 **Adolescent Domain Oct KMCHC Notes *Recorder: Aarion Gray Facilitator: Connie Satzler***

| **Gaps and Challenges Around** **Alignment Opportunities** | **Action Items for Collaboration/ Improvements** | **Next Steps:****Responsibility?****Who? By when?** |
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| **MCH Topics**: Comprehensive School-Based Health; well-child visits; immunizations; mental health and suicide prevention **Related MCH Plan items**: NPM 10; Priorities 5, 7 and 8 |
| * Need presumptive eligibility.
* MCOs talked a lot about identifying at-risk pregnant patients during the presentations, use the same type of approach to identify at-risk teen patients.
* Agree with idea of screening and risk stratifications. What are some risk stratification tools that we can all agree with?
* HPV vaccine; continue to align efforts on this. Could you give gas cards for that? Issue: people are suspicious about the vaccine – better to incentivize the visit as a whole. Also, don’t want them just showing up to get their HPV shot; want them there for a well-child visit.
* Increasing reimbursement for providers who vaccinate – incentives on both sides (providers and patients).
* How to expand incentives to adolescent to receive well visits paid by MCOs (i.e. gas cards, Starbucks).
* Related to school health clinics, could incentivize families around that.
* Is there a restriction from a policy level for MCOs to provide services at a school? Don’t think they are prohibited, but it is not a requirement of the contract to provide.
* Relationship/potential relationship between an MCO and a School-Based Health Center?
* Want to set the school-based health up as a medical home.
* Can the school be a true medical home?
* Access to behavioral health. There is an overwhelming need in schools. Need effective model for behavioral/mental health in schools. How do they staff, how do they get reimbursed for that. School side: space needs, privacy issues.
* Suicide prevention education.
* Need a conversation with the Dept of Education on suicide training. Jason Flatt Act.
* United does mental health. They include families. Mental health first aid: does United provide this, and who receives mental health first aid? Families?
* Can MCOs help come up with creative solutions for privacy/mental health in schools issues?
* Related to mental health, a lot of primary care providers don’t want their hands in mental health, they don’t want to deal with it. Can MCOs they help incentivize providers?
* MCOs should be using ACES (Adverse Childhood Experiences). See <http://www.kansaspowerofthepositive.org/> for more information.
* Partnering with Boys & Girls Club membership, United YMCA. Work in partnership with community clubs to help promote well visits and wellness.
* Problems with special health care needs & well-visits – needs to be better integrated and coordinated. Example: primary care provider or school nurse checked off vision, but wasn’t a real vision check, so when they go to a hospital, they can’t get vision check needed at Children’s Mercy because says was already checked. So, need to be sure that if they get a visit at a school, it doesn’t prevent from going to see a primary care doc if they need a comprehensive well-child visit & if they need something more in-depth.
* Issues of providers just drawing a line through everything on the physical form without really testing it; especially an issue for CYSHCN (examples: says vision okay when parents know it is *not;* Annie with Kansas School for the Deaf say she gets physical forms for her students with line drawn through hearing as though it is okay when “they are at this school for a reason!”)

Comments on specific services and populations: dental, vision, pharmacy, asthma, special needs (also relates to above, especially well visits)* Asthma – pharmacy coverage, inhalers. Could MCOs do something to help?
* Can MCO fill prescription through mail order for adolescents with transportation issues?
* Special need glasses not covered
* Appliances for dental not covered
* Vision: MCOs don’t cover special needs glasses. They aren’t that expensive, but for some reason not covered! Could we find out why?
* Special needs appliances or glasses – what are the different types of special needs appliances for dental or vision that need to be covered by aren’t? Ask families: for some reason, even when it is medically necessary it is denied.
* Dental and vision with all 3 MCOs are outsourced.
* Outside source / some are not in network (appeal process) – this is especially an issue for CYSCHN who need certain dental or vision providers to accommodate their child’s special needs.
* They no longer partner with Children’s Mercy for dental and vision services; medically fragile children need this! For medically fragile children, how do we guarantee they can get these at a hospital? Appeal process takes a year! Partner somehow to make sure it doesn’t take a year.
* Dentists not taking Medicaid – may say they *technically* take Medicaid, but then they are full of their percentage of Medicaid patients and not taking more
* Walk-in clinics don’t work, in physician’s opinion. Don’t known when or where the MCOs are doing this.
* Provider comments: Need better communication from MCOs about incentives and everything else. They get a bunch of forms, but they don’t really know what they all are! Need a cover letter, some sort of explanation as to what is actionable from this form. Is it just for information? Are they supposed to do something with it?
* Centralized health history – doesn’t get transmitted.
* Providers: Some of the info on the value-added services (VAS) list sound very positive, but we don’t always know about them, and the MCOs don’t coordinate with us. They are checking boxes and marketing services, but it doesn’t always translate very well into the clinical world, and coordinating with providers.

Other* Issue of trust brought up, especially for CYSHCN: there are challenges with who to trust, who to get information from, challenges. If you are seeing multiple providers, like NP going into home, then you have your doctor. The home visits are confusing to many patients. Too many “players: If adolescents are seeing multiple providers, they don’t know who to trust.
* For adolescents with social and emotional problems but physically healthy, could fit into well-child visits. If being seen by mental health provider, don’t prioritize physical health well visits and those physical needs, can get overwhelmed with social/emotional needs and not stay on top of physical wellness checks.
* Similar issue for children with special healthcare needs. e.g., kids with Down syndrome, may be seeing cardiologist, etc. but they still need to see a primary care physician and have a well-child visit. They don’t prioritize this because of their other health issues.
 | Do a lot to incentivize pregnant women to show up. Can they expand this incentive process to the adolescents and their families?One suggestion: Use newsletters or other communication with parents and adolescents to increase awareness on topics such as mental health, suicide prevention, vaccines. Can an MCO do a study around access to behavioral health in a school?Communication of intent and plans and programs. That is not always in coordination. We need to do more provider education.Providers need action items when something is sent to them. Not just a form. What are they supposed to do? What do they need to follow-up on? Need cover letter with key action items. Risk stratify.Notes/comments on what MCOs do from an MCO rep who stopped by group* Do an annual mailing to parents – attempt to address gaps in care, if they haven’t had a visit.
* Also should send a gaps in care list to providers.
* Will check and see if there are healthy rewards if well-child checkups. Adolescents do have rewards or points.

🡨 Also see ideas for action items in gaps/opportunities column. | Overarching action items related to multiple MCH topics discussed at October meeting and recommended action steps. Updates of any information gathered in the meantime will be given at January meeting before next steps are finalized. At January meeting, further prioritize, clarify next steps and assign responsibility. * Consider implementing more aggressive incentive programs and risk stratifications to adolescents, similar to the initiatives for pregnant women. As a next step, Aarion will reach out to MCOs to request the following information: Are they using any type of risk stratification? What are MCOs offering now for incentives for adolescents, particularly related to well visits?
* Improved communication and collaboration with families and providers, especially related to CYSHCN. Next steps: (1) reach out to SHCN program to determine expected provider-family touchpoints and potential improvements needed related to communication/collaboration (be specific, (2) Aarion will ask MCOs to list their touchpoints with families, and (3) ask families (e.g., Families Together representatives) about the number of connections they have with providers and examples of uncoordinated overlap (be specific).
* Give providers more detailed information of services offered and explain what is being sent to them. In particular, include a cover letter or expected action items when info is sent to providers – which info is actionable? do they need to follow-up in some way? Is it just info? Next steps: (1) Aarion will reach out to MCO providers to see what information they currently doing and if a cover letter with specific, actionable items can accompany provider communication (e.g., “info only” or “follow-up with a, b, and c”), (2) ask physicians to provide specific examples of information being sent to them without explanation or follow-up advisement.
* Explore issues related to C&Y with special needs, in particular, medically necessary vision and dental needs that aren’t being covered, and/or require a long appeal process for approval. Next steps: collect specific list of appliances and medically necessary vision, dental, and other needs that aren’t being covered. Ask Families Together for assistance in collecting list and/or examples.
* Better understand what MCOs are offering, look for collaboration opportunities and better alignment opportunities with MCOs to improve well-child visits, implement school health clinics, and address mental/behavioral health. Next steps (1) Aarion will follow-up with MCOs on what (if anything) they are currently doing with schools, or if they are partnering with schools, (2) determine if MCOs have any interest in working more directly with schools, and (3) prepare an update for a future KMCHC meeting on the school-based healthy initiative, including scope of services offered by Coffeyville clinic and planned pilot in Cowley County.
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