Alliance for Innovation in MCH: Expanding Access to Care

AIM-Access Objectives: Ensuring continuity of coverage and care for pregnant women and children, Improving systems of care for CYSCHN, and Implementing Bright Futures guidelines

Universal Adoption of Bright Futures
Location: Georgia
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Category: Cutting Edge

PROGRAM BACKGROUND

On November 1, 2010, the Georgia Department of Community Health (DCH) Division of Medical Assistance Plans adopted the American Academy of Pediatrics (AAP) 2008 Bright Futures Recommendations for Pediatric Health Care periodicity schedule for its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Since the transition to the 2008 Bright Futures periodicity schedule, DCH has adopted the updated periodicity schedules, published in 2014 and 2015.

The EPSDT benefit covers a comprehensive array of preventive, diagnostic, and treatment services for Medicaid-eligible infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). This benefit is also available to the state’s CHIP (PeachCare for Kids®) members from birth up to nineteen (19) years of age. A brochure designed for new members explains the program and states, “This federal benefit allows your child to have services that: keep them healthy; identify signs of poor health; find the causes of poor health; and get treatment for those causes.”

Implementing the 2008 schedule in 2010 allowed the fee-for-service and managed care members and their providers to operate on the same periodicity schedule. To assist with the transition and alignment of the periodicity schedule, the DCH EPSDT program staff revised the EPSDT Provider Manual, which identifies the services and documentation required for each preventive health visit.

STRATEGIC PARTNERS AND COLLABORATIONS

The Performance, Quality and Outcomes Unit of the DCH Division of Medical Assistance Plans (the Unit) contributes quarterly updates as needed to the EPSDT Provider Manual as well as updates to the EPSDT reporting requirements. The Unit executes performance tracking and outcomes monitoring for the DCH managed care and fee-for-service populations relative to the EPSDT program. In order to effectively track and improve the EPSDT program’s performance and outcomes, it is critically important that stakeholders be a part of the conversation. The Unit has a strategic partnership with the Georgia Chapter of the American Academy of Pediatrics (GAAAP). To sustain this partnership, the two communicate at least monthly via conference call.

The monthly conference calls include GAAAP members, representatives from the American Academy of Family Physicians (AAFP), practice managers, and representatives from the managed care organizations (referred to as CMOs in Georgia). The calls focus on compliance with EPSDT policy, quality measurements, and methods to engage providers in quality improvement activities. As an example, during one of the calls, the group discussed the situation whereby providers were not billing for certain screening services provided during the EPSDT preventive health visit. This negatively impacted the calculated screening rates for this quality measurement. The group learned that some providers were unaware of the reimbursement available for the screening services so the GAAAP worked to educate all affiliated pediatric providers about this EPSDT policy. Challenges and the strategies to address them are discussed on the monthly calls and subsequent updates to the EPSDT Provider Manual are made when needed.

In addition to the monthly GAAAP calls, the Unit conducts bi-weekly meetings with representatives from the CMOs, including the chief medical officers and the quality and medical management staff. These meetings include discussions regarding the quarterly EPSDT medical record reviews that are mandatory for the CMOs to conduct. During these record reviews, the CMOs remind providers that documentation of services is critical, and any required procedure or action not recorded will be deemed non-compliant. To assist with the reviews, the CMOs use a medical record review tool created by DCH, which aligns with the Bright Futures schedule. The tool has several components: an overarching summary of the medical record review process; the review tool for the individual providers; a summary review tool; an EPSDT equipment list; and a corrective action plan. When the CMOs identify a provider who is not compliant with the Bright Futures requirements, the provider must complete a corrective action plan and the
CMOs conduct a follow up review with the provider to ensure subsequent compliance.

Measurements, such as the performance measure rates for well child visits, immunizations and developmental screenings, are also discussed during the bi-weekly CMO meetings. The CMOs’ and the DCH statewide Healthcare Effectiveness Data and Information Set (HEDIS) are compared to HEDIS national percentiles. Any measures that fail to meet the desired targets are discussed and strategies to meet the desired outcomes are developed. When providers implement these strategies, they impact all of the populations they serve. As an example, the rates for providers’ documentation of the BMI percentile were low when first measured. Discussions with the CMOs revealed misalignment between the providers’ documentation of the BMI for the EPSDT medical record review and documentation of the BMI for HEDIS measurement. DCH modified the requirements for documentation of the BMI for the medical record review to align with the HEDIS requirements for a related measure and included this change in the EPSDT Provider Manual. As a result, the state saw improvements in the HEDIS BMI performance metric.

HEDIS is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service.

PROGRAM OUTCOMES

Through analysis of the performance metrics, the Unit is able to identify areas of strength and opportunity. For instance, the DCH childhood immunization rate increased significantly over a five year span and is near the target rate while the developmental screening rate, which is improving, is significantly less than the desired target rate. The Unit has also identified improvements in the state’s well-child visit rates and providers’ documentation of counseling parents about appropriate physical activity and nutrition for their children.

The Unit recently collaborated with its external quality review organization (EQRO) to implement rapid-cycle process improvement projects for the CMOs in an effort to spur additional improvements in outcomes. Federal regulations require Medicaid managed care plans to participate in performance improvement projects that are validated by the EQRO. To facilitate the new rapid-cycle process, the EQRO created guidance for the CMOs, which they used when implementing their rapid cycle performance improvement projects focused on Bright Futures. Ongoing technical assistance is provided by the EQRO during the rapid cycle projects. Georgia is one of only two states that received CMS approval to allow their EQRO to use a validation process specific for rapid cycle process improvement projects.

The three CMOs’ rapid cycle projects allow them to test improvement strategies and observe in quick fashion what works and does not work. Using this methodology, interventions are evaluated in real time and decisions whether to adopt, adapt, or abandon the intervention are made within months instead of years, as was the case under the old performance improvement process. Examples of the rapid cycle projects follow.

CMO 1 - partnered with providers to reduce past due well child visits by converting other visit types into in-depth preventative health visits. After implementation of this intervention, the providers and the CMO soon recognized that while there was some flexibility in the providers’ daily schedules, there was insufficient time to consistently convert other visit types into a comprehensive well-child visit. Additionally, seasonal surges in patient volume such as during cold and flu season or the back-to-school rush impacted the providers’ abilities to convert other visits into well-child visits.

CMO 2 - worked with two pilot sites to dedicate special clinic days and times for well-child visits. Although some of the events were scheduled around the local school calendar allowing members to participate without missing school, not all events were scheduled during non-school hours. When the pilot sites identified no-shows, they followed-up with the parents who reported they didn’t see the necessity of a preventative visit every year, and didn’t want to take their children out of school just to see the doctor when they weren’t obviously sick. The CMO recognized that implementing strong health literacy strategies would assist with patient education and wellness promotion.

CMO 3 - implemented member and provider incentives with two provider offices to boost their well child visit rates. Although one provider was eligible for the incentive after meeting the established metrics, overall, the CMO did not see meaningful improvement in the providers’ well child visit rates.

Each of the CMOs will be revisiting their barrier analyses along with the process mapping they previously conducted to better identify the root causes impacting their Bright Futures projects. These analyses will help to ensure the next interventions tested will better align with identified barriers.

PROGRAM ASSOCIATED COSTS

There were no additional costs to implement the 2008 Bright Futures periodicity schedule, however with the adoption of the 2014 and 2015 schedules, there were costs associated with implementing recommended screenings, including reimbursement for newly recommended laboratory screenings. The DCH EPSDT program director and program specialist manage the program and work closely with other agencies and the CMOs.
STRENGTHS and GROWING PAINS

With the adoption of each update to the Bright Futures periodicity schedule, the EPSDT program staff announce the upcoming changes in the EPSDT Provider Manual and allow providers three months to prepare before the change is fully implemented. The changes are discussed with the GAAAP and the CMOs to facilitate consistent adoption across all provider types (managed care and fee-for-service) delivering EPSDT services. The three months of notice also allow the program staff the time needed to confer with other state agencies about the impact the changes will make to their programs and it gives the program staff time to make configuration changes to the Medicaid Management Information System (MMIS) as necessary. As an example, implementation of the 2014 periodicity schedule required collaboration with the Department of Public Health to ensure Critical Congenital Heart Defect screening was added to their newborn screening panel and coding and pricing was updated in the MMIS for HIV screening for children 16 to 18 years of age.

LOOKING AHEAD

The DCH Division of Medical Assistance Plans is working with the Department of Public Health’s Title V program to create a new Title V/Title XIX Memorandum of Understanding (MOU). The two agencies currently have data sharing and other agreements to monitor childhood immunizations and lead screenings – two components of the Bright Futures periodicity schedule. The agencies hope to expand their working relationship through the MOU.

To sustain the universal adoption of Bright Futures and the Bright Futures periodicity schedule, DCH will continue to monitor updates to the schedule and communicate standards and requirements to GAAAP, the CMOs, physicians, and other stakeholders. The state will continue to monitor its performance relative to the Bright Futures program through the use of HEDIS and other performance metrics including the EPSDT medical record reviews.

RESOURCES PROVIDED

Georgia Department of Public Heath EPSDT Manual
Federal EPSDT guidelines
Bright Futures Resources

**For more information about this program please contact:**

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