Pennsylvania Department of Public Welfare
DRAFT Pediatric EQUIP

Focus Area	Lead Agencies	2011 Objectives	Provider Goals
Pediatrics	**OMAP, DOH, CHIP, DOE**	**Acceptance Rates, Metric Rates, Clinical Rates**	
Improve Quality, Cost Containment, Efficiency	1. Predictive Modeling/Risk Stratification, as necessary 2. Expand immunization registry to include BMI surveillance and vision, hearing and lead screenings 3. Focus on childhood obesity 4. Clinical decision support and links to current treatment guidelines 5. Pharmacy utilization rates (ability of the Department to track medication usage, adherence and abuse) 6. Medical Case Manager for co-existing medical conditions (all EQUIPS) 7. Physician access to pharmacy data	**Acceptance Rates:** 1. Twenty percent of participating ARRA providers are using a certified EHR/EMR **Metric Rates:** 1. Monitor HEDIS rates for: a. Weight assessment and counseling for nutrition and physical activity for children and adolescents ages 2 years to 17 years b. Childhood immunization status c. Lead screening d. Follow up care for children ages 6 years to 12 years prescribed ADHD medications e. Annual dental visits for children and adolescents ages 2 years to 21 years 2. Additional HEDIS measures: a. Well-child visits in the first 15 months of life b. Well-child visits in 3rd,4th, 5th and 6th years of life c. Adolescent well-child visits d. Use of appropriate medications for people ages 5 years to 18 years with asthma e. Appropriate testing for children ages 2	1. Automatic Order Sets 2. EPSDT screens/Well-child visits 3. Link to DOH Immunization Registry and Philadelphia DOH Immunization Registry 4. E-prescribing (all EQUIPS) a. Weight-based dosing calculator b. Prompts for FDA indications 5. Asthma Action Plans 6. Chronic Care Plans 7. BMI assessments, referrals and internal tracking 8. Blood pressure monitoring and guideline-based definitions 9. Screening, referral, tracking and feedback for: a. Developmental/Autism b. Lead c. Vision and hearing 10. Smoking assessments and cessation counseling for recipients ages 10 and older

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		years to 18 years with pharyngitis f. Appropriate treatment for children with URI g. Children and adolescent access to PCP h. Follow up hospitalizations for mental illness for individuals ages 6 years and older **Clinical Rates:** 1. Vision and hearing screening 2. Developmental screening 3. Dental home/annual dental visits: referral, visit and feedback to PCP 4. Depression screening 5. Monitor use of ADHD medications, narcotics, benzodiazepines, antipsychotic medications, illicit drugs, methadone and/or suboxone 6. Labs: a. Lead b. Atypical medications: HbA1c, lipid panel, FBS, LFT, Thyroid (TSH) 7. EKG for children taking ADHD medications 8. Decreased incidence of smoking	11. Anticipatory Guidance 12. Depression screening of mothers on first post-partum visit[1] 13. Depression screening of pediatric patients using validated tool 14. Prescription for behavioral health referral: office visit and feedback to PCP 15. Chlamydia, HIV, pregnancy screening; educate patients about HIV, STDs and pregnancy 16. PDL adherence (all EQUIPS)

[1] Conduct a two question screening: 1) Over the past two weeks, have you ever felt down, depressed or hopeless? 2) Over the past two weeks, have you felt little interest or pleasure in doing things? If positive, follow up with a more comprehensive, validated assessment tool.

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Engage Patients and Families	1. Identify race/ethnicity for review of treatment disparities 2. Develop pop-up alerts for providers that signify needed care (all EQUIPS) 3. Develop pop-up alerts for consumers that signify needed care (all EQUIPS) 4. Ability to send/ receive text/ email messages to providers (all EQUIPS) 5. Access to preventative care/health information 6. Peer support/coaching (enrollee or caregiver) (all EQUIPS)	**Metric Rates:** 1. CAHPS Surveys **Clinical Rates:** 1. Increase outreach in schools and WIC programs to identify MA eligibles 2. HealthChoices and ACCESS Plus Member services: Develop programs that allow consumers to access medical records and assist with creating an EHR, which could include scheduling, canceling and re-scheduling appointments (all EQUIPS) 3. Computer kiosks in FQHCs and RHCs for consumers to access their: a. Health information, include consumer or caregiver access to current medication list for reconciliation b. Current care plan c. Upcoming appointments d. Review care gaps	1. Text messages to parents/teens to remind them of appointments and needed immunizations (all EQUIPS) 2. Ability to send/ receive text/ email messages to consumers (all EQUIPS) 3. Availability of appointments (appointment standards), and ability to schedule and re-schedule appointments 4. Website for health information, including the same hyperlinks to MA Guidelines that are available via the ACCESS Plus website (all EQUIPS) 5. Use of alternative social networking services to "blast" healthy tips 6. Physician and Case Manager educating patients about illness prevention, disease management and treatment options 7. Comprehensive patient-centered care plan, and provider collaboration with consumer and caregiver in the development of electronic care plan (all EQUIPS)

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Pediatrics	**Would this be the same as above, or TBD?**	**Acceptance, Metric and Clinical Rates**	
Improve Coordination of Care	1. Referrals to IMCM, as needed for congenital anomalies, high-risk neonates 2. Case management, as needed for disease management, identify care gaps, increase referrals for needed services 3. Identify adolescents with special needs or chronic conditions (SN indicator) 4. Improve coordination of physical health and behavioral health: substance abuse, depression 5. Develop pop-up alerts for providers that alert the transition to adult care (age-outs) six months to 12 months prior to a consumer with special needs turning 21 years of age 6. Equip providers with links to community resources, professional referral sources, early intervention services and Vaccinations for Kids program 7. Links for providers to patient specific data (all EQUIPS) 8. Links to school immunization records. Question ability to download data from school	**Clinical Rates:** 1. Establish Medical/Dental home assignments 2. Increase screening for: a. BMI b. Developmental Delays/Autism c. Vision, hearing and lead screens d. Depression e. Drug and alcohol f. Smoking 3. Use of electronic patient care plans 4. Ensure any child requiring case management services receives them	1. Referral to Medical/Dental home 2. Developmental surveillance: use of validated screening tool 3. Depression screening: use of validated tool; psychosocial/behavioral assessments and referrals for appropriate care; feedback to PCP 4. Appropriate referrals for nutrition, physical activity counseling for overweight or obese children and adolescents, and follow up report to PCP 5. EMR/care plans identify other specialists involved in patient's care 6. Patient care plans have embedded HEDIS measures 7. Medication reconciliation and adherence: prescription and alternative medications (Medication possession ratio)

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Pediatrics	**Would this be the same as above, or TBD?**	**Acceptance, Metric and Clinical Rates**	
	records to DOH registry.		
Reduce Cycle Time between "New" Evidence-based Healthcare and Community Practice	1. Provider education, training and practice support on use of technology 2. Department will incorporate preventative guideline updates in EPSDT periodicity schedule 3. Provide providers with hyperlinks to best practices related to Disease Management programs 4. Long term goal: Question ability to get a license for "Up-to-Date" (non-personal use) and provide a link for providers to access; question cost	**Clinical Rates:** 1. Integrate HEDIS guidelines into the certified EHR/patient care plan 2. Create provider links to current treatment guidelines, for example: AAP, Bright Futures, validated screening tools; consistent with national evidence-based guidelines.	1. Participation of providers in tracking trends and performance measures in clinical care (P4P, HEDIS)