DHCS Care Coordination Project:
Preventive Services and Clinical Screenings

Background

Preventive services and clinical screenings are an essential component of medically necessary health care for all people. DHCS requires that its Medi-Cal managed care health plans (MCPs) ensure the provision of all preventive screenings for adults per Grade A and B recommendations from the United States Preventive Services Task Force (USPSTF), and for children, per the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule. DHCS requires that all age appropriate preventive services and clinical screenings be provided at the Initial Health Assessment (IHA), or a plan for their provision be documented; however, it is not always clinically reasonable or often pragmatic to provide all such services during one visit (or provide documentation for a plan for each of those services) when other medical issues may take priority depending on the patient's clinical status. Further, providers need to retain clinical judgement with regard to when to provide particular preventive services and clinical screenings. The DHCS care coordination project provides an opportunity to redesign a more efficient and clinically pragmatic approach to preventive services and clinical screenings.

Framing the Issue

DHCS contracts with the MCPs require that the MCPs provide preventive health visits for all children (members under 21 years of age) at times specified by the most recent AAP periodicity schedule, and that as part of the periodic preventive visit, all age specific assessments and services required by the Child Health and Disability Program, which follows AAP Bright Futures, be provided. For adults, DHCS contracts with MCPs require that MCPs ensure that the latest edition of the Guide to Clinical Preventive Services published by USPSTF is used to determine the provision of clinical preventive services to asymptomatic, healthy adult members (age 21 or older). All preventive services identified as USPSTF "A" and "B" recommendations must be provided.

DHCS Policy Letter 08-003, *Initial Comprehensive Health Assessment*, defines the IHA to include a comprehensive history, preventive services, and comprehensive physical exam. For asymptomatic healthy adults, the provision of those preventive services must follow USPSTF Grade A and B recommendations and the status of current recommended services must be documented. For children (members under 21 years of age), the IHA must include preventive services as outlined in the AAP Bright Futures periodicity schedule. DHCS has received feedback that the requirement to provide all age appropriate preventive services and screenings during the IHA is neither clinically feasible nor always clinically appropriate. Often members present for their first visit with a provider with numerous acute clinical issues that must be addressed. Given the amount of time for a typical clinic visit, and the lack of staff to assist with

documentation, it's not reasonable to expect that providers can either provide all age appropriate screenings at one visit or document a plan for each of those screenings. Those screenings may have to wait until the next visit when less urgent issues are present. Further, certain clinical screenings, while having a Grade A or B recommendation from the USPSTF, may not yet be widely embraced by providers (e.g., lung cancer screening). Finally, perhaps DHCS should consider focusing on certain high priority preventive services and/or screenings, given that providers only have a small amount of time with many members. Specific stakeholder feedback is noted below:

- Reduce/redesign DHCS required assessments/screenings.
- DHCS preventive services and clinical screening requirements are found throughout the contract, All Plan and Policy Letters, and various other documents. There needs to be a single source that outlines what is required of MCPs and providers with regards to preventive services and clinical screenings and how it is to be assessed.
- Providers often require and perform assessments/screenings in addition to those required by DHCS which often results in duplication or redundancy to meet DHCS requirement to use a separate health assessment tool (IHA/IHEBA).
- Clinical screenings and preventive services should be accounted for in the overall care coordination structure but not linked to the MCPs' risk stratification process.
- Assessments/screenings should be linked to actionable resources.
    - Providers shouldn't be required to assess/screen if there isn't a clear link to resources, interventions or treatment. A directory of Medi-Cal resources for linkage should be made available to all providers by the MCP.
- DHCS needs to focus on high priority preventive services and clinical screenings as not all have the same health impact.

Additional Information

- **Policy Letter Initial Health Assessments 08-003:** http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL%202008/PL08-003.PDF
- **MMCD Boilerplate Contracts, Exhibit A, Attachment 10:** http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf
- **AAP Bright Futures Periodicity Schedule:** https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
- **USPSTF Grade A and B Recommendations:** https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
- **Annals of Family Medicine: Relative health impact and cost-effectiveness for evidence-based preventive services:** http://www.annfammed.org/content/15/1/14.full
- **Assessment and Screening Background Chart**: This chart provides summary information on several Medi-Cal assessments and screenings. See attached chart.

Discussion Questions.

1. Should DHCS define a structure for the provision of a core set of preventive services and clinical screenings for children and adults that can then be augmented by the MCP or individual provider?
2. EPSDT effects multiple delivery systems (managed care, behavioral health, dental, CCS, etc.) – how can DHCS better define and monitor the EPSDT benefit in Medi-Cal?

3. Should DHCS use a standard other than AAP Bright Futures for child preventive services and clinical screenings?
4. Should DHCS use a standard other than USPSTF Grade A and B recommendations for adult preventive services and clinical screenings?
5. Should clinical screenings be tied to an initial health assessment, or rather conducted in the routine clinical setting and with the timing determined by the medical provider?
6. Should DHCS narrow the focus of required preventive screenings to high priority focus areas: see the referenced article from the Annals of Family Medicine which examines the relative health impact and cost-effectiveness for evidence-based preventive services: http://www.annfammed.org/content/15/1/14.full