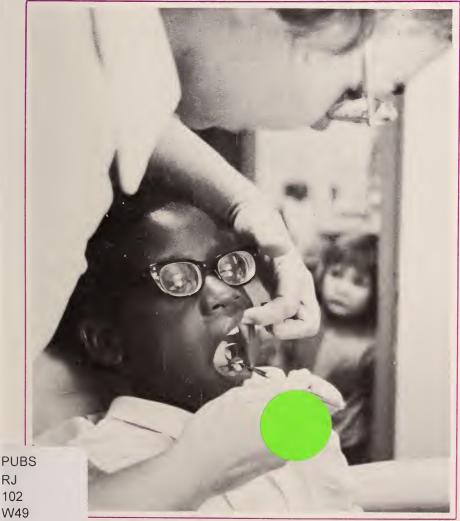
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**PUBS** RJ 102

1977



The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services under Medicaid are a program of prevention, early detection, and treatment, aimed at one of our most vulnerable groups—welfare children. Wordsworth said, "The child is father of the man." We often hear that children are our greatest resource. Yet, we are not making the most of this tremendous asset. We know that poverty and health status are intimately interrelated. We know that untreated health defects lead to disease and disability. We know that disability leads to dependency and in turn to the perpetuation of the welfare cycle.

Data from the National Health Interview Survey reveal more disability days (restricted activity, bed disability, work loss, or school loss) among those in lowest income groups. Although the prevalence of chronic conditions is only slightly greater in the lower educational and income groups, the conditions which they have are considerably more disabling.

EPSDT attempts to provide health services which might correct and eliminate at least the health-related causes of disability, dependency, and poverty. Children and Youth Projects under Maternal and Child Health programs have demonstrated that comprehensive child-health services, which emphasize preventive care, pay off by reducing long-term illness and hospitalization.

Benefits from German measles prevention, for example, include substantial reductions in the need for special education programs and reduction in the need for acute and long-term health care facilities. Measles vaccine costs less that \$1 per dose; immunizing a child population of 3 or 4 million requires about \$3.5 million per year. Compare this with the cost figure of \$140 million annually for care and treatment of the child victims of the 1964 measles epidemic.

This type of human and economic savings can be produced, but only if the children who need and might benefit from these programs can be sought out, identified, and treated. This is what EPSDT is designed to do.

There are approximately 25 million poor or near-poor children out of a total of about 80 million children; of these, about ll.5 million are Medicaid eligible, that is, children who might be

reached through the EPSDT program. EPSDT attempts to introduce eligible children into the health care system; make services available before health problems become chronic and expensive to treat; and increase the chances that welfare children can in later life become productive members of society and independent of Federal assistance programs.

In order to accomplish all this, EPSDT has to be much more than just a screening program. Studies have shown that defects or diseases are identified easily enough, even on repeat screenings, yet the problem is either never corrected, incompletely treated, or corrected temporarily, only to recur or to be repeated in another child in the same family. Screening must be considered only the first step in identifying, through relatively simple and inexpensive tests and observations, children who either have deficiencies now or who have a high liklihood of having them in the future unless they are treated.

Each screening program should be designed for the specific community in which it will be used and must meet standards for acceptable preventive care and health maintenance.

The basic screening package suggested in the EPSDT guidelines includes taking medical history and performing a physical exam; immunization status assessment; dental, hearing, and vision screening; developmental assessment; and screening for anemia and lead absorption, tuberculosis, bacteriuria, and sickle cell disease and trait.

Historically, most screening programs had failure built in because responsibility ended with referral of the patient. The ideal program would fit EPSDT within the scope of regular and continuous pediatric care in a one-to-one physician-child relationship.

Recognizing that many communities lack adequate doctors for the numbers of Medicaid children to be taken care of, a compromise may have to be made. Perhaps, in these situations, the screening could better be carried out by nurses or paraprofessionals in health department or clinic settings. Only the children who are found to have a problem or who are at risk of developing problems are referred to a doctor and a regular source of health care is established.

Whatever arrangements are made in a particular State or locality, it is important that the plan for providing services to Medicaid children be worked out by both the State Medicaid agency, and the State medical professional organizations. Consumer representation should be included in the program planning.



The physician is not expected to act alone in treating a patient but should utilize all other resources and supportive services available to reinforce the medical care he/she delivers. For example, it is not sufficient for a physician to treat a case of lead poisoning in a hospital and then send that child back to the same environment. Medical components of the treatment of lead poisoning should also include:

\* Testing siblings for lead levels.

\* Sending community workers or visiting nurses into the home to identify the lead paint source and arrange for correction.

\* Notifying health departments.

\* Arranging for follow-up developmental testing and appropriate special schooling if indicated.

To make the EPSDT program really effective, the definition of medical components must necessarily be broad and include not only the usual medical textbook treatments but other actions necessary to restore and maintain good health. All community services must be called upon. It is only through this kind of an approach that disadvantaged children can be helped to become independent and self-supporting men and women who can contribute to, rather than depend on, society.