2018 Plan First and Patient 1st Protocol Updates

Satellite Conference and Live Webcast
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Produced by the Alabama Department of Public Health
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Faculty

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Multiple protocol changes

- **Both Patient 1st and Plan First have had several protocol changes throughout the year.**
- **Both programs now require ALL questions on the risk assessment to be answered even if the response is N/A.**

Plan First Flip List and Medicaid Roster

- **The form used for maternity contacts will now also be used for the contacts with the Flip List and Medicaid Roster.**
- **The forms are due to your Manager and/or Director by the 6th of the following month.**

The form

Plan First Maternity, Flip List, and Medicaid Roster Patient Contacts

Care Coordinator/Designee _____

County_____

Patient Name	Date of Contact	Mail/Phone (M/P)	Successful Contact (Y or N)	FP Appt made (HD or PP or N)	High Risk (Y or N) or N/A for non-maternity patients

Plan First MOU

- **Medicaid and ADPH renew the Plan First MOU on an annual basis.**
- **Medicaid requested supporting documentation for the 15-1 recruitment time.**
- **The request was not going to be possible in the required timeframes.**

History of the 15-1 time

- Medicaid requires that patients be offered case management services.
- Several years after the program was developed, the risk assessment was updated to include the documentation for the patient accepting or refusing services.

Plan First Protocol change

- The 15-1 will be “turned off” in ACORN.
- All face to face time spent with the patient for the risk assessment, including offering case management services to the high risk patients, will be coded to 15-6.

Activity Type 6

- High Risk Assessment
- All time associated with the face to face interaction with the patient during the annual family planning risk assessment will be coded to Activity Type 6.

Activity Type 6

- All time spent completing the psychosocial assessment and any face to face time with the patient will be coded to Activity Type 6.
- No more than 2 hours per patient per year can be coded to Activity Type 6.

Coding a High Risk patient

- All face to face time with the patient will be coded to the 15-6.
- All documentation will be coded to the 15-4.
- This means one less SSR for new high risk patients!

Plan First Coding

- 15-2: Face to Face time not in conjunction with the risk assessment, no more than 2 hours per patient per day
- 15-3: Successful phone call with the patient, no more than 1 hour per patient per day
- 15-4: Documentation, no more than 1 hour per patient per day

Plan First Coding

- **15-5: Low risk assessment, no more than 2 hours per patient per year**
- **15-6: High risk assessment, no more than 2 hours per patient per year**
- **15-7: Case closed, no time**
- **15-9: Unsuccessful phone calls to the patient and the documentation, no more than 15 minutes per patient per day**

Questions?

- **Any questions related to this Plan First protocol change or any Plan First questions?**

Patient 1st

- **Several changes have been made to the Lead Protocol including the structure.**
- **Information on unconfirmed lead levels grouped together.**
- **Information on confirmed lead levels grouped together.**

Testing methods

- **Capillary testing is a finger stick.**
- **Venous testing is a blood draw and is the preferred testing method.**

Goals of Lead Case Management

- **Ensure unconfirmed blood lead levels receive follow-up testing.**
- **Decrease the venous blood level with two consecutive tests of less than 5.**
- **Educate families on lead hazards.**
- **Eliminate lead hazards.**

Unconfirmed Lead Tests

- **One capillary specimen of $\geq$ 20.**
- **A missed appointment to repeat an unconfirmed capillary specimen.**
- **The goal is to have confirmatory testing completed through a venous specimen.**

Confirmed Lead Tests

- One venous specimen of ≥ 5.
- Two capillary specimens of ≥ 10.

Initial home visit for confirmed lead tests

- 5-19 within 2 weeks of referral
- 20-44 within 1 week of referral
- 45-70 within 48 hours of referral
- >70 within 24 hours of referral

Repeat Venous Testing

- 5-14: within 3 months
- 15-44: within 1-3 months
- 45-59: within 48 hours
- 60-69: within 24 hours
- ≥ 70: immediately

Environmental Survey

- During the home visit, an assessment of the child's living environment should be documented on the required form.
- If the child has a level ≥ 15 an Environmentalist will conduct an environmental survey.
- However, the case manager's assessment should be conducted first.

Environmental Survey

- If the level is < 15 the case manager will be the only professional in the home.
- When the case manager has the opportunity to go out with the environmentalist, pay attention to what to look for and ask questions to help when the case manager is the only professional in the home.

Direct referrals from a physician

- Notify the Lead Coordinator through completion of the Elevated Blood Lead Environmental Surveillance Form FHS-135.
- Fax the form to: 334-206-3726.

Requests for an Environmental Survey

- A physician can make a request via a written order on a prescription pad for the inspection for any children with a lead level of <15.
- This should be faxed to the Lead Coordinator at 334-206-3726.

Requests for an Environmental Survey

- A case manager can request the survey after completion of a home visit when the lead hazard can not be identified.
- Supervisory approval is also required.

Closing a Lead Case

- Two consecutive tests <5.
- If the case has been opened for a year a case review is required.
- The case review can be in consultation with the Manager and/or Director and/or the Social Work Consultant to determine other interventions to consider.

Report to Referring Provider

- Within 30 days of opening the case.
- After a lead test is completed.
- Anytime something significant occurs in the case, like an environmental survey.
- Upon case closure.

Goal of Newborn Hearing Referrals

- Remember 1, 3, 6
- Rescreened by 1 month of age
- Diagnosed by 3 months of age
- Early Intervention by 6 months of age

Newborn Hearing Referrals

- The Newborn Hearing Staff receives referrals from the hospital on Wednesday.
- If the newborn failed the hearing screen on Tuesday those results are reported to ADPH on Wednesday.
- If the newborn is rescreened on Thursday, prior to discharge, those results aren't reported until the following Wednesday.

First step

- First contact should be with the delivering hospital to see if the newborn passed the hearing screen prior to discharge and should be documented in the progress note.
- If not, the newborn will need to be rescreened.

Testing Method

- If the newborn was tested in the hospital with the ABR method the rescreen can NOT be completed with the OAE.
- The ABR goes to the brainstem and the OAE stops at the inner ear.

Rescreening Method

- If the infant failed the ABR hospital screen and the rescreen has not occurred prior to the infant being 6 months of age the infant will need an age appropriate hearing screen.

Completion of Rescreen

- If the infant passes the rescreen in both ears, the case can be closed if no other needs have been identified.
- If the infant does not pass in both ears the infant needs to be referred for diagnostic testing.

Diagnostic Testing

- If the infant is diagnosed with a hearing loss, be sure to document the type and severity of hearing loss.
- Refer patient to Early Intervention Services.

Report to Referring Provider

- Send report within 30 days of opening case.
- Send report anytime anything significant happens in the case, like attending a diagnostic appointment.
- The report has multiple questions, if you get a report that does not have any questions, check the referral form to ensure it was completed correctly.

Newborn Hearing Training

- **For more detailed instructions on the completion of the Report to Referring Provider please see the training on the On Demand webpage from July 12, 2016 titled: Alabama Newborn Screening Program – Early Hearing Detection and Intervention (EHDI).**

Questions?