more on screening.) The group consensus was that a major divide exists between primary providers and other service systems. With new emphasis on the pediatric medical home in Medicaid, primary care providers will have more responsibility for referrals and linkages to other providers. At the same time, additional mechanisms are needed to assure consistent and effective linkages.

The Workshop participants identified 24 topics of common concern. In keeping with the focus of the Workshop, many topics were aimed at improving early childhood oral health, mental health, and developmental status for young at-risk children. Through extensive discussion and two rounds of prioritization, the group consensus supported six priority areas for short-term action. The priorities reflect consensus and participants views regarding the potential for impact and the feasibility of various strategies and actions. The selected priorities included the following.

- **Boost mental health services' capacity in community health centers/Federally Qualified Health Centers (FQHC).** Illinois has emphasized screening for early health and social-emotional development, as well as maternal depression screening. At the same time, substantial unmet need exists for mental health services to young children and their families. Under current State law, FQHCs can be reimbursed for mental health services. Because FQHCs both see children and families with higher risks and operate in medically underserved communities, they provide a location where mental health capacity could be of considerable benefit. The group gave high priority to hiring and training mental health professionals to work in FQHCs.
- **Increase clinic capacity and recruiting dentists for safety net clinics.** Illinois has efforts underway to expand the number of safety net dental clinics; however, a shortage of dental providers will still exist. One effective approach is to simultaneously buy equipment to expand clinical facilities and actively recruit dentists to serve in safety net clinics. Workshop participants believed that more recruitment is essential to increasing the capacity to provide dental services to young children in underserved communities.
- **Consultation from pediatric specialist and sub-specialist medical providers.** Typical recruitment strategies aimed at increasing provider capacity or improving the geographic distribution of providers have not proven effective with specialist and sub-specialist physicians. Illinois has begun to use more consultation to maximize the available supply. For example, one specialist physician can provide consultation to a network of primary care physicians. Telephone and Internet technologies support such approaches. The group gave high priority to wider and more consistent use of this type of consultation.
- **Increase provider reimbursement for pediatric specialists and sub-specialists.** Provider reimbursement for pediatric medicine beyond primary care was seen as a priority in Illinois. Targeted reimbursement increases may be needed to create sufficient capacity for increased numbers of young children with conditions detected through screening, as well as to support the medical home.
- **Grow and develop the early childhood mental health workforce.** While Illinois is ahead of many States in terms of legislation and funding to support healthy mental and social-emotional development, State leaders hope to apply approaches used in other States to augment capacity. These include: training and retooling existing professionals, redefining the range of qualified providers under Medicaid, engaging community mental health centers as hubs for training and supervision, and developing an expanded network of early childhood mental health consultants to work with early care and education providers (e.g., child care centers, Head Start).
- **Use All Our Kids (AOK) sites for development of community pilot projects serving at-risk children.** With increased screening and use of medical homes, more early

childhood risks to health and development will likely be detected. Many young children will have risks but not the developmental delays that could lead to eligibility for entitlement to Part C Early Intervention services. Some States (e.g., Rhode Island) have developed provider networks and service capacity specifically to serve such children. Illinois leaders see an opportunity to use the AOK community sites as a laboratory for piloting strategies to serve young at-risk children.

Iowa

Iowa's EPSDT program covers more than 200,000 children each year. (This figure includes some individuals eligible for EPSDT under a State Children's Health Insurance Program Medicaid expansion.) In 2005-06, Iowa Medicaid covered 25 percent of children under age 18 — below the national average of 27 percent.

The Workshop was built on prior State policy discussions. In October 2005, more than 100 Iowa leaders met at a conference to set a policy framework for early childhood health systems integration and principles for assuring that all of Iowa's children get "Off to a Good Start." Building on the recommendations of that meeting, 25 Iowa leaders representing key initiatives and agencies concerned with child health and development met on April 27, 2006 to discuss opportunities to more effectively use the EPSDT program to improve child health. Participants included representatives from State agencies, representing Medicaid and public health (e.g., early childhood comprehensive systems, dental care, immunization, children with special health care needs/child health specialty clinics). In addition, representatives from provider organizations such as the Academy of Pediatrics, Academy of Family Practice, federally qualified health centers, University Hospital, and Visiting Nurse Association, as well as advocates from the Child and Family Policy Center and Center for Developmental Disability were active participants.

The agenda and group discussion focused particularly on opportunities to improve the health of Iowa's youngest citizens through increased collaboration, building on existing initiatives. Identified barriers included: provider availability, limitations for pediatric primary care practices that make it challenging to implement developmental screening recommendations or use a medical home approach, insufficient family support, access to services for children at-risk for developmental problems, weak linkages between pediatric primary health care providers and other that affect the referral process, fragmentation of children' programs and funding streams.

After substantial discussion and two rounds of voting, the group consensus supported the following priority actions.

- **Support universal child health coverage**. The participants felt that the time was right to press for universal child health coverage in Iowa. Child health advocates would play a leading role.
- **Strengthen the role and capacity of local (county) EPSDT care coordinators.** These individuals should play a more active role in linking pediatric primary care providers to community-based resources. The ongoing training and development of EPSDT care coordinators was viewed as a high priority.

- **Educate policy makers.** Child health leaders should play an active and ongoing role in educating policy makers about the importance of early childhood preventive and developmental services and about the impact of cost-sharing for child health coverage.
- **Create a new model for financing well-child visits**. The group noted that primary care providers and the associations which represent them are ready to use new models and adapt their practices. Options to be considered include tiered well-child health care visits or a pay-for-performance approach.
- **Create a pediatric primary care quality study or quality improvement "practice collaborative."** In particular, one or more practice collaboratives should be developed to continue and expand the lessons learned from ABCD II and Iowa's Medical Home Project.
- **Conduct an analysis of how the concept of wrap-around services might work for CSHCN and a review of case management activities**. This would involve a review and revision of State policies and guidance in order to assure compliance with the DRA amendments related to Medicaid case management.
- **Use DRA "Family Opportunity Act" provisions to create a new type of family information center.** Building on its long history of family leadership, Iowa might become a leader in creating the family information center of the future, with greater integration of family and child concerns. For example, such a modernized center would focus on the needs of families whose children have an array of special health care needs (mental health, physical disabilities, chronic illnesses, etc.).

Maine

Maine's EPSDT program covers more than 120,000 children each year. (This includes children covered under a CHIP Medicaid expansion.) In 2005-06, Maine covered 30 percent of children under the age 18 — above the national average of 27 percent.

The Maine Workshop was held on January 11-12, 2007. Workshop participants included staff from: the Departments of Health and Human Services (e.g., Office of MaineCare/Medicaid, Center for Disease Control and Prevention, Family Health Branch, Office of Minority Health); and Education. Other participants represented the perspectives of local county public health agencies, early childhood programs (e.g., Infant Mental Health), and federally qualified health centers. Others appeared on behalf of organizations such as the Academy of Pediatrics, Academy of Family Physicians, Dental Association, and Family Voices. Staff and leaders from the State's ABCD project, early childhood comprehensive systems initiative, and providers who have piloted developmental screening strategies also participated.

Speaking at the start of the meeting, Michael J. Hall, Director, MaineCare (Medicaid) described the creation of EPSDT as "a dramatic step in history and one of the most remarkable decisions Congress ever made." He emphasized how Maine has tried to maximize the potential of EPSDT, assure access to a comprehensive range of child health services, and foster cross-system collaboration. Christine Zukas-Lessard, Deputy Director, Maine Center for Disease Control and Prevention, described the partnerships among various agencies concerned with the health of children and families. Brenda McCormick, Director, Division of Health Care Management,

MaineCare, described the State's plans to expand collaboration and coordination in order to address specific access barriers and increase health promotion. Valerie Ricker, Director of the Family Health Division (Title V) spoke to the challenging role of assuring access and creating systems of care that work for children and families, as well as the importance of using data to guide health policy decisions.

The meeting was focused on improving services for children of all ages, with particular emphasis on early childhood health and development and adolescent health. The majority of the meeting was divided into segments that focused on five specific agenda topics that had been identified by the planning committee: 1) boosting developmental screening and its impact on child development, 2) enhancing the health of adolescents, and 3) assuring care coordination for children and youth with special health care needs, 4) assuring necessary follow-up services, and 5) collaboration to achieve Maine's health goals for children and youth.

Multiple barriers and opportunities were identified during the group discussions. Through its ABCD project, Maine aims to increase use of developmental screening and its impact on child development. The focus is on approaches to offer more effective developmental screening and referrals for children birth to five through EPSDT and its providers. The health of adolescents is another concern. The group discussed the role of pediatric primary care providers, school health, and others in assuring adolescent health (physical, mental, and oral). Further discussions focused beyond screening visits. Maine has a somewhat unique approach for assuring referrals and linkage to follow-up services. Reports from the public health nurse EPSDT follow-up program in Maine indicate that many opportunities are missed to link children with appropriate follow up services. The group saw multiple opportunities to strengthen child health services across the continuum of care and the potential to reduce child health disparities.

Based on the Workshop discussions, Maine leaders identified opportunities to build from existing efforts or as necessary next steps to improve EPSDT and child health. Through extensive discussion and three rounds of prioritization, the group consensus supported several priority actions. These included the following:

- **Improve provider education and effective practice.** By increasing use of "academic detailing" to inform all staff in practices, maximizing education opportunities in professional meetings, developing new quality improvement collaborative projects, and linking to professional association initiatives. Examples of activities suggested included: oral health screening and prevention in primary care, primary care action to support the transition to adulthood, objective developmental screening, medical home, and integration of mental and physical health services into primary care.

- **Improve communication and feedback loops between physicians and public health nurses.** By conducting a systems analysis of the current process, standardizing forms, creating a public-private sector advisory committee, increasing personal contacts, and conducting pilot projects to assess the feasibility and impact of changes in process, forms, etc.

- **Increase efforts to reduce health disparities.** By reviewing data, integrating Medicaid into Maine CDC efforts to promote cultural and linguistic competence among State agency staff, and building on current efforts to improve the cultural and linguistic competency and skills of providers. The group noted that health disparities exist among persons of color, across racial/ethnic groups, and affect persons with disabilities.

- **Improve efficiency in care coordination/case management.** By conducting a cross-system review (including primary care, mental health, CSHCN), addressing areas where duplication of effort are identified, assuring that such services are family centered, and adjusting fees to assure appropriate compensation.

- **Address data and information gaps.** By reviewing current data sources, their purposes (e.g., tracking, performance measurement and program management), assessing the consistency and quality of data collected by race and ethnicity, and developing data and information system linkages (e.g., integrated child health database).

Michigan

In 2006, more than 1 million children under age 21 were eligible for EPSDT benefits in Michigan. (This figure includes some individuals eligible for EPSDT under a State Children's Health Insurance Program.) In 2005-06, Michigan Medicaid covered 27 percent of children under age 18 — the same as the national average for that time.

The Michigan State Leadership Workshop was held on January 15-16, 2008. Workshop participants included State agency staff from: Medicaid (e.g., Bureau of Medicaid Policy, Managed Care Plan Division); Department of Community Health (e.g., Women, Infants and Children Division, Children's Special Health Care Services, Bureau of Community Mental Health Services, Bureau of Epidemiology); Department of Education (e.g., Office of Early Childhood Education and Family Services); and Department of Human Services (e.g., Bureau of Children's Services, Policy and Program Division). Other participants included local county public health leaders, school nurses, and parents. Others appeared on behalf of organizations such as the Academy of Pediatrics, Academy of Family Physicians, Primary Care Association, Head Start Association, and Family Voices. Staff and leaders from the State's ABCD project, Early Childhood Investment Corporation (early childhood comprehensive systems initiative), and providers who have piloted developmental screening strategies also participated. Staff from managed care organizations represented additional private sector health leadership.

Janet Olszewski, Director of the Michigan Department of Community Health, opened the meeting with an overview of efforts to improve maternal, child, and family health in Michigan. She reminded the group that while Michigan has reduced infant mortality, with important declines in rates for African American babies, much more needs to be done to reduce health disparities. Ms. Olszewski discussed the importance of collaboration and inter-agency efforts in addressing health challenges, as well as the role of local community health leadership. In

addition, she emphasized that an important step toward improving health for more children is to provide family coverage.

The meeting was focused on early childhood health and development, including EPSDT, CSHCN, Part C, ABCD project, and the Great Start early childhood systems initiative. The majority of the meeting was divided into segments that focused on four specific agenda topics that had been identified by the planning committee: 1) assuring screening, diagnosis, and treatment benefits; 2) assuring a medical home; 3) building community systems of family support, care coordination, and case management; and 4) cross system collaboration to improve the health of young children.

In terms of assuring EPSDT benefits, Workshop participants saw many opportunities. For example, they suggested: improving local connections through schools and early care and education settings, better using linkages to families in newborn screening follow up or WIC, and changing referral protocols and linkages to better connect primary care providers with providers of Part C, mental health, or local public health. Michigan's community providers and resources could be far better linked, and the State has community health efforts to support such advances. The group also noted that it is essential to stop negative treatment and disrespect for Medicaid beneficiaries. Another opportunity is to use the momentum created by release of the new Bright Futures guidelines from the American Academy of Pediatrics.

Opportunities for action are linked to larger health care quality discussions in our society. Quality improvement projects are underway for children and adults, such as a pediatric quality improvement collaborative. With increased attention from the National Committee on Quality Assurance, American Medical Association, and other organizations, the group saw opportunities to improve the definition and implementation of the medical home concept (i.e., is it having a primary care provider, having a provider who assures care round the clock, having a provider committed to coordination of services, etc.). Notably, multiple definitions and few incentives translate into an absence of medical homes.

Other opportunities to improve the health and development of young children are linked to emerging issues and projects. For example, the ABCD project has generated increased interest among primary care providers in developmental screening. The Great Start (early childhood comprehensive system) Collaboratives are engaged in community planning to promote early childhood health and development. Workshop participants also stressed the need to increase access to early childhood mental health services. Strengths and weaknesses of the Part C Early Intervention (Early On) program were discussed.

Providing appropriate services for children with special health needs is a challenge in all States. Currently, Michigan is changing from a policy that "carved out" these services from Medicaid managed care to increased use of managed care arrangements. This will require interagency collaboration and new contracts and capitation arrangements with managed care organizations. Michigan hopes to learn from the experience of other States (e.g., VA, WI) which have adapted Medicaid managed care contracts to better serve CSHCN.

The Workshop participants identified 15 topics of common concern. Through extensive discussion and three rounds of prioritization, the group consensus supported six priority areas for short-term action. These included the following.

- **Maximize use of data to help assure access and quality.** The aim would be to provide the data and information linkages needed across systems. The primary approach recommended was to use the Michigan Care Improvement Registry (MCIR), which currently serves as the immunization registry, as a tool to collect and use data from multiple plans and across systems. This MCIR improvement project might begin by adding information from lead, hearing, vision, newborn metabolic, and developmental screening and continue with addition of EPSDT and Part C Early On data. On a parallel track, the group saw the opportunity to improve the processes and tools that support primary care referrals and link health claims to see the fuller pattern of care for an individual child.

- **Increase use of Medicaid managed care to serve CSHCN.** By changing the approach to enrollment options for families of CSHCN, developing a co-managed system between Children's Special Health Care Services and Medicaid, clarifying policy and agency roles, securing an actuarial analysis to guide establishment of appropriate provider payment rates, modifying the Medicaid managed contract. Workshop participants also saw potential to continue modifications of Medicaid managed care with focus on enrollment of children in foster care.

- **Assure appropriate information exchange across services and systems**. By reviewing system feedback loops, clarifying roles and responsibilities, developing better information systems to support the medical home, and use of technology to improve communication. Workshop participants set high priority on improving cross-system linkages. They also wanted further discussion of care coordination approaches used in other States such as local/county EPSDT coordinators (e.g., IA, MN) and 211 "warm lines" (e.g., CT Help Me Grow).

- **Implement and operationalize a common definition of the pediatric medical home**. By engaging pediatric providers (pediatricians, family physicians, nurse practitioners), working with and through other medical home projects, refining pediatric concepts, training and certification for pediatric medical home providers, and using NCQA strategies. Workshop participants felt it was important to work within the context of Medicaid managed care and existing managed care contracts. Beyond development of a common definition, the next challenge would be to create more incentives and improved financing to support pediatric medical homes.

- **Improve the Part C Early Intervention (known as Early On).** By improving interagency collaboration, enhancing linkages to physicians who provide developmental screening (particularly those in ABCD), focusing on internal program improvements, increasing attention to social-emotional concerns, and better financing for early childhood developmental intervention/ treatment services. With regard to financing, the group recommended a review of Medicaid benefit and payment policies and action to clarify when Medicaid is responsible for Part C and related services.

- **Improve access to early childhood mental health services**. The highest priority was to increase provider capacity to deliver early childhood mental health services, and Michigan hopes to apply approaches that have been used in other States such as training and retooling, redefining the range of qualified providers under Medicaid, engaging community mental health centers as hubs for training and supervision, and developing an expanded network of early childhood mental health consultants to work with early care and education providers (e.g., child care centers, Head Start). Workshop participants also hope to redefine and clarify the Medicaid/EPSDT benefit to make it appropriate for younger children, including implementation of the DC:0-3 diagnostic coding system.

Nevada

Approximately 150,000 children are eligible for Medicaid and Nevada's Children's Health Insurance Program (CHIP) known as Check-Up – are all eligible for the Nevada Healthy Kids (EPSDT). In 2005-06, Nevada Medicaid covered 14 percent of children under age 18 – one of the lowest proportions across the country.

The Nevada Workshop was held on September 7, 2006. Workshop participants included State agency staff from: Medicaid (Health Care Finance and Policy); Welfare (eligibility); and Health Division Bureau of Family Health Services (e.g., immunization, public health nursing, and children with special health care needs). Other participants included local county public health leaders and representatives from non-State entities such as the Nevada Medical Association, Nevada Hospital Association, School Nurse Association, American Indian tribal organizations, federally qualified health centers/Primary Care Association, rural health centers, Family Voices, and legal services.

The agenda and group discussion focused on opportunities to increase provider participation, family outreach, and interagency coordination. Mary Wherry, Deputy Administrator of the Nevada Department of Health Care and Finance Policy, opened the meeting with an overview of the State's commitment to expanding provider participation and assuring quality in order to improve child health outcomes.

The Workshop participants identified 16 topics of common concern. From this set of topics, after extensive discussion and three rounds of voting, the group consensus supported the following five priority actions.

- **Improve early childhood developmental and mental health screening following the example of other States.** Many promising practices exist from States (e.g., FL, CO, IA, IL, NC, and MN) that have launched initiatives to promote early childhood screening for developmental concerns – physical, cognitive, and social-emotional. Based on the experience of these States, Nevada might start by: recommending specific screening tools, conducting a pilot project, adding quality improvement projects or measures to managed care contracts, and/or clarifying billing rules for developmental screening.
- **Better implement automatic newborn enrollment rules for births financed by Medicaid.** With implementation of the electronic birth certificate and changing rules

under DRA, Nevada leaders gave priority to a review of how well Federal policy is working for Medicaid financed births. They aimed to study the process of automatic newborn enrollment under both managed care and fee-for-service arrangements.

- **Support parents in their role through education, motivation, and knowledge of how to use the health care system**. Proposed approaches included broader use of: MCO incentives, parent-to-parent communication, culturally and linguistically appropriate materials, tool-free hotlines and 211 "warm-lines," and family resource centers, home visitors, school-based clinics, etc.
- **Better use the capacity of essential community providers and tribal health services:** With expansion of managed care and new contract MCOs, relationships between health plans and essential community providers such as FQHC and LHD, as well as tribal health providers, have become more important. Participants at the meeting called for a review of existing contract language and practices.
- **Improve cross system linkages to EPSDT:** The group called for a review of linkages among various programs (e.g., early intervention, child welfare, mental health, Head Start) to identify possible areas for improvement. Of particular concern are mechanisms for payment, referrals, data, eligibility process, care coordination.

Puerto Rico

An estimated 1 million children live in Puerto Rico, representing a larger child population than about half of the States of the United States. The child poverty rate is high – 55 percent. The percentage of low birthweight births, share of births to teens, and infant mortality rates are higher than the U.S. average for the mainland.

Medicaid and variety of other federally funded programs (e.g., CHIP, Child Care Development Fund, and Temporary Assistance for Needy Families-TANF) operate under special fiscal rules in Puerto Rico. The Medicaid Federal matching rate is set at 50 percent and total Federal Medicaid spending is caped. The Governor of Puerto Rico testified before Congress on June 15, 2005 that the Federal Medicaid support was approximately $20 per recipient month, compared to an average of $330 per month for the States. As a result of these fiscal constraints, Puerto Rico is not obligated to cover all of the same Medicaid benefits required of the States.

Puerto Rico strives, however, to maintain child health services quality through EPSDT and CHIP. In particular, Puerto Rico Medicaid managed care contracts call for well child visits according to the AAP standards and guidelines. Medicaid managed care arrangements are used to cover more than 90 percent of child recipients.

The Puerto Rico Workshop was held on March 27-28, 2008. Workshop participants included State agency staff from: Puerto Rico Health Insurance Administration (PRHIA or ASES in Spanish), which manages Medicaid operations, and the Department of Health, Medicaid Office and Central Office including the Title V, Part C Early Intervention, and Vaccines for Children Programs. Other participants included representatives from non-State entities such as the American Academy of Pediatrics Puerto Rico Chapter and the University of Puerto Rico, School of Public Health. The group also included medical directors, quality directors and other staff

from leading Puerto Rico Medicaid managed care organizations, including: COSVI, Humana, MCS-HMO, and Triple C.[**]

The meeting opened with welcoming remarks from Dr. Maria del Carmen Rullan, Director of Title V and Dr. Wendy Matos, Director of the Department of Health Medicaid Office, who jointly described the current status of child health programs. Luz Cruz, coordinator for Medicaid Regional Training Offices described the approach to supporting quality practice in the field. Dr. Annie Alonzo of the University of Puerto Rico, School of Public Health provided background on immunizations and other public health initiatives.

In the next segment of the Workshop, Kay Johnson, President of Johnson Group Consulting, presented an overview on "EPSDT & Cross-system Collaboration," with emphasis on opportunities to improve primary care services. Neva Kaye, Senior Program Director at the National Academy of State Health Policy, gave an overview on "Opportunities to Improve Child Development Services through Policy Change," which highlighted the successes of the Assuring Better Child Health and Development (ABCD) program.

The majority of the meeting was divided into segments that focused on three specific agenda topics that had been identified by the planning committee: 1) building community systems, 2) assuring quality, and 3) maximizing the efficiency and effectiveness of services through improved collaborative effort.

The agenda and group discussion focused on opportunities to: build community-level systems, maximize the use of available providers, engage providers as partners in quality improvement, and strengthen early childhood health and development initiatives. Participants provided background on the current status of programs in Puerto Rico and described an array of challenges facing payers and providers.

In particular, participants spent considerable time discussing provider-related issues. They reported that primary care providers face major challenges in trying to coordinated services and meet family needs in brief 15-minute visits. The concept of the medical home has not been widely embraced. Puerto Rico pediatric primary care providers and their partners in government and managed care organizations also faced challenges in achieving or maintaining immunization levels. Proper implementation of the Federal Vaccines for Children program had not been achieved. On the positive side, the ABCD Initiative had promoted use of a standardized developmental screening tool for all young children at appropriate ages; with a cross-system strategy being used to include child care, Head Start, Part C, and health providers in this effort.

The Workshop participants identified 17 topics of common concern. From this set of topics, after extensive discussion and two rounds of voting, the group consensus supported the following seven priority actions.

- **Review and strengthen the EPSDT periodic visit schedule**. With publication of the latest edition of Bright Futures, every State and Puerto Rico had an opportunity to update their EPSDT periodicity schedule. This was a priority for child health leaders in Puerto Rico.

[**] Note that Triple-S Inc. and Human Health Plans of Puerto Rico Inc. have been ranked among the top five larges Medicaid managed care organizations in the United States. Rankings were done by InterStudy Competitive Edge.

- **Improve the EPSDT section of Medicaid managed care contracts**. While current Medicaid managed care contracts do mention EPSDT, child health leaders believe these provisions could be strengthened and improved. Such changes could benefit children, their families, providers, managed care organizations, and government agencies.
- F**ocus on improved implementation of the Vaccines for Children Program.** Specific actions were discussed that could help to assure adequate immunization levels and program integrity.
- **Assure objective developmental screening for all young children through cross-system efforts**. Building on the ABCD Initiative and work of pilot practices in Puerto Rico was a high priority for child health leaders. Managed care organizations want to play a role in such efforts.
- **Provide support to pediatric primary care providers who seek to improve their practices**. Change and quality improvement is challenging for any primary care practice, especially because their time and resources are limited. Practice support—whether in the form of enhanced fees, on-site training, or quality improvement collaboratives—was identified as a priority.
- **Increase use of care coordination/case management.** Both children with social risks and those with medical risks or special health care needs can benefit from care coordination/case management. Collaboration between Title V, Medicaid, providers, health plans, and families is essential to successful development of care coordination/case management approaches.
- **Increase family demand for preventive health services.** Workshop participants saw important opportunities for using health promotion, health education, outreach, and informing activities to encourage families to use preventive services and well-child visits. Such efforts should be family-centered, culturally competent, and community-based.

Tennessee

The Tennessee State Leadership Workshop was held on February 11-12, 2009. The meeting was hosted by the Governor's Office of Children's Care Coordination. Workshop participants included State agency staff from the Departments of Health, Finance and Administration, Children's Services, and Education, as well as the Governor's Office of Children's Care Coordination. These individuals represented perspectives of program areas including: Medicaid/TennCare, Title V Maternal and Child Health, Children with Special Health Care Needs, Oral Health, Children's Mental Health, Part C Early Intervention, and Child Welfare. Other participants included local county public health leaders and representatives from academic medicine. Provider representatives attended on behalf of organizations such as the Tennessee Chapter of the American Academy of Pediatrics (TNAAP), Tennessee Academy of Family Physicians, and Tennessee Primary Care Association. Families and their advocates were represented by the Tennessee Voices for Children and Family Voices. (See Appendix A for list of participants.)

The first day began with welcoming remarks from Dr. Jeanne James, Medical Director, TennCare (the State's Medicaid program) and Dr. Veronica Gunn, Chief Medical Officer, Department of Health.

Kay Johnson presented an overview of Medicaid and Title V issues, as well as a summary of adolescent health issues. She summarized recent recommendations, the Guidelines for Adolescent Preventive Services (GAPS) from American Medical Association, and best practices from the professional literature.

A recent report from the Institute of Medicine/National Research Council on "*Adolescent Health Services: Missing Opportunities*" summarized what is known about improving use of adolescent health services and made recommendations for action. Several of the recommendations from NRC were of particular importance for purposes of the Workshop. The goal of having a coordinated primary health care system to improve health services for adolescents is particularly important in the Workshop discussions of interagency and cross-sector collaboration. State leaders also can improve the focus on groups of adolescents vulnerable to risky behavior or poor health. In fact, EPSDT has the potential to provide financing and protocols for improving services to higher risk, lower income adolescents. Public health leaders and their community partners have an opportunity to make prevention, health promotion, and behavioral health a major component of health services. In addition, State policies and financing can assist in development of coordinated, linked, and interdisciplinary adolescent health services at community level. To truly achieve greater coordination, however, leadership from providers, families, and community-based organizations would be required at the community level. Finally, State leaders can directly influence coverage policies and the laws, policies and guidelines that enable adolescents to give their own consent for health services and to receive services on a confidential basis.

The Workshop was focused on improving adolescent services, health, and development, particularly ensuring the benefits of EPSDT as related to specialty services for these two areas. The majority of the meeting was divided into segments that focused on four specific agenda topics that had been identified by the planning committee: 1) strengthening child and adolescent health systems; 2) assuring screening, diagnosis, and treatment; 3) engaging providers as partners; and 4) maximizing the efficiency and effectiveness current services.

Improving system connections at the community level is a key challenge, particularly for adolescents who receive services across an array of providers. The group started with a "system mapping" exercise to stimulate discussion about how community service systems interface. During this discussion, Workshop participants described an array of providers who come into contact with adolescents, including staff in primary care practices, community health centers, emergency rooms, health department clinics, family planning clinics, sexually transmitted disease (STD) clinics, mental health clinics, and school health. Given the myriad contacts that adolescents have with the health care system, the group agreed that coordination of services is essential to providing quality care for adolescents and improving health outcomes in this population. The State of Tennessee is currently working on an initiative to strengthen medical homes for children. Already, TennCare assigns each beneficiary a primary care provider, who can serve as the hub for coordination of services through the primary care medical home.

Workshop participants noted a variety of efforts in Tennessee to promote adolescent health. For example, the adolescent health brochure and website was designed to inform teens about the advantages of getting well visits. The Governor's Office of Child Care Coordination has formed an adolescent health subcommittee. These efforts can form the basis for next steps.

While the State has had a major initiative focused on school health, Workshop participants believe that more could be done to maximize the capacity of school health providers. For example, school health providers might deliver more risk screening and health education, better support provider linkages at the community level, or promote comprehensive well-child (EPSDT) visits.

One strategy discussed would focus on sentinel events or "red flags" that indicate high risk behavior among adolescents. Some encounters with the health care system point to risky behaviors. These include a negative pregnancy test, evidence of binge drinking, or early smoking. When adolescents with such conditions are identified, a series of actions might be initiated. For example, adolescents might come to hospital emergency departments, health department clinics, or other locations where such red flags should be noted in health records, screening should be done, and efforts should be made to link to primary care.

Quality improvement strategies were discussed. The general approach would be to engage a group of providers in collaborative efforts to implement practice change. Tennessee's START project to improve early childhood developmental screening is one example of how to engage providers in improving the content and quality of preventive visits. Other related projects have been conducted in more than half of the States through the Assuring Better Child Health and Development (ABCD) initiative funded by the Commonwealth Fund. A range of quality improvement topics were discussed. These include: improved screening, office-based brief interventions (e.g., alcohol, tobacco, obesity), and medical home.

The group discussed providing opportunities for providers to be trained in best practices for treating adolescents (dealing with issues of confidentiality, strengths-based assessment, etc). Group members also felt that providers could work to educate parents and other caregivers on the "value" of a well-child visit for adolescents, given that many caregivers may not realize the breadth of the EPSDT visit and the benefit of the care provided therein. Finally, the group felt strongly that provider outreach and education efforts should be broadened to include family practice physicians. Recognizing that many adolescents are seen by providers other than pediatricians, inclusion of the family physicians is essential.

Tennessee Workshop participants identified 16 topics of common concern. Some of these topics were large and complex, while others were more discrete and focused on opportunities for change. In keeping with the focus of the Workshop, many topics were aimed at improving the utilization of well-child visits/preventive EPSDT services among adolescents. The Workshop participants defined three broad goals for their efforts and organized key topics under these goals: 1) getting adolescents into care, 2) making care appropriate for adolescents, and 3) improving system coordination. Through extensive discussion and rounds of voting on priorities, the group consensus supported four priority areas for short-term action.

- **Using mandates and/or incentives for preventive visits.** The discussion and the literature supported the idea that most adolescents do not have incentives to seek preventive visits. Workshop participants expressed strong support for exploring the feasibility of having a mandate linked to one or more adolescent preventive visits (e.g., linked to getting a work permit, to taking a drivers' license test, or to entry into grade 9). Opportunities to increase incentives for youth to complete recommended visits were discussed, including: cash, job skills training, material goods, and memberships. These should be age appropriate and culturally competent. The group also hopes to explore incentives for families, which might include scholarships or other financial incentives.

- **Meeting youth where they are; screening at every encounter.** Workshop participants gave priority to locating services where adolescents spend their time. This would include: schools, youth centers, select stores, food banks, community centers, and homeless shelters. A variety of community-based organizations might support and assist with these efforts, particularly faith community and civic organizations. The opportunities vary among urban and rural geographic areas across the State. A related topic was combined into this category: assuring efficient/problem-oriented screening at every encounter, in various settings. For example, when adolescents present at a hospital emergency department efforts could be made to screen for a core set of risks and conditions and to link the patient to a primary care provider (or medical home). Another example would be augmenting sports physicals to provide comprehensive well-child visits that meet the standards of the American Academy of Pediatrics Bright Futures guidelines and the EPSDT program.

- **Developing and implementing a quality improvement initiative.** A number of themes — including quality collaboratives, quality studies, medical home, and provider training — were embedded in an overarching focus on quality improvement. The goal would be to change the way that care is delivered and improve the quality and appropriateness of services for adolescents. Tennessee's START (ABCD) project to improve early childhood developmental screening is an example of how to engage providers in improving the content and quality of preventive visits. The Institute for Healthcare Improvement "Model for Improvement" also offers additional strategies. Some child health improvement projects have focused specifically on adolescents and offer demonstrated effectiveness (Lustig in California, and Duncan through the Vermont Child Health Improvement Project – VCHIP). The core approach would be to engage a multi-practice group that would agree to participate in a "learning collaborative" focused on improving the quality of adolescent health. As with all such initiatives, the project should include both clinical providers and administrative staff in learning.

- **Enhancing outreach and informing for youth and families.** In recent years, Tennessee has undertaken a wide array of outreach activities related to comprehensive well-child (screening) visits in EPSDT. Workshop participants agreed that now would be a good time to review ongoing efforts, understand their effectiveness, and compare what Tennessee does to best practices for reaching and serving adolescents. Following this assessment and analysis of current efforts, an informed "redesign" of outreach efforts for adolescents could be undertaken. Tiered or triaged outreach efforts, which begin with written communication and move on through telephone and face-to-face contact, were

discussed. Some specially targeted activities may be needed to reach the higher risk adolescents, youth with special health care needs, gay, lesbian, bisexual and transgendered (GLBT) youth, specific racial/ethnic groups, and so forth.

Virginia

Virginia's EPSDT program covers nearly 550,000 children each year. (This includes some children covered under a CHIP Medicaid expansion.) In 2006, Virginia covered 17 percent of children under the age 18 — far below the national average of 27 percent.

The Virginia Workshop was held on January 7-8, 2008. Workshop participants included staff from: the Departments of Medical Assistance Services; Education; Mental Health, Mental Retardation, and Substance Abuse Services, and Health (e.g., Family Health Services, Community Health Services). Participants also represented the perspectives of local county public health agencies, behavioral health plans, early childhood programs (e.g., Head Start), and federally qualified health centers. Others appeared on behalf of organizations such as the Academy of Pediatrics, Association of Children's Services Boards, Early Childhood Foundation, Virginia Poverty Law Center, and Family Voices. Staff and leaders from the State's ABCD project, early childhood comprehensive systems initiative, and providers who have piloted developmental screening strategies also participated. Staff from five managed care organizations represented additional private sector health leadership.

The meeting opened with welcoming remarks from Patrick Finnerty, Director of the Department of Medical Services. Mr. Finnerty described the overall priorities of the Medicaid program and the importance of serving children well. He also discussed some of Governor Kaine's health policy priorities, including:

- efforts to expand coverage, such as Virginia Shares (providing premium assistance to individuals at or below 200 percent of the Federal poverty level) and expansion of Medicaid for women up to 200 percent of poverty;
- proposals to improve access to health care services, particularly by increasing enrollment in existing plans and expanding safety net capacity; and
- plans to overhaul and improve the States' mental health system.

Dr. Suttle, Director of Family Health Services described the role of public health generally, and Family Health Services in particular, in assuring health across the lifespan. Dr. Suttle also described how the Title V MCH Block Grant provides funding for an array of services and supports. He noted that they do not, however, support clinical capacity in local health departments.

The majority of the meeting was divided into segments that focused on three specific agenda topics that had been identified by the planning committee: 1) building community systems, 2) assuring quality, and 3) maximizing the efficiency and effectiveness of services through improved collaborative effort.

Barriers were identified during the group's discussions. Some participants expressed concern that family support services are not consistently available. Care coordination and case management,

particularly the role of managed care organizations, was another area of concern. The group also discussed the need to improve linkages to community resources. The group spent a considerable amount of time discussing data gaps and opportunities. Another challenge identified by participants is assuring that older children and adolescents receive the recommended routine well-child exams on the EPSDT schedule. In terms of capacity for follow-up and treatment, several concerns were identified, particularly in rural, underserved communities.

Several current State efforts provide natural opportunities for further improvement of EPSDT. The group discussed opportunities to build upon the momentum generated by release of the new “Bright Futures” guidelines for preventive child health services. Work under the State’s ABCD project will point to ways to remove the barriers to expanding routine use of objective developmental screening. The evolution of Medicaid managed care in Virginia appears to have improved access to basic services for children with and without special health care needs. There was consensus, however, that many providers do not have a clear understanding of what is covered by Medicaid/ EPSDT for children.

The group adopted a clear vision for child health. It is as follows:

> *All children receive the “gold standard” preventive, well-child care (i.e., based on the AAP standard of care and reflected in EPSDT guidelines). This includes age-appropriate, well-child examinations consistent with the AAP Bright Futures recommendations. Access to optimal preventive, well-child care should not vary by type of coverage (public or private).*

Based on the Workshop discussions, Virginia leaders identified opportunities to build from existing efforts or as necessary next steps to improve EPSDT and child health. Through extensive discussion and three rounds of prioritization, the group consensus supported several priority actions. These included the following.

- **Increase provider knowledge of EPSDT and its benefits**. By condensing and streamlining Medicaid/EPSDT provider manuals, creating a pediatric provider toolkit, developing and disseminating a brochure on “Treatment Services under EPSDT,” creating a project for “academic detailing” through which State or MCO staff visit physician practices to provide them with information and updates, and funding for additional training and quality improvement projects that support the medical home concept.

- **Take lessons from ABCD project to scale.** By implementing the ABCD project (i.e., completing work with the pilot practices, collecting data), making necessary regulatory and policy changes to facilitate widespread use of objective developmental screening, identifying “champions” who can speak about their experience and encourage others to make changes in practice, recruiting volunteers to replicate successful pilot project activities in at least 10 other practices across the State, identifying referral resources and increase engagement of community-based, non-health providers, and increasing collaboration with and effectiveness of referrals to Part C.

- **Augment community resource and referral information.** By reviewing the capacity and effectiveness of existing hotlines, toll-free lines, and 211 lines, reviewing available print/online resources, developing a plan for pooling resources and capacity, maximizing the availability and use of parent toolkit, and implementing a plan for pooling resources and capacity.

- **Improve parent informing and outreach**. By developing a campaign to increase awareness of and focus attention on preventive, well-child health visits, linking MCO outreach efforts to community-based outreach efforts; develop ongoing communication mechanisms, increasing support for existing family empowerment efforts (e.g., Parent-to-Parent), and developing new and more effective methods for informing parents about rights and actions related to denial of services.

- **Increase children's mental health provider capacity**. By studying successful efforts in other States, linking to ongoing policy development and advocacy to improve mental health services capacity, developing materials (e.g., fact sheets) to be used in policy advocacy for improved children's mental health services, including information on the needs of young children, studying unmet needs for early intervention and young children, and streamlining the administrative processes for billing and prior authorization.

Washington State

In 2006, more than 630,000 children under age 21 were eligible for EPSDT benefits in Washington State. (This figure includes some individuals eligible for EPSDT under a State Children's Health Insurance Program.) In 2005-06, Washington State Medicaid covered just over 400,000 or 31 percent of children under age 18 – somewhat above the national average of 27 percent.

The Washington State Leadership Workshop was held on September 27-28, 2006. Workshop participants included State agency staff from: Medicaid (Health Resources and Services Administration); Department of Health (e.g., maternal and child health, children with special health care needs, immunization, early childhood comprehensive systems); and Children's Administration. Other participants included local county public health leaders and school nurses, as well as representatives from private entities such as the Washington Chapter of the American Academy of Pediatrics (and private, office-based pediatricians), MCOs/health plans, university pediatric departments, federally qualified health centers, Parent to Parent, and other family advocates.

Dr. Maxine Hayes, State Health Officer, MaryAnne Lindeblad of the Department of Social and Health Services, and Judy Schoder of the Office of Maternal and Child Health opened with an overview of Washington State objectives for the meeting. Dr. Edward Schor of the Commonwealth Fund, Child Health and Development Program, provided on overview of opportunities to improve well-child care on the first day of the Workshop and, on day two, a

presentation on strategies for engaging pediatric primary care providers in child health improvement.

The Workshop participants discussed strengths, weaknesses, opportunities, and challenges over the course of the day and one-half session. Agenda topics included: learning lessons from pilot and demonstration projects, structuring EPSDT for maximum positive impact, focusing on early childhood development, optimizing pediatric primary care, and improving the child health system. In particular, lessons learned from the State's ABCD and Early Childhood Comprehensive Systems initiatives, as well as innovative local pilot pediatric care projects.

Areas of concern that were discussed by the Workshop participants included: outreach and services to adolescents, community-level linkages to facilitate service delivery, care coordination and case management, parent education and outreach, provider participation and incentives, reducing health disparities, and data use. Some additional areas of particular interest to the group included: increasing the number of children who have and use a medical home, improving the quality of well-child visits in EPSDT (and across the child health system), and building on missed opportunities and existing infrastructure (e.g., teen sports physicals, existing case managers, local public health capacity).

The Workshop participants identified 18 topics of common concern. Based on discussion and two rounds of voting, the group consensus supported one overarching objective and eight priority actions. The group agreed that an ongoing, overarching objective is to strengthen joint approaches to Title V / Medicaid collaboration related to EPSDT. Other topics of common interest are shown below.

- **Develop provider incentives for quality screening**: While Washington State has used pay-for-performance incentives with MCOs to improve EPSDT well-child visit rates in recent years, more can be done. Such incentives might be used to: increase provider participation, improve the comprehensiveness of visits, and/or encourage referrals and follow up.
- **Create pilot projects to redesign or re-engineer well-child care/child health care**: Dr. Ed Schor of the Commonwealth Fund and others have proposed strategies for redesigning or re-engineering EPSDT well-child visits. (Schor, 2004) Approaches might include: tiered visits based on a child's risk status, visits sequenced to maximize opportunities for developmental screening, improved protocols that emphasize Bright Futures pediatric care guidelines. Such projects also might aim to maximize use of non-physician providers in the practice setting.
- **Develop quality improvement practice collaborative(s)**: Quality improvement practice collaboratives have been used across the country to change provider knowledge, attitudes, and practices.
- **Augment efforts to increase family empowerment:** The consensus of Workshop participants was that more effort should be made to engage families as partners in child health, to educate families about child health and development, and to encourage families to use well-child visits. The Family Opportunity Act provisions of the DRA might be used to stimulate parent involvement and leadership.

- **Improve coordination of care coordinators, case managers, and medical home care coordination**: Whether Medicaid/EPSDT "case-management," Title V CSHCN "care coordination," or a medical home project, financing and coordinating health and related services for children is a challenge. Workshop participants identified a particular need to assess the current situation, identify barriers, and recommend potential solutions for this challenge. In particular, moving to scale with the medical home concept will require more consistent and reliable use of care coordination resources.
- **Promote community linkages**: Because children's services are fragmented across public program and professional boundaries, most communities can benefit from efforts to create a more cohesive system of care. Linkages could be improved among and between primary health care providers, special education/early intervention programs, schools and early learning centers, mental health providers, WIC, and others.
- **Increase adolescent screening rates**: EPSDT screening rates and use of adolescent health services are low across the country. One important opportunity identified by Washington State leaders is to assure that sports and school-entry physicals provided to those ages 12-18 are comprehensive well-child/EPSDT visits. Another opportunity is to create a quality improvement practice collaborative focused on teens (see general topic above). The latter approach has been used with success in Vermont.
- **Conduct a study of unequal treatment and disparities.** Health disparities among racial/ethnic and socio-economic groups continue to be reported in Washington State and across the country. Since the 2003 release of an Institute of Medicine study on Unequal Treatment, (Smedley et al., 2003) health leaders have looked for opportunities to eliminate this cause of disparate outcomes. Given some data and many anecdotal reports of variation in quality of screening and consistency of referrals by race and ethnicity, Workshop participants called for a study of unequal treatment and health care access disparities in Washington State.

Wyoming

The Wyoming EPSDT program covers more than 54,000 children each year. (This does not include children covered under CHIP.) In 2006, Wyoming covered 57 percent of children under the age 18 – well above the U.S. average of 27 percent. Children accounted for 65 percent of beneficiaries and 25 percent of expenditures in 2006.

The Wyoming Workshop was held on November 27-28, 2007. Workshop participants included staff from: the Departments of Health (e.g., Medicaid, Maternal and Family Health, Public Health Nursing, Oral Health, Mental Health); and Education. Other participants represented the perspectives of local county public health agencies, early childhood programs (e.g., Head Start), and federally qualified health centers. Others appeared on behalf of organizations such as the Academy of Pediatrics, and Family Voices.

The Workshop opened with remarks from Dr. Brent Sherard, Director of the Wyoming Department of Health (DOH). Dr. Sherard described the DOH mission and the way it touches the lives of every citizen. As director, he aims to focus DOH work on prevention and health promotion. He discussed the overall importance and impact of Medicaid and EPSDT on the health coverage and status of Wyoming's 138,000 children. As in some other States, Medicaid finances approximately half of all births in the State. DOH also has undertaken a major initiative that aims to promote use of the Total Health Record (an electronic health record linked to the medical home). This and other projects are designed to help the State manage health care costs by promoting health and managing disease. He stressed that providers do not currently have strong incentives to focus on prevention and health promotion. Dr. Sherard closed his remarks by noting that Wyoming has advantages in being a small State government, in which personal relationships can foster collaboration and coordination.

Three other State officials spoke next. Dr. James Bush, Medicaid medical director, presented EPSDT data for Wyoming. The data indicate problems with reporting and suggest an undercount of what actually occurs in practice. For example, no referrals resulting from EPSDT screening visits are being captured. Dr. Bush also raised concerns about the conflict between the Federal Medicaid requirement for universal lead screening and the recommendations of the Task Force on Clinical Preventive Services which are against universal lead screening. Dr. Grant Christiansen, State Dental Director, also noted that dental visits are underreported, with the number representing little more than the number of visits he completed in his own practice. Finally, Dr. Paul Ramirez described the role of the Maternal and Family Health Division, including the program for Children with Special Health Care Needs (CSHCN). Dr. Ramirez noted the important role of community partnerships and how public health works on the front lines to promote and assure health.

Group discussion during the remainder of the Workshop focused on three specific agenda topics that had been identified by the planning committee: 1) building community systems, 2) assuring quality, and 3) maximizing the efficiency and effectiveness of services.

The group discussion identified a current challenge in distinguishing between three types of care coordination/case management roles financed by DOH. The group also spent a considerable amount of time discussing data gaps and opportunities. These leaders also believe the current Medicaid/EPSDT data do not fully capture the child health services being financed. The group discussed challenges in terms of coding for EPSDT screening and referrals. They also discussed pervasive primary care shortages in rural communities, both in terms of medical and dental care. Another topic that emerged is that three major public payers (Medicaid, KidCare/CHIP, and Title V) set up fee structures for CSHCN which are influencing provider behavior in a negative way.

Based on the Workshop discussions, these Wyoming leaders prioritized five topics for follow up action. These topics were seen as opportunities to build from existing efforts or as necessary next steps to improve EPSDT and child health. The group identified specific strategies and actions to be taken in each of these areas.

- **Maximize care coordination/case management resources.** By convening a meeting to discuss the respective roles of State and county public health nurses and APS case management staff working under contract to Medicaid, clarifying in

writing the roles and responsibilities of care coordination/case management between the medical home, public health nursing, and APS, reviewing departmental expenditures for care coordination/case management through Medicaid, Title V, public health nursing, Part C, and other programs, and adopting new strategies to support the medical home concept in primary care.

- **Develop a Total Health Record Pediatric Quality Improvement Initiative.** By engaging a group of pediatric practices with high concentration of Medicaid patients in a demonstration project for the Total Health Record with the aim of improving EPSDT tracking, recall-reminder, screening, and coding rates and arranging consultation from other pediatric practice collaboratives.

- **Improving the validity and utility of EPSDT program data.** By reviewing reports to check for errors and problems, reviewing data to determine how providers are using well-child vs. EPSDT comprehensive well-child, developing simplified and/or better approaches to EPSDT billing and coding (e.g. drop code modifiers, revised forms), working across agencies to educate clinical practices regarding EPSDT billing codes and forms, linking to Total Health Record provider education.

- **Improve the integrated child health database.** By convening a workgroup to discuss whether or not the State will give priority to an integrated child health database, building on the IT initiative underway in the department, completing current work on linking vital records, Best Beginnings home visiting, Early Hearing Detection & Intervention (EHDI), and newborn metabolic screening, and adding other child health data such as: immunization, EPSDT, WIC, Part C, and birth defects surveillance.

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Appendices

Appendix A: Workshop Participants

These State Leadership Workshops were supported by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. MCHB contracted with Johnson Group Consulting, Inc. to develop and conduct these Workshops. An active group of state leaders contributed their time and excellent ideas to the planning of the Workshops. Without their efforts, these Workshops would not have been possible. The list below shows the degree to which States' had higher level health and public health decision makers involved in Workshop planning. (Note that the titles are shown as they were at the time of each State's Workshop and may not represent current positions.)

Alaska

- **Stephanie Birch**, Title V & CSHCN Director, Section Chief , Women's, Children's and Family Health, Division of Public Health Department of Health and Social Services
- **Barbara Hale**, Medical Assistance Administrator/ SCHIP Coordinator
- **Renee Gayhart**, Tribal Health Program Manager , Office of the Commissioner
- **Michael Huelsman**, (EPSDT coordinator)
- **Michelle Lyons-Brown**, Medicaid State Plan Coordinator, Department of Health and Social Services
- **Jeri Powers**, Public Health Specialist, Division of Health Care Services, Department of Health and Social Services

Arkansas

- **JoAnn Bolick**, Department of Health/MCH
- **Martha Hiett**, Department of Human Services/Division of Child Care and Early Childhood Education
- **Nancy Holder**, Title V CSHCN Director, Division of Developmental Services, Department of Human Services
- **Dr. Richard Nugent**, Title V MCH Director, AR Department of Health
- **Kellie Phillips** (EPSDT coordinator)
- **Dr. Eldon Schulz**, Chief of Developmental-Rehabilitative Pediatrics, Department of Pediatrics, University of Arkansas for Medical Sciences
- **Peggy Starling**, Provider Relations Manager, Medicaid Managed Care Services, Arkansas Foundation for Medical Care

Colorado

- **Joan Eden**, Deputy Director, Prevention Services Division, Department of Public Health and Environment
- **Gina Robinson**, Program Administrator, Office of Client and Community Relations, Department of Health Care Policy and Financing (EPSDT coordinator)
- **Claudia Zundel**, Division of Mental Health, Department of Human Services
- **Terri Pinney**, Director, Smart Start Colorado
- **Kathy Watters**, Director, Children with Special Health Care Needs Unit

Illinois

- **Tanya Anderson**, Clinical Director, Child and Adolescent Services, Department of Human Services, Division of Mental Health
- **Janet Gully**, Part C Early Intervention
- **Deborah Saunders**, Bureau Chief, Maternal and Child Health, Department of Healthcare and Family Services
- **Bridget Schank**, Policy Associate, Ounce of Prevention Fund
- **Nancy Shier**, Director of Kids PEPP, Ounce of Prevention Fund
- **Dr. Myrtis Sullivan**, Associate Director, Community Health and Prevention (Title V director)
- **George Vennikandam**, Department of Child and Family Services

Iowa

- **M. Jane Borst**, Bureau Chief, Bureau of Family Health, Division of Health Promotion & Chronic Disease Prevention, Iowa Department of Public Health
- **Gretchen Hageman**, Bureau of Family Health/State Empowerment Team, Iowa Dept of Public Health
- **Carrie Fitzgerald,** ABCD II Consultant, Iowa Department of Public Health
- **Sally Nadolsky**, Policy Specialist, Iowa Medicaid Enterprise (EPSDT coordinator)
- **Dr. Chris Atchison**, Board Co-Chair ,Associate Dean, College of Public Health, University of Iowa

Maine

- **Nancy Birkhimer**, Director, Teen and Young Adult Health, Maine Center for Disease Control and Prevention, DHHS
- **Ellen Bridge**, Public Health Nurse Consultant, Public Health Nursing, Maine Center for Disease Control and Prevention, DHHS
- **Judith A. Feinstein**, Director, Oral Health Program, Maine Center for Disease Control and Prevention
- **Brenda McCormick**, Director, Health Care Management Division, Office of MaineCare Services (Maine's Medicaid program), DHHS
- **Sheryl Peavey**, Coordinator, State Early Childhood Comprehensive Systems (ECCS) Initiative, Maine Center for Disease Control and Prevention, DHHS
- **Valerie J. Ricker**, Director, Family Health Division (Title V Director), Maine Center for Disease Control and Prevention, DHHS
- **Toni Wall**, Director, Children with Special Health Needs (CSHCN Director), Maine Center for Disease Control and Prevention, DHHS

Michigan

- **Dr. George Baker,** Chief Medical Consultant, Children's Special Health Care Services Division Medical Services Administration, Michigan Department of Community Health (MDCH)
- **Alethia Carr,** Director, Bureau of Family Maternal & Child Health; Women, Infants and Children (WIC) Division; Public Health Administration, MDCH
- **Brenda Fink,** ACSW, Director, Division of Family and Community Health, MDCH

- **Gail Maurer,** Policy Specialist, Program Policy Division (EPSDT coordinator), Medical Services Administration, MDCH
- **Susan Moran**, Director, Bureau of Medicaid Program Operations and Quality Assurance Medical Services Administration, MDCH
- **Kathy Stiffler**, Director, Children's Special Health Care Services Division, Public Health Administration, MDCH
- **Cheryl Bupp, Director**, Managed Care Plan Division, Medical Services Administration, MDCH

Ohio

- **Maureen Corcoran**, Assistant Deputy Director, Ohio Health Plans (Medicaid), Ohio Department of Job and Family Services (ODJFS)
- **Harvey Doremus**, Assistant Deputy Director, Ohio Health Plans, ODJFS
- **Robin Harris**, Executive Assistant, Office of the Governor
- **Karen Hughes**, Chief, Division of Family and Community Health Services, Ohio Department of Health (Title V MCH Director)
- **Alicia Leatherman**, Director, Governor's Early Childhood Cabinet

Nevada

- **Marti Cote**, Medicaid Services Supervisor
- **Gloria Deyhle**, Health Program Manager for Children with Special
- **Phillip Nowak**, Bureau Chief, Medicaid Managed Care and Nevada Check
- **Tammy Ritter**, (former EPSDT coordinator)
- **Debra Wagler**, Health Program Manager-Real Choice Systems Change Project, Bureau of Family Health Services
- **Judy Wright**, Bureau Chief, Family Health Services (Title V director), Nevada Department of Health

Puerto Rico

- **Annie Alonso,** University of Puerto Rico, School of Public Health, MCH/Development Disability & Early Intervention Program
- **Dr. Luisa Alvarado**: Director Department of Pediatrics, Episcopal San Lucas Hospital
- **Luz E. Cruz**, Coordinator of Medicaid Office Training Section
- **Maritza Espada**. Puerto Rico Health Insurance Administration (EPSDT Coordinator)
- **Hector Garcia**, Director of Quality and Planning Office, PR Health Insurance Administration (CHIP director)
- **Leixa Molina**: Director of Prevention and Education Program of Humana PR
- **Dr. Wendy Matos** Executive Director, Commonwealth of Puerto Rico Medicaid Program

Tennessee

- **Ruth Allen**, EPSDT Director, American Academy of Pediatrics, Tennessee Chapter
- **Dr. Veronica Gunn**, Chief Medical Officer, Department of Health
- **Dr. Jeanne James**, Associate Medical Director, Medicaid
- **Jena Napier**, EPSDT Coordinator, Governor's Office of Children's Care
- Coordination
- **Dr. Theodora Pinnock**, MCH Director, , Department of Health

- **Dr. Michael Warren**, Medical Director, Governor's Office of Children Care Coordination

Virginia

- **Joanne Boise**, Director, Division of Child and Adolescent Health, Department of Health
- **Nancy Bullock**, Director, CSHCN Program
- **Brian Campbell**, EPSDT Coordinator, Department of Medical Assistance Services
- **Dr. Colleen Kraft** , President, Virginia Chapter – American Academy of Pediatrics (VA AAP)
- **Dr. David E. Suttle,** Director, Office of Family Health Services, Department of Health
- **Anne Rollins**, Adolescent Health Coordinator, Department of Health
- **Tamara Whitlock**, Manager, Maternal and Child Health Division, Department of Medical Assistance Services

Washington State

- **Teresa Cooper**, Nursing Consultant, Public Health, Child and Adolescent Health, Washington State Department of Health
- **Jan Fleming**, OMCH Director, Washington State Department of Health
- **Civillia Winslow Hill**, Health Services Consultant, CSHCN Section, Washington State Department of Health
- **Maria Nardella**, CSHCN Section Manager, Washington State Department of Health
- **Judy Schoder**, Adolescent Health Consultant, Child and Adolescent Health, Washington State Department of Health

Wyoming

- **Dr. James Bush**, Wyoming Department of Health, Staff Physician
- **Megan Cormier**, APS Consultant
- **Angela DeBerry**
- **Teri Green**, Medicaid Senior Staff
- **Sheree Howell**, EPSDT Coordinator
- **Dr. Paul Ramirez,** CSHCN Director
- **Beth Shober**, Title V Director
- **Crystal Swires,** Family Advocate, Title V-CSHCN program

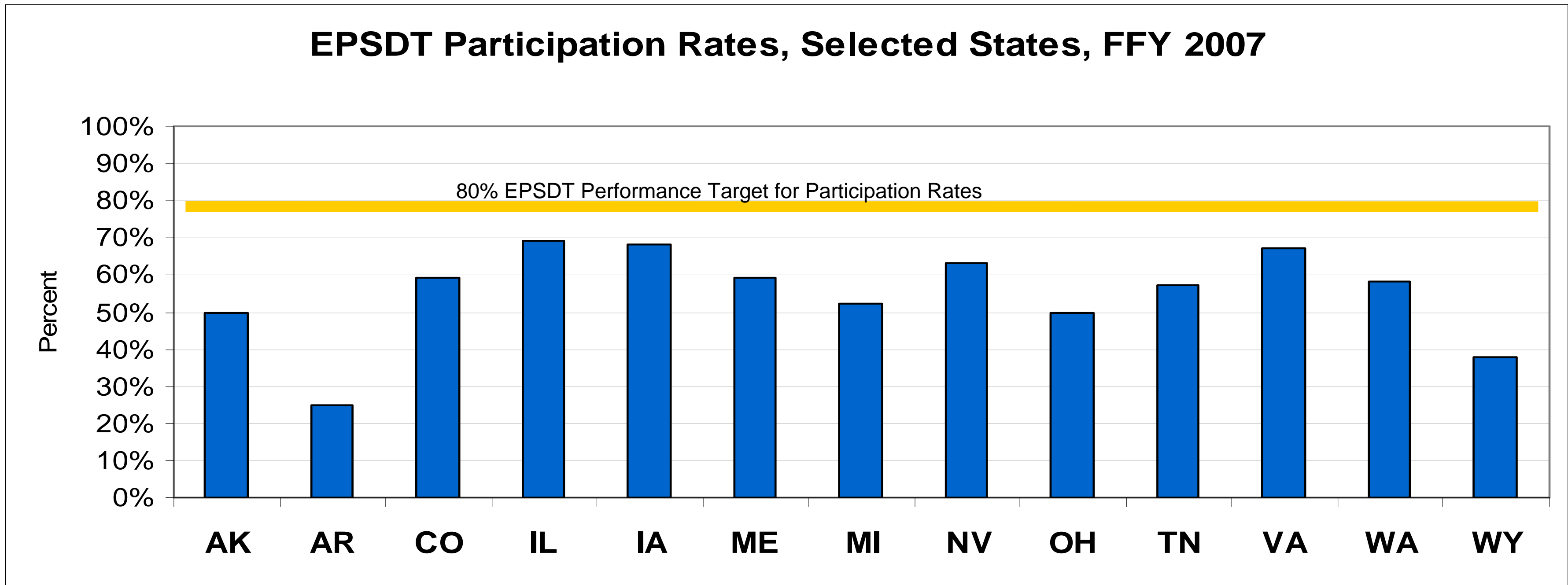
Appendix B: Decision Matrix for Workshop State Selection

Purposes stated in application	EPSDT screening ratio (all ages, 3-5, and 10-14)	EPSDT participation rate (all ages, 3-5, and 10-14)	Permits 12-month continuous eligibility period	Rank MDC / CHIP payment per child enrollee	Percent of Medicaid Beneficiaries enrolled in managed care (all ages)	Percent of Medicaid enrollees that are children	Rank for Title V state match	Distribution of Title V earmarks for children (primary care/ CSHCN)	Ongoing activities that indicate momentum	Likely Workshop impact
	Data from 2003, 2005, 2006, and 2007	Data from 2003, 2005, 2006, 2006, 2007	Data from 2004, 2005, 2006, and 2007	Data from 2001-04	Data from 2001, 2003, 2005, and 2007	Data from 2001, 2003, 2005, and 2007	Data from 2006, 2007, and 2008	Data from 2006 and 2007	*(on a scale of 1-3)*	*(on a scale of 1-3)*

Appendix C: Data for Selected States

Data from Annual EPSDT Participation Reports, Selected Workshop States, Children of All Ages, FFY2007

	AK	AR	CO	IL	IA	ME	MI	NE	OH	TE	VA	WA	WY
Total no. eligible for EPSDT	84,203	387,393	338,186	1,392,361	248,169	136,617	1,103,459	154,025	1,227,384	816,486	548,732	646,521	53,642
No. due for at least one screen	49,949	297,888	247,503	928,387	152,964	110,718	836,739	94,133	1,076,142	653,222	346,748	402,229	40,584
No. received at least one screen	25,050	74,016	145,856	641,636	104,553	64,806	431,366	59,161	537,123	375,016	231,025	232,628	15,219
Participation rate	50%	25%	59%	69%	68%	59%	52%	63%	50%	57%	67%	58%	38%
Screening ratio (adjusted)	70%	21%	77%	100%	96%	86%	73%	80%	66%	91%	88%	78%	54%
No. reported referrals	2,029	0	192,735	208,588	5,441	22,321	0	539	66,088	294,933	56	8,376	0
No. received dental care	32,174	95,299	121,642	505,471	107,631	46,667	346,356	36,803	448,649	293,391	200,857	281,044	17,964
No. enrolled in managed care	0	318,078	336,744	161,240	160,126	82,400	882,191	103,237	1,053,897	816,486	404,509	444,297	0



Appendix D: Application for State Leadership Workshop

WORKSHOP APPLICATION

For HRSA/MCHB Technical Assistance Project State Leadership Workshops on Title V and Medicaid Collaboration to Improve EPSDT and Child Health

The goal of this project is to provide **technical assistance through State Leadership Workshops** that will foster successful coordination between State MCH and Medicaid agencies regarding the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and child health. This technical assistance is sponsored by the Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB-HRSA), which has contracted with Johnson Group Consulting to develop and conduct these Workshops. Please refer to the project brochure for additional background (www.mchb.hrsa.gov). Use this application if your State Title V program would like to have this technical assistance and host a Workshop.

Applicant's State Name: ______________________________

Each State Leadership Workshop on EPSDT and Title V Collaboration will be developed by a State planning group, working closely with Johnson Group and HRSA/MCHB staff to define an agenda for the Workshop and to identify 25 participants to discuss the State's challenges and priorities. For this application, please identify the five core members of your proposed planning group.

Names of individuals (5) to serve as core planning group for Workshop:

1. Name of Title V Director:______________________________

   Name/contact information for assistant or logistics contact in Title V: ______________

2. Name of Medicaid Senior Staff: ______________________________

3. Name of EPSDT Coordinator: ______________________________

Name of two additional senior child health leaders (public or private sector) to serve on your State's Workshop planning group:

4. ______________________________

5. ______________________________

Each Workshop application will be reviewed by Johnson Group and HRSA/MCHB staff. Five (5) States will be selected for Workshops. Please assist us in assessing whether or not a Workshop might be useful as technical assistance in your State by providing the information requested below.

1. **Please describe the current level of collaboration in your State between Title V and Medicaid regarding child health and EPSDT.**
2. **State the three (3) main reasons your State is seeking this technical assistance Workshop.**
3. **After reviewing the sample agenda (attached to email) to get an idea about the range of possible topics a Workshop might cover, please identify specific issues of concern which might be important for a Workshop in your State.**
4. **Describe any recent or anticipated changes to Medicaid or CHIP in your State.**

"Need to Know Questions" to prepare for EPSDT Leadership Workshop

(These questions were answered by each selected State at the beginning of the planning process.)

1) Are Medicaid and Title V located in separate or the same agency/department?
    a. If yes: List agency/department
    b. If no: List the separate agencies/departments

2) What is co-located under Title V?
    a. Are the MCH and CSHCN agencies located in the same agency/department?
        i. If yes, list agency/department
        ii. If no, list the separate agencies/departments
    b. Is the Part C Early Intervention Program located in the MCH program?
        i. If no, is Part C located in the Department of Education?
        ii. If no, please list the department/agency that houses Part C

3) Tell us more about the management of EPSDT screening.
    a. Does the State have special EPSDT projects underway (data, quality studies, etc.)?
    b. Are providers permitted to bill for a well-child visit that is not a comprehensive EPSDT screen?
    c. Does the State require or recommend use of objective developmental screening with a validated tool? For young children? For various age groups of children?

4) Does the State use managed care arrangements for children? If yes:
    a. Is enrollment mandatory for a majority of children?
    b. Is the managed care model:
        i. HMO or other full risk plans for primary medical coverage
        ii. PCCM:
            1. Do PCP's get a separate fee payment for "case management" or a medical home fee?
            2. Are there mechanisms that link payment to fulfilling of certain duties as PCCM (e.g. pay for performance)?
    c. Is there specific language in the contracts that details responsibilities with regard to EPSDT or just wording saying they must provide EPSDT?
    d. Are children with special health care needs (CSHCN) enrolled in managed care arrangements? If not, are certain groups of children or certain services "carved out?"

5) How is case management/care coordination financed for children?
    a. Does the Medicaid agency pay for EPSDT coordinators or outreach workers to assist children in general in appropriately using services?
    b. Does the Medicaid agency pay case management/care coordination for those with high utilization costs (CSHCN)?
    c. Does the Title V MCH/CSHCN program pay for case management/care coordination for CSHCN? Does it bill Medicaid for the case management/care coordination services when the child is enrolled in both Medicaid and CSHCN?

6) Does the State have local EPSDT case management workers or public health nurses?
    a. If yes, is this funded with public health dollars to the local health department?
    b. If yes, does Medicaid finance these services (in whole or in part)?
    c. Otherwise, how is this funded/coordinated?

Appendix E: Workshop Agendas

Model Agenda for State Leadership Workshops on Title V and Medicaid Collaboration to Improve EPSDT and Child Health
June 2007

Based on experience from six State Leadership Workshops regarding EPSDT and six State Leadership Workshops related to Medicaid managed care and child health, our project staff team has identified a set of core topics that are issues of concern and areas that need improvement in most States. Whether workshops focused on the interaction with managed care organizations, on health care in early childhood, on children's mental health, children with special health care needs, or on other populations, four core systems topics emerged as themes in the discussion.

The attached model agenda is built around these four main topics.

1. Family Outreach, Informing, and Enrollment
2. Assuring Quality in Screening, Diagnosis, and Treatment Benefits
3. Maximizing the Use of Available Providers
4. Community Systems: Care Coordination, Case Management, and Family Support

We believe this model agenda is a starting point for the discussions of EPSDT in any State. We do not expect each *State Leadership Workshops on Title V and Medicaid Collaboration to Improve EPSDT and Child Health* to have the same agenda.

The specific agendas will vary by State, with the sample agenda tailored by each State core planning group to fit with their unique challenges and opportunities. For example, building on this sample agenda, the planning group might discuss how family outreach, informing, and enrollment processes could be improved through increased collaboration between Title V MCH programs and Medicaid. In terms of quality, one State might choose to discuss possible changes to their EPSDT periodic visit schedule, while another State might focus on maximizing use of a new or existing quality improvement practice collaborative. Provider supply discussions in one State might have a problem with supply and distribution of primary care providers, and in another State the focus might be on dental provider participation. Last, but not least, increasing attention is being given to the role of community systems and care coordination. Some States have a statewide network of staff (e.g., public health nurses, managed care case managers, etc.) who have responsibility for EPSDT care coordination, while other States are looking at other options to assure linkages among providers and programs (e.g., warmlines, medical home models).

Model Agenda for State Leadership Workshops on Title V and Medicaid Collaboration to Improve EPSDT and Child Health

9:00-9:45 Welcome and Introductions

9:45- 10:30 **Overview presentations**

10:30-10:45 Break

10:45 – Noon **Family Outreach, Informing, and Enrollment**

- What outreach and informing assists families in using EPSDT (e.g., reminder cards, direct contact)?
- In States using managed care approaches, does the enrollment process work smoothly?
- How could this be improved through Title V & Medicaid collaboration?

12:00-12:30 Lunch

12:30- 2:30 **Assuring Quality in Screening, Diagnosis, and Treatment Benefits**

- What are current screening rates and visit schedules?
- What quality improvement (QI) mechanisms (data, practice collaboratives, etc.) might be used to improve quality of services?
- What is the status and role of pediatric medical homes?
- How could quality be improved through Title V & Medicaid collaboration?

2:30-2:45 Break

2:45-5:00 **Maximizing Use of Available Providers**

- How are fee-for-service and/or managed care arrangements used?
- How can the supply of private and public providers be improved (e.g. use of nurse practitioners, federally qualified health centers)?
- What about specialty providers for CSHCN
- How can Medicaid engage dental, mental health, and other providers?
- How could this be improved through Title V & Medicaid collaboration?

<u>Day Two</u>

8:30-10:00 **Community Systems: Care Coordination, Case Management, and Family Support**

- How do the multiple service systems interface (e.g., pediatrician to Part C, to home visiting, to mental health)?
- Who provides care coordination and support to families (e.g., helping families keep appointments, find resources, coordinate multiple providers)?
- How could systems of care be strengthened?
- How could these systems be improved through Title V & Medicaid collaboration?

10:15-Noon **Synthesis and Prioritization:**
Prioritizing ideas generated in the workshop based on feasibility and potential impact. The result will be a set of tangible action steps to take from the Workshop.

Alaska State Leadership Workshop on EPSDT and Title V Collaboration to Improve Child Health Outcomes

Agenda

May 23, 2006	**Improving Health for Alaska's Children**
9:00 – 10:15 AM	**Welcome and Overview – Project Team** **Call to order** - Robert Fordham, Johnson Group Consulting **Introductions** – Mark Gibson, Oregon Health Sciences University **Alaska Welcome –** Jerry Fuller, Director, Medicaid Richard Mandsager, Director, Public Health **Overview of EPSDT and Title V** - Kay Johnson, Johnson Group Consulting; Mike Huelsman, DHSS/HCS
10:15 – 10:30 AM	Break
10:30 AM - NOON	**Group Discussion: Improving Child Health Quality** Facilitation: Johnson and Gibson **A. Achieving the standards of care and practice** *Focusing on how Alaska can achieve its goals for improving child health. Reviewing the Federal legal requirements for EPSDT, the new AAP/Bright Futures guidelines, and special areas such as developmental screening. Also, considering different screening schedules recommended for dental, hearing, etc.* **B. Using quality improvement strategies** *Exploring tools and approaches for monitoring quality, as well as strategies such as medical home approach and practice collaboratives and case management/care coordination.*
12:00 - 1:00 PM	Lunch- on your own
1:00 – 1:30 PM	**Assuring effective outreach and informing of families** *Discussion of tools and methods used in other States and under development in Alaska.* Michael Huelsman
1:30 – 2:15 PM	**Group Discussion: Monitoring Child Health Care and Outcomes** Facilitation: Johnson and Gibson *What does Alaska hope to achieve for kids? Considering recent changes in Federal law, existing State goals and AAP guidelines, how can Title V and Medicaid work together to monitor EPSDT process and child health outcomes, including discussion of indicators and data.*
2:15 – 2:30 PM	Break
2:30 – 3:30 PM	**Synthesis and recommendations** Facilitation: Gibson and Johnson **A. Prioritizing ideas from discussion** **B. Setting an agenda for action -** *Given the collaborative relationship that currently exists between the Title V programs and Medicaid, what should child health programs(particularly EPSDT) look like in five years and what strategies should be implemented together to achieve this?*
3:30 – 4:30 PM	**Group Discussion: Next steps**
4:30 PM	Adjourn

May 24, 2006 **FOCUS ON OPPORTUNITIES IN EARLY CHILDHOOD**

8:30 – 8:45 AM **Introduction**

Welcome and Introductions – Mark Gibson & Kay Johnson
Alaska Objectives – Stephanie Birch

8:45– 10:00 AM **Linking early childhood programs and systems** –
Presentation and Facilitation: Kay Johnson,
Shirley Pittz ECCS Coordinator and Erin Kinavey, Early Intervention Manager, DHSS/OCS

Presentation followed by discussion of opportunities for collaboration among State agencies, such as EPSDT, Part C Early Intervention, Children with Special Health Care Needs (CSHCN), mental health, medical home, and other programs serving young children. Discussion will include ideas and strategies from the State Early Childhood Comprehensive Systems (ECCS) grant initiative and plan.

10:00 -10:15 AM **BREAK**

10:15 – 11:30 AM **Group Discussion continues:**

Facilitation: Johnson and Gibson

A. Boosting developmental screening and its impact

Focusing on opportunities to offer effective developmental screening and referrals for children birth to five through EPSDT and its providers, including billing codes and screening tools. Discussing the role of Title V, Part C Early Intervention, and other agencies in assuring effective developmental screening.

B. Promoting healthy social-emotional development

Discussing how EPSDT and other programs can be used to foster healthy social-emotional development and mental health. Topics would include level 1 and 2 screening and assessments, services to at-risk children, and early childhood mental health consultation, as well as strategies for using Medicaid dollars to finance behavioral health screens, assessments and treatment. Lessons from other States will be reviewed.

11:30 - 12:30 PM **Group Discussion: Conclusions and next steps**

12:30 PM **Adjourn**

Arkansas Leadership Workshop on EPSDT:
Advancing a Collaborative Action Agenda to Improve Child Health
Agenda
November 27-28, 2007
Donaghey Plaza South, Conference Room A
700 Main Street, Little Rock

Day One: November 27, 2007

9:30 - 10:15 AM **Welcome and Introductions**

- Moderator: Robert Fordham, Johnson Group Consulting
- Arkansas Welcome: Dr. Paul Halverson, Director, Arkansas Department of Health; Janie Huddleston, Deputy Director, Arkansas Department of Human Services
- Federal Welcome: James Resnick, Maternal and Child Health Bureau, Health Resources and Services Administration

10:15 - 11:00 AM **Overview Presentations and Discussions**

- Kay Johnson, Overview on EPSDT & Title V Collaboration
- Neva Kaye, Overview on Opportunities to Link Practice and Policy Change

(Note group discussions throughout the meeting will be co-facilitated by Kay Johnson and Neva Kaye.)

11:00 – 12:30 **Group Discussion -**
Building Community Systems: Family Support, Care Coordination, and Case Management

- How does the child health system work and how does it interface with other child and family service systems? (Mapping)
- What are the connections and feedback loops to the child's primary health care provider/medical home?
- How can State leaders make more efficient use of existing capacity and resources?
- How can cross-system collaboration strengthen family support, care coordination, and case management?

12:30 - 1:00 PM Lunch (provided)

1:00 – 2:30 PM **Group Discussion -**
Assuring Screening, Diagnosis, and Treatment Benefits

- How are communication and collaboration being used to improve child health services? What more might be done?
- How can outreach and referral mechanisms be improved through cross-system and/or interagency collaboration?

- What are the implications of the new Bright Futures Guidelines for the EPSDT visit schedule?
- How might efforts build upon or interface with the ABCD project?

2:30-2:45 PM Break

2:45-5:00 PM **Group Discussion – Engaging Providers as Partners in Quality Improvement**

- What quality improvement mechanisms (practice collaboratives, quality initiatives, incentives, etc.) might be used to increase quality and consistency of services?
- How can Medicaid use fee structures to support medical home, pay for performance, and promote quality care?
- How might the ABCD pilot efforts be taken to scale?
- What is the role of pediatricians in identifying and confirming developmental problems?
- Are there special concerns relative to specialty providers for CSHCN?

Day Two: November 28, 2007

8:30-9:30 AM **Group Discussion - Promoting Early Childhood Development**

- What has been learned from the other States' ABCD projects that could be used by Arkansas leaders?
- What particular efforts in Arkansas provide opportunities for progress (early childhood systems development, Part C program structures)?
- How can collaboration and coordination increase access to and utilization of services that promote healthy development of children birth to five?

9:30-9:45 AM Break

9:45-11:30 AM **Synthesis and Prioritization**

- Facilitators will present a synthesis of key topics generated at the Workshop.
- The group will prioritize the key ideas generated in the Workshop based on criteria such as feasibility and potential impact.

11:30-Noon **Next Steps**

- The group will generate a list of next steps corresponding to the priorities for action.

12:00 PM **Adjourn**

Colorado State Leadership Workshop on
EPSDT and Title V Collaboration to Improve Child Health Outcomes

Agenda

Denver

9:00 – 10:15 AM	**Welcome and Overview**
	Welcome - Robert Fordham
	Introductions
	HRSA Project Objectives - James Resnick
	Overview of EPSDT and Title V - Kay Johnson
	Questions from participants
10:15 – 10:30 AM	Break
10:30 AM - NOON	**Group Discussion: Maximizing the Potential of EPSDT to Foster Early Childhood Development**
	Facilitation: Johnson
	A. Boosting developmental screening and its impact
	Focusing on opportunities to offer effective developmental screening and referrals for children birth to five through EPSDT, including billing codes and screening tools.
	B. Screening and intervention to foster healthy mental development
	Discussing how EPSDT screening, diagnosis, and treatment services can be used to foster healthy mental development. Topics would include level 1 and 2 screening and assessments, services to at-risk children, use of managed care arrangements, and early childhood mental health consultation.
12:00 - 1:00 PM	Lunch
1:00 – 2:30 PM	**Group Discussion: Using EPSDT in the Context of Early Childhood Systems Development**
	Facilitation: Johnson and Resnick
	A. Linking early childhood programs and systems
	Discussing opportunities for collaboration among State agencies, such as EPSDT, Part C Early Intervention, Children with Special Health Care Needs (CSHCN), Project Bloom, medical home, and other programs serving young children.
	B. Monitoring process and outcomes of EPSDT
	Considering recent changes in Federal law, existing State goals and AAP guidelines, how can Title V and Medicaid work together to monitor EPSDT process and outcomes, including discussion of indicators, data systems, and managed care contracts.
2:30 – 2:45 PM	Break
2:45 – 3:30 PM	**Synthesis and recommendations**
	Facilitation: Levi and Johnson
	A. Prioritizing ideas from discussion
	B. Setting an agenda for action
3:30 – 4:30 PM	**Group Discussion: Next steps**
4:30 PM	Adjourn

Iowa State Leadership Workshop on
EPSDT and Title V Collaboration to Improve Child Health Outcomes

April 27, 2006
Johnston (Iowa) Public Library

Agenda

12:30 – 1:30 PM **Welcome and Overview**

Welcome - Robert Fordham
Introductions
HRSA Project Objectives - James Resnick
Overview of EPSDT and Title V - Kay Johnson
Questions from participants

1:30 – 3:30 PM **Group Discussion: Using EPSDT in the Context of Early Childhood Systems Development**

Facilitation: Johnson and Levi

A. Linking early childhood programs and systems

Identifying and discussing opportunities for collaboration among State agencies, such as EPSDT, Part C Early Access, Children with Special Health Care Needs (CSHCN), early childhood healthy mental development/ABCD II, Iowa Medical Home Initiative (IMHI), and other programs and projects serving young children. Discussion will be framed in the context of Early Childhood Iowa's early childhood comprehensive systems planning and other initiatives.

B. Focusing on Outcomes in Changing Times

Considering recent changes in Federal law, existing State goals, and current AAP guidelines, how can Title V and Medicaid work together to improve and monitor the health outcomes of low-income and publicly insured children in Iowa.

3:30 – 3:45 PM Break

3:45 – 4:15 PM **Synthesis and recommendations**

Facilitation: Levi and Johnson

A. Prioritizing ideas from discussion
B. Setting an agenda for action

4:15 – 4:30 PM **Group Discussion: Next steps**

4:30 PM Adjourn

Illinois Leadership Workshop on Title V and Medicaid
Collaboration to Improve EPSDT and Child Health

AGENDA

Chicago, IL June 25-26, 2008

<u>Day One: April 1, 2008</u>

9:30 - 10:15 AM — **Welcome and Introductions**

- Illinois Welcome
- Ounce of Prevention Welcome

10:15 - 11:00 AM — **Overview of Strategic Opportunities**

- Kay Johnson, Johnson Group Consulting,

  Overview on EPSDT & Cross-system Collaboration

(Note group discussions throughout the meeting will be facilitated by Kay Johnson.)

11:00 – 12:30 — **Group Discussion –**
Building Community Systems: Family Support, Care Coordination, and Case Management

- How do community service systems interface? (mapping)
- How can outreach help to assure access to care? Who provides it?
- Who currently provides care coordination, case management, and support to families?
- What are the finance mechanisms that drive the approaches?
- How does the PCCM program fit into the big picture?
- How can State leaders build on existing capacity (e.g., home visiting, child welfare, Head Start/Early Head Start, Part C, etc.)?
- How can cross-system collaboration strengthen community systems and family support?

12:30 - 1:00 PM — Lunch (provided)

1:00 – 2:30 PM — **Group Discussion –**
Assuring Screening Benefits

- What areas are indicated for improvement by current EPSDT data?
- What is the role of medical home providers and PCCM in assuring screening and referrals?
- Are screening services available across the State (geographic availability)?
- What more can be done to assure that young children receive appropriate screening for general development and social-emotional development?
- How can collaborative efforts support Illinois' roll out of the new AAP Bright Futures guidelines for preventive, well-child care?

- How can collaboration help to assure access to and utilization of comprehensive well-child EPSDT (screening) visits?

2:30-2:45 PM — Break

2:45-5:00 PM — **Group Discussion – Assuring Diagnostic and Treatment Benefits**

- What are the special concerns for young children birth to five (e.g., children in need of early intervention, in the child welfare system, children with developmental or social-emotional risks but no diagnosis, etc.)?
- What are the special concerns for children with special health care needs (CSHCN), including those with physical, mental health, and other developmental needs? How are CSHCN defined and served?
- What are the special issues in assuring early childhood mental health services and supports for young children (e.g., provider capacity, diagnostic challenges, family interventions, etc.)?
- How can Illinois strengthen capacity to provide dental services (preventive, routine, and specialty) for young children?
- What can be done to address the geographic distribution of providers, which limit access to other child health services?
- How can collaboration help to assure that children receive medically necessary treatment?

Day Two: April 2, 2008

8:30-9:30 AM — **Group Discussion - Cross-system collaboration to improve the health of young children**

- What particular initiatives in Illinois create opportunities for progress (ABCD/EDOPC, early childhood systems development, Part C Early Intervention program, early childhood mental health, perinatal depression)?
- What has been learned from Illinois' and other States' collaborative projects that can help to inform future efforts?
- How can collaboration be used to increase access to and utilization services that promote healthy development of children birth to five?

9:30-9:45 AM — Break

9:45-11:45 AM — **Synthesis and Prioritization**

- Prioritizing ideas generated in the Workshop based on criteria such as feasibility and potential impact.

11:45-12:30 — **Next Steps**

12:30 PM — **Adjourn**

Maine State Leadership Workshop on
EPSDT and Title V Collaboration to Improve Child Health Outcomes

Agenda

Augusta, Maine January 11-12,, 207

Thursday	**January 11, 2007**
9:00 – 9:45 AM	**Welcome and Introduction**
	Call to Order - Robert Fordham, Johnson Group Consulting
	Introductions
	Welcome
	- J. Michael Hall, Director, MaineCare
	- Christine Zukas-Lessard, Deputy Director, Maine CDC
	Maine Workshop Objectives
	- Valerie Ricker, Director, Family Health Division, Maine CDC
	- Brenda McCormick, Director, Division of Health Care Management, MaineCare
	HRSA Objectives - James A. Resnick, Maternal and Child Health Bureau, Health Resources and Services Administration
9:45 – 10:30 AM	**Overview of EPSDT and Title V**
	Presentation by Kay Johnson, Johnson Group Consulting
	Questions from participants
10:30 – 10:45 AM	Break
10:45 – 11:45 AM	**Group Discussion: Boosting developmental screening and its impact on child development**
	Focusing on approaches to offer more effective developmental screening and referrals for children birth to five through EPSDT and its providers. Discussing the role of Title V (public health), Part C Early Intervention (CDS), and other agencies in assuring effective care, as well as ideas and strategies from the Early Childhood State plan. Lessons from other States' efforts to improve early childhood health (physical, mental, and oral) will be described.
11:45 – 12:30 PM	Lunch (on site)
12:30 – 1:30 PM	**Group Discussion: Enhancing the Health of Adolescents**
	Exploring ways to increase utilization of EPSDT screening by adolescents, including incentives for participation. Discussing the role of pediatric primary care providers, school health, and others in assuring adolescent health (physical, mental, and oral). Lessons

from other States efforts to improve adolescent health discussed.

1:30 – 2:30 PM **Group Discussion: Assuring Care Coordination for Children and Youth with Special Health Care Needs**

Discussing the strategies used by Maine and other States to assure care coordination and case management for children and youth with special health care needs. What is the role of public health? Of MaineCare? Of medical and dental providers? What is the potential impact of the Deficit Reduction Act (DRA) changes in Medicaid case management?

2:30 – 2:45 PM Break

2:45 – 3:30 PM **Group Discussion: Assuring Necessary Follow Up**

Discussing how follow-up and continuity can be improved. Reports from the public health nurse EPSDT follow-up program in Maine indicate that many opportunities are missed to link children with appropriate follow up services. What is the role of public health? Of MaineCare? Of medical and dental providers? How can Maine systems be adapted to "close the loop" and assure appropriate follow up?

3:30 – 4:00 PM **Recap of Day One discussion** – Kay Johnson

4:00 PM End of Day One

Friday January 12, 2007

8:30 – 8:45 AM **Welcome and recap** – Kay Johnson

8:45 – 9:45 AM **Group discussion: Developing an action agenda to achieve Maine health goals for children and youth**

Building from the Federal legal requirements for EPSDT and the new AAP/Bright Futures guidelines, and Maine goals, what should EPSDT look like in five years and what strategies should be implemented together to achieve this? How can collaborative relationships among public health, MaineCare, providers, and families be strengthened to support this work? What strategies can support providers and families in achieving optimal health for children (e.g., medical home approach, practice collaboratives, and case management/care coordination)?

9:45 – 10:00 AM Break

10:00 – 11:30 AM **Prioritizing ideas from discussion**

11:30 – 12:30 PM **Group Discussion: Next steps**

12:30 PM **Adjourn**

Michigan Leadership Workshop on
Collaboration to Improve EPSDT and Child Health

AGENDA

January 15-16, 2008
333 East Michigan Avenue, Lansing, Michigan

<u>Tuesday, January 15, 2008</u>

9:30 - 10:15 AM **Welcome and Introductions**

- Moderator: Robert Fordham, Johnson Group Consulting
- Michigan Welcome – Janet Olszewski, Director, Michigan Department of Community Health

10:15 - 11:00 AM **Overview of Strategic Opportunities**

- Kay Johnson, Overview on EPSDT & Cross-system Collaboration
- Neva Kaye, Overview on Opportunities to Improve Child Development Services through Policy Change

(Note group discussions throughout the meeting will be co-facilitated by Kay Johnson and Neva Kaye.)

11:00 – 12:30 **Group Discussion –**

Assuring Screening, Diagnosis, and Treatment Benefits

- How can outreach help to assure access to care?
- What areas are indicated for improvement by current EPSDT data?
- What are the special concerns for young children birth to five (e.g., children in need of early intervention, in the child welfare system, children with developmental or social-emotional risks but no diagnosis, etc.)?
- What are the special concerns for children with special health care needs (CSHCN), including those with physical, mental health, and other developmental needs?
- How might Michigan assure that the EPSDT periodicity (screening visit) schedule align with the new Bright Futures Guidelines?
- How can collaboration help to assure access and utilization?

12:30 - 1:00 PM Lunch (provided)

1:00 – 2:30 PM **Group Discussion –**

Assuring a Medical Home

- What is a medical home and how can the concept be operationalized?
- What is the role of medical home providers in assuring screening and referrals?
- What are the special issues relative to assuring a medical home for CSHCN?
- What mechanisms (practice collaboratives, quality initiatives, incentive payments, etc.) might be used?

- What are the particular opportunities in managed care arrangements? In fee-for-service arrangements?
- How can cross-system collaboration increase the number of children who have a medical home?

2:30-2:45 PM Break

2:45-5:00 PM **Group Discussion –**

Building Community Systems: Family Support, Care Coordination, and Case Management

- How do community service systems interface? (mapping)
- Who currently provides care coordination, case management, and support to families?
- What are the finance mechanisms that drive the approaches?
- How can State leaders build on existing capacity (e.g., medical home, home visiting, managed care, child welfare, Head Start/Early Head Start, Early On, etc.)?
- How much of this work should be carried out through the medical home?
- How can cross-system collaboration strengthen family support, care coordination, and case management?

<u>Wednesday, January 16, 2008</u>

8:30-9:30 AM **Group Discussion -**

Cross-system collaboration to improve the health of young children

- What particular efforts in Michigan create opportunities for progress (Governor's Summit, early childhood systems development, Part C/Early On program structures, CSHCS strategic planning, infant mental health projects, foster care, Head Start/Early Head Start)?
- What has been learned from Michigan's and other States' collaborative projects that can help to inform future efforts in Michigan?
- How can collaboration be used to increase access to and utilization services that promote healthy development of children birth to five?

9:30-9:45 AM Break

9:45-11:30 AM **Synthesis and Prioritization**
Prioritizing ideas generated in the Workshop based on criteria such as feasibility and potential impact.

11:30-Noon **Next Steps**

12:00 PM **Adjourn**

Nevada State Leadership Workshop on
EPSDT and Title V Collaboration to Improve Child Health Outcomes
AGENDA
September 7, 2006 Reno, NV

9:00 – 9:45 AM	**Welcome and Overview**
	Call to Order - Robert Fordham, Johnson Group Consulting
	Welcome – Mary Liveratti, Health and Human Services
	State Objectives
	– Phil Nowak, Health Care Financing and Policy
	– Judy Wright, Bureau of Family Health Services
	HRSA Project Objectives - James Resnick, Maternal and Child Health Bureau, Health Resources and Services Administration
	Introductions
9:45 – 10:15 AM	**Overview of EPSDT and Title V** - Kay Johnson, Johnson Group Consulting
10:15 – 10:30 AM	Break
10:30 – 11:15 AM	**Group Discussion: Achieving the standards of care and practice**
	Focusing on how Nevada can achieve its screening goals. Reviewing the Federal legal requirements for EPSDT and the new AAP/Bright Futures guidelines.
11:15 AM - NOON	**Group Discussion: Provider Participation and Retention**
	Exploring approaches to encourage provider participation and to support providers so they will remain active in EPSDT, including discussion of other State projects and national initiatives.
12:00 - 1:00 PM	Lunch
1:00 – 1:45 PM	**Group Discussion: Using quality improvement strategies**
	Exploring tools and approaches for monitoring quality, as well as strategies such as practice quality improvement collaboratives, performance monitoring, and case management/care coordination.
1:45 – 2:30 PM	**Group Discussion: Family Outreach and Informing**
	Discussing on how Title V and Medicaid work together to reach families, promote use of preventive care, and assure each child has a medical home.
2:30 – 2:45 PM	Break
2:45 – 3:30 PM	**Synthesis and recommendations**
	A. Prioritizing ideas from discussion
	B. Setting an agenda for action – *Building from the current work plan, what should EPSDT look like in five years and what strategies should be implemented together to achieve this? How can collaborative relationships among Title V, Medicaid, providers, and families be strengthened to support this work?*
3:30 – 4:30 PM	**Group Discussion: Next steps**
4:30 PM	Adjourn

AGENDA

Puerto Rico Leadership Workshops on Collaboration to Improve EPSDT and Young Children's Health

March 27-28, 2008

<u>Day Two: March 27, 2008</u>

9:00 - 10:00 AM **Welcome and Introductions**

- Call to Order: Robert Fordham, Johnson Group Consulting
- Puerto Rico Welcome – Dr. Rosa Perez, Secretary of Health
  Dr. Wendy Matos, Director, Medicaid

10:00 - 10:45 AM **Overview of Strategic Opportunities**

- Kay Johnson, President, Johnson Group Consulting;
  Overview on EPSDT & Cross-system Collaboration
- Neva Kaye, Senior Program Director, National Academy of State Health Policy; Overview on Opportunities to Improve Child Development Services through Policy Change

10:45-11:00 AM Break

(Note group discussions throughout the meeting will be co-facilitated by Kay Johnson and Neva Kaye.)

11:00 – 12:30 **Group Discussion -**
Building Community Systems: Family Support, Care Coordination, and Case Management

- How does the child health system work and how does it interface with other child and family service systems? (Mapping)
- What are the connections and feedback loops to the child's primary health care provider/medical home?
- How can State leaders make more efficient use of existing capacity and resources?

12:30 - 1:00 PM Lunch (on-site)

1:00 – 2:30 PM **Group Discussion –**
Maximizing the Use of Available Providers

- What is the role of pediatric primary care providers and the concept of the "medical home" for children?
- How can the managed care organizations (MCOs) and their provider networks support improvement of child health?
- What is the role of Federally Qualified Health Centers (FQHC)?
- Are there special concerns relative to specialty providers for CSHCN?
- What are the next steps to advance the ABCD pilot projects? What are plans to replicate, take these efforts to a larger scale?

- What quality improvement mechanisms (practice collaboratives, quality initiatives, incentives, etc.) might be used to increase quality and consistency of services?

2:30-2:45 PM Break

2:45-5:00 PM **Group Discussion -**
Assuring Screening, Diagnosis, and Treatment Benefits

- What are current screening rates (HEDIS, 416, and other data)?
- What is the current periodic visit schedule? What are the implications of the new Bright Futures Guidelines for the EPSDT visit schedule?
- What forms and tools are used or recommended for use in EPSDT comprehensive well-child visits? What are the MCO responsibilities?
- How do billing codes support efficient and effective service delivery?
- Are providers required to use objective developmental screening tools for young children?
- How might efforts build upon the ABCD project?
- How well do current arrangements work for referral and follow up treatment?

Day Two: March 28, 2008

8:30-9:30 AM **Group Discussion -**
Promoting Early Childhood Health and Development

- What has been learned from the other States' ABCD projects that could be used by child health leaders in Puerto Rico?
- What particular projects and programs in Puerto Rico offer opportunities (United for Early Childhood, ECCS, Part C Early Intervention, School of Public Health projects and research)?
- How can collaboration and coordination increase access to and utilization services that promote healthy development of children birth to five?

9:30-9:45 AM Break

9:45-11:30 AM **Synthesis and Prioritization**

- Facilitators will present a synthesis of key topics generated at the Workshop.
- The group will prioritize the key ideas generated in the Workshop based on criteria such as feasibility and potential impact.

11:30-12:30 **Next Steps**

- The group will generate a list of next steps corresponding to the priorities for action.

12:30 PM **Adjourn**

Tennessee Leadership Workshop on
Collaboration to Improve Child and Adolescent Health
February 11-12, 2009
Bureau of TennCare, Nashville

Day One:

9:00 - 9:45 AM **Welcome and Introductions**

- Call to Order: Robert Fordham, Johnson Group Consulting
- Tennessee Welcome:

  Dr. Jeanne James, Medical Director, Medicaid

  Dr. Veronica Gunn, Chief Medical Officer, Department of Health

9:45 - 10:15 AM **Overview Presentations and Discussions**

- Kay Johnson: Overview on EPSDT & Title V Collaboration

(Note group discussions throughout the meeting will be facilitated by Kay Johnson.)

10:15 - 10:30 AM Break

10:30 AM – Noon **Group Discussion -**
Strengthening Child and Adolescent Health Systems
Mapping how the system works from outreach through screening and treatment. Discussing the strategies used by Tennessee and other States to assure linkages to health and other supportive services.

- How do child and adolescent health service systems interface?
- What are key outreach and linkage strategies for adolescents?
- How can collaboration strengthen linkages?

12:00 - 12:30 PM Lunch (provided)

12:30 – 2:00 PM **Group Discussion -**
Assuring Screening, Diagnosis, and Treatment

Exploring ways to increase utilization of health services by adolescents. Lessons from other States efforts to improve adolescent health discussed.

- What is the role of pediatric primary care providers, school health, managed care plans, and others in assuring adolescent health (physical, mental, and oral)?
- How might efforts build upon or interface with current projects and initiatives in Tennessee (e.g., GOCCC teen subcommittee, adolescent health brochure and website, sickle cell awareness preconception health project, high school pilot project)?
- How can collaboration improve access and utilization?

2:00-2:15 PM — Break

2:15-4:30 PM — **Group Discussion –**
Engaging Providers as Partners

- How might a focus on advancing "medical homes" be used to improve adolescent health?
- What quality improvement mechanisms (practice collaboratives, quality initiatives, record reviews, etc.) are being used or might be used to increase quality and consistency of services?
- What quality mechanisms are built into managed care contracts and operations (e.g., integration of physical and behavioral health, EQRO, special focus)?
- How can collaboration improve access to dental, mental/behavioral health, specialty providers for CSHCN, and other providers for adolescents?

Day Two:

8:30-9:30 AM — **Group Discussion -**
Maximizing the Efficiency and Effectiveness Current Services

Building from Tennessee goals, what should EPSDT look like in five years? What strategies should be implemented to improve adolescent health? How can collaborative relationships among patients, public health, providers, and health plans be strengthened?

- How can communication and collaboration be used to improve efficiency and effectiveness of adolescent health services?
- How can State leaders build on existing capacities?
- What are the greatest opportunities in light of current projects?

9:30-9:45 AM — Break

9:45-11:30 AM — **Synthesis and Prioritization**

- Prioritizing ideas generated in the Workshop based on criteria such as feasibility and potential impact.

11:30-Noon — **Next Steps**

12:00 PM — **Adjourn**

Virginia Leadership Workshop on
Collaboration to Improve EPSDT and Child Health
AGENDA
January 7-8, 2008

Doubletree Hotel, Richmond Airport

<u>Day One: January 7, 2008</u>

9:30 - 10:15 AM **Welcome and Introductions**

- Moderator: Robert Fordham, Johnson Group Consulting
- Virginia Welcome – Patrick Finnerty, Commissioner, Department of Medical Assistance
- Federal Welcome: James Resnick, Maternal and Child Health Bureau, Health Resources and Services Administration

10:15 - 10:45 AM **Overview of Strategic Opportunities**

- Kay Johnson, Overview on Collaboration to Improve EPSDT and Child Health

(Note group discussions throughout the meeting will be facilitated by Kay Johnson.)

10:45-11:00 AM Break

11:00 – 12:30 **Group Discussion – Building Community Systems: Family Support, Care Coordination, and Case Management**

- How do community service systems interface? (mapping)
- Does current outreach help to assure access to care?
- Who currently provides care coordination, case management, and support to families?
- What are the finance mechanisms that drive the approaches?
- How can State leaders build on existing capacity (e.g., managed care, medical home, home visiting, Part C, managed care, child welfare, Early Head Start, etc.)?
- How can cross-system collaboration strengthen family support, care coordination, and case management?

12:30 - 1:00 PM Lunch (provided)

1:00 – 2:30 PM **Group Discussion – Assuring Screening, Diagnosis, and Treatment Benefits**

- What areas are indicated for improvement by current EPSDT data?
- How might Virginia assure that the EPSDT periodicity (screening visit) schedule aligns with the new Bright Futures Guidelines?
- What are the particular opportunities in managed care arrangements?

- What are the special concerns for children with special health care needs (CSHCN), including those with physical, mental health, and other developmental needs?
- How can collaboration help to assure access and utilization?

2:30-2:45 PM Break

2:45-5:00 PM **Group Discussion – Assuring Quality Care and a Medical Home**

- What is the role of medical home providers in assuring screening?
- What mechanisms (practice collaboratives, quality initiatives, incentive payments, etc.) might be used?
- What are the particular opportunities in managed care arrangements? In fee-for-service arrangements?
- What are the special issues relative to assuring a medical home for CSHCN?
- How can Medicaid engage dental, mental health, and other providers?
- How can cross-system collaboration help?

Day Two: January 8, 2008

8:30-9:30 AM **Group Discussion - Cross-system collaboration to improve the health of children**

- What particular efforts in Virginia create opportunities for progress (Governor's Smart Beginnings Initiative, managed care, Part C program structures, CSHCN strategic planning, infant mental health projects)?
- How can collaboration be used to increase access to and utilization services that promote healthy development of infants, children, and adolescents?

9:30-9:45 AM Break

9:45-11:30 AM **Synthesis and Prioritization**

- Prioritizing ideas generated in the Workshop based on criteria such as feasibility and potential impact.

11:30-Noon **Next Steps**

12:00 PM **Adjourn**

Washington State Leadership Workshop on
EPSDT and Title V Collaboration to Improve Child Health Outcomes

Agenda

DAY ONE

9:00 – 9:30 AM	**Welcome and Introductions**
	Call to Order - Robert Fordham, Johnson Group
	Introductions
	Welcome – Maxine Hayes, MD, MPH, Washington State Department of Health, State Health Officer
	MaryAnne Lindeblad, Washington State Department of Social and Health Services
	Judy Schoder, Washington State Department of Health, Office of Maternal and Child Health
	HRSA Project Objectives - James Resnick
9:30 – 11:15 AM	**Overview Presentations and Discussion**
9:30 – 10:00 AM	**Overview of EPSDT and Title V** - Kay Johnson
	Questions from participants
10:00 – 10:30 AM	**Overview of Opportunities to Improve Well-child Care** – Dr. Ed Schor, The Commonwealth Fund
	Questions from participants
10:30 – 10:45 AM	Break
10:45 – 11:15 AM	**Discussion: Lessons From Pilot and Demonstration Projects**
11:15 – 12:30 PM	**Group Discussion 1.: How can the structure of EPSDT screening visits be improved**
	A. Structuring EPSDT for maximum positive impact
	Considering existing Federal, State, and AAP guidelines, how can the EPSDT periodicity schedule and visit protocol be improved? Options such as group visits, tiered well-child care, revised EPSDT visit content, and revised periodicity schedules, use of maternal and children's services providers to enhance EPSDT (First Steps, Nurse Family Partnership, public health, Head Start, ECEAP, WIC, and school health and screening services, including school-based clinics) and the use of media and education for families (CHILD Profile) and providers will be discussed.
12:30 - 1:00 PM	Lunch
1:00 – 2:00 PM	**B. Special focus on early childhood development**
	Focusing on opportunities to offer effective developmental screening and referrals for children birth to five through EPSDT and its providers, including billing codes and screening tools. Discussing the role of Title V, Part C Early Intervention, Department of Early Learning, Kids Matter, Kids Get Care, Docs for Tots, Head Start, ECEAP, WIC, schools, and other agencies and projects in assuring effective developmental screening.

	Group Discussion 2: How can we better link child health programs and systems?
2:00 – 3:00 PM	**A. Mapping the child health system** *Focusing on the key elements of a child health system, discussion will address topics related to assuring a medical home, care coordination, collocation, and services for children with special health needs.*
3:00 – 3:15 PM	**Break**
3:15 – 4:30 PM	**B. Opportunities for improving the child health system in Washington State** *Discussion of existing resources, projects, and political will. What are the opportunities for collaboration among State agencies, such as EPSDT, Part C Early Intervention, special education, Children with Special Health Care Needs (CSHCN), and other programs related to child health? How can Washington State move toward a more comprehensive approach to child health and improve cohesion within the child health system? What resources are needed to orchestrate change efforts? Who needs to be at the table?*
4:30 PM	End of Day One

DAY TWO

8:30 – 8:45 am	**Review of Day One Discussions**
8:45 – 9:15 AM	**Engaging Pediatric Primary Care Providers in Child Health Improvement** – Dr. Ed Schor, The Commonwealth Fund
9:15 – 10:30 am	**Group Discussion 3: Opportunities for optimizing the pediatric primary care providers available in Washington State** *Considering the available supply and distribution of pediatric primary care providers, what steps should be taken to advance practice and improve quality?*
10:30 – 10:45 am	Break
10:45 – 11:30 AM	**Synthesis and recommendations** Facilitation: Johnson **A. Prioritizing ideas from discussion** **B. Setting an agenda for action**
11:30 - 12:30 PM	**Group Discussion: Next steps**
12:30 PM	Adjourn

Wyoming Leadership Workshop on Title V and Medicaid
Collaboration to Improve EPSDT and Child Health
AGENDA
September 24-25, 2007

Qwest Building, 6101 N. Yellowstone Rd., Cheyenne, WY 82002

Day One: September 24, 2007

10:00-10:45 AM **Welcome and Introductions**

- Wyoming Welcome
- Federal Welcome: James Resnick, Maternal and Child Health Bureau, Health Resources and Services Administration

10:45- Noon **Overview Presentations and Discussions**

- Kay Johnson, EPSDT Overview & Title V Collaboration (20 min)
- Dr. James Bush, Wyoming EPSDT Data Overview(10 min)
- Beth Shober, M.A, Wyoming Maternal and Family Health Update (10 min)

12:00-12:30 PM Lunch (provided)

12:30 – 2:30 PM **Group Discussion -**
Building Community Systems: Family Support, Care Coordination, and Case Management

- How do community service systems interface?
- How does family outreach and informing work now?
- Who currently provides care coordination, case management, and support to families?
- How can State leaders build on existing capacities (e.g., APS, public health nursing, automated systems, electronic records, etc.)?
- How can collaboration strengthen family support, care coordination, and case management?

2:30-2:45 PM Break (refreshments provided)

2:45-5:00 PM **Group Discussion -**
Assuring Quality in Screening, Diagnosis, and Treatment Benefits

- What areas are indicated for improvement by current EPSDT data?
- Does the EPSDT visit schedule conform to AAP recommendations (i.e., Bright Futures Guidelines)?
- What quality improvement mechanisms (data, practice collaboratives, etc.) might be used to increase quality of services?
- How might efforts build upon or interface with the Total Health Record (medical home initiative) for Wyoming?
- How can objective data be used to drive change and improvement?

Day Two: September 25, 2007

8:30-9:30 AM **Group Discussion -**
Maximizing the Efficiency and Effectiveness Current Services

- How can communication and collaboration be used to improve efficiency and effectiveness?
- How can collaboration be used to strengthen systems of care?
- How can duplication of efforts be minimized?
- How can Wyoming agencies work together to improve the health of the larger population of children, not just the segments they serve?

9:30-9:45 AM Break (refreshments provided)

9:45-11:30 AM **Synthesis and Prioritization**

- Prioritizing ideas generated in the Workshop based on criteria such as feasibility and potential impact.

11:30-Noon **Next Steps**

12:00 PM **Lunch (provided)**

1:00 PM **Adjourn**