Pediatric Healthcare Improvement Initiative for Tennessee

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

PHiiT Well Care Project Description

PROJECT SUMMARY

This project will assist ambulatory pediatric practices in improving annual, well care visit completion rates. These rates will increase through the implementation and sustainment of several process changes.

The required process changes include:

- Process Mapping of patient work flow for acute and well visits
- Using practice billing data to identify active patients not completing annual well care

The optional process changes include:

- Create a monthly recall system
- Assess the well child visit completion status at each acute visit
- Scheduling next well care at each visit
- Perform well care elements at acute visits
- Other process developed by practice leadership

WELL CARE IMPACT

We know that well care is a fundamental component of the improving health of children over the last four decades. "Research has shown that evidence-based preventive services can save lives and improve health by identifying illnesses earlier, managing them more effectively, and treating them before they develop into more complicated, debilitating conditions, and that some services are also cost-effective[1]." In the 1980's the Federal Government and the American Academy of Pediatrics began an organized collaboration to standardize well care, define high-quality well care and increase the rate of annual completion of well care services. This led to the development of Bright Futures and the codification of well care services in social security regulations as Medicaid's Early and Periodic Screening, Diagnostic, and Treatment or EPSDT. But, the rate of children participating in annual EPSDT screens has slowly declined from 64 percent in 2011 to 54 percent in 2016. The rates are much lower in adolescent populations (40-50%)[2]. The current system must be improved through practice collaboration or it will not be sustainable, effective or succeed in it's current goals[3,4].

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PROJECT BACKGROUND

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) sought to improve qualitative and quantitative well care by establishing state EPSDT reporting requirements[5,6,7]. In response to OBRA 1989, an overall goal was set at an 80 percent annual beneficiary participation rate in EPSDT in 1989[8]. The last decade has seen a clear failure to implement and sustain both high quality and regular well care[9, 10,11,12,13,14]. In 2014, the national average participation rate was only 59%[15]. Nationally, only 8 states achieved 80% PR at least one year between 2006-13[16]. In FY 2014, participation ratios across the US were highest for infants under one year, at 88%, but only 43% for 15 to 18 year-olds., and 25% for 19 to 20 year-olds[17].

PROJECT STRUCTURE

AIM

To increase the percentage of children seen in office who are up to date on their last well check up by 5% for children ages 3-21 over the 12-month project.

What PHiiT Provides Your Practice Through the Annual Well Care Project

"Business Case for Well Care" Suzanne Berman, MD, FAAP (Webinar)

Provide MOC Part IV credit, CME credit, and support for peer to peer learning

Personalized PHiiT Team Visits to Practice

- Complete PHiiT Quality Improvement training with all staff
- Review quality improvement capability and support practice QI Team construction/augmentation
- Train QI Team on QI Teamspace, project requirements, and data collection
- Walk QI Team through initial PDSA Cycle on QI team infrastructure, ability to query data in Claims/EHR, process for entering data into QI Teamspace
- Assist QI Team in practice work flow process mapping

Readily Available PHiiT Project Support Services

- Periodic check-ins with practices by phone
- Monthly support calls with PHiiT leaders and other practice leaders
- On site consultation as needed
- Final project recognition/celebration
- Annual learning collaborative session

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PRACTICE RESPONSIBILITIES

Throughout the project, the practice will increase the likelihood of successful improvement by the completing the following mandatory requirements:

- Complete Practice Assessment Tool at beginning and end of project
- Develop and meet regularly (bi-weekly) with office QI Team
- Select and document process changes and PDSA cycles using Monthly Check-in/PDSA form in QI Teamspace (required quarterly)
- Participate in 6 of 11 support calls over 12 months
- Share individual practice experience at PHiiT Learning Collaborative after data collection is complete

Complete Training and Education

All PROVIDERS must view and complete the following modules:

- PHiiT QI 101 (If not completed for other PHiiT projects)
- Bright Futures/AAP Recommendations for Preventive Services and EPSDT

All STAFF must view and complete the following module:

- Bright Futures/AAP Recommendations for Preventive Services and EPSDT

Implement Process Changes

QI teams will implement the following required process changes over the course of the project:

- Use Process Mapping or other QI Tools to improve visualization of patient work flow for acute and well visits
- Develop a protocol to, monthly, use practice billing data to identify active patients not completing annual well care and calculate the percentage of active patients receiving and not receiving annual well child visits.

In addition, QI teams will select one (1) or more of the following process changes over the course of the project as appropriate for their practices:

- Create a monthly recall system for patients who have not completed annual well care.
- Implement a plan to assess the well child visit completion status at each acute visit and communicate with office provider team for well care planning.
- Develop a practice protocol to schedule next well child visit before each patient leaves the clinic
- Execute a procedure to perform well care elements at acute visits when circumstances and time permits.

- Put into effect other interventions and process changes identified at the practice level that enable improvements in well child visit rates.

DATA COLLECTION:

Definitions:

- **ACTIVE PATIENTS** will be defined as all unique patients seen by the practice in the past 36 months. All unique patients three years and above and seen in the last 36 months will be identified from billing data to include MRN, first and last name, birthday, date of service and billing codes. The practice will sort the unique patients by billing codes to identify which have had a well visit code billed in the past year.
- **CURRENT PATIENTS will be defined as all unique patients seen by the practice in the past 12 months.** All unique patients three years and above and seen in the last 12 months will be identified from billing data to include MRN, first and last name, birthday, date of service and billing codes. The practice will sort the unique patients by billing codes to identify which have had a well visit code billed in the past year.
- **REACHED PATIENTS will be defined as a patient** with a well care visit code charged in the past 12 months.
- **UNREACHED ACTIVE PATIENTS** will be defined as an active patient with no well care visit code charged in the past 12 months.
- **UNREACHED CURRENT PATIENTS** will be defined as a current patient with no well care visit code charged in the past 12 months.
- **WELL CARE BILLING CODE includes 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395**

The definition of "Active Patient" and "Current Patient" are necessarily limited because, for ease of data collection, practices are only required to submit billing data. We understand that these definitions will overestimate the number of active and current patients in a practice. Although the following types of patients might be considered "active" or "current" according to these definitions, we understand they do not properly count the following types:

- *Patients who have been seen in the past 3 years/1 year but have left the practice, from moving away, being discharged, transferring care*
- *Patients who were seen as a one-time out-of-town visitor, as cross-cover for a colleague, or for hospital care only*
- *Patients who have aged out of the practice*
- *Deceased patients*

With this understood, it's impossible for anyone to achieve 100% well visit rates for active or current patients. However, we have opted to use these definitions because they can be extracted uniformly from billing data and can be benchmarked readily over time.

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Data Dictionary:

Measure Name	Numerator	Denominator
Active Patient Well-Child Completion (annually)	# Active Patients with well child visit in the last 12 months	# total patients age 3-21 seen in the last 3 years (Active Patients)
Current Patient Well Child Completion Rate (monthly)	# Current Patients seen in the 12 months with Well Child Visit in the last 12 months (by age group)	# total patients age 3-21 seen in the last 12 months (Current Patients)
Acute Visits for Current Reached Patients	Average # of acute visits per patient for patients age 3-21 with a well visit in the last 12 months (Current Reached Patients)	N/A
Acute Visits for Current Unreached Patients	Average # of acute visits per patient for patients age 3-21 presenting for a visit in the last 12 months with no well visit in that time (Current Unreached Patients)	N/A
Total Outreach Percentage (OPTIONAL)	# Patients who were contacted by the clinic staff	# of Active Patients with no well visit in 12 months at baseline (Active Unreached Patients)
Scheduled Well Child Visit with Outreach (OPTIONAL)	# Unreached Patients who were contacted by the clinic staff and scheduled a well visit during the measurement period	# Unreached Patients who scheduled a well visit during the measurement period
Completed Well Child Visit with Outreach (OPTIONAL)	# Unreached Patients who were contacted by the clinic staff and completed a well visit during the measurement period	# Unreached Patients who completed a well visit during the measurement period
Subjective PRE- and POST practice assessment (Balancing Measure)		
QI Time Investment (Balancing Measure)	Amount of time to invested in QI work by providers, nursing, and administrative staff	N/A

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References

1 Maciosek, Michael V. "Greater Use Of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost." *Health Affairs* 29.9 (2010): 1656-660.

2 CMS Form-416 Reporting, https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

3 Schor EL. Rethinking Well-Child Care. Pediatrics 2004;114: 210-216

4 Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press; 2001:4

5 Social Security Act, § 1905(r)(1)(B), 42 U.S.C. § 1396d(r)(B).

6 OBRA 1989, P.L. No. 101-239, Title VI § 6403(b)(3) (adding Social Security Act, § 1902(a)(43)(D), 42 U.S.C., § 1396a(a)(43)(D)).

7 OBRA 1989, P.L. No. 101-239, Title VI § 6403(c) (amending Social Security Act, § 1905(r), 42 U.S.C. § 1396d, by adding annual participation goals at the end of that section).

8 CMS, State Medicaid Manual, Pub. No. 45, § 5360(A) and (B). Beneficiary participation in medical screenings is measured using the participant ratio. This is calculated by dividing the number of eligible children receiving at least one medical screening by the number of eligible children who should receive at least one medical screening according to the screening schedules for their respective States.

9 American Academy of Pediatrics, Periodic Survey of Fellows 46. Elk Grove Village, IL: American Academy of Pediatrics; 2001

10 A recent study suggested that it is not possible, in the time available, to provide even the few preven- tive services most highly recommended by the US Preventive Services Task Force.23

11 Yarnall KSH, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? Am J Public Health. 2003;93: 635– 641

12 Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press; 2001:4

13 Hall DMB, Elliman D. Health for All Children. 4th ed. Oxford, UK: Oxford University Press; 2003

14 Schor EL. Rethinking Well-Child Care. Pediatrics 2004;114: 210-216

15 "Stronger Efforts Needed to Ensure Children's Access to Health Screening Services." United States General Accounting Office, July 2001. http://www.gao.gov/assets/240/232056.pdf

16 FY 2016 Data. Early and Periodic Screening, Diagnostic, and Treatment. https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

17 Recommendation Followup Memorandum Report: CMS Needs To Do More To Improve Medicaid Children's Utilization of Preventive Screening Services, OEI-05-13-00690. OFFICE OF INSPECTOR GENERAL. DEPARTMENT OF HEALTH AND HUMAN SERVICES. November 12, 2014. https://oig.hhs.gov/oei/reports/oei-05-13-00690.pdf.