Well Child Visits: We can do Wellerer

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QTIP Jump Off – January 23rd, 2011
EPSDT is born!

- Enacted in 1967 based on research findings from health exams of young Vietnam war draftees and early head start programs
- Finance the preventive standard of medical necessity that specifies “early” coverage to “correct or ameliorate” physical/mental conditions
EPSDT Mandatory Benefits

- EPSDT program contains the following benefits:
  - Comprehensive Health and Developmental History
  - Comprehensive Unclothed Physical Exam
  - Appropriate Immunizations
  - Laboratory Tests
  - Lead Toxicity Screening
  - Health Education
  - Vision Services
  - Dental Services
  - Hearing Services
Chip, Why do we do them?

Chip Hart, Physicians Computing Company

- Preventing dangerous illnesses,
- managing developmental concerns, and
- teaching parents are what distinguish you from family practices, retail-based clinics, and the Internet. You need to focus on your strengths.

http://www.pedsource.com/chipsblog
• No Margin, No mission
  ◦ Sister Irene Kraus
Established well visits paid an average of $185.37, while established sick visits (99212 through 99215) paid an average of $76.33. That’s nearly 2.5 times as much!
Office Visits by Type

Figure 2. Pediatric Office Visits by Type of Visit by Patient Age, 2004-2007 Annual Average

![Bar Chart showing the number of visits by age and type (Well Visit and Sick Visit)]

Source: AAP analysis of 2004 to 2007 National Ambulatory Medical Care Survey
Visits by age vs. Practitioner type

Figure 3. Well-Child and Sick Visits by Provider Specialty by Patient Age Group, 2004-2007 Annual Average

Note: Both (a) well and sick visit estimates for the age 15-21 group to general and subspecialist pediatricians, and (b) well visit estimates for pediatric subspecialists, are unstable due to small sample size. Interpret with caution.

Source: AAF analysis of 2004 to 2007 National Ambulatory Medical Care Survey
CHIPRA / HEDIS 17

- **N:** 0, 1, 2, 3, 4, 5, 6 visits or greater
- **D:** Percentage of Members who turned 15 months old during measurement year and are CONTINUOUSLY enrolled from 31 days after birth to 15 months.
  - Available data for FY 2007 – present
  - Data set comprises 2 ¼ years of patient data
“Continuous” Enrollment

- 7,000 children drop off Medicaid each month
- DHHS has 45 days to make a decision on any application
Palmetto Children’s Health Initiative

- 2 year federal grant to certify community organizations as a Medicaid Attestation Location
- Receive $2.00 per eligible application submitted.

http://childrenshealthsc.org/
# 2009 SC HEDIS Results

## WCC Number 0 – 15 months

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<th>HMO &amp; PCCMS</th>
<th>FFS</th>
<th>National</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>5.11</td>
<td>3.94</td>
<td>5.6 (0.6-6.8)</td>
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<tr>
<td>1</td>
<td>6.46</td>
<td>5.72</td>
<td>3.3 (0.5-6.4)</td>
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<td>2</td>
<td>8.87</td>
<td>7.41</td>
<td>3.9 (1.2-7.5)</td>
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<td>3</td>
<td>14.72</td>
<td>11.85</td>
<td>6.2 (2.9-9.9)</td>
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<td>4</td>
<td>22.43</td>
<td>17.89</td>
<td>10.9 (5.1-16.1)</td>
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<td>5</td>
<td>24.29</td>
<td>18.99</td>
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<tr>
<td>6</td>
<td>18.11</td>
<td>34.19</td>
<td>53 (29-73.7)</td>
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Well Child Visits
(First 15 Months)
CHIPRA / HEDIS 18

- N: One WCC in Measurement Year
- D: Age 3, 4, 5 or 6 and continuously enrolled during measurement year.

<table>
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<tr>
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<tr>
<td>Rate</td>
<td>45.1</td>
<td>43.7</td>
<td>65.3</td>
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Percent with Well Child Visits

(Ages 3, 4, 5, and 6 Years)

Note: Regardless of plan type, rates indicate results below the 10% percentile of the national benchmarks for each fiscal year.
CHIPRA / HEDIS 19

- N: One comprehensive well-care visit with PCP or OB-GYN during measurement year
- D: Continuously enrolled children age 12-21

<table>
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</thead>
<tbody>
<tr>
<td>Rate</td>
<td>23.8</td>
<td>16.21</td>
<td>42 (27.2-56.7)</td>
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</table>
Visits by age vs. Practitioner type

Figure 3. Well-Child and Sick Visits by Provider Specialty by Patient Age Group, 2004-2007 Annual Average

Note: Both (a) well and sick visit estimates for the age 16-21 group to general and subspecialist pediatricians, and (b) well visit estimates for pediatric subspecialists, are unstable due to small sample size. Interpret with caution.

Source: AAF analysis of 2004 to 2007 National Ambulatory Medical Care Survey
New Tools

- Encounter Pro
- E-MDs
- Electronic Health System
- All Scripts
- GE Centricity
- Practice Partner
- SRS Soft
Center for Health Care Strategies: Best Clinical and Administrative Practices Initiative

- Typology for Improvement
  - Identification
  - Stratification
  - Outreach
  - Intervention
Identification

- How do you identify the patients in the 1-15 month, 3-6 and 12-21 year range?
- How do you identify children with risk factors for developmental delay (abnormal screen, SES, FH)
- How do you identify children receiving services for identified delay?
- How do we identify siblings within a practice to target multiple patients at a time
Stratification

- How do you identify children due or overdue for WCC?
- How do you identify need for inc WCC/Sick Visit ratio?
- How do you identify families with impediments to WCC attendance?
  - Multiple children
  - Need for transportation
Outreach

◦ How do you reach families to remind of / notify missed WCC? What’s the return
  - Mailings
  - Phone Calls

◦ How do you communicate importance of WCC for developmental guidance vs. time for immunization

◦ How do you incentivize the family to attend WCC?

◦ How do you utilize other services to serve as points of reminder?

◦ How do you interact with the entities to which you refer?
Outreach – Possible Partners

- SCHOOLS! – Medicaid Medical Concierge
- WIC – q 6 months
- BabyNet – q 6 months
- First Steps
- Nurse-Family Partnership
Nurse Family Partnership

q week: 1st 6 weeks
qO week: Until 20 months
Q month: Until 2nd Birthday
Intervention

- What changes affect the rate of WCC attendance?
  - Insurance coverage?
  - Time to 3rd next visit
  - Consistent provider?
- How can systems be changed to improve flow and efficiency in provider during WCC?
- How can we utilize services of Managed Care Organizations to help?
**Setting Aims**
Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

**Establishing Measures**
Teams use quantitative measures to determine if a specific change actually leads to an improvement.

**Selecting Changes**
All improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.
HOW GOOD?

BY WHEN