From Medscape Education Business of Medicine

Preventive Services for Children: Getting the Message to Parents and Caregivers CME/CE

Colleen Kraft, MD Faculty and Disclosures

CME/CE Released: 09/11/2012; Valid for credit through 09/11/2013

Supported by the Centers for Medicare & Medicaid Services, a U.S. Department of Health and Human Services Agency.

Preventive care has been an established practice for infants and young children for several decades. Under this policy, well-child visits for vaccinations and patient education were provided without co-pay or cost-sharing. Now, under the Affordable Care Act (ACA), children up to age 17 have similar expanded coverage for important preventive services.

Group health plans and individual policies were required to cover preventive services as defined by the Bright Futures guidelines of the American Academy of Pediatrics, at no additional cost to enrollees for plan or policy years beginning on or after September 23, 2010; there are no co-pays, deductibles, or co-insurance for a number of defined preventive services when supplied by in-network providers.[1]

"It has made sense to people across the years that preventive care for children is important for proper growth and development," states Colleen Kraft, MD, a practicing pediatrician at the Carilion Clinic in Roanoke, Virginia, and Chief Medical Officer of the accountable care organization (ACO) MajestaCare, a Medicaid-managed care partnership between the Carilion Clinic and Aetna. "We are seeing the beginnings of the idea that adult preventive services are important, with the focus moving toward the idea of visiting the doctor to stay well instead of visiting only when you are sick. But pediatrics was really the first to take this approach."

The ACA also supports preventive care available in Medicaid and the Children's Health Insurance Program (CHIP), via the extension of funding for CHIP through fiscal year 2015 and continuing authority for the program through 2019.[2] States are required to maintain eligibility, benefits, and cost-sharing levels that were in place when the law passed to prevent cuts or increased cost-sharing for preventive services as a part of budgetary solutions.[3]

Unfortunately, cost-sharing strategies tend to reduce the likelihood that people will use preventive services.[4] Previously, up to 11 million children did not have health insurance that covered all of the recommended immunizations.[5] Although the elimination of cost-sharing has a positive effect regarding preventive services across all ages, it is especially beneficial when addressing the needs of older children, says Dr Kraft.

"Well-child visits for very small children are pretty well accepted, but getting older children into the office for well-child visits has been problematic," she states. "However, making the Bright Futures screening available without a copayment has been a big motivator for families, so that's been a good result."

Overview of Current Recommendations

The ACA requires private insurers to cover the preventive services recommended by the Health Resources and Services Administration's (HRSA's) Bright Futures Project, an initiative that provides evidence-based recommendations for the improvement of the health and wellbeing of infants, children, and adolescents.[6] These recommendations are summarized in the chart below:

Table 1. Covered Preventive Services for Children [7]

Preventive Service	Age
Alcohol and drug use assessments	Adolescents
Autism screenings	18 months and 24 months
Behavioral assessments	By age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Blood pressure screening	By age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Cervical dysplasia screening	Sexually active females
Congenital hypothyroidism screening	Newborns
Depression screening	Adolescents
Developmental screening	<3 years and childhood surveillance
Dyslipidemia screening	At risk children, by age group (1-4 years; 5-10 years; 11-14 years; 15-17 years)
Fluoride chemoprevention supplements	All ages of children without fluoride in water source
Gonorrhea preventive medication	Eyes of newborns
Hearing screening	Newborns
Height, weight, body mass index (BMI) measurement	By age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Hematocrit/hemoglobin screening	All children
Hemoglobinopathy/sickle cell screening	Newborns
HIV screening	At-risk adolescents
Iron supplements	Children at risk of anemia, ages 6-12 months
Lead screening	Children at risk of lead exposure
Medical history	All children
Obesity screening and counseling	All children
Oral health screening	Young children, by age group (0-11 months; 1-4 years; 5-10 years)
Phenylketonuria (PKU) screening	Newborns
Sexually transmitted infection (STI) screening and counseling	At-risk adolescents
Tuberculin test	At-risk children, by age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Vision screening	All children

Vaccinations are also included in the recommendations; the following tables delineate immunization schedules by age groups. Comprehensive listings with explanations are available at Vaccines.gov.

Table 2. Immunizations: Birth to 6 Years [8]

Vaccine	Doses	Age(s)
HepB *Hepatitis B*	3	Birth, 1-2 months, 6-18 months
RV *Rotavirus*	3	2 months, 4 months, 6 months
DTaP *Diphtheria, tetanus, acellular pertussis*	5	2 months, 4 months, 6 months, 15-18 months, 4-6 years
Hib *Haemophilus influenzae type b*	4	2 months, 4 months, 6 months, 12-15 months
PCV *Pneumococcal conjugate vaccine*	4	2 months, 4 months, 6 months, 12-15 months
IPV *Inactivated poliovirus vaccine*	4	2 months, 4 months, 6-18 months, 4-6 years

Flu *Influenza*		Yearly after 6 months
MMR *Measles, mumps, Rubella*	2	12-15 months, 4-6 years
Varicella *Chickenpox*	2	12-15 months, 4-6 years
HepA *Hepatitis A*	2	12-23 months

In addition, the meningococcal conjugate vaccine MCV4 should be given at a minimum of 2 years of age, according to immune status and level of exposure.[8]

Table 3. Immunizations: Ages 7 to 18 Years [9]

Vaccine	7-10 years	11-12 years	13-18 years
Tdap *Tetanus, diphtheria, acellular pertussis*		Recommended	Catch-up
HPV *Human papillomavirus*		Recommended (3 doses)	Catch-up
MCV4	High Risk	Recommended	Catch-up
Flu	Recommended yearly		
PCV13	High Risk		
HepA	High Risk		
HepB	Catch-up		
IPV	Catch-up		
MMR	Catch-up		
Varicella	Catch-up		

In requiring coverage of these recommendations, the Affordable Care Act has already made additional services available to approximately 18.5% of children through insurers.[3] Furthermore, an estimated 13.7% of American children receive preventive services without cost-sharing.[3] The number of children benefiting from the expansion of preventive services will increase over time, as the insurance plans that were in place prior to the 2010 cut-off status will decrease.

Increasing Patient Access to Services

In many cases, families may not currently pursue preventive care because they are unaware of changes to their coverage. Therefore, patients should be encouraged during office visits to take advantage of preventive health services for improving health outcomes as well as to avoid the costs associated with treating a disease that could have been prevented.

To insure that preventive services are incorporated effectively into a practice, Dr Kraft recommends involving the entire staff, rather than having clinicians shoulder the entire responsibility. By including all of the contributors to the patient care process, the staff not only becomes aware of the services offered, but they are also instrumental in identifying and correcting any obstacles to ensuring patient access to important services.

"When we decided to incorporate a developmental screening test called the Ages and Stages into our practice, we discussed with our office staff and nurses where the best place for parents to fill out the form would be, and decided it was the waiting room," Dr Kraft says. After 30% of parents didn't complete the task, the staff noted that some parents struggled with literacy and others were unable to concentrate due to monitoring their children, and the workflow was subsequently altered in these cases to compensate. "If we identify a parent with literacy concerns, for example, the nurse will go over the questions with the parent after they are moved to a room. If it is a particularly busy day, the nursing staff will communicate with the doctor so that the doctor can go over the questions."

In another scenario, care was taken in Dr Kraft's practice for the incorporation of HPV vaccinations into preventive services due to sensitivity among some parents surrounding transmission of the virus." As a practice, we decided that there should be more conversation about the prevention of cancer than about how someone gets the disease," she explains. "Therefore, we incorporate HPV vaccination into the 11-year-old visit the same way we incorporate every other vaccination." Staff informs the parents at check-in that the child will receive Tdap and HPV vaccinations that day, and the message is reiterated by the nurse in the room, and later by the attending physician. With a consistent message, Dr Kraft reports that patients are much more likely to get vaccinated.

Unfortunately, the increase in patients receiving robust services has been in the short term perceived as a reduction in pay by some physicians, as the copayments that supplemented insurance payments can no longer be collected. Although the insurance companies

were to make up for the loss of copayments, Dr Kraft points out that this is a practice that has not reached across the United States. It is in this kind of situation, she says, that ACOs really do make a difference to physicians.

"The focus of accountable care is really on population health, so you are not going to be paid piecemeal, as in fee-for-service," Dr Kraft explains. "We are moving toward more of a global payment where bonuses are based on quality. The idea is to align physician compensation with population health, which gives the physician incentive to perform all of the different Bright Futures preventive screenings. These preventive services are easy and relatively inexpensive actions you can take to prevent complications down the line, and it makes sense financially."

References | Abbreviations | Additional Resources

Print Email Like Tweet Google+

From Medscape Education Business of Medicine

Preventive Services for Children: Getting the Message to Parents and Caregivers CME/CE

Colleen Kraft, MD Faculty and Disclosures

CME/CE Released: 09/11/2012; Valid for credit through 09/11/2013

Supported by the Centers for Medicare & Medicaid Services, a U.S. Department of Health and Human Services Agency.

Preventive care has been an established practice for infants and young children for several decades. Under this policy, well-child visits for vaccinations and patient education were provided without co-pay or cost-sharing. Now, under the Affordable Care Act (ACA), children up to age 17 have similar expanded coverage for important preventive services.

Group health plans and individual policies were required to cover preventive services as defined by the Bright Futures guidelines of the American Academy of Pediatrics, at no additional cost to enrollees for plan or policy years beginning on or after September 23, 2010; there are no co-pays, deductibles, or co-insurance for a number of defined preventive services when supplied by in-network providers.[1]

"It has made sense to people across the years that preventive care for children is important for proper growth and development," states Colleen Kraft, MD, a practicing pediatrician at the Carilion Clinic in Roanoke, Virginia, and Chief Medical Officer of the accountable care organization (ACO) MajestaCare, a Medicaid-managed care partnership between the Carilion Clinic and Aetna. "We are seeing the beginnings of the idea that adult preventive services are important, with the focus moving toward the idea of visiting the doctor to stay well instead of visiting only when you are sick. But pediatrics was really the first to take this approach."

The ACA also supports preventive care available in Medicaid and the Children's Health Insurance Program (CHIP), via the extension of funding for CHIP through fiscal year 2015 and continuing authority for the program through 2019.[2] States are required to maintain eligibility, benefits, and cost-sharing levels that were in place when the law passed to prevent cuts or increased cost-sharing for preventive services as a part of budgetary solutions.[3]

Unfortunately, cost-sharing strategies tend to reduce the likelihood that people will use preventive services.[4] Previously, up to 11 million children did not have health insurance that covered all of the recommended immunizations.[5] Although the elimination of cost-sharing has a positive effect regarding preventive services across all ages, it is especially beneficial when addressing the needs of older children, says Dr Kraft.

"Well-child visits for very small children are pretty well accepted, but getting older children into the office for well-child visits has been problematic," she states. "However, making the Bright Futures screening available without a copayment has been a big motivator for families, so that's been a good result."

Overview of Current Recommendations

The ACA requires private insurers to cover the preventive services recommended by the Health Resources and Services Administration's (HRSA's) Bright Futures Project, an initiative that provides evidence-based recommendations for the improvement of the health and wellbeing of infants, children, and adolescents.[6] These recommendations are summarized in the chart below:

Table 1. Covered Preventive Services for Children [7]

Preventive Service	Age
Alcohol and drug use assessments	Adolescents
Autism screenings	18 months and 24 months
Behavioral assessments	By age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Blood pressure screening	By age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Cervical dysplasia screening	Sexually active females
Congenital hypothyroidism screening	Newborns
Depression screening	Adolescents
Developmental screening	<3 years and childhood surveillance
Dyslipidemia screening	At risk children, by age group (1-4 years; 5-10 years; 11-14 years; 15-17 years)
Fluoride chemoprevention supplements	All ages of children without fluoride in water source
Gonorrhea preventive medication	Eyes of newborns
Hearing screening	Newborns
Height, weight, body mass index (BMI) measurement	By age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Hematocrit/hemoglobin screening	All children
Hemoglobinopathy/sickle cell screening	Newborns
HIV screening	At-risk adolescents
Iron supplements	Children at risk of anemia, ages 6-12 months
Lead screening	Children at risk of lead exposure
Medical history	All children
Obesity screening and counseling	All children
Oral health screening	Young children, by age group (0-11 months; 1-4 years; 5-10 years)
Phenylketonuria (PKU) screening	Newborns
Sexually transmitted infection (STI) screening and counseling	At-risk adolescents
Tuberculin test	At-risk children, by age group (0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
Vision screening	All children

Vaccinations are also included in the recommendations; the following tables delineate immunization schedules by age groups. Comprehensive listings with explanations are available at Vaccines.gov.

Table 2. Immunizations: Birth to 6 Years [8]

Vaccine	Doses	Age(s)
HepB *Hepatitis B*	3	Birth, 1-2 months, 6-18 months
RV *Rotavirus*	3	2 months, 4 months, 6 months
DTaP *Diphtheria, tetanus, acellular pertussis*	5	2 months, 4 months, 6 months, 15-18 months, 4-6 years
Hib *Haemophilus influenzae type b*	4	2 months, 4 months, 6 months, 12-15 months
PCV *Pneumococcal conjugate vaccine*	4	2 months, 4 months, 6 months, 12-15 months
IPV *Inactivated poliovirus vaccine*	4	2 months, 4 months, 6-18 months, 4-6 years

Flu *Influenza*		Yearly after 6 months
MMR *Measles, mumps, Rubella*	2	12-15 months, 4-6 years
Varicella *Chickenpox*	2	12-15 months, 4-6 years
HepA *Hepatitis A*	2	12-23 months

In addition, the meningococcal conjugate vaccine MCV4 should be given at a minimum of 2 years of age, according to immune status and level of exposure.[8]

Table 3. Immunizations: Ages 7 to 18 Years [9]

Vaccine	7-10 years	11-12 years	13-18 years
Tdap *Tetanus, diphtheria, acellular pertussis*		Recommended	Catch-up
HPV *Human papillomavirus*		Recommended (3 doses)	Catch-up
MCV4	High Risk	Recommended	Catch-up
Flu	Recommended yearly		
PCV13	High Risk		
HepA	High Risk		
HepB	Catch-up		
IPV	Catch-up		
MMR	Catch-up		
Varicella	Catch-up		

In requiring coverage of these recommendations, the Affordable Care Act has already made additional services available to approximately 18.5% of children through insurers.[3] Furthermore, an estimated 13.7% of American children receive preventive services without cost-sharing.[3] The number of children benefiting from the expansion of preventive services will increase over time, as the insurance plans that were in place prior to the 2010 cut-off status will decrease.

Increasing Patient Access to Services

In many cases, families may not currently pursue preventive care because they are unaware of changes to their coverage. Therefore, patients should be encouraged during office visits to take advantage of preventive health services for improving health outcomes as well as to avoid the costs associated with treating a disease that could have been prevented.

To insure that preventive services are incorporated effectively into a practice, Dr Kraft recommends involving the entire staff, rather than having clinicians shoulder the entire responsibility. By including all of the contributors to the patient care process, the staff not only becomes aware of the services offered, but they are also instrumental in identifying and correcting any obstacles to ensuring patient access to important services.

"When we decided to incorporate a developmental screening test called the Ages and Stages into our practice, we discussed with our office staff and nurses where the best place for parents to fill out the form would be, and decided it was the waiting room," Dr Kraft says. After 30% of parents didn't complete the task, the staff noted that some parents struggled with literacy and others were unable to concentrate due to monitoring their children, and the workflow was subsequently altered in these cases to compensate. "If we identify a parent with literacy concerns, for example, the nurse will go over the questions with the parent after they are moved to a room. If it is a particularly busy day, the nursing staff will communicate with the doctor so that the doctor can go over the questions."

In another scenario, care was taken in Dr Kraft's practice for the incorporation of HPV vaccinations into preventive services due to sensitivity among some parents surrounding transmission of the virus." As a practice, we decided that there should be more conversation about the prevention of cancer than about how someone gets the disease," she explains. "Therefore, we incorporate HPV vaccination into the 11-year-old visit the same way we incorporate every other vaccination." Staff informs the parents at check-in that the child will receive Tdap and HPV vaccinations that day, and the message is reiterated by the nurse in the room, and later by the attending physician. With a consistent message, Dr Kraft reports that patients are much more likely to get vaccinated.

Unfortunately, the increase in patients receiving robust services has been in the short term perceived as a reduction in pay by some physicians, as the copayments that supplemented insurance payments can no longer be collected. Although the insurance companies

were to make up for the loss of copayments, Dr Kraft points out that this is a practice that has not reached across the United States. It is in this kind of situation, she says, that ACOs really do make a difference to physicians.

"The focus of accountable care is really on population health, so you are not going to be paid piecemeal, as in fee-for-service," Dr Kraft explains. "We are moving toward more of a global payment where bonuses are based on quality. The idea is to align physician compensation with population health, which gives the physician incentive to perform all of the different Bright Futures preventive screenings. These preventive services are easy and relatively inexpensive actions you can take to prevent complications down the line, and it makes sense financially."

References | Abbreviations | Additional Resources

Print Email Like Tweet Google+