Well-child visit (ages 3-6) needs assessment
October 2019

What are the biggest challenges you anticipate to meeting your target improvement for this measure?

- Provider access and availability; better mechanisms for scheduling and customer service
- Getting hold of parents, **providing enough appointment slots**; **no-show rates**
- Communicating about the value of preventive visits and make sure there is aligned messaging with patients and providers. **Get a lot of feedback from providers that they don't know what Medicaid will or won't cover.** They wait until kid turns a certain age and then schedule (needs to happen by that birthday, not after).
- Majority of peds pop falls within two clinics. How do we hold all clinics responsible, not just those two clinics. **Also scheduling before birthday not after – after is typical for clinics in our area.**
- Biggest challenge is needing updated phones and addresses.
- **A lot of clinic systems may have the ability to get up to date contact info but doesn't necessarily trickle back to OHA's data so need mechanisms so that makes its way through entire data system.**
- This age group, most parents think it's just about immunizations. Opportunity to talk about oral, behavioral health, not just a vaccine appt.
- Communication to providers and members: **Why these are important to overall health – making sure you stay well, opportunity to answer parent's questions, concerns, overall value of visit.**
- **Hours and wait times**. Many parents can't get away from work, can't spend extra time in waiting room. Also help with transportation issue.
- **Recalls from EHRs and getting them set up**; **education of parents** – get out of routine after age two
- A lot of our **patients just don't show up**, so we reschedule and they don't show up again. We call them, we send them letter, do three reminders. They say they forgot or are busy, so not sure what else we can do.
- If several siblings, **won't fall under normal +1 for NEMT**
- We help patients get set up with Ride Line, but they **often don't have enough rides available**.
- Language barriers, parents not wanting to fill out paperwork (ASQ, demographics, health history); Not having good contact info or a great avenue to get that
    - We reduced ASQ form from 10 pages down to 1. Don't have problems with parents doing that.
- Regarding ASQ, sometimes need to make sure doctor has a conversation with parent about the importance of it.

What types of assistance would be the most helpful in overcoming those challenges?

- Are **technical specifications** available? Effective scheduling – if sooner, fewer no-shows
- **Is there a hard stop date (by age X?** like immi?) could be a barrier
- **More connection to other CCOs and sharing** (TAG less of a venue for this); could be collaborative and reflection would facilitate improvement.
- We frequently hear confusion from providers about what Medicaid will and will not cover. In support of all of kindergarten readiness measures would be great if OHA had a **website that providers could go to around KR effort, why these elements are all important, what is covered, what does it mean etc.** Would help CCOs to communicate and send providers to that resource.
    - Love that idea for health education around parents of this age group.
    - Shorter, **one-page handout for members** that don't have access to internet would be great for those clinics. Make the case for why the visit is important.
    - If it comes from OHA with that emblem on it, it might be perceived more as statewide thing vs clinic wanting more money. A lot of times parents feel like we're calling them just to meet the metric. One pager could help show them important for your kid's outcomes.
- From data perspective, **analysis of differences in adolescent outcomes for kids that have had WCV etc – here's why this is important, talking points.** Looking through developmental screening rates we've seen big improvements overall but still see big disparities by language. Would be great to know if there are **known disparities in this age range/metric** as well.
- If there was an entity re: getting in contact with families. We work with Babies First who will go to home and help coordinate WCV. But those nurses are sometimes stretched thin. If there is another **option for places that**

can provide the service of going to the home to assist the clinic when contact info isn't there or clinic can't get into contact with the family

What's working

- We have one main clinic that does **extended hours – open til 7 pm and open on weekends**. That is really helpful for getting folks in.
- Using CHW has been helpful.

What is your top strategy when it comes to getting 3–6-year-olds into their well-child visits?

- When families have multiple children in age range, I try to **schedule family together on same day**. That seems to ease burden of transportation and time off work. Siblings play with each other in waiting room too.
- We have a **community health outreach program that's heavily involved with local schools**. Also **Starting Strong program** (0-5) and using that space to capture the population. Back-to-school event – helping parents register for appointments (message: you don't just buy school supplies to get ready for school year, you need to have your good health ready too). Also using other school events where families are already going. Some **clinic systems are holding their own wellness fairs** where provider does wellness check (did with AWV). But we're primarily doing scheduling – **will get families scheduled before they leave the school event. We can also arrange help for transportation** or make sure they're getting to a clinic with extended hours if they need that.
- We just got a huge **mobile medical unit. Hoping to get it going to the preschools** to conduct WCV in areas that are low in resources. Set up for medical and dental – can get both measures done in the same day.
- **Doing recalls for patients**, if we're able to catch them at 5 when we know they need shots, setting up a recall so we can reach out in six months to see if they have an appointment scheduled. We do flags/reminders in EHR. Front office manages that. Every time a patient leaves after their well check, they go on a list for their next well check. Have seen a little bit of an improvement.
- Rex (immi program) to clinics– do you **chart scrub for acute care visits**? To do well child at that visit, or schedule.
    - Sometimes. We talk about doing it a lot, but don't always have time. We try, no formal process.
    - Yes, we do that scrub
    - Rex – more and more kids are on delayed vaccine schedules. Have struggles getting kids up to date after age 1 or 2 (transition to annual WCV). **When patients come into acute care visits, can convert to WCV or use it to schedule WCV**. Takes a lot of work to get the logistics down.
    - My department **chart scrubs for upcoming appointments for all clinics**. If there is a care gap, we document it in the system so can complete at the next appointment or schedule a future one. Do this for vaccines, ASQs too. We work off the gap list from the CCO. We get it every month, scrub or all open care gaps. AWV is one of the biggest gaps we work with. Compare gap list against upcoming appts for the next week. Notify provider of those gaps.
- Rex – for clinics that don't get that kind of list from CCO, is there a way to generate that gap list in your EMR?
    - We do that ourselves. We also get a quarterly report from CCO that helps with that.

Are there new/innovative strategies you are considering?

- **Adventist Health did multi mods – not sure if those meet the WCV metric**. There's a huge event they put on every year and it's geared for 3-6 yos. Multi modular visit but not sure what is covered at each station.
- Not done by us but our local United Way does dental kits for K-3rd graders. Could maybe reach out to them to **get the info about WCV into the dental kits** that kids are already receiving.
- We offer member incentives on some measures, **gift certificate upon completion of visit**. We offer $25 gift card currently for AWV. Send out letter if they're in the eligible age range, bring letter in when they come for exam, gets processed by CCO and then gift card is sent out. May choose to do for WCV. Has had a big impact on AWV metric. Also potentially **swag event. Either lunch pails or water bottles** when they come in for WCV (for KR readiness, would also encourage drinking water and able to have it in class with them).
- We have two SBHCs and they're doing wellness checks but we've identified there needs to be TA around what should be included. Not being done in volume for 3-6 yos. Might need **quality assurance TA with SBHCs**.
- We are engaged with our **early learning hubs** and been focusing on developmental screening, but this is a ripe opportunity to **shift toward this measure and dental**. Not doing yet but seems like we could
- **Could also loop the WIC program** into WCVs too to have them encourage those visits as well.

- Jolene (state WIC) – Going to be talking with all WIC coordinators soon. One of our main objectives is to refer. If there's a way to make that a closed loop referral that's great. We'd love to have more conversations.

How is your CCO collaborating with clinics to provide/discuss gap lists/scrubbing of data?

- We do this quite a bit, have tools in place, try to connect to EHR as much as possible (lag in claims data) for AWV; most meaningful if have tools that interface with EHR and scrub gap lists regularly; do at CCO and communicate with clinics; one of our primary go-tos but **we'd like to see other things that would be more engaging of community**. Connecting with families around kindergarten readiness? **Front-end work with community would be more proactive than gap lists** (reactive)
- Yes, monthly meet with almost all our clinics individually to talk about individual performance, CCO performance, distribute gap lists; for dev. screening were doing but not coding; usually same person from CCO, shares learnings across clinics; over next two months and four months (nov-feb) work with clinics for new metrics to figure out how to tackle (Epic population health tool)
- We have not yet built it out for this measure, but we do it for AWV **so clinics have a year to date report of who has received a visit**. Has been helpful to show whether they've had the visit they needed this year, but also when they came in last time (if visit was in Nov, it's okay if they aren't in by June this year). That has been really useful and we plan to build it out for this measure and dental measure as well. It's pretty easy for us to repurpose for a new measure since metric specs are there – just swap out one set of codes for the next.
- Our **primary care learning collaborative** meets in person every quarter. On off months, have check-in call. Reps from all large medical facilities. Go over what's working, what's not, how can we help you? Update lists of gaps where we need to push, what's working for various clinics. Have a panel coordinator in each county to supply the clinics with that data, assist with scrubbing charts, gap lists etc. In the past strategies have been very proprietary, now there is sharing and collaborating between clinics that didn't used to do that.

To CCOs: One question that came up on the clinic call was "How are we ideally supposed to work with our CCO to meet this measure?" – How would you answer this question?

- Haven't done well with clinics; have only given how they're doing and gap lists instead of real tools (workflows and what's successful in other clinics) for learning; need more concise and practical toolsets; more collaborative standpoint – **more active engagement from both clinics and CCOs to figure out models of excellence and share with others; concise framework for doing this from OHA to help create model around which to do that?**
- **How to communicate to parents around importance**, **what barriers do they hear from members**, **data sharing**.
- **We have some roles that are identified to specifically provide TA to clinics and providers to share best practice workflows**, how the metric is typically met. A lot of this is clear communication and education, and **this is a metric where once it's understood it's about navigating the parents' barriers**. What's difficult with pediatric metrics is they're about working with whole family, how can provider serve whole family. Providing ways that that is achievable and not cost-prohibitive.

How would you change the context or message for families about the value of taking children to well child visits?

- Maybe after postpartum? Don't know, don't think we provide interactive environment for this or well communicated; if we had an environment that sustained the preventive piece to keep people engaged

How would you reinvent the well-child visit to make it more attractive to parents?

- Sometimes **visits are so rushed that patient isn't sure of the point of coming in**. Not sure how to address that. Work with physicians in some way.
- Rex (immi) – **do we know what the most valuable piece of the well care visit is for the parent?**
  - Transformation Center – haven't conducted that in Oregon, but have work out of WA. Benefit of WCV as it relates to KR: Families value opportunity for referral for coordination and care management across health, early learning, literacy, EI/ECSE. Providing guidance on milestones coming up, how to support future development.
- Have any clinics worked with other locations that do ASQs and received feedback about doing the ASQ in both locations and how that is perceived amongst families?

    - I don't think it's a big issue or that we have a lot of kickback from parents about that. When it has happened, it's usually just explaining why we do it to have it in our system.
- Does anyone do **Reach Out and Read**?
    - Yes. Some providers are better than others about early literacy. Mostly just book distribution. We also encourage book donations and provide books to siblings. Also books in Spanish.
    - Early Learning Hub – We provide money for the clinics to purchase books. **We would be very excited to be involved with more clinics to increase that partnership and encourage kids to read**. Get partnerships between Head Start, doctors etc. Would be interested in learning about other partnerships.
    - Early Learning Hub – One of our pediatricians does Reach Out and Read, but we don't have a very strong partnership with her or the program. We could help strengthen that on the south coast.
    - Reach Out and Read recently hired an Oregon person so communication has gotten much better.
    - Julie Reeder (WIC) – most people are interested in having good reading skills, ready for kindergarten, etc. Not just about getting a book. Can present it as "Here is a way to enhance the richness of the visit."

Ideas around rationale, reasons for parents to value WCV:

- A lot are hard sells. **Vision screening** might be easier because it's really linked to school readiness. Parents are usually motivated to come in when something is wrong.
- We say it's **easier for kids to interact with provider when healthy and happy** vs. when sick. Then provider knows baseline of being healthy and happy, so kid isn't scared of going to doctor.
- Transformation Center – Washington campaign: Kids that get a WCV do better in school.

How is your clinic working with your CCO to address well-child visits for 3-6-year olds?

- **Embedded panel coordinator** in two clinics, works for CCO. Role is to outreach for all our CCO 2.0 metrics in those clinics. Participates in leadership mtgs, training with providers and MAs, sets up outreach calendars. **Three months that we specifically target 3-6 yos before school starts in September.**
- **New thing is to address discrepancies in the patient list from CCO. Working together to clean up list** to have a more accurate picture of who we need to reach out to. Have a clean panel.
- Tried to help make appointments for families less intimidating is giving out the **CDC developmental milestones** booklet (CDC Act Early). It is structured by the various well child visits and divided into ASQ domains, so families can have that info going into a WCV. Can help them remember their questions for the provider too.
    - Sherri Alderman is Oregon's CDC ambassador for the Act Early milestones program.