

***Health Care Professionals' Feedback  
Regarding Provision of Child Health  
Check-Ups (Early and Periodic Screening,  
Diagnosis & Treatment, EPSDT)***

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Department of Family and Preventive Medicine  
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Submitted to

***The Oklahoma Health Care Authority***

This report completes Article IV, Section 4.2, Part f. of a contract with the Oklahoma Health Care Authority which states, "Contractor shall prepare a written report detailing the feedback gathered from providers regarding EPSDT screens in children (ages 3-9) to be submitted to OHCA by Wednesday, December 3, 2008.

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## *Health Care Professionals' Feedback Regarding Provision of Child Health Check-Ups (Early and Periodic Screening, Diagnosis & Treatment, EPSDT)*

### **EXECUTIVE SUMMARY**

**Purpose:** This report describes the results of a study conducted by faculty and staff in the Primary Care Health Policy Division, Department of Family & Preventive Medicine (DFPM) at the University of Oklahoma Health Sciences Center (OUHSC) on behalf of the Oklahoma Health Care Authority (OHCA). The purpose of this study was two-fold: (1) to provide professional consultation and support for internal policy decisions to OHCA regarding child health check-ups (referred to by the Centers for Medicare and Medicaid as Early and Periodic Screening, Diagnosis, and Treatment, (EPSDT), and (2) determine the extent to which PCPs are conducting regular, standardized screening to identify children at risk for developmental disabilities. Previous studies of child health check-ups (EPSDT) were conducted and some comparisons from previous studies can be drawn.<sup>1,2</sup>

**Background:** Currently, 28 million children are covered by Medicaid in the United States, about 37%.<sup>3</sup> About 8.8 million children, 11.4%, are uninsured and 69% of these children are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). These programs are state administered and each state sets its own guidelines, within federal regulations, regarding eligibility and services. In Oklahoma, more than 385,000 children (56%) are covered by SoonerCare, an increase of 139,000 from 1999.\*

In 1967, Congress mandated that child health check-ups be performed on a regularly scheduled basis (EPSDT Periodicity Schedule)

for all Medicaid qualified children from birth to age 21. The purpose of child health check-ups is, "to ascertain physical and mental defects and to provide treatment to correct or ameliorate any defects or chronic conditions found."<sup>4</sup> Qualified beneficiaries pay no cost-share for mandated child health (EPSDT) services.<sup>5</sup>

Despite the proven benefits of regular screening,<sup>6,8</sup> no cost-share for recipients, and bonus payments for PCPs, compliance with EPSDT guidelines by PCPs and parents/caregivers has been variable. PCPs say missed appointments ("no shows") were the main reasons they were unable to comply with child health check-up guidelines, while parents/caregivers cite transportation and work/school conflicts as the reasons they couldn't get their children in for check-ups.<sup>1,2</sup> The first component of this study is to provide OHCA with data they can use for internal policy decisions regarding child health check-ups.

A second component of this study was to gather data regarding providers' knowledge and performance of developmental screening in children from birth to age 3 as an adjunct to EPSDT child health check-ups. Developmental screening is, "a procedure designed to identify children who should receive more intensive assessment or diagnosis for potential developmental delays."<sup>9</sup> In the U.S., 17% of children have a developmental or behavioral disability, such as autism, mental retardation, and Attention-Deficit/ Hyperactivity Disorder (ADHD). Less than 50% of these children are identified before starting school. PCPs who see children for regular check-ups may miss the early signs of developmental disability because they see the child so seldom and have little time in a busy practice to perform a detailed develop-

\*Source: Oklahoma Health Care Authority, <http://www.communicationservices/reporting&statistics/monthlyfastfacts/monthlyfastfacts/childunder18>, August 11, 2008.

mental screen.<sup>10,11</sup> PCPs may perform regular developmental surveillance, defined as “an ongoing process of monitoring the status of a child.” PCP observation during a clinic visit is one form of developmental surveillance. Developmental screening, however, is “proactively testing children to identify those at high risk of clinically significant but, as yet, unsuspected deviations or delay from normality.”<sup>10,11</sup> In short, screening is testing; surveillance is observing.

**Methods:** DFPM staff helped OHCA (1) develop, administer and analyze a PCP feedback survey (Appendix A) and cover letter (Appendix B), and (2) conduct interviews with PCPs who agreed to answer additional questions about child health check-ups or developmental screening (Appendix C).

**Subjects:** The inclusion criterion was a valid PCP contract with OHCA to see SoonerCare children as of June 1, 2008; 584 PCPs met the criteria. Surveys were mailed to all 584 PCPs on June 17, 2008; 13 were undeliverable or unusable resulting in a total of 571 surveys distributed; 211 surveys were received and analyzed, a 36.9% response rate.

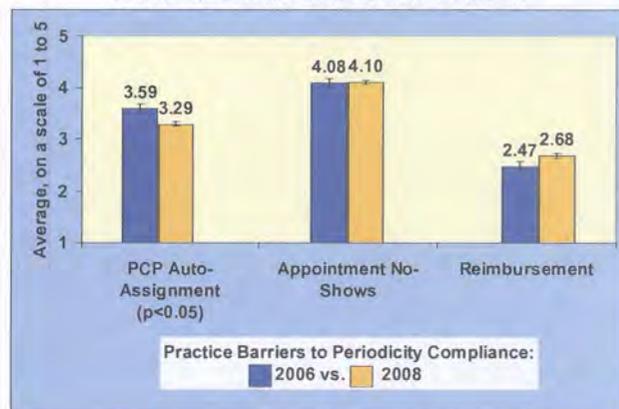
**Survey Instruments:** DFPM staff assisted OHCA in developing the survey instrument and cover letter using previously reported methods.<sup>10,11</sup> Some questions were similar to those on the previous survey, which allowed us to compare responses.<sup>1,2</sup>

**Data Analysis:** Raw data (available upon request) were analyzed with Excel. Some findings pertaining to child health checks-ups were compared with results from a previous study.<sup>1,2</sup> Phone and e-mail interviews were held with 26 respondents to gather additional feedback. Survey comments (Appendix D) and authors’ credentials (Appendix E) are attached.

## Key Findings:

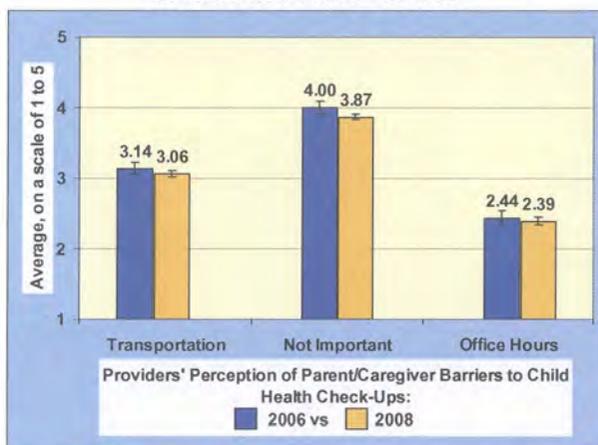
1. Surveys were mailed on June 17, 2008 to all 584 PCPs who met inclusion criteria; 13 were unusable; 211 valid surveys were received, a 36.9% response rate.
2. Most respondents were physicians (52%) (61% family physicians, 35%, pediatricians, 4%, general practitioners); 24% were PAs or nurse practitioners. The remaining respondents (24%) were nursing or administrative staff.
3. 64, 30.3% of 211 respondents, gave contact information; 7 were unreachable. We attempted to contact 57 providers. Of those, 22 spoke with us on the telephone, 3 responded to an e-mail, and 1 via fax. These exchanges confirmed the survey findings, especially regarding frustration over missed appointments and lack of parental responsibility.
4. The majority of respondents indicated they “Understood” (39%) or “Understood Well” (36%) the EPSDT periodicity schedule.
5. Missed appointments (“No-shows”) were the major barrier for PCPs in meeting EPSDT periodicity schedule guidelines; PCP auto-assignment was 2<sup>nd</sup>, and reimbursement, 3<sup>rd</sup>. These results are similar to a prior study (Figure 1).<sup>1,2</sup>

**Figure 1. Barriers to PCP Compliance with EPSDT Guidelines: 2006 vs 2008**



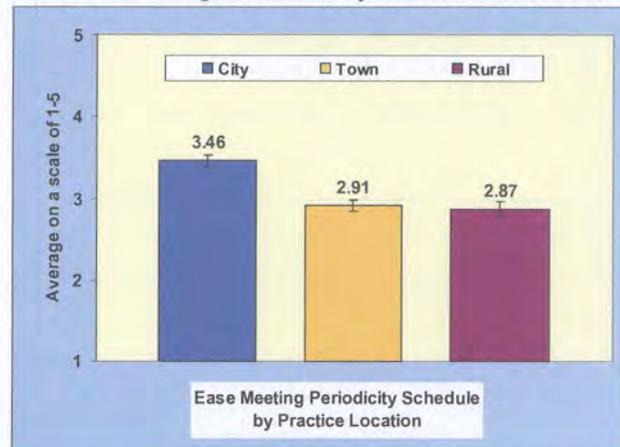
6. Based on interviews, only about half of PCPs are aware that the PCP assignment methodology will be changing in Jan., 2009.
7. PCPs felt the main reason parents/caregivers did not bring children in for regular child health check-ups was that they were “Not Important”; “Transportation” issues were 2<sup>nd</sup>, and “Office Hours” conflicts were 3<sup>rd</sup>. These results are similar to prior findings (Figure 2).<sup>1,2</sup>

**Figure 2. PCP-Identified Barriers to Parent/Caregiver Compliance with EPSDT Guidelines: 2006 vs 2008**



8. PCPs with city practice locations found it easier to meet periodicity schedule guidelines (avg, 3.46 on a scale of 1 to 5) than those in towns (avg, 2.91), or rural areas (avg, 2.87). The differences between “City” and both of the other variables were statistically significant ( $p < .05$ ). The differences between “Town” and “Rural” were not statistically significant (Figure 3).

**Figure 3. Ease or Difficulty Meeting Periodicity Schedule Requirements by Practice Location**



9. 96% of survey respondents indicated they performed developmental screens in their practice, but only 36% knew about the \$8.40 additional payment for each properly coded screen (page 13).
10. 44% of respondents indicated they “use” the Ages & Stages Questionnaire (ASQ) in their practice, and 38% indicated they use the Parents’ Evaluations of Developmental Status (PEDS) test. 25% had never heard of ASQ and 32% had never heard of PEDS. Many said they used the Denver Developmental Screen Test (DDST).
11. Nursing staff (3%) and billing, coding and clerical personnel (3%) were far less likely to know about the additional payment for a properly coded developmental screen than were physicians (48%), physician extenders (21%), and office management (22%).
12. Some respondents were under the mistaken impression that completing the Developmental Assessment section of the OHCA Child Health Supervision (EPSDT) Visit form constituted a developmental screen (Figure 36).

## Recommendations:

1. Develop outreach and implement educational efforts for providers explaining the reimbursement system for child health check-ups.
2. Develop educational approaches for parents/caregivers explaining the importance of child health check-ups. Consider PSAs, flyers, etc.
3. If the lower compliance with the periodicity schedule in towns and rural areas as compared to cities is due to transportation problems for SoonerCare recipients, as we think may be likely, then strategies to increase awareness of the SoonerRide program should be explored. In the parent report to follow, we will do a data analysis of the transportation issues by location.
4. Federal mandates should be clarified, through PSAs, conference booths, etc., to mitigate potential emotional reactions from providers, specifically regarding lead screening.
5. Implement outreach efforts for providers, especially PSAs, mail-outs, booths at various provider association meetings, etc., to explain the new PCP assignment process.
6. Develop outreach and implement educational efforts for providers about the various developmental screening tools, especially the ones which are most likely to yield valid results, and those which should be avoided.
7. Develop and implement outreach for parents and caregivers about the purpose and importance of developmental screening. These could include examples of the parent-completed tools.
8. Develop outreach and implement educational efforts for PCPs and office staff explaining what constitutes a developmental screen.
9. Develop outreach and implement educational efforts for PCPs and office staff explaining the additional payment of \$8.40 available for a properly coded developmental screen.
10. Explore training tools, brochures, etc., or conduct conferences or classes about these different instruments in an effort to educate providers about the appropriate ways to most accurately identify children at risk for developmental delay.
11. Future studies could investigate the frequency with which health care professionals are conducting developmental screening tests, and which tools they prefer.
12. Make available anticipatory guidance training in all of the following areas:
  - Developmental and Behavioral Screening and Counseling (81 requests)
  - Nutritional Screening (61 requests)
  - Violence (46 requests)
  - Injury Prevention (38 requests)
  - Sleep Positioning (25 requests)
13. Make available staff and provider EPSDT training for the following topics:
  - Developmental and behavioral screening (64 requests)
  - Hearing (47 requests)
  - Vision (41 requests)
  - Lead/anemia (37 requests)
  - Dental (26 requests)

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# Introduction

## Purpose

This report describes the results of a study conducted by faculty and staff in the Primary Care Health Policy Division, Department of Family & Preventive Medicine (DFPM) at the University of Oklahoma Health Sciences Center (OUHSC) on behalf of the Oklahoma Health Care Authority (OHCA). The purpose of this study was two-fold: (1) to provide professional consultation and support for internal policy decisions to OHCA regarding child health check-ups (referred to by the Centers for Medicare and Medicaid as Early and Periodic Screening, Diagnosis, and Treatment, (EPSDT), and (2) determine the extent to which PCPs are conducting regular, standardized screening to identify children at risk for developmental disabilities. Previous studies of child health check-ups (EPSDT) were conducted and some comparisons from previous studies can be drawn.<sup>1,2</sup>

Project researchers assisted OHCA in developing a survey (Appendix A) and cover letter (Appendix B) for PCPs with OHCA contracts to see SoonerCare (Medicaid) children as of June 1, 2008. The survey was distributed to all 584 PCPs who met inclusion criteria.

In addition to administering the survey, DFPM staff conducted telephone interviews and e-mail exchanges with respondents who provided optional contact information. Interview questions and a grid outlining responses are attached (Appendix C). The purpose of the interviews was to gather additional data about both EPSDT and developmental screening.

Previous studies of child health check-ups (EPSDT) were conducted.<sup>1,2</sup> Comparisons with current results were made to determine trends where appropriate.

## Background

“Children make up 50% of the U.S. Medicaid population.”<sup>3</sup> In fact, 28 million children are currently covered by Medicaid in the United States, about 37% of all children from birth up to age 19.<sup>3</sup> Of about 8.8 million children, 11.4%, are uninsured and 69% of these children are eligible for Medicaid or the State Children’s Health Insurance Program (SCHIP). In Oklahoma, more than 385,000 (56%) children are covered by SoonerCare, an increase of 139,000 from 1999.\*

A growing body of evidence supports the fact that early preventive health care reduces the incidence of health problems, and improves growth and development for children.<sup>6-8</sup> In 1967, Congress mandated by law regular child health check-ups (EPSDT) for all children covered by Medicaid from birth to age 21 years. The purpose of child health check-ups is, “to ascertain physical and mental defects and to provide treatment to correct or ameliorate any defects or chronic conditions found.”<sup>4</sup> The goal of child health check-ups (EPSDT) is, “to ensure that children received preventive care ... [including] regular health, vision and dental check-ups,”<sup>12</sup> as well as screening for hearing, devel-

\*Source: Oklahoma Health Care Authority, <http://www.communicationsservices/reporting&statistics/monthlyfastfacts/monthlyfastfacts/childunder18>, August 11, 2008.

opmental, and nutritional status. If a PCP identifies a potential health or developmental threat during a regular check up, EPSDT includes referral for appropriate diagnostic services and provision of all medically necessary treatment.<sup>13,14</sup> Qualified beneficiaries pay no cost-share for mandated child health (EPSDT) services.<sup>5</sup> Unfortunately, many parents and individuals caring for low-income children are often unaware that their children might qualify for Medicaid coverage, what the EPSDT services include, and the positive impact child health check-ups can have for the growth and development of children.<sup>7,13-15</sup>

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) requires states to reach out aggressively to qualified beneficiaries and provide services to ensure access to preventive care, including transportation, case management, translation, and assistance scheduling appointments.<sup>14</sup> In Oklahoma, to increase compliance with EPSDT periodicity schedule guidelines, OHCA rewards PCPs who meet or exceed an established benchmark. The bonus can be as much as 20% of their annual Medicaid capitation (for children only).\*

Despite the proven benefits of regular screening, the fact that beneficiaries have no co-payment for services, and a bonus payment system for PCPs who meet or exceed guidelines, compliance with EPSDT guidelines by both PCPs and parents/caregivers has been variable. A study by Millar et al. reported that EPSDT completion rates in Oklahoma stood at 60% in 1998. Although this is a dramatic increase from 17.6% in 1990, it is still below the target of 80% set by the OHCA and the Center for Medicare & Medicaid Services (CMS).<sup>16</sup> Recent data, from the National Center for Children in Poverty show that 59% of Oklahoma children between the ages of 1 and 2 received at least one EPSDT screen compared with only 44% of children between 3 and 5.<sup>17</sup> (Nationally, Delaware had the highest screening percentage for children age 3 to 5 at 103% and Wyoming had the lowest

percentage, 37%.<sup>18</sup>) Oklahoma ranks below the Center of Medicare & Medicaid Services (CMS) benchmark of 80% for child health check-ups (EPSDT) for children on Medicaid (SoonerCare in Oklahoma.)

In previous studies, PCPs indicated that missed appointments (“no shows”) are the main reason they are unable to complete regular screening services, while parents and caregivers cite transportation and work/school conflicts as the reasons they can’t get their children in for check-ups.<sup>1,2</sup> The first component of this study is to provide OHCA with data they can use for internal policy decisions regarding child health check-ups.

A second component of this study was to gather data regarding providers’ knowledge and performance of developmental screening in children from birth to age 3 as an adjunct to EPSDT child health check-ups. In the U.S., 17% of children have a developmental or behavioral disability, such as autism, mental retardation, and Attention-Deficit/Hyperactivity Disorder (ADHD). Currently, less than 50% of these children are identified before beginning school. Physicians and other health care professionals who see children for regular check-ups often miss the signs and symptoms of development disabilities because they see the child so seldom and have little time in a busy practice to perform a detailed developmental screening exam.<sup>10,11</sup>

There are two terms that refer to types of developmental assessment: developmental surveillance and developmental screening. Developmental surveillance is “an ongoing process of monitoring the status of a child.” Physician observation of a child during a clinic visit is one form of developmental surveillance.<sup>10</sup> Developmental screening, however, refers to the process of “proactively testing children to identify those at high risk of clinically significant but, as yet, unsuspected deviations or delay from normality.”<sup>10</sup> In short, screening is testing while surveillance is observing.

\*In 2005, OHCA ear-marked \$1,000,000 for EPSDT provider bonuses.

**Table 1. Overview of Available Developmental Screening Tests<sup>10</sup>**

Test	Age	Time (minutes)	Description
<b>General Screening Tests</b>			
Battelle Developmental	6-96 mo	30	96 items testing social, adaptation, motor, communication & cognition
Bayley Infant Neurodevelopmental	3-24 mo	15-20	6 sets of 11-13 items. Tests basic neuro, expressive, receptive, & cognitive.
Brigance Screens	0-96 mo	10-15	tests fine, gross motor; receptive, expressive language; self-help skills; social emotional. Assesses reading, math at older ages.
Early Screening Inventory	48-72 mo	20	3 sections, 30 items. Tests language, cognition, visual-motor/adaptive, gross motor/body awareness.
First STEP	32-72 mo	15-20	Tests 5 domains: cognition, communication, physical functioning, emotional and social status. 12 subsets that use games.
Denver Developmental	0-72 mo	20-30	125 items in 4 sections: gross motor, fine motor/adaptive, personal/social, language skills. Similar to growth chart.
<b>Cognitive Screening Tests</b>			
Cognitive Adaptive Test (CAT)/ Linguistic and Auditory Milestone Scale (CLAMS)	1-36 mo	10	CAT test visual-motor problem-solving; CLAMS test receptive and expressive language. 2 scores equal quotient for cognitive function.
Slosson Intelligence Test	2 wk- 26 yr	30	Assesses cognitive abilities by testing language skills, verbal problem solving, and general information.
<b>Language Screening Tests</b>			
Early Language Milestone Scale	0-36 mo	2-10	43 items in 3 categories testing auditory expressive, receptive, and visual.
Peabody Picture Vocabulary	2.5- 40 yr	10-15	17 sets of 12 questions arranged in increasing difficulty to test receptive vocabulary and verbal ability from children to adults.
Token Test for Children	3-12.5 yr	10-20	61 items testing functional receptive language.
<b>Neuromotor Screening Tests</b>			
Alberta Infant Motor Scales	0-24 mo	10-15	58 items, 4 subscales focusing on weight bearing, postural alignment and antigravity movements.
Milani-Comparetti Developmental	1-16 mo	10-15	27 items testing primitive reflects, tilting, righting, spontaneous posture, movement by attaining independent posture.
Toddler & Infant Motor Evaluation	4-42 mo	10-15	5 subscales: mobility, motor organization, stability, functional performance, social/emotional.
<b>Behavioral Screening Tests</b>			
Eyberg Child Behavior Checklist	2.5-11 yr	7	36 statements of common behavioral problems.
Pediatric Symptom (Behavior) Checklist	4-16 yr	7	35 items tests external behavior (conduct) and internal behavior (depression, anxiety, adjustment).
Vineland Adaptive Behavior Scales	0-19 yr	20-60	tests communication, daily living skills, socialization, motor skills; also identifies problem behaviors, if present.
<b>Parent-completed Tests</b>			
Ages and Stages (ASQ)	4-60 mo	10-15	30 questions testing fine motor, gross motor, communication, problem-solving and personal-social skills. To be completed by parents at regular intervals beginning at 4 months.
Child Development Inventory (CDI)	0-72 mo	15-20	300 questions testing social, self-help, fine and gross motor, communication, letters, numbers.
Parents' Evaluations of Developmental Status (PEDS)	0-9 yr	2	10 questions about parent concerns. No score but can determine when to refer, provide 2nd screen, offer patient education or monitor closely.

There are a number of screening tools available, some for PCPs (or other professionals, e.g., social worker, psychologist, etc.) and others for parents (Table 1, adapted from Rydz et al, 2005<sup>10</sup>). Most provider-administered tests take less than 30 minutes and many take as few as 10 minutes. Nonetheless, even a 10-minute screening test can be difficult in a busy primary care practice. Parent completed screening tests are available and have been validated. These tests can take as little as 2 to 20 minutes, could be completed by the parent or caregiver in the office setting or at home, and would give the health care provider insight into the child's development and any problems that might be worth a second look.

As with child health check-ups (EPSDT), Oklahoma clinicians who perform developmental screening and code appropriately on the encounter form, can receive as much as \$8.40 per screen over and above any payment for the visit.

In spite of additional reimbursement for health care professionals and no out-of-pocket cost for recipients, compliance issues and barriers remain. This report describes the results from a survey designed to collect feedback from clinicians about the obstacles they face in meeting the routine child health check-ups as recommended on the EPSDT periodicity schedule guidelines, and to gather data on the developmental screening processes in clinics that routinely bill for EPSDT services. An equally important part of the survey and the accompanying explanatory material was to educate PCPs, with the goal of improving the quality and completion rates of childhood screening in Oklahoma.

# Methods

Faculty and staff from the DFPM assisted OHCA with the conduct of this study using methods previously described.<sup>1,2</sup>

## Subjects

Target subjects for this study were 584 PCPs with OHCA contracts to see SoonerCare children as of June 1, 2008. Surveys were mailed on June 17, 2008; 13 were undeliverable, unusable, or received after the August 22, 2008 cut-off date) resulting in a total of 571 surveys distributed; 211 surveys were received and analyzed, a 36.9% response rate.

## Survey Instrument

DFPM faculty and staff helped OHCA develop a PCP feedback instrument (Appendix A) and an accompanying explanatory letter (Appendix B). The 16-question survey included basic demographic questions (identification of individual completing the survey, and practice location), questions specifically related to provision of routine child health check-ups (EPSDT) as required by the EPSDT periodicity schedule, and questions related to developmental screening knowledge and practices. Two questions about training opportunities (anticipatory guidance and specific screening tests required by the CMS-mandated EPSDT periodicity schedule) invited providers to select training they or their staff might need to improve their screening and child health check-up services. The survey also

included two open-ended, narrative questions (see Appendix A).

These questions were asked in 4 formats:

1. Check box,
2. Likert scale (1-5) responses,
3. Fill in the blank, and
4. Narrative.

The final question on the survey allowed the respondents to provide optional contact information if they were interested in answering additional questions about child health check-ups or screening for development disabilities. Sixty-four respondents (30.3%) provided contact information; 7 were unreachable (no longer working in practice, duplicate, etc.). Of 57 respondents, 22 participated in telephone interviews, 3 responded via e-mail and 1 responded via fax.

A complete list of the interview script and a grid detailing the results of those interviews are attached (Appendix C).

## Data Analysis

Survey questions were entered into an Excel spreadsheet for statistical analysis by one or more team members. Data entry was subjected to random checking by a staff member who was not involved in data entry to ensure accuracy.

All statistical analyses were performed using the formulae in Excel, including those in the Excel Descriptive DataPak. These analyses included mean, median, mode, standard deviation, standard error of the mean, and Student T-

test, depending on the data and the questions being asked. Charts and figures for this report were also generated in Excel.

Answers requiring a written response were entered exactly as they appeared on the completed survey. Responses were coded to identify themes that might be useful for OHCA. A complete list of narrative responses from the survey is attached in Appendix D. The raw data for this study are available upon request.

### **Telephone Interviews and E-mail Exchanges**

Sixty-four survey respondents (30.3%) completed question 16. Optional Contact Information, indicating they would be willing to discuss child health check-ups and/or developmental screening with DFPM staff. Of the 64, 7 left incomplete information, had moved or no longer worked at that facility. Attempts were made to contact the remaining 57 respondents; 22 were interviewed on the telephone, 3 responded via e-mail and 1 responded via fax. A complete grid of interviews is attached (Appendix C).

These interviews gave providers the opportunity to clarify survey responses and to reiterate areas in which they would like to see changes occur to assist them in meeting the goals and objectives of EPSDT, for both child health check-up and screening to identify potential developmental delay. In addition, new questions, which were not included as part of the survey, were added about approaches to preventive services in their practices, and the level of communication they have received from OHCA. One question was added that asked if respondents had heard about the upcoming changes to the PCP assignment system. This question had the dual purpose of gathering provider responses to this change and educating those providers who had not heard about the change (see Appendix C).

### **Resources and References**

Since its inception in March 2003, the Primary Care Health Policy Division has been building a library of relevant health policy materials. These materials include newspaper accounts, research reports and articles, and internet resources. Citations to these materials were entered into an EndNote Reference Management Library database. To date, the library includes 1,032 documents and citations. Materials relevant to Medicaid program innovation, uninsured and underinsured working adults and families, and current national discussions about health care are included in this library. The database and the library are available for use by OHCA staff, and by others upon special request. The numerous references cited in this report are part of this library and database.

Biographical sketches for all program faculty and staff are attached in Appendix E.

### **Limitations of this Study**

The inclusion criterion for survey participants was a valid contract with OHCA to provide health care services for children with SoonerCare as of June 1, 2008. Surveys were mailed to all 584 PCPs who met the inclusion criteria; 13 surveys were undeliverable or unusable (blank or received after the deadline of August 22, 2008). Completed surveys were returned by 211 PCPs, a 36.9% response rate. The choice of survey recipients was not randomized; the survey was sent to all PCPs who met the selection criteria. There was no way to control which PCPs would complete the survey, and which would not. Therefore, a certain amount of selection bias must be assumed. In addition, some of the questions called for estimates and opinions, which require subjective responses.

Another limitation is that not all respondents answered every question, which may affect the data analysis. Every effort was made, during the

analysis process, to allow for these discrepancies. To facilitate understanding, the number of responses received for each data point is reported in the results section, where applicable. We have included the number of respondents who did not answer a specific question if it would help clarify the results.

However, the relatively high response rate (36.9%) should allow policy makers to utilize this study with reasonable assurance that the results represent the opinions, feelings, and suggestions from the majority of health care professionals providing child health services to SoonerCare participants.

# Results

**Reader's Note:** Not all respondents completed every survey question. Therefore, the number of responses for each individual question may vary. Where possible and necessary to fully understand the results, we have added the number of non-respondents.

## Abbreviations used in this analysis

Avg = average, or mean

SEM = standard error of the mean

p-value = a measure of probability that indicates whether a difference between two groups happened by chance or that the difference was real (using a 2-tailed Student's T-test).

pop = population

A total of 584 PCPs who had valid contracts to provide health care services for children with SoonerCare on June 1, 2008, were sent surveys on June 17, 2008; 13 were either undeliverable or unusable (incomplete, or received after the August 22, 2008 cut-off date) resulting in a total of 571 surveys distributed; 211 surveys were received and subjected to data analysis, a 36.9% response rate. Each question was analyzed using formulae available in Excel.

The Results section is divided into three sub-sections. The first section shows the results for each question in the order they appeared on the survey. The second section contains comparative analyses, in which data were cross-analyzed by demographic variables to determine whether certain demographics predicted responses to some of the questions. Questions were chosen for comparison based on the likelihood they would yield valuable information for program managers and policymakers.

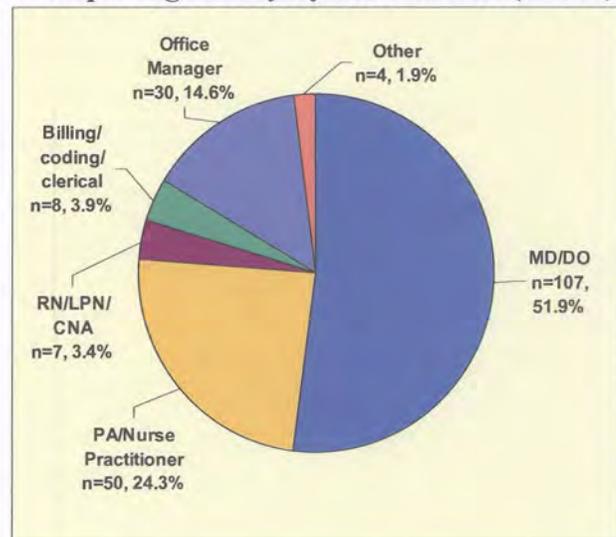
The final section reports the findings from the telephone interviews and e-mail exchanges

with respondents who indicated on their surveys that they would be interested in talking to us further about child health check-ups and/or development screening.

## Survey Results by Question

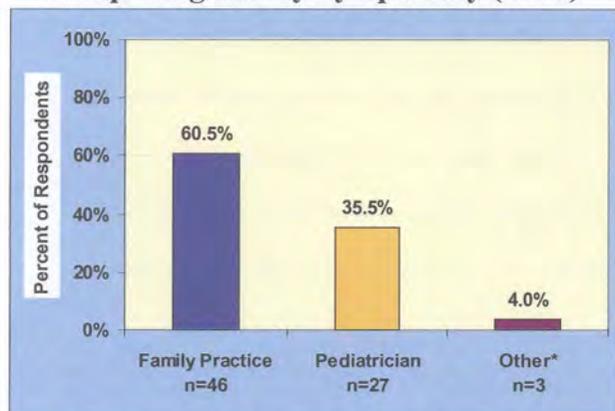
**1. Person completing survey.** The majority (79.6%) of individuals completing this survey were clinical staff; the remaining respondents served in an administrative capacity. More than half of respondents were physicians (51.9%); 24.3% were PAs or nurse practitioners; and 3.4% were RNs, LPNs, or CNAs. The remaining 20.4% were managerial or clerical staff, with the majority of those being office managers (Figure 4). Compared with a previous study, more clinicians completed this survey (as opposed to administrative staff) than completed a similar survey conducted in 2006.<sup>2</sup>

**Figure 4. Breakdown of Individuals Completing Survey by Job Position (n=206)**



Of the physicians completing the survey who indicated a specialty, most were family physicians (60.5%, n=46); 35.5% were pediatricians (n=27), and 4.0% were general internists (n=3) (Figure 5). These results are similar to the 2006 survey.<sup>2</sup>

**Figure 5. Breakdown of Physicians Completing Survey by Specialty (n=76)<sup>†</sup>**

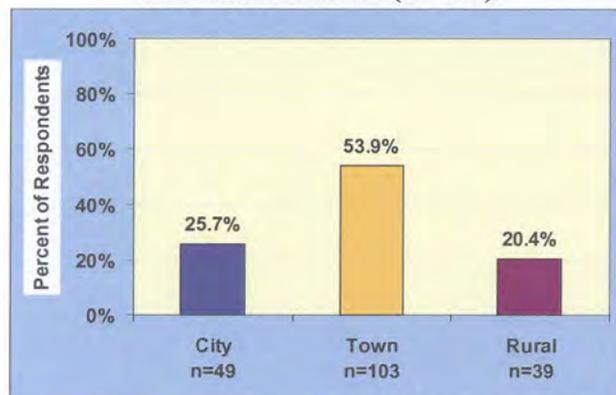


\*Other: General Internal Medicine, Internal Medicine.

<sup>†</sup>Thirty-one (31) respondents who identified themselves as either MDs or DOs did not answer the question about specialty.

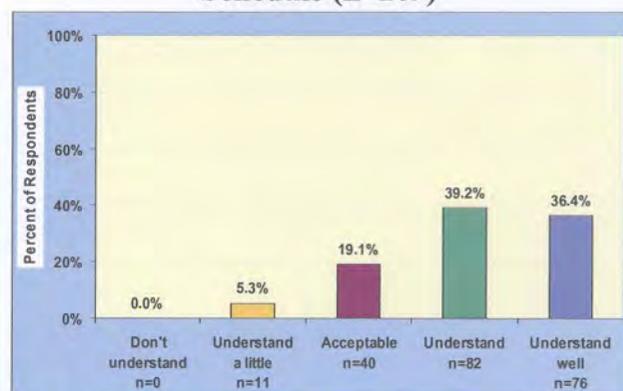
**2. Practice location (city, town, rural).** Often, data analysis will reveal a connection between survey responses and location. In this sample, most respondents (53.9%, n=103) identified their practice locale as a “Town” (population from 2,500 to 50,000); 25.7% (n=49) said their practice was in a “City” (population 50,000+), and 20.4% (n=39) indicated their practice was “Rural” (Figure 6). These data will be used in the comparative analyses to determine whether survey responses differ by practice location.

**Figure 6. Breakdown of Respondents by Practice Location (n=191)**



**3. How would you rate your knowledge of the SoonerCare periodicity schedule and guidelines?** The frequency of child health check-ups and the screening exams to be performed at each visit are mandated by CMS and are outlined on what is called a “periodicity schedule.” Respondents were asked to rate their understanding of the requirements for an EPSDT visit as described on the periodicity schedule (Figure 7).

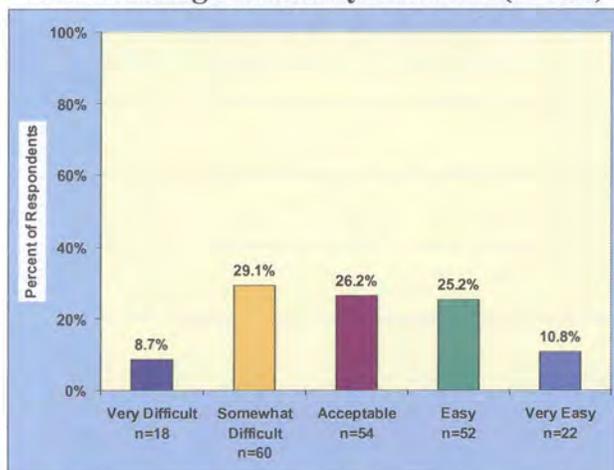
**Figure 7. Self-Reported Level of Understanding of EPSDT Periodicity Schedule (n=209)**



All respondents indicated at least some level of understanding of the periodicity requirements, and nearly 76% indicated they had a reasonably good understanding (Understand, 39.2%, n=82; Understand well, 36.4%, n=76) (Figure 7). Only 5.3% (n=11) indicated they had a less than adequate understanding of the requirements and 19.1% (n=40) said their understanding was “Acceptable.” The average response, on a scale of 1 (“Do Not Understand”) to 5 (“Understand Well”) was 4.07 (SEM=0.03) for the 209 respondents answering the question.

**4. How difficult it is for your practice to meet the Sooner Care periodicity schedule?** Respondents were asked to rate the degree of difficulty they had in meeting the periodicity schedule for child health check-ups in their practice (Figure 8).

**Figure 8. Self-Reported Ease or Difficulty with Meeting Periodicity Schedule (n=206)**



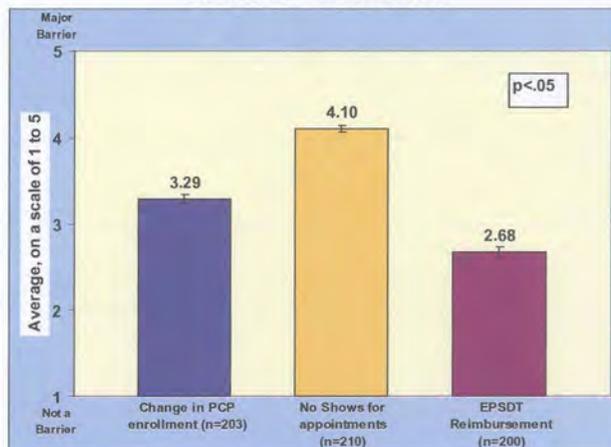
Most of the responses fell between “Somewhat Difficult” and “Easy” (80.5%, n=166 out of 206 responses) (Figure 8). When data were averaged, on a scale of 1 (“Very Difficult”) to 5 (“Very Easy”), the mean response was 3.00 (SEM=0.05) indicating that most respondents found meeting the periodicity schedule guidelines “Acceptable.” This is somewhat improved over a survey conducted in 2006 in which responders rated their compliance 2.66 (SEM=0.09), a little less than acceptable.<sup>2</sup>

**5. Barriers to providing child health check-ups as part of the EPSDT periodicity schedule.** To determine what specific areas PCPs felt were problematic within their practices in complying with EPSDT scheduled care, we asked survey respondents to rate three possible obstacles on a scale of 1 (“Not a Barrier”) to 5 (“Major Barrier”):

1. Change in PCP enrollment (auto assignment),
2. Appointment no shows, and
3. EPSDT reimbursement.

“Appointment No Shows” was the greatest obstacle to compliance (avg=4.10, SEM=0.03). Changes in PCP assignment (also called auto-assign or auto-reassign) was the second greatest challenge (avg=3.29, SEM=0.05), and reimbursement was the least problematic (avg=2.68, SEM=0.04) (Figure 9). All differences were statistically significant (p<.05).

**Figure 9. Barriers to PCP Compliance with EPSDT Guidelines**

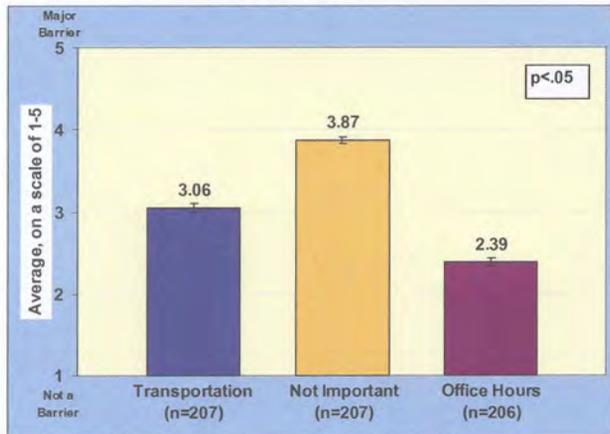


**6. PCP-identified barriers to parents/caregivers’ compliance with child health check-ups (EPSDT).** To determine what specific areas PCPs felt were most problematic for their patients in complying with regularly-scheduled child health check-ups, we asked them to rate three possible barriers or indicate “Other”:

1. No car/transportation,
2. [Parents/caregivers] don’t think check-ups are important,
3. Can’t come during office hours,
4. Other (list).

On a scale of 1 (“Not a Barrier”) to 5 (“Major Barrier”), respondents felt that the greatest barrier to compliance with child health check-up (EPSDT) guidelines for parents/caregivers was that they didn’t understand the importance of the check-ups (“Not Important,” avg=3.87, SEM=0.04). Lack of “Transportation” was second (avg=3.06, SEM=0.04), and “Office Hours” was last (avg=2.39, SEM=0.05) (Figure 10). All differences were statistically significant (p<.05).

**Figure 10. PCP-Perceived Barriers to Parent/Caregiver Compliance with EPSDT Guidelines**



Other barriers mentioned included:

*“No responsibility or accountability.”*

*“Some assigned patients are Native Americans and go to Indian clinic.”*

*“Multiple children, lack of alternative childcare provider.”*

**7. New office procedures to improve EPSDT compliance.** Based on the issues raised previously about lack of compliance with EPSDT periodicity guidelines, we asked providers if their practice had instituted any procedural or administrative changes to try to increase child health visits. Sixty-three percent (63%) of respondents said they had initiated procedures to draw more patients in for regular check-ups; 37% said they had not (Figure 11).

**Figure 11. Instituted Office Procedures to Improve Compliance with Child Health Check-Ups (n=206)**

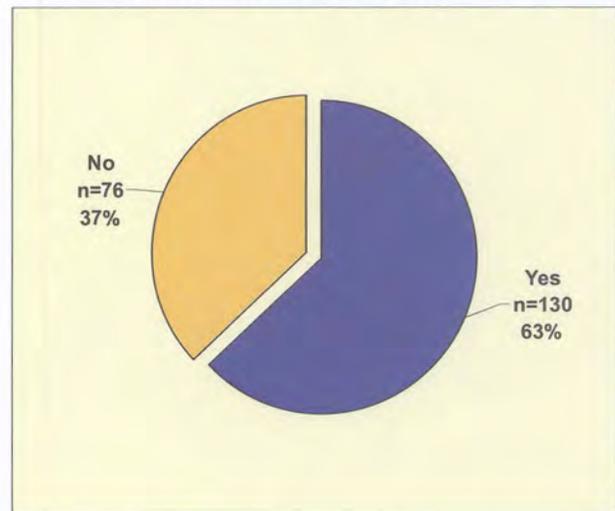
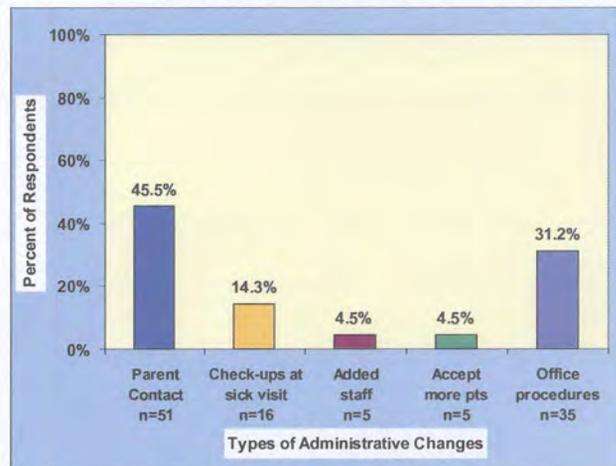


Figure 12 shows the narrative responses to this question coded by theme. Note that not all of the 206 respondents who indicated they had made changes provided a description of the changes they implemented (n=112)

**Figure 12. Types of Procedures Implemented to Improve Compliance with Child Health Check-Ups (n=112)**



Some of the comments about the changes included:<sup>\*</sup>

*“Doing check-ups when patient comes in for other issues.”*

<sup>\*</sup>For a complete list of all narrative responses, see Appendix D.

*“Appointment reminders and screen at each appointment.”*

*“Discussing importance of healthcare to keep up with shots.”*

*“Front office staff attempting to contact new enrollees for appointment.”*

*“Send out reminders.”*

*“More assertive with scheduling and follow-up.”*

*“Call backs.”*

*“Sending birthday card to 1 y.o.'s as a reminder.”*

*“Calling and offering on daily basis instead of designated day.”*

When asked whether they thought the changes were successful, responses were split. About half felt that were getting more children in for appointments, while half felt there were still too many no-shows for appointments and that further efforts were needed.

One very enthusiastic provider who participated in a telephone interview with one of our staff indicated that they actively schedule child health check-ups when parents bring kids in for a sick visit. This clinic also developed a number of parent education hand-outs for things like colds, musculoskeletal injuries, and vitamins for kids.

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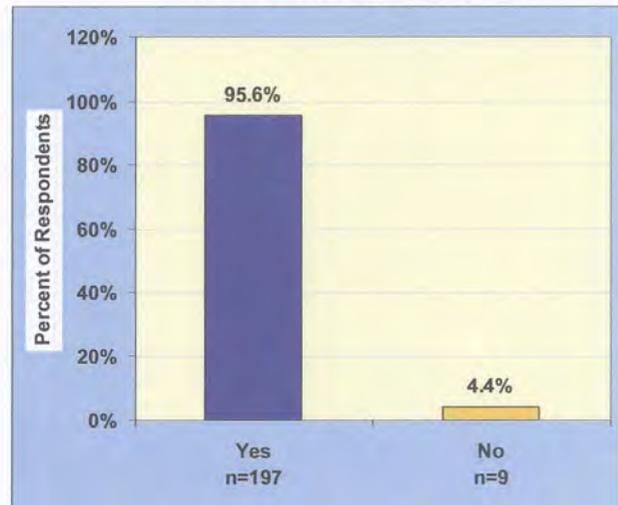
### Questions 8 through 11 addressed screening for developmental delay.

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**8. Do you perform developmental screening as recommended by SoonerCare?** Survey respondents were asked to indicate whether they performed routine developmental screens as recommended by SoonerCare (Medicaid). Developmental screening involves completing a validated developmental screening test for each child, especially from birth to age 3. This is as opposed to developmental surveillance, which is the ongoing and objective observation of a child's development.<sup>10</sup>

Nearly 96% (95.6%, n=197) of respondents reported performing developmental screening in their practice. Fewer than 5% (4.4%, n=9) reported they did not (Figure 13).

**Figure 13. Percentage of Respondents Who Report Conducting Developmental Screens in their Practice (n=206)**



Of those responding “No,” reasons given were:

*“Unfamiliar with tools, time constraints.”*

*“Not sure?”*

*“Formal screening no. General screenings yes. No recourse for formal test”.*

*“Not set up for it.”*

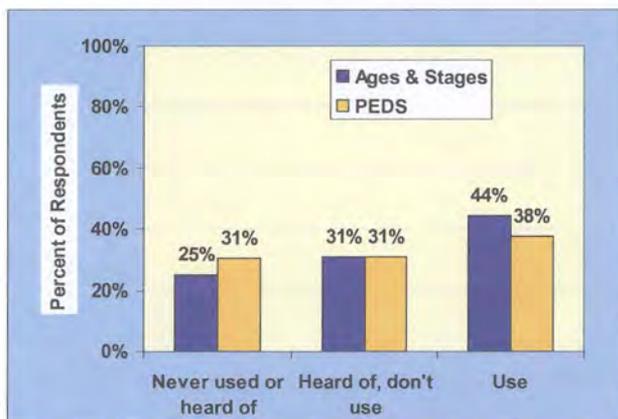
*“Inadequate reimbursement ... takes too long to administer and lose money.”*

A common response in the interviews and in the survey narrative was that respondents used the screening form from the OHCA website. (This will be explained further in the Discussion section of this report.)

**9. Familiarity with Developmental Screening Tools.** There are several validated screening tools for children from birth to 3 years of age for developmental delay. Among the most common are the Ages & Stages Questionnaire (ASQ) (a 30-item tool for children from 4 to 60 months of age completed by parents), and the Parents' Evaluation of Developmental Status (PEDS) (a 10 question tool for parents with children from birth to 9 years) (see Table 1, page 3 for a overview of these tools).<sup>10</sup>

We asked respondents to rate their familiarity with and/or use of these tools, and to tell us about any other developmental screening tools they used. Figure 14 shows that fewer than half of those surveyed used either the ASQ or the PEDS in their practice, and less than one-third had even heard of these screening instruments. Approximately one-third (31% for both tools) had heard of the instruments but didn't use them in their practice. The number of responses for each of the variables was different: 198 respondents answered the question about ASQ and 199 answered the question about PEDS.

**Figure 14. Respondents' Familiarity and/or Experience with ASQ and PEDS Developmental Screening Tools**



Of those who provided answers to the "Other" query, most said they used the Denver Developmental Screening Test (DDST), a health care professional administered test for children from birth to 6 years. This 125-item test takes about 20-30 minutes to complete, which makes it difficult to conduct in a busy practice setting. In addition, there have been some studies suggesting that the sensitivity and specificity of the DDST are questionable.<sup>10,11</sup> Some respondents (both on the survey and during an interview) mentioned using the American Academy of Pediatrics (AAP) screening tool.

**10. If you aren't using either Ages & Stages (ASQ) or PEDS, why not?** Reasons given for not using either ASQ or PEDS included:

- 1. Have other tools in use in the practice.** The most common reason (n=30) given for not using the ASQ or the PEDS developmental screening tool was that another tool – either in the office electronic medical record (EMR) or another form – was already being used. The most frequently cited instrument was the DDST. Some developed their own form.

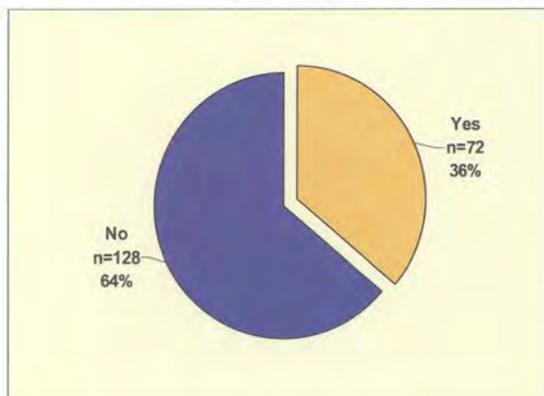
Additionally, 5 respondents mentioned that they use the "Medicaid EPSDT" form, as did some interviewees. This will be discussed further in the Discussion section of this report.

- 2. Don't have forms.** The 2nd most common reason cited was the respondent did not have access to either ASQ or PEDS (n=22).
- 3. Don't know about them** was the 3<sup>rd</sup> most commonly cited reason (n=9). Many in this group requested more information.

Four respondents mentioned the cost of the screening instruments, both monetary and time, and two said they were in the process of implementing use of the tools. Only one respondent cited "Parent Reliability" as the reason for not using either ASQ or PEDS.

**11. Knowledge of additional reimbursement for developmental screening.** Respondents were asked if they knew they could receive an additional \$8.40 for each properly coded developmental screening visit above the regular charge for the visit. Only about one-third (36%, n=72) knew about the additional payment whereas 64% (n=128) did not (Figure 15).

**Figure 15. Knowledge of Additional Reimbursement for Developmental Screening (n=200)**



**12. Anticipatory guidance.** SoonerCare requires health care professionals to provide age-appropriate education for parents and caregivers. This education, called anticipatory guidance, provides “information that helps families prepare for expected physical and behavioral changes during their child’s or teen’s current and approaching stage of development.”\* Anticipatory guidance is different from counseling, which is advice given in response to specific, identified problems.<sup>19</sup> Through anticipatory guidance, providers help parents, guardians and children understand each stage of a child’s development. It offers providers the opportunity to give advice about the benefits of healthy lifestyles and practices, as well as accident and disease prevention.<sup>19-21</sup>

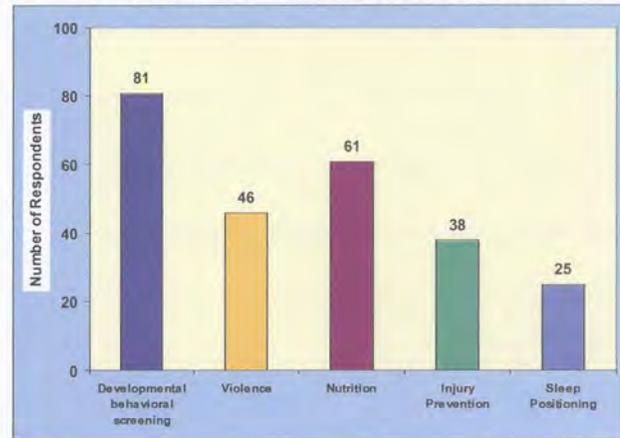
OHCA requested that respondents identify topics about which they would like additional education and training in order to improve their provision of anticipatory guidance. These topics, provided by OHCA, were:

- Developmental/Behavioral Screening,
- Violence (e.g., gun safety<sup>19</sup>)
- Nutritional Screening,
- Injury Prevention (e.g., seat belts, helmets, etc.<sup>19</sup>)
- Sleep Positioning,
- Other (e.g., discipline, TV viewing<sup>19</sup>).

\*Bright Futures, Georgetown University, Accessed at: <http://www.brightfutures.org/healthcheck/resources/glossary.html>

Respondents were asked to check any or all of the anticipatory guidance training areas they were interested in. “Developmental/Behavioral Screening” was the most frequently requested training (n=81), followed by “Nutrition” (n=61), “Violence” (n=46), “Injury Prevention” (n=38), and “Sleep Positioning” (n=25) (Figure 16). No “Other” topics were suggested.

**Figure 16. Anticipatory Guidance Topics Identified for Additional Education**



In the Comparative Analysis section, which follows presentation of survey results, we show a breakdown of the training requests by area to facilitate organizing training programs.

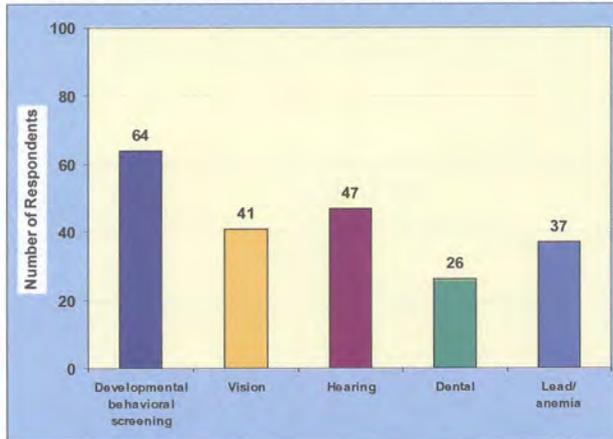
**13. Items from the EPSDT periodicity schedule for which PCPS and/or staff would like additional training or guidance.** In addition to regular medical exams and immunizations, the EPSDT periodicity schedule includes the following items:

- Developmental and Behavioral
- Vision
- Hearing
- Dental
- Lead/Anemia

To assist OHCA in developing appropriate and necessary materials to educate health care professionals about all areas of child health check-ups as mandated on the EPSDT periodicity schedule, we asked respondents to indicate any or all screening topics for which they would like additional training or guidance for themselves and/or their office staff. In

addition, respondents were given an “Other” line on which they could list any additional training or education they would like to receive (Figure 17).

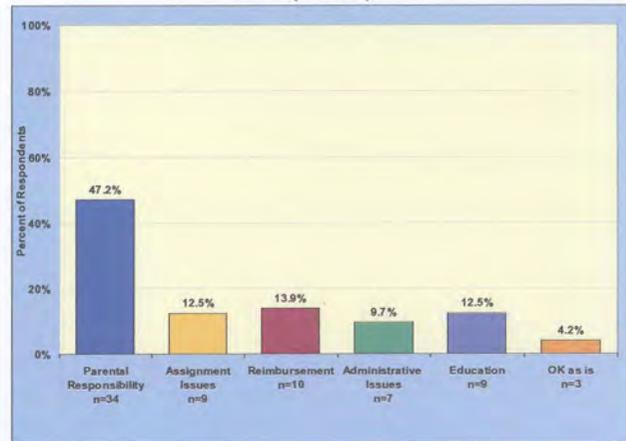
**Figure 17. Items from the EPSDT Periodicity Schedule Identified for Training or Guidance**



Most respondents requested training in “Developmental and Behavioral Screening” (n=64), followed by “Hearing” (n=47), “Vision” (n=41), “Lead/Anemia” testing (n=37), and “Dental” (n=26). Only one respondent entered a request into the “Other” column and that was for help properly coding for EPSDT visits. However, respondents participating in interviews also mentioned wanting additional help with appropriate coding for developmental screening.

**14. Ways to improve EPSDT.** We asked providers, “If you were in charge of the Sooner Care child health check-up (EPSDT) program, how would you improve it?” Responses fell into six general areas (Figure 18).

**Figure 18. Six General Areas in which Respondents Would Make Changes to the Child Health Check-up (EPSDT) System (n=72)**



Some typical comments were:

**Parental Responsibility**

- “More parental involvement and guidance.”
- “Have a small co-pay for each visit so that they think about their problem a little bit before “needing” an appointment.”
- “Cash incentives for the parents.”
- “Encourage parent and guardian to bring their children for regular check ups.”
- “Make it mandatory for parents to bring them in for EPSDT or lose benefits.”

**PCP Assignment Issues**

- “Stop changing PCPs for no apparent reason.”
- “Stop enrollment Doctor changes!”
- “Stop changing PCP’s every few months.”

**Reimbursement**

- “Better reimbursement.”
- “Increase reimbursement.”
- “Pay providers more for doing them. Pay for quality for those who need it, not for the quantity of enrollees you currently have.”

**Administrative Issues**

- “Simplify paperwork for clinician and staff.”

*“You want 6 visits before first birthday but don't allow 1 yr shots to be given before first birthday so we don't do the 6th visit until after the first birthday, so we miss the bonus!”*

*“Have social worker or case manager visit every consumer for cleanliness, diet, good child care, proper discipline.”*

*“Patients who are Native American use Indian Health, don't know what they are signing up for when they apply, they don't know what it is and don't come to their Sooner Care provider because they want to use IHS.”*

### Education

*“More hands on education to be more efficient.”*

*“Educate the patients.”*

### OK As Is

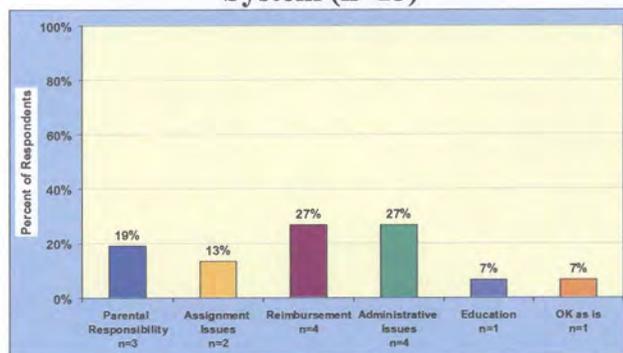
*“No. I think it is well managed already.”*

*“I already think you are doing a good job.”*

*“Works great for us.”*

**15. Additional Comments.** Providers were asked to offer additional comments and suggestions on any aspect of SoonerCare child health check-ups (EPSDT) (Figure 19).

**Figure 19. Themes of General Comments about the Child Health Check-up (EPSDT) System (n=15)**



Only 15 survey respondents offered additional comments. Some typical comments were:

*“Better compensate PCPs for developmentally delayed patient.”*

*“We cannot spend 30 minutes for screens that pay us \$8.40.”*

*“Our main problem is that 50% of the kids assigned to us never come to our practice for any appointments so we can't schedule child health check-ups.”*

*“Have a list of approved providers online who provide vision/dental/hearing screens.”*

*“It has improved greatly from what it was a year ago.”*

**Table 2. Survey Results At A Glance**

Survey Question		Results	Interpretation														
1	Please identify yourself:	MD/DOs, 51.9% PA/NPs, 24.3% RN/LPN/CAN, 3.4% Office Managers, 14.6% Coding/Clerical, 3.9% Other, 1.9%	51.9% of respondents were physicians; 60.5% were family physicians, 35.5% pediatricians, 4%, general practitioners. Hands-on health care professionals accounted for ~80% of total respondents.														
2	Practice location: city, town, rural	City, 25.7% Town, 53.9% Rural, 20.4%	Most respondents practiced in an area with from 2,500 to 50,000 population (town).														
3	Understanding of SoonerCare child health check-up (EPSDT) screening requirements.	Understand well, 36.4% Understand, 39.2% Acceptable, 19.1% Understand a little, 5.3% No understanding, 0	All providers indicated at least some understanding of the child health check-up screening requirements. Average on a scale of 1 to 5, was 4.07 (SEM=0.03).														
4	Ease or difficulty of meeting EPSDT periodicity schedule, average on a scale of 1 ("Very Difficult") to 5 ("Very Easy"). (2008 compared with 2006.)	2008: Avg. 3.00 (SEM, 0.05) 2006: Avg. 2.66 (SEM=0.09)	Most of the 206 respondents indicated that complying with the periodicity schedule was doable (3.00, on a scale of 1-5). This is slightly improved from 2006, when the average was just below the mid-point (2.66, on a scale of 1-5)														
5	Barriers to providing child health check-ups as part of the EPSDT periodicity schedule, average on a scale of 1 ("Not a Barrier") to 5 ("Major Barrier"). (2008 compared with 2006.)	<table border="1"> <thead> <tr> <th>2008</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td colspan="2"><b>PCP assignment</b></td> </tr> <tr> <td>3.29 (SEM, 0.05)</td> <td>3.59 (SEM, 0.09)</td> </tr> <tr> <td colspan="2"><b>Appointment no-shows</b></td> </tr> <tr> <td>4.10 (SEM, 0.03)</td> <td>4.08 (SEM=0.08)</td> </tr> <tr> <td colspan="2"><b>Reimbursement</b></td> </tr> <tr> <td>2.68 (SEM, 0.04)</td> <td>2.47 (SEM=0.1)</td> </tr> </tbody> </table>	2008	2006	<b>PCP assignment</b>		3.29 (SEM, 0.05)	3.59 (SEM, 0.09)	<b>Appointment no-shows</b>		4.10 (SEM, 0.03)	4.08 (SEM=0.08)	<b>Reimbursement</b>		2.68 (SEM, 0.04)	2.47 (SEM=0.1)	Appointment no-shows (missed appointments) continue to be the number one barrier to providing EPSDT services identified by health care professionals.  <i>"Penalize patients for repeat no-shows."</i>
2008	2006																
<b>PCP assignment</b>																	
3.29 (SEM, 0.05)	3.59 (SEM, 0.09)																
<b>Appointment no-shows</b>																	
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6	Provider-identified barriers to parents/caregivers' compliance with child health check-ups (EPSDT), average on a scale of 1 ("Not a Barrier") to 5 ("Major Barrier"). (2008 compared with 2006.)	<table border="1"> <thead> <tr> <th>2008</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td colspan="2"><b>Transportation</b></td> </tr> <tr> <td>3.06 (SEM, 0.04)</td> <td>3.14 (SEM, 0.09)</td> </tr> <tr> <td colspan="2"><b>Not important</b></td> </tr> <tr> <td>3.87 (SEM 0.04)</td> <td>4.00 (SEM, 0.08)</td> </tr> <tr> <td colspan="2"><b>Office hours</b></td> </tr> <tr> <td>2.39 (SEM, 0.05)</td> <td>2.44 (SEM=0.09)</td> </tr> </tbody> </table>	2008	2006	<b>Transportation</b>		3.06 (SEM, 0.04)	3.14 (SEM, 0.09)	<b>Not important</b>		3.87 (SEM 0.04)	4.00 (SEM, 0.08)	<b>Office hours</b>		2.39 (SEM, 0.05)	2.44 (SEM=0.09)	Providers continue to feel the main reason parents/caregivers don't bring children in for regular check-ups is that they do not think they are important.  <i>"Send a quarterly reminder to parents about importance of screening."</i>
2008	2006																
<b>Transportation</b>																	
3.06 (SEM, 0.04)	3.14 (SEM, 0.09)																
<b>Not important</b>																	
3.87 (SEM 0.04)	4.00 (SEM, 0.08)																
<b>Office hours</b>																	
2.39 (SEM, 0.05)	2.44 (SEM=0.09)																
7	New office procedures to improve EPSDT compliance.	Yes, 63% (n=130) No, 37% (n=76)	Examples included birthday reminders, adding office hours, doing child health check-up during acute visit, etc. Some indicated changes had helped; others remained ambivalent but hopeful.														
<b>Questions 8-11 Addressed Screening for Developmental Delay</b>																	
8	Do you perform developmental screening as recommended by SoonerCare?	Yes, 95.6% (n=197) No, 4.4% (n=9)	Nearly all respondents said they were performing developmental screening as required by SoonerCare.														
9	Familiarity with Developmental Screening Tools (Ages & Stages, ASQ, or Parent's Evaluation of Developmental Status (PEDS)	<b>ASQ</b> Never used or heard of, 25% Heard of, don't use, 31% Use, 44% <b>PEDS</b> Never used or heard of, 31% Heard of, don't use, 31% Use, 38%	Many survey respondents say they are using either ASQ (44%) or PEDS (38%) in their practice to screen for developmental delay. The most common other tool mentioned was the Denver Developmental, which is a health care professional administered test as opposed to ASQ and PEDS, which are parent administered.														
10.	If you aren't using either ASQ or PEDS, why not?	Narrative, open-ended question	Several reasons given were: 1. Other tools used in practice (e.g., Denver Developmental); 2. Don't have the forms; 3. Don't know about the forms; 4. Cost.														
11	Knowledge of additional reimbursement for developmental screening	Yes, 36%, n=72 No, 64%, n=128	Only 1/3 of providers knew about additional reimbursement for properly coded developmental screen. Compare this to the 96% of providers who indicated they routinely performed developmental screens in their practice.														
12.	Anticipatory guidance	Developmental/behavioral, 81 Nutrition, 61 Violence, 46 Injury Prevention, 38 Sleep positioning, 25	Educational opportunities are welcomed by providers and staff.														
13.	Periodicity schedule training	Developmental /behavioral, 64 Hearing, 47 Vision, 41 Lean/anemia, 37 Dental, 26	Several respondents commented that lead screening should be removed from the EPSDT periodicity schedule and that screening should only be performed if the child was at risk.														
14.	Ways to improve EPSDT	Parent responsibility, 47.2% Reimbursement, 13.9% Fix auto-assign, 12.5% Education, 12.5% Administrative issues, 9.7% OK as is, 4.2%	Expanding parent responsibility remains high on the list of important ways to improve child health check-up compliance. Various suggestions included: cash incentives, parental education on importance, and drop coverage for those who fail to comply.														

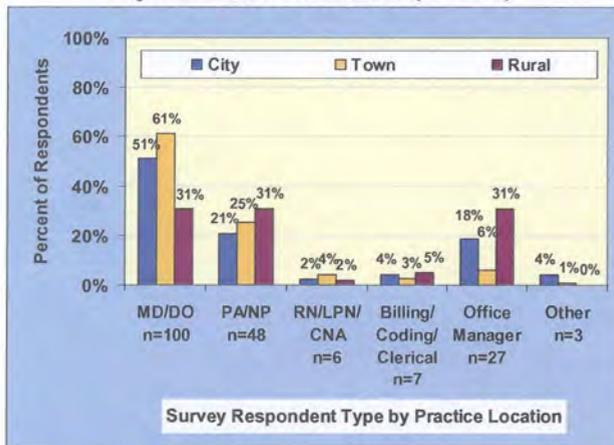
\*SEM=Standard Error of the Mean

## Comparative Analyses

Eleven (11) comparative analyses were run on the data from this survey, 9 of which combined multiple variables. Questions for cross-analysis were chosen based on their potential to shed light on policy issues about how to improve the quality and quantity of child health check-ups in Oklahoma, and to assess the developmental screening practices among PCPs seeing children as part of SoonerCare. Statistical comparisons were run in Excel. The Student-t test was used, where applicable to assess statistical significance.

**1. Identity of respondent compared by practice location.** Physicians completed most of the surveys. To see if location had any impact on whether the survey was completed by a physician, another health care professional, or a member of the office staff, we cross analyzed identity of the responder by practice location (city, town, rural). As shown in Figure 20, most of the surveys from cities and towns were completed by physicians, physician assistants, and nurse practitioners. Office managers were most like to complete the survey in rural areas, compared with cities or towns. Given the low population density in rural Oklahoma and the number of physician extenders practicing in rural areas, these results are not surprising.

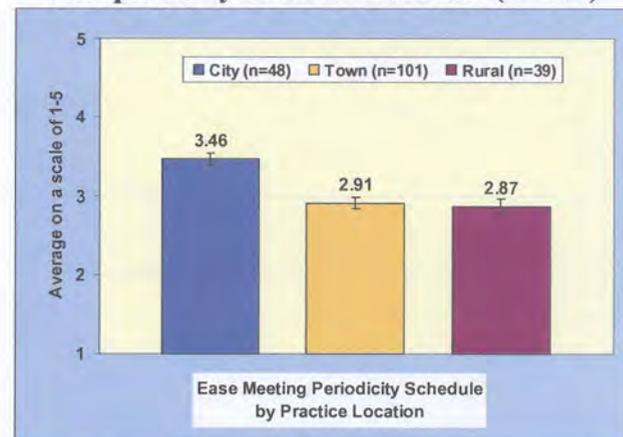
**Figure 20. Identity of Responder Compared by Practice Location (n=191)**



**2. Difficulty meeting periodicity schedule compared by practice location.** We performed a cross-analysis to see whether practice location had any impact on the ease or difficulty with which the practice and the providers were able to meet the requirements of the EPSDT child health check-up periodicity schedule.

On a scale of 1 (Difficult) to 5 (Easy), practices in cities (pop. 50,000+) found it much easier to comply with the EPSDT periodicity schedule than practices in towns (pop. 2,500-50,000) or in rural areas (pop. less than 2,500). The variable "City" was statistically significantly different from both "Town" and "Rural" ( $p < .05$ ). There was no statistically significant difference between "Town" and "Rural" ( $p > .05$ ) (Figure 21). It could be that in a densely populated area where public transportation may be more readily available and reliable, parents or caregivers find it easier to bring their children to the office for check-ups than those living in smaller or rural areas.

**Figure 21. Ease or Difficulty Meeting Periodicity Schedule Requirements Compared by Practice Location (n=188)**

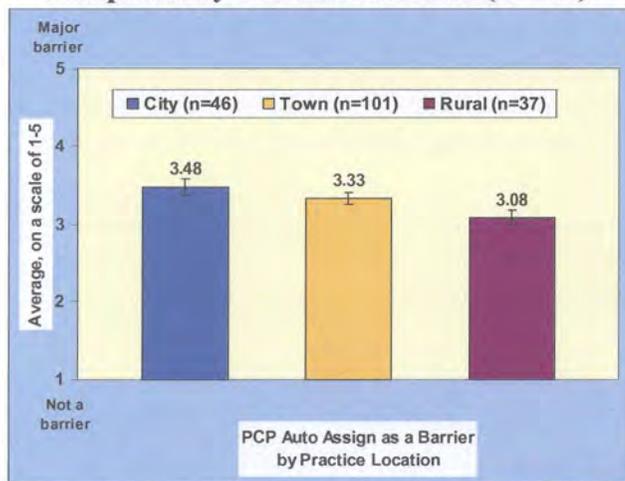


**3. PCP auto-assign and re-assign as a barrier to EPSDT compliance compared by practice location.** The assignment and regular re-assignment of primary care providers (PCP) has been an issue plaguing compliance with EPSDT guidelines for several years.<sup>1,2</sup> Sooner Care PCP assignment has been determined by a complex, computer-generated algorithm which

takes into account geographical location, previous PCP assignment, and family member PCP, among other things.\* A number of factors can contribute to a SoonerCare member being re-assigned to a different PCP (they move and fail to re-enroll with their previous provider, a family member enrolls with a different provider, etc.). Often, neither patient nor provider realize the re-assignment has taken place until the patient presents at the clinic. We performed a cross-analysis to see whether problems with auto-assign and re-assign are affected by practice location.

On a scale of 1 (“Not a Barrier”) to 5 (“Major Barrier”), there were no statistically significant differences among practice locations with regard to the challenges of PCP assignment. All locations found PCP assignment to be a barrier to their ability to comply with the periodicity schedule and to maintain a relationship with their SoonerCare patients (Figure 22).

**Figure 22. PCP Assignment/Re-assignment as a Barrier to Child Health Check-Ups Compared by Practice Location (n=184)**



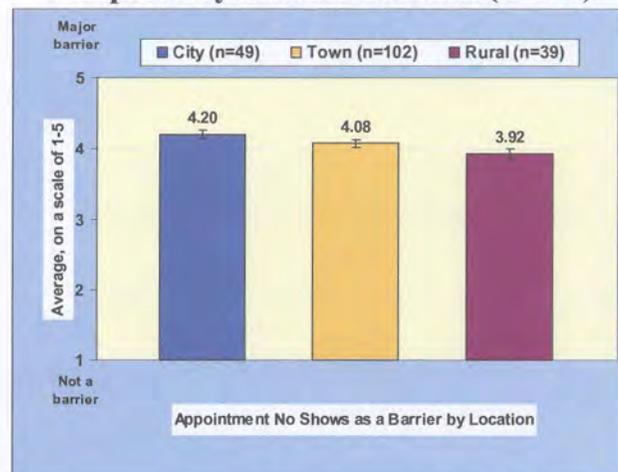
*“Stop patients from being automatically transferred to another provider.”*

\* In January, 2009, OHCA will be implementing a new methodology for determining PCP assignment which should alleviate some of these problems and eliminate others altogether.

**4. Appointment no-shows as a barrier to EPSDT compliance compared by practice location.** Parents/caregivers who fail to bring their children in for scheduled appointments are the greatest barrier to compliance with child health check-up (EPSDT) compliance, according to respondents to this survey and to previous surveys.<sup>1,2</sup> To determine whether practice locations (city, town, or rural) exacerbated this problem, we cross-analyzed these variables.

On a scale of 1 (“Not a Barrier”) to 5 (“Major Barrier”), practices in all locations felt strongly that missed appointments were a “Major Barrier” to compliance with child health check-up guidelines. None of the differences were statistically significant ( $p > .05$ ) (Figure 23).

**Figure 23. Appointment No-Shows as a Barrier to Child Health Check-Ups Compared by Practice Location (n=190)**



*“Make participants accountable. They do not value things that are free. I would like to see patients pay \$.50 or \$1 for visits. If they value it, they will be more likely to show up. There should be consequences for not keeping WCC† appointments like making them pay \$1 for each missed visit or no shows.”*

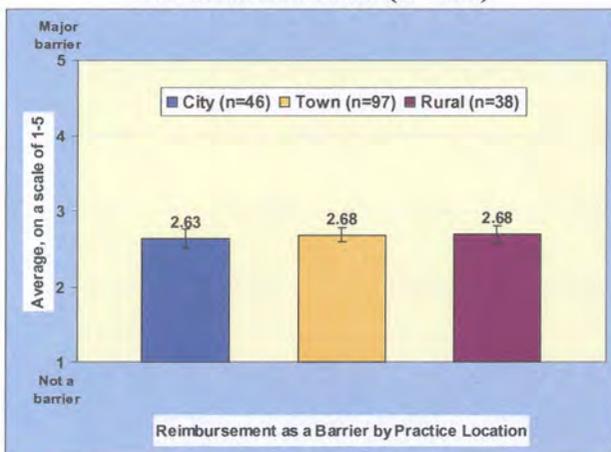
**5. Reimbursement as a barrier to EPSDT compliance compared by practice location.** Of all the potential barriers to compliance with the EPSDT periodicity guidelines for child

†WCC: well child check-up.

health check-ups, “Reimbursement” was the lowest ranked by survey respondents on this and previous studies.<sup>1,2</sup> To determine whether this varied depending on practice location, we cross-analyzed these two variables.

On a scale of 1 (“Not a Barrier”) to 5 (“Major Barrier”), practices in all locations rated “Reimbursement” as a modest barrier to compliance with child health check-up guidelines, indicating that both “Appointment No-Shows” and “PCP Auto-Assignment/Re-assignment” were much more problematic. None of the differences were statistically significant ( $p > .05$ ) (Figure 24).

**Figure 24. Reimbursement as a Barrier to Child health Check-Ups Compared by Practice Location (n=181)**



*“Reimbursement is inadequate. Patients are demanding. Too many visits non-urgent medical matter. No patient accountability/responsibility.”*

*“Increase reimbursement so you would have more providers.”*

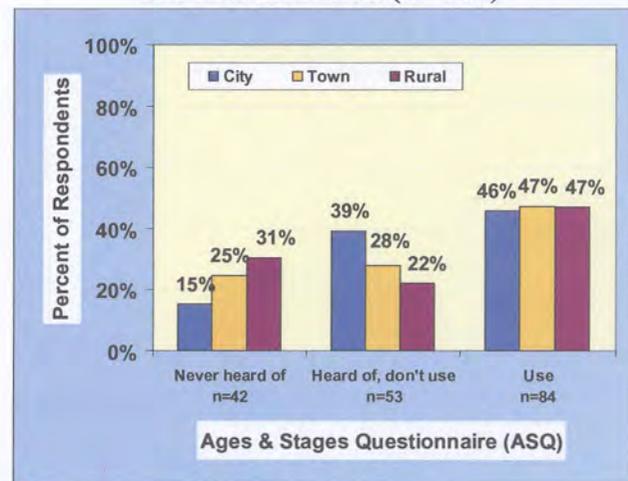
**6. Knowledge and use of the Ages & Stages (ASQ) or Parents’ Evaluations of Developmental Status (PEDS) compared by location.**

According to survey respondents, 44% use the parent-completed Ages and Stages Questionnaire (ASQ) and 38% use the Parents’ Evaluations of Developmental Status (PEDS) tool. To see if location had any impact on the use of

either of these parent-completed tests, we cross-analyzed the responses by city, town, or rural.

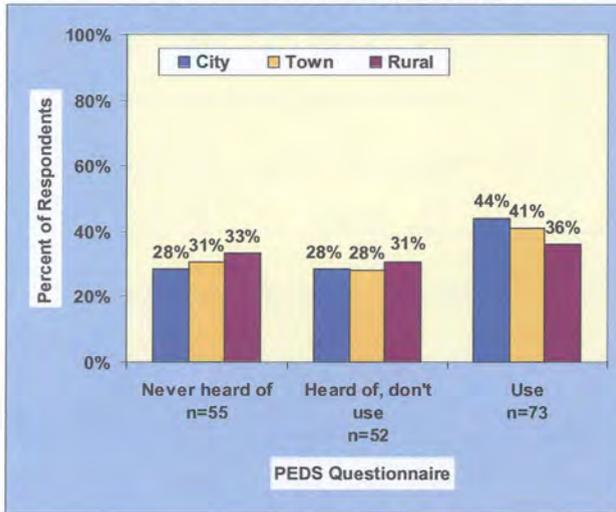
Nearly 50% of respondents from all locations indicated they currently use the ASQ developmental screening test (“City,” 46%; “Town,” 47%; “Rural,” 47%) (Figure 25). Far fewer respondents with city practices (15%) had never heard of ASQ than those with practice locations in towns (25%) or rural areas (31%).

**Figure 25. Knowledge or Use of ASQ by Practice Location (N=179)**



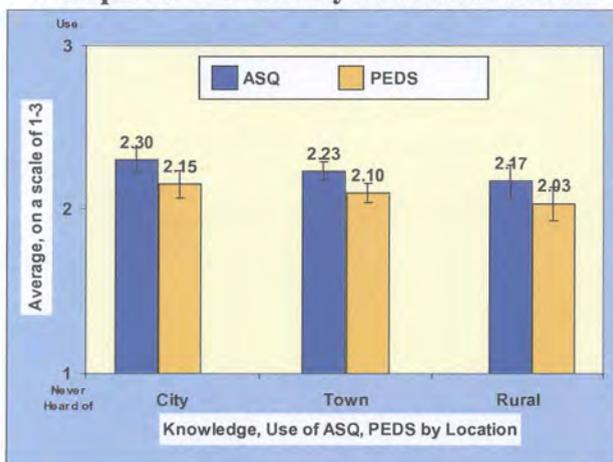
Fewer respondents were using the PEDS instrument (“City,” 44%; “Town,” 41%; “Rural,” 36%) (Figure 26). Only slightly fewer city practices had never heard of (28%) PEDS compared with both town (31%) and rural (33%) practices (Figure 26).

**Figure 26. Knowledge or Use of PEDS by Practice Location (n=180)**



To test whether any of these differences were statistically significant, Student T-Tests were run comparing the averages for each screening test in each practice location. Although the averages, on a scale of 1 (Never Heard Of) to 3 (Use) were somewhat higher for ASQ in all locations, and the averages for both tests were higher in “City” than in “Town” or “Rural” areas, none of the differences were statistically significant ( $p > .05$ ) (Figure 27).

**Figure 27. Knowledge or Use of ASQ Compared to PEDS by Practice Location**



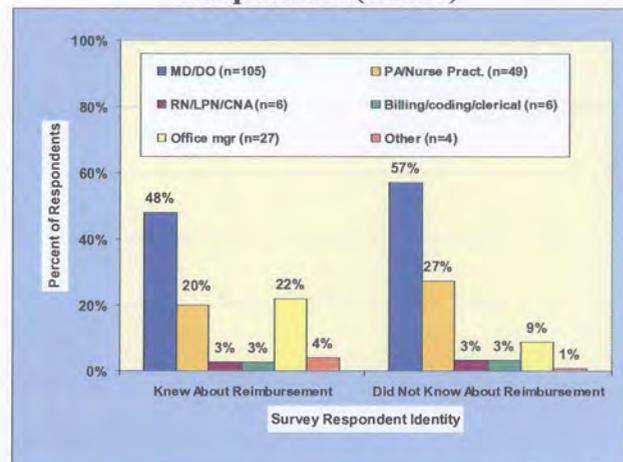
Three comparative analyses were run to determine the extent of the respondents’ knowledge

about the additional payment for properly coded developmental screens.

**7. Knowledge of developmental screening additional payment compared by respondent identity.** More than half of those completing the survey identified themselves as physicians (MD or DO) (52%). Including PAs, Nurse Practitioners and nurses (RNs, LPNs, CNAs), nearly 80% of survey respondents were hands-on clinical providers. Although 97% of respondents said they performed routine developmental screening tests in their practice, only 36% knew about the additional payment of \$8.40 for each properly coded developmental screen.

To test whether the identity of the person completing the survey (physician, other health care provider, office staff member) predicted knowledge of the developmental screening bonus, we cross-analyzed those data. Physicians (48%), office managers (22%) and physician extenders (PAs and Nurse Practitioners) (21%) were much more likely to know about the additional payment than the nursing staff or the billing, coding or clerical staff, although more in each group had not heard about the additional payment than knew about it (Figure 28).

**Figure 28. Knowledge of Developmental Screening Additional Payment by Identity of Respondent (n=197)**

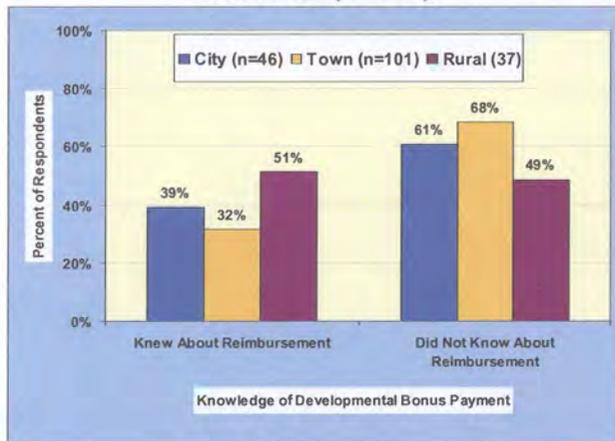


It would seem especially important to make sure that the billing and coding personnel were

aware of the additional payment, but to ensure proper payment, all members of the practice should be aware of appropriate procedures for coding a developmental screening test.

**8. Knowledge of developmental screening additional payment compared by practice location.** To test whether the practice location influenced knowledge of the developmental screening bonus, we cross-analyzed those data. Interestingly, 51% of practices that identified themselves as “rural” (population less than 2,500, n=37) knew about the additional payment compared with 39% of “City” practices (population +50,000, n=46) and 32% of “Town” Practices (population 2,500-50,000, n=101) (Figure 29).

**Figure 29. Knowledge of Developmental Screening Additional Payment by Practice Location (n=184)**

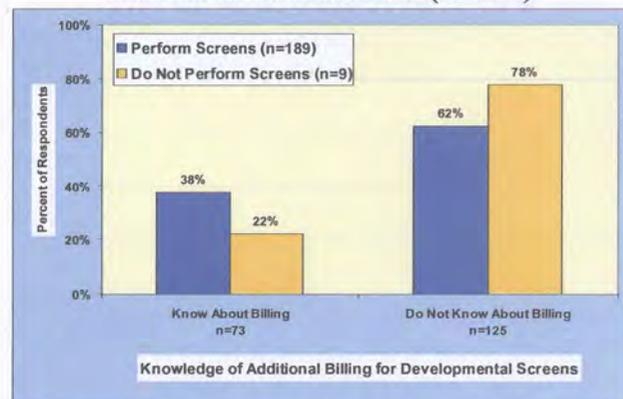


**9. Knowledge of developmental screening additional payment compared by whether or not respondents report performing developmental screening tests.** Nearly 96% of respondents indicated they complete screens for developmental delay in their practices. Some use standardized tests (PEDS, ASQ, Denver Developmental) and others use in-house or electronic medical records forms. However, only 36% of responders reported that they were aware of the additional payment for a properly coded developmental screening exam.

To test whether performing developmental screens determined whether or not the person

completing the survey had knowledge of the additional payment, we cross-analyzed those data. Because only 9 respondents reported that they did not perform regular developmental screens, the data shown on Figure 30 are skewed. Still, there is some interesting information here. Only 38% of those who indicated that they performed developmental screens reported knowing about the additional payment compared with 22% of those who do not perform screens. The interesting part is that 62% of those who report performing developmental screens **did not** know about the additional payment. That is compared with 78% of those who do not do developmental screening. Because the number of respondents who do not report doing developmental screens is so low (n=9, or 4% of the 198 respondents who completed both questions used in this cross-analysis), a comparison of those data with that for providers who do perform screening is not helpful. What is helpful is the knowledge that only one-third of providers who currently report performing developmental screening for their SoonerCare patients were aware that they could receive an additional payment for a properly coded encounter.

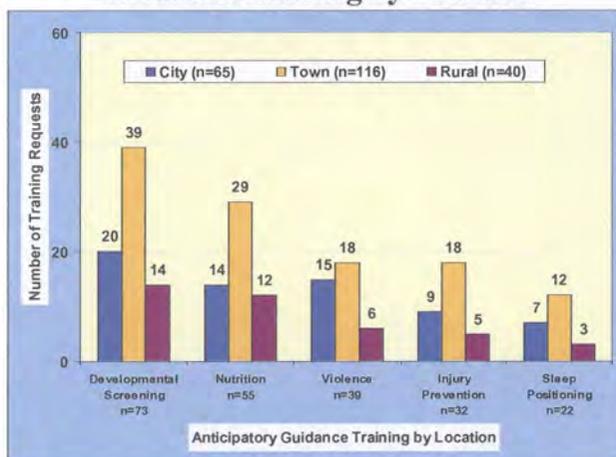
**Figure 30. Knowledge of Developmental Screening Additional Payment by Whether Screens are Performed (n=198)**



**10. Anticipatory Guidance Training.** Anticipatory guidance is, “Information that helps families prepare for expected physical and behavioral changes during their child’s or teen’s current and approaching stage of develop-

ment.”\* To provide OHCA with some data upon which to determine where to target anticipatory guidance training, we broke out the requests for training for the five anticipatory guidance topics (developmental & behavioral, nutrition, violence, injury prevention, sleep positioning) and analyzed the results by respondent practice location. Because 54% of practices that responded to the survey were located in “Towns” (population 2,500-50,000), it is to be expected that the largest number of requests in each category will be from towns (Figure 31). Therefore, the important thing to note about this figure, and the next, is the number of requests for training on each topic. Developmental and behavioral training was the most requested anticipatory guidance topic in all locations (Figure 31).

**Figure 31. Requests for Anticipatory Guidance Training by Location**

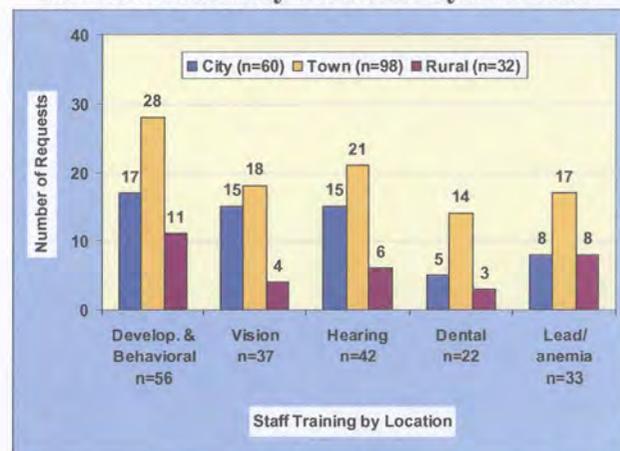


Keep in mind that respondents could check as many topics for anticipatory guidance training as they wished. Therefore the number of respondents for this question, and the next, may not correspond with the number of respondents on other figures in this report.

**11. Periodicity Schedule Training.** Respondents were also asked to select as many topics for training as they wished to help them understand and comply with guidelines for child health check-ups as outlined on the periodicity sched-

ule. To determine where OHCA could best expend its resources to provide this training, we broke out the responses for each of the five child health check-up training topics and analyzed them by practice location (Figure 32). Most of those who requested periodicity schedule training from all locations were interested in help with the developmental and behavioral aspects of the child health check-ups. Nutrition was next, although slightly more individual respondents in cities were interested in violence training than in nutrition (Figure 32).

**Figure 32. Requests for Training about Items on the Periodicity Schedule by Location**



As with the previous figure, keep in mind that respondents could check as many topics for periodicity schedule training as they wished. Therefore, the number of respondents for this question may not correspond with the number of respondents on other figures in this report.

### Telephone Interviews and E-Mail Exchanges

Sixty-four (64) survey respondents completed the contact information on the survey indicating they would be willing to answer additional questions about child health check-ups and/or developmental screening; for 7, the contact information had changed, the phone number was no longer valid, or they had left the practice. Program staff attempted to contact the

\* <http://www.brightfutures.org/healthcheck/resources/glossary.html>

remaining 57 individuals (30.3% of the 211 survey respondents). Telephone interviews were conducted with 22, 3 responded to interview questions via e-mail, and 1 responded via fax.

A list of questions (a script) was generated based on the survey, survey results, and discussions with OHCA staff (Appendix C). Questions were designed to solicit provider feedback as well as to educate providers about several aspects of the OHCA child health program including: federal mandates on lead screening, upcoming changes to the Oklahoma PCP assignment process, and the extent to which OHCA can assist providers with the challenge presented by missed appointments. The interview questions were:

1. *Please tell us what you think about the preventive services for children under SoonerCare.*
2. *Has your office developed any patient educational approaches (anticipatory guidance) to educate parents?*  
*If yes, what?*  
*Is it improving child health check-ups?*
3. *Has your office implemented any outreach efforts to get children in for their check-ups?*  
*If yes, describe.*  
*Are they working?*  
*If not, why have you not?*
4. *Do you have any suggestions on how OHCA can help with the missed appointment/no show problem?*
5. *Does your office routinely ask the parent questions about potential developmental delays?*
6. *If you use a screening tool, is it health care professional administered or is it a parent-complete tool?*  
*Why did you choose that tool?*
7. *What do you do that you would want other practices to know that help your office with child health check-ups?*
8. *Has your office received any communication and/or support from OHCA regarding child health check-ups?*  
*If so, what?*  
*Was it helpful?*
9. *Are you aware that beginning in January 2009, methods for selecting or assigning SoonerCare PCPs will change?*
10. *What would you change about child health check-ups?*

Many of these questions mirrored those from the survey (Appendix A) but some were based on new information (e.g., change in PCP assignment for SoonerCare) or designed to get details about specific methods they have initiated in their practices to help them comply with child health check-ups (EPSDT) and with developmental screening. A copy of the interview “script” and a complete list of responses are attached in Appendix C.

For the most part, comments from telephone and e-mail exchanges echoed those from the surveys. The following are results for those questions that were not on the initial survey (e.g., Questions 1, 2, 7 and 8).

**Question 1.** When asked what they thought about preventive services for children under SoonerCare, most interviewees were very enthusiastic.

*“Good plan and coverage. Reimburses provider for the extra preventive things.”*

*“Love them! Basis of everything... anticipatory guidance, good solid foundation—very important for parents.”*

Others, however, mentioned the lack of parental responsibility, and a lack of parental understanding of the importance of these child health check-up exams.

*“Good. The problem is parents don’t understand about child health check-ups.”*

**Question 2.** When asked whether they had implemented any “anticipatory guidance” to help educate parents, most (18 of 26) responded “Yes.” Types of education included:

*“Created hand-outs for colds & musculoskeletal injuries.”*

*“Hand-outs – Children First information from Health Department”*

***“Give age & development-appropriate hand-outs.”***

**Question 7.** Nearly all respondents said they had received communication of some sort from OHCA. Types of information they reported receiving included:

- Flyers
- Mailing regarding lead and hemoglobin
- Letter about a practice panel
- Provider reps
- Website and forms helpful

Respondents found interaction with OHCA to be helpful, and especially the appreciated having a representative “dedicated” to their practice so they could develop a relationship. One respondent indicated they had been “audited.” They found the audit very useful and learned a lot, including information about the upcoming PCP assignment change.

**Question 8.** This question asked interviewees whether they were aware that the PCP assignment was going to change in January, 2009. About 69% said Yes, and 31% said No.

Based on the response from the respondent whose practice had been audited, and the comfort level they expressed with the upcoming changes, it would seem essential for OHCA to publicize the process and details about how the change will work to promote provider understanding. Some concerned respondents were worried that many providers would opt out of caring for SoonerCare members.

All in all, the general – and overarching – theme for all providers, both through the survey and as part of the interviews, was increased parental responsibility.

***“The only thing that I see is that parents aren’t held accountable enough. We need to figure out a way to get parents attention, penalize them if they don’t bring their children in.”***

# Discussion

The Center for Medicare & Medicaid Services (CMS) is responsible for overseeing the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for all Medicaid-qualified children up to age 21. In Oklahoma, the Oklahoma Health Care Authority (OHCA) is responsible for assuring that all Medicaid – SoonerCare in Oklahoma – qualified children receive routine and regular preventive health care, including screening for potential developmental disabilities. These child health check-ups are provided at no cost to enrollees, and offer financial incentives above the SoonerCare capitation rate for providers. Yet national and state data continue to show that Oklahoma’s compliance rate with EPSDT remains below the national average, and well below the 80% benchmark set by CMS.<sup>16-18</sup>

A study by Millar et al. reported that EPSDT completion rates in Oklahoma stood at 60% in 1998. Although this is a dramatic increase from 17.6% in 1990, it is still below the target of 80% set by the OHCA and CMS.<sup>16</sup> According to CMS data collected in 2005 (the most recent CMS data available), only 56% of children entitled to routine child health check-ups in Oklahoma received those exams.<sup>22</sup> More recent data, from the National Center for Children in Poverty show that 59% of Oklahoma children between the ages of 1 and 2 received at least one EPSDT screen compared with only 44% of children between 3 and 5.<sup>17</sup> (Nationally, Delaware had the highest screening percentage for children age 3 to 5 at 103% and Wyoming had the lowest percentage, 37%.<sup>18</sup>).

Faculty and staff in the Primary Care Health Policy Division, Dept. of Family & Preventive Medicine (DFPM), University of Oklahoma Health Sciences Center (OUHSC) have assisted the Oklahoma Health Care Authority (OHCA) with previous studies of providers and parents/caregivers with regard to compliance with EPSDT guidelines. Previous work resulted in two reports.<sup>1,2</sup> The first component of this study is to provide OHCA with data they can use for internal policy decisions regarding child health check-ups. A second component of this study was to gather data regarding providers’ knowledge and performance of developmental screening in children from birth to age 3 as an adjunct to EPSDT child health check-ups. Results from this report were compared, where possible and applicable, to results from one of the previous studies.<sup>1,2</sup> An additional study in which parent/caregivers will be asked to provide feedback giving their perspective on child health check-ups is underway.\*

A total of 584 PCPs who had valid contracts to provide health care services for children with SoonerCare on June 1, 2008, were sent surveys on June 17, 2008; 13 were either undeliverable or unusable (too incomplete, or received after the August 22, 2008 cut-off date) resulting in a total of 571 surveys distributed; 211 surveys were received for analysis, a 36.9% response rate. More than half of survey respondents were physicians (51.9%), and most of the physicians were family physicians (60.5%); 35.5%, pediatricians, and 4%, general practitioners or general

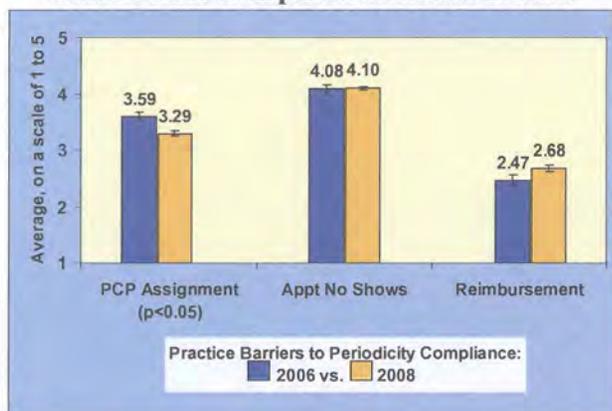
\*The study on parent/caregiver feedback about child health check-ups is underway and will be reported to the OHCA in the spring, 2009.

internists. More than half (53.9%) said their practice was in a “Town” (population 2,500-50,000); 25.7% practiced in a “City” (50,000+), and 20.4% said their practice was “rural.”

With regard to **child health check-ups** as mandated by the EPSDT periodicity schedule, the majority of respondents indicated they had a reasonably good level of understanding of the EPSDT periodicity schedule (avg, 4.07 on a scale of 1 to 5) (SEM=0.03). Only 5.3% of respondents indicated they found understanding the periodicity “Somewhat Difficult.” Respondents indicated they found meeting the periodicity schedule in their practice acceptable (avg., 3.00, SEM, 0.05). Although this is somewhat improved from previous studies (avg., 2.66, SEM=0.09),<sup>1,2</sup> these data show that challenges or obstacles still exist for practitioners to meet the guidelines for EPSDT child health check-ups.

We asked providers to rank potential obstacles to compliance with EPSDT guidelines within their practices. Three variables were chosen based on previous studies: (1) PCP assignment and re-assignment, (2) Missed appointments (“no-shows”), and (3) reimbursement for child health check-ups.<sup>1,2</sup> A comparative analysis with data from the previous study showed that, far and away, providers feel that missed appointments are the single greatest obstacle to compliance with EPSDT child health check-up guidelines (Figure 33).

**Figure 33. Practice Obstacles to Provider Compliance with EPSDT Periodicity Schedule: 2006 Results Compared with 2008 Results**



Providers continue to feel that missed appointments are the main problem they face in their practices in attempting to comply with EPSDT periodicity guidelines for child health check-ups. The problem has grown in the past two years (average, 4.08 in 2006 compared with 4.10 in 2008).

PCP assignment dropped from an average of 3.59 (on a scale of 1 to 5) in 2006 to an average of 3.29 in 2008. That difference was statistically significant. We received comments suggesting that providers were experiencing fewer problems with assignment than suggested by previous studies.<sup>1,2</sup> However, during the interviews and e-mails, one respondent expressed concern over the up-coming changes to the PCP assignment process, the main concern being that the process was “too complicated” and might force many PCPs to stop accepting SoonerCare assignment.

Although more of an issue in 2008 (average, 2.68) than it was in 2006 (average, 2.47), reimbursement appears to be the least of providers’ problems with the delivery of child health check-ups.\*

Several respondents said they had instituted administrative and clinical practices to improve compliance rates, especially to try to reduce the number of missed appointments. More than 45% of those who answered this question said they had initiated additional parent contact methodologies in their practices (e.g., birthday phone calls) or tried to do child health check-ups during an acute visit. Most, however, said they had met with minimal success and appealed to OHCA for help resolving this seemingly intractable obstacle.

*“Make the parents keep appointments for the screenings.”*

*“Have one central location in each county that is specified to do all screenings, lab and*

\*In January, 2009, OHCA will be implementing a new methodology for determining PCP assignment which should alleviate some of these problems and eliminate others altogether.

*check ups - pts had to get appt and make them or they would not receive welfare check or food stamps.”*

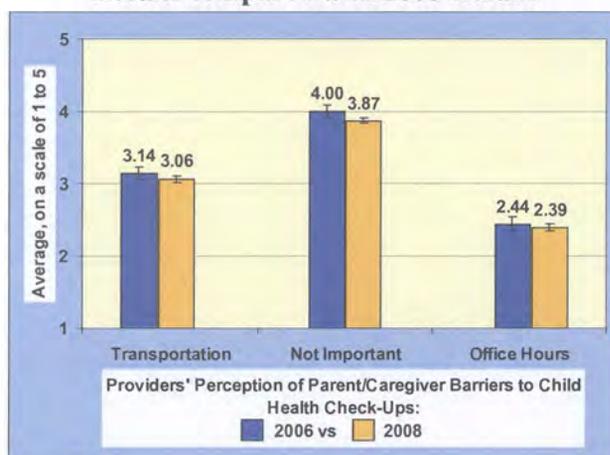
Telephone and e-mail exchanges with respondents reflected the same frustration with missed appointments and again asked for help from OHCA.

*“[We] call the day before ... Still have no-shows.”*

*“OHCA should mail information, especially about who their provider is.”*

Parents and caregivers of children receiving SoonerCare benefits also face barriers bringing their children in for child health check-ups. Providers were asked their perception of how much of a problem each of three previously identified barriers were for their patients: (1) transportation to appointments, (2) child health check-ups not important, (3) office hours conflict with work or school.<sup>1,2</sup> The results from the current study were compared with those from one of the previous studies (Figure 34).

**Figure 34. Providers' Perceptions of Obstacles Parents/Caregivers Face in bringing their Children in for Child Health Check-ups: 2006 Results compared with 2008 Results**



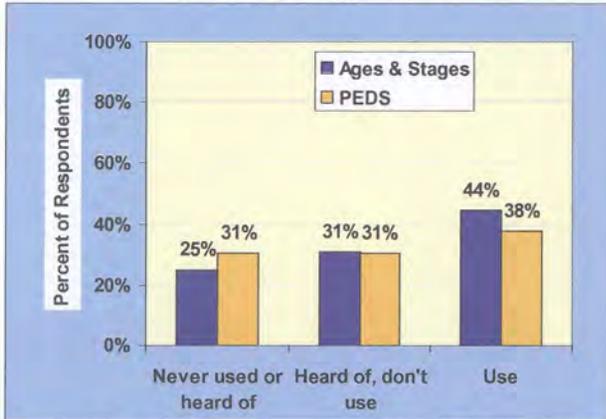
Providers still feel that a lack of understanding of the importance of child health check-ups (average, 4.00 in 2006, and 3.87 in

2008) is the main obstacle preventing parents and caregivers from complying with EPSDT recommended check-ups. Lack of transportation was the second greatest obstacle (average, 3.14 in 2006 and 3.06 in 2008); although several providers did suggest that more education and outreach about SoonerRide could help reduce transportation as a barrier to care. Providers felt that office hours and conflict with school or work were the least problematic for parents and caregivers. Many indicated that they had already expanded office hours and added evening and weekend hours in an attempt to get more children in to be seen, but that parents would continue to “no show” to the appointments.

**Developmental screening** is an important component of child health check-ups, especially in children from birth to 3 years of age (although continued screening into adolescence is also important). Only 50% of children with developmental disabilities are identified before starting school.<sup>10,11</sup> We asked providers several questions about their developmental screening practices.

Ninety-six percent (96%) of respondents indicated that they performed regular developmental screens. What is unclear from this study is whether these screens were performed utilizing an approved, validated screening tool. Fewer than half of those responding indicated that they use ASQ (44%) or PEDS (38%) (Figure 35).

**Figure 35. Use of Validated, Parent-Completed Developmental Screening Tools (ASQ or PEDS) by Survey Respondents**



It was beyond the scope of this study to determine whether the screens were performed regularly, as recommended by Medicaid. For example, the ASQ, a 30-question test which takes 10-15 minutes, should be administered to children from 4 to 60 months at intervals ranging from every 2 months during the earliest years of life to every 6 months once the child is older; the PEDS test, which consists of 10 questions and takes only about 2 minutes, should be conducted with every child health check-up.<sup>10</sup> Future studies could investigate the frequency with which health care professionals are conducting developmental screening tests, and which tools they prefer.

In addition, based on survey results and comments, it is unclear if providers completely understood the nature of the mandated developmental screening process. Many responded that they used OHCA forms from the Child Health Check-Up web page for developmental screening. Figure 36 (next page) is the form used for the 2-month child supervision (EPSDT) visit, which does contain a short section on basic developmental assessment. Many PCPs are using this form and considering its completion to be a full developmental screen.

In reviewing this form (next page), it is easy to see why PCPs would feel they were completing a developmental screen using a sanctioned tool. Based on discussions with OHCA

personnel and from reading the literature on developmental screening,<sup>9-11,23</sup> however, the brief observations listed on the 2-month child health supervision (EPSDT) visit form do not constitute a complete developmental screening exam. It is clear from this study that there is confusion about what constitutes developmental screening as compared with developmental surveillance, and that additional guidance, education and outreach should be undertaken to clear up these misconceptions. Although the form itself describes that section as “developmental assessment” and asks whether additional developmental screening tools (ASQ or PEDS) have been used, it might be useful to more adequately explain – on these forms – the necessity of using a parent-completed tools such as ASQ or PEDS in order to make providers more fully aware of the need to use a *validated* screening tool.<sup>10,11</sup>

*“[We use] the state form or Denver Developmental.”*

*“[We do developmental screens] per EPSDT form.”*

Several providers indicated they use the Denver Developmental Screening Tool (DDST). The DDST is “the most widely used test for developmental screening.” However, results from research testing the sensitivity and specificity of this instrument have been equivocal, demonstrating “questionable scores.”<sup>10,11</sup> National studies<sup>10,11</sup> and OHCA personnel, tend to prefer ASQ and PEDS, both parent-completed forms, for identifying children at risk for developmental disabilities as compared with the DDST, which is a provider-completed tool.

Figure 36. OHCA 2-Month Child Health Supervision (EPSDT) Visit Form



## 2- Month Child Health Supervision (EPSDT) Visit

Patient Sticker

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DOV \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ MED REC# \_\_\_\_\_

HT _____ ( _____ %)	Temp _____	Pulse _____	Meds: _____
WT _____ ( _____ %)	Pulse Ox-Optional _____		
HC _____ ( _____ %)	Resp: _____		
	Allergies: _____	<input type="checkbox"/> NKDA	
	Reaction: _____		

**HISTORY:**  
Parent Concerns: \_\_\_\_\_  
\_\_\_\_\_

**Maternal & Birth History:**  Birth HX form reviewed

**Initial/Interval History:**

**FSH:**  FSH form reviewed (check other topics discussed):  
 Daily care provided by  Daycare  Parent  
 Other \_\_\_\_\_  
 Adequate support system?  Yes  No \_\_\_\_\_  
 Adequate respite?  Yes  No \_\_\_\_\_

**DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT**  
Parent Concerns Discussed? (Required)  Yes  
Standardized Screen Used? (Optional)  Yes  No  
See instrument form:  PEDS  Ages & Stages  
 Other \_\_\_\_\_  
**DB Concerns:** (e.g. crying/colic) \_\_\_\_\_

**Clinician Observations/History: (Suggested options)**

<b>Motor skills</b> (observe head, trunk and limb control)		
Visually tracks objects horizontally and vertically	Y	N
Moves arms and legs equally	Y	N
Arms and legs are not always flexed	Y	N
Partial head lag in pull to sit from supine	Y	N
Raises chest off table in prone	Y	N
<b>Fine Motor skills</b>		
Hands are often unfisted	Y	N
Still grasps objects reflexively	Y	N
<b>Language/Socioemotional skills</b>		
Vocalizes/Coos	Y	N
Smiles at seeing parents' face	Y	N
Startles at loud noise	Y	N
Turns head toward direction of sound	Y	N
<b>Parent - Infant Interaction</b> (maternal depression present in 50% of post-partum mothers):		
Interaction appears age appropriate	Y	N
Clinician concerns re interaction:		

**SENSORY SCREENING:**  
Any parent concerns about vision or hearing?  Yes  No

**Vision:**  
Blinks in reaction to bright light  Yes  No  
Blinks in reaction to visual threat  Yes  No (normal by 3m)

**Hearing:**  
Passed NBHS (B)  Yes  Not Given  U/K  Failed NBHS  
Responds to sounds  Yes  No  Left  Right

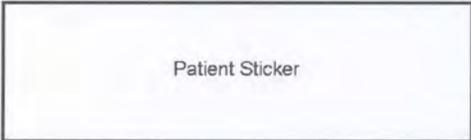
**PHYSICAL EXAMINATION (check appropriate box)**

	N L	A B	N E	COMMENTS
General				NL-normal, AB-abnormal, NE-not examined
Skin				
Fontanels				
Eyes: Red Reflex, Appearance				
Ears, TMs				
Nose				
Lips/Palate				
Teeth/Gums				
Tongue/Pharynx				
Neck/Nodes				
Chest/Breast				
Lungs				
Heart				
Abd/Umbilicus				
Genitalia/				
Femoral Pulses				
Extremities,				
Clavicles, Hips				
Muscular				
Neuromotor				
Back/Sacral dimple				

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**(EPSDT) 2-Month Visit Page 2**

NAME \_\_\_\_\_ DOB \_\_\_\_\_  
MED RECORD # \_\_\_\_\_



**ANTICIPATORY GUIDANCE:**

Select **at least one** topic in each category (as appropriate to family):

**Injury/Serious Illness Prevention:**

- Car Seat  Falls  No strings around neck  No shaking
- Burns-hot water heater max temp 125 degrees F  Smoke alarms
- No passive smoke  No sun exposure
- Fever management  Other \_\_\_\_\_

**Violence Prevention:**

- Adequate support system?  Adequate respite?  Feel safe in neighborhood?
- Domestic Violence?  No Shaking
- Other \_\_\_\_\_

**Sleep Safety Counseling:**

- Sleep (on back)  Sleep Safety  Normal for newborns to sleep most of the day and night
- Other \_\_\_\_\_

**Nutrition Counseling:**

- Breast  Formula  Solids (4-6mos)  3-4 hour between feeding
- Less frequent stools typical for bottle fed infants  5-8 wet diapers/day
- Vitamins  No honey  No bottle prop  No microwave
- No infant feeders  Other \_\_\_\_\_

**What to anticipate before next visit:**

- Sleep cycle gets more regular  Change in feeding/stooling patterns
- Rolling over by 4 mos  Okay to add cereal at 4 mos  Back to work?
- Weaning?  Temperament may become more evident
- Other: \_\_\_\_\_

**PROCEDURES:**

- Hereditary/Metabolic Screening needed
- Hereditary/Metabolic Screening results reviewed – Normal
- Hereditary/Metabolic Screening results reviewed – Other: \_\_\_\_\_

**DENTAL REMINDER**

PCP screen at 1<sup>st</sup> tooth eruption

**IMMUNIZATIONS DUE at this visit:**

**HepB2** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**DTaP1** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**Hib1** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**IPV1** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**PCV1** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**Rotavirus1** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**Reason Not Given if due**      **List Vaccine(s) not given:**

- Vaccine not available \_\_\_\_\_
- Child ill \_\_\_\_\_
- Parent Declined \_\_\_\_\_
- Other \_\_\_\_\_

**ASSESSMENT:**  Healthy, No problems

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**PLAN/RECOMMENDATIONS:**  Do vaccines/procedures marked above  Other \_\_\_\_\_  
 Anticipatory Guidance discussed (as described in box above)

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**Next Health Supervision (EPSDT) Visit Due:** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Additionally, many of those who indicated they didn't use either ASQ or PEDS said they had never heard of them or had no access to the forms. Several responded that they used the forms in their electronic medical record (EMR). A few mentioned the prohibitive cost of the tools both in dollars and time. Only one provider said he/she did not trust the parent to accurately complete the form.

It would, therefore, be beneficial to develop tools, brochures, etc., or conduct conferences or classes about these different instruments in an effort to educate providers about the appropriate ways to most accurately identify at risk children.

Based on our study, only one-third of those who answered that they performed developmental screens were aware that there was an additional payment over and above the charge for the regular office visit or the child health check-up. When asked about additional training on both anticipatory guidance for parents and additional assistance or training for office staff about periodicity schedule issues, help with developmental and behavioral screening and counseling were the most requested topics. This is an area in which marketing and education efforts could be beneficial.

In terms of general comments about child health check-ups, survey respondents strongly feel that methods for encouraging parent/caregiver responsibility would yield the greatest benefit in improving the quality and quantity of child health check-ups, and that additional education and training would enhance their ability to perform and accurately code for developmental screens.

*“Put more responsibility on parents. If they don't comply; revoke insurance benefits.”*

*“Reimbursement is inadequate. Patients are demanding. Too many visits non-urgent medical matter. No patient accountability/responsibility.”*

*“I would take the responsibility off the provider and put it on the parents if they don't take the children for their check ups, they may lose benefits.”*

*“Make participation in EPSDT program necessary for patient to continue to receive health care.”*

# Key Findings and Recommendations

## Key Findings:

1. Surveys were mailed on June 17, 2008 to all 584 PCPs who met inclusion criteria; 13 were unusable; 211 valid surveys were received, a 36.9% response rate.
2. Most respondents were physicians (52%) (61% family physicians, 35%, pediatricians, 4%, general practitioners); 24% were PAs or nurse practitioners. The remaining respondents (24%) were nursing or administrative staff.
3. 64, 30.3% of 211 respondents, gave contact information; 7 were unreachable. We attempted to contact 57 providers. Of those, 22 spoke with us on the telephone, 3 responded to an e-mail, and 1 via fax. These exchanges confirmed the survey findings, especially regarding frustration over missed appointments and lack of parental responsibility.
4. The majority of respondents indicated they “Understood” (39%) or “Understood Well” (36%) the EPSDT periodicity schedule.
5. Missed appointments (“No-shows”) were the major barrier for PCPs in meeting EPSDT periodicity schedule guidelines; PCP auto-assignment was 2<sup>nd</sup>, and reimbursement, 3<sup>rd</sup>. These results are similar to a prior study.<sup>1,2</sup>
6. Based on interviews, only about half of PCPs are aware that the PCP assignment methodology will be changing in Jan. 2009.
7. PCPs felt the main reason parents/caregivers did not bring children in for regular child health check-ups was that they were “Not Important”; “Transportation”

issues were 2<sup>nd</sup>, and “Office Hours” conflicts were 3<sup>rd</sup>. These results are similar to prior findings.<sup>1,2</sup>

8. PCPs with city practice locations found it easier to meet periodicity schedule guidelines (avg, 3.46 on a scale of 1 to 5) than those in towns (avg, 2.91), or rural areas (avg, 2.87). The differences between “City” and both of the other variables were statistically significant ( $p < .05$ ). The differences between “Town” and “Rural” were not statistically significant.
9. 96% of survey respondents indicated they performed developmental screens in their practice, but only 36% knew about the \$8.40 additional payment for each properly coded screen (page 13).
10. 44% of respondents indicated they “use” the Ages & Stages Questionnaire (ASQ) in their practice, and 38% indicated they use the Parents’ Evaluations of Developmental Status (PEDS) test. 25% had never heard of ASQ and 32% had never heard of PEDS. Many said they used the Denver Developmental Screen Test (DDST).
11. Nursing staff (3%) and billing, coding and clerical personnel (3%) were far less likely to know about the additional payment for a properly coded developmental screen than were physicians (48%), physician extenders (21%), and office management (22%).
12. Some respondents were under the mistaken impression that completing the Developmental Assessment section of the OHCA Child Health Supervision (EPSDT) Visit form constituted a developmental screen (Figure 36).

## **Recommendations:**

1. Develop outreach and implement educational efforts for providers explaining the reimbursement system for child health check-ups.
2. Develop educational approaches for parents/caregivers explaining the importance of child health check-ups. Consider PSAs, flyers, etc.
3. If the lower compliance with the periodicity schedule in towns and rural areas as compared to cities is due to transportation problems for SoonerCare recipients, as we think may be likely, then strategies to increase awareness of the SoonerRide program should be explored. In the parent report to follow, we will do a data analysis of the transportation issues by location.
4. Federal mandates should be clarified, through PSAs, conference booths, etc., to mitigate potential emotional reactions from providers, specifically regarding lead screening.
5. Implement outreach efforts for providers, especially PSAs, mail-outs, booths at various provider association meetings, etc., to explain the new PCP assignment process.
6. Develop outreach and implement educational efforts for providers about the various developmental screening tools, especially the ones which are most likely to yield valid results, and those which should be avoided.
7. Develop and implement outreach for parents and caregivers about the purpose and importance of developmental screening. These could include examples of the parent-completed tools.
8. Develop outreach and implement educational efforts for PCPs and office staff explaining what constitutes a developmental screen.
9. Develop outreach and implement educational efforts for PCPs and office staff explaining the additional payment of \$8.40 available for a properly coded developmental screen.
10. Explore training tools, brochures, etc., or conduct conferences or classes about these different instruments in an effort to educate providers about the appropriate ways to most accurately identify children at risk for developmental delay.
11. Future studies could investigate the frequency with which health care professionals are conducting developmental screening tests, and which tools they prefer.
12. Make available anticipatory guidance training in all of the following areas:
  - Developmental and Behavioral Screening and Counseling (81 requests)
  - Nutritional Screening (61 requests)
  - Violence (46 requests)
  - Injury Prevention (38 requests)
  - Sleep Positioning (25 requests)
13. Make available staff and provider EPSDT training for the following topics:
  - Developmental and behavioral screening (64 requests)
  - Hearing (47 requests)
  - Vision (41 requests)
  - Lead/anemia (37 requests)
  - Dental (26 requests)

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# *Appendices*

- A. Child Health Check-Up Provider Survey
- B. Survey Cover Letter
- C. Respondent Telephone Interview and E-Mail Exchange Question Script and Grid
- D. Narrative Survey Comments
- E. Biographical Sketches of Project Faculty and Staff

## Appendix A. Child Health Check-Up Provider Survey

**Please note: For the purposes of this survey Medicaid = SoonerCare, and EPSDT = child health check-ups**

1. Please identify yourself.
- M.D/D.O. Specialty: \_\_\_\_\_
  - Physician's Assistant/Nurse Practitioner
  - RN/LPN/CNA
  - Billing/Coding/Clerical
  - Office Manager
  - Other: \_\_\_\_\_

2. Where is your practice located? (If you have more than one practice location, check all that apply.)
- City (50,000+)  Town (2,500-50,000)  Rural (2,500 or less)

**General Child Health Check-Up (EPSDT) Questions. Circle the number.**

3. How would you rate your knowledge of the SoonerCare periodicity schedule and guidelines?

Do Not Understand	Understand a Little	Acceptable	Understand	Understand Well
1	2	3	4	5

4. How difficult it is for your practice to meet the Sooner Care periodicity schedule?

Very Difficult	Somewhat Difficult	Neutral	Easy	Very Easy
1	2	3	4	5

5. Please rate the following barriers to achieving regular child health check-ups within your practice.

	Not a Barrier	Small Barrier	Neutral	A Barrier	Major Barrier
PCP enrollment change	1	2	3	4	5
Appointment no shows	1	2	3	4	5
Reimbursement	1	2	3	4	5

6. Please rate how much of a barrier each of the following is for your patients in keeping their child health check-up appointments in your practice:

	Not a Barrier	Small Barrier	Neutral	A Barrier	Major Barrier
Transportation	1	2	3	4	5
Pts don't think it's important	1	2	3	4	5
Pts can't come during regular office hours	1	2	3	4	5
Other (list): _____					

7. Has your office made changes within the last year to accomplish more child health check-ups?
- Yes  No
- If Yes, please describe: \_\_\_\_\_

Were the changes beneficial? Why or why not? \_\_\_\_\_

**Developmental Screening Questions.**

8. Do you perform developmental screening as recommended by SoonerCare as a part of your practice?
- Yes.  No.
- If No, why not? \_\_\_\_\_

9. Please indicate your familiarity with the following.

	Never Used or Heard Of	Heard Of Don't Use	Use
Ages & Stages (ASQ)	1	2	3
Parents' Evaluation of Developmental Status (PEDS) Tool	1	2	3
Other*	1	2	3

\*Please list: \_\_\_\_\_

10. If you answered Yes to question 8, If you aren't using Ages & Stages or the PEDS form, why not? \_\_\_\_\_

11. Did you know that in addition to your primary visit billing, you may bill additionally for a properly performed developmental screening?  Yes  No

**Did you know???** SoonerCare pays an additional \$8.40 per developmental screen. Proper CPT coding is required. Visit the OHCA child health check-ups web site for more information.  
[http://www.ohca.state.ok.us/providers.aspx?id=588&menu=74&parts=7581\\_7583](http://www.ohca.state.ok.us/providers.aspx?id=588&menu=74&parts=7581_7583) )

12. SoonerCare requires you to provide age-appropriate anticipatory guidance for your patients in areas, such as those listed below Please check all areas in which you would like further training for you or your staff.
- Developmental Behavioral Screening/ Counseling
  - Violence
  - Nutritional Screening
  - Injury prevention
  - Sleep positioning
  - Other (list): \_\_\_\_\_

13. The SoonerCare periodicity schedule includes the following items Please check all areas in which you would like further training for you or your staff.
- Developmental and behavioral
  - Vision
  - Hearing
  - Dental
  - Lead/Anemia
  - Other (list): \_\_\_\_\_

14. If you were in charge of the SoonerCare child health check up program, how would you improve it?
- \_\_\_\_\_

15. Additional comments: \_\_\_\_\_

16. OPTIONAL: Contact Information.
- Name: \_\_\_\_\_
- Address \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- E-mail \_\_\_\_\_

## Appendix B. Provider Survey Cover Letter



### **Health Care Provider Survey SoonerCare (Medicaid) Child Health Check Ups (EPSDT) and Developmental Screening for Children ages Birth to 3 years**

EPSDT refers to a series of scheduled child health check-ups prescribed by Medicaid to assure the appropriate growth and well-being of children ages birth up to 21 who are covered by Medicaid (SoonerCare in Oklahoma). Developmental screening, combined with anticipatory guidance for parents, is an important component of preventive child health services. Developmental screening performed at birth, 3, 6, 9, 28, 24 and 36 months helps to assure the early identification of factors that could impede a child's ability to learn and grow normally. SoonerCare is working hard to promote awareness of the importance of developmental screening as a component of routine, child health check-ups for children ages 3 and under.

To gather information from you, the providers, about the provision of EPSDT services and developmental screening, the Oklahoma Health Care Authority (OHCA), the agency that oversees Medicaid (SoonerCare), has asked independent researchers at the University of Oklahoma Health Sciences Center, Division of Primary Care Health Policy, to assist them with conducting this survey.

**Please complete the survey on the reverse side of this page and either mail it back in the enclosed postage page envelope or fax it to Sarah-Hyden, Projects Coordinator for the OUHSC Primary Care Health Policy Division, at (405) 271-8800.**

All survey information collected will remain anonymous and survey results will be reported to OHCA in aggregate. No identifying information will be used. Findings will be used by OHCA to assist with policy and procedure development with the goal of enhancing and increasing the number of developmental screens performed in primary care practices.

In addition to this survey, discussions or interviews with primary care physicians about developmental screening will be conducted. If you would be interested in talking with a research in person or on the phone, or participating in a discussion group in your area, please complete the contact information on the survey.

If you have any questions about this survey, please feel free to contact Sarah-Hyden at (405) 271-8000, Ext. 32110 or Laine McCarthy at (405) 271-8000, Ext. 32109.

Thank you for taking your time to complete this survey. The results will help create a happier and healthier future for Oklahoma's children.

## Appendix C. Respondent Telephone Interview and E-Mail Exchange Question Script and Grid

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### Provider Discussion and Interview Questions

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- 1) Please tell us what you think about the preventive services for children under SoonerCare.
- 2) Has your office developed any patient educational approaches (anticipatory guidance) to educate parents?
  - a. If yes, what?
  - b. Is it improving child health check-ups?
- 3) Has your office implemented any outreach efforts to get children in for their check-ups?
  - a. If yes, describe. Are they working?
  - b. If not, why have you not? (Cost, lack of staff time, etc?)
- 4) Do you have any suggestions on how OHCA can help with the missed appointment/no show problem? *If payment for no-shows and/or kicking them out of the program is mentioned explain that the federal guidelines prohibit it.*
- 5) Does your office routinely ask the parent questions about potential developmental delays? If you use a screening tool, is it physician or health care professional administered or is it a parent-complete tool? Why did you choose that tool?
- 6) What do you do that you would want other practices to know that help your office with child health check-ups?
- 7) Has your office received any communication and/or support from OHCA regarding child health check-ups?
  - a. If so, what?
  - b. Was it helpful?
- 8) Are you aware that beginning in January 2009, methods for selecting or assigning SoonerCare PCPs will change?
  - a. Yes
  - b. No
- 9) What would you change about child health check-ups? *If blood lead screens are mentioned explain that federal guidelines prohibit changing it at this time.*

## Appendix C.

### Respondent Telephone Interview and E-Mail Exchange Question Script and Grid

#### Discussion Group and Telephone Interview Responses

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10/9	The only thing I see is parents aren't held accountable enough. We need to figure out a way to get parents attention, penalize them if they don't bring their children in.	No, not really. Nothing organized.	N/A	N/A	Not yet.	N/A	Lack of staff until now.	We really don't have a no-show problem. The parents just don't make appointments or bring their kids in. We have more of a problem with them using the ER.	Physician administered.	Nothing right now.	Yes, an audit.	In a recent OHCA audit, they provided us with lots of EPSDT forms to use with parents.	Yes	Yes, I learned while they were here doing the audit.	Increase parental responsibility.
10/10	Great, glad we have it.	Yes	Created hand-outs for colds & musculo-skeletal injuries.	I think so. More patients taking vitamins now.	Yes	When they come in for acute care we check the chart and if they're due for a well check-up, ask them to schedule an appointment.	N/A	The OHCA used to send out "missed appointment" notices, but don't any longer. Contact parents when child is born and give info. to the new moms. Encourage breast feeding.	Yes, kids do screening on the physical forms. Tool already in place when she came here to work.	Nothing right now.	Yes	Had visitors who left patient hand-outs about EPSDT (need more).	Yes	No	Add parenting classes!  Will we come to visit and show more resources?
10/10	Works fine.	Yes	Use Practice Partner from PMSI.	Yes and no. Improved use of EPSDT and immunizations. But parent-driven for follow-up	No, we just discuss when they are in the office.	N/A	Mail-outs costly.	No, this is parent-driven, some are not interested others are. Life happens in the families.	Not unless the child is not on schedule. Doctor discusses. Atrocious for getting appointments with specialists!	With all kids under 18, they pull up the OSIS to see if they need EPSDT or immunizations.	No	N/A	N/A	Yes	Give parents an incentive (\$5.00)
10/13	Good, when parents bring the kids in.	No, this is a very small practice.	N/A	N/A	Yes	We send our own letters, but not much success.	N/A	OHCA send out the letters	Physician discusses when doing physical. No specific tool used.	Nothing to share.	No	N/A	N/A	No	Wouldn't change anything. The exams are time-consuming.

## Appendix C. Respondent Telephone Interview and E-Mail Exchange Question Script and Grid

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10/13	Great. Only problem is getting them in to the office.	Yes	Use the physical forms from the OHCA web site....they are very good.	Yes	Yes	Send letters, make phone calls. Also do a hearing, visions and urine check when they come in because of illness.	N/A	OHCA should send out letters....they have more clout when coming from them.	Yes, the health care professional screens all children.	Use OSIS for immunization records. Thankful for the forms on the OHCA web site.	Yes	They are always willing to answer questions. Forms are also very helpful.	Yes	No	Wish we had more staff to contact parents to get the children in.
10/13	Good plan and coverage. Reimburses provider for the extra preventive things.	Yes	Use Electronic records system with a standard guide.	Yes	No	N/A	N/A	OHCA should mail information, especially about who their provider is.	Yes. Use form from OHCA web site. PEDS- parent completes. Use electronic records screening tool that was already in place here.	Having screening tools readily accessible, especially for what Sooner Care wants.	Yes	Flyers, media blitz	Yes	Yes	Nothing
10/13	Good, adequate.	Yes	Uses hand-outs. Uses Children First info from Health Dept.	Hit & miss. Getting the child back in, especially after age 2 is rare.	No	N/A	Too labor intensive.	Parents get cards/reminders from OHCA. Help educate parents to call ahead when cancelling an appointment.	Yes. Ask questions at visits based on knowledge and experience.	Use of electronic medical record program (EMD), especially the growth grid....engages parents.	Yes	Mailed info on lead and hemoglobin. Also letter format about this practice panel.	Yes	Yes. Lots of concern about the "shake-out". Fear physicians will pull out. May have to add a cap.	Send better, simpler info. in letters, they are too wordy and confusing to parents with limited reading ability. Don't use "EPSDT". Send post cards.
10/13	Adequate, appropriate number & timing.	YES	Use AAP "well-check" forms. Give age & development appropriate hand-outs.	Have always done it, so can't tell.	Call day before. Remind no-shows of policy.	Yes, but still have no-shows.	N/A	Parents be accountable. By the time they miss 3 appts that is three time slots that could have been available for someone else.	Yes, use the AAP "well check" forms are administered by the nurse. Add detail questions if appropriate. Most accurate & likely to find a delay.	I deal with my SoonerCare patients the same way as with all patients, though income doesn't cover expenses.	Don't recall any.	N/A	N/A	Yes	Implement a small co-pay. Provide more education about the process and parent responsibility.

## Appendix C.

### Respondent Telephone Interview and E-Mail Exchange Question Script and Grid

#### Discussion Group and Telephone Interview Responses

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10/16	Love them! Basis of everything... anticipatory guidance, good solid foundation—very important for parents.	No, but we use the SoonerCare forms and information from the web site, helps with paper work & EPSDT.	N/A	Yes	No, but sometimes at the focused visits they do the EPSDT exam.	N/A	N/A	SoonerCare sends reminders for the young children...can they also send for the school-age children? They are rarely brought in for well checks.	Yes, it's the 1 <sup>st</sup> question. Use forms from OHCA, would like a combined form with more precise questions. HC professional administers. Good for preventive care.	Take the necessary time and really listen to the parents' answers.	Yes,	Provider Reps were very helpful and referenced resources on the OHCA web site.	Yes, especially when they had "dedicated" reps who got to know the practice.	No	Need notices from OHCA to school-age kids to get them in. Direct families to the Internet for more info....WebMD
10/16	Good. The problem is parents don't understand about well check-ups.	No	N/A	N/A	No, but at focused visits they do EPSDT and immunizations.	N/A	N/A	SoonerCare used to call after missed appts. Wish we had that again.	Yes, physician and PA/NP always do use the forms from the OHCA web site...has all the developmental info.	Use the forms, ask the questions.	Yes	Team came out 2x.	Yes	Yes	General education for parents...TV commercial about well checks and the value of them. System re: panels are complicated.
10/20	Great. Patients don't show.	Yes	Discuss why it is important to get shots AND child health check-up, not just shots.	No	Yes	Notification by phone calling program, calls in advance. Also missed appt. calls. Also cards sent re: missed appt.	N/A	No	Yes, nurse covers with parent, dr. discusses. Use forms on OHCA web site, Keep these! Age appropriate, handy & fast.	Automated phone reminder program to call patients.	No	N/A	N/A	Yes	Spend money on educating parents...TV ads and cell phone messages.
10/20	Great. High quality, just need compliance.	No	N/A	N/A	Yes.	Yes. If child is brought in for complaint, also he also completes the child health check and keeps shots up to date.	N/A	No. Hands are tied, no accountability for parents.	Yes, use EMD, very concise, uses exam templates, developmental milestones and grow chart. Adds anticipatory guidance.	Use EMD!!	Yes.	Have had an audit, gave good suggestions, involved with quality metrics.	Yes	Yes	Make it illegal to smoke around children.

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10/21	Good, good purpose.	Yes	Use forms printed out from OHCA web site.	Helps to motivate parents.	Yes	Nurse goes over the list and calls. Too early to tell if this is working.	N/A	No, patients change address and phone numbers too often.	Yes, use OHCA screening forms with info. by age group. The nurse goes over with parent, then dr.	Tell about the problems with newborns being in the system. Metabolic screening needed. Parent has code for dr. to use.	Yes	Use info. From the web site.	Yes	Yes, but it isn't real clear. Won't have a panel, will see whoever comes in. Will be harder to follow-up.	Make it easier to get in touch with parents, especially about needed well checks.
10/21	Preventive services are great but too much time consuming paperwork for the doctor.	No	N/A	N/A	No	N/A	N/A	This is not a big problem with this practice.	No tool used.	Nothing to share.	Yes	Threaten to take them out of the program.	Yes, contract reviewed	Yes, planning to speak with rep this week re: the contract.	Go back to fee for service.
10/21	No complaints. Kids have it made under SoonerCare	Yes	Use EPSDT sheet from OHCA... whole sheet is good.	Yes	No	N/A	Lack of staff... more paperwork.	Send letters when kids are overdue for check-up.	Yes. Dr administers, uses sheets available from OHCA. Age appropriate milestones.	Nothing to share.	Yes	Info. received quarterly.	Yes, realized clerks were using wrong codes.	Yes	Nothing to share.
10/21	Fairly good.	Yes	Kids care TV and brochures at offices.	Yes	No, used to call...but not helpful.	N/A	Cost	Better transportation service. Toy/food when child comes in.	Yes, dr. administers. Uses OHCA info from web site.	Remind parents about their eligibility review.	Yes	Send helpful info. all the time. Learned that screens can be done more often than the schedule.	Yes	Yes	Provide brochures for parents re: early childhood development in very simple language.
10/21	Good, love it.	Yes	AAP info. Hand-outs re: accident prevention, immunizations and developmental info.	Yes	Yes	Yes, reminder cards to children on their panel, especially new ones.	N/A	Send referral form after 3 missed appointments	Yes. Dr. uses templates from OHCA website. Good info, effective and available.	Nothing to share	Yes	Mailing re: medical home, PR help and meetings.	Yes	Yes	More money.

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10/21	Fine, good support for families.	Yes	During visits use OHCA info.	Yes	Yes	Yes, Staff sends reminders.	N/A	No	Yes, use MCHAT autism screen at 18 & 24 months. Use OHCA check list forms.	Nothing to share.	Not aware.	N/A	N/A	Yes	More hand-outs for parents.
10/22	Good, good screening and for immunizations.	No, just individualized effort.	N/A	N/A	In 2 months practice will go paperless.	N/A	N/A	Send patient reminders ahead of time, not just after missed appts.	Yes, use OHCA EPSDT forms, dr. assesses.	Just be diligent.	Not that I'm aware of. Use forms from web site.	N/A	N/A	No	Nothing
10/22	Great, wonderful.	Yes	Use well-baby forms. Use OSIS for immunizations, alert prevention sheet	Yes	Call parents for follow-up visits.	Yes	N/A	No	Yes, every time they bring kids in, nurse administers.	Getting access & using OSIS. Advanced MD software very helpful.	No	Go to available workshops Medical Home this month.	Yes	No	Mandatory parenting Classes for parents. Living Skills for all high school students.
10/22	Pretty good.	Yes	Use own forms from National Standard books. Also use Bright Futures.	Can't measure.	Yes	Yes, Call all kids on the panel	N/A	Fine the parents, they need to be accountable.	Yes, dr. uses Ages & Stages.	Nothing to share.	Yes	Following survey 2 yrs ago OHCA began using this dr. hand-outs on the web site.	Yes	Yes	Make parents accountable.
10/22	Not sure yet of all they offer.	Yes	Face-to-face, use DDT and EPSDT form from OHCA web site.	Yes	Nothing formal, just remind parents of need for next visit.	N/A	N/A	Reminders from OHCA about needed check-ups.	Yes, use DDT. Assessment form from OHCA give "red flags".	Nothing to share.	Yes	She called about available programs.	Yes	Yes	Nothing.
10/22	Very great, valuable.	Yes	Personally, case-by-case.	Yes	Yes, send out cards.	Yes	N/A	Personal calls to parents.	Only sees kids over 4.	Nothing to share.	No	N/A	N/A	Yes	Yearly exams for adolescents. Incentives for parents. Questionnaire for teens.

## Appendix C.

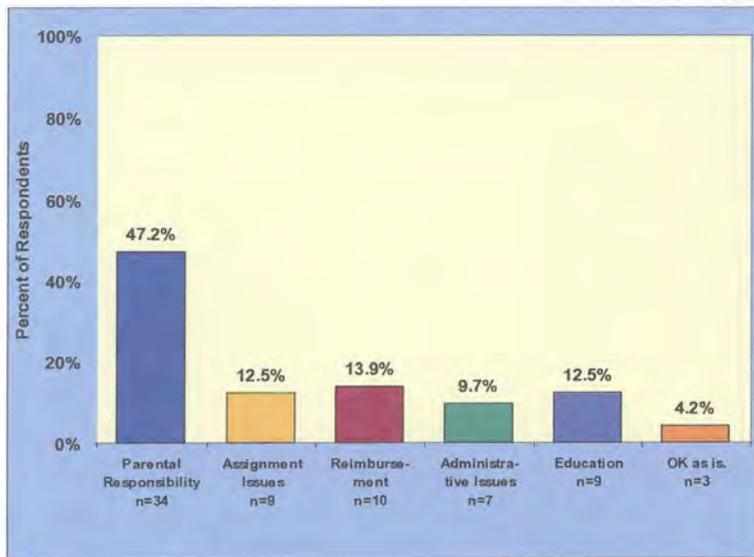
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10/27	I like the importance stressed to parents of EPSDT. I am glad for all my patients to have the availability of hearing, language, and other screening at the Health Department.	Yes	Using guidance suggestions on EPSDT forms from web site. Planning to create hand-outs for parents.	Yes	Yes	I believe we now call parents to ask them if they would like to schedule check-ups, from our roster, if I recall. (recent program)	N/A	No, this is a difficult one of course.	Yes. MA's ask a few questions, the ones of the EPSDT age-appropriate forms we printed from the web site. We plan to administer the Ages & Stages soon.	The Medical Assistants ask the questions and provide the guidance of the forms. If anything is abnormal or there are questions, the provider reviews and answers.	Yes	Administration had a representative visit.	N/A	No	I can't think of anything.
10/28	Need to be made mandatory and only to assigned providers.	No	N/A	N/A	Yes	Working somewhat.	N/A	Make the check-ups mandatory.	No tools.	Nothing	No	N/A	N/A	No	Make them mandatory.
10/31	Use hand-outs from University of Kansas Pediatrics Department.	Yes	American Academy of Pediatrics	If the parent reads the information - it helps.	Yes	We send letters to patient with our hours, phone number for appts, shots, etc.	N/A	No	Yes, American Academy of Pediatrics.	We use OHCA Developmental/ Behavioral Assessment.	Yes	OHCA INJ Program and Tools OHCA provides.	No answer	Yes, somewhat. Need more information regarding the teens. Requirements in detail.	Wish they applied to private pay and regular insurance.

## Appendix D. Narrative Survey Comments

Comments: Q14. If you were in charge of child health check ups, how would you improve it.



"More parental involvement and guidance."  
 "Have a small co-pay for each visit so that they think about their problem a little bit before "needing" an appt."  
 "Cash incentives for the parents."  
 "Better reimbursement."  
 "Simplify paperwork for clinician and staff."  
 "You want 6 visits before first birthday but don't allow 1 yr shots to be given before first birthday so we don't do the 6th visit until after the first birthday, so we miss the bonus!"  
 "More hands on education to be more efficient."  
 "Make it more user friendly. Too many regs."  
 "Inform parents of need for child health check-up exams."  
 "Increase reimbursement."  
 "Encourage parent and guardian to bring their children for regular check ups. ."  
 "No. I think it is well managed already."  
 "Have social worker or case manager visit every consumer for cleanliness, diet, good child care, proper discipline."  
 "Educate the patients."  
 "I wish we could help make parents responsible."  
 "Stop changing PCPs for no apparent reason."  
 "3 no shows and case worker would be notified and do something about it."  
 "I already think you are doing a good job."  
 "Patients who are Native American use Indian Health, don't know what they are signing up for when they apply, they don't know what it is and don't come to

their Sooner Care provider because they want to use HIS."  
 "Make it mandatory for parents to bring them in for EPSDT or lose benefits."  
 "Stop lead screening."  
 "Make them responsible or tell them you will cut them off."  
 "Require to remain on SoonerCare family must have check-ups."  
 "Bombard parents with information on why we do these, to find abnormalities early so they can be corrected."  
 "Add accountability to parents (from ER visits to no show appointments)."  
 "I would limit 2 children per family on SoonerCare."  
 "unclothed total body exams on 12 yo girls? Really? For \$8?"

"make parents more aware from SoonerCare about EPSDT's."  
 "You want 6 visits before first birthday but don't allow 1 year shots to be given before 1st birthday so we don't do the 6th visit until the 1st birthday - so forget any bonus!"  
 "Improve reimbursement."  
 "Send a quarterly reminder to parents about importance of screening."  
 "Stop changing PCP's every few months."  
 "Require families to bring their kids in for child health check-up visits. They tend to bring them in during illness only. Also require them to pay part of the office visit when they no-show their appointments. Then maybe they would show up."  
 "handouts for age appropriate anticipatory guidance - illegible comment."  
 "no PCP."  
 "Make care child fee -for -service and tie their enrollment to their compliance with well-child exams."  
 "I have received 2 letters stating I don't do enough EPSDT's and we do more than we get credit for - is this a billing/coding problem?"  
 "Be more demanding of families and PCP's that EPSDT's be done. ."  
 "Stop enrollment dr changes!"  
 "I would make sure that when a pt requests a certain provider or clinic they are assigned to that place/person."  
 "let parents know they are required to bring them in - be tough, firm and very strict."  
 "Make periodic checkups mandatory to stay in the program."

## Appendix D. Narrative Survey Comments

- "Stop holding physicians responsible for parental irresponsibility."
- "Make it fee-for-service and charge a nominal co-pay."
- "web site isn't user friendly. When I call I have to talk to several different people before I can get my question answered. Sometimes more than one person gives a different answer. I likely missed a portion of training when I was first listed as a provider due to the lapse of being recognized by SoonerCare and the time I actually started in practice. I have signed up for a training class."
- "Providing educational material about its importance. If they don't show up then we can drop them from SoonerCare, we should also have \$5 co-pay for each visit whether well-child or sick, it may increase compliance and reduce over utilization."
- "don't change pcp's often - keep them with the same. ."
- "enroll in SoonerCare after a checkup."
- "send children straight to eye and dental appts not pcp."
- "No opinion."
- "Mandatory compliance for parents. Lose your benefits. Put responsibility on parents."
- "no one is clear about the rules we get different info from different employees."
- "cash incentives for parents."
- "It is pretty important to have a check up between age 3 days and 1 week - seeing a child at birth then 3 months leaves an enormous gap especially for breastfeeding infants. The first 2 months is a lot of work and no one dealing with at risk families."
- "have a small charge (\$5) copay to weed out unnecessary visits."
- "establish medical home."
- "stop pts from being automatically transferred to another provider."
- "give the parent/patient more responsibility."
- "Educate PCP's and staff more frequently on forms and make if uniform for all providers and educate on billing."
- "Pay providers more for doing them. Pay for quality for those who need it, not for the quantity of enrollees you currently have."
- "not switching patients from provider to provider."
- "works great for us."
- "better regulation of vaccine progress."
- "require patients to have their checkups to continue to get SoonerCare."
- "Giving info packets to mothers in the hospital after birth."
- "better continuity - not changing PCP's so much."
- "hold parents responsible for not bringing their children to appointments."
- "Make participants accountable. They do not value things that are free. I would like to see pts pay \$.50 or \$1 for visits if they value it, they will be more likely to show up. There should be consequences for not keeping wcc appts like making them pay \$1 for each missed visit or no shows."
- "Make monetary incentives for patients to get screenings and exams."
- "Increase reimbursement so you would have more providers."
- "get pts to come more regular, be on time, and follow instructions and educate pts more."
- "reimbursement should be better."
- "make participation in EPSDT program necessary for patient to continue to receive health care."
- "make it mandatory to receive SoonerCare."
- "some penalty for pt no show."
- "illegible."
- "penalize pts for repeat noshows."
- "system doesn't work well for our clinic - no real suggestions on improvement."
- "I would take the responsibility off the provider and put it on the parents if they don't take the children for their check ups, they may lose benefits."
- "Remind parents and start incentive program."
- "Better reimbursement, better enforcement to those pts that abuse the system."
- "make parents more accountable and no health care check then add stipulation Texas makes their Medicaid pay \$5 per month."
- "Lead level should not be mandatory. Do if indicated after proper screening."
- "penalize parents for not being responsible for check ups/wcc despite multiple services available."
- "runs great now."
- "I would send each provider a sample packet explaining how EPSDT's should be done for each age group and CPT codes to get the maximum reimbursement."
- "In home assessment at least yearly for high-risk kids."
- "encourage more patients to be compliant."
- "make sure its done before giving them beer and cigs."
- "make the periodicity schedule evidence-based or at least follow recommended guidelines more closely."
- "assign representatives at each office so the questions can stay with just one person instead of dealing with other people every time you call."
- "educate parents."
- "educate parents on its advantages."
- "stop putting the responsibility on the providers and put it on the parents."
- "incentive for family for baby's attended in a timely manner."
- "I don't visit web sites". improve the clinics understanding of the need for the service."
- "send epsdt reminders."
- "Inform about transportation. Prevent PCP changes."
- "better info for 1st time mothers."
- "pay for well and sick visits together in reimbursement."

## Appendix D. Narrative Survey Comments

"SoonerCare computer generate reminders for parents. As a requirement for receiving benefits, all parents must attend quarterly meetings where videos are should about the importance of the above. ."

"More education."

"reimbursement is inadequate. Pts are demanding. Too many visits non-urgent medical matter. No patient accountability/responsibility. ."

"offer more incentives for docs and patients."

"make it mandatory for pt to stay current or drop coverage for them."

"Put more responsibility on parents. If they don't comply; revoke insurance benefits. ."

"Mandatory physical exam annually."

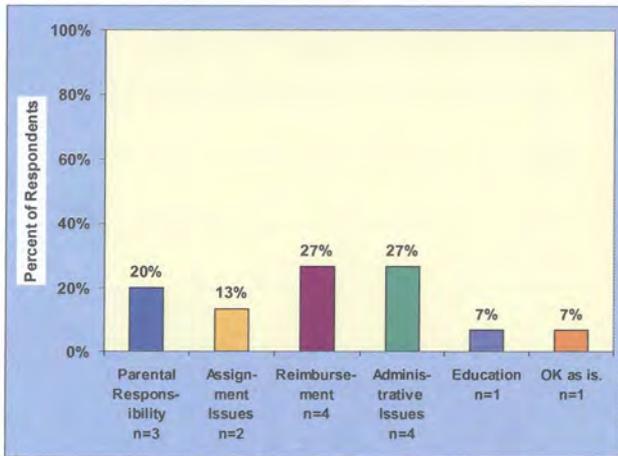
"Make the parents keep appts for the screenings."

"Have one central location in each county that is specified to do all screenings, lab and check ups - pts had to get appt and make them or they would not receive welfare check or food stamps."

"Requiring yearly physicals after age 5 is excessive! I can't accommodate that in my busy practice!"

## Appendix D. Narrative Survey Comments

### Q15. Additional Comments?



“Our main problem is that 50% of the kids assigned to us never come to our practice for any appoints so we can't schedule well checks.”

“It has improved greatly from what it was a year ago.”

“We need a program to help children who don't qualify for Medicaid and have no private insurance.”

“Have a list of approved providers online who provide vision/dental/hearing screens.”

“Explain the importance to them.”

“There is [no reimbursement] unless fee for service.”

“We are interested in Ages & Stages and PEDS tool.”

“Encourage parent compliance.”

“SoonerCare should pay for develop. Screen from 6 mos to 2 yrs.”

“Pay more.”

“Web site above has changed for coding.”

“Better compensate PCP's for developmentally delayed patients.”

“We cannot spend 30 minutes for screens that pay us \$8.40.”

“provide transportation if they cannot make it for appt.”

“Increase parent responsibility.”

“Attached note regarding CA DHS: In CA DHS offices - when parents came in to meet with case workers, there was an intentional delay during which the parents sat in a room where videos were being shown that stressed the importance of numerous issues, one being Child Health Check Ups. Many anticipatory guidance issues were also shown vidoes.”

“I would like to attend training sessions.”

“Put some responsibility on parent.”

## **Appendix E.**

### **Biographical Sketches of Program Faculty and Staff**

***Garth L. Splinter, M.D., MBA***

***Division Head, Primary Care Health Policy Division***

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Dr. Garth Splinter began his post-secondary education at the University of Oklahoma where he majored in industrial engineering, receiving his Bachelor of Science degree in 1974. He then enrolled at Harvard University's business school where he earned his MBA in 1976. He graduated from the Oklahoma University College of Medicine in 1984, with a Doctor of Medicine degree. He completed residency training in family medicine in 1987 and joined the faculty at the Oklahoma University Health Sciences Center (OUHSC) as the Director of the Health Sciences Center for Health Affairs and Rural Health Programs and part-time Medical Director for the Employees Group Insurance Board. Dr. Splinter served as Special Assistant on Health Care Issues to Governor David Walters from 1991–1994. He was also the Chair of the Commission on Oklahoma Health Care and served as Principal Investigator for the Robert Wood Johnson Grant of State Initiatives on Health Care granted to the Governor's office.

In 1994, Dr. Splinter was appointed by the Governor and confirmed by the Oklahoma Senate as Chief Executive Officer of the newly created Oklahoma Health Care Authority, the agency that oversees Medicaid. During Dr. Splinter's five years as CEO, the Oklahoma Medicaid program was successfully converted to statewide managed care. In 1999, Dr. Splinter joined the Department of Family Medicine, University of Oklahoma College of Medicine, as an Associate Professor. From 1999 to 2003, he also served as the Chief Medical Officer of the University Hospitals Trust under a contract with the University. From 2001 to the present, he has served as a board member for Ribomed Biotechnologies, Inc., a Carlsbad, CA - based startup company. From 2003 to the present, he has been the Director of the Primary Care Policy Division in the Department of Family Medicine. In that position, he oversees health policy studies addressing such issues as Medicaid reform, employee sponsored health care, and issues related to the uninsured and underinsured in Oklahoma.

***Laine McCarthy, MLIS***

***Associate Professor and Writer/Analyst, Primary Care Health Policy Division***

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Laine McCarthy, MLIS, joined the Department of Family & Preventive Medicine on January 1, 1984 as a Research Assistant. She served as a Senior Administrative Manager and as a Technical Writer before her promotion to the rank of Instructor on January 1, 1995. In June, 1998, Ms. McCarthy was promoted to Clinical Assistant Professor, and then in June 2001, she received promotion to Clinical Associate Professor. She has a BA degree in English Education from the University of Arizona-Tucson, and a Masters in Library and Information Studies from the University of Oklahoma-Norman.

During her tenure with the University, Ms. McCarthy has been the recipient of several education and training grants including two grants from the Bureau of Health Professions, Health Research and Services Administration (HRSA), US Department of Health and Human Services. The first grant was awarded in 1992 (\$320,000) to establish a library in the Department of Family & Preventive Medicine, and develop and implement a residency curriculum in evidence-based medicine. The second grant, awarded in 1998 (\$500,000), established a faculty information technology training program for in-house and community physicians. She has presented the results of these grant programs in several national forums including the Society of Teachers of Family Medicine and the American Academy of Family Physicians. Ms. McCarthy is also the author of numerous manuscripts and books on a variety of topics including primary prevention of microalbuminuria (published in the *Journal of Family Practice*), writing case reports, medical terminology and evidence-based medicine. She has participated in the design and conduct of numerous successful research projects for the Oklahoma Health Care Authority. Laine currently serves as writer/analyst for the Division of Primary Care Health Policy.

## **Appendix E.**

### **Biographical Sketches of Program Faculty and Staff**

#### ***Sarah D. Hyden***

##### ***Health Policy Research Coordinator, Primary Care Health Policy Division***

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Sarah Hyden joined the University of Oklahoma Health Sciences Center (OUHSC), Department of Family and Preventive Medicine, Primary Care Health Policy Division as Project Coordinator in May of 2003. She holds a Bachelor of Science degree from Southern Nazarene University. Prior to joining OUHSC, she spent six years in healthcare sales and marketing field, with a focus on outreach and contact management, specifically with physicians and other health practitioners. Ms. Hyden is responsible for supervision of projects within the Primary Care Health Policy Division. Additionally, she ensures all work requirements and time deadlines are met; establishes protocol for completion of grants, contracts and/or Division research and analysis projects. She conducts research projects including presentations, survey administration and data collection to targeted populations throughout Oklahoma and serves as liaison between the Department, the Division and various government and university agencies. She has participated in the design and conduct of numerous successful research projects for the Oklahoma Health Care Authority. Ms. Hyden is currently the projects coordinator for the division.

#### ***Denise M. Brown, PHR***

##### ***Senior Administrative Manager, Primary Care Health Policy Division***

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Denise Brown has been in the healthcare field since 1974. Denise has been with the University of Oklahoma Health Sciences Center (OUHSC) since 1984 and joined the Department of Family and Preventive Medicine in 1989. Ms. Brown holds a Bachelor of Science degree in Social Work and is a certified Professional in Human Resources. She has an extensive background in human resource, administrative and hospital based management; including patient and employee relations. As senior administrative manager, she works closely with the projects coordinator.

#### ***Susan M. Hall, MSM***

##### ***Outreach Coordinator, Primary Care Health Policy Division***

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Susan Hall joined the University of Oklahoma Health Sciences Center (OUHSC), Department of Family and Preventive Medicine, Primary Care Health Policy Division as Outreach Liaison in October, 2008. She holds a Bachelor of Arts degree in Education from Northeastern State University and a Master of Science degree in Management from Southern Nazarene University. Before joining OUHSC, Ms. Hall worked for 37 years for the Oklahoma Department of Human Services and has an extensive background in human services, training, technical assistance and program management. She received the Social Security Public Service Award in 1984 for her contributions to the national implementation of Work Programs under the Aid to Families with Dependent Children Program. Ms. Hall is responsible for outreach coordination and functions as a community liaison for the division. She assists in conducting the research projects of the division.

## Appendix E. Biographical Sketches of Program Faculty and Staff

**Steven A. Crawford, M.D.**

***The Christian N. Ramsey, Jr., M.D., Endowed Chair in Family Medicine  
Department of Family and Preventive Medicine***

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Steven A. Crawford, M.D., is the University of Oklahoma, College of Medicine's Christian N. Ramsey, Jr., M.D., Chair in Family Medicine. Dr. Crawford graduated Magna cum laude from Claremont McKenna College in 1975 and from the University of Illinois, College of Medicine in 1979. He completed his residency training at the Waco Family Practice Residency Program in 1982 and a family medicine teaching fellowship, also in Waco, in 1983. Dr. Crawford served as chair of the family medicine department at the Oklahoma City Clinic, a private for-profit, physician-owned, multi-specialty group practice, from 1989 until 1998. He has served as Professor and Chair of the Department of Family and Preventive Medicine since 1999. His prior appointments include Interim Chair, Vice-Chair, Residency Program Director, and Associate Residency Program Director at OU. He has also served as Chief of the Family Medicine Service at the OU Medical Center since 1990 and Chairman of the OU Medical Center Board of Trustees since 2000.

Dr. Crawford has served as the elected president of the Oklahoma County Medical Society in 2002 and served as the president of the Oklahoma Academy of Family Physicians in 1994. He has also served as Chair of the Oklahoma Health Care Authority's Medical Advisory Committee and in many other professional positions over his career.

Biographical Sketches of Program Faculty and Staff  
Appendix E

Steven A. Crawford, M.D.

The Chairman M. Ramsey, Jr., M.D., Endowed Chair in Family Medicine  
Department of Family and Preventive Medicine

Steven A. Crawford, M.D., is the University of Oklahoma College of Medicine's Chairman. He completed his residency training at the West Virginia University School of Medicine in 1979 and from the University of Illinois College of Medicine in 1982 and a family medicine teaching fellowship, also in West, in 1983. Dr. Crawford served as chief of the family medicine department at the Oklahoma City Clinic, a private for-profit, physician-owned, multi-specialty group practice, from 1985 until 1988. He has served as Professor and Chair of the Department of Family and Preventive Medicine since 1989. His prior appointments include Internist Chair, Vice-Chair, Residency Program Director, and Associate Residency Program Director at OU. He has also served as Chief of the Family Medicine Service at the OU Medical Center since 1990 and Chairman of the OU Medical Center Board of Trustees since 2000.

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