CHCS

Center for
Health Care Strategies, Inc.

Improving Preventive Care Services for Children

TOOLKIT

Best Clinical and Administrative Practices for Medicaid Health Plans

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A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans

About the Center for Health Care Strategies

The Center for Health Care Strategies promotes high quality health care services for low-income populations and people with chronic illnesses and disabilities. We achieve this objective through awarding grants and providing "real world" training and technical assistance to state purchasers of publicly financed health care, health plans, and consumer groups. Our projects aim to improve access to care, increase the use of effective preventive care services, prevent unnecessary hospitalizations and institutionalizations, promote clinical quality by using accepted standards of care, and build organizational capacity to improve managed care services.

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A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans

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[1] Dr. Glauber was awarded a grant from CHCS to evaluate a single antigen, timeliness immunization measure as an alternative method for measuring immunization performance. Results will be available in mid-2002.

Preface

Best Clinical and Administrative Practices (BCAP) is a five-year, $3.8 million initiative of the Center for Health Care Strategies (CHCS) to improve the quality and cost effectiveness of care provided by health plans serving Medicaid and State Children's Health Insurance Program (SCHIP)* enrollees. The program is funded under a major grant from The Robert Wood Johnson Foundation.

To develop BCAP and clarify the challenges facing Medicaid health plans, CHCS conducted interviews with medical directors and senior quality management staff from plans in 10 states. The interviews revealed that serving Medicaid beneficiaries in managed care often is more challenging than serving Medicare or commercial members. Reasons for this include:

- Unlike Medicare, there are no national purchasing standards for Medicaid, and regulatory environments vary greatly by state.
- Medicaid health plans experience higher member turnover than Medicare or commercial health plans. As many as 10 to 15 percent of Medicaid members disenroll from health plans each month.[2]
- Medicaid members are far less likely than commercial or Medicare members to have stable housing, a reliable mailing address, a telephone, or a long-term relationship with a health care provider.[3]

Because of these obstacles, interventions that are successful in Medicare or commercial populations may not work as well within Medicaid. CHCS created BCAP to respond to these barriers.

BCAP targets key areas for quality improvement, including birth outcomes, preventive care services for children, achieving better care for asthma, children with special health care needs, and adults with chronic illnesses and disabilities. For each topic, BCAP convenes a workgroup of eight to 15 health plan medical directors to develop and pilot best practices. These best practice models are shared with health plans nationwide through workshops and toolkits.

This BCAP workgroup focused on *Improving Preventive Care Services for Children*. Many children do not receive the full scope of preventive services needed to avoid illness and promote wellness. Incomplete immunizations, delays in routine screenings, low participation rates for Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and adolescent access to family planning and behavioral health services all present daily challenges to health plans serving Medicaid members. Assuring that these children have access to preventive care services is a priority for health plans in terms of serving members well, improving health plan finances, and satisfying state regulations and National Committee for Quality Assurance (NCQA) expectations. It is our goal to share the experiences of BCAP to advance the quality of care and improve the health of children served by your health plan.

*Activities in this toolkit relate to both Medicaid and State Children's Health Insurance Program enrollees. To simplify text, Medicaid is used throughout the toolkit to represent both populations.

[2] Health Care Financing Administration. *The Evolution of the Oregon Health Plan: First Interim Report*. Springfield, VA. National Technical Information Service, 1999.

[3] Brodsky K. and Baron R.J. "A 'Best Practices' Strategy to Improve Quality in Medicaid Managed Care Plans." *Journal of Urban Health*, December 2000. 77(4): 593.

How Will This Toolkit Benefit Your Health Plan?

This toolkit offers a structured approach for addressing quality improvement and a collection of "lessons learned" by a diverse group of health plans serving Medicaid members. Whether your health plan intends to develop a new preventive care program or is seeking to improve an existing program, this toolkit offers practical, realistic approaches that can help you:

- Recognize common barriers faced by Medicaid plans in improving preventive care services for children.
- Develop strategies to overcome these barriers.
- Review clinical and administrative strategies that other health plans have implemented.
- Measure incremental and long-term change.

The available literature on clinical preventive practice supports the dictum to "make every visit a preventive visit." Most health plan leaders agree that it is important to develop programs supporting these preventive practices because:

- Children represent 50 percent of Medicaid beneficiaries, making them the largest demographic group in the Medicaid population.[4] In addition, nearly all SCHIP enrollees are children.
- Only about 50 percent of two-year-olds on Medicaid receive the full regimen of immunizations.[5]
- While preventive care service delivery is a problem in both private and public settings, poor children tend to receive less preventive care.
- State and federal Medicaid officials often target preventive care services for children as a quality improvement project.
- Child prevention measures often are used as performance measures in report cards and other consumer materials.
- It is the right thing to do.

How this Toolkit is Organized

This toolkit begins with a brief discussion of the process improvement model used in BCAP. It then presents the "typology for improvement" developed for the *Improving Preventive Care Services for Children* workgroup, followed by an in-depth discussion of the typology categories. For each typology category, an inventory of change strategies is listed, followed by case studies of innovative pilot projects. The next chapter describes methods to improve provider practices in designing more effective preventive care services. The last chapter outlines effective communication tactics to facilitate change. Finally, the Appendices provide sample tools from BCAP workgroup health plans and other relevant materials.

[4] *Kaiser Commission on Medicaid and the Uninsured.* "Health Coverage for Low-Income Children." Factsheet #2144-02, March 2001.

[5] National Committee for Quality Assurance website. National Medicaid Results for Selected 2000 HEDIS and HEDIS/CAHPS Combination 1 immunization rate, www.ncqa.org/Programs/HEDIS/medicaidchildhood00.htm. 2000. National Averages for Commercial HEDIS Measures, www.ncqa.org/Programs/HEDIS/00commavgs.htm.

How this Toolkit was Developed

The contents of this toolkit reflect the experiences of the *Improving Preventive Care Services for Children* workgroup, a group of eight health plans that collaborated to develop and pilot best practices within their own health plans to improve immunizations, well-child visits, and other preventive care services for children. At the initial meeting, the medical directors gathered to review current research, share their own successes and challenges in improving preventive care services, and brainstorm ideas for successful improvement initiatives. After the first meeting, each medical director committed to piloting a series of small-scale quality improvement projects within his or her health plan, examples of which are highlighted throughout this toolkit.

Over the following nine months, health plans met two more times, bringing additional staff members into the initiative for a team approach (plan participants and contact information are listed in Appendix K). Plans with common pilot projects worked together to discuss common barriers and share strategies for overcoming these barriers.

The health plans in the *Improving Preventive Care Services for Children* workgroup continue to refine their BCAP-related quality improvement strategies and actively participate in the BCAP Network (Appendix L), a growing collaboration of health plans joined by the common goal of furthering the quality and cost-efficiencies of Medicaid managed care.

Table 1: Improving Preventive Care Services for Children Workgroup Health Plans

Health Plan	Location	Medical Director Participant	Number of Medicaid/SCHIP Members*
AlohaCare	Hawaii	Richard Banner, MD	30,000
Amerigroup Illinois	Illinois	Prentiss Taylor, MD	39,000
AmeriChoice of Pennsylvania	Pennsylvania	James Mumford, MD	110,000
Blue Cross of California	California	Dawn Wood, MD	733,000
Community Health Network of Connecticut	Connecticut	Elizabeth Smith, MD	41,500
Neighborhood Health Plan of Massachusetts	Massachusetts	James Glauber, MD	109,000
Neighborhood Health Plan of Rhode Island	Rhode Island	Renee Rulin, MD	69,000
The Wellness Plan of Michigan	Michigan	Deloris Baker, MD	130,000
Total Medicaid/SCHIP Membership			***1,261,500***

* Plan estimates as of December 2001.

Measuring for Success: A Process Improvement Strategy

How to Approach Process Improvement

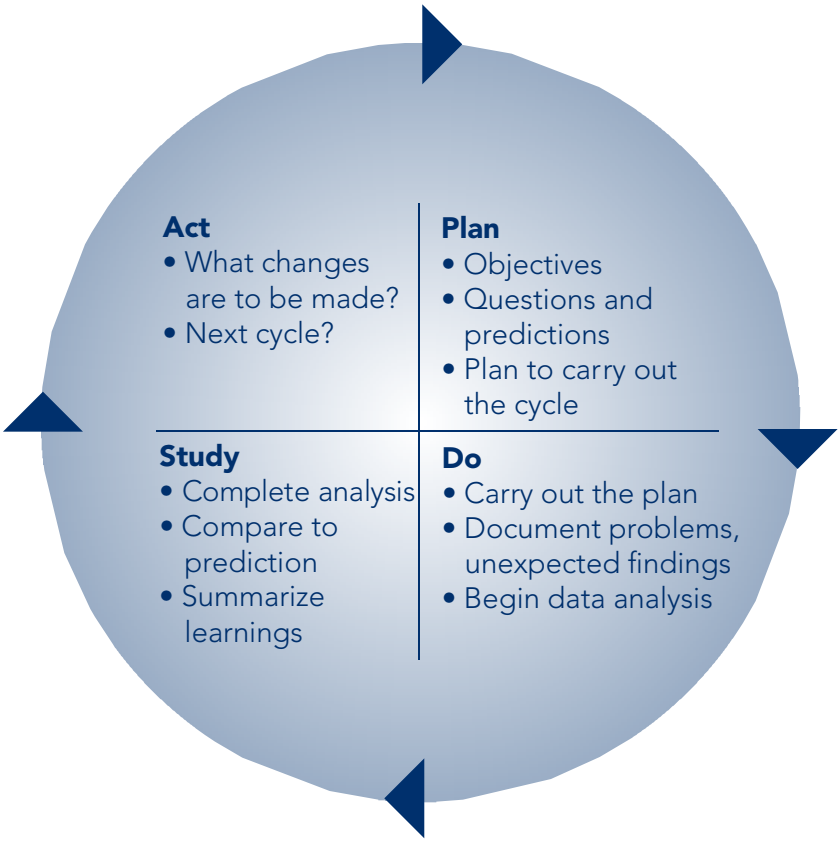
Sustained improvement requires fundamental change in the care-delivery system.[6] Health plans in BCAP are encouraged to test changes for long-term viability using a structured model for improvement. Such models provide guidance and focus for health plans implementing change. They also create a common language and approach that facilitates communication and shared learning within the health plan.

A Brief Guide to The Model for Improvement

There are numerous improvement models used in the managed care industry. All offer a systematic guide for identifying problems and making changes. The Model for Improvement[7] used by the *Improving Preventive Care Services for Children* work-group identifies aim, measure, and change strategies by asking three questions:

AIM	What are we trying to accomplish?
MEASURE	How will we know that a change is an improvement?
CHANGE	What changes can we make that will result in improvement?

These questions are followed by the use of learning cycles to plan and test changes in systems and processes. These are referred to as P-D-S-A (Plan-Do-Study-Act) cycles. The P-D-S-A cycles guide improvement teams through a systematic analysis and improvement process.



[6] Headrick L., Katcher W., Neuhauser D., and McEachern E. "Continuous Quality Improvement and Knowledge for Improvement Applied to Asthma Health Care." *Joint Commission Journal on Quality Improvement*. 1994; 20: 562-568.

[7] Langley G., Nolan K., Nolan T., Norman C., and Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco. Jossey-Bass, 1996.

Step 1: Creating Your Aim Statement

An Aim Statement recognizes a deficiency in an important process or performance measure. It provides a clear goal for your plan's quality improvement team. An effective Aim Statement is clear and specific, and sets "stretch" goals (quantitative targets that are a real reach).

Principles of an Effective Aim Statement

- Write clearly.
- Use specifics.
- Set direction.
- Set numerical goals.
- Set "stretch" or ambitious goals.

Examples of Aim Statements

"Identify 80 percent of all two-year-olds who have not received recommended immunizations."

"Successfully complete 90 percent of all attempts to contact members with children who have overdue immunizations."

Step 2: Creating Measures for Improvement

Process measures will let you know whether your change is having the expected impact, and in some cases, can highlight the cause of unexpected results. These measures provide short-term feedback to evaluate ongoing improvement efforts. Process measures should be a direct reflection of the Aim Statement. Measurement for improvement differs substantially from judgment-based measurement in clinical research.[8] Large amounts of data collected over long periods are rarely required to assess the impact of a change. Small repeated samples collected over time will allow you to document progress toward your aim.

Creating Process Measures

- Seek usefulness, not perfection.
- Use small, repeated samples.
- Measure over time and over a wide range of conditions.
- Include quantitative and qualitative measures.

Linking Measures to Aims

Aim	Measure
"Successfully complete 90 percent of all attempts to contact members with children who are overdue for immunizations."	Numerator: # of successful outreach attempts to members with children who are overdue for immunizations Denominator: total # of members with children who are overdue for immunizations

Establishing a "culture of measurement" within health plans is critical to providing quality, cost-effective care. Most health plans have quality improvement departments responsible for creating initiatives to improve the health care and satisfaction of their enrolled members. Where these initiatives often fall short, however, is in measuring the effectiveness of the implemented approach or improvement. The Health Plan Employer Data and Information Set (HEDIS)[9] guidelines establish outcomes by which health plans measure improvement, but these measures are collected at lengthy intervals and are mainly useful for analyzing long-term trends. Participants have reported that using the Model for Improvement in the BCAP process has helped them create a culture of measurement that focuses on small-scale process improvements within their own organizations.

[8] Solberg L.I., Mosser G., and McDonald S. "The Three Faces of Performance Measurement: Improvement, Accountability, and Research." *The Joint Commission Journal on Quality Improvement*. 1997. 23: 135-147.

[9] HEDIS is a registered trademark of the National Committee for Quality Assurance.

Step 3: Identifying, Planning, and Testing a Change

This toolkit inventories the change strategies tested by the plans in the *Improving Preventive Care Services for Children* workgroup. The workgroup members selected strategies based on the needs of their own organizations. As you review these, consider which aims most closely reflect those of your organization. Then, review the strategies and barriers listed to determine which are best suited for your health plan. Test selected changes on a small scale, review measures, make adjustments, and measure again. Repeat the cycle until you are satisfied with the results.

As you plan to test a change, specify the "who, what, where, and when," so that all project staff know their roles clearly. Careful planning will foster successful implementation. Be sure to plan for appropriate **training** and **communication** when you "go live" with the change. Use an "Improvement Documentation Form" (Appendix A) to help with planning the change.

Why Test a Change?

- Document magnitude of expected improvement.
- Opportunity for "failure" without having an impact on performance.
- Evaluate "side effects" of change.
- Learn how to adapt the change to your local setting.
- Minimize resistance on full implementation.

Key Principles for Testing a Change

- Start small.
- Use volunteers.
- Don't worry about full buy-in.
- Plan multiple cycles to test and adapt change.

The improvement strategies documented in this toolkit are not "one-size-fits-all." Running testing cycles before full implementation offers a safe way to try something new and make modifications, while minimizing resource use and impact on the organization.

Measuring in Common: Highlighting Trends Over Time

Health plans participating in the *Improving Preventive Care Services for Children* workgroup agreed to collect a common set of measures to reflect the progress of the initiative on a broader scale. The shared measures included HEDIS measures as well as one additional measure. The purpose of collecting common measures is to document improvement and to show how each plan is improving from its own baseline. These measures provide a common metric for health plans in the BCAP workgroup to track progress. They also express a consensus judgment about which measures are broadly useful and more likely to be meaningful in a variety of settings.

What Common Measures **Are Not**

Market variations, carve-outs, population differences, physician practice patterns, and plan design may vary significantly among health plans. Common measures are not intended for comparisons of health plan performance, but rather to highlight improvement trends within each health plan.

Collecting BCAP Workgroup Measures

We encourage you to identify a number of key measures within Table 2 that will allow you to track the overall success of your improvement initiative, in addition to measuring the effects of individual changes. The measures are useful for documenting improvements to compare to your baseline levels.

Table 2: BCAP Workgroup Common Measures to Improve Preventive Care Services for Children

Measure	Source	Description
Childhood Immunization Status	HEDIS	The percentage of enrolled children who turned two-years-old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthday, who were identified as having four DPT/DtaP, three IPV/OPV, one MMR, two H influenza type b, three hepatitis B, and one chicken pox vaccine by the second birthday.
Adolescent Immunization Status	HEDIS	The percentage of enrolled adolescents who turned 13 during the measurement year, were continuously enrolled for 12 months immediately preceding their 13th birthday, and who were identified as having had a second dose of MMR, three hepatitis B, and one VZV by their 13th birthday.
Children's Access to Primary Care Practitioners	HEDIS	The percentage of enrollees age 12 months through 24 months, 25 months through six years, and seven years through 11 years who had a visit with a health plan primary care practitioner. Health plans report the percentage of children who have had a visit with a health plan primary care practitioner during the measurement year and prior to the year.
Well-Child Visits in the First 15 Months of Life	HEDIS	The percentage of enrolled members who turned 15-months-old during the measurement year, who were continuously enrolled in the health plan from 31 days of age, and who received either zero, one, two, three, four, five, six, or more well-child visits with a primary care practitioner during their first 15 months of life.
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	HEDIS	The percentage of members who were three-, four-, five-, or six-years-old during the measurement year, who were continuously enrolled during the measurement year, and who received one or more well-child visits with a primary care practitioner during the measurement year.
Adolescent Well-Care Visits	HEDIS	The percentage of enrolled members who were age 12 through 21 years during the measurement year, who were continuously enrolled during the measurement year, and who have had at least one comprehensive well-care visit with a primary care practitioner or an obstetric/gynecologist practitioner during the measurement year.
Outreach Response Rate[10]	BCAP Workgroup	# of responses to an outreach activity / # of outreach attempts

[10] Individual plans can adjust this measurement to meet the needs of their own particular outreach strategies.

A Typology for Improvement

CHCS developed a "Typology for Improvement" to classify health plans' activities in designing quality initiatives. The four-step classification system addresses barriers commonly faced by health plans serving Medicaid beneficiaries. The model was developed based on interviews with health plan medical directors and quality improvement directors in 10 states. Participating health plans have found the structure of the typology useful in considering strategies for improvement. It offers a template for approaching quality initiatives that can be customized for a variety of clinical quality improvement projects.

Typology Category	Description
Identification	How do you identify the relevant population?
Stratification	How do you assign risk within that population?
Outreach	How do you reach the target population?
Intervention	What works to improve outcomes?

Applying the Typology Toward Improving Preventive Care Services for Children

▶ **Identification** Identification of your target population is the first step toward assuring that critical services are delivered in a timely manner. Action items to improve identification include:

- Examining the current tools the health plan uses to identify children in need of preventive services.
- Identifying when a child is due, or overdue, for a preventive service.

Health plans that invest in improving their identification systems are in a better position to target outreach and intervention services to those children most in need of preventive services.

▶ **Stratification** Once the health plan has identified children in need of preventive services, how does it determine which members are most at risk? Health plans need to determine which services members have already received and what they currently need. Examples of data sources to help plans determine this include:

- Claims.
- Immunization registry.
- Chart audits.
- Vaccines for Children (VFC) programs.[11]
- Laboratory data.
- Lead screening test results.
- EPSDT forms received.

[11] Vaccines for Children is a federally-sponsored program to deliver free vaccines to children.

- **Outreach** Ongoing outreach efforts must be in place to ensure that members have access to appropriate services and adhere to immunization schedules and other preventive care guidelines. Health plans must evaluate:

  - How does the health plan reach its members?
  - Does the health plan make regular calls to members?
  - Does the plan have a home visiting program, or a school/community presence?

- **Intervention** Once the health plan has identified a child in need of preventive services, determined what services are needed, contacted the child's family, and encouraged the child's parents to bring him or her in for care, what services does the plan actually offer? What investments is the health plan prepared to make in improving the capacity of its network to deliver preventive services consistently and reliably? This question may be easy to answer for some preventive services (e.g., immunizations), but less clear for others (e.g., lead abatement or adolescent mental health services). Questions to consider include:

  - What programs are available to children who present with particular risk factors?
  - Are these programs cost effective?
  - Does the health plan offer incentives to encourage them to receive ongoing preventive care?
  - Do children and their families use the services and find them valuable?
  - What is the plan's strategy for working with its provider network?
  - Can the plan document improvements in health outcomes as a result of these programs?

While this typology is useful for organizing tactics into a systematic strategy, there also can be overlap between typology categories. A successful effort to improve identification, for example, can promote activities in stratification, outreach, and intervention. This toolkit is meant as a guide to help organize ideas, but also is designed to allow flexibility for creative planning and design of new initiatives.

In this BCAP workgroup, most health plans found it effective to merge the identification and stratification components of the typology, especially if their focus was immunizations. For instance, identifying the population of three-year-olds was not a major problem for plans, but identifying three-year-olds with incomplete immunizations (requiring the health plan to stratify their three-year-old members by knowing each child's immunization record) was the more challenging task. Thus, identification and stratification activities are presented together in the next chapter.

Identification and Stratification

How can a Plan Effectively Identify and Stratify Children at Risk?

By identifying children in need of preventive services, health plans can address risk factors through outreach and intervention strategies. State and federal regulators often use guidelines such as EPSDT or HEDIS to evaluate a health plan's effectiveness in providing preventive care services within a specified timeframe. Therefore, it is important both from a public health perspective and from a regulatory perspective to identify children in need of services as early as possible.

Stratification allows a plan to determine which subpopulations of children are most at risk of not receiving preventive care services. This process also assists the plan in determining which children could benefit from enhanced outreach services that will encourage them to seek care. Chart reviews, member welcome calls, and enrollment broker data can be used to assess members who have children in need of specific preventive care services.

Tapping Data Sources for Identification and Stratification

To identify and stratify children in need of preventive care services, health plans must assess all available sources of information. Plan data systems and information sources might allow the plan to get basic demographic information, but may not provide detailed data that will help the plan more effectively target limited resources. Some target populations are fairly easy to isolate, others are more difficult to identify, for example:

Easy:	All three-year-olds in health plan.
Harder:	All children less than age two, including newborns.
Harder:	All Southeast Asians age 2-18.
Harder:	All children living in a "lead hot spot" census tract.

A variety of sources are used by many health plans to identify children in need of preventive care services. Examples of common sources of data and the pitfalls of using these data are listed in Table 3. BCAP workgroup participants found that to improve identification and stratification of children in need of preventive services, they either needed to use the data in new ways or consider alternative sources of information.

Table 3: Common Sources of Data for Identification

Source of Data	Common Barriers
Provider Reporting	Inconsistent and untimely.
Member Reporting	Intermittent at best.
Lab Data Analysis	Multiple lab contracts means data are scattered; confidentiality barriers in releasing lab results.
Claims or Encounter Data	Find out after member has received service and does not identify children in need of services. Plan may not receive data if child received services from VFC programs or county health departments.
Enrollment Brokers	Untimely reporting about new enrollees.
Risk Assessment Forms	Standard risk assessment forms used by health plans and providers may not capture relevant risk factors for preventive health services.

Strategies to Identify and Stratify Children in Need of Preventive Care Services

Provider Reporting

- Meet with high-volume providers to enhance relationship between plan and providers, to review the importance of complete immunization records, and to develop workable reporting procedures.
- Offer or enhance provider incentives to submit immunization or well-child visit notification.
- Collaborate with other plans in your region to develop a common reporting process.
- Consider revising reimbursement from capitation rates to fee-for-service for key preventive services.
- Perform chart reviews for "missed opportunities."
- Stratify providers by specialty, practice affiliation, and number of members to evaluate variations in practice patterns and create a profiling system.
- Offer provider incentives or tools to screen children for specific risk factors (e.g., immunization status, missed well-child visits, depression, smoking, sexual activity).
- Standardize health risk assessment tools across health plan providers.
- Work with other health plans in service area to standardize health risk assessment tools to improve provider reporting.

Member Reporting

- Add a question about immunization status and other standard well-child care needs to any welcome calls made to new members.
- Provide an online or voice-activated risk assessment to members who call the health plan or visit the health plan website.

Lab Claims Data

- Data mining of lab data for lead screening tests.

Medical Claims or Encounter Data

- Use claims data systems to identify children who have not received immunizations and other well-child services.
- Use claims data systems to identify recent deliveries and/or prenatal care services to proactively identify infants and toddlers.
- Evaluate computer systems to coordinate all systems that capture preventive care service information.

Enrollment Data

- Work with enrollment broker to receive enrollment forms earlier.
- Work with enrollment broker to make sure initial screening includes questions about immunization status and need for other preventive services.
- Use monthly enrollment tapes to evaluate demographics of population and determine number of children by age category.

Other Sources of Data

- Use birth certificate data and link to health plan data to identify all newborns in health plan.
- Assign an identification number to unborn children of pregnant members to expedite the identification of newborns.
- Compare membership data to claims data to identify children who have not seen a provider for services.
- Identify children in need of particular services through a "missed opportunity" report.
- Compare health plan internal data with external sources such as an immunization registry or a Vaccines for Children program list.
- Use GEOAccess and Map coding (most appropriate for lead screening).
- Participate in immunization registries in the area.

Maximize Data from Health Risk Assessment Forms

Health risk assessment forms are a common tool that health plans use to flag members with specific risk factors or who may need certain services. Health risk assessment forms also can help health plans target resources toward children most at risk of not receiving important preventive care services. Following are methods to maximize the use of health risk assessment data.

- Establish a process to evaluate data and determine appropriate follow up.
- Designate one department within the health plan for data collection and distribution.
- Standardize health risk assessment tools across health plan departments (e.g., member services, case management).
- Develop a decision tool to highlight members with modifiable risk factors.
- Use risk assessment forms, claims, and encounter data to stratify members for potential risk factors and/or cultural barriers:
    - First-time parents.
    - Ethnicity.
    - Medicaid eligibility category.
    - Language spoken at home.
    - Premature birth.
    - Other children at home with inadequate preventive care.
    - Census tract to evaluate lead exposure in the home.
    - Homelessness.
    - Teenage mother.
    - Foster child.

Health Plan Case Studies

The Wellness Plan: Identification and Stratification of Children by Immunization Status

BACKGROUND: The Wellness Plan is a non-profit health plan in Michigan with 130,000 Medicaid enrollees. For its BCAP project, the health plan wanted to better identify immunized children and decrease the administrative costs associated with collection of immunization data for HEDIS.

OVERALL AIM: Increase The Wellness Plan's immunization rate for two-year-olds from 43 percent in 2000 to 80 percent by 2004.

IDENTIFICATION-STRATIFICATION AIM: Identify 100 percent of The Wellness Plan's 12-18-month-old members and stratify them by immunization status. Determine the accuracy of health plan data by following up with provider and parent verification of immunization status.

MEASURE: $\frac{\text{\# of two-year-old members} - \text{\# of two-year-old members not fully immunized}}{\text{\# of two-year-old members}}$

CHANGE: The Wellness Plan's administrative data identified only 0.44 percent of children with complete immunizations by age two. To update plan records on member immunization status, the plan implemented a cross-referencing system that evaluates whether:

- The member has been assigned to more than one primary care provider while enrolled in the health plan.
- The member has more than one member identification number.
- The assigned practice has more than one practice site and/or more than one medical record per member.
- The member has duplicate insurance and has had no encounters with The Wellness Plan.

Once members were cross referenced in the system, letters were sent to providers with lists of the providers' members and their immunization status. Providers were asked to submit revised documentation if the immunization status listed was incorrect. Letters also were sent to members asking parents to review their child's immunization records and to contact the child's provider for an appointment if immunizations were missing.

RESULTS/LESSONS LEARNED: Using the cross-referencing system, The Wellness Plan increased the number of two-year-olds with complete immunization records captured by the health plan's administrative data from .44 percent to 17 percent. The Wellness Plan then identified remaining children with incomplete immunizations and contacted the child's parent and/or primary care provider. The plan received a significant response from providers and parents who submitted updated immunization information and/or scheduled well-child visits. Overall, The Wellness Plan achieved a nine percentage point increase in its HEDIS immunization rates between 2000 and 2001 (from 43 percent to 52 percent).

AlohaCare: Assign Temporary Identification Numbers to Newborns

BACKGROUND: AlohaCare is a private, non-profit, Medicaid-only, community health center-based plan with 30,000 Medicaid enrollees. AlohaCare is based in Honolulu, Hawaii.

OVERALL AIM: Reduce by 50 percent the number of newborns receiving no preventive services by 15 months of age by July 2002.

IDENTIFICATION AIM: Beginning January 2001, identify 100 percent of births with the use of temporary identification (ID) number in the health plan information system prior to birth.

MEASURE: $\frac{\text{\# of prospective newborns assigned a temporary ID number prior to birth}}{\text{\# of deliveries included in health plan's study population}}$

CHANGE: Every prospective newborn is assigned a temporary ID number from the date that the provider requests authorization for prenatal services. If the temporary ID number is not assigned prior to birth, it is assigned by AlohaCare staff at delivery. The temporary ID is derived from the mother's identification number, using alpha prefixes to indicate Baby Boy or Baby Girl, with a third letter A or B to indicate twins, etc.

RESULTS/LESSONS LEARNED: From January through June 2001, AlohaCare assigned a temporary ID number to 63 percent of prospective newborns (286 out of 453 births). AlohaCare underestimated the difficulties in modifying its information system to accommodate the temporary ID number for prospective newborns. To overcome this barrier, AlohaCare integrated EPSDT or other utilization data from the main health plan data system into a separate database for newborn tracking. (See Appendix B for ACCESS database template).

AmeriChoice of Pennsylvania: Identify Immunization "Missed Opportunities"

BACKGROUND: AmeriChoice of Pennsylvania is a for-profit network model health plan, with 110,000 Medicaid enrollees in the five-county Philadelphia area.

OVERALL AIM: To reduce the average number of "missed opportunities" per child in the first two years of life by 25 percent.

STRATIFICATION AIM: Alter the office procedures of all high-volume primary care practitioners (PCPs) (>100 panel members) to demonstrate a significant decrease in overall "missed opportunities."

MEASURE:

$$\frac{\text{\# of acute visits in high-volume PCP practices where immunizations were not delivered}}{\text{total \# of acute visits in high-volume PCP practices}}$$

CHANGES:

1. AmeriChoice of Pennsylvania developed a "missed opportunity" letter (Appendix C) that included the total number of visits to the PCP, visit dates where no immunizations were given, and date ranges where immunizations should have been given, but were not, and visit dates where immunizations were provided. These letters were sent to high-volume PCPs to notify them of possible opportunities missed to complete immunizations. AmeriChoice provided a stamped postcard for PCPs to send back as notification that they received the letter.
2. Performed a medical record review on all two-year-olds for high-volume PCPs.

RESULTS/LESSONS LEARNED: Through its "missed opportunity" letter, AmeriChoice found a "missed opportunity" rate of 54 percent. To evaluate the validity of the "missed opportunity" letter, AmeriChoice staff visited 19 high-volume pediatricians and reviewed 95 member records. This process resulted in an actual "missed opportunity" rate of 15.8 percent, leading AmeriChoice to conclude that the true problem was physician reporting. AmeriChoice addressed poor physician reporting by implementing the following activities:

1. Direct incentives for submission of encounter data.
2. Financial incentives for EPSDT encounters.
3. Bonus structure for high-volume PCPs based on increases in preventive health visits and increases in status on physician profiling report. AmeriChoice is monitoring encounter data for these PCPs and results will be available in Summer 2002.
4. Changed from a capitated arrangement to fee-for-service with one high-volume physician practice.

AmeriChoice health plans in New York City and New Jersey have implemented "missed opportunity" letters and have uncovered similar issues with inadequate physician reporting. These plans also revised the bonus structures for their high-volume PCPs.

Health Plan Action Steps for Identification and Stratification

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of children identified as lacking appropriate preventive care. For example: *Identify 100 percent of children age 0-12 who live in a lead "hot spot."*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in lead poisoning) and develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:

# of children age 0-12 in the health plan identified as living in a lead "hot-spot"
# of children age 0-12 in the health plan

Change:

Evaluate current methods of identification and/or stratification. Evaluate change strategies that will effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Outreach

How does a plan reach families to encourage the use of preventive care services?

After members have been identified and stratified by risk level, health plans need effective ways to contact members and encourage their use of appropriate health services. Outreach to the Medicaid population is particularly challenging for the following reasons:

- Medicaid members tend to move frequently and addresses provided by the state and/or kept by the health plan are often out of date.
- Members may distrust health plan efforts to assist them.
- Members may feel that if their child is not sick, a doctor's visit is not necessary.
- Cultural, linguistic, and literacy barriers may be present.

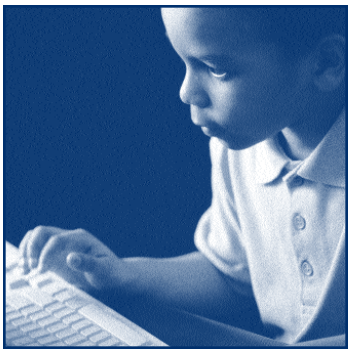
Health plan activities that are often used to reach out to members in need of preventive care services and some barriers to their success are listed in Table 4.

Table 4: Common Outreach Strategies

Strategy	Barriers
Telephone Calls to Members	• Phone numbers for Medicaid enrollees often are inaccurate. In some markets, many low-income households do not have a phone line.[12] • Cultural competency and language barriers need to be addressed.
Mailings to Promote Preventive Care Services	• Medicaid members tend to move more frequently than commercial enrollees. • Mailing addresses are frequently out of date. • Literacy issues also should be considered.
Home Visits by Community Outreach Workers	• Home visitors may find it difficult to find members and, once found, may not have success convincing them to bring children in for services. • Plans may have problems recruiting staff willing to visit inner city or remote rural areas.
Mobile Vans/Community Presence	• Need to determine how many of health plan's enrollees – as opposed to the overall community – will benefit from this service.

Successful health plan outreach efforts identify what members need or value. Health plans might link outreach services to risk factors identified in the health plan's stratification efforts. If a child consistently misses scheduled well-child appointments, a review of her file may reveal that her family has inadequate access to transportation. A health plan also may want to review its auto-assignment policy to make sure that children in the same family are assigned the same pediatric provider or practice. An outreach program designed to help members with social service needs (e.g., housing, transportation, child care) may be more effective in getting children in for care than one focusing solely on clinical care improvements.

[12] BCAP workgroup health plans noted phone number inaccuracy in the range of 30-70 percent.



Strategies to Improve Outreach to Promote Preventive Care Services for Children

Provider Outreach Strategies

- Offer financial incentives to providers for immunizations and other well-child visits.
- Offer financial incentives to provider office staff to schedule well-child visits and remind members and their parents about upcoming appointments.
- Notify providers of data integrity and deficiency issues and help troubleshoot, when possible.
- Conduct face-to-face performance reviews with high-volume providers.
- Provide incentives for increasing reported encounters – profile around a bell-curve and target those on the low end of curve.
- Reward and recognize providers with high immunization or other preventive care service rates.
- "Unbundle" preventive services from regular capitation, both for incentive and for data acquisition purposes.

Member Outreach Strategies

- Distribute topical brochures to families (e.g., screening for Attention-Deficit/Hyperactivity Disorder).
- Send targeted reminders to families at key immunization intervals: newborn, one year, and 18 months.
- Conduct targeted mailings to families with incomplete immunization records.
- Conduct targeted mailings to families with refrigerator magnets that remind them of immunization schedules.
- Remind incoming callers about the importance of up-to-date preventive care services for children.
- Ask incoming callers if their children have up-to-date immunizations.
- Conduct welcome calls to every new plan member that include a prevention message.
- Develop outreach programs targeted at grandparents and other relatives who may play a key care-taking role.
- Maintain up to four alternative addresses and telephone numbers (e.g., grandparents, siblings, cousins) for each member to increase the chances of contacting members during outreach efforts.

Community or Vendor Outreach Strategies

- Work with churches, synagogues, and mosques to assist with outreach and to host health fairs.
- Contract with public health departments to provide outreach.
- Work with school nurses or school-based health centers at schools with high numbers of Medicaid or SCHIP enrollees.
- Partner with community agencies such as Women, Infants, and Children (WIC) to coordinate delivery of preventive care services for children.[13]
- Contract with enrollment broker to perform initial preventive care service screening for all new enrollees.

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[13] Bell K.N. *WIC and Managed Care: A Resource Guide Executive Summary*. Center for Health Care Strategies. August 2001.

Health Plan Case Studies

Community Health Network of Connecticut: Engaging Teenagers in Preventive Health Services

BACKGROUND: The Community Health Network of Connecticut (CHNCT) is a non-profit, federally qualified health center (FQHC)-based health plan with 41,500 Medicaid enrollees. For its BCAP pilot project, CHNCT worked with one of its FQHC owners, Generations Family Health Center, to improve adolescent participation in EPSDT.

OVERALL AIM: Improve CHNCT's overall EPSDT participation ratio from 66 percent in 2000 to 80 percent in 2001.

OUTREACH AIM: Notify 100 percent of enrolled adolescents age 15-20 at Generations Family Health Center of the incentive available for scheduling and keeping an appointment for an EPSDT screening.

MEASURES: $\frac{\text{\# of eligible members successfully contacted}}{\text{\# of members due or overdue}}$

$\frac{\text{\# of eligible members who scheduled and kept appointments}}{\text{\# of members due or overdue}}$

CHANGE: Letters were mailed to eligible members notifying them that they would receive free movie tickets if they scheduled and kept an appointment for an EPSDT screen at Generations Family Health Center.

RESULTS/LESSONS LEARNED: CHNCT was able to raise its EPSDT rates by 11.8 percentage points at this site. Results from this pilot project are listed in Tables 5 and 6. Lessons learned from this pilot project include:

1. Member contact information on state eligibility tapes often was incorrect. CHNCT convinced state officials to accept address changes from health plans, rather than requiring that the information come directly from members.
2. It was difficult for some members to take advantage of the movie tickets given their rural location. This also was evident by the fact that the outreach program was more successful among 19-20-year-olds than 15-18-year-olds (22.3 percentage point improvement vs. 8.8 percentage point improvement). Older teens are more likely to have cars and therefore take advantage of the movie tickets.
3. CHNCT launched a pilot project in another site and modified the incentive program to target office staff. Discussion of this pilot project is included in the Intervention section of this toolkit.

Table 5: Total Number of EPSDT Appointments Kept Due to CHNCT Outreach

	Total # of Children	Total who Received EPSDT
Total Overdue for Appointment	60	7 (12%)
Total Due for Appointment	32	2 (6%)
Overall	92	9 (10%)

Table 6: EPSDT Participation Rate for Eligible Members: Improvement From Prior Year

	EPSDT Participation Ratio		
Age Groups	15-18	19-20	15-20
2/1/00 - 4/30/00	24.2%	32.2%	25.9%
2/1/01 - 4/30/01	33.0%	54.5%	37.7%
Percentage Point Improvement	8.8%	22.3%	11.8%

Neighborhood Health Plan of Massachusetts: Reminder Strategy to Boost Immunizations

BACKGROUND: Neighborhood Health Plan (NHP) of Massachusetts is a non-profit, community health center-based plan with 109,000 Medicaid lives.

OVERALL AIM: Improve HEDIS immunization scores for two-year-olds from 72 percent in 1999 to 93 percent by 2003.

OUTREACH AIM: To promote timely age appropriate immunizations with all NHP parents of 18-month-olds.

MEASURES: $\frac{\text{\# of children with up-to-date immunizations at 24 months of age}}{\text{total \# of members who are 24 months of age}}$

$\frac{\text{\# of parents who verified their child's immunization record}}{\text{\# of parents surveyed}}$

CHANGE: Send monthly immunization reminder letter in English or Spanish to parents of 18-month-olds.

RESULTS/LESSONS LEARNED: Since Massachusetts is a universal vaccine purchase state, NHP does not have complete immunization data internally. In order to identify under-immunized children, NHP used data from a study by the University of Massachusetts as the baseline for the plan's improvement initiative. This data showed that the typical two-year-old who was deficient in immunizations by HEDIS criteria had experienced almost 10 missed opportunities and that fully immunized two-year-olds experienced as many as eight late immunizations. NHP then sent reminder letters to all parents of 18-month-olds to encourage parents to bring children in to complete immunizations by age two. Lessons learned from this pilot project include:

1. Contact information was inaccurate for many health plan members. Approximately 350 letters are mailed monthly of which 25-30 percent are returned because of incorrect addresses. Member services flags the returned address in the system to notify health plan personnel to request updates if the member contacts the plan.
2. Neighborhood Health Plan conducted a phone survey of parents receiving the letter to see if parents found the letter helpful. Thirty-four parents were successfully contacted. Of the 21 who received the letter, 19 (90 percent) followed through by verifying their child's immunization status.
3. Neighborhood Health Plan expanded its targeted reminder letter strategy to parents of eight-month-old infants as a proactive strategy. Targeting parents of children at eight months of age and again at 18 months of age increases the likelihood that parents will be reached and immunizations will be completed on time. Refrigerator magnets (Appendix D) are sent with the letter to remind these parents of immunizations needed prior to age two.

AlohaCare: Encouraging Mothers to Choose a Provider for Newborns Prior to Delivery

BACKGROUND: AlohaCare is a non-profit, Medicaid-only, community health center-based plan with 30,000 enrollees. AlohaCare is based in Honolulu, Hawaii.

OVERALL AIM: Reduce by 50 percent the number of newborns receiving no preventive services by 15 months of age by July 2002.

OUTREACH AIM: To have 100 percent of prospective mothers select a primary care provider for their newborn prior to delivery.

MEASURES:

$$\frac{\text{\# of mothers who selected a PCP prior to delivery}}{\text{\# of deliveries in health plan's study population}}$$

$$\frac{\text{\# of newborns with a PCP prior to age one month}}{\text{\# of newborns in health plan's study population}}$$

CHANGES:

1. AlohaCare promoted the "Keiki Health Connection" to enhance the relationship between "keikis" (children in Hawaiian) and providers and increase well-child visits and preventive care. The health plan's global authorization form has a section for updating both obstetric and potential pediatric risk factors (Appendix E). AlohaCare uses mail, phone, and fax to promote the plan's initiatives to providers.
2. When the mother's prenatal provider requests authorization for services, AlohaCare staff reminds them to encourage mothers to select a PCP for the baby.
3. A Maternity Packet is sent to all expectant mothers encouraging them to select a PCP for their baby.
4. At eight weeks prior to Expected Date of Confinement (EDC), health plan staff faxes a letter to prenatal providers who have not submitted newborn PCP selection or risk factor information.
5. At four weeks prior to EDC, the health plan calls prenatal providers who have not submitted requested information.

RESULTS/LESSONS LEARNED: From January through June 2001, AlohaCare gathered baseline statistics and found that 10 percent of deliveries occurred with prior PCP selection. In addition, approximately 18 percent of newborns had a PCP prior to one month of age. For the time period July-November 2001, AlohaCare found the number of deliveries with prior PCP selection increased to 14 percent and the number of newborns with a PCP prior to one month of age increased to 21 percent.

Health Plan Action Steps for Outreach

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
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_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of members and/or providers the health plan contacts. For example: *Increase health plan visits to providers with low immunization rates from 20 to 50 percent within one year.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in immunization preventable diseases) and develop measures that link directly to your Aim Statement. For example:

$$\frac{\textit{\# of providers with low immunization rates visited by health plan}}{\textit{total \# of providers with low immunization rates}}$$

Change:

Evaluate current outreach methods and evaluate change strategies that will most effectively fulfill your Aim Statement. To help you brainstorm, an inventory of change strategies is included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Intervention

What activities can health plans implement to improve the delivery of preventive care services?

What works to improve outcomes? Clearly, there is evidence that preventive care services such as immunizations can prevent illness. Other preventive care services, such as depression screening in adolescents, can identify key health issues before they reach a crisis stage. What is challenging with the Medicaid population is both finding members and then getting them in for care.

An assumption of all plans in the *Improving Preventive Care Services for Children* workgroup is that there are interventions that can make a difference, and plans tended to focus on increasing capacity in provider offices to improve delivery of preventive care services. While this chapter provides examples of interventions tried by BCAP workgroup members, many of the activities piloted in identification, stratification, and outreach also led to an increase in health plan interventions. (For example, The Wellness Plan's efforts to stratify children by immunization status resulted in families calling providers to schedule missed immunizations).

Health plan activities to improve preventive care services and some barriers to their success are listed in Table 7.

Table 7: Common Interventions in Preventive Care and Potential Barriers

Intervention	Barriers
Comprehensive evaluations, such as EPSDT	• Many Medicaid beneficiaries do not schedule routine visits that allow for lengthy, time-consuming assessments.
Follow up for members who drop out of care	• Many provider offices that serve primarily Medicaid beneficiaries may function without appointment systems or have no routine procedures for missed appointments.
Reminder calls for scheduled appointments	• The health plan may have incorrect phone numbers and some members may not have telephones. Language and cultural barriers are more common in Medicaid populations than among commercial members.
Building provider capacity to "make every visit a preventive visit"	• Getting providers' attention in a complex and heterogeneous market place is challenging.

Strategies for Interventions to Promote Preventive Care Services for Children
✓ Provide incentives to members, such as free toddler car seats or gift certificates for completed preventive care.
✓ Solicit local businesses and non-profits to provide donations to use for physician and member incentives.
✓ Link provider compensation to measured delivery of preventive services or to documented adoption of plan-sponsored preventive care office systems.
✓ Educate physician office staff on immunization practices.
✓ Assign quality management nurses to monitor high-volume provider sites.
✓ Help providers establish a recall/reminder system (e.g., patient letters, recall toolbox that includes file stickers encouraging providers to check immunization status).
✓ Screen and promote a tool for minimizing missed opportunities.
✓ Educate providers on solutions to missed opportunities (e.g., screen child AND siblings at urgent care visits).
✓ Provide incentives to providers to improve physician reporting of preventive services.
✓ Create a family medical record.
✓ Facilitate coordinated transition between obstetric providers and pediatricians.
✓ Encourage provider practices to adopt open/advanced access appointment scheduling policies.[14]
✓ Help provider offices implement office tracking systems.
✓ Support development of registries.

[14] Kilo C. M.D. "Open Access in Clinical Office Settings: Benefits and Challenges." BCAP Network Exchange Call Summary. Center for Health Care Strategies Resource Center, www.chcs.org.

Health Plan Case Studies

Neighborhood Health Plan of Rhode Island: Courting Adolescents for Comprehensive Physicals

BACKGROUND: Neighborhood Health Plan of Rhode Island (NHPRI) is a non-profit, community health center-based, network model health plan with 69,000 Medicaid members. For its BCAP pilot project, the plan focused on improving the rate of adolescent well-child visits. NHPRI worked with Thundermist Health Associates, the health plan's community health center partner in Woonsocket, RI. Thundermist sponsors several school-based health centers (SBHC) in the area. Prior to this intervention, only 19 percent (72/386) of the eligible student population at Thundermist Health Associates received a complete physical exam (CPE).

OVERALL AIM: To improve the HEDIS "Adolescent Well-Care Visit" score for the entire NHPRI adolescent population from 53 percent in 2000 to 75 percent by 2005.

INTERVENTION AIM: Increase the number of 13-16-year-olds who are enrolled at a school-based health center by 50 percent. Raise the number of eligible 13-16-year-olds who receive a CPE at a school-based health center from 19 percent to 50 percent.

MEASURES:

$$\frac{\text{\# of 13-16 year old NHPRI/Thundermist members newly enrolled at SBHC}}{\text{\# of 13-16 year old NHPRI/Thundermist members currently enrolled}}$$

$$\frac{\text{\# of 13-16 year old NHPRI/Thundermist members who receive a CPE}}{\text{\# of 13-16 year old NHPRI/Thundermist members (both current and new)}}$$

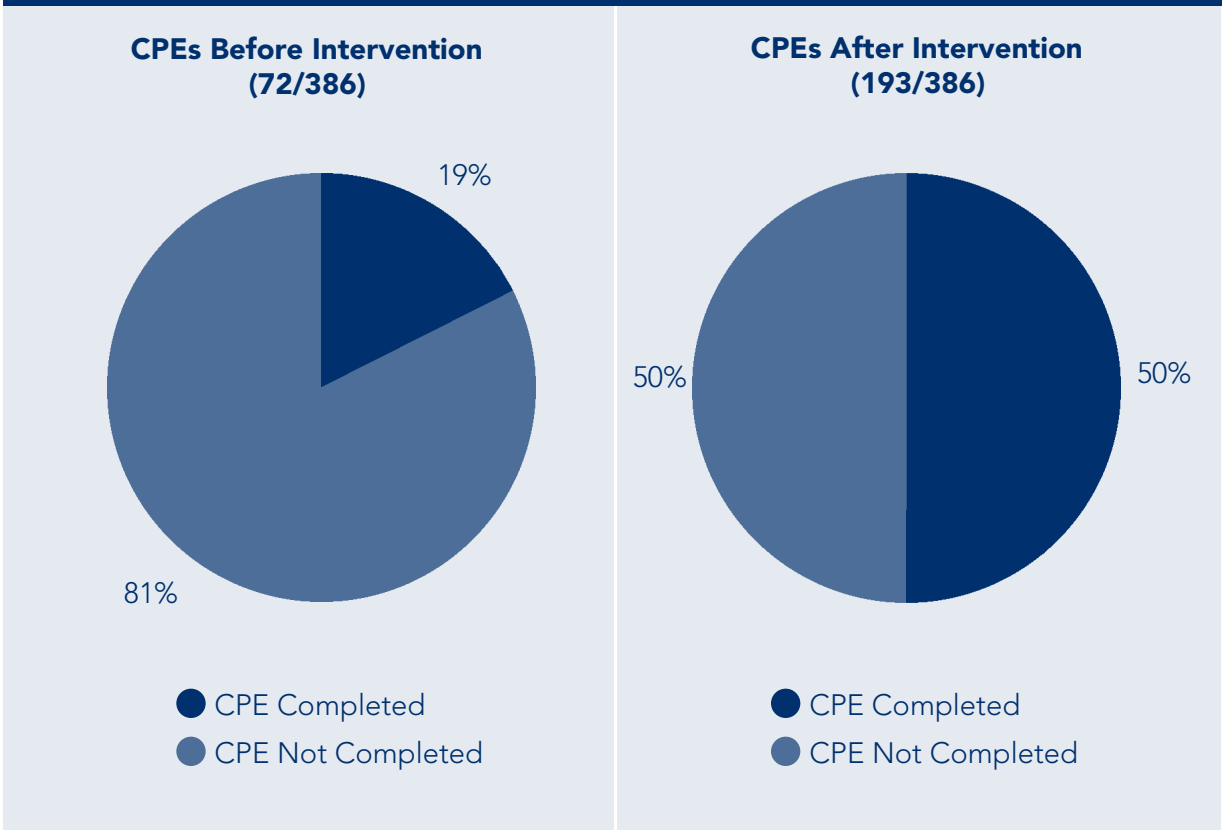
CHANGES:

1. Students who scheduled and kept a CPE appointment received a $10 gift certificate for a video store, music store, or pizzeria.
2. Instituted a membership tracking spreadsheet tool within the SBHC to keep track of members who scheduled and kept appointments. SBHC staff also used the spreadsheet to conduct targeted student outreach.

RESULTS/LESSONS LEARNED:

1. There are 386 NHPRI/Thundermist members at the school. As a result of this project, 57 NHPRI/Thundermist members enrolled in the SBHC. This increased the number of NHPRI/Thundermist enrollees in the SBHC from 207 to 264 and represents a 22 percentage point increase.
2. Thirty-seven percent (21/57) of newly enrolled members completed a CPE.
3. Of the 135 NHPRI/Thundermist members who were previously enrolled in a SBHC, but had not completed a CPE, 100 (74 percent) had a CPE during the project.
4. As a result of this project, an additional 121 CPEs were completed, thus raising the percent of eligible students who received a CPE from 19 percent to 50 percent (see Figure 1).
5. NHPRI learned the importance of having a strong relationship with the partnering school-based health centers. Health center staff engaged "champions" and played key roles in encouraging students to access preventive services.
6. NHPRI used student focus groups to identify valued incentive options. The focus groups identified benefits and barriers to using SBHCs, which helped guide the SBHC's outreach efforts.
7. Before student data was shared between the SBHC and the community health center, protocols were established and a contract or confidentiality agreement between the involved parties regarding the use of data was signed. A sample confidentiality agreement is included in Appendix F.
8. Some providers were reluctant to participate in the project because of financial concerns or fears that SBHCs would not share information. Early and continued communication with network providers assured the success of this intervention.

Figure 1: Eligible Thundermist Enrollees Who Received a Complete Physical Exam (CPE)



Blue Cross of California: Physician Fax-Back Immunization Recall System

BACKGROUND: Blue Cross of California is a for-profit health plan with 733,000 Medicaid enrollees in 13 counties through its State Sponsored Programs. As part of its efforts to improve the childhood immunization rate and immunization tracking by the health plan, Blue Cross of California State Sponsored Programs (BCC) instituted a fax-back recall system. Every month, each primary care physician (PCP) is faxed a list of nine- and 18-month-old patients in need of immunizations according to health plan claims data. PCPs are requested to check their patients' medical records to determine whether the immunization has been administered and fax back the information to BCC.

OVERALL AIM: Increase BCC's ranking in the NCQA National Medicaid Percentiles for the childhood immunization HEDIS measure from the 50th percentile to the 90th percentile.

INTERVENTION AIMS:

1. Increase physician participation in the BCC immunization recall system from 38 percent to 50 percent.
2. Increase physician participation in a qualified, alternate immunization reminder/recall system to 50 percent.

MEASURES: Through physician office audits, establish baseline data from January-June 2001 for the following:

$$\frac{\text{\# of physicians with 250+ members using the BCC recall system at the beginning of the period}}{\text{total \# of physicians with 250+ members}}$$

$$\frac{\text{\# of physicians with 250+ members using an alternate reminder/recall system at the beginning of the period}}{\text{total \# of physicians with 250+ members}}$$

CHANGES:

1. From faxes returned, BCC determined that 38 percent of physicians participated in the BCC recall system. Health plan staff focused on physicians who have 250+ members and did not fax back member immunization information from January-June 2001.
2. Create educational packets for providers explaining the use of a reminder/recall system (BCC or alternate) to increase childhood immunization rates.
3. Schedule health plan visits to high-volume physicians (250+ members) to distribute the educational packets and assess participation in the BCC immunization recall system or in an alternate system.

PRELIMINARY RESULTS:

1. Visited 224 of 248 high-volume physicians (90.3 percent) who were not participating in the BCC immunization recall system.
2. Out of 224 visited physicians, 196 (87.5 percent) reported using the BCC recall system and/or an alternate system. The assessment did not elicit qualifying information about the alternate system.

RE-MEASURES: Through physician office audits, establish post-intervention data from July-December 2001 for the following:

$$\frac{\text{\# of physicians with 250+ members using the BCC recall system at the end of the period}}{\text{total \# of physicians with 250+ members}}$$

$$\frac{\text{\# of physicians with 250+ members using an alternate reminder/recall system at the end of the period}}{\text{total \# of physicians with 250+ members}}$$

$$\frac{\text{\# of members in the childhood immunization HEDIS measure assigned to physicians with 250+ members}}{\text{total \# of members in the childhood immunization HEDIS measure}}$$

NEXT STEPS:

1. Revise the assessment tool to determine the quality of alternate immunization reminder/recall systems (see Appendix G).
2. Limit the assessment to the evaluation of reminder/recall systems.
3. Meet with health plan staff to get feedback on the assessment process and the revised tool.
4. Conduct assessments of physicians with 250+ members.

Amerigroup Illinois: Increase HEDIS Well-Visit Scores through Provider/Member Education

BACKGROUND: Amerigroup is a for-profit Medicaid-only health plan with 39,000 enrollees in Cook County, Illinois.

OVERALL AIM: Increase HEDIS scores for well-child visits by 10 percent between 2000 and 2001; increase score by at least 10 percent in 2002.

INTERVENTION AIM: Educate 100 percent of high-volume PCP offices (300+ members) on the EPSDT and HEDIS guidelines for well-child visits by September 2001.

MEASURE: $\frac{\text{\# of high-volume PCP offices contacted by the health plan's medical director}}{\text{\# of high-volume PCP offices contracted with the health plan}}$

CHANGES:

1. Instituted Quarterly Quality Improvement Forums with PCP offices to promote use of Bright Futures system to provider offices. Bright Futures guidelines from the Maternal and Child Health Bureau promote improved health care for children and adolescents (www.brightfutures.org).
2. Follow-up meetings by the health plan medical director with 25 PCP offices with 300 or more members to address improving well-child visits.
3. Medical director sent letters to the top 40 PCP practices (by volume) with a Bright Futures Pocket Toolkit to assist providers in making appropriate decisions regarding preventive care services.
4. Implemented an incentive program for all PCPs that provided an additional $15 per visit for preventive care visits. The health plan also partnered with the city of Chicago and the state of Illinois to obtain funding for computers to design child recall reminder systems in PCP practices.

RESULTS/LESSONS LEARNED: As of November 2001, the health plan achieved a 39 percent increase in encounters for preventive care services. The health plan's medical director contacted 95 percent of high-volume PCP offices. More information about Amerigroup's provider communication techniques is discussed in the Communicate to Create Change chapter of this toolkit.

Community Health Network of Connecticut: Engaging Office Staff in Preventive Health Services

BACKGROUND: The Community Health Network of Connecticut (CHNCT) is a non-profit, federally-qualified health center-based plan with 41,500 Medicaid enrollees.

OVERALL AIM: Improve CHNCT's overall EPSDT participation ratio from 66 percent in 2000 to 80 percent in 2001.

INTERVENTION AIM: Improve EPSDT participation rates at Meriden Community Health Center, one of the health centers affiliated with CHNCT, by at least 10 percent over the same quarter of 2000.

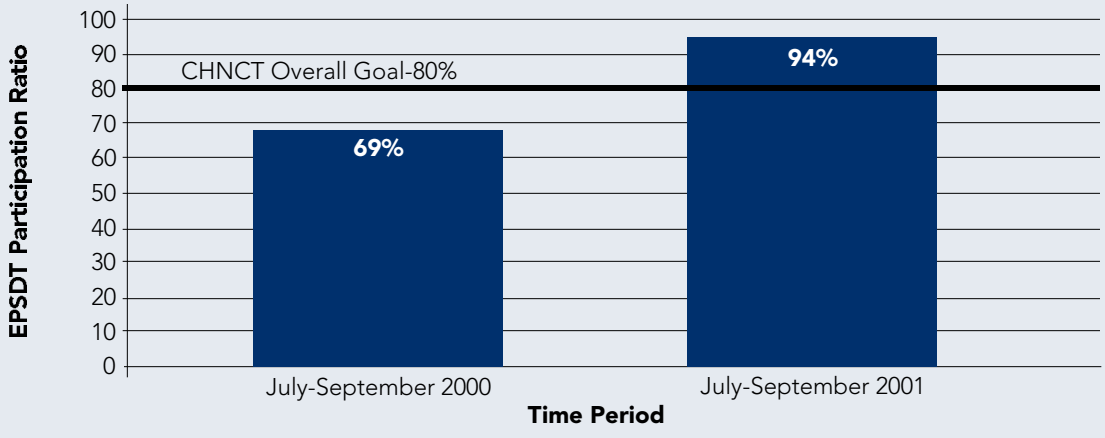
MEASURE: EPSDT rate for third quarter of 2001 – EPSDT rate for third quarter of 2000.

CHANGE: Office staff at Meriden Community Health Center were given incentives to improve the EPSDT participation ratio by at least 10 percent from the same quarter in the prior year. The office staff used CHNCT-generated lists of assigned members who were due and overdue for EPSDT screening exams.

RESULTS/LESSONS LEARNED: Meriden Community Health Center raised its EPSDT rates to 94 percent. This represents a 25 percentage point increase in EPSDT participation rates from the prior year (see Figure 2). Factors contributing to the site's success include:

1. The presence of a "champion" at the provider office to obtain buy-in and commitment from the office staff. Office staff must feel that they have control over the outcome and that the process chosen will work.
2. Office staff names were entered into a raffle for each EPSDT appointment scheduled. Drawings were held weekly to reward office staff efforts. CHNCT paid for raffle rewards (e.g., gift certificates, t-shirts) through donations and from the marketing department.

Figure 2: EPSDT Participation Ratio for CHNCT-Meriden Community Health Center



AlohaCare: Increase EPSDT Visits for High-Risk Newborns

BACKGROUND: AlohaCare is a non-profit, Medicaid-only, community health center-based plan with 30,000 enrollees. AlohaCare is based in Honolulu, Hawaii.

OVERALL AIM: Reduce by 50 percent the number of newborns receiving no preventive services by 15 months of age by July 2002.

INTERVENTION AIM: AlohaCare hopes to promote timely receipt of appropriate preventive services for newborns by confirming selection of an infant's provider and tracking the number of EPSDT visits within the first five months of life. The plan's intervention aim is to provide two EPSDT visits to 100 percent of high-risk infants by the fifth month of life.

MEASURES:

$$\frac{\text{\# of high-risk infants with two EPSDT service claims received by the fifth month of life}}{\text{total \# of high-risk infants included in health plan's study population}}$$

$$\frac{\text{\# of high-risk infants with no EPSDT service claims received by the fifth month of life}}{\text{total \# of high-risk infants included in health plan's study population}}$$

CHANGES:

1. AlohaCare developed a list of risk factors to classify an expectant mother's risk of delivering a high-risk infant. AlohaCare case managers use provider feedback on an expectant mother's risk factors as a predictor for infants at risk of not receiving EPSDT visits (Appendix E).
2. The case manager logs and tracks all infants monthly based on whether EPSDT services claims are received by the fifth month of life.
3. All infants receiving EPSDT screens are tracked and recorded for EPSDT audit purposes.

RESULTS/LESSONS LEARNED: For the baseline period of January through June 2001, approximately 20 percent of high-risk infants received two EPSDT visits by five months of age. Results from the pilot project will be available in Summer 2002 and posted on the CHCS website.

Health Plan Action Steps for Intervention

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of children who receive intervention services. For example: *Increase the percent of infants who receive at least four EPSDT visits by age one by 15 percent*.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Develop measures that link directly to your Aim Statement. For example:

$$\frac{\text{\# of infants who receive four or more EPSDT visits by age one}}{\text{total \# of infants}}$$

Measure this for the initial time period and on an ongoing basis.

Change:

Evaluate current interventions for ensuring that infants receive EPSDT services and change strategies that will most effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Helping Providers Improve Preventive Services for Children

What Makes Prevention in Pediatrics Difficult?

There are many barriers to effective preventive care delivery. Preventive care recommendations (e.g., immunization schedules) are numerous, complex, and change frequently. Respected groups such as the American Academy of Pediatrics and the Maternal and Child Health Bureau offer recommendations for more than 300 age-specific immunizations, screening, and counseling services in the first five years of life. These guidelines are strongly supported by the pediatric community, but the approaches have yet to be systematically implemented in most practice settings because doing so requires changes to established patterns of office practice.

Health plans seeking to improve the delivery of preventive services need to use effective approaches to changing practice performance. Research on effective ways to change provider behavior suggests that the use of interactive learning opportunities and simple tools and strategies are the most effective in producing changes in clinical care.[15,16]

This chapter reviews efforts by the Partners in Prevention (PIP) project in North Carolina to influence provider behavior in the delivery of preventive care services to children. Health plans seeking to improve provider performance in key preventive care services can implement lessons learned from this project.

The Partners in Prevention project piloted an intervention at PCP offices to increase rates of preventive services in pediatric and family practices. This project involved 44 urban and rural practices in two regions of North Carolina. PIP was a collaborative effort of private funders and state and federal agencies.

PIP project staff helped practices review their performance and test and implement new processes (e.g., chart screening) and tools (e.g., flow sheets). The proportion of children with age appropriate preventive care for four primary outcomes (immunizations, screening or risk assessment for TB, anemia, and lead) was measured over three years in randomly selected charts of children 24-30 months of age.

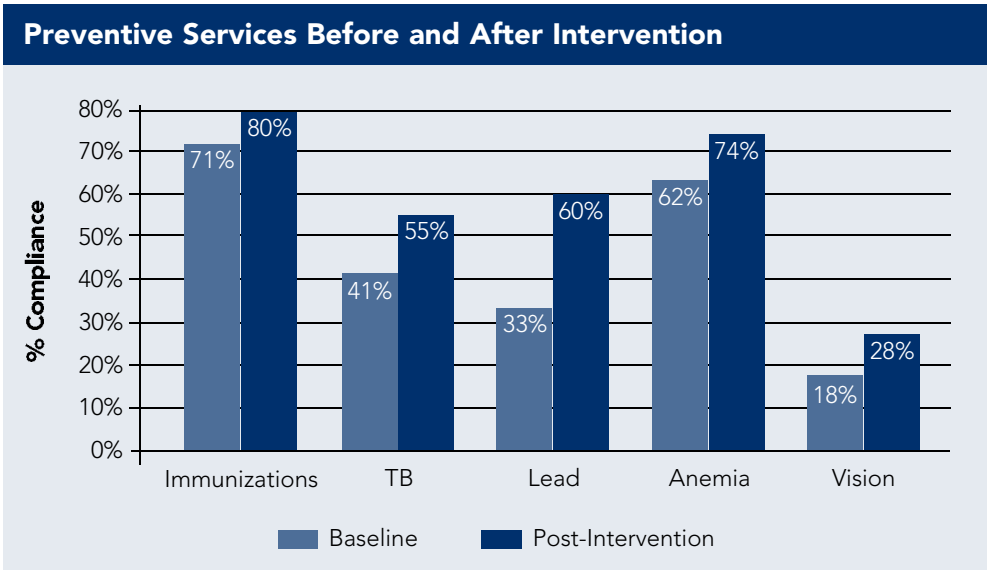
The practices that participated in PIP were 79 percent pediatric, 21 percent family, 84 percent group, and 23 percent rural. The average percent of children on Medicaid was 29 percent, with a range of 0-95 percent. At the beginning of the project, there were no significant differences in rates of preventive care. Following the period of assistance, there were no significant improvements in preventive care in control practices. Statistically significant improvements occurred in intervention practices for all primary outcomes.

---

[15] Davis D.A., Thomson M.A., Oxman A.D., and Haynes R.B. "Changing Physician Performance: A Systematic Review of the Effect of Continuing Medical Education Strategies." *Journal of the American Medical Association*. 1995; 274: 700-705.

[16] Davis D.A., Thomson M.A., Freemantle N., Wolf F.M., Mazmanian P., and Taylor-Vaisey A. "Impact of Formal Continuing Medical Education: Do Conferences, Workshops, Rounds, and Other Traditional Continuing Education Activities Change Physician Behavior or Health Care Outcomes?" *Journal of the American Medical Association*. 1999; 282(9): 867-874.

Figure 3: Partners In Prevention



Practices in the intervention group improved the delivery of preventive services at a rate 2.5 times faster than the control group. Ninety percent of intervention practices adopted new processes, including: clinician prompting, reminder/recall systems, routine monitoring of care processes, and redistributed preventive care activities across office staff.

Helping Providers Improve the Delivery of Preventive Services

The first step in translating guidelines into practice is to identify practical strategies that have been shown to improve children's health and development. These strategies include summarizing the status of each child's need for preventive services, prompting clinicians to deliver preventive services, tracking children who fail to come in for care, and measuring current rates of preventive services in the practice. At present, fewer than 20 percent of primary care practices use any of these strategies to ensure that children receive preventive care.[17,18]

In order to assist practices in implementing changes, health plans can provide tools such as simplified guidelines, flow sheets, or educational materials for community health centers, and measurement instruments that clinicians can use to translate concepts into practice. Health plans also may choose to offer incentives to practices that adopt endorsed tools.

As part of the Partners in Prevention project, The National Initiative for Children's Healthcare Quality developed and refined the following tools and processes for improving the delivery of preventive services in the pediatric population.

[17] Randolph G.D., Margolis P.A., Fried B., Keyes L.L., and Bordley W.C. "Diffusion of Preventive Service Tools to Family Medicine and Preventive Practices." *Ambulatory Pediatrics Association* poster session. Boston, MA, May 13, 2000.

[18] Bordley W.C., Chelminski A., Margolis P.A., Kraus R., Szilagyi P.G., and Vann J.J. "The Effect of Audit and Feedback on Immunization Delivery: A Systematic Review." *American Journal of Preventive Medicine*. 18(4): 343-50, 2000.

Table 8: Office Processes and Tools to Support Them

Process	Tool	BCAP Typology Category
Identifying service needs	Preventive service summary sheet	Identification/Stratification
Prompting provider	Chart post-its	Intervention
Educating patients	Patient activation cards	Outreach
Documenting services	Flow sheet	Intervention
Following up	Tracking system	Intervention/Outreach
Monitoring effectiveness	Periodic chart reviews	Reiterates importance of measurement

Identifying Service Needs

- *Guidelines*

  While most pediatricians have a routine schedule of well-child visits, most office practices do not have practice-wide preventive service guidelines. Lack of agreement about which services to perform and when to provide them makes it difficult to create protocols and train staff to assist in care delivery. Health plans work with high-volume practices to build consensus on several key guidelines and help practices streamline the system for ancillary clinical staff. Listing the age-appropriate guidelines on the appropriate health maintenance record in the chart, for example, can serve as a reminder about needed preventive services. An example is listed in Appendix H.

- *Summarize a Child's Preventive Service Needs*

  Guidelines also are more likely to be followed if they are clearly listed on an individualized flowsheet. This allows the provider or the provider's administrative staff to tell at a glance whether the child is missing any age-appropriate immunizations or other preventive care services. An example is listed in Appendix I. A patient specific flowsheet can be checked at non-well-child patient encounters (e.g., acute, chronic illness) to decrease missed opportunities. Practices that use flowsheets have experienced 10-20 percent increases in rates of preventive services.[19] An electronic medical record that prompts the provider offers a "high tech" approach to undertaking this same change concept.

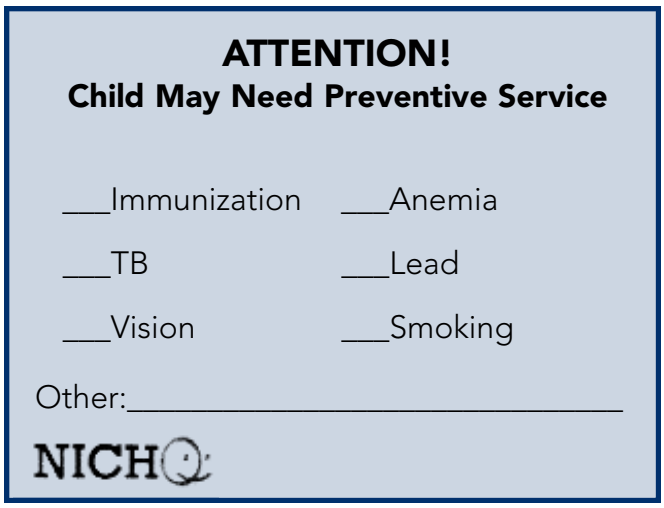
Prompting Providers

- *Screening Charts and Prompting Physicians*

  All staff members, including the administrative team, can easily check a summary flowsheet at each patient encounter to identify a child who is missing a preventive service. Helpful reminders such as post-it notes (Figure 4) affixed to the front of the chart alert clinicians that a preventive service is needed. These systems can be even more powerful when applied to both well-child and acute visits, thus encouraging providers to "make every visit a preventive visit."

[19] Prislin M.D., Vandenbark M.S., and Clarkson Q.D. "The Impact of a Health Screening Preventive Services Prompting Sheet on the Performance and Documentation of Health Screening Procedures." *Family Medicine*. 1986; 18: 290-292.

Figure 4: Sample Medical Chart Post-it Notes



Educating Patients

- *Counseling and Patient Education*
  Health plans can help practices by providing standardized materials to distribute to parents. These materials should inform parents about what to expect at a given visit and review normal growth and development as well as age-appropriate health and safety topics. Member materials should encourage parents to discuss concerns with the clinician and prompt the parent to remember and ask questions. Studies have shown that the use of these materials helps ensure that parental concerns are addressed and satisfaction is increased.

- *Community and Educational Resources*
  Appointing someone in the office to routinely update and maintain a list of frequently used community resources and referral numbers is an effective strategy for strengthening health center and community ties. Health plans may develop a resource bank and make it available either in hard copy, online, or by telephone in the case management department.

- *Documenting Services*
  Health plans can help practices develop practical and efficient methods for documenting services. For example, a flowsheet can serve to document services as well as prompt staff about needed services.

Following Up

- *Tracking (e.g., Immunization Registry)*
  A centralized tracking system allows a practice to identify children who may need services, but have not come in for care. The first step in developing a tracking system is to generate a list of all children followed in the practice born in a particular month. Many practice information systems contain tracking features (e.g., age or missed well-child checkup). Once providers have selected tracking criteria, they can pull the charts of these patients and identify children in need of preventive services, or, if an office-based registry supports them, they may be able to generate these reports without chart review. Plans can support the development and implementation of office-based registries.

  Note that tracking systems either can be low-tech (e.g., an index card 'tickler' file) or high-tech (e.g., an electronic immunization registry). Plans can use their information systems to generate the names of patients who are behind on services. Public agencies also may be able to provide data from statewide registries.

Monitoring Effectiveness

- *Monitoring (Measurement of Rates)*
  Simple measures can be used to track progress when implementing quality improvements. Discussing results with the practice team can help reinforce practice goals. Health plans can support providers in their monitoring efforts by:

  1. Giving providers protocols for internal chart reviews, like the ones used by the health plan quality improvement staff. Incentives may help to encourage providers and their office staff to adopt the chart review.
  2. Developing and distributing health plan flow sheets and then surveying practices to provide feedback on rates of use.

  Health plans that choose to support providers in this way need to take extra care to assure providers that they will not be penalized for instituting self-auditing procedures that may highlight less-than-desirable performance.

A Case Study: Monitoring the Effectiveness of Vision Screening

Guidelines recommend vision screening for children beginning at three years of age in order to assure effective identification and treatment to prevent amblyopia. However, most practices do not implement vision screening until the pre-kindergarten physical examination, assuming that children under five years of age will have difficulty cooperating with the screening instructions and tasks.

The physicians at Boice-Willis Pediatrics Clinic in Rocky Mount, North Carolina, wanted to implement vision screening for three-year-olds, but the nurses who performed the screening thought this would be very difficult, if not impossible. The lead physician convinced the nurses to try screening three- and four-year-olds for two days, and keep track of the results. A simple tracking sheet with child's name, age, and whether they passed the exam was placed next to the eye chart. The nurses found that 75 percent of three-year-olds could be successfully screened. This encouraged the practice to increase its efforts at vision screening and significantly improve its delivery of this important service. Because of this pilot, the lead physician motivated the other physicians and clinician support staff to adopt vision screening in younger children.

Communicate to Create Change

Without effective internal and external communication, even the best quality improvement ideas will falter moving from theory to reality. Good communications strategy can solidify buy-in within your organization and, externally, can facilitate collaboration with states, enhance support from providers and their staff, and increase understanding of and participation of members.

A good communications strategy is largely common sense: Whom do I need to reach to make this initiative as successful as possible? What does the target audience(s) need to know? How do I reach the audience(s)? Successful communications depends on committing time at the beginning of a project to answer these questions and outlining a consistent strategy to deliver your message. A written "communication plan" that clearly outlines each of the three components and how they are addressed is a useful starting point.

Identify Your Audiences

The first step in developing a communications strategy is to define your audience. Internal audiences are essential to building organizational support for your project. Think beyond the team working on your quality improvement project. You might ask, "Whose cooperation do I ultimately need to keep this project moving?" It might be information services contacts whom you rely on for data extraction, front-office staff who answer calls and direct enrollees to case managers, and/or a senior executive whose approval you need for additional staffing support.

Keep your plan's public relations/communications staff aware of your activities. Their support and knowledge of your activities is vital to promoting your accomplishments in established communications vehicles, including internal and/or external plan newsletters, press releases, and media outlets.

Potential Audience

Internal:
- Health Plan CEO
- Information Services
- Claims Department
- Quality Improvement
- Public Relations/Communications
- Member Services

External:
- Members
- Providers
- State health purchasers
- Other health plans
- Consumer organizations
- Media
- Accrediting bodies

External audiences include anyone outside your plan whose cooperation is necessary to achieve pilot program goals as well as anyone who would be interested in the successful outcome of the initiative. For example, clear communication with providers and their office staff is critical in successfully identifying members, assessing risk, and implementing interventions. Outreach activities for members require communications tactics geared specifically toward their specific needs and desires. State Medicaid and SCHIP contacts should not be overlooked as an audience. Keeping states aware of plan quality initiatives and accomplishments will go far in building collaborative partnerships toward a common goal of providing quality care for Medicaid beneficiaries.

Colorado *Access* Recognition Letter

Merely taking the time to send a letter can be a stepping-stone to building partnerships and garnering support from key external audiences. After Colorado *Access* participated in the BCAP *Toward Improving Birth Outcomes* workgroup, the plan informed the state's Medicaid director of its accomplishments under BCAP. Shortly thereafter, the state Medicaid director sent a letter to Colorado *Access*' Chief Executive Officer, lauding their quality improvement effort.

Define Your Messages

Once you identify audiences to reach, the next step is crafting a compelling message to reinforce at every opportunity. In most cases, you will start with your overall Aim Statement linked to your quality initiative and reframe it slightly for each audience depending on their perspective. Internally, you may use the same message with different gradations based on your audience. To help revise the message for each audience, answer the following: Why do they care? and/or How will it help them? The message should be simple and easy to remember, for example:

- **Internal – *Increase identification of children who need immunizations within ABC Health Plan by 25 percent in 2001.*** This is important for ABC Health Plan because it will potentially improve children's health and improve HEDIS scores.
- **Providers – *Submit immunization notifications to ABC Health Plan and receive a $25 incentive.*** This is important for providers because reimbursement will increase and patients will receive more coordinated care.
- **Members – *Has your child been immunized? Visit your doctor now to keep your baby healthy.*** This is an important message for parents to hear.
- **State – *ABC Health Plan is working to improve immunization rates by identifying children in need of services.*** This is important for the state because these children will ultimately receive higher quality, more responsive, and more cost-effective care.

Use Communications Tools Creatively

Effective communications need not break the budget or require intensive time commitment. A successful communications strategy could entail tactics as simple as distributing a clearly written, monthly e-mail status report to important internal contacts. Posting graphics in a public location showing ongoing results of your project provides recognition for team members and can build support and enthusiasm throughout the organization. The key to employing communications tools effectively is consistent use, reinforcement, and gearing tools for specific audiences. Your communications strategy will guide the specific tools or tactics that you use.

Samples of communications tools include:

- Letters, memos.
- Quarterly internal updates.
- Quality improvement status meetings.
- Quality improvement e-mail updates.
- Newsletters (print or e-mail).
- Website.
- Posters, flyers.
- Standardized presentation.
- Press releases.
- List-servs.

Evaluate Effectiveness of Communications

Evaluate the effectiveness of your communications strategy to determine what works and does not work for your target audiences. Define the desired response of your communication up front (e.g., consistent use of a new form, cooperation with a new procedure, referrals, etc.). Then, when you review overall outcomes of your quality initiative, devote time to examine how your communications strategy supported the overall goal of the project. If the target audience did not respond appropriately, you may want to rethink your communications strategy to reach them more effectively.

Thinking "Beyond the Box" to Communicate with Providers

Amerigroup of Illinois developed a strategy to communicate with providers to work toward increasing HEDIS scores for well-child visits by 10 percent between 2000 and 2001. Communications tactics included:

- One-on-one meetings with the 20 highest-volume physician offices.
- Quarterly "Quality Care Forums" – breakfast meetings with physicians and office staff.
- "Outstanding Physician Award," which honored eight physicians who scored 99 to 100 percent on the 2000 annual medical records audit. Amerigroup pursued local media recognition for the physicians who received the award.
- Amerigroup received recognition from the Chicago Medical Society for their efforts to improve communication with providers.

Appendices A-L

Appendix A

Improving Preventive Care Services for Children
Improvement Documentation Form

PLAN NAME: _____

Category: ❑ Identification ❑ Stratification ❑ Outreach ❑ Intervention

Aim Statement:	
Measure(s):	_____
Change:	

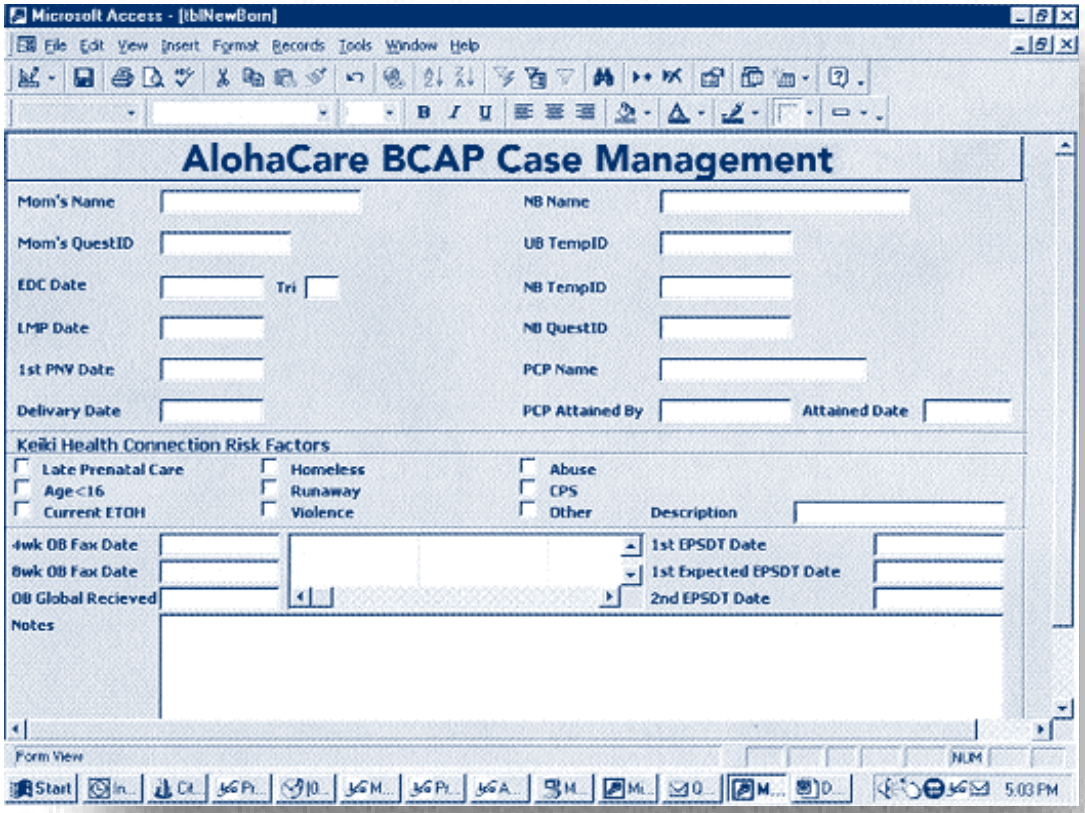
Implementation Plan:

Who:	
What:	
When:	
Training:	
Communication:	
Troubleshooting:	

Appendix B

AlohaCare Database Template for Identifying Newborns Prior to Birth

AlohaCare
Aloha is the Difference.



Appendix C

AmeriChoice of Pennsylvania Missed Opportunity Letter

[Click here and type recipient's address]

Dear Doctor:

Do you have in place a system to take advantage of all visits (including sick visits) to immunize children, and perform lead screening? The AmeriChoice of Pennsylvania audited and certified data system has taken information provided by you, other PCPs, and the Philadelphia City Registry to create A MISSED OPPORTUNITY IMMUNIZATION REPORT for your AmeriChoice member panel.

The number of your two-year-old members officially counted by *HEDIS® for year 2000 are ____. The percentage of possible immunizations that were given in 2000 are ____. The average number of well and sick visits to a PCP per each two-year-old member was _____. The average number of well and sick visits to a PCP in which no immunizations were given was _____. The percent of visits, well or sick, in which no shot was given was _____.

Your AmeriChoice medical record review nurses will contact you to verify this information through a small sample of medical records, and then work with you where needed, using selected proven office care management tools. Please get to know your nurses.

Our hope is three-fold: Your patients will receive all immunizations; you may qualify for added compensation or quality bonus; and you will feel good about the proven preventive care performed in your office.

Sincerely,

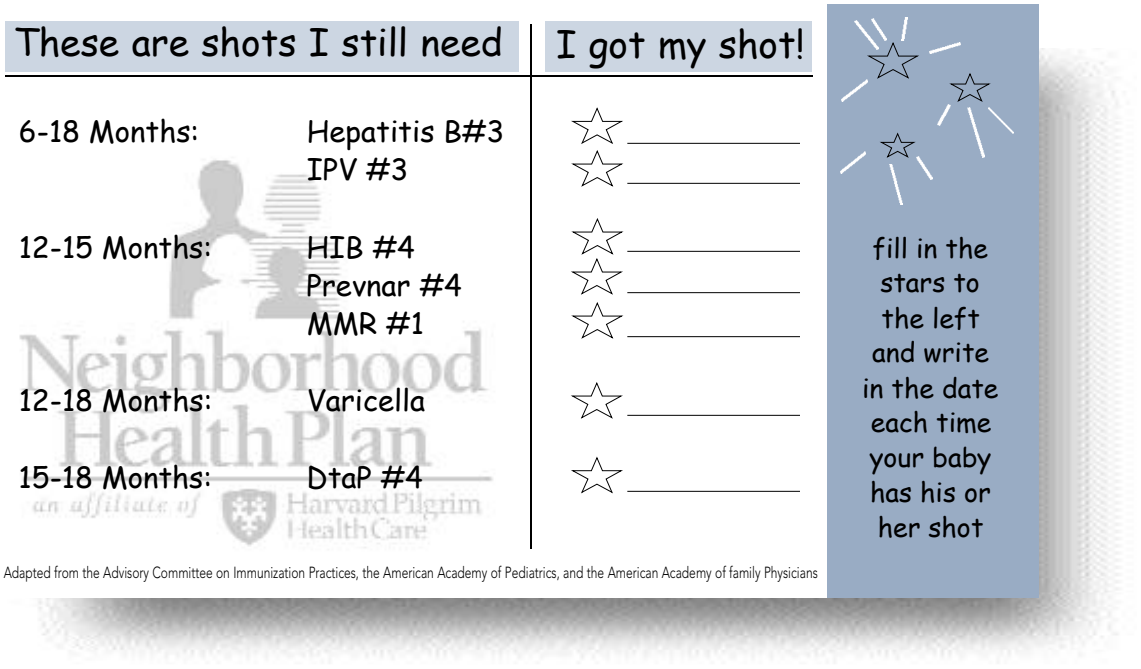
James G. Mumford, M.D.
Vice President of Quality Management
AmeriChoice Health Services, Inc.

*HEDIS® means Health Plan Employer Data Information Set. The childhood immunization indicator is one of the annual performance indicators required by your state. In order to be counted in this measure, a Medicaid child must have reached two years of age sometime in the measurement year, and must have been continuously enrolled between the 1st and 2nd birthdays (except for one brief period). The system excludes valid exceptions or contraindications to immunization. Full HEDIS® information is available from the NCQA website, www.NCQA.org, searching on the word HEDIS.

Appendix D

Neighborhood Health Plan of Massachusetts Reminder Magnet

Neighborhood Health Plan of Massachusetts produced 5,000 refrigerator magnets for $2,000.



Appendix E

AlohaCare Global Authorization/Risk Factor Fax Form

AlohaCare
Aloha is the Difference.

Fax Transmittal

GLOBAL OB NOTIFICATION	Date: _____ Sent by: _____
Patient's Name (print):	Birthdate:
LMP:	EDC:
Date of first prenatal visit (regardless of facility):	
Risk Factors: ☐None ☐List: _____	
AUTHORIZATION # _____ DATE: _____ INITIALS _____	

OB UPDATE	Date: _____ Sent by: _____
MATERNAL RISK FACTORS ☐ NONE	**"KEIKI HEALTH CONNECTION" RISK FACTORS** ☐ NONE
(List)	BABY'S PCP:
	☐ Late prenatal care ☐ Age: <16 years ☐ Current ETOH/substance use ☐ Social concerns: ☐ Homeless/runaway ☐ Violence/abuse ☐ Previous CPS involvement ☐ Other: _____

Health Plan	FAX NUMBER	Health Plan	FAX NUMBER
Queen's	532-6999	HMSA	948-5648
AlohaCare	973-0676	HMAA	947-8055
Kapiolani	535-7850	Patient's Health Plan Number:	

This communication is intended solely for the individual or the entity to which it is addressed, and may contain information that is privileged, confidential or prohibited from disclosure. If the reader of this communication is not the intended recipient, you are hereby notified that any review, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address listed on the right via the U.S. Postal Service. Thank you.

Appendix F

Neighborhood Health Plan of Rhode Island/Health Center Confidentiality Agreement Template

CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT is made as of this ____ day of DATE between by XXX Health Plan ("XXXHP"), a Rhode Island business corporation, with a principal place of business in Providence, Rhode Island, and XXX Health Center, a Rhode Island corporation, with its principal office in CITY, Rhode Island ("XXXHC").

RECITALS:

A. XXXHP and XXXHC are considering entering into an agreement by which XXXHP staff will conduct a pilot study on XXXHC's school based clinic patients whereby XXXHP/XXXHC will provide certain resources, data and services to XXXHC/XXXHP; and

B. To this end, the parties need to exchange certain confidential information concerning their business and operations, and they wish to enter into an agreement providing for the protection of this confidential information.

NOW, THEREFORE, the parties hereto agree as follows:

1. For purposes of this Agreement, the term "Confidential Information" shall include all documents, materials and information, written, verbal or electronic, provided by one party to the other under this Agreement regarding the contemplated transaction, including, without limitation, business plans, strategic plans, business development proposals, contracts, financial statements, client lists, patient data, formal documents, memoranda, marketing plans and projections, and other equivalent information related to a party's organizational structure, business or operations. The parties acknowledge and agree that the Confidential Information contains valuable trade secrets and that this Agreement itself is Confidential Information.

2. For purposes of this Agreement, the term "Confidential Information" shall not include: (a) information obtained from a source other than one of the parties, which source is not under a duty to keep the information confidential; (b) information that is otherwise available to the general public, such as information in public records; or (c) information that a party is required by law to disclose.

3. Each of party hereto agrees that it will hold all Confidential Information provided to it by the other party in trust and confidence and will refrain from using or disclosing any or all of said Confidential Information for any purposes other than for evaluating the desirability of the contemplated transaction. Each party hereby agrees not to sell assign, lease, license, disclose, give, or otherwise transfer or use in any way any Confidential Information or any copy thereof provided to it by the other party to any person or entity other than its own agents, partners, employees and consultants who have a need to know such information in order to enable said party to evaluate the desirability of the contemplated transaction. Each party will safeguard any and all copies of Confidential Information provided it by the other party against unauthorized disclosure and shall take all necessary steps to ensure that the provisions of this Agreement are not violated by any person under its control or in its service.

4. The parties agree that the provisions of this Agreement shall remain in effect regardless of whether the contemplated transaction takes place. Each party further agrees to return all copies of Confidential Information provided to it by the other party immediately upon the request of the party who furnished such Confidential Information.

5. The parties hereto further acknowledge that the Confidential Information exchanged hereunder comprises unique and valuable assets and that each party hereto has the right to seek whatever equitable and legal redress may be available to it for the breach or threatened breach of the provisions of this Agreement.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date first set forth above.

HEALTH PLAN	HEALTH CENTER
_____	_____
By:_____	By:_____
Its:	Its:

Stand-still. This Agreement will remain in effect until DATE and may be extended by written agreement of the parties. During the term of this Agreement, the parties agree to negotiate with each other in good faith and only with each other regarding the transactions contemplated herein, and will not solicit, consider or otherwise act on any similar proposals from any other entity. No party will make any public or private announcement of this Agreement or the contemplated transactions to others for any reason without the other party's prior approval.

Appendix G

Blue Cross of California Childhood Immunization Reminder/Recall System Assessment Form

BlueCross of California	Date:			County	
	Reviewer:				
	Clinic/PCP Name:				
	Clinic/PCP Address:				
	Interviewee:				
	❑ Refused Assessment				

CHILDHOOD IMMUNIZATION REMINDER/RECALL SYSTEM ASSESSMENT FORM

***INSTRUCTIONS*: Sections A and B must be completed. In Section A, the criteria (✓) under each system must be met in order for that system to apply.**

A. What system(s) do you use to track immunizations?
This question identifies the system used to track immunizations that are due and/or immunizations that have been missed.

Check all systems used by the physician office:

- ❒ **BCC Fax-Back System**
- ❒ **Schedule Next Immunization Appointment During Current Office Visit**
- ❒ **Medical Records**
  - ✓ Flag patient's charts with the next immunization date
  - ✓ Scan the chart rack once per month for upcoming and/or missed immunizations
- ❒ **Card File (example: index cards filed in a box)**
  - ✓ Document on a card the dates immunizations were given and due dates of future immunizations
  - ✓ Review the cards once per month for upcoming and/or missed immunizations
- ❒ **Logs**
  - ✓ Make a list of patients and due dates of future immunizations
  - ✓ Review the list once per month for upcoming and/or missed immunizations
- ❒ **Electronic System or Registry (examples: personalized database, local health department registry)**
  - ✓ Search records and generate monthly reports of patients due for an immunization
- ❒ **No System**

B. What method(s) do you use to remind/recall your patients?
This question identifies the method used to remind patients of upcoming immunizations and/or recall patients who fall behind schedule.

Check all methods used by the physician office:

- ❒ **BCC Sample Reminder Letter and Mailing Labels**
- ❒ **Postcard or Letter (manual or electronic)**
- ❒ **Telephone Call (manual or electronic)**
- ❒ **Face to Face Reminder (office visit or home visit)**
- ❒ **No Method**

FOR CAMARILLO OFFICE USE ONLY

Check one:
❒ BCC Fax-Back System ❒ Both BCC + Alternate System
❒ Alternate System ❒ No System

Appendix H

National Initiative for Children's Healthcare Quality Age-Appropriate Health Maintenance Record

Name:_____ Birth Date:_____ Chart Number:_____

Date:_____ **Health Maintenance Record** Age: _____

2 month **3**

Parent's Page

Please tell us about your baby:

1. Have you moved since your last well child visit?
   ❑ yes ❑ no

2. What are you feeding your baby? (check all that apply)
   ❑ Breast milk
   ❑ Formula (type) _____
   Ounces per day _____
   ❑ Solid food (type): _____

3. Does your baby sleep through the night?
   ❑ yes ❑ no
   Wakes up how many times? _____

4. How often does your child ride in the car seat?
   ❑ always ❑ sometimes ❑ never

5. Does anyone smoke near your baby? (check all that apply)
   ❑ at home ❑ at day care ❑ at relatives

6. Does your baby:
   ❑ Lift head to 45°
   ❑ Babble/coo
   ❑ Smile at you

7. Please list any concerns you may have for the nurse or doctor: _____
   _____

Please remember to bring your child's shot record to all visits.

Signature: _____
Parent/Guardian

Relationship to child: _____

Doctor's Page

Lgth _____ % Wt _____ %

HC _____ %

Nursing concerns:

❑ shot record given Nurse: _____

EXAM	NL	AB	Comments:
Skin			
Head (fontanels)			
Eyes (Conj. gaze)			
Ears-Pharynx			
Neck/Nodes/Lungs			
Heart/Pulse			
Abdomen			
Genitalia			
Musculo-skeletal (hips)			
Neurological			
Reflexes, Tone			
Other			

Discussion Points:
See parent's page

❑ Feeding instructions
❑ Water heater temp (<120°)
❑ 2 month information sheets
❑ Smoke detector
❑ Fall prevention
❑ What to do if sick (Tylenol dosage)

Preventive Services:
❑ DTaP #1 ❑ IPV #1 ❑ HIB #1

Follow up: _____

Signature: _____
Physician

NICHQ National Initiative for Children's Healthcare Quality

Appendix I

National Initiative for Children's Healthcare Quality
Preventive Services Prompting Sheet

Name:_____ D.O.B:_____ Chart #:_____

AGE	0 - 2 WK	1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	11-12 YR	14-16 YR
Supine Position	RA														
Metabolic Tests															
Smoke Exp.															
Flouride					RA										
Dental Referral															
Hgb (anemia)															
TB Screen							RA			RA	RA	RA	RA	RA	RA
Lead							RA			RA					
BP															
Vision															
Hearing	RA														

N = No Y = Yes RA = Risk Assessment

IMMUNIZATIONS:

AGE	0 - 2 WK	1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	11-12 YR	14-16 YR
Hep B	Hep B-1		Hep B-2		Hep B-3									Hep B PRN	
DTAP														Td	
HIB															
OPV/IPV															
MMR														PRN	
Varicella														PRN	

NICHQ National Initiative for Children's Healthcare Quality

Appendix J

Recommended Readings

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Appendix K

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Appendix L

CHCS
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The BCAP Network

The BCAP Network is an emerging alliance of health plans joined by the common goal of furthering the quality and cost-efficiencies of Medicaid and SCHIP managed care. BCAP Network activities include:

- **BCAP Workgroups** – Up to 15 Medicaid/SCHIP health plans collaborate to develop replicable best practice models for targeted clinical and administrative areas.
- **BCAP Workshops** – Hands-on workshops allow attendees (up to 30 health plans) to develop quality improvement initiatives for their Medicaid/SCHIP populations.
- **BCAP Quality Summit, October 16-18, 2002** – Accomplishments from each BCAP workgroup will be highlighted at this national quality gathering for Medicaid/SCHIP health plans.
- **BCAP e-News Update** – Bi-monthly electronic newsletter containing updates on health plan best practice activities. To subscribe, e-mail rb@chcs.org.
- **BCAP Network Exchange Calls** – Lively teleconference discussions about current issues in health care with experts in the field.
- **CHCS Website** – Features current updates on BCAP projects, resources for Medicaid and SCHIP health plans, and CHCS Managed Care Best Practices Publications. **www.chcs.org**
- **Best Practices Grants** – Grants of up to $100,000 are available to Medicaid and SCHIP health plans that want to develop, test, or refine "best practice" programs to improve delivery of managed care in the public sector.

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