



East Hawaii IPA

PEDIATRIC HUDDLE

February 23, 2017

AGENDA



| TOPIC | Speaker | Time |
|---|--|---------------|
| East Hawaii IPA Updates | Susan Mochizuki, Administrator | 10 min |
| Pediatric Payment Transformation | Leolinda Parlin, Director Hilopa'a Family to Family Health Information Center- Hawaii Pediatric Association Research & Education Foundation | 50 min |
| Announcements | Susan Mochizuki, Administrator | 5 min |

COMMUNICATION

- ✓ **WATCH FOR WEEKLY EMAILS FROM IPA ON WEDNESDAYS**
- ✓ **SEE ALERTS WITH LINKS TO BACKGROUND INFO**
- **CHECK OUR WEBSITE BLOG (under construction) FOR WEDNESDAY UPDATES**
- ✓ **PLEASE PROVIDE TWO EMAIL ADDRESSES PER OFFICE:**
 - Provider**
 - Staff Representative**





ELECTRONIC HEALTH RECORD RECOMMENDATION

- **Board selected e-Clinical Works as recommended system**
- **Currently negotiating best agreement/contract for 2017 commitment -- need to know how many will sign on?**
- **Looking at billing, lab interfaces to minimize extra costs**
- **Board committed to \$150K budget for training, implementation & support costs**

OTHER UPDATES



NEW EMPLOYEE-

Welcome Jane Bontuyan- Administrative Assistant

NEW SPACE FOR IPA OFFICE-

- **More Space for Training Sessions**
- **Behavioral Health, Diabetic Education**
- **Care Managers**

BOARD OF DIRECTORS NOMINATIONS

- **Three Available Positions- 3 Year Term (PCPs only)**
- **Nomination Forms Due- February 24**
- **Election at Annual Meeting- April 26**

EAST HAWAII IPA PEDIATRIC REPRESENTATIVE

- **Dr. Brenda Camacho**

Adult Measures in 2017

PT Metrics & 20% Engagement

February 23, 2017

pediatric Payment transformation



Communication



Performance



Engagement

Today's Agenda

Adult P4Q Measures

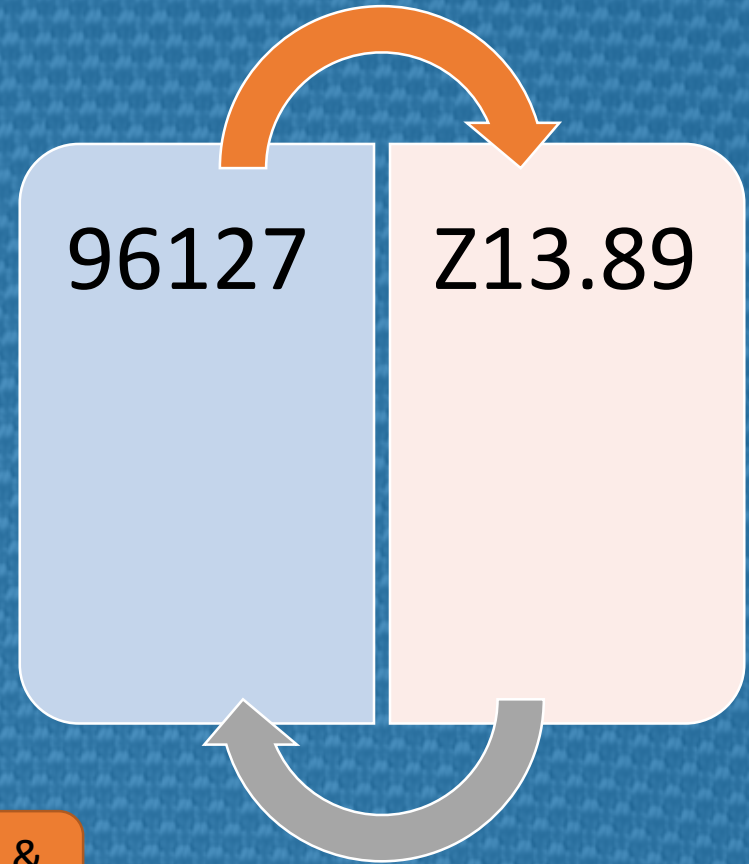
- Depression & Anxiety Screening
- Tobacco SBIRT
- Influenza Vaccine
- Cervical Cancer Screening

20% Engagement Measures

- Cozeva Use
- Annual Outreach
- Referral to Ecosystem
- Sharecare RealAge
- EPSDT Forms

Screening for Symptoms of Clinical Depression and Anxiety

- Annual Screen
- ≥ 18 years of age Depression and **Anxiety** screening
 - PHQ-4
 - HMSA requirement



<18 Depression, >18 Depression & Anxiety

PHQ-4

| PHQ-4 | | | | |
|---|------------|--------------|-------------------------|------------------|
| Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Use "✓" to indicate your answer) | Not at all | Several days | More than half the days | Nearly every day |
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 4. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

(For office coding: Total Score T ___ = ___ + ___ + ___)

+ Screen Follow Up

Anxiety

- GAD 7
- Referral

Depression

- PHQ 9
- Referral

Things to Consider

+ PHQ-4 requires additional screen



Use PHQ-4
and
Rescreen +



Use Full
Screens



Tobacco Screening, Cessation & Counseling

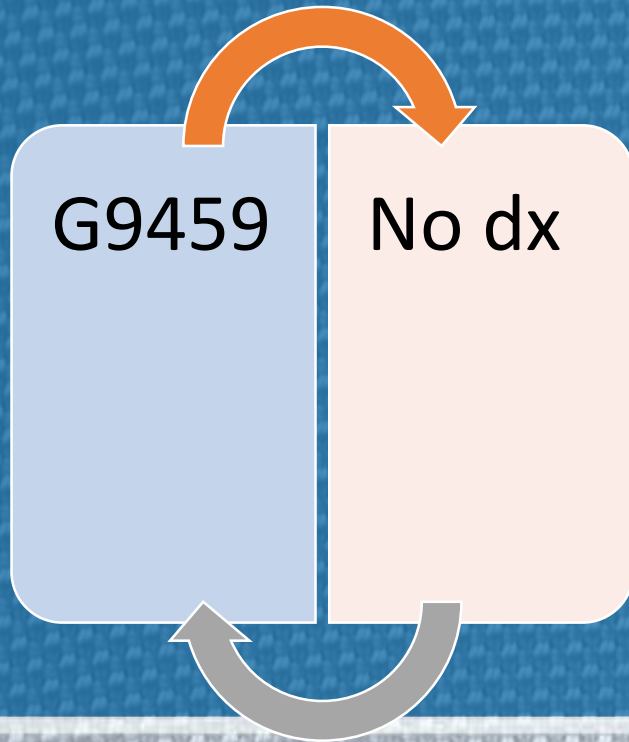
- Annual Event
- Complete Screen & Counseling
- Different Coding for Non-smoker/Smoker
 - Different Coding for Non-smoker by age
 - Different Coding for Non-ACA/ACA Plans



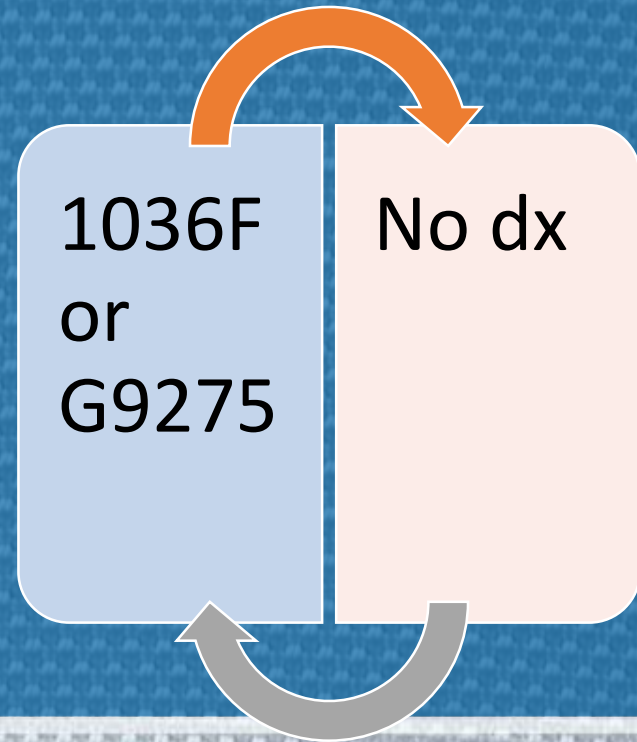
Tobacco Screening, Cessation & Counseling



Non-smoker <20

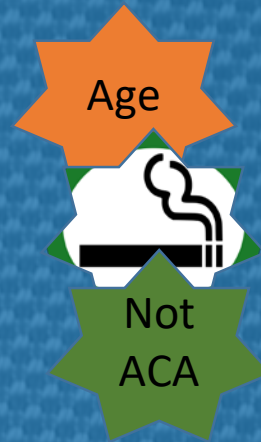
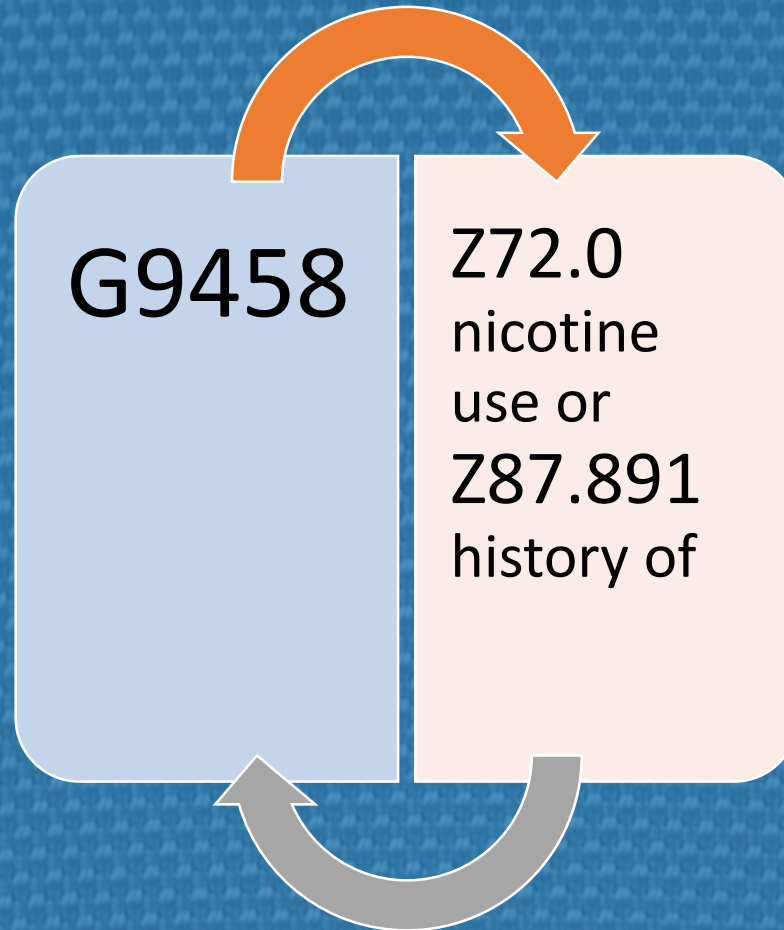


Non-Smoker ≥ 20



Tobacco Screening, Cessation & Counseling

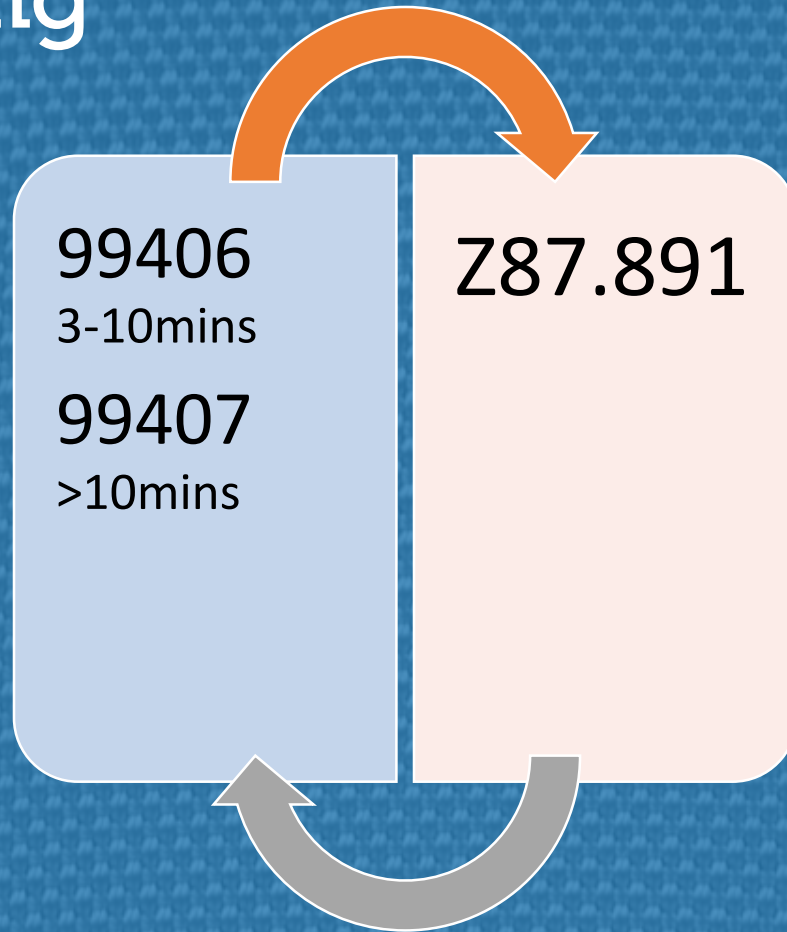
- Smoker <20



Tobacco Screening, Cessation & Counseling



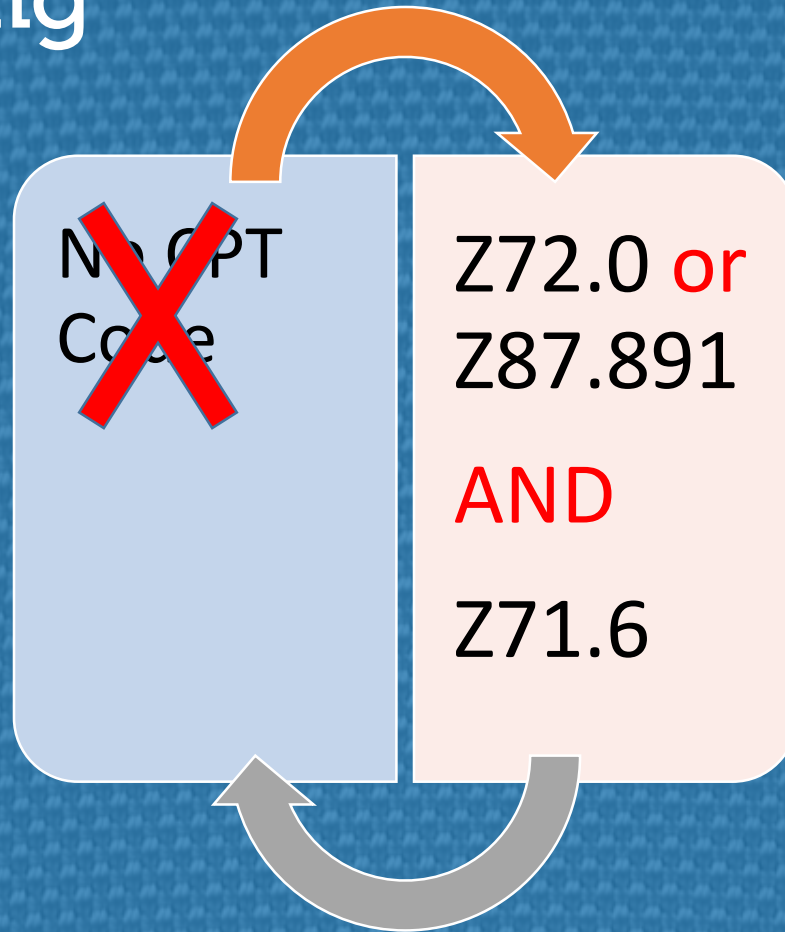
- Smoker ≥ 20



Tobacco Screening, Cessation & Counseling



- Smoker ≥ 20



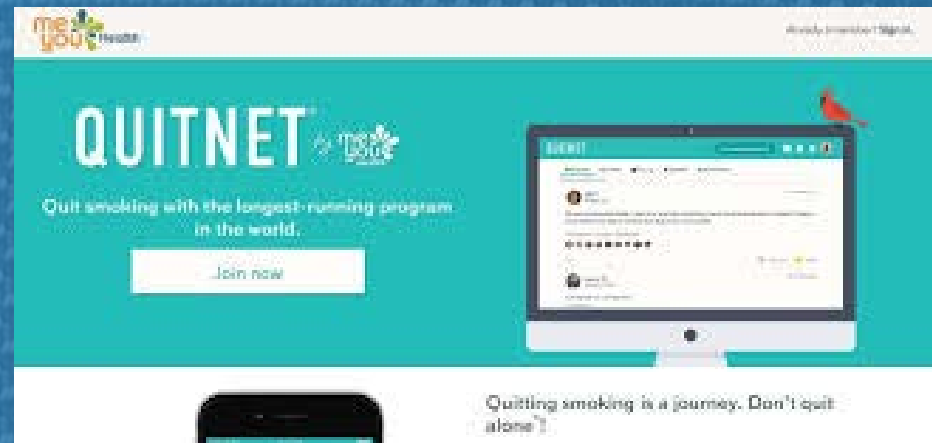
Recommendation



287.891

Referral

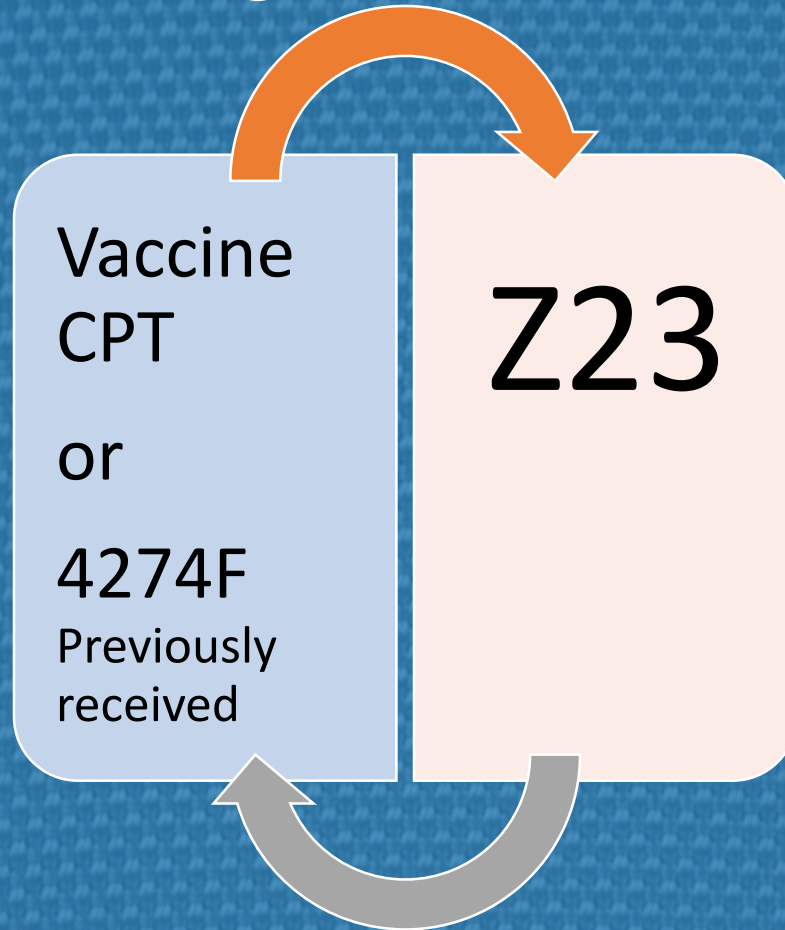
- Hawaii QuitLine (800) 784-8669
- QuitNet® (855) 329-5461
- All Medicaid plans are required to have their own program



Influenza Vaccine ≥ 18 years of age

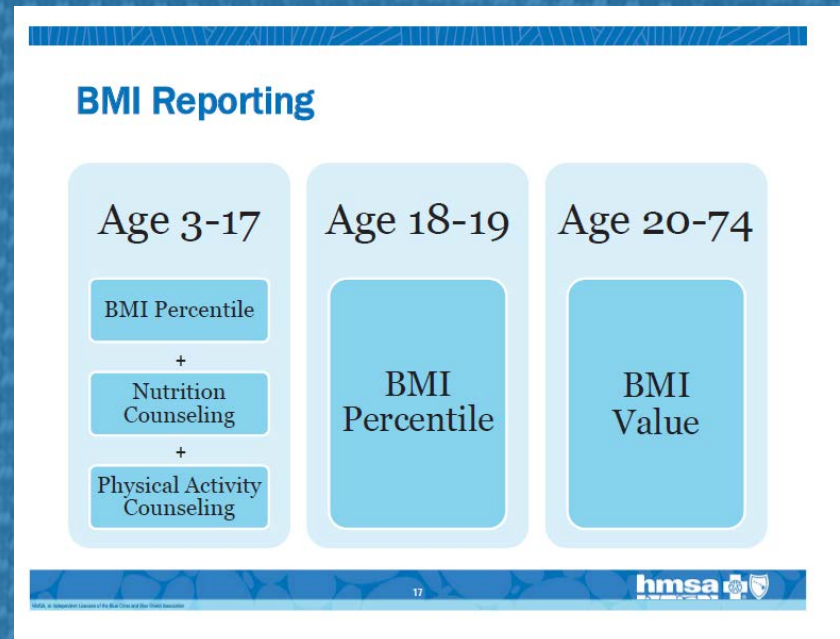
Document

- Date administered or
- Date received



Weight Assessment, Physical Activity and Nutritional Counseling

- Z68.51
- Z68.52
- Z68.53
- Z68.54
- Z71.3 - nutrition
- Z71.89 – physical activity



Cervical Ca Screening 24-64 years

- **Recommendation:**

- **21-29 years: Pap q 3 yrs**

- **30 – 65 years: Pap & HPV q 5 years**

20% Engagement

Oh boy



Engagement #1: Cozeva Monthly

Get online monthly!





Engagement: #2 Annual Patient Survey

- In the past 12 months, did this Provider or someone else from their office contact you about your health and well-being? (Check all that apply)

Had an in-person visit

Called me

Emailed me

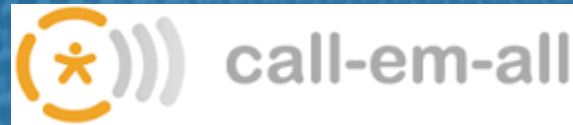
Provider interacted with me via HMSA's Online Care

Texted me

Sent me a letter, postcard, or brochure/pamphlet

No Contact

Check on well-being of all patients???



- Patient Portal
- Cozeva
- Post Cards \$0.34 
- www.call-em-all.com
 - 6¢ – 9.5¢ /call
 - Voice
 - Text
- www.call-em-all.com/wellconnect
- <http://www.meetingburner.com/b/callemall/watch?c=TRKCJH&h=f>



Engagement #3: Ecosystem Referral



Engagement with Ecosystem (Coordinated Care)

By signing below, I certify that I have referred HMSA members to programs in the ecosystem to support their health and well-being, including but not limited to the following:

Check all that apply:

- HMSA Care Model
- Diabetes Education Programs- e.g. InControl Diabetes Center, Diabetes 101, Queens' Diabetes Education
- HMSA and Healthways health education workshops - e.g., Diabetes 101, Hypertension Explained, Family Fitness, Stress Bucket
- HMSA and Healthways health coaching - e.g., chronic disease management, depression, substance abuse, smoking
- Dr. Dean Ornish Program for Reversing Heart Disease™
- Healthways Financial Well-Being™ Powered by Dave Ramsey
- Healthways SilverSneakers™ Fitness
- QuitNet™ - tobacco cessation program
- Aloha Kidney - kidney disease education program
- QCIPN Care Coordination
- Hospice- e.g. Islands Hospice, Hospice Hawaii
- Other (e.g. community-based programs or other resources to assist patients in reaching their health and well-being goals)

I also certify that I referred number of HMSA members to the above-mentioned programs.

I hereby affirm that the above information is complete, accurate and true to the best of my information, knowledge and belief. By signing this attestation electronically, it means I acknowledge and agree that the above statements are correct and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this attestation. In other words, typing my name as an electronic signature indicates I acknowledge and agree to the above statements as if my handwritten signature would on a traditional paper form.

Date:

01/19/2017

Note : Attestation for this measure will be accepted after October 1,2017.

Tracking?

Engagement #4 Sharecare RealAge

- Sharecare's RealAge Assessment annually ≥ 18 years of age
- <https://www.sharecare.com/satic/realage-test>
- <https://auth.doctoroz.com/realage>



Engagement #5 EPSDT DHS 8015

- BMI, BMI%
- Developmental Screening 9M, 18 M, 24M-36M
- CSHCN Screener ©
- Depression / Anxiety Screening
- Tobacco Screening

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam
Please COMPLETELY fill in this form by supplying the requested information and filling in the appropriate O

| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|----|----|----|----|---|---|---|---|---|----|----|----|----|----|----|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------|
| Screen Date (MMDDYY) | Indicate the EPSDT periodic screening age being reported | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>14</td><td>20</td><td>2</td><td>4</td><td>6</td><td>9</td><td>12</td><td>15</td><td>18</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>9</td><td>12</td><td>14</td><td>16</td><td>18</td><td>20</td> </tr> <tr> <td>Y</td><td>d</td><td>m</td><td>m</td><td>m</td><td>m</td><td>m</td><td>m</td><td>m</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> | 14 | 20 | 2 | 4 | 6 | 9 | 12 | 15 | 18 | 2 | 3 | 4 | 5 | 6 | 9 | 12 | 14 | 16 | 18 | 20 | Y | d | m | m | m | m | m | m | m | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | | | | | | | | | | | | | | | | | | | Sex M F |
| 14 | 20 | 2 | 4 | 6 | 9 | 12 | 15 | 18 | 2 | 3 | 4 | 5 | 6 | 9 | 12 | 14 | 16 | 18 | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | d | m | m | m | m | m | m | m | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name (Last, First, Middle Initial) | Medicaid/QUEST ID Birthdate (MMDDYY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MEASUREMENTS For infants, head circumference and weight for length should be assessed and documented in the Medical record. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Blood Pressure | Height (in) | Weight (Lbs) | BMI # | BMI % | BMI Reference - For Information Only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | Normal < 85% Overweight 85%-94% Obese ≥ 95% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMUNIZATIONS GIVEN TODAY AND STATUS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HepB | PCV | MMR | Tdap | Immunization(s) Not Given | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DTaP | Rotav | Vaccinia | MCV4/MPSV4 | Immunizations up to date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IPV | Influenza | HepA | HPV | Catch Up Scheduled | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hib | Other (List) | Refused (List) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Comments: | | Contraindicated (List) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SCREENING DONE TODAY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision Screening: Snellen, Allen, Tumbling Et. LEA Symbols 9y, 6y, 9y, 6y, 10y, 12y, 14y, 16y, 18y | Normal | Abnormal | Done | Blood Lead Level 9-12m, 2y (please required by 2 years) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y | | | | Hgb/Hct 9m - 12m, Female 12y - 14y | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Developmental Screening (See back) 9m, 18m, 24m-36m (3 screenings required by 36 months) | PEDS ≥ 2 predictive concerns - Abnormal ASQ ≥ 1 domain falling below normal cut-offs - Abnormal Other (List) | | | Comments for screenings not done: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Autism Screening (See back) 18m, 24m Fail - Abnormal | CHAT M-CHAT Other (List) | | | Has the child seen a dentist within the past year? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| As part of surveillance per the AAP/Bright Futures recommended periodicity (see back), the following should be done and documented in the medical record: TB risk assessments, lead risk assessment, psychosocial/behavioral assessments, and for adolescents: alcohol/drug use assessment, and as appropriate - dyslipidemia, STI, and cervical dysplasia screening. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REFERRALS MADE TODAY By leaving this section blank, I am confirming that there are no referral needs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Already referred or receiving state or specialty services. | H-KISS | PHN | CAMHD | WIC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient/parent refused. | PT/OT/Speech/Audiology | DOE | DDD | Child Welfare | Dentistry | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Behavioral Health/Substance Abuse (List name & specialty) | Nutrition/Exercise (List name & specialty) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical/Surgical/Developmental (List name & specialty) | Other(s) (List name & specialty) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CARE COORDINATION ASSISTANCE NEEDED Please call patient's Health Plan for Care Coordination assistance if needed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No Care Coordination Needed | Managing medical condition and/or medications | Obtaining foreign/sign language translation | Obtaining dental care (If yes, call CCMC) | Scheduling/Keeping appointments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arranging transportation | Coordinating multiple appointments | Family needs assistance in following the POC | Obtaining specialty services | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If assistance is needed, please provide parent's/caregiver's telephone no. The health plan will call to facilitate coordination. | | List additional information or other assistance needed: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone Numbers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Aloha Care | 808-975-1600 (Dialing) 1-800-245-9900 (Toll Free) | Kaiser QUEST | 808-432-5700 (Dialing) 1-800-651-2207 (Toll Free) | CCMC Dental Resource | 808-486-9000 (Dialing) 1-888-486-9000 (Toll Free) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HMSA QUEST | 808-948-6488 (Dialing) 1-888-440-0940 (Toll Free) | Obama Health Plan | 1-800-946-4262 | Evercare | 1-888-960-0729 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PROVIDER STATEMENT: A complete EPSDT exam also includes a history (initial or interval), a physical exam, age appropriate surveillance and anticipatory guidance. By signing below, I confirm that these were performed and documented in the patient's medical record. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider Name (Print) | Signature | NPI # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| For additional forms, contact ACS at 808-952-5570 (Dialing) or 800-235-4378 (Toll Free). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

DHS 8015 (01/10)



Ka Huli'au

1155 W. Englewood Avenue, Suite 200, Honolulu, HI 96819

https://hmsa.com/portal/provider/zav_pel.aa.PAY.100.htm

HMSA Payment Transformation

P R O G R A M G U I D E



- [https://hhin.hmsa.com/HHIN/1180-6864_Payment_trans_program_guide_\(HF1\)_Jan_2017_120916.pdf](https://hhin.hmsa.com/HHIN/1180-6864_Payment_trans_program_guide_(HF1)_Jan_2017_120916.pdf)



SAVE THE DATE

East Hawaii IPA 21ST ANNUAL

Healthcare Symposium

AUGUST 18-20, 2017

FAIRMONT ORCHID HOTEL | WAIKOLOA | HAWAII ISLAND | HAWAII



EHI IPA'S NEW PHONE NUMBER:

808-797-3113



EHI IPA'S FAX NUMBER:

808-935-4472

SUSAN'S NEW EMAIL:
smochizuki@ehiipa.com

JOYCE'S NEW EMAIL:
jvitaless@ehiipa.com

NEW WEBSITE ADDRESS:

<http://www.ehiipa.com/>



NEXT PEDIATRIC WORKSHOP DATES:

- Thursday, April 27
- Thursday, July 27
- Thursday, September 28
- Thursday, November 9

Visit our calendar of events at www.ehiipa.com

Download RSVP forms for:

- Super Huddles
- Pediatrician Meetings
- Symposium
- Workshops
- Special Events

