

## **AMCHP 2009 ANNUAL CONFERENCE**

### **Using Partnerships and Bright Futures to Improve the Delivery of EPSDT Services**

February 20 - 27, 2009

JUDITH SHAW: ...mall and go -- take advantage of all the free Smithsonian exhibits. My name is Judy Shaw, and I'm from the University of Vermont. And I have a faculty appointment in the Department of Pediatrics, and I'm thrilled to have this workshop today where we're bringing together, I think, a stellar group of people to fill you in on some of the work we've been doing on partnerships and Bright Futures and EPSDT. We've got a real packed agenda. We're going to try to stick to it and see if we can get through it, but also be very flexible to adjust to your needs and questions. So, I think what I'll do is let - why don't the four of us just briefly introduce ourselves so then we don't have to do that. So, Paula, do you want to...

PAULA DUNCAN: Hi there. I'm Paula Duncan. I'm a pediatrician from Vermont. And I work with the American Academy of Pediatric under Bright Futures [inaudible]. Well, I was the MCH director of Vermont for five years, and then I was the principal assistant to the Secretary of Human Services in Vermont for another five years before I came back to medical school to work on [inaudible]. So, when Wendy Davis, who became the Commissioner of Health in Vermont [inaudible] and three weeks ago, I can't possibly be there [inaudible].

SUSAN CASTELLANO: Hi, I'm Susan Castellano, [inaudible] Department of Human Services [inaudible] state Medicaid agencies. Well, I'm responsible for [inaudible].

JENNIFER MAY: And I'm Jennifer May. I'm a policy specialist at the National Academy for State Health Policy. And we have a project right now. We're working with the Medicaid [inaudible] coordinator [inaudible].

JUDITH SHAW: Jane, I wonder if you could - no, I wonder if you could see if they could bring in some more chairs...

JANE: Sure.

JUDITH SHAW: ...because I think we're going to have a problem here. Yeah. Well, they gave us a count of 49 people who had signed up, and then I walk in this room and I thought, "Uh-oh."

Okay. So, let's move on and I just wanted to give you the brief agenda, a brief overview of the agenda for the session. We're going to have three sections, and each section is going to have brief presentations and then followed by discussions, small group discussions. So, we don't want to lecture to you and we want to garner as much information and knowledge from you as we possibly can.

The first will be EPSDT and Bright Futures, the standard of care? The second will be MCH programs and Bright Futures. And the third will be primary care providers, state strategies to implement Bright Futures and improve EPSDT. So, really, the standard of care, MCH, what's going on in public health and in states, and then let's get down to the delivery system and see what's going on in the delivery system. So, that's the chunk. We'll have brief presentations on each one and then we're going to have discussions after each ones. So, I'm going to turn it over to Susan, who's going to kick us off on the first one.

SUSAN CASTELLANO: Thanks, Judy. Can I ask, is there anybody in the room who, in fact, works for the state Medicaid agency in the United States or they do EPSDT? How many people do EPSDT stuff even if you're not a Medicaid person? Okay. So, just trying to get a sense of how many people know how much about EPSDT. I'm going to give you a brief history in trying to brief just to sort of set the context for what Judy is going to say.

The EPSDT program was created in 1967, and by the way, EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment, you'll see that in future slide, was created during the Johnson administration actually as a result of the Vietnam draft. They saw a lot men coming through the draft who had problems that had they been addressed in childhood would never have been problems as adults. And so, that prompted the president to go ahead and create EPSDT. And the purpose was to provide continuing followup and treatment so that handicaps don't go neglected rather.

It applies to the Medicaid well children birth to age 21, and it provides a broader range of access to services than may otherwise be available in the state Medicaid plans. So, for example, your state may decide that it doesn't cover dental services for adults. Well, it sort of doesn't have that option under EPSDT, that's sort of - for kids. Each state has less choices you have to cover the complete array of Medicaid services.

And there's two parts to EPSDT that often gets confusing to people because we in the Medicaid world switch back and forth between them when we talk, but there's an administrative or access part to EPSDT, and that's the informing piece. That's where states are responsible for actually telling enrolled families that they can access preventive services, assist - helping them access those services, scheduling appointments, sending reminders, helping with interpreters, helping with transportation. There's a whole piece in federal law about getting the kid to a preventive visit, as well as following up on referrals and helping them schedule additional diagnosis and treatment if necessary.

The second part is the part you all may be more familiar with, and that's the part where the actual screening occurs. So, it's assessing the child's health needs through initial periodic examinations and evaluation to make sure that those health problems are found and treated. So, that provides for the assessment treatment, and I included this language here in the second bullet to correct or ameliorate the condition. If you get into discussions about medical necessity, that actually has some significance. So, here's the federal EPSDT [inaudible]. I'm going to kind of tell you what the Feds asks states to do

with regard to EPSDT. It's in some ways, one of the more prescriptive federal laws and - but in other ways, flexible.

So, the periodicity schedule, and that means - you just say it puts out a schedule of visits that the child is supposed to receive. The periodicity schedule has to meet reasonable standards of medical and dental practices determined by the agency, and this is actually language from statute, and in consultation with recognized medical and dental organizations, and certainly, Bright Futures is a recognized medical and dental organization nationally. And then it also says that specific screening services applicable at each stage of the recipient's life. So, you - so, for example, blood screening happens when you're one and two, but blood screening doesn't happen when you're 10. And then, at the agency's option, additional screening can be provided. And the federal law requires states for Medicaid children to achieve an 80 percent participation rate. And what they mean by that is that 80 percent of the children who were due for a visit according to the periodicity schedule, if they were due that year for a screening, they receive one. And when I'm using the word screening, we're really talking about comprehensive well-child visits. I hope everybody gets that. But this is a well-child check up that's comprehensive.

So, within the federal laws and policy, there's also a lot of flexibility for states. States can pick the periodicity schedule, meaning, the frequency with which children are seen for services. So, for example, you might decide that you need to see children every other year at age two, age four, age six, age eight, you might decide you need to see

children every year. There's an amazing amount of flexibility there in terms of the frequency even though not in the content with the component. So, just to give you an example, Minnesota has 20 visits on their schedule for children birth to age 21, and the program does go to age 21. We did an informal survey in 2006, so this is before the current Bright Futures was out - 39 states had more visits than Minnesota, up to three visits actually, two states have fewer visits, and nine have the same number of visits. So, there's a range out there in states about how many visits children are actually required to receive under their Medicaid program. And as I said there, the number of visits range from 15 visits to 30, so double in various states from birth to age 21. And then the Deficit Reduction Act provided some additional flexibility around benchmark benefits. I'm not going to go into that now, but we'd be happy to talk to people if they're interested in that. There are states that have taken advantage of that.

So, here are the components. Now, I just told you that they give flexibility with regard to the frequency of the visits, but the components are fairly well laid out in federal statutes and policy and they consist of the following: comprehensive health and developmental history including mental and physical development, a comprehensive physical exam, it actually says unclothed, that is actually in law, immunizations and laboratory tests including the mandatory blood lead screening at age one and age two, vision and hearing screening, dental screening, and referral to a dentist, health education and anticipatory guidance, and diagnosis and treatment for services as medically necessary.

Any questions so far? Feel free to raise your hand and ask questions because I'm from Medicaid and this is all familiar to me, so sometimes they are the forest for the trees problem, and I'm missing stating the obvious.

So, that's going to kind of lay the groundwork for you for the requirements of EPSDT and keep of all that in mind now as Judy talks about how Bright Futures works.

JUDITH SHAW: Thanks, Susan. It's getting cozy in here, but that's exciting.

UNKNOWN SPEAKER: Yeah.

JUDITH SHAW: So, I'm going to give you the whirlwind tour through Bright Futures. How many of you own one of this? How many of you have seen one of this and own one of this? Okay. How many of you have no idea what this is? Be honest. Okay. Our goal is when you leave today, you'll have some sense of what this book is. I'm also going to give you the ability to take what is - I still haven't memorize the 600 pages and turn it down to a discrete set that you can use. Whether you are Title V directors, whether you are families, whether you are a healthcare professional, whether you work with families with children with special healthcare needs, whether you're early intervention, Head Start, whether you're in early education, working the school systems, whatever, we feel that this is a resource for you. And I'm going to show you how this could be a resource for you and that we all will speak the same language.

So, in the past, Bright Futures was published by Georgetown. It's now - the contract for Bright Futures has gone to the American Academy of Pediatrics and what resulted in producing this. But if you were a healthcare professional or anyone interested in what's - what are the requirements for EPSDT, you had a multiple choices to pull from. These are a few. We had the old former version of Bright Futures, we had health supervision guidelines, which the American Academy of Pediatrics produced, we had the AMA's GAPS, Guidelines for Adolescent Preventive Services, and we also had other guidelines that other smaller groups would make. The question is, with all of these, what's a provider to do? So, what do providers generally do when they're faced with all of these guidelines?

UNKNOWN SPEAKERS: Whatever is most comfortable.

JUDITH SHAW: Whatever is most comfortable, they make it up. I mean, they don't make it up, but they choose one that is preferable to them, they develop their forms based on that, their guidelines. What happens when parents go between practices, or even those of us talk about what's going on in EPSDT and well-child care, there's a lot of variability. And we saw that. So, the American Academy of Pediatrics, Maternal and Child Health Bureau and Chris DeGraw notices here, he's our project officer for the Maternal and Child Health Bureau, puts the Bright Futures contract out to bid. And the American Academy of Pediatrics bid on the contract and agreed to do their best to try to combine at least these, if not other guidelines into a uniform stand.

And I always say when I talk to my public health colleagues, if the pediatricians can all agree on a single set of guidelines, we better pay attention because that's a big deal. And so, what was born was Bright Futures that would take a minute to read the definition that took us at least a day. There's many people in this room that were around the table that hashed out this. And I have to tell you, as a multidisciplinary group of people that worked on Bright Futures - families, nurses, pediatricians, family physicians, psychiatrist, nutritionists, psychologists - all of us worked together. This is the definition: it's a set of principles, strategies and tools that are theory-based, evidence-driven and systems-oriented that can be used to improve the health and well-being of all children to culturally appropriate interventions that address the current and emerging health promotion needs that the family clinical practice community helps us in the policy levels a comprehensive set of EPSDT of what Susan just said, guidelines for what to do. So I'm going to take you quickly through an example. I don't have my slides, but basically, the first half of the book are great sections on child development promoting healthy sexuality, promoting community resources. Those are great overviews and backgrounds on the state-of-the-art at the time when we published this, which was October of '07. The second half of what we call the visit, the traditional – what happens at each visit?

I'm going to take that second half of the book, the visits, and make it even smaller for you so that this doesn't look so overwhelming when you walk out of the room today. So, an 18-month old – I'm going to use the 18-month-old visit. So, you got the Bright Future's book. If you open to the 18-month visit, this is what you see on the first page – on any visit page, context. It starts with the context. The 18-month-old requires gentle

transitions, patients, consistent limits and respect. One minute, they insist on independence; the next minute, he's clinging fearfully. Can't you see that little 18-month-old during that run back, trying to be very independent? Who is this good for? The context. Anybody who hasn't seen an 18-year-old or doesn't have any – an 18-month-old who wants a good overview? Medical students? A new employee? If you're dealing in a wet clinic and somebody's coming in that's 18 months and you've got a new staff member, a great overview that just gives you who that child is. Nice description, nice last minute.

If you're in practice or whatever you do, and at a certain age child comes in, you haven't seen that for a while, pull out the context and get a brief summary of the kid. Turn the page. Up in this section, we have priorities for the visit. What I have to tell you is that the one thing we heard loud and clear from everyone, not just clinicians, everyone, don't give me that long, long, long, long list of everything I should think about and deal with that particular visit. And then, in addition, say, well, if I - the kid missed the last visit, then you need to go back and remember what you missed there. Don't do that to me. Come up with priorities with a visit. I'm talking about anticipatory guidance, obviously, medical screening. There's mandates for that. But in regards to anticipatory guidance, try to help with some priorities. So, it took us a long time and a lot of work. We're not going to go into the details of how that transpired to come up with five priorities for each visit. So, I'm going to show you what those are and how that works. Of course, I need a guinea pig. So who has an 18-month-old in this audience? Who

knows an 18-month-old? Who has a grandchild or a brother and sister? Would you like to do it?

UNKNOWN SPEAKER: Oh, do what?

JUDITH SHAW: Do what? Be my guinea pig for the 18-month-old. Who else? A couple other people raised their hands. Okay. What I need is – if you were taking your child in – and don't open your Bright Futures books if you have them and cheat. If you're taking your child in for an 18-month-old visit, what would be some of the things that you might want to talk with the health care professional about? And then we're going to look at the priorities and see how well they match up.

UNKNOWN SPEAKER: Nutrition.

JUDITH SHAW: Nutrition.

UNKNOWN SPEAKER: Toilet training.

JUDITH SHAW: Toilet training.

UNKNOWN SPEAKER: Speech.

JUDITH SHAW: Speech.

UNKNOWN SPEAKER: Safety.

JUDITH SHAW: Safety.

UNKNOWN SPEAKER: Temper tantrums.

JUDITH SHAW: Temper tantrums. Anything else? All right. Let's see. You want to see what the – what?

UNKNOWN SPEAKER: Oral health.

JUDITH SHAW: Oral health. Oh, that's somebody that's really on top of the guideline. Let's see. So, let's take a look at what we've got here. I'm going to move away from the mic for a second, I apologize. The priorities are here and in parenthesis a descriptor of what we need. So, in this situation – did I do – no, I didn't. We've got family support. Child development and behavior, that's where your language and you're speaking language promotion and hearing, toilet training readiness, and safety. So, which are the ones that we mentioned that are not up there? Nutrition.

UNKNOWN SPEAKER: Oral health.

JUDITH SHAW: Oral health. That was at a...

UNKNOWN SPEAKER: Healthy sexual development.

JUDITH SHAW: Healthy sexual development. And I forgot what age group that.

UNKNOWN SPEAKER: Mental health.

JUDITH SHAW: Mental health. Well, it's under child development. Adaption to non-parental care.

UNKNOWN SPEAKER: And family support.

JUDITH SHAW: And family support. What we did – what you will notice is things like nutrition. You recover nutrition zero to 12 months, but after that, we don't have nutrition as a header. We have it embedded in establishing routines, turning off the TV at meal time, having healthy snacks, having a routine. Same things sometimes people mention – sleep. Sleep is actually not – that's the outcome you want to achieve. How you do it is establishing routines. So, what you'll see is the priorities are the – are really in a contextual framework of what you're trying to achieve, which, I think, what we're finding means a lot more to all of us doing the care because it's not just about sleep. What if you could talk about establishing healthy routines and talk about sleep time, nap time, feeding time, consistency in that child's life? That's really what we want.

And if we do that well, they should have healthy nutrition because they're being fed at certain times, and they should have better sleep patterns because they've got a routine. So, that's an example of the priorities and how we've done that. I'm going to give you some examples of that. The next couple of sections on that page are health supervision and observation of the parent-child interaction. More for the clinician, but certainly, what you've asked us to do is don't just tell me what to do, but give me the words that I can use to do it. And so, a lot of this you will see are actually in the words that you can use. And again, for people who interact with children other than health care professionals, primary care providers, we believe that this could be a tool as well. You can use the language, and I'll show you what we mean by that. The upper right hand corner on this visit is surveillance of development. Now, we know that the 18-month-visit is a structured – is recommended to do a structure developmental screen at this visit. But we elected to leave the milestones and the description of development in each visit despite the fact that certain visits, we recommend that you would administer a structure developmental screening tool.

And what I wanted you to see here is socio-emotional. You can see that the questions are in the words that you can use. How does your child act around other children? How does your child communicate? What do you think your child understands? So, instead of just doing socio-emotional screen, we're starting to give you some of the language and the tools that you can use. And again, what we hope is, is that Bright Futures won't just be for pediatricians in practice, that the way we phrase this we can all have a common language with how we interact with families. The next page is the physical

exam. I'm going to go very quickly through physical exam. Every visit, there's a physical exam, but we also point out here are the things that you pay special attention to. The screening tables, we've put the medical screening altogether in one table. And as you can see, universal and selective screening. Universal means it gets done for every child at that visit. Selective is based on a risk assessment. And I'm going to show you the tools that we have to go with that. The last section is the anticipatory guidance. So, all of that before that is physical exam, the priorities, and the screening. And now, here's the anticipatory guidance section. So, let's just take a look at this.

Remember our priorities and remember – I'm going to take two of them, child development and language promotion. There they are in the screen, in dark green -- same thing that was in the priorities but listed up there. So, if you are – I'm not going to pick on anybody in here, I could. A pediatrician who's been in practice for years – I will pick on Tom {inaudible} back there. If I say that, Tom, language promotion and hearing, he probably goes, "Bingo. I know what to do. We'll go right into the room." If you say to an early intervention person, "You need to assess this child for language promotion," and they've been in the field for years. They probably have a good sense of what we're talking about. They don't, they might want to look underneath in that light blue area and go, "Oh, I see what it means. It says encouragement of language, use of simple words and phrases, engagement in reading, singing, and talking. Boom. I know what to do. Go in the room or do what they do." However, if you're new to the field or you want to understand a little bit more of what we meant by that, underneath, we have more of a description about what it means. So, think about the people in your world and where

you work when you're thinking about these priorities. If they need more information, they can look.

Sometimes it's got some data, sometimes it's got some facts. It gives you more of the context of what we mean by that. The last piece is right here, sample questions. Again, don't tell me what to do, but tell me what to do and how to do it. So, you asked us for – if you're going to assess the language promotion or child development, give me some sample questions I can use and give me the anticipatory guidance in the language that I can use to encourage that particular area. So, let's do a quick example. Language promotion, there's the priority. So what does it say here? The development of language and communication during early childhood is of central importance. Communication is built on interaction and relationships. Parents may ask about the effects of being raised in a bilingual home. So, it gives you a little bit more about what that means. Let's take a look at some of the sample questions. How does your child communicate what she wants? Who or what does she called by name? What gestures does she use? For example, does she point? Does she wave bye-bye? So, there's some sample questions. Anticipatory guidance. Encourage your toddler's language development by reading and singing to her and by talking about what you're both seeing and doing together. Books do not have to be read. Do not be surprised if she wants to hear the same book over and over and over. Not a true statement.

So, think about this: if you've been in practice a long time, you probably don't need this. But anyone new in training, in the worlds, in the environments that you were in, we're

hoping that this becomes useful so that we're all describing and talking the same language. I'm going to give you a quick overview of the tools. These are still embargoed so they're not in the slide set that I've submitted, unfortunately, because they're still under development. But you get to see what's coming for Bright Futures. We've got a pre-visit questionnaire. One of the problems – remember how I said we had all those guidelines? Everybody made up their own tools. So, we now will have a set of tools that will link to the Bright Futures book and be consistent with the priorities and everything. Pre-visit questionnaire, this means prior to the visit. It's a paper format. Many people ask about Web formats, parents doing it online.

Obviously, if you've got a parent population or an electronic medical record vendor that wants to put it out there that parents can complete an electronic format, that's absolutely fine. I'm going to show you the paper version, but we're certainly working with the health IT groups to see about getting these translated appropriately into where those systems are. Pre-visit questionnaire. Setting the agenda, what would you like to talk about today? There's our medical screening, the medical screening questions. And here's the developmental surveillance. So, let's take each one. Here's setting the agenda.

Remember our priorities, okay? There they are, and there they are for the parents. Did you notice that family support is nowhere up there? We've translated it in the language that the parent can understand. Child development and behavior is your child's behavior. Talking and hearing is language promotion and hearing. So, again, we don't expect the parents to understand the clinical terms that we use. This section here,

which are all the other descriptors, you will find right here as a check box for the parents.

So, this says, "What would you like to talk about today?" There's a blank line. And then here are some checkboxes to help hone in on what that parent would like to discuss.

Again, the most important thing is to address the parents' concerns. Hopefully, they'll identify it up there or through a conversation. Otherwise, you're giving them a sense of what the context of this visit is, and in a way educating them about the priorities for this particular visit. Let's go on the medical screening -- questions about your child.

Remember that medical screening table that I showed you where we said there were universal screening and selective. With the selective screening, underneath it says risk assessment, positive on risk screening questions.

Well, where are the risk screening questions? Those are right here, okay? So we've translated those into a checklist about risk. So that's your medical risk section. And then the bottom part is developmental surveillance. Remember those developmental surveillance questions? They are just listed right now as checkboxes at the bottom.

Remember this 18-month, we prefer that you use instruction developmental screening tool. But we do have some milestones at the bottom. The second piece is the parent handout. And if you noticed, there is the parent words talking and hearing your child's behavior. But on the side, for you, we put what the provider terms are. Why that's important? The first 12 months, it talks about feeding your child, but there are subtle nuances between each visit. We're hoping this becomes a tool that you can use and

write on as it's not just something you give to the parent after the visit. But you use this in the visit, encircle, and write and highlight different sections. The last piece is down the bottom, right hand corner, what to expect at your child's two-year visit. So it gives them what's coming up at the next visit, so they have an understanding of that. Then I turn it over to Susan to talk a little bit about Bright Futures in Minnesota.

SUSAN CASTELLANO: Thanks, Judy. And, you know, Jennifer just made a good point which is that the tool that you saw up there is not meant to replace any of the standardized screening tools that you think of, like, a developmental screening tool or a mental health screening tool or a led-questionnaire screening tool. This is a general tool for the health history and the documentation of the visit, but it's in no way meant to replace those other tools that you might be familiar with.

UNKNOWN SPEAKER: I just have a quick question. When you do find there's an issue, are there tools in there to tell the clinician where to send the parents for additional help? Say, with the behavioral issues or, I mean, more serious.

SUSAN CASTELLANO: Not in Bright Futures because Bright Futures is just about health supervision. And it -- the only place is when there's a medical screen, if they fail the medical screen in, let's say, audiometry. Other than that, no, because otherwise we would have needed a dump truck to put all of that in. There was a lot of discussion about well what if this is positive? And that's really where the secondary documents, books, guidelines come in, if that makes sense. Chris, do you want to?

CHRIS: [Inaudible] our systems tools, we're working on that. And one of the things that Bright Futures still encourage practices or [inaudible] to accept the community resources, something you know when something comes up right [inaudible] you know these are [inaudible] projects for...

UNKNOWN SPEAKER: Okay.

CHRIS: Yeah, that's always a problem. So that's why we really encourage [inaudible] practices all departments to do figure that out upfront so it's not a [inaudible] to the process.

SUSAN CASTELLANO: Good question. Thanks. Well, so now and I'm going to give you a little example, at least in the Medicaid world and in the Title V world actually in our state about how Bright Futures relates to our everyday jobs. In Minnesota, as I mentioned, we have a 20-visit schedule that does not match Bright Futures in many places. Kids are only seen every other year, every three-year, every four years. So we're currently considering how to update our periodicity schedule based on the Bright Futures' recommendation. Our Title V agency endorses and promotes the Bright Futures' recommendations for public health clinics, and we're working on having them endorse and promote that as a statewide set of recommendations. For those of you who are in Title V, how many of you actually have something that you endorse statewide? So, if a private provider calls you and said, "When do I screen kids that you would have

a tool that you would recommend to them?" You would say Bright Futures or you would say some other local periodicity schedule. Do many of you act as leaders in that regard and that you kind of set the agenda for your state regarding tools, or how many of you don't but wish you did? Okay. Nobody is going to raise a hand on that. Okay. And the issues for us are very practical ones in Medicaid. Of course, we pay for screenings.

And so if we're going to add a whole bunch of screenings to our schedule, guess what, that's going to cost some money, it's a Medicaid money, which we all know is a little tight these days. It's going to [inaudible] that 80 percent participation rate I mentioned. We get measured by that federally every year. And if we put more visits down, I mean I think it's generally assumed that the more times you expect the parent to show up for something, the more times they have an opportunity to fail at showing up for it. And so, we have a concern that if we set the bar at the right place, we kind of, we damage ourselves from a measurement's standpoint and we have to come up with more money in order to do it. So those are the issues that we're wrestling with, not that we don't know what the right thing is to do but how we get from point A to point B.

Couple other points about the comprehensive nature of EPSDT requirements. If you saw all those components, I don't know how familiar you are with other well-child things but there is this sports physical that's pretty brief and that type of thing. EPSDT is a very comprehensive list of activities and it lends itself very well to the Bright Futures guidelines, I think. Sometimes, we could ask or challenge, maybe ask is a kind word, the pediatric providers about why Medicaid kids get more? You know, they say, "We

don't do some of these stuffs for kids who have private practice. Why do you want us to do all these stuff for the kids who get Medicaid?" When they're on the public dime is kind of the unspoken challenge there. We direct them to Bright Futures and we say comprehensive care is recommended for all kids. This isn't just about kids who are poor and at high risk. Comprehensive care is a good idea for everybody. And I think it's significant that Bright Futures shouldn't say, okay, here's the set of guidelines for at-risk kid and here's the set of guidelines for everybody else. These are the guidelines for all kids. And if anybody's worked with practices, you know that it's very hard to have them try and have two sets of guidelines. We do this for this group of kids and every time a child walks in the door, we have to decide, okay, now, which kid is this and so which things am I doing? It's not workable from a practice standpoint. So that's where we're at that. Minnesota is struggling with those questions.

The other thing I wanted to mention, we're trying to cool the room down a little bit because it's getting a little warm in here, is that when we were developing the guidelines for Bright Futures, that question for all or what do we do with Children with Special Healthcare Needs? And we had a long discussion about that, that many, many people weighed in on, and there was the debate of do we have a companion guide for Children with Special Healthcare Needs and then Bright Futures? And we really felt that that is not what we wanted to do, that this was about promoting the health of all children and that we are developing and supporting families in partnership with their clinician. We do have in each section in the beginning, section of Children with Special Healthcare Needs under child development and we have tried to weave throughout [inaudible]

many people from Family Voices and many of the families were involved in reviewing this to make sure it reflected what they thought should be in this document. So it is an integrated book. And I think that your question earlier about what do you do if there's a problem? We didn't go into, what if the family is homeless, you do this, or if it's a child with special needs or if the parent doesn't speak English as their primary language or if the parents are literate. We really felt like those are things that are secondary companion pieces of information to the Bright Futures and could compliment that. But otherwise, the document would have been unwieldy. One of the things we would love to see is if there are special areas, what are those? What are the other areas that you feel might need to be developed that could compliment this that would be of a resource in your world? And we would be very interested in hearing that as we roll it out. But that was a very conscious decision we made not to differentiate Children with Special Healthcare Needs. And so, we'll see. I mean, let's see how it works for...

JUDITH SHAW: Yeah, and I just have to say the way I always pictured this, the medical home is the overarching concept and structure. And within medical home, there's the health promotion side, the health prevention side, the things that we do for every kid. And one of the things we are worried about is the Children with Special Health Needs. Often, we're worried that they get their care for their asthma and their other issues but they don't get their well-person care. And so, this is really designed for every kid who needs these things. We need to talk about routines, we need to talk about strengths, we need to talk about all those things, make sure that there is one visit that's or one time that kids got that special care. So definitely, it's part of the medical home but medical

home is overarching, the big concept is medical home and this is the health promotion side of the house.

PAULA DUNCAN: So what we wanted to do is rather than talk, talk, talk, I know there's a lot of expertise in the room. Rather than just open it up to discussion, we want you to just work in small groups at your table and discuss among yourselves. We gave you some questions. What you heard here and what you learned? And if you wanted to sort of turn your tables around in a larger group, and we'll float around if you have questions for us. Let's take about five or 10 minutes, share among yourselves what you're doing, what you've heard here. Use these questions, if you want to guide you. Do you follow a schedule? Does your Title V agency promote a schedule? If so, how do you use it? What's the lay of your land in your state? What have you learned? What would you recommend? Where do you need help? And what people or groups are involved in determining the standard of care for preventive services? So let's take about maybe five minutes to just let you guys talk a little bit about this, does that make sense? So go to it.

Conversations? Right. I wish we could do longer because as we said, we know a lot of expertise in this room. One thing I did here was that some people are confused about does Medicaid have to do this? If we go back and we start waving this in the face of Medicaid, they have to do EPSDT but remember in the very first slide that we're showing, there's a group that has to get together of a state level and decide what the periodicity schedule is going to be. But the idea is that we've had all these experts, including families, get together and determine what we think is the best guidelines. And

in the book, there's also an evidence and rationale chapters, so there's not a lot of evidence about preventive services, but the reasons that we made these decisions are important. I just thought I'd give you an example. The 30-month visit is not a visit that we had in the period of city before and we did two years and three years.

And so, these group of experts, all of us, together, said, wait a minute, though, you don't know when you see the kid at two, you don't know if they really have a language delay or not. They can't really quite tell. And then by the time they're three you know you've missed it. You've missed that whole year that you could have been working on things. So if you're trying to make the rationale with your organization about why we need a 30-month visit, that's the reason, because instead of doing things just according to some chronological age thing, we said, what's children's development look like and when do we need to do things for them? So this is a very child-focused periodicity schedule. If you're not going to do a 30-month visit, look at language really, especially at two, that's fine and do your standardized developmental screen then. We would have put those standardized screens in the book if we could have, but they're owned by people and so they're not free. [Inaudible] and ages and stages the parent filled out developmental screens that we think are so helpful to us in finding kids early and making sure that they get the care they need.

UNKNOWN SPEAKER: I apologize because I haven't [inaudible] in the meeting, but did the group feel that ages and stages, social, emotional with the act of the screening for autism or...

PAULA DUNCAN: In this work, we're doing a separate autism screening but that's also because the AMCHIP is free and so...

UNKNOWN SPEAKER: But we didn't assess that.

PAULA DUNCAN: No, we didn't assess that. Yeah, we didn't assess it.

UNKNOWN SPEAKER: Okay.

PAULA DUNCAN: But that's a good question. I'm just going to also pick up that thread about the community. So one of the ideas is that we couldn't put together a community guide for the country because, everybody said, obviously, it's not -- we try. Actually, we worked on it for a while, we did. We got national and state, oh, my gosh, and we got lost. If you try to see [inaudible] oh, poor Betsy Anderson. She's such a good sport.

UNKNOWN SPEAKER: [Inaudible]

PAULA DUNCAN: That's what we came up with, that everybody needs to look and make sure the practice -- and maybe it's one of the things I'm going to talk about is the role for public health. One of our roles in public health can be to help practices, clinics and groups, know what their resources are. It's a beautiful partnership. So, what all we have is -- [inaudible], we have it and it's what Chris has alluded to -- we have a list of

different kinds of community resources that people need to think about for their area. And this columns, as you get your whole practice together, you get your whole clinic together, you get your workgroup together, and you say, "Let's look at this list together and see which ones we have a good relationship with already and we don't need to do anymore, check." And that's the first. Then you say, "Okay, got those." Here's some other ones. We could probably use a better relationship with this particular – we have no relationship with this particular group. Our families need this kind of a service. So, don't have a relationship but need one. And the third category is, "Don't need this resource."

So, it's just a tool that we can help you go through and see what you jog your mind about what you want to do. Then, how you get the community resource that you gather is another situation, but it's something as we roll Bright Futures after we've done a lot of working with communities about. One of the things that people have found is that they have what we call North Carolina [inaudible] because we learned it from North Carolina. So, you get the practice of the clinic or the -- you get those people together with other – the people that they need to refer to, and face to face, eyeball to eyeball, I guess it's really hard to turn somebody down when you've already met them, when they call you for a referral. So, there's a little tricks like that that are part of the implementation of Bright Futures as we take it to the next step.

Can we just tell you a little bit about some of the ideas about MCH in Title V? I think, certainly, I hope you would see that Bright Futures addresses a couple of the public

health priorities, to help the well-being of all children and families because this was not just about kids all the time, family support, maternal depression, access to health and dental care. Obviously, this is something that we really want to have for everybody. Disparities is a big part of – and inequity is a big part of Bright Futures. We've tried to take that into account. And then I think performance measures. I think that if everybody got services according to Bright Futures preventive services, that a lot of the MCH priorities that we have to report on as part of our Title V would really be addressed; some of the dental health, some of the adolescent pregnancy. People we're talking about, you can see how this could all relate to each other.

So, let's think about just some ideas, and you probably have more of your own, but use Bright Futures is a guide to develop policies and programs to address – improve the quality of children's healthcare. And Judy and Susan are going to talk about that in the next section a little bit more. These Bright Futures is a common standard. That would obviously help us all because then we'd all be doing the same thing. These materials, some of the materials, from here will help parents in youth get prepared and make the most of every visit. I think a lot of that stuff parents could read and like, some of those things about what to do, what to think about for the next visit, but also even in the book, those context sections, they kind of speak, I think, with some of the language that the folks that wrote them. I didn't have anything to do with writing that part, but that part was really good to me. It really speaks to people in a way that addresses their heart, as well as their brain, using anticipatory guidance sections for educational community partners, other child health professionals and parents directly.

When you look at those, if you have a chance to look at those anticipatory guidance sections, they really are put together in a way that you could use them with parents and with clinics. You could use them across the board, lots of different ways you could think about looking at those things. As an experienced clinician, I think that what you could do is – or if you're [inaudible] person, the physicians you work with, the nurse practitioners, you could say, "Maybe I just want to read this once." See if there's anything new you could pick up about the 18-month-old by reading through that anticipatory guidance section because it was really put together that way. You could also consider using the Bright Futures themes in your agency education activity. So, you could look at the first part of the book and say, "What's new in oral health?" It's about 20 pages long and you could look at it and say, "Maybe we'll do something in oral health, and here's all the stuff that we need." And then you could also use strength-based approaches and shared decision-making strategies to engage with community partners and parents. I think public health has got that, don't you think? I think we understand that if we don't use strength-based approaches and shared decision-making strategies, we're not going to get very far with changing people's behavior, which is really the thing that is most important right now in terms of all children and families, and the decisions that they're making about physical activity, nutrition, all those things.

So, I think that by thinking about using that kind of an approach – and Judy and I are doing a session on that tomorrow, so I'll leave that. But we're going into the nitty-gritty of how you would actually do shared decision-making and strength-based approaches. But

I'll just tell you one quick story from a patient of mine when I was talking to about what I could be doing better – she's 16 – in my visit. And she said, "Well," she said, "You know, what you – all you've ever do with me, you say, 'Don't do this and don't do that.'" She said, "Do you understand that I could be sitting in my room on a Friday night, not having sex, not doing drugs, not doing anything wrong and being perfectly miserable?" Should I pick you? You better think about what kids need to say yes to, and then start talking about it. So, my career goes in a different direction based on one person's opinion. And it's true, I think that we've all – and I think in public health, we knew that for a long time, that if we can – for all families, all children, especially children with special needs, especially children and families in difficult situations, if we can make sure that we're helping them think about what they need to say yes to and not just this negative way, it's a very strong developmental thing. It's very consistent with Bright Futures. Oops, sorry, I went the wrong way.

What about public health clinics and practices? Do any of you work in public health where you actually deliver services? Any [inaudible] doing that now? Okay, we'll skip over this quickly then. Bright Futures gives everybody, the same patients a chance to document great care. There's new office systems approaches we can think about that Judy and Susan are going to talk about. Physicians can get ready for recertification and nurse practitioners for paper performance, improved access to community resources, knowledge of the best practices, and network of committed professionals who are trying to learn together. And I think that public health, as a key partner, we can do a number of things. We can provide information about content tools. Once we get the content tool kit

done, if you like some of those things that you saw, how do people order them, how can they get them, how can they use them, training them how to use them. Referral resources this morning was saying, "It's a really beautiful marriage between public health and people that are seeing patients directly." They're trying to make sure that they have the resources they need and surrounding them with this kind of health that they could use.

Public health data is invaluable. I know in public health, we spend a lot of our time trying to make sure that the data is right, the performance measure data, all the data that we have. I just think that one of the things – one of the phrases I really like is, there's data for research, and we all know about that, and control routes, and blah, blah, blah. And then there's data for change. And I think public health is all about data for change. And I think that we can really partner in this because the practitioners are busy seeing the patients. The parents are busy doing what they're doing with their kids, trying to have them have the best life possible. And I think public health, by providing the data that we keep measuring and looking and using, data for change, getting everybody to agree on what they want to look at and then how to improve it, can be really powerful. And that I think, also, public health can provide training and support for office systems change. One of the really beautiful things [inaudible] if we can get that data for parents. The questionnaires that we do have from [inaudible] group about how did the [inaudible] go, did you get them, with the anticipatory guidance, right for what you needed? Is the developmental screening done? Those kinds of things can really be powerful. We did a

small project in Vermont and North Carolina, where we used those parent-filled-out questionnaires to help guide practitioners in their anticipatory guidance.

I have to say that some of our practitioners were kind of sad. They thought they were doing better. But when we ask the parents if they were really meeting all their needs, the parents said not quite, even though these parents love these practitioners. So, I think that just using data in a way that can be really supportive of change can be very helpful. We just wanted to also just tell you a little bit about the National Center for Cultural Competence review Bright Futures because we think that this is key. Obviously, health equity is one of the things that public health is most concerned about. And they gave us some ideas. And then Jeff Goldhagen, another public health physician, actually did the red parts about how it links in. They said that we put in – suggest they review the guidelines. So, we went back and put in more strongly all the things that they had suggested. They focused on literacy. They said, how do you prefer – how do we prefer to receive information, language spoken at home, family structure, who lives in the home and supports, sources of advice, what do – where do people really look for that, parental expectations, child-rearing beliefs and health beliefs, home environment, community environment, access to play and neighborhood safety, establishing trust, and do you see anyone else who got the healthy [inaudible] for their family? So, all the [inaudible] practitioners are alternative medicine, people that people are seeing [inaudible]. They suggested that we want to definitely know all those things, right? So, all the stuff got woven back in. Within there, but it wasn't strong enough, obviously, or they would've noticed it. So, we really want to thank all the people that reviewed this

document. Over 2,000 people reviewed. We got 7,500 comments and two public reviews of this document. Maybe some of the people in this room helped us with that. It was an enormous task for the review. But the center really helped us focus on something that was extremely important to us and as we know, public health people. Susan, I think this is yours.

SUSAN CASTELLANO: So, in Minnesota, just by way of background, we have two agencies that our Title V and our Title XIX are in different places, where our Title V activities reside in our health department, our Title XIX and Medicaid activities reside in our Department of Human Services. So, we don't sit by each other in the same building or naturally, of course, financially, of course, to work fit together in any particular way. But we have forged a really strong working relationship, and I think it's been so beneficial to have the Title V, people who are viewed more as a – I don't know how it works in your state, but in our state, Medicaid is viewed very much as the regulator and the payer, and – but even though we have plenty of the people with expertise in our agency, no one looks at us as the place to get good ideas or information. We're just a big, bad Medicaid agency. And we don't think of ourselves that way, of course, except a lot of people do. And so, it's really been important for us to partner with Title V because they have a different reputation in the community, and they can help us promote things and come off in a way that we, as the state Medicaid agency, don't or can't. So, we actually contract with them to do education activities for us. They provide EPSDT trainings around the state where they literally go out and tell people – teach people how to do each of the components of the EPSDT visit. They've developed online training

modules for us. Now, we're trying to figure out particularly to get the private providers who don't have any time. They're in clinic all day, taking time away from clinic as money that they would've earned. So, how do we get in touch with these people?

And this is one way that we've developed that seems to be working, and I know other states have done this too. Washington, D.C., in fact, has great online screening modules. I would say, look at theirs before you look at ours. But they've developed screening modules in all of these topic areas, and that's been really helpful. They developed Your Growing Child brochures, which I'm thinking might be supplanted by what's now in Bright Futures, where it kind of tells you what to think about for your kid at the age appropriate, developmentally appropriate, and those are handed out at each, well, visit by private providers. They created age-specific screening templates, which, again, will help – will be supplanted by the two of the Bright Futures [inaudible], but it's literally a way to go through and document and remember the things that you're supposed to talk about at each visit.

And I should mention that templates are kind of underrated. All of the research that's out there demonstrates that when providers use the template, the visit goes better because they don't forget things. You think you're going to remember everything, but you rushed through and you just don't, and the research bares that out. And it also access a really easy way to document stuff. I mean, when we did a chart review for our Medicaid agency a few years ago, we found that we run in and looked at the chart for all those components of a visit and couldn't find them, and the providers say, "We do that stuff."

But when we tell Johnny to wear a bike helmet, we don't write down, "I told Johnny to wear a bike helmet." They just say it. And documentation charts like that can help you just quick check things, where you're not having to write everything down. It's an easy way to document what actually happened.

So, those have been really helpful in our state. And then we also contract with the county Title V agency, so that access or administrative part I was talking about, EPSDT, where you're writing letters to the families, you're calling the families, you're helping them get transportation, that sort of thing, we actually contract all that out to our Title V agency, and they do that work for us. So, we work very close with our Title V agency, and they actually pay for someone to come in. And if they kept asking us for Medicaid data for years and years, just send us your Medicaid data, and we said, "You have to understand claims and eligibility, and it's not just quite as simple as shipping you a data set." And they finally said, "Well, let's – how about if we pay to have an employee located in your agency to do data work that we're interested in or that we're both interested in?" And so, they pay for research scientists in our agency to do research projects that are of mutual interest to us. So, we contract with them and they contract with us, and we work very closely together.

PAULA DUNCAN: Thanks, Susan. What I think I'm going to do in the interest of time is go through the next set of slides and then open it up for discussion because I think the next step, we want to make sure that we don't miss. And I'm going to go quickly through each of examples and I'm going to turn it over to Jennifer from [inaudible] to talk about

[inaudible] because now we're going to go into what's going on at the state levels and collaborations across states and how those can be vehicles for sharing what we're doing and what we're learning. So this one's about primary care provider state strategies to implement, so what's happening in the state. I'm the director of VCHIP, the Vermont Child Health Improvement program in the state of Vermont. We have a mission to optimize the health of Vermont children by initiating and supporting measurement-based efforts to enhance private and public child health practice. We work with anyone in the state that has an interest in children. This is our timeline of projects that we've done. I'm not going to spend a lot of time on it, but suffice it to say that we started with a periodicity schedule. Vermont agreed upon a single periodicity schedule back in the 1990s. I moved up from Boston then in 1999, early 2000, and we started working with providers on quality improvement projects, taking the guidelines and the standards and looking at how practices were doing and trying to help practices improve the system of care, so really partnering with our Title V, our EPSDT, our Health Department to be the action arm in the practices.

What happened is we started with this project called the Vermont Preventive Services Initiative down there around 2000 and we exploded because we got everyone -- that gets in the next practice outside -- we got almost everyone in the state pediatricians and family practices to work with us. I don't have a lot of time to go into this. If people are interested in this, Monday afternoon at 3:30, we're going to go into this in a lot more detail. Nan Streeter is going to talk about Utah. Susan is going to talk a lot more about Minnesota. We're going to go into more detail. I was going to try to see if Karen Hughes

would join me. She's in the back because she's doing a lot of great work in Ohio and I hadn't had a chance to e-mail her but I'll put her on the spot.

So we're going to talk a lot about that but I wanted you to understand that we've got the Bright Futures guidelines, we've got the Title V, we've got the state, and now we're beginning to develop across the country interest in collaboration about how to do this work. So rather than me going out to teach states how to develop VCHIP-like programs, and that's what they call me. Can you teach me how to do a VCHIP in my state? I said, no, let's call it something different. We call it an improvement partnership, durable regional collaboration of public and private partners that uses measurement-based efforts and a systems approach. So, this is what we've got. Ed Shore from the Commonwealth Fund has funded Vermont to teach other states how to do this. I go to the state and I say, I hope I never have to come back again. We're going to let you know how we're doing this, but I want you to be a partner. So these are partnerships in the states working at the ground level in implementing and making change at the practice to improve the quality of care. We started with Vermont, and we taught New Mexico and Utah for free.

And then finally I got some funding to teach some other states how to do it. I'm not going to go into details but I want to show you -- oh, quickly, each state is doing it a little different. Some are housing it in AAP chapters, some in Medicaid agencies, some in public health departments. We're learning about what it takes to do quality improvement, to really work on the system of care collaboratively in the state. And here,

I'm proud to announce is nine of the logos of the different programs. So Minnesota Child Health Improvement Partnership, West Virginia has Kidinitiative, the Quality Improvement Partnership. UPIQ in Utah, Michigan, VCHIP, I thought this is interesting. Isn't this like -- I don't know what this is. I got to find out what's [inaudible]

UNIDENTIFIED SPEAKER: [inaudible]

PAULA DUNCAN: But I think they want it to be -- they're like, want to go look like VCHIP, don't you think? Then there's a Michigan here.

UNIDENTIFIED SPEAKER: I am, and I've never seen it.

PAULA DUNCAN: Yeah. [Inaudible] We're just [inaudible].

UNIDENTIFIED SPEAKER: [Inaudible]

PAULA DUNCAN: Yeah, it's a fingerprint, I think. [Inaudible] New Mexico, the Initiative for Child Health Quality [inaudible] Oklahoma [inaudible] Arizona is Best Care for Kids we measure up. So what's the best care for kids, and it involves measurement. So these are groups, they're starting to spawn and to be developed around the country, and we are trying to work together to share strategies, tools, ideas we would love to implement Bright Futures. Why should each state do it in isolation of each other? This

might be a vehicle for us to share strategies for how we're doing this. I'll turn it over to Susan and then -- or do we want Jennifer to...

UNIDENTIFIED SPEAKER: No. I still have -- only got a few things so...

PAULA DUNCAN: Okay, at the end of this?

UNIDENTIFIED SPEAKER: Yeah, that would be great.

UNIDENTIFIED SPEAKER: You might want to buzz to this when you're...

SUSAN CASTELLANO: Yeah. Yup, I'm going to buzz through that because really, Judy is the expert and if you want to learn how to do this, you should go to her session. So we established an improvement partnership in Minnesota and I alluded earlier to the fact that Medicaid -- how the Medicaid agency is viewed, how Title V is viewed that we have kind of different personas in our state. And we realized that we could get a lot more done if we did it together than if we did things separately. And there was a growing interest from providers in doing quality improvement activities. Some of our largest clinic systems in the metro areas were doing kind of their own thing, but each one was doing a different topic, you know, that didn't translate outside the clinic system. And then a lot of the littler clinics around the state couldn't participate in that. They were just kind of on their own.

So this provided a vehicle for any clinic no matter how small throughout the state to participate in a project and work on improving the quality of their activities. We have a state AAP chapter that is small with limited resources. We wanted to partner with them to see how we could support each other. And certainly, you've heard that phrase that if you want to have a doctor listen to you, have another doctor tell them. And so, this is we thought one step better than our Title V agency. Let's all get behind the AAP chapter and help them move this forward. There were occasional cost-saving projects coming from the health plans but really the focus was cost, it was necessarily quality. And there was no existing structure to focus on quality improvement for children. We have a very strong quality improvement organization for adults that they didn't do kid stuff. So that was the reason we did it. It housed in Minnesota in [inaudible] pediatrics, and the other two main partners were human services and health, but we've started inviting lots of other partners to the table including families -- family practice docs, that type of thing.

And their goal is to increase -- so this is our first project. I'm going to go really fast to this. And this is part of our ABCD screening project for [inaudible] academy as well as the first project under a grant from VCHIP. But we were trying to increase the standardized developmental and mental health and maternal depression screening tools that happened in well child visits. We got quite far in the developmental and mental health and a few practices are even doing maternal depression screening, because it's still important to the development of the kids. So that's exciting. Illinois is doing a great job on this, too, by the way, if you want to look at their Web site. We have nine practice [inaudible] from around the state. It was a one and a half to two year

project, and we kicked it off with a learning collaborative where we taught them about the tools and things like that. And then we supported them throughout that year and a half with monthly phone calls. We went out and did site visits, talked through the problems and barriers they were having, and then have them collecting data which we compiled and sent back to them and it was great.

These are the types of things that the clinics had to figure out in order to implement this in their practice. I'm not going to go through those. This is a type of support and activities that we conducted with them. They actually did the chart reviews on their own, and here are the findings. So we saw -- oh, and I didn't grab my notes. We saw developmental screening increase dramatically from --that you can see baseline there to time two, and mental health screening went up quite a bit as well. I'm just going to grab the numbers so I can tell you actual increases went from.

So developmental screening went from 55 percent at baseline to 89 percent of the kids getting screened, and mental health went from three percent to 11 percent of kids getting screened. And much of that will go up a lot more. A lot of the practices just hadn't had a chance to implement. They did it sequentially; first developmental then mental health. And in our next step [inaudible] that we're going to go around the rest of the state and figure out how to share this information with other practices. Well, all the sort of problem solving that those nine practices did, they kind of worked it all out and now we're going to go and give that information to other practices around the state. And

this is done jointly by our AAP, our Department of Human Services and our Department of Health. They all go out and we all go out as a team and help them do this work.

UNIDENTIFIED SPEAKER: So I want to turn it over to [inaudible]

PAULA DUNCAN: Well, I just -- I wanted to say I think that Susan did a really great job with sort of showing, you know, the strategies and the potential of collaborating whether it's, you know, with MCH and Medicaid. And I had mentioned earlier about a Medicaid project [inaudible] about...

SUSAN CASTELLANO: It's okay. I'm just going to hit [inaudible].

PAULA DUNCAN: [inaudible] project we were working with the EPSDT coordinators, the Medicaid staff who is designated at the EPSDT coordinators, the peer-to-peer learning network kind of group that we're, you know, we have a discussion form and we're also having webinars, where they're exchanging information and learning. And the point I think I wanted to hit home about the partnerships was there are several states who are reporting that they're using Bright Futures in their periodicity schedules. And it's really the Medicaid agencies and the MCH agencies who are collaborating to make that happen in the states. And so that was the one point I just wanted to make about partnerships. And then the second was earlier folks were discussing, well, you know, are we going to have different things for different kids within practices? Some -- the Medicaid kids gets one thing and the [inaudible] insured kids get another thing.

But the screening academy, [inaudible] screening academy project which you're talking about, one of the things that we -- we've recently wrapped that up and one of the things that the states overwhelmingly reported that whether they were just using the AAP 2006 statement about developmental screening of when it should happen or whether they were adopting Bright Futures, what was happening when providers were into it and took on Bright Futures or that following this new schedule, they did that through their whole practice. They didn't really want to differentiate between, like, what kids had for insurance and what they're provided. And they recognize that that their delivery of care for well child, during well child visits. So I think that that also speaks to, you know, Medicaid worked closely with the screening academy, worked closely with the providers to -- they used providers to -- get providers to use these new standards of care, not new but to think more about what they were doing during well child care. And so that happened across the board, so I think -- I'm just hitting home the partnership with, so thanks.

JUDITH SHAW: So that's the formal presentation. We had some questions for small group discussion. Why don't I open it up for a few minutes to see if there's any general questions? We've covered a lot in this session. I know we covered a lot but we wanted to give you more of a broad overview than to go really deep into one area. I hope that work for you. I hope that was okay. Thanks for hanging in and flying along with us. We wanted to provide some tables discussion, so let's open it up to general questions and

then maybe you, the last few minutes, you may want to talk among yourselves and make some connections based on what you heard. So, yeah.

UNKNOWN SPEAKER: In your states...

JUDITH SHAW: Do you guys want to come up?

UNKNOWN SPEAKER: --did you have a structure for how the clinics, I mean, identify the problem [inaudible] One thing we've done in Iowa is really enhance the [inaudible] formation which is key to, I think, to the clinics [inaudible] why would a pediatrician want to ask about [inaudible] if they find that -- and the mother is depressed. I mean...

JUDITH SHAW: And we would love for Iowa to be part of this and learn how you guys did that because we know you do it very well. Do you want to talk about the youth and the Craft Screening because that was...

UNKNOWN SPEAKER: Yeah. So--

JUDITH SHAW: --and example for us and Vermont.

PAULA DUNCAN: When we implemented with 55 practices, preventive services screen in Bright Futures, really, for adolescence, the main thing was that the provider said that they don't want to ask about substance abuse if there's nobody to put in place to send

the [inaudible] not what they need to do. So what we did first was do some of these North Carolina [inaudible] and get -- we made -- first we made a book of the list of all the adolescent substance abuse treatment providers. And, of course, you have to do mental health if you're going to do substance abuse because there's such an overlap. And we really try to introduce the practices to -- not the physicians and nurse practitioners but the nurses and the front desk people to these agencies face to face, what's the number because, you know, sometimes the number changes. And so we try to do that a little bit formally. I'll tell you two things that happened. One was that we found out that it's really important for practitioners to know the people. They know who are their -- when they're referring for an orthopedic referral, they know who the person is, who the doc on the other end of that referral is and how the patient is going to be treated. Our physicians and practitioners, they don't want to send families to people they don't know, because they don't know how things are going to go. They usually care about their patients a lot. So, it was really important for him to meet people.

The second thing was, a lot of people who aren't ready for the referral. Have any of you found that, especially for mental health? They're just not ready to go. The family is not interested. And so, even though we had all these referrals set up, what our practitioners said is, actually we're going to have get better at this because we're the ones that are going to have to help people with the first steps of being treated for mental health and behavioral health issues. And then, maybe be able to refer them after that. So, both things happen. And I think -- so your point is, like, really well taken, number one, and I think it's one of the things that we can do in public health, Medicaid, and child health

improvement programs, to solidify and keep this very vibrant and new, because you know how fast this number is outdate, or the person is no longer at that job. And so, I think we really need some innovative strategies to figure out that referral for early childhood, as well for developmental issues as well.

JUDITH SHAW: Same thing when I was working at Boston, we had – the doctors – I did an audit on – asking about how many it is. And they said, “We’re not going to ask if we don’t know where to refer him to.” So, we got to actually a whole giveaway helmet program where they went to the local CDS and lobby who’ve sent the helmet. I mean, again, it’s absolutely true. It’s very difficult to ask if you don’t know where to send them, and then the other project that Paula had was that screening using the Craft Screening Tool. Same thing, why would I administer the Craft Screening Tool, identify if the kid is positive, and then have nowhere to send them. And the health plans in Vermont all agreed about a 1-800 number. So, we laminated the Craft Screening Tool, you flip it over, and there was the phone number that they assured that there would be something on the other end of the phone to do that.

So, you – that is absolutely – I mean, it’s one thing to know who the resources are in your community – critically important. But then, when resources and scarce supply, the other pieces, they want to make sure that there’s somebody there and they can get that child and family in. It’s a huge problem. So, any suggestions that anyone has in Iowa – that’s the one thing about these improvement partnerships is that we really want to build the sharing and learning from each other, so that we don’t have to start all over again

and do that. If Minnesota has done something, I want to be able to steal it. If we've done something, you can steal it from us. We'd give it all away, even our grant applications. You can take them, put your name on them, change the [inaudible] and submit them. We really – there's not enough time for us to recreate the will. So, if we can all share, I think we'll get further much faster. Maureen?

MAUREEN: Just to pick up on that point [inaudible] is. It would be helpful in many instances if the family did get the diagnosis that's probably more – you know, there really is a problem here. I'm sorry that we don't have a place to send you – I'm sorry the state lacks whatever resource to help you. But I think it's really important for that family to know now that the general statement [inaudible] situations where I think wouldn't be helpful. But I think, generally speaking, a family needs to be verified in what they are thinking might be going on, that they can then advocate for – again, not every family is going to do it – choose upstate for those resources that are lacking. So, I want to just...

JUDITH SHAW: Yeah.

MAUREEN: You mentioned the flipside of the [inaudible] I think. It's important for the family to get the information to [inaudible]. You guys [inaudible]

JUDITH SHAW: Where is the tool kit, the little tool kit? I mean, with the little pocket guide? Oh, there it is. You know, that's in line with what I say when I talk about this is the pocket guide that goes with it. What do medical students do when they go into a

room and see a parent, and the parent asks a difficult question? They have this in their pocket. They'd run out to the bathroom and they sit in the bathroom going like this. It's the same thing. I encourage them, "Open this up." Or you can open up the book and say, "You know what, your child is 18 months old; I've got some guidelines that I – they recommend I follow. Would you mind if I went through these?" What are you telling the parents? That you're not making it up, that you're doing this. And then, in the same vein, here's what I can do for you and here's what I can't do for you. I mean, that's all in the partnership with the family. I really think that this should be integrated into the visit.

If the tools are certainly part of the visit, there's nothing wrong with a medical student saying, "I'm in training and I'm not - You know, well, think about it from your standpoint. I'm trying to remember everything versus – I've got some guidelines. Let's go through this together. Here's the medical screening that your child is going to, and here's some anticipatory guidance. You know, I'm going to talk to you about these things. I notice on the pre-visit you sent these, but I'm going to bring this out so I'll make sure that I do a really good job." Again, there's nothing wrong with acknowledging that you don't have it all in here or that you don't have all the resources in the community, back there and then up here.

UNKNOWN SPEAKER: A severe limitation however is time. And there is just no possible way...

UNKNOWN SPEAKER: Right.

UNKNOWN SPEAKER: ...to cover everything by teachers when [inaudible]. And that makes it quite challenging to know exactly what to recommend. It's – even though Bright Futures was meant to be -- footwork we want you to – we're trying to [inaudible] this down so you cover just these things...

JUDITH SHAW: It's the...

UNKNOWN SPEAKER: ...it takes an hour to cover those things. And so, it's harder to know what to [inaudible].

JUDITH SHAW: And I think part of it is the better we can get at getting the pre-visit information collected ahead of time, our goal is to make that face-to-face time, face-to-face time, get the documentation, get the information done ahead of time. We're working towards that, but I agree. I absolutely agree.

UNKNOWN SPEAKER: [Inaudible] because I had...

PAMELA DUNCAN: So, I just want to say though that now we've been working on this for five years. We didn't have it overnight, but we do have those 55 practices that I was telling you about; working for the small sticker and has summarized those things on it, and they are getting through it when we look at their charts.

UNKNOWN SPEAKER: How long do they have for visits?

PAMELA DUNCAN: Mostly about 15 minutes of face-to-face time.

UNKNOWN SPEAKER: So, the docs are only talking in anticipatory guidance or do the docs only do the [inaudible]

PAMELA DUNCAN: But their – well, I know. It's a mixture of things, and I'm just saying – I'm just saying that there is – we do have some tools. If you use the [inaudible] with questionnaires and you use these handouts and some other ways that some practices are able to get through it. Now, obviously, if you get a kid that's sexually active without contraception, you're going to have stop and decide what you're going to do.

And we're – we wouldn't really emphasize it today as much. We did some but we're also staying – the most important thing is what the parents' concerns are, or the kids' concerns. And so, if we don't get to the list, we don't get to the list, because if – we got to meet that as our primary responsibility to focus. But I'll be happy to – and you're absolutely right. But I think we're really trying to say – we're trying to put the system around the practitioner in a way that allows them to do the maximum of the therapeutic relationship that they have through that 15 minutes.

UNKNOWN SPEAKER: Because you're right, we're not going to get more time.

JUDITH SHAW: One thing before we break. I got to make sure I say Bright Futures, the book, is free and available on the website in PDF format. I don't know if you know that. Because this is federally funded, this information is all – you can purchase the book. You have to purchase it. Obviously, it cost the academy to print it. But every page in that book is on the AP's Web site. If you go to AP and find Bright Futures, it is there and available. A wonderful resource for – if you can't afford to purchase the book or you're traveling like this and you want to look up something up. Do you have a question?

UNKNOWN SPEAKER: How was the thing integrated into the education component for physicians, for nurses, for those practitioners that are going to be engaged in direct services?

JUDITH SHAW: You want to take that one?

PAMELA DUNCAN: Sure.

JUDITH SHAW: Yeah.

PAMELA DUNCAN: Well, Mary Margaret got us to this – the representative from those practitioners and she's – she's an educator of various practitioners, so we're waiting for these tools to be done. They're being tested right now so we can't – we decided that nurse practitioners, physician assistants and physicians in training needed to have the tools. And if they have the tools that they could start right out from the beginning, using

the same things they're going to use when they're in practice, not this longer set of things that you do when you're in training and then different things. So, we're really working a lot with our residency programs. Just see if we can use the same things, the little stickers that I was telling you about that only have a few things on them. Let's learn – when they do it as a resident, let's have them use the same tools and the same strategies of setting up a practice in a clinic that allows you to do those things, by using all of the other people on your team to the utmost of their ability. All the nurses and all the medical assistants and all the front desk people are doing everything the most that they can do to make this – work out and do things in that. So, we are definitely doing training but...

UNKNOWN SPEAKER: [Inaudible]

PAMELA DUNCAN: But with the tools that – oh, right. Go ahead.

JUDITH SHAW: If I could just comment that that's one of the roles our Title V agency is taking on is establishing a relationship with the nursing and medical teaching colleges and [inaudible] around the [inaudible]. They actually work with them to get to know them and say, "You know, we'll feed you all the latest information." I mean, I can't say it's been – they're all the way there yet, but it's kind of an uphill battle. But that's an important role for the Title V agencies.

UNKNOWN SPEAKER: I was wondering if from this partnerships that we Title V improvement project, whether [inaudible] we've only got the [inaudible] how they are working with their [inaudible] intervention from [inaudible]

UNKNOWN SPEAKER: Right.

UNKNOWN SPEAKER: ...[inaudible]

JUDITH SHAW: They are, to some extent, I have a great staff that I delegate a lot of this too, so I think the – they probably have the better answer to that than I do. I'm also working very closely with Help Me Grow and [inaudible] group in Connecticut who are giving out grants to the 211 to try to integrate. So, I think we're looking at that all coming together. Karen, are you doing that? Is that what...

KAREN: In Ohio, we are working very closely. It is actually [inaudible] program that's driving the [inaudible] but there – the early intervention courtesy programs are part of our [inaudible]. So, that helps.

JUDITH SHAW: Yeah. And the...

KAREN: And we started doing developmental screening is doing Bright Futures. I just want to be clear that it's not a separate project over here – let's do developmental

screening. Everything [inaudible] being done to [inaudible] in Bright Futures. And [inaudible].

JUDITH SHAW: Louis?

LOUIS: I can't see enough about everyone is really committing to the training of residents and nurses and all because they are [inaudible] given time in their [inaudible] clinics to, you know – when you got a physician and you offered them [inaudible] time to teach them until walk differently or [inaudible]

JUDITH SHAW: That's too hard. Right.

LOUIS: [Inaudible]. But I'll tell you, the future is in the training because it's been such [inaudible] work week and you have to get the [inaudible] so the residence get half an hour and interns get an hour, I mean, really, they actually spend time on this.

PAMELA DUNCAN: Have you enjoyed it?

LOUIS: Where – I haven't [inaudible] yet. I'm trying.

PAMELA DUNCAN: I know that you were doing a lot of early childhood – on screening of those things.

LOUIS: Those things are all in our [inaudible]

PAMELA DUNCAN: See? And that's Bright Futures. So, you've already got...

JUDITH SHAW: Yeah.

PAMELA DUNCAN: You're going to [inaudible] of any door. You're not probably going to take the whole thing and download it tonight and the majority tomorrow.

LOUIS: I'm not thinking of making a major investment in this book, just to get it started [inaudible] have time.

JUDITH SHAW: So, residents actually was Jane. Don't they get this on the PDA?

JANE: Yeah, all of the – all 30 are residents, first, second, third-year residents is trying to [inaudible] they've got the [inaudible] PDA. All the pediatric program director [inaudible] to give to their – each resident to log on. If you have trouble with that, I can give you [inaudible].

JUDITH SHAW: Yeah.

JANE: And also, the [inaudible] Bright Futures – you picked up a [inaudible] on your [inaudible] that I dreamt last night, and the pocket guide is on there too. There's lots of

resources for teaching. It's really a great website that we worked hard on. Continue to look at that [inaudible] let us know as well.

JUDITH SHAW: There's one more question and then we're going to have to stop.

PAMELA DUNCAN: And I just want to be sure that I haven't missed something early on in your [inaudible] something about [inaudible] six pages.

JUDITH SHAW: Yes.

PAMELA DUNCAN: How do you do that? I didn't see that.

JUDITH SHAW: No. The – I am boiling down those visits. When you look at the 10 pages of [inaudible] that priority is the physical exam, screening question. The priorities are blown up into more information. But that's what I mean is...

PAMELA DUNCAN: ...for each of those areas.

JUDITH SHAW: Each of those areas. So, six pages is an exaggeration. The pocket guide boils it down even more. We took the priorities and had to figure out, in the priorities, what we thought were the most substantial points. So, this actually really – one visit for two pages. That's really a boil down version, okay? That's what I mean is when you look at the book, it's so overwhelming. And I wanted you to get a sense of it

shouldn't be overwhelmed in these discreet pieces. If anyone in the room is interested in implementation of Bright Futures, the improvement partnerships, you got our names; we would love to be a partner with you, we'd love to hear from you, we'd love to, you know, hear your comments and thoughts. I just want to say thank you to everyone. I hope this was helpful and I appreciate it.