

ARTICLE 1

Health Reform for Children The Affordable Care Act Gives Parents Greater Control Over Their Children's Health Care. Quality, Affordable Health Care for All Children

This is the official summary from the White House

- **Eliminates Pre-existing Coverage Exclusions for Children**
 - This year, prohibits health insurers from excluding coverage of children because of preexisting conditions.
- **Extends the Children's Health Insurance Program**
 - Extends federal funding for the Children's Health Insurance Program (CHIP) through September 30, 2015, and provides states with additional funding to ensure children have access to this proven successful program. Increases outreach and enrollment grants to help reach more eligible children.
- **Pediatric Benefit Package Includes Oral and Vision Coverage for all Children**
 - Requires coverage of not only basic pediatric services under all new health plans, but also oral and vision needs, starting in 2014. Many health plans do not provide coverage for needed child health services, and 12 percent of children have not had a doctor's visit in the past year.
- **More Pediatric Providers Where Kids Need Them**
 - Expands the health care workforce – including pediatricians, pediatric nurse practitioners, specialists in pediatrics, and pediatric oral health professionals – to ensure that children will have access to high quality health care. This year, requires that parents enrolled in new plans be allowed to select their child's pediatrician from among any participating provider.
- **Improve Quality of Care for Children**
 - Develops children's quality priorities and promote children's quality measurement and reporting to improve the care that our nation's children receive. A recent study found that children receive recommended care less than half of the time.
- **Coverage for Children Aging Out of Foster Care**
 - Makes mandatory the current state option to extend Medicaid coverage up to age 26 to foster children who have aged out of the foster care system, effective 2014. Children aging out of the foster care system face many challenges, including finding quality, affordable health insurance.
- **Initiatives to Address Childhood Obesity**
 - Provides \$25 million in funding for the Childhood Obesity Demonstration Project, which was established through the Children's Health Insurance Program (CHIP) legislation signed by President Obama. The Secretary of Health and Human Services will award grants to develop a comprehensive and systematic model for reducing childhood obesity.
 - Requires the Secretary to provide guidance to States and health care providers on preventive and obesity-related services available to Medicaid enrollees and requires each state to design a public awareness campaign on such services.

Lowers Costs to Cover Children

- **Preventive Care for Better Health**

- This year, requires new plans to cover prevention and wellness benefits and exempts these benefits from deductibles and other cost-sharing requirements. This will help ensure that all children have access to free preventive services.
- Invests in prevention and public health to encourage innovations in health care that prevent illness and disease before they require more costly treatment. Preventive care is a key first step towards the development of a healthy and long life, yet 32 percent of kids are overweight or obese, putting them at risk for conditions such as diabetes and heart disease.
- **Expands Coverage to Improve Access to Care**
 - Provides health insurance choices through state-based health insurance Exchanges to families without job-based coverage and provides tax credits to those who can't afford it. Expanding insurance to all children will enable them to access needed care which is proven to enhance their development and learning, laying the foundation for a healthy life. Children who are uninsured have decreased access to well-child care, immunizations, basic dental services, and prescription medication.
- **Lowers Health Care Costs**
 - This year, eliminates all lifetime limits on how much insurance companies cover if beneficiaries get sick and bans insurance companies from dropping people from coverage when they get sick. The Act also restricts the use of annual limits in all new plans and existing employer plans this year, until 2014 when all annual limits for these plans are prohibited. Two-thirds of middle class families with access to employer-based coverage said their child remained uninsured because they could not afford the health plan. These reforms will help reduce health care costs for families and help to ensure more children are insured.
 - Going forward, plans in the new Health Insurance Exchanges and all new plans will have a cap on what insurance companies can require beneficiaries to pay in out-of-pocket expenses, such as co-pays and deductibles.

Greater Choices to Meet the Needs of Children

- **More Affordable Choices**
 - Creates state-based health insurance Exchanges to provide families with the same private insurance choices that the President and members of Congress will have, including multistate plans to foster competition and increase consumer choice.
- **One-Stop Shopping - Putting Families in Charge**
 - Provides standardized, easy-to-understand information on different health insurance plans offered in a geographic region so Americans can easily compare prices and health plans and decide which quality, affordable option is right for them and their children.
- **Insurance Security**
 - Ensures that children have access to affordable child-only health insurance policies, regardless of whether their parents change jobs, leave a job, move, or get sick. Parents should be able to provide health coverage for their children regardless of their job situation.
- **Extends Dependent Coverage**
 - This year, allows young adults to stay on their parents' health care plan until age 26. (This applies to all plans in the individual market, all new employer plans, and existing employer plans if the young adult is not eligible for employer coverage on his or her own. Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have an offer of coverage through their employer.)

ARTICLE 2

Providing Culturally Sensitive Care

by Marcia Carteret

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For many years, cultural factors were largely absent from health care dialogues around patient-centered care and medical home initiatives. The current strong emphasis on cultural factors in medical care mirrors the rapid demographic changes in this country, and cultural competency has now become a favorite buzzword of policy makers, researchers, medical educators, and health care providers. The term cultural competency is most often used, but there is also debate about its applicability; its detractors say the word competency suggests one is either competent or incompetent, which in turn points towards a kind of pass/fail attitude that necessitates measurement. Measurement, however, follows being able to define and codify "competency" - which most of us would agree is a work still in process. Even with [CLAS Standards](#) in place (National Standards on Culturally and Linguistically Appropriate Services) one only has to follow conversations on relevant list serves to see that people are still debating what it means to be culturally competent. The CLAS standards are primarily directed at health care organizations, and though individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible, the standards contribute little to the challenges of somehow measuring individuals' cross-cultural knowledge, skills, and attitudes.

What Is Culturally Sensitive Care?

As a cross-cultural communications instructor, I prefer the term culturally sensitive care, defined as an extension of patient centered-care that includes paying particular attention to social and cultural factors in managing medical encounters with patients from very different social and cultural backgrounds. In practice this boils down to giving health care providers a set of tools - questions and skills for negotiation based on cultural knowledge - which they can incorporate into their interactions with patients from diverse cultural backgrounds. Examples include finding out about the patient's history of present illness, their health beliefs and use of alternative treatments, their expectations of care, and any culturally-based family dynamics that guide decision-making processes. The literature supports the fact that it is important for physicians to not only be aware of cultural factors, but to demonstrate their ability to manage and negotiate them in order to improve health outcomes.

A basic premise of culturally sensitive care is that health care professionals must be able to recognize the client's culture, their own culture, and how both affect the patient-provider relationship. The following are key in addressing this important premise:

- **Everyone** has a culture.
- There is an American medical culture and it is very different from many of the cultures that our patients and their families come from.
- We need to understand where our American medical culture differs from other cultures in significant ways that impact communication and influence health outcomes for patients.

- Resistance to cultural difference is part of being human, and reactions to cultural difference are automatic, often subconscious, and can have strong influence on the patient-provider relationship.
- A provider's culture is influenced by his/her own personal values and beliefs, as well as those of the western medical culture.
- A provider's ability to communicate effectively in cross-cultural interactions is greatly enhanced by his/her grasp of cross-cultural communication skills.
- Culturally sensitive care requires a broad understanding of how culture affects health beliefs and behaviors.
- Providing linguistically appropriate care requires being able to assess the need for interpreters in the clinical setting and interact with interpreters effectively.

Understanding Your Own Culture

"In all affairs it's a healthy thing now and then to hang a question mark on the things you have long taken for granted." -- Bertrand Russell

Self-reflection is crucial to the cross-cultural learning process. Without understanding that everyone has a culture, and that knowledge of one's own culture is crucial, we have a tendency to reduce learning about culture to a manual-based approach, applying lists of dos and don'ts too rigidly and thereby stereotyping. Self-reflection begins with gaining knowledge about dimensions of culture and learning to apply these informed generalizations to our own culture. We thus develop a baseline for making effective comparisons about cultural differences and understand better why we respond in different situations the way we do.

Western Medical Culture

For American health care professionals, knowing about one's own culture is inseparable from knowing Western medical culture. In American culture, a person's life work informs their identity to such a large degree it sometimes seems that the credo should be "you are what you do." Some of the core values of Western medical culture are caring, empathy, truthfulness, promoting health and autonomy, and respecting an individual's choices. It is important to recognize that the health care system in the United States and some other Western countries assumes the autonomy of the patient, as seen in the Patient Self Determination Act which secures this right legally for all patients in the U.S. However, the applicability of this act to patients from various cultural backgrounds has often been debated. (Refolo 1992, Ersek 1998). In collectivist cultures, the good of the individual is often so enmeshed with the good of the family or in-group that family members may have a greater say in health care decisions than the patient does in some circumstances. For example, in many countries, family members may become very upset if a physician reveals bad news directly to a patient. Thus, physicians will not value truth-telling in the same way American doctors do because it would be culturally appropriate for them to withhold negative information from patients, especially terminal diagnoses. Even in the United States, families of certain cultural backgrounds may be more likely to prefer this approach (Blackhall et al. 1995). Some Navajos, for example, may consider it inappropriate to make mention of any negative future events because voicing them is akin to wishing them to happen.

Truth-telling is a good example of how differently people from individualist and collectivist cultures value the role of physicians. This is also a great example of why self-reflection is crucial. A physician who understands that his/her own expectations and behaviors are based on his/her culture will be more likely to consider that families may have very different expectations. He/she will be more inclined to check things out first - for example by asking who will be involved in decision making. The literature shows that patient-provider relationships are enhanced by bringing critical questions to the surface, such as: *Who have you asked for help/advice about this health problem? How, and by whom, are decisions made by your family about health care? Who should be present for support or to help in decision-making?* These and other questions will be explored in greater depth in upcoming newsletters.

As we begin the second year of cross-cultural communication workshops, it is important for us to hang a key question mark of our own. Why are we dedicating time to becoming more culturally aware, sensitive, and responsive? Hopefully we aren't just jumping on the proverbial cross-cultural bandwagon, directed by CLAS Standards and the extensive literature supporting cultural competence in health care. In presentations for over sixty private pediatric practices, the anecdotes and conversations shared by attendees are the best indication that the answer to this question lies in the personal dedication of individuals helping kids and families every day.

References

Michael A. Refolo, The Patient Self-Determination Act of 1990: Health Care's Own Miranda, 8 J. CONTEMP. HEALTH L. & POL'Y 455, 467-68 (1992).
Leslie J. Blackhall, MD et al, Ethnicity and Attitudes Toward Patient Autonomy. JAMA. 1995;274(10):820-825.
The Elements of Providing Culturally Sensitive Care
Marcia Carteret, M.Ed.
Instructor, Department of Pediatrics
University of Colorado School of Medicine
Director of Cross-Cultural Communications for Colorado Children's Healthcare Access Program

ARTICLE 3

Developmental Screening for Children Covered by Medicaid

Screening tools are available in Colorado to help primary care providers improve the identification of children with developmental delay by using a highly effective standardized screening test. Practices that provide standardized developmental screening at preventive care visits for Medicaid children can bill for this service and will currently be reimbursed an additional \$36.50 for this screening.

Using only clinical impressions rather than formal screenings leads to under-detection and decreases the likelihood of a child receiving early intervention services. National studies show that only 30% of children with disabilities are detected before school entrance.” (*AAPCOP Policy Statement, July 2006*). Based on Colorado’s current population, potentially 40,000 infants and toddlers in our state have disabilities, but only 6,000 children from birth to three in Colorado were referred for early intervention services last year (Part C, Colorado Department of Human Services, 2006). This raises the concern that a significant number of children are not being identified and are missing the opportunity for early intervention services during these crucial first few years of life.

In order to promote early identification of developmental concerns, the use of a standardized screening tool that meets a threshold of 70% sensitivity and specificity is now recommended at well child visits for children birth to six years of age (*AAPCOP Policy Statement, July 2006*). The perceived barriers to screening in practices include: time, staff and inadequate reimbursement.

While there are several valid and standardized developmental screening tools available, the Ages & Stages Questionnaire (ASQ) was selected by all of the practices participating in the Colorado pilot based on its diagnostic elements and practical application. Participating primary care offices identified several advantages of using the tool and integrating developmental screening into their practice.

Providers’ Perspectives: Advantages to Using a Standardized Developmental Screening Tool

- Time efficient – The ASQ utilizes a questionnaire completed by the parent in the waiting room or an exam room
- Supports anticipatory guidance - Serves as a talking guide with parents, identifying a child’s strengths as well as things the child is not doing yet.
- Practical – Scoring takes 1-2 minutes and can be done by paraprofessionals.
- Cost-efficient – The tool is affordable and the parent questionnaires may be photocopied for on-going use; practices can bill for reimbursement
- Valid and reliable – helps to accurately identify when further diagnostic assessment is recommended

Screening Tools:

Colorado does not mandate which tools providers use in their offices. Payment for a developmental screening, however, DOES require the use of a nationally recognized tool.

Although the ASQ is highly recommended, several other standardized developmental screening tests are acceptable to state Medicaid and qualify for the Developmental Screening reimbursement. Please reference the [Birth-5 Developmental Screening and Assessment Instruments](#) link on the HCPF website at:

<http://www.colorado.gov/cs/Satellite?c=Page&cid=1218622605039&pagename=HCPF%2FHCPFLayout> or:

<http://www.nectac.org/~pdfs/pubs/screening.pdf>

Visit www.cchap.org to see the long list of accepted developmental screening tools

Additional References:

<http://www.dbpeds.org/>

<http://www.earlychildhoodconnections.org/>

<http://www.abcdresources.org/>

http://www.developmentalscreening.org/screening_tools/

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

ARTICLE 4

Practice Manager's Corner

Kevin Heckman

Medicaid PAR Hotline

Providers can call to check on the status of Preauthorization Requests. This service does not provide assistance with PAR completion or submission.

The number is 1-866-956-9409

Third Party Insurance Contact

To report termed commercial insurance on a Medicaid patient please contact:

Pete Garcia

Third Party Insurance Specialist

303-866-5701

Pete.garcia@state.co.us

New Bi-Lingual Medicaid ID Cards

Beginning June 1, 2010 the Department will begin issuing Medical Identification Cards with a new look. The new cards will be bilingual – English and Spanish – and more informative.

These new cards do not replace cards issued before June 1, 2010, therefore, please accept both versions.

For more information, please contact Roberta.Lopez@state.co.us

National Health Reform and Colorado

National health reform does not negatively impact our goals outlined in the CO Health Care Affordability Act. We are good to go and will move forward with all efforts including the expansions to Medicaid parents to **100% FPL and CHP+ up to 250% FPL to be implemented on May 1, 2010.**

Note: It is important to remember that all program implementations are dependent upon the Centers for Medicare and Medicaid Services, or CMS, approval of the hospital provider fee. We expect to receive approval the first week of April.

Colorado PEAK Online Eligibility Overview

<http://www.colorado.gov/benefits/>

In addition to growing client enrollment rates in the Colorado Benefits Management System (CBMS) programs, Colorado is experiencing more widespread use of e-communication and Web-based interactions, as well as a demand for increased client and community outreach capabilities from its public service agencies. In order to meet these diverse needs head on, the State of Colorado has begun work to implement revolutionary enhancements that will allow it to continue to improve the lives of its citizens.

The Colorado Program Eligibility and Application Kit (PEAK) is the flagship tool that will allow the State to meet these new service needs. PEAK is a Web-based portal designed to provide clients and community partners with a modern and easily accessible tool to apply for public assistance benefits. It currently allows new CBMS clients to screen themselves for potential program eligibility and allows our existing clients to check on their benefits. **Coming in April 2010, clients will be able to apply for benefits.**

The Colorado PEAK also eliminates the sometimes time-consuming process of waiting on the application submission and benefits approval for clients. Instead, the Colorado PEAK creates new opportunities for benefits screening, application, and client information updates that do not require assistance from a county or state employee. In addition, care providers are able to make applications on behalf of their clients, further streamlining the application process.

The Colorado PEAK puts control of benefits applications back in the hands of the clients and increases client self-sufficiency. Through this, the State of Colorado is able to ensure the CBMS performance is being enhanced to meet increasing and changing client needs, is able to improve customer service, and is able to improve statewide accountability for public assistance benefits.

Administration and Prior Authorization of Synagis® Immune Globulin

Palivizumab (Synagis®) is a preparation used for passive immunoprophylaxis against respiratory syncytial virus (RSV) in high-risk infants.

To determine if prior authorization is needed for services administered in a physician's office, please see below.

Additional information and details on this policy is available in the April 2010 Provider Bulletin [Medicaid Program News and Updates \(B1000282 - 04/10\)](#).

Additional information on immunizations in general is available in the [Immunization Benefit Update \(B1000276 - 01/10\)](#) bulletin, which can be found in the [Provider Services Bulletins](#) section of the Department's Web site at <http://www.colorado.gov/hcpf>.. For additional questions, please contact Christy Hunter at christy.hunter@state.co.us.

Synagis Administered in Physician Office

1. Client is under age 2 at start of current RSV season or at time of the first injection for current RSV season, and meets one of the following:

- Diagnosis of Chronic Lung Disease and have had one or more of the following clinical needs during previous 6 months:
 - Supplemental oxygen
 - Regular use of inhaled or oral bronchodilators
 - Recent use of corticosteroid therapy
 - Regular or intermittent use of diuretics to treat pulmonary disease
- **OR** diagnosis of interstitial lung disease and/or new molecular disease which impacts pulmonary function
- **• OR** diagnosis of congenital heart disease and meets any of the following criteria:

- Receiving medication to control congestive heart failure (diuretics, antihypertensives)
- Suffer moderate to severe pulmonary hypertension
- Suffer Cyanotic heart Disease
- **OR** diagnosis of hemodynamically significant heart disease defined as having one or more of the following:
 - Infants receiving medication to control congestive heart failure
 - Infants with moderate to severe pulmonary hypertension
 - Infants with cyanotic heart disease
- **OR** under 6 months of age, born between 29 and 32 weeks gestation
- **OR** under 12 months of age, born at 28 weeks gestation or younger
- **For the above conditions, a maximum of five monthly doses is recommended. For below, a maximum of three monthly doses is recommended or until the child reaches 3 months of age.**
- **OR** under 3 months of age at start of RSV season, born between 32 and 35 weeks gestation and meets one or more of the following risk factors:
 - Currently attends day care;
 - Has a sibling younger than 5 years of age;
 - Congenital abnormalities of the airway;
 - A neuromuscular condition that compromises handling of respiratory secretions.

For all of the above, no Prior Authorization Required - Do Not Submit PAR

Physician provides Synagis and submits claim on CO1500 paper form or as an 837P transaction

2. Client is age 2 or older at the start of each RSV season but physician believes that client requires Synagis

Prior authorization is required

Physician must submit:

- Prior authorization form #10013 (US Bioservices form not acceptable) and
- Letter of medical necessity

The PAR form can be found at colorado.gov/hcpf > [Providers](#) > [Provider Services](#) > [Forms](#) > [Prior Authorization Request Forms](#)

Submit to PARS. P.O. Box 30, Denver, CO 80201-0030

ARTICLE 5

Colorado Department of Health Care Policy and Financing Efficiencies and Cost-Containment Initiatives March 2010

The mission of the Department of Health Care Policy and Financing is to improve access to cost-effective, quality health care services for Coloradans. Since 2007, Governor Ritter, the Department and the General Assembly have implemented an approach to health care reform that is strategic, incremental and system-wide so that every Coloradan can access high-quality, affordable health care. The results of this approach are the implementation of many strategies that improved access to health care; created efficiencies; defined consumer value for the dollar; and promoted transparency to the taxpayer.

- **Preferred Drug List** established by Executive Order to better manage the pharmaceutical benefits for Medicaid clients, using objective, scientific evidence to determine the efficacy of medications and to create a rational formulary for Medicaid clients. The use of the list and the aggressive negotiation of rebates from pharmaceutical companies are saving the state over \$9 million per year.
- **Long-Term Care Partnership** launched to ensure older Coloradans have access to long-term care services when they need them, and provides an alternative to using Medicaid as their only resource for long-term care. The program has helped more than 6,000 middle-income Colorado families purchase affordable, quality long-term care insurance.
- **Medical Homes for Children** established standards for providers to ensure children have access to preventative care, coordination of services, and 24/7 phone consultation. The state is saving money and improving care for children by avoiding unnecessary use of emergency departments for services that should be provided in primary care settings. Currently, 236,000 children are served in medical homes.
- **Colorado Regional Integrated Care Collaborative** is a program designed to better serve high-need/high-cost Medicaid clients. Health plans provide robust care-coordination and manage the utilization of services. Savings are found through avoiding unnecessary hospitalizations and better coordinated care that reduces duplication of services.
- **PACE** programs that coordinate services between Medicare and Medicaid were expanded to eight sites, allowing 2,000 elders to live at home and in their communities instead of in nursing facilities. An expansion is planned for 2010.
- **Emergency Room Diversion** projects were funded in two communities with a federal grant. The projects are designed to educate Medicaid clients regarding inappropriate use of emergency rooms when primary care providers are available to serve them. Thousands of individuals in these two communities have since scheduled visits with primary care clinics.

- **The Benefits Collaborative** is a Department-led initiative for defining the amount, scope and duration of each Medicaid benefit. This effort will save the state money by ensuring that all benefits offered are medically necessary and consistent with current evidence and medical standards.
- **Colorado Health Care Affordability Act (HB09-1293)** expands coverage to more than 100,000 Coloradans without General Fund by using the hospital fees to draw down federal Medicaid matching funds. The combined \$1.2 billion will support Medicaid and CHP+ expansions and will be used to improve hospital reimbursement. Covering more of the uninsured reduces the amount of uncompensated care in the health care system, and reduces the amount of cost-shifting of that care that is passed on to individuals with insurance.
- **Program Integrity** activities identify potentially excessive or improper utilization, or improper billing to Medicaid by providers. These efforts recover approximately \$8 million per year.
- **Benefits Coordination** is designed to recover costs for medical care paid for by Medicaid from other insurance plans, trusts, estate recoveries, and recovering any payments to clients who were discovered to be ineligible for Medicaid. The Department recovered \$45 million of Medicaid payments from estate recovery efforts.
- **Health Information Technology** is a key tool in improving health outcomes and reducing unnecessary expenditures in the health care system. The Department is partnering with CORHIO, the statewide entity establishing guidelines and developing health information exchanges, to develop the tools for providers to exchange data and information about Medicaid clients. This will save the state money by allowing providers to talk with one another through secure internet or email capabilities, sharing information about client tests and treatments that will avoid duplication of services, repeated tests, and the use of inaccurate information that leads to medical errors.
- **Smoking Cessation** is an important tool for improving health outcomes and reducing Medicaid costs associated with tobacco-related illnesses. Medicaid coverage was expanded to provide clients access to additional medications to help them quit smoking successfully.
- **Medical Errors**, or serious reportable events, will no longer be covered by Medicaid as a result of Executive Order D 006 09. This policy results in improved patient safety, decreased Medicaid costs and saves taxpayers money.
- **Avoidable Hospital Readmissions** that occur within 24 hours of discharge for a related condition will no longer be reimbursed by Medicaid. This policy will encourage better patient support during and after a hospital discharge and save taxpayers money.
- **Quality Incentive Payment Programs** were adopted to provide financial incentives to nursing homes to provide higher quality services, and will be implemented with hospitals as well. A certain portion of the payment will be directly related to the achievement of quality and outcome goals. Page 2 of 4

- **Prior Authorization** is an important tool in managing the utilization of high cost benefits. Medicaid now requests all outpatient clinics obtain prior authorization for non-emergent CT, non-emergent MRI and all PET scans. Justifying these non-emergent services ensures necessity and saves taxpayers money.
- **The Nurse Advice Line** is being aggressively marketed to Medicaid clients as a way to reduce unnecessary use of emergency rooms. The toll-free number is now on Medicaid identification cards, in enrollment packets, and in client correspondence. The Department sent letters to clients who visited ERs more than six times, giving them the toll-free number and scheduling many of them for visits with primary care providers. The number of calls to the line increased by 300% in 2009.
- **The Accountable Care Collaborative** will save the state approximately \$14 million per year by holding regional organizations accountable for delivering high-quality, patient-centered, coordinated care to Medicaid clients using community-based care coordinators.
- **CHP+ at Work** will be expanded, allowing the Department to provide coverage to more children through their parents' insurance. This keeps families in the same plan, and allows the Department to pay premiums for children instead of enrolling them in a public plan.
- **Three-Share Community Projects** are health coverage programs that bring together employers and workers without coverage, with community providers offering direct services to those workers. Everyone shares in the cost – the employer, the employee and the community so individuals get good, basic primary care services. The Department will support the expansion of the project in Pueblo and expand to the San Luis Valley. This expansion will be accomplished with \$761,000 from a five-year federal grant.
- **The Center for Improving Value in Health Care** will establish an all-payer claims data based, giving providers and consumers' information about the costs and quality of health care provided throughout Colorado. Consumers will have transparency into the costs of services, and be able to plan for out-of-pocket expenses associated with their health care.
- **Public Health and Population Health Initiatives** can save the state and other payers' money by focusing on keeping the overall population healthy. The Department will be partnering with *Baby and Me - Tobacco Free* – a program that combines smoking cessation support specific to pregnant women with the incentive of free diapers to help motivate the women to stay smoke-free during the first months of the baby's life. The Department will be promoting *5 Alive!* – a collaborative, community-wide initiative to provide a supervised wellness program to Colorado 5th graders who have limited access to healthy lifestyle choices for fitness and nutrition. The Colorado Behavioral Healthcare Council will assist the Department to survey behavioral health providers on their current health promotion activities and interventions; identify improvement areas; and implement and evaluate needed health promotion and wellness interventions.
- **Veterans in the Veterans Affairs Health Care System** connects eligible Colorado veterans with benefits for which they are eligible but of which they have not yet taken advantage. By working with Veterans Affairs to establish regular care for Colorado's veterans, the high costs of emergency care can be avoided while maximizing the federal dollars contributed to the VA program.

- **Health Insurance Buy-In Program** will enroll an additional 100 new clients for FY 2009-10. The program generates savings by paying the premiums, deductibles, and co-insurance for clients who would otherwise be utilizing higher cost services. The clients can continue seeing their physicians of choice thus maintaining continuity of care.
- **Fluoride Varnish Treatments** allow the Department to avoid costly dental and medical procedures by providing children up to age 6 with effective, preventive dental care through fluoride varnishing.
- **Manual Pricing of DME, Injectibles, and Medical Services** removal allowed the Department to automatically set reimbursements a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists, rates were set using the Department's average paid, other states' Medicaid average paid, or the commercial average paid rate. By developing an automated reimbursement rate setting methodology, the Department ensures that it is always generating value for medical goods and services by reimbursing at appropriate prices.
- **Evidence-Guided Utilization Review** will divert clients away from inappropriate medical care by providing reviews of services received and reimbursing only those services that are medically necessary. The Department's designated Quality Improvement Organization (QIO) will expand the scope of services currently reviewed, providing additional savings while also identifying situations and allowing for intervention where utilization patterns are not in the best interest of our clients.
- **Coordinated Payment and Payment Reform** will streamline payment processes, enhance recovery efforts and provide for proactive integration of care while expanding the application of performance-based payment structures which incentivize desired outcomes. Physician Payment Reform and Waiver Rate Reform will create payment plans based upon health outcomes, allowing the Department to purchase better health rather than to simply purchase medical services.

ARTICLE 6



We are pleased to announce a cooperative project between National Jewish Health and Northeast Denver Housing Center sponsored by HUD that will help identify and fix or remediate asthma triggers in the homes of children living in Northeast Denver. In addition to helping families this project examines the efficacy of a low-cost, sustainable home assessment and intervention system for indoor asthma triggers. Past research has shown that environmental factors within homes can significantly impact the asthma symptoms of the people who live within those homes. The purpose of this study is to evaluate home environmental factors and to determine if knowledge of potential hazards, combined with educational intervention and possible remediation will reduce the impact of the home environment upon children with asthma.

We are looking for:

- **Families who speak English or Spanish and have a child under the age of 12 with asthma or recurrent wheezing;**
- **Families who live in one of the following neighborhoods:
Globeville, Elyria Swansea, Five Points, North Capital Hill, Cole, Whittier, Skyland, Northeast Park Hill, City Park West, City Park North and Clayton**

For participating, families receive:

- **A detailed report about any problems we find and what you can do to improve these.**
- **A free vacuum cleaner and other household cleaning and safety supplies.**
- **The possibility of free professional assistance in repairing problems.**

Each family enrolled in the project will receive 2 home visits, approximately 9 to 12 months apart. During the initial home visit the project staff will ask the participant some questions about their home environment and their child's asthma. They will also conduct a visual survey of the participants home and will collect dust and air samples. This visit will last about 3 hours and the participant will be given approximately \$150.00 worth of cleaning supplies, including a vacuum cleaner.

Shortly after the first visit we will mail the parent the results of what we found including recommendations for how conditions in the home might be changed in order to improve your child's asthma. **If the parent agrees, the results of these tests will also be sent to you and the child's health care provider.** Project Staff will also speak with the parent over the phone in order to go over the results and the recommendations made. Depending on the problems identified, families may be offered up to \$5000 in professional remediation provided through the Northeast Denver Housing Center.

We hope that you will consider sharing information about this project with eligible families within your practice.

For more information please call Mike Vandyke, PhD at 303-398-1034 or Andres Diaz at 303-398-1447.

Visit <http://www.cchap.org/nl37/#6> for flyers in English and Spanish