

HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING

Building Blocks for Promising Practice Models

October 14 - 17, 2007

Examples of Collaboration between MCH and Medicaid programs in Improving Early Prevention, Screening, Detection, and Treatment (EPSDT) Rates

KAY JOHNSON: Judith, do you want to start talking while—

JAMES RESNICK: Yeah, why don't you start?

JUDITH WRIGHT: Well, you should have this in your—

JAMES RESNICK: Yeah, it's in the notebook.

JUDITH WRIGHT: It's in the notebook while he finds it. The early periodic screening, detection and treatment program in Nevada is known as Healthy Kids and if you ever find the first slide, that's what's up there.

Nevada historically, like other states, has had low rates of EPSDT screening. For example, in 2005, and I don't know where Kay got her data, we had out of 155,178 eligible children, 55 percent of the infants birth to one had a screening, but only 19.5 percent of the adolescents. In Nevada, we have an umbrella

agency called the Department of Health and Human Services and under that agency, we have the health division that I'm part of. We have Welfare and Supportive Services, which does Medicaid eligibility and then we have Healthcare Financing and Policy, which does all the rest of the Medicaid, paying the bills, the outreach, the reports and everything else. They also have Nevada Check Up, which is our SCHIP program.

We'll find it yet Ron, slide two.

JAMES RESNICK: It's okay. Just keep going.

JUDITH WRIGHT: Okay, we've been in a lot of discussions over the years with Medicaid. Of course, we've got our hotline, which all states are supposed to have and we've always been concerned about low levels of EPSDT.

The discussions led us to identify weak areas of partnering across state agencies particular as one of the main reasons for these low levels and to recognize the need to partner with community-based organizations and others across the state to make a difference.

Nevada is peppered with Federally Qualified Health Centers or FQHCs due to a lack of providers and it's not just in our rural communities. Even they did not have high EPSDT rates. Physicians don't seem to know the value of it and parents

didn't seem to know to ask for it or what to do with it if they got it. When the opportunity arose, we asked for the technical assistance from--from--

JAMES RESNICK: I'll get somebody.

JUDITH WRIGHT: We asked for technical assistance from MCHB and we got James and Kay, and we wanted to have a leadership workshop to bring everybody together to talk about what was going in the state. And I want to say that it took us nine months to plan it and I can't emphasize the length of time that it took to plan it, to identify the people we wanted to have at the meeting, to talk them into coming to the meeting and to get everybody on board, and we're a state where a lot of people wear multiple hats. So it wasn't a large number of people, but we did have a very good representative. Nope.

KAY JOHNSON: Okay, keep going.

JUDITH WRIGHT: The workshop was held on September 7th 2006, you're on slide three now if you're going through your book. The draw was a low number of EPSDT screens identified by do--both Title V and Title XIX partners. Thirty people attended.

Nevada has 17 counties. Of those 17, three have a locally controlled health department and then the others are all out of the state health division. So when I

say that we had the three county health departments there, you know we had all of them. We had the two parent organizations, which are Family Voices and Parents Encouraging Parents. We had the Intertribal Council health department. Nevada Health Centers, which has most of the federally qualified health centers across the state, Washington Legal Services, the Reno-Sparks Indian Colony and the two Medicaid HMOs were there and very, very present, Anthem and Health Plan in Nevada. We have a state based CDC individual who is with us for immunizations and then, of course, the DHHS personnel. We had the deputy director of the department. We had the deputy administrator of Healthcare Financing and Policy and then, we had--okay, is that three?

KAY JOHNSON: Go back a little?

JUDITH WRIGHT: Yeah, I think that's where we are. Let me look to be sure.

KAY JOHNSON: Okay.

JUDITH WRIGHT: Yeah, that's where we are. Where was I? So we had a fair range of people from across the state there. In the morning session, we've identified some 26 topics that we wanted to deal with and nobody's going to deal with 26 topics, you can all guess that, but they all focused around communication: communication with families, communication among community organizations including the providers and a communication across the agencies.

And by the afternoon, we were divided into work groups to identify priorities and let me see if I can find the right button here. We've--we came up with four priorities and I'm just going to list them here. One we call tribal Federally Qualified Health Centers local health districts, that's the CO and the manage care organizations, because these are the folks that are our safety net providers and we really want them to be doing EPSDT screens if anybody is. Parent Support and Education because the group really felt that parents needed to be educated not only on what EPSDT is, but how to use it and what to do with it once it was done. And Automatic New Born Registration, when a mom has a baby, that baby should just be right there on Medicaid and into the periodicity schedule. And then, Cross-Linkages and this is the one that's given us some problem, but a lot of the discussions were around--I'll say a special needs child having multiple case managers--one for foster care, one from somewhere else. So it was all very, very, very--very, very lively discussions. And you see on here that the groups' progress were supported to the governor appointed Maternal and Child Health advisory board. The group really felt that there wasn't someone overseeing what happened after the workshop. You've been to workshops would come up with all these plans and it gets put on the shelf. They wanted a group that is--has some authority in the state to look at what was the outcomes and to hear the reports, and ask the hard questions when they hear the reports and keep us on track. So that's what's going on with that.

The Tribal--one, you can see there. Members of this group included representative in Nevada Health Centers. Like I said, they've got fairly qualified health centers all over the state, the three county health departments, the Medicaid HMOs, Indian Health Services, the Las Vegas Paiute Tribe, the Reno-Sparks Indian Colony, the Great Basin Primary Care Association, which is our Primary Care Association has an Indian liaison, and HAWK, which is the Federally Qualified Health Center in Washoe County, which is Reno. And of course, all of our state employees from Healthcare finding--from DHHS and I should've said, at the beginning, we've had Medicaid's EPSDT person with us all along so she's been there.

You can see from the slide the proposed activities. Building provider capacity. Almost the entire state is a HPSA of one sort or another. We don't just have a provision--a physician shortage, we don't have specialists and especially, pediatrics specialist. We have whole counties that are dental and mental health HPSAs. We talked about the MCO networks and what they can do to encourage the members to promote EPSDT. We have credentialing issues because you could be certified here, but not certified there. So that's one of the things that came up on this and there was of course, the whole discussion about the adequacy of payment for EPSDT screens. And since these workshops, Medicaid has been very careful to preserve the fairly high-level of payments that they have and actually, I heard in a meeting last week, they are cutting some providers, but they are not cutting the EPSDT providers. So that's one good outcome that we

had.

The dual purpose of the Parent Support and Education, at the slide, work group was to support parents in their role through education, motivation and knowledge of how to use the system. Members of the group represented the parent groups, of course, community service agencies, the HMOs, the Reno-Sparks Tribal Council, the University of Nevada Early Childhood Unit, the three county health departments, other childcare stop--staff, Nevada Public Health Foundation and, of course, our state employees.

There's been a lot of discussion focused on what the Medicaid HMOs could do such as including and offering incentives to come in for screenings. They talked about parent to parent verbal and written communication, emphasized culturally and linguistically appropriate materials, encouraged evening and weekend hours, and accessibilities through both the usual hotlines in the state, just one statewide with the 211 line, and so through that medium. They talked about better utilization of family resources, baby centers, home visitors and school-based clinics, just trying to identify what resources we have in Nevada and where we can do some education on the values of EPSDT.

Automatic newborn registration, I think, has been our most successful. They worked to streamline enrollment notification and reduced the time between birth and Medicaid enrollment. This group was for primarily state staff, but included

are FQHCs, public health nurses, welfare and supportive staffs since they do eligibility, Medicaid and health staff, and the three county health departments, Great Basin Primary Care Association.

They started by reviewing federal requirements and how well it was working in a Medicaid financed births. This has been the most successful, like I said, are the four work groups. Medicaid adjusted their data systems so that when the baby is born, it's just moved right into the data system and it's right there eligible when the physician pulls it up for those EPSDT screens. Medicaid and Welfare had to work together to do this and that was a pretty major accomplishment. We got electronic birth certificates this year and that's helped, and they also discussed what to do if the mother was not on Medicaid for her pregnancy and also what happens if she's fee for service, which is still the situation in all of our rural communities. Cross-Linkages has been, I would say, the least successful of the four groups, but we're not done with it. They've only met once. It's goal is to review the various programs and the problems of multiple case managers like I said before for Children with Special Health Care Needs, which would depend on how many services the child is receiving. Say, they were in an early intervention and foster care, they'll have one in earlier intervention for this and foster care, they'll have one for that, and who knows what else. And they could be seeing our metabolic folks and so they'll have a case manger there.

Their members include the parent group's early interventions services, Washoe

Legal Services and we've had two or the three health departments show up and state staff. In its one meeting, they planned what they would do for next steps including reviewing the various rules and regulations that govern all the programs and identify activities to take such as memorandums of understanding to address problems. Data sharing has been a prime concern, how to manage the specialty screenings, which we provide, and immunizations when there are multiple providers. As noticed, the group is more--more and more state workers are getting together now and I think there'll be some activity on that soon.

There are, of course, been challenges. One of them was that welfare and support of services does only eligibility. They don't do services. So they were kind of slow to come to the table and I've already said the infrastructure really needs help. The lack of providers in the state is a huge handicap. Data sharing is happening, but not to the extent that we'd like to see. To identify what services the child is getting, but this new electronic birth certificate is giving us some more modules we can look at that I'm hoping is going to help address that issue. And some of the issues can only really be discussed within state offices; we're not something we're going to put out in an open meeting. You all have open meeting laws. I'm sure you understand that.

For our overall successes, it's just the improved communication. There has been huge communication improvements and all the partners, the manage care organizations have been great and they actually put incentives in the new

Medicaid contract. So if family comes in for EPSDT, they get, I think, that's a gift card. I don't know. Brad, do you remember what that was? There's been a rot-- revival of Welfare's notification of EPSDT and its benefits when they determine that the child is eligible and we just found out they had been doing it, but it had been dropped because of case turnover and you've all had that problem.

Somebody needs to be looking at it to make sure that when there's staff turnover, you don't lose things.

There's been more networking between state agencies and community-based agencies where a small state and it really shouldn't take that long to get everybody together. We have an EPSDT tool kit on our website and you see the health division's website there. When you get to it, you have to go to the Bureau of Family Health Services then to Children with Special Health Care Needs and then, to the EPSDT sidebar. We don't have page addresses anymore, which I'm not too happy about. But anyway, and Medicaid is reporting to us that more the providers understand the screen and are billing properly, so that's it. That's a major occurrence, I think.

Our future activities, the work groups with the exception of auto newborn enrollment are continuing. We now are looking at the Iowa model for outreach, which I hope Gretchen is going to talk about because we've been talking to Jane Borst about Medicaid approached us about Title V taking it over. So that's kind of exciting.

There's continual monitoring of systematic notification process that Welfare is doing and there's been some eligibility worker training so that they're reeducated in it. We're working on our data sharing agreements and Medicaid is working on monitoring and training for coding the screening form that providers all love, which for some reason they dropped when HIPAA came in. They've put back in now and so everybody's happier with that and this has really improved that consistency with the billing and data recording. And we're really just beginning the process. We had our workshops September of 2007 and we've seen progress, and we still have a ways to go. So thank you.