

ARTICLE 1

Resource Fair for Practice Managers was a BIG SUCCESS LEARN MORE ABOUT THE 17 ORGANIZATIONS THAT CAN HELP YOUR PRACTICE.

The CCHAP Resource Fair was a big success. With 17 different community resource providers participating, CCHAP Practice Managers had the opportunity to learn about and ask questions of each of these agencies. Many of the participants and the practice representatives stated how helpful it was to be able to speak face to face with staff from the community organizations and have their questions answered.

CCHAP provided a prize of Ages and Stages Questionnaires-3 in both Spanish and English to a Practice. The winner was Tracy Stram of Parker Pediatrics. A gas gift card was given to the practice staff that traveled the farthest. Wendy Foster and Georga Senseney drove up from Canon City and represented the Office of Marc Sindler, MD.

We are delighted with the contribution of the community and the involvement of the practices to support our efforts to build a more cohesive service delivery system for our children and families.

Participating Agencies included

(Please visit www.cchap.org/nl31/ for more information on each program)

Assuring Better Child Development (ABCD) – provides support and training to enable providers to do developmental screening

Access Behavioral Health – behavioral health HMO serving Denver County Medicaid clients – to help you obtain mental health evaluation and treatment for children on Medicaid

Behavioral Health, Inc – behavioral health HMO serving Adams, Arapahoe and Douglas counties Medicaid clients – to help you obtain mental health evaluation and treatment for children on Medicaid

Cavity Free at Three – statewide effort to prevent oral disease in oral disease in young children, providing training in the application of fluoride varnish

CCHAP Cultural Competency Training – training in improving the cultural awareness and responsiveness of your practice

Colorado Immunization Information System (CIIS) – Statewide computerized system for the input and retrieval of immunization records for Colorado patients.

Colorado Access – Non-profit insurance company administrating CHP+ and short term Medicaid.

Colorado Adolescent Maternity Program (CAMP) – provides prenatal care and support for adolescents

Colorado Children’s Immunization Coalition (CCIC) - works to ensure that Colorado children receive all recommended vaccines at appropriate ages, providing maximal protection from vaccine-preventable disease.

Early Intervention Colorado (EI) – provides assessments for developmental delays for children 0-3

Early Intervention and Periodic Screening Diagnosis and Treatment (EPSDT) – provides special health care within Medicaid for children age 20 and under

Family Voices – an organization providing advocacy, case coordination and resources for families and children with special needs

Foothills Behavioral Health – behavioral health HMO serving Boulder, Broomfield, Clear Creek, Gilpin and Jefferson – to help you obtain mental health evaluation and treatment for children on Medicaid

Health Care Program – CDPHE – provides services and care coordination to families with Children with Special Needs. The new name for the old Handicapped Children’s Program

Health Care Policy and Financing (HCPF) – administers the Medicaid Program in Colorado.

Jewish Family Service – provides a program of counseling services for school age children in certain Denver Public Schools

Medical Home Certification – helps providers complete the Medical Home Index

Provider Resource Helpline – assists providers in identifying appropriate services and resources for children with chronic illness or special needs and for their families

Vaccines for Children (VFC) - Provides no-cost vaccines to providers to be administered to Medicaid children

ARTICLE 2

The Pediatrician's Role in Infant Oral Health

Pediatricians ask their patients to open their mouths and say “Ahhh” every day in their practices. But how comfortable are they looking at the teeth and gums and making an oral health assessment? We now know that dental decay is the #1 chronic childhood condition and is more prevalent than asthma. Colorado statistics generated by the CDC School Survey indicate that 23% of Colorado kindergarteners began school with untreated decay and 53% of 3rd graders had either treated or untreated decay.

Pediatricians are in a unique position to improve oral health among children since they see children earlier and more frequently than community dentists. They can perform counseling on the importance of oral health and hygiene at home and review diet and risk factors to improve oral health and overall wellbeing in their patients. Risk assessment and anticipatory guidance counseling may begin as early as 3-6 months depending on the child. In addition to counseling, the pediatrician may also apply fluoride varnish twice a year to help remineralized the teeth and prevent cavities. Pediatricians should be properly trained on how to apply fluoride before attempting this procedure in the office.

The American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) have recently joined forces to create the Oral Health Initiative of the AAP. The goal of this program is to educate pediatricians about the Age One dental visit as well as training physicians how to perform infant oral health assessments and risk assessments in their office. In addition to national initiatives, there are local programs offered by The Children's Hospital Dental Clinic and the University of Colorado School of Medicine Area Health Education Centers (AHEC). The program, called Cavity-Free at Three, offers dental care for children less than three years old and oral health training for community providers interested in learning more about current oral health practices and techniques.

Cavity-Free at Three Dental Clinic:

The Children's Hospital Dental Clinic in conjunction with the University of Colorado School of Dental Medicine has created the Cavity-Free at Three Program to help address the need for preventive dental care in young, underprivileged children.

The program serves children less than three years of age with the primary goal of preventing dental decay by educating caretakers about the best oral health care practices for their children. The program accepts Medicaid, CHP+, all insurance types and offers payment plans for self-pay patients. At each appointment a board certified pediatric dentist, together with the child's primary caretaker, reviews oral hygiene practices at home, fluoride exposure, diet considerations, and general anticipatory guidance principles. The child also receives a dental prophylaxis, dental examination and fluoride varnish application. Currently the Cavity-Free at Three Program sees children on Thursdays and Fridays at the Children Hospital's Dental Clinic. Appointments for Cavity-Free at Three can be made by calling (720) 777-6788.

Cavity-Free at Three Physician Training:

The Cavity Free at Three Physician Training Program is a collaborative statewide effort directed towards prevention of oral disease in young children. This program is now administered through the Colorado Area Health Education Center (AHEC) within the University of Colorado at Denver School of Medicine. Cavity Free at Three provides training and technical assistance to

dental and medical providers in the community interested in performing oral health assessments, counseling to primary caregivers as well as risk assessment skills. The comprehensive oral health training provided by the Cavity-Free at Three Program consists of a lecture component and a practical hands-on session. This program offers training opportunities for primary care providers to perform oral health assessments and apply fluoride varnish so they may be reimbursed according to the new Medicaid guidelines introduced July 1, 2009.

In addition to the training opportunities through the Cavity Free at Three Program, providers can access training online through the Smiles for Life curriculum at <http://www.smilesforlife2.org/powerpoints.html>. Completion of Module 2, “Child Oral Health,” and Module 6, “Fluoride Varnish,” are vital to the success of implementing oral health into everyday practice. It is also recommended that providers view the videos on the “Lap to Lap Child Oral Exam,” and the “Application of Fluoride Varnish,” at <http://www.smileforlife2.org/videos.html>.

For more information about the Cavity-Free at Three program and how to implement oral health assessments and counseling in your office, please contact Dr. Elizabeth Shick at The Children’s Hospital Dental Clinic at (720) 777-7038 or Karen Savoie at the AHEC office at (720) 724-4750. To schedule oral health training through the Cavity-Free at Three Program, contact Susan Evans at (303) 724-5191.



Prevention of cavities by primary care providers for children on Medicaid

Children, whose care is covered by Medicaid, have 2-3 times as many cavities as other children. Reduction in the number of cavities can be accomplished by preventive counseling (especially regarding the child’s specific high risk factors) and by application of fluoride varnish. Colorado Medicaid would like primary care providers to assess cavity risk, do a good oral exam, provide anticipatory guidance on cavity prevention and apply fluoride varnish. And Colorado Medicaid is reimbursing generously for this.

Effective July 1, 2009, trained medical personnel may administer fluoride varnish for moderate to high caries risk Medicaid children, ages 0 through 4 (until the day before their fifth birthday), in conjunction with an oral evaluation and counseling with a primary caregiver after performing a risk assessment. Risk assessment forms may be found at:

<http://www.cavityfreeatthree.org/GetMaterials/ProviderMaterials> and documentation should be part of the client’s medical record. The fluoride varnish can be applied by a medical assistant. The oral exam, risk assessment and counseling should be done by the primary care provider. Medical personnel that can bill directly for these services include MDs, DOs, and nurse practitioners. Trained medical personnel employed through qualified physician offices or

clinics can provide these services and bill through the physician's or nurse practitioner's Medicaid provider number.

You need to do the following at a well child visit:

1. complete oral exam and assessment of risk factors (like nighttime bottle) by provider
2. anticipatory guidance about preventing cavities
3. apply fluoride varnish

And then you can bill for (1) the well child visit (and you will get the enhanced reimbursement for being a CCHAP-affiliated medical home), (2) the comprehensive oral exam and anticipatory guidance and (3) applying the fluoride varnish. The reimbursement for numbers 2 and 3, when combined, will average between \$35 and \$45 depending on the age of the child. Here is what Colorado Medicaid says to do on the billing for the dental care

For children ages 0-2 (until the day before their third birthday):

In private practice, children ages 0 through 2, **D1206** (topical fluoride varnish) and **D0145** (oral evaluation for a patient under three years of age and counseling with primary caregiver) should be billed on a Colorado 1500 paper claim form or electronically as an 837P (Professional) transaction.

For children ages 3 and 4 (from their first birthday until the day before their fifth birthday):

In private practice, children ages 3 and 4, **D1206** and **D1330** (oral hygiene instructions [in place of D0145]) should be billed on a Colorado 1500 paper claim form or electronically as an 837P transaction.

Reimbursement - The fluoride varnish **D1206**=\$15.37. **Medical providers** must do **D0145** for under age 3 and **D1330** for over three. Therefore, the reimbursement for under age three is $\$15.37 + \$29.20 = \$44.57$ and for ages three and four is $\$15.37 + \$20.45 = \$35.82$.

Additional information from Medicaid – They want medical providers to do this only a maximum of 2 times a year per child and only at well child visits. In order to provide this benefit and receive reimbursement, the medical provider must have participated in on-site training from the Cavity Free at Three team or have completed Module 2 (child oral health) and Module 6 (fluoride varnish) at the Smiles for Life curriculum at <http://www.smilesforlife2.org/powerpoints.html>.) It is also recommended that providers view the videos on the Lap to Lap Child Oral Exam and the Application of Fluoride Varnish at <http://www.smilesforlife2.org/videos.html>. Documentation for this training should be saved in the event of an audit.

ARTICLE 3

Cross-cultural Health Care

Culturally-Based Family Dynamics

By Marcia Carteret

Culturally-Based Family Dynamics

This newsletter addresses cultural differences in family dynamics family dynamics, introducing a few fundamental concepts and covering important questions that need to be asked by providers to understand the family experience unique to each individual patient and how that affects decision-making, compliance, and successful treatment outcomes.

Individuality vs. Interdependence: Cultures differ in how much they encourage individuality and uniqueness vs. conformity and interdependence. Individualistic cultures stress self-reliance, decision-making based on individual needs, and the right to a private life. In collectivist cultures absolute loyalty is expected to one's immediate and extended family/tribe. The term familism is often used to describe the dominant social pattern where decision-making processes emphasize the needs of the family/group first, and the concept of having a "private life" may not even exist.

Nuclear vs. Extended Family Models: In western cultures, and particularly in European American culture, families typically follow a nuclear model comprised of parents and their children. When important health care-related decisions must be made, it is usually the parents who decide, though children are raised to think for themselves and are encouraged to act as age-appropriate decision makers as well. Upon reaching adulthood, when parental consent is no longer an issue, young American adults may choose to exercise their right to privacy in health care matters. This is markedly different from collectivist cultures that adhere to an extended family model. In cultures such as American Indian, Asian, Hispanic, African, and Middle Eastern, individuals rely heavily on an extended network of reciprocal relationships with parents, siblings, grandparents, aunts and uncles, cousins, and many others. Many of these people are involved in important health care decisions, including some who are unrelated to the patient through blood or marriage. For example, in Hispanic families the godparents play a critical role. In American Indian families, tribal leaders, the elderly, and medicine men/women are key individuals to be consulted before important decisions are made.

Multi-generational Households: It is very common for families in collectivist cultures to establish multi-generational households. (This is less true when a family becomes acculturated in the United States or other western countries where privacy is more highly valued and in cases where socio-economic gains create opportunities for greater independence.) In most multi-generational households, there are at least three generations living together; the grandparents are expected to live under the same roof as their adult children and grandchildren. In multi-generational households the family of orientation (one's self, siblings, and parents) often takes precedence over the family of procreation (one's self, spouse, and offspring). This is the reverse of how European American family households usually function. In traditional Asian families, it is the oldest male in the family who brings his bride to live with his parents. The daughter-in-law is often expected to be submissive to her mother-in-law who rules the roost. In Hispanic families, grandparents from either side may live under that same roof as their children and grandchildren.

Mothers often gain a great deal of support from the grandmothers in domestic matters, but this varies depending on the dynamics unique to each family.

It is extremely important for health care providers to ask who lives in a patient's household in order to better understand how relationships are structured. Who are the authority figures? In Asian and Hispanic traditional families, the father is the main authority figure. He will most often make decisions about matters outside the home, speaking for the family in public settings and signing consent forms. It is usually a female figure who takes charge of domestic life. Depending on the family, this matriarch may be the mother, but it may be the mother's mother. Thus healthcare providers need to ask the mother, "who gives you advice about raising your children?" And "who will participate in making important decisions?" In Asian and Hispanic families especially, grandmothers often decide about using traditional medicines and healing practices, thus having enormous influence on patient compliance.

Role flexibility & Kinship: In dealing with culturally diverse families it is useful for health care professionals to understand the basic concepts of role flexibility and kinship and how these affect family dynamics. American kinship structure is *bilateral*; we are not "more related" to our father's family than our mother's, or vice versa. In *unilineal* cultures, family membership is traced either through a male or female ancestor. In the Middle East, for example, a *patrilineal* pattern is established so family belonging is passed via the father's side. Some American Indian cultures, like the Navaho and Hopi tribes, are *matrilineal* cultures, passing membership through the mother's family. In the Navaho tribe, property and privilege are passed from male to male, but it is the mother's brother who will pass both to his own sister's children. Thus it makes sense that a Navaho maternal uncle might bring his nephew into the hospital expecting to be empowered to sign an informed consent.

Similarly, in both American Indian and African American families, role flexibility can be an important issue. It is not uncommon for Native American grandparents to raise grandchildren while the parents leave the reservation to find work. In African American families, the mother sometimes plays the role of the father and thus functions as the head of the family. In addition, older children sometimes function as parents or caretakers for younger children. The concept of role flexibility among African American families can be extended to include the parental role assumed by grandfather, grandmother, aunts, and cousins. (Boyd-Franklin 1989) It is a good idea to determine if older children will be involved in patient care and to include them when possible in patient care training. This is important to consider for all multi-generation households.

Family Dynamics and Acculturation: Finally, it is important to consider the enormous stresses families encounter in the process of acculturation due to sudden and radical shifts in family dynamics. Parents in a recently migrated family often are aligned with the culture of the country of origin, while their offspring are likely to adapt to the dominant culture more rapidly. This often leads to intergenerational conflicts. For example, a father may lose his traditional role as the head of the family if his wife begins to work outside the home, earning income and greater independence. Similarly, if his children quickly adopt the attitudes and values of the new dominant culture, he may find it harder to communicate with them. Both parents and

grandparents may feel a loss of status due to language barriers, especially if their children learn English more quickly. This can be especially problematic in healthcare settings where responsibility is shifted to younger family members who can navigate the health care system better than their parents can. In cases where children are able to communicate with health care workers in English, they may be asked to interpret for their parents. This leads to a host of potential problems for the family, including feelings of shame and betrayal that children would relay information of a personal nature to someone outside the family. This is one of the main reasons children should not be used as interpreters.

Summary: Because cultures adapt and change, making assumptions about family dynamics is problematic; families in the United States today from *all* cultures display a variety of configurations. Arguably, there is no longer any such thing as a “typical” family. One can, however, expect that families from more traditional cultures not acculturated in U.S. ways will *tend* to value familism and display family structures that are quite different from the middle-class European American family model.

There are many aspects of of culturally-based family dynamics not addressed within the scope of this newsletter article. Some of the best resources for learning more about cross-cultural family dynamics come from the mental health and child development fields. A few resources for further learning are listed here.

- [Counseling the Culturally Different](#) by Derald Wing Sue and David Sue
- [Diagnosis in a Multicultural Context](#) by Freddy A Paniagua
- [Kids: How Biology and Culture Shape the Way We Raise Children](#) by M. F. Small
- [The Cultural Nature of Human Development](#) by Barbara Rogoff

ARTICLE 4

Practice Manager's Corner

By Kevin Heckman

H1N1 Immunization

The vaccine to protect against Influenza A (H1N1) is expected to ship in mid to late October and will be made available at no cost to providers; therefore, Medicaid will pay for the administration of the vaccine but not for the vaccine itself. Providers interested in providing the H1N1 vaccine may obtain information by calling the Colorado Immunization Program at 303-692-2650 or visiting <http://www.cdphe.state.co.us/epr/h1n1.html> All Medicaid clients are eligible to receive the vaccine.

For each administration of the H1N1 vaccine, report one unit of HCPCS Level II code *G9141 Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)*, with the ICD-9-CM diagnosis code V04.81 *influenza*. Payment for G9141 is \$6.50. Reimbursement is limited to a one-time administration fee of \$6.50. An evaluation and management (E/M) code should not be reported when the only purpose of the office visit is to administer the H1N1 vaccine.

Clients will not be able to get the vaccine at a pharmacy as Medicaid has no ability to pay for vaccines at this venue.

Preparation checklists, toolkits, and guidelines that will assist healthcare providers and services organizations in planning for a pandemic outbreak can be found at <http://pandemicflu.gov/professional/hospital/>.

For questions, please contact Marcy Bonnett at 303-866-3604.

Additional Links for Coding & Billing:

<http://www.aap.org/pcorss/pcnoquiz/ReportingH1N1InfluenzaImmunizations.pdf>

<http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20090916h1n1-paymt.html>

Additional Contact:

Margaret Huffman at 303-692-2332 and margaret.huffman@state.co.us

Medicaid Nurse Advice Line

Medicaid provides a no cost Nurse Advice Line that is available to your Medicaid patients for after-hours coverage. A practice can add this information to their after-hours phone message and meet the minimum requirements of 24x7 accessibility for Medical Home Certification.

Medicaid Nurse Advisor Line 1-800-283-3221.

ARTICLE 5

Colorado Health Care Affordability Act

Governor Ritter signed House Bill 1293, the Colorado Health Care Affordability Act on April 21, 2009. The Act authorizes the Department to collect a hospital provider fee. The Act will expand health care coverage to more than 100,000 Coloradans.

What will implementation of the Act accomplish?

Secure sustainable funding for expanding health care access in the following ways:

Increase Medicaid eligibility for parents up to 100% of the FPL

Increase CHP+ eligibility for children and pregnant women up to 250% of the FPL

Offer Medicaid eligibility to adults without dependent children up to 100% of the FPL

Improve the quality of health care for clients served by public health insurance programs

Provide twelve-month continuous Medicaid eligibility for children on Medicaid

Implement quality incentive payments for hospitals

Secure increased funding for hospital care for Medicaid and uninsured clients

Increase Medicaid hospital inpatient rates up to 100% of Medicare rates

Increase Medicaid hospital outpatient rates up to 100% of costs

Increase hospital CICIP rates up to 100% of costs

Reduce cost-shifting to private payers

Increase number of insured Coloradans by 100,000

Increase Medicaid and CICIP reimbursement rates to hospitals

How much funding will be generated?

- Hospital provider fees – not to exceed 5.5 percent of net patient revenues – will be assessed and matched by federal dollars
- An estimated \$600 million will be collected to be matched by \$600 million federal dollars for a total of \$1.2 billion annually

What is the timeline?

April 2010

Obtain approval of waiver from the Centers for Medicare and Medicaid Services

Implement Medicaid eligibility for parents up to 100% of the FPL

Implement CHP+ eligibility for children and pregnant women up to 250% of the FPL

Increase inpatient rates up to 100% of Medicare rates

Increase outpatient rates up to 100% of costs

Increase hospital CICIP rates up to 100% of costs

July 2011

Implement buy-in program for people with disabilities up to 450% of FPL

January 2012

Implement Medicaid eligibility for adults without dependent children up to 100% of FPL

February 2012

Implement twelve-month continuous Medicaid eligibility for children on Medicaid

Who will provide oversight?

A 13-member Hospital Provider Fee Oversight and Advisory Board including five hospital members; one statewide hospital organization member; one health insurance organization or carrier member; one health care industry member; two consumers; one health insurance member; and, two Department members.

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