CCHAP Practice Manager's Meeting

EPSDT, Periodicity, KPI, Healthy Communities, PARs

Friday January 17th 2014 Noon – 1:00PM

Instructions to join the meeting remotely:

1. Open a web browser and enter URL: www.readytalk.com
   Enter participant access code: 2093166
2. Phone in for the audio portion of the conference:
   1-866-740-1260 - then enter the access code: 2093166

MEETING HANDOUTS:
www.cchap.org/pmmeeting

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PRESENTERS

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
promoting and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	PRENATAL[2]	NEWBORN[3]	3–5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY																															
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	■	■	■	■																			
Weight for Length		■	■	●	●	■	●	■	■	■	■																				
Body Mass Index												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●[6]	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●[7]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	■	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																															
Developmental Screening[8]							■			■		■																			
Autism Screening[9]										●	●																				
Developmental Surveillance[8]		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		■	●	●	●	●	●	■	■	■	■	●	■	■	●	●	●	●	■	■	●	■	●	■	■	●	●	■	●	■	●
Alcohol and Drug Use Assessment																						★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION[10]		■	●	●	●	●	●	■	■	■	■	●	●	■	●	●	●	●	■	■	●	■	●	■	■	●	■	●	■	●	●
PROCEDURES[11]																															
Newborn Metabolic/Hemoglobin Screening[12]		●—<	●	——>																											
Immunization[13]		■	●	●	●	●	●	■	■	●	■	●	●	■	●	●	●	●	■	■	●	●	●	●	■	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[14]						★			●		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[15]							★	★	★or★		★	★or★		★	★	★	★															
Tuberculin Test[16]				★			★		★		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[17]												★			★		★		★		★	★	★	★	★	★	★	★	●—<	●	>●
STI Screening[18]																						★	★	★	★	★	★	★	★	★	★	★
Cervical Dysplasia Screening[19]																						★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH[20]							★	★	★or★		★or★	★or★	★or★	●[21]			●[21]															
ANTICIPATORY GUIDANCE[22]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child misses another one for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/6/1445].
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, reassessment, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434].
5. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
6. If the patient is uncooperative, screen within 6 months per the AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;119/1/181].
7. All newborns should be screened per AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs." (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;120/4/898].
8. Use AAP Pediatric Ability Handbook, 6th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States. MMWR. 1998;(RR-1):1-46.
9. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036]. Additionally, screening should be done in accordance with state law where applicable.
10. Perform risk assessments or exams as appropriate, based on universal screening requirements for patients with likelihood or high prevalence cases.
11. Tuberculosis testing per recommendations of the Committee on Infectious Disease, published in the current edition of Red Book: Report of the Committee on Infectious Diseases. Testing should be done on recognition of high-risk factors.
12. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: http://circ.ahajournals.org/cgi/content/full/106/25/3143] and "The Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity" Supplement to Pediatrics. In press.
13. All sexually active patients should be screened for sexually transmitted infections (STIs).
14. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
15. Referral to dental home, if available. Dithiolate, administer and health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
16. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
17. Refer to the specific guidance by age or level in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.)

KEY

●— to be performed ★— risk assessment to be performed, with appropriate action to follow, if positive —<●—>— range stating which a service may be provided, with the symbol indicating the preferred age

RCCO Program Measures

Key Performance Measure	Rolling 12 months 09/2012-08/2013	Program YTD 2013/07-2013/08
% Improvement 30 Day Readmits PKPY	(3.9) %	7.8 %
% Improvement ER Visits PKPY	3.1 %	0.6 %
% Improvement High Cost Imaging PKPY	(7.1) %	3.2 %
% Complete Well-Child Checks	79.7 %	--

Total Cost of Care

Performance Measure	Rolling 12 months 09/2012-08/2013	Program YTD 2013/07-2013/08
Variance from Budget (PMPM $)	N/A	$45.51
Paid (PMPM $)	$310.66	$318.57

Potentially Preventable Events

Performance Measure	Rolling 12 months 09/2012-08/2013	Program YTD 2013/07-2013/08
Paid Preventable (PMPM $)	$46.53	$59.51
Variance PPR Admits PKPY	(0.1)	0.6
Variance PPA Admits PKPY	0.6	(3.9)
Variance PPV Visits PKPY	15.9	3.2
Variance PPS PKPY	(310.8)	(125.3)

Rx Utilization

Performance Measure	Rolling 12 months 09/2012-08/2013	Program YTD 2013/07-2013/08
Variance Rx Scripts PKPY	595.7	1,455.0
% Rx Generic Scripts	80.37 %	79.87 %

Quality Measures

Performance Measure	Rolling 12 months 09/2012-08/2013	Program YTD 2013/07-2013/08
Adult Clients with Diabetes and annual HbA1c	79.7 %	--

Budget Basis

Base risk score	0.994
Current risk score	0.924
Base budget	$312.96
Current budget	$290.78

Population Data
12/2012-11/2013

All Members: 994,738

17.72%	Non User
46.06%	Healthy
8.16%	Stable
9.41%	At Risk
11.06%	Simple Chronic
6.78%	Complex Chronic
.81%	Critical

Reports

- Care Management Patient List
- Provider Panel Report
- Recorded Gap: Chronic Fallout
- Recorded Gap: Jump in Illness Burden
- Recorded Gap: Lack of Discharge Follow-up
- Recorded Gap: Newly Chronic
- Recorded Gap: No Office Visit in Last 6 Months
- Rx Report: Client Utilization Detail

Supporting Resources

- Dashboard User Guide
- Clinical Risk Groups (CRGs) Overview
- Overview: Potentially Preventable Events (PPEs)
- Overview: Potentially Preventable Readmissions (PPRs)
- Overview: Potentially Preventable Admissions (PPAs)

What is EPSDT

- Medicaid's program for children up to the age of 21 with a preventive treatment approach
- Diagnostic and screening services are the backbone of the program
- The "correct and ameliorative" aspects of the program are included in many of the services

Other Treatments?

- Individualized health care, diagnostic services, and "treatment" as listed in the Federal Medicaid statute, must be provided when medically necessary to correct and ameliorate physical and mental conditions discovered during screening services whether or not included in the state plan

Is EPSDT Different From Medicaid

- Through EPSDT, each state's Medicaid plan must provide to any EPSDT recipient any medically necessary health care service, even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
- EPSDT does not pay for services

EPSDT Exceptions

Coverage does not include:

- Experimental treatments
- Services or items not generally accepted as effective
- Services or items in which an equally effective but less expensive option is available
- Services for the caregiver's or provider's convenience

Certain services* may not be covered by EPSDT

- Respite
- Environmental Modifications including those to the home or vehicle
- Vocational
- Educational

*These service might be covered under a waiver program or in the child's IEP

The EPSDT Benefit Also Consists of:

- Helping Medicaid clients and their parents or guardians effectively use these resources

EPSDT Overview

- **Remote Attendees please open a separate web browser tab and navigate to:**

  www.cchap.org/pmmeeting

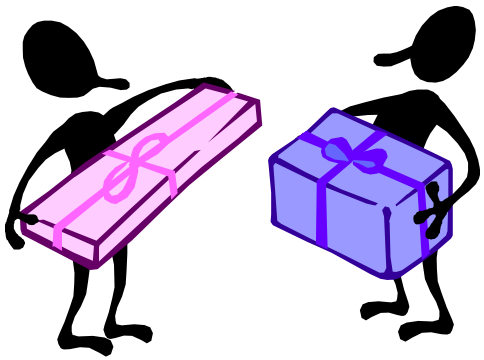
Then click on the link for the EPSDT Overview

Healthy Communities:
Free Resources for Families and Providers

- Required to notify every enrolled family of the scope of EPSDT benefits, outreach, and coordination support services
- Guide families to appropriately use their Medicaid benefits with emphasis on education, prevention, diagnosis and timely treatment

Explanation of Benefits

- A benefit is not a benefit if you do not know you have it
- A benefit is not a benefit if you do not know how to use it
- A benefit is not a benefit if you do not have a provider to render service



Providers

- Inform providers of our role in the social system
- Follow up on clients per request
- Recruit for community
- First level advocate for clients
- Inform providers of community resources
- Assist families in arrangements for travel to out of county facilities

Healthy Communities Overview

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