Slide notes

CHILD AND TEEN CHECKUPS PERIODICITY SCHEDULE UPDATES FOR OCTOBER 1, 2017

These notes are an accessible version of the slide notes embedded in the PowerPoint presentation of the same title.

Slide 1 – Introduction

- Welcome, introductions
- Purpose of this training: to go over the changes of the C&TC Periodicity Schedule implemented October 1st, 2017

Slide 2 - Contact

- The Minnesota Department of Human Services (DHS) is the state Medicaid agency – they determine policy and administer Child and Teen Checkups, which is Minnesota's version of the federal EPSDT (Early Periodic Screening Diagnostic and Treatment) program.
- The go-to place for official and current policy updates is the (Minnesota Health Care Programs) MHCP Provider Manual, C&TC Section. [Go to the MHCP Provider manual website.
- [Point out the following:]
- The first link on this website "Revised [date]" will bring you to the most recent changes as of that date.
- "Screening exceptions" is an important section. This tells providers how to document and code for a required screening component, and get credit for a complete C&TC visit, if a patient or parent declines a required screening component or service, or if the service is contraindicated or not medically necessary (e.g. already diagnosed).
- The Minnesota Department of Health (MDH) provides health consultation and training. The MDH C&TC website has clinical resources for each of the CT&C screening components and preventive services.
- [Go to the MDH C&TC website and point out the following:]
- The Spotlight (on the right) has recently added resources.
- On the left navigation panel, "Fact Sheets" will bring you to a 2-page fact sheet for each screening component that tells you exactly what is required, who can do it, how it needs to be documented, recommended tools, and resources for screening and referral.
- "Information for: Providers" may be the most important spot for providers and clinics. It links you to the current C&TC Periodicity Schedule, and lists resources for each component.
- New resources here:

- Under Developmental & Mental Health Screening, a list of recommended tools commonly used in primary care settings for developmental and mental health screening birth through 20 years of age.
- Under laboratory tests and risk assessment:
- A letter template that clinics can use and revise to share information with families about confidential services that are a part of every well visit
- An HIV FAQ that can help clinics explain why the universal HIV test is being offered to every youth, at least once between 15-18 years of age. Clinics can revise the first paragraph, but should leave the bullet points the same (vetted CDC/MDH STI information)

Slide 3 – Updates based on…

The Child and Teen Checkups schedule is regularly revised to align with Bright Futures guidelines from the American Academy of Pediatrics, recommendations of the US Preventive Services Task Force, the CDC, and other national bodies that provide evidence-based recommendations for pediatric preventive health care. All of these sources were used to inform changes to the periodicity schedule, with the goal of ensuring evidence-based health promotion and early identification and effective treatment for health concerns of children and youth who are eligible for C&TC. Note that this is a higher risk population than the average pediatric population: lower income, more diverse, more health disparities. DHS & MDH look at the most current health statistics for our state's Medicaid-eligible population to help determine needs of this group.

DHS and MDH also met with and requested input from the Minnesota Academies of pediatrics (MN AAP), family medicine (MAFP), and pediatric nurse practitioners (MN NAPNAP) and clinician representatives regarding proposed changes.

Slide 4 - The updated schedule

Here is the updated C&TC Schedule, effective October 1. We will discuss all the changes to the schedule.

Point out the following:

- Larger size (8 ½ x 14 legal size) to accommodate additional visits – consistent with long-standing Bright Futures guidelines.
- Hyperlink to fact sheets in left upper corner of table. There is a fact sheet for each component, which describes what needs to be done, who can do it, how it is documented, referral resources, and more information.
- An asterisk * indicates a new requirement. More information is available on the back for each of these.
- Other symbols are the same as on the current schedule that was posted in 2016. Key at the bottom:
  - Bullet point or dot indicates required screening or preventive service
  - R indicates a screening that is strongly recommended, but not required

- Arrows indicate a range that this screening can be done. A set of arrows from one age to another indicates that the screening should be provided at least once in that age range (example: a screening blood hemoglobin test once for menstruating adolescents). In general, screening earlier in the time range may be preferred, in case the patient misses future recommended C&TC visits. However, in some cases it may better to wait based on other medical or individual factors (for example, if the adolescent female just began menstruating 1-2 months ago, it may be better to wait until the following year to do the screening hemoglobin.)

Slide 5 – More frequent visits

(Discuss slide content)

For the 30 month visit, there are no new or additional screening requirements.

- The basic elements are all the same as every visit (health history, anticipatory guidance, measurements, physical exam) – but here is an additional opportunity to spread out developmental, social-emotional and autism screening at this crucial period in development.
- Anticipatory guidance can focus especially on supporting healthy development.
- This visit is also another opportunity to catch up on lead or other screenings if the child is behind.

Many clinics already provide annual C&TC visits as their established practice, and it may be easier for parents and patients to remember to do annual visits.

- Rates of well child visits get lower and lower after elementary school age. When a health care provider emphasizes that preventive visits are important, and why, it can make families and children more likely to come in for those annual visits.
- Health plans and C&TC Coordinators and outreach staff also play an important role in encouraging and supporting more regular Child and Teen Checkups. Work is going on at the state level to especially focus on adolescent and young adult visits – for ages 10 and older.

Slide 6 – Child and youth in foster care or out-of-home placement

We encourage providers and clinics to follow these recommendations. More frequent visits are billable for Medicaid-eligible children.

The first link brings you to a variety of resources from the AAP to help clinics and providers support the health of children and youth in foster care.

The second link brings you to a 2-page document that outlines the special needs of this population, and specific recommendations for well child visits for these children and youth.

Slide 7 – What are the new requirements?

These are the additions or changes to the schedule. Many clinics already provide these services; for others the practices may be new. We'll go through each of these now.

Remember that each of these components has an updated fact sheet that goes over requirements, recommended tools, and other resources.

Slide 8 – Weight for length percentile

Electronic Health Records often already have the ability to calculate and plot weight-for-length percentiles on a growth chart. As with other physical measurements, clinicians will look at the child's growth pattern over time, and use this information along with the health history and physical exam to ensure appropriate follow-up and anticipatory guidance. All C&TC-eligible children birth through 5 should be referred to WIC, but for infants or toddlers with excessively low or high weight-for-length percentiles, this is especially important.

Slide 9 – Mental health screening

Mental health or depression screening in youth 12-17 years of age is not new to Minnesota clinics – they have been reporting on this as a clinical quality measure with Minnesota Community Measurement for the last couple of years, and the screening rate is now over 70 percent. However, there are screening disparities especially by geography: rural vs. urban.

- The Mental Health Screening Fact Sheet lists recommended tools and referral resources. The recommended tools are also listed at this link, and described in a more detailed table at this link.
- Local referral resources can be a challenge. The American Academy of Pediatrics also offers important resources for integrating mental health services with primary care, which many clinics and health systems are doing. Clinics may be aware of local mental health agencies that serve children and adolescents. Additionally, here is a link to a map and list of agencies that provide school-linked mental health services across the state of Minnesota.

Slide 10 – HIV screening

Universal screening for HIV among all youth 15 to 18 years of age has been on the American Academy of Pediatrics Bright Futures schedule for several years now. However, in previous years, Minnesota's incidence and prevalence rate of HIV did not meet the threshold to add this to the C&TC Schedule; however, now it is at that level where universal screening should be happening.

The Child and Teen Checkups schedule does already include STI risk assessment, so risk assessment for HIV should already be a standard part of their clinics' practice.

There are several things clinics will be considering as they implement this, if they haven't already:

- Communicating with parents and young people that an HIV blood test will be offered to every patient at least once in this age range – MDH will be offering sample letters or scripts for clinics to use and adapt for this purpose.
- Ensuring confidentiality: While clinics should clearly communicate the screening process to youth (and their parents, if they're under 18), HIV testing falls under Minnesota's minor's consent statute. Therefore, the testing should be offered to the youth in a confidential conversation with the provider, and it is the youth (not the parent/guardian) that has the right to accept or decline the testing. Follow up on results should be confidential and communicated only and directly to the young person, unless the patient explicitly gives permission for that information to be shared with their parent/guardian.
- As with any screening, clinics will need to be prepared for further evaluation and treatment when screening results are positive. The CDC offers clear guidance and resources for this.

Slide 11 – Dyslipidemia risk assessment

Lipid testing is explicitly called out on the Bright Futures schedule, but was previously only listed on the C&TC schedule as part of the "other labs as medically indicated" line. Clinics needed further guidance on this.

Risk assessment for dyslipidemia is likely already a part of the clinic's practice as they do the personal and family health history, measurements including BMI and blood pressure, and asking about tobacco use, nutrition, and physical activity. Specific family history factors are listed in the fact sheet (refer to the 1st bulleted hyperlink). More detailed recommendations for screening and management of dyslipidemia are covered in the Expert Panel document (2nd bulleted link).

Slide 12 – Vision screening: Include Plus lens (near vision screening)

When the vision screening recommendations were released in 2015, based on national guidelines and Minnesota's expert panel process, plus lens (or near vision screening) was added as a recommendation for all children who were 5 years and older, who passed their distance visual acuity screening and who did not already have corrective lenses. However, there was confusion as to whether this was required or not.

The new schedule clarifies that as of October 1, plus lens or near visual acuity screening is a part of the required vision screening. It is not coded or billed separately, it is part of vision screening.

The addition of plus lens screening is a very inexpensive and quick way to identify children with near vision problems before they run into academic problems with school work. 2.5+ lenses are available at low cost from many local stores, and the screening itself can be accomplished in under a minute while the child is still standing in front of the 10 foot distance vision screening wall chart.

The procedure is laid out on the vision screening manual, and the vision screening e-learning module – both on MDH's website.

Regarding instrument-based screening: The current recommendation is that these instruments can be used with children who are unable or unwilling to cooperate with routine visual acuity screening. Photo screening and handheld auto refraction may be used as an alternative to visual acuity screening with vision charts from 3 through 5 years of age. Currently, instrument-based vision screening is not recommended for children older than 6 years of age who can be screened using visual acuity charts.

Slide 13 – Hearing screening: Add high frequency screening for NIHL

The American Academy of Pediatrics added high frequency hearing screening at 6000 and 8000 Hz to their most recent (2017) Bright Futures guidelines. However, 8000 Hz is difficult to screen for in the average clinic setting (vs. a sound-proof audiology screening setting), and literature review indicates that NIHL can be identified well using just the 6000 Hz level. Therefore the recommendation is to add 6000 Hz at 20 dB to the routine pure tone audiometry (500 Hz @ 25 dB and 1000, 2000, and 4000 Hz @ 20 dB) beginning at 11-12 years of age.

One challenge is that many clinics have been using hand-held audiometers that do not provide this range of screening. Recommended audiometers can provide manual (not automatic) pure tone screening from 250 through 8000 Hz, ideally with headphones instead of a hand-held ear apparatus.

To ensure that the screening environment is quiet enough, do an "environmental noise level check" first: have a staff person with normal hearing check that they can hear all the screening frequencies (500, 1000, 2000, 4000, and 6000 Hz) at 10 dB below the screening levels (that would be 15 dB at 500 Hz, and 10 dB for all the other levels).

Slide 14 – Fluoride varnish application (FVA)

Fluoride varnish is now a requirement for all infants and children through 5 years of age at each C&TC visit. This is based on strong clinical evidence, as recommended by the US Preventive Services Task Force and the American Academy of Pediatrics.

- Fluoride varnish is a very effective, "passive" preventive measure to prevent dental decay in young children.
- Medicaid-eligible children are at high risk for dental caries, and as we know, access to dental care continues to be a challenge in Minnesota, as demonstrated by 2016 rates of preventive dental care services by continuously eligible C&TC patients through age 5 years.
- Fluoride varnish, applied routinely, helps prevent caries, and actually helps re-mineralize mild decay that is already present on the teeth. It is safe and effective.
- Providers may ask "what if they had FVA somewhere else recently?" The benefits of routine application (every 3 months for high risk children) are well documented, and FVA is not dangerous or toxic. If FVA was done very recently, there is no need to reapply, but

there is also no harm. Given current low access to dental care, these cases may not be very frequent.
    - If FVA was provided in another setting within the last 30 days, providers may code for a screening exception (refer to the MHCP Provider manual for details). They should document the date FVA was provided in the medical record.
- The fluoride varnish for C&TC website offers more information, including resources for staff training and information for parents.
- C&TC providers should continue to promote connection to a dental provider by giving a verbal referral at every C&TC visit for preventive services at the dental home.
- Performing an Oral Health Risk Assessment, as recommended by the AAP, can help clinics decide which patients may also benefit from oral fluoride supplement drops, and who should have more active assistance from the clinic to access dental services.

Slide 15 – Preventive dental visit rates for birth through 5 years

- Access to routine preventive dental services in Minnesota continues to be a challenge, but is still important. You can see from this graph that very few Medicaid eligible children are currently accessing preventive dental care with a dentist even once per year.
- Primary care clinics and clinicians play a separate and important role for oral health:
    - Anticipatory guidance
    - "Lift the lip" exam as part of a physical exam
    - Application of fluoride varnish routinely for prevention of caries
    - Verbal referral at every visit to encourage routine preventive visits at a dental home
    - Oral health risk assessment can help decide the following:
        - Whether oral fluoride supplementation should be prescribed
        - Whether the C&TC provider/staff need to provide an active referral and support for the child to get in for care with a dentist

Slide 17 – Question: Billing for a complete C&TC?

No notes

Slide 18 – Thank you

C&TC Coordinators/outreach staff –

Please contact us with questions or clarifications.

Consider replacing this information (a repeat from slide 2) with YOUR contact information.

For More Information

The Child and Teen Checkups (C&TC) program is administered through a partnership between the Minnesota Department of Human Services and the Minnesota Department of Health.

For questions or to obtain this information in a different format, call 651-201-3760 or email health.childteencheckups@state.mn.us.