Changing Course:
Road Map to Increase Pediatric Blood Lead Level Testing Rates

Ohio Healthy Homes Conference

Gahanna, Ohio – May 1, 2026

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Financial Relationship Disclosure

Speaker: Gail Gettens, MS
Company: Meridian Bioscience
Nature of Relationship: Consultant
Mitigation Statement: All relevant financial relationships for this individual have been mitigated

Please note that this relationship has been reviewed and mitigated by our Nurse Planner to ensure the content remains independent and free of commercial bias.

Changing Course:

Road Map to Increase Pediatric Blood Lead Level Testing Rates

Introduction: Where the Road Trip Started: 2015

Identifying Barriers and Developing Effective Strategy for Change

Part II: Restarting the Engine After the COVID Pandemic

Revitalizing Pediatrician Engagement: Quality improvement project utilizing the ECHO® Model for continuing medical education

Part III: The Last Stretch: Closing the Medicaid Gap

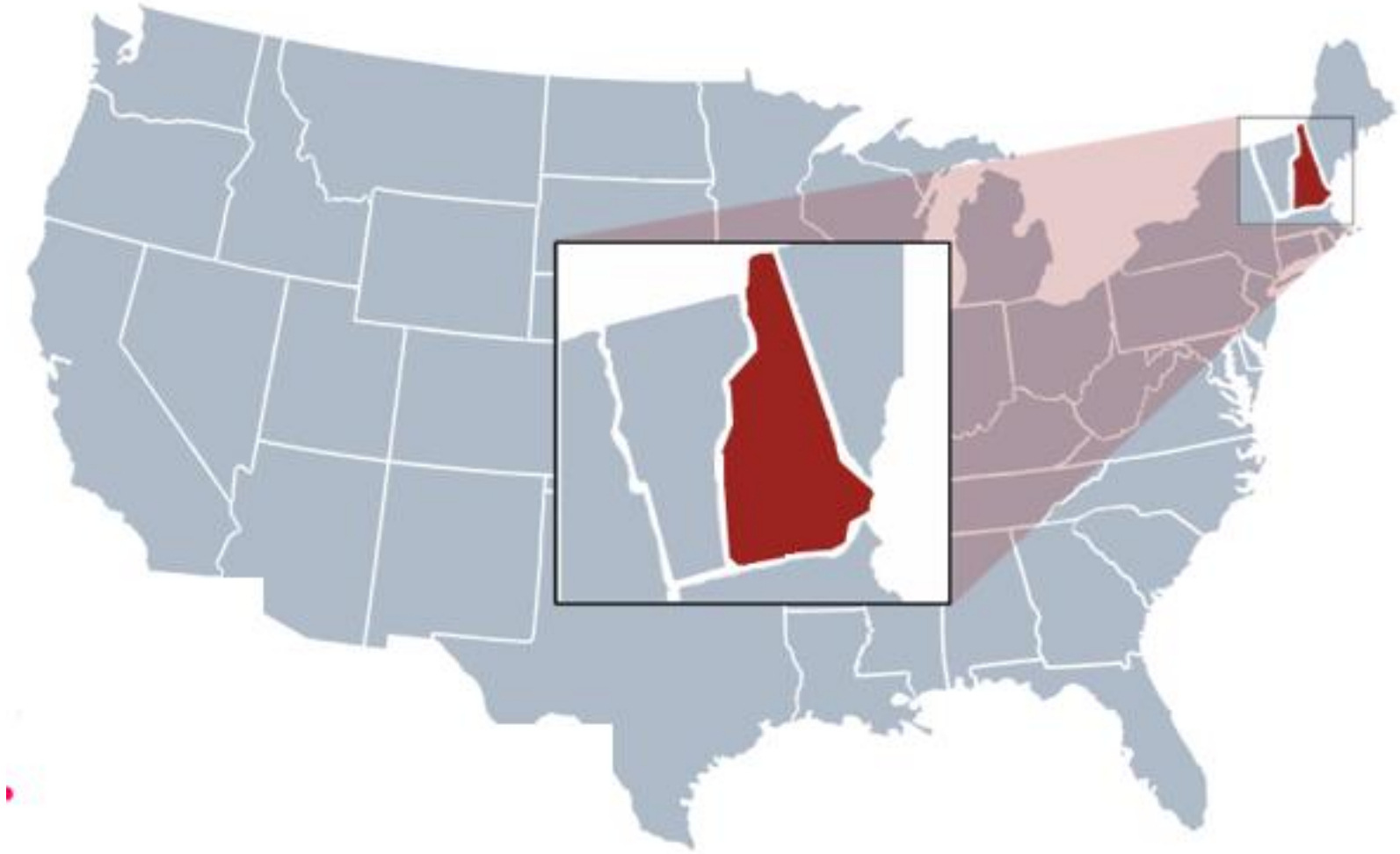
The Impact of the (*misaligned*) HEDIS® Measure:
Collaborating with state-level Offices of Medicaid Services for change

Closing: Road Trip Tips for a Successful Journey

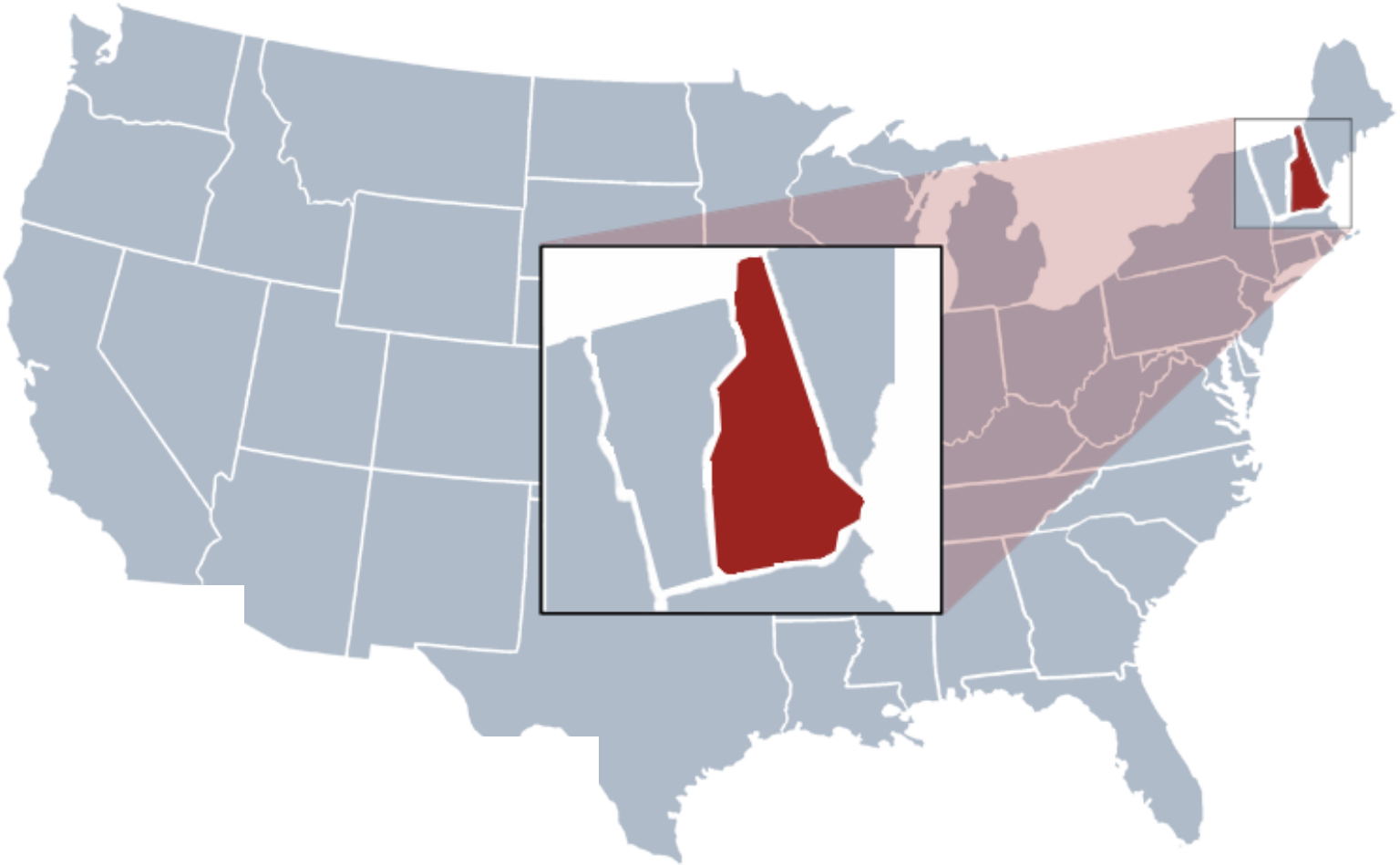
Who Am I? Where Am I From?

- Semi-retired after over a decade of service with NH DHHS Division of Public Health Childhood Lead Poisoning Prevention Program as of December 2025.
- Speaking nationally to share successful initiatives and providing technical support to increase lead level testing and prevent childhood lead exposure.
- Paying it forward. Donating my professional time and personally paying my travel expenses to come to Columbus and many other conference nationwide.
- GCG Consulting, LLC (My semi-retirement 'lemonade stand'.)

Who Am I? Where Am I From?



New Hampshire




Pittsburg
Colebrook
Errol
North Stratford
Groveton
Lancaster
Berlin
Whitefield
Gorham
Littleton
Bethlehem
Twin Mountain
Lisbon
Woodsville
Glen
North Conway
Lincoln
Conway
Warren
Wentworth
Plymouth
Moultonborough
Center Ossipee
Hanover
Ashland
Ossipee
Lebanon
Enfield
Wilmot
Meredith
Bristol
New Hampton
Wolfeboro Falls
Sanbornville
Grafton
Plainfield
Danbury
Laconia
Grantham
Union
Georges Mills
Franklin
Tilton
Belmont
Alton
Andover
Northfield
Farmington
Milton
Claremont
Newport
North Sutton
Boscawen
Pittsfield
Rochester
Goshen
Somersworth
Charlestown
Contoocook
Henniker
Concord
Bellows Falls
Hillsboro
Weare
Durham
Walpole
Stoddard
Gilsum
Antrim
South Hooksett
Raymond
Epping
Portsmouth
Bennington
Pinardville
Manchester
Exeter
New Boston
Kingston
Hampton
Keene
Marlborough
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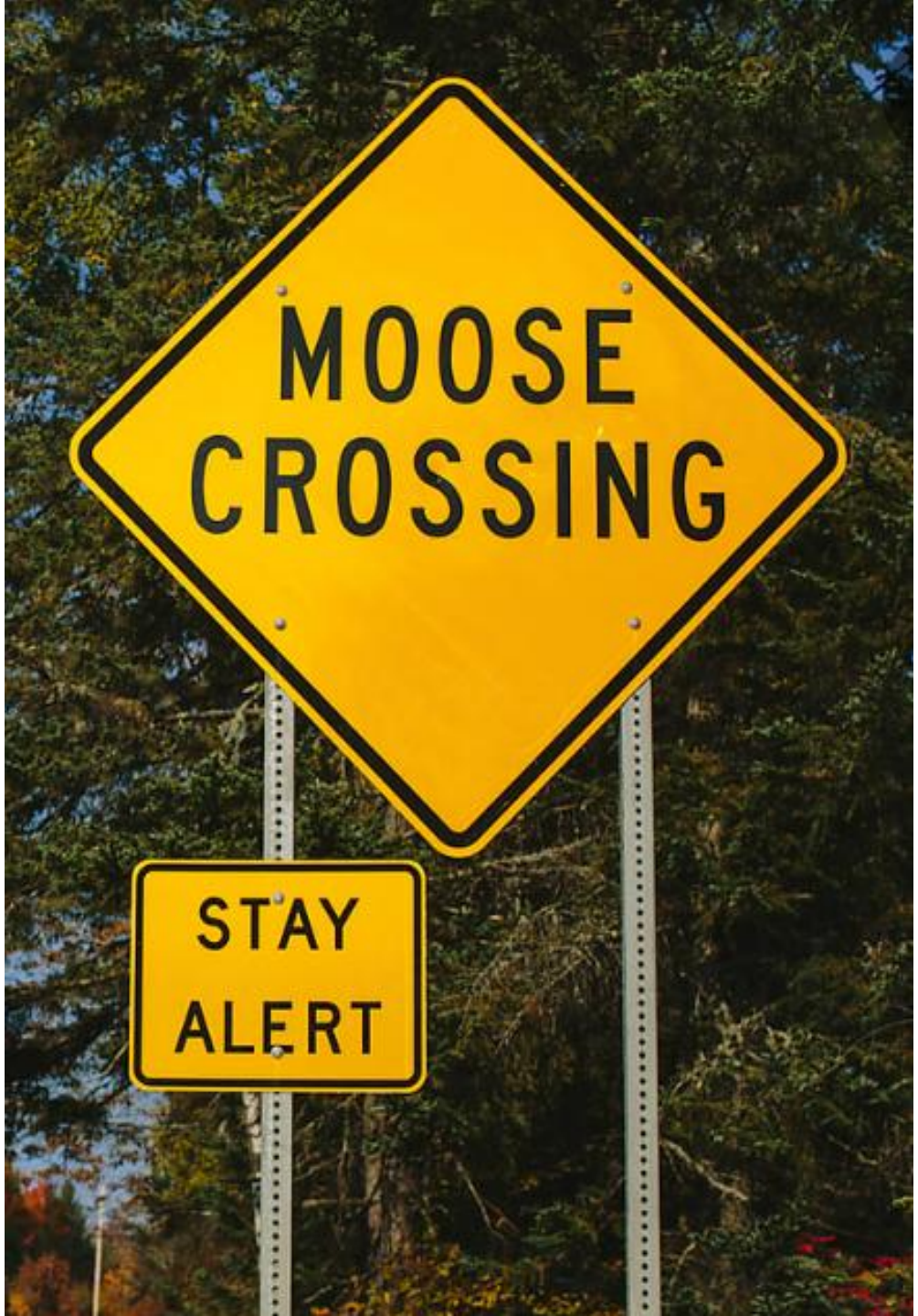
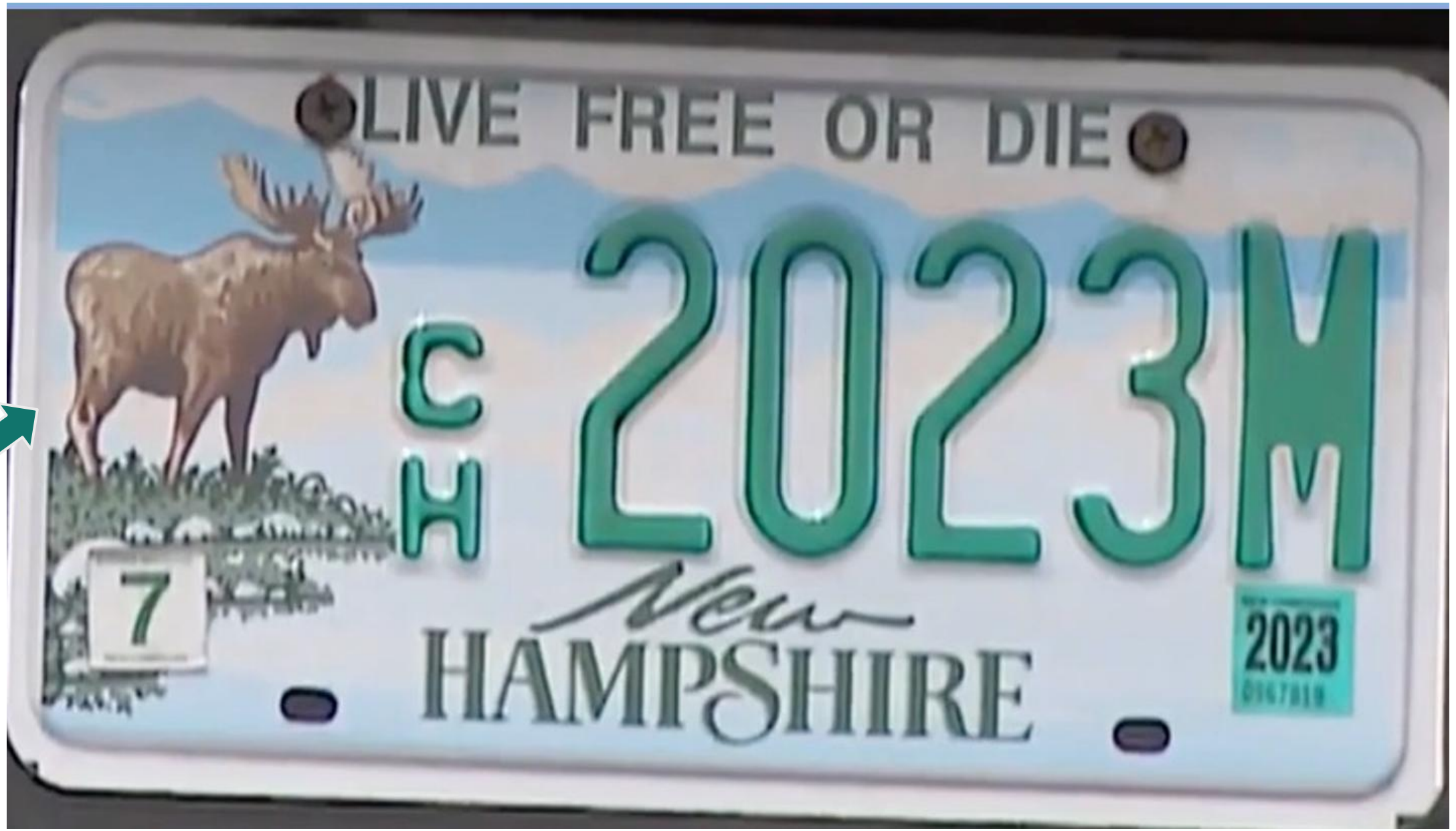

MOOSE
CROSSING
STAY
ALERT

In NH's (only) airport: Manchester-Boston Regional Airport

In NH's children's science museum: The Montshire Museum

In NH's outlet shopping malls: Merrimack Premium Outlets



On our license plates: Moose plates are a coveted, status-symbol

Small State = Big Pb Problem

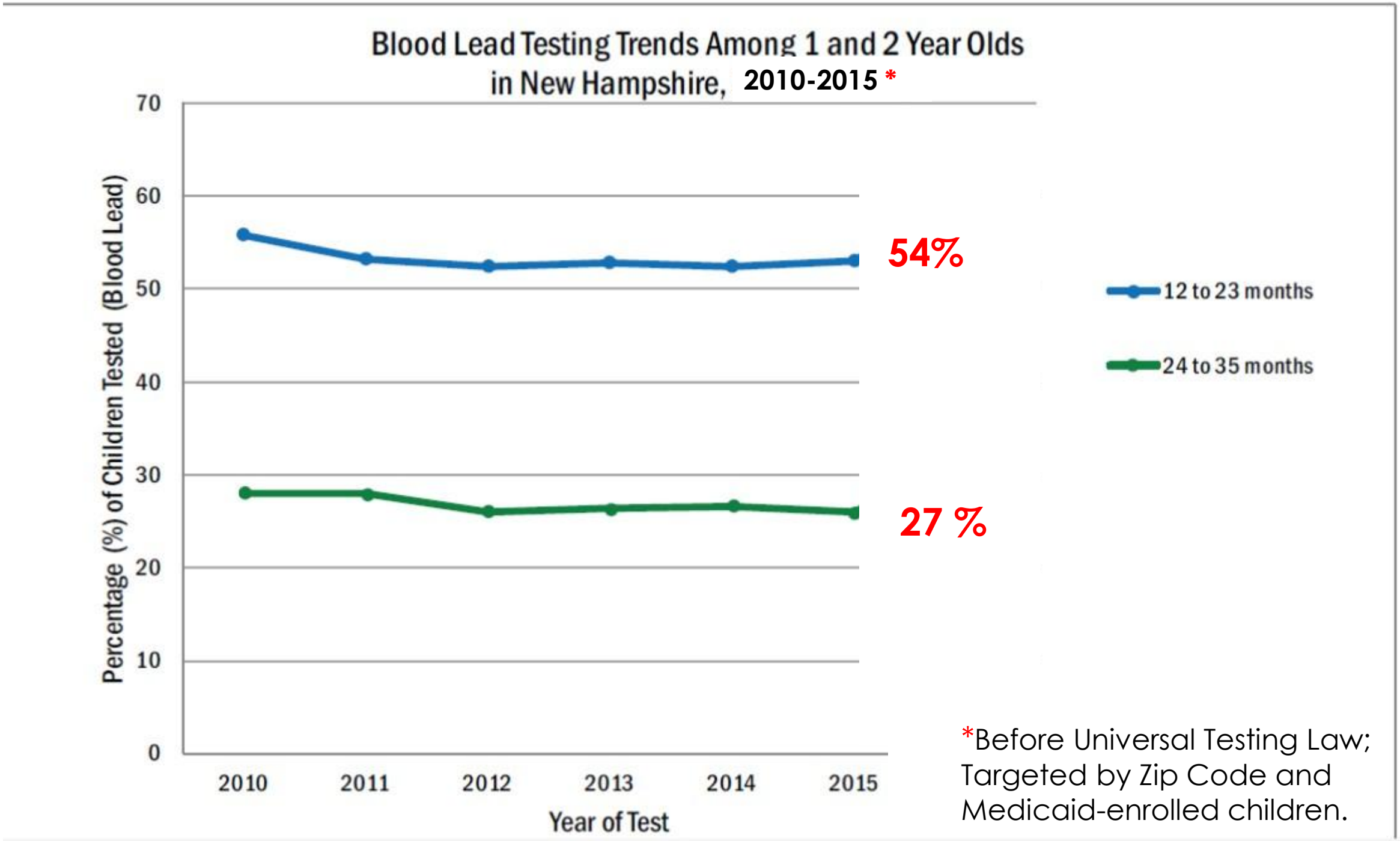
A lot of Moose, A lot of Lead Exposure

Changing Course: Road Map to Increase Pediatric Blood Lead Level Testing Rates

Introduction:

Where the Road Trip Began: 2015

Identifying Barriers:
Developing Effective Strategy for Change



*Before Universal Testing Law; Targeted by Zip Code and Medicaid-enrolled children.

Barriers Identified

- Venous sample testing had lower compliance
  - Required separate visit to lab draw site – families frequently don't go
  - Costly follow-up time for pediatricians.
- Very limited use of Point-of-Care (POC) testing (five)
  - In-office with finger-stick (capillary) sample, immediate results
  - Research demonstrates higher testing rates with POC testing
- Pediatrician Knowledge Gap of Lead Exposure in NH
  - Testing and medical management of EBLLs
  - POC-testing available with immediate results

Strategy for Change

- Implement education program for pediatricians
  - *The Toxic Truth: Pediatric Lead Exposure in New Hampshire (CME/CNE)*
  - Testing and surveillance data included
  - "Lunch and Learn" format within pediatric practice during clinic day.
- Increase physician awareness of POC testing
- Create and distribute medical reference materials
- Increase availability of POC testing equipment
  - Developed Education and Equipment "Grant"

Quick Reference Clinical Guides for Pediatricians

Quick Reference Clinical Guides for Pediatricians

Quick Guide for Medical Management for Lead Level Testing and Treatment

Department of HEALTH & HUMAN SERVICES | Division of Public Health

LEAD POISONING
CHILD MEDICAL MANAGEMENT
Quick Guide for Lead Testing & Treatment

Schedule for Venous Confirmation of Capillary Blood Lead Levels (BLL)

Capillary BLL	Confirm With Venous Test
0-3.4 mcg/dL	No confirmation. Continue to screen for exposure risk (see reverse). Ensure testing at 1 & 2 yrs.
3.5-4.9 mcg/dL	Confirm within 3 months.
5-9 mcg/dL	Confirm within 1 month.
10-19 mcg/dL	Confirm within 2 weeks.
20-44 mcg/dL	Confirm within 1 week.
45-64 mcg/dL	**URGENT! Conduct venous test within 48 hours.** - Inform NH Lead RN at 800-897-5323. - Symptomatic child requires ED evaluation. - Contact Poison Control 24/7 at 800-222-1222.
65+ mcg/dL "HIGH" result on Lead Care II	**EMERGENCY! Send child for venous test NOW.** **Note:** STAT venous result NOT available in NH. - Symptomatic child requires ED evaluation. - Contact Poison Control 24/7 at 800-222-1222.

The higher the capillary test result, the more urgent the need for a confirmatory venous test

Schedule for Follow-Up Testing of Venous Blood Lead Levels (BLL)

Initial Venous BLL	Early Follow-Up Schedule
0-3.4 mcg/dL	No follow-up needed. Continue to screen for exposure risk (see reverse). Ensure testing at 1 & 2 yrs.
3.5-9 mcg/dL	Test every 3 months until result is <3.5 mcg/dL.
10-19 mcg/dL	Test every 1 to 3 months.
20-44 mcg/dL	Test every 2 weeks to 1 month.
45+ mcg/dL	Contact Poison Control for guidance 24/7 at 800-222-1222.

Scan the QR code below for Table 2: "Schedule for Later Follow-up Blood Lead Testing"

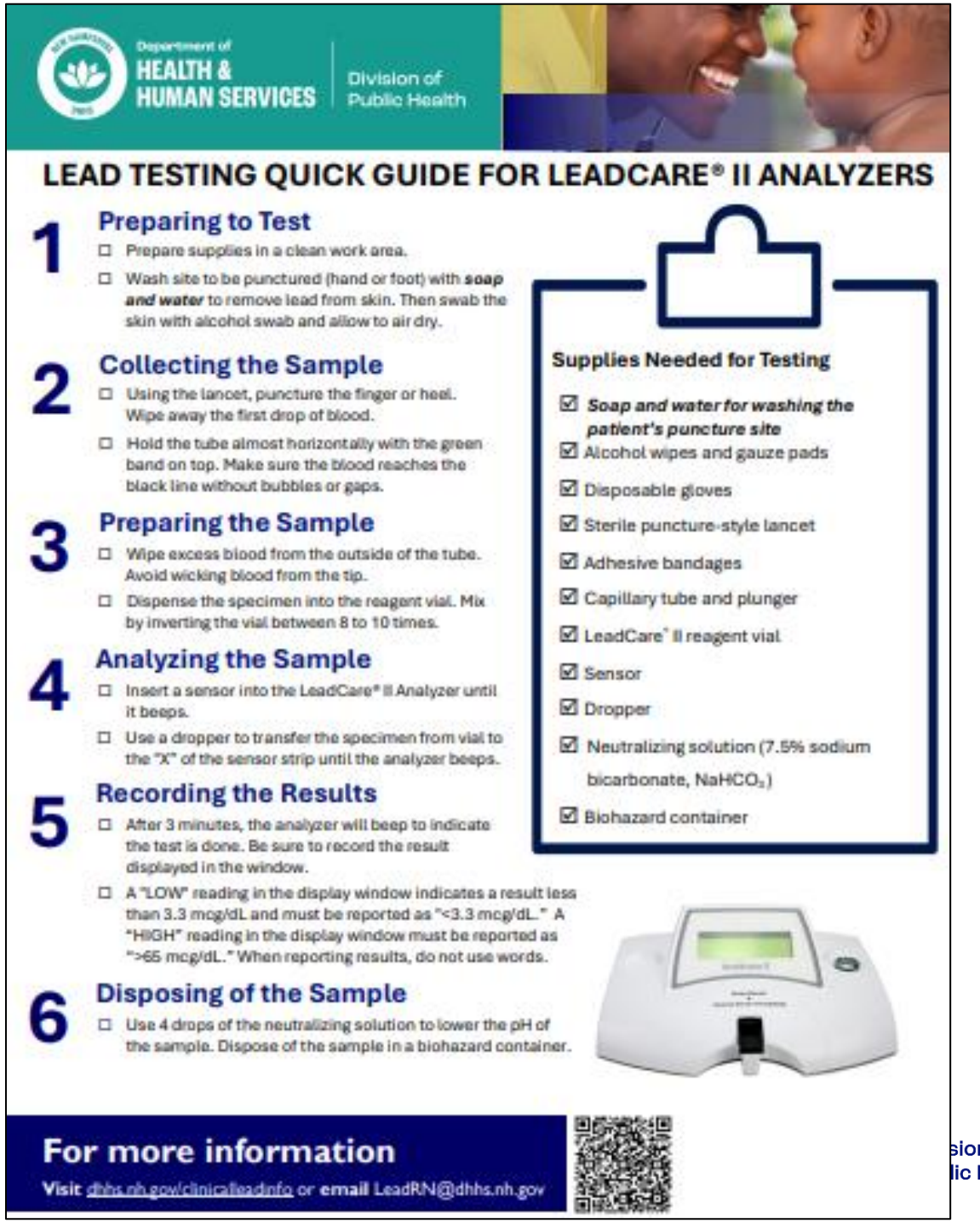
QUESTIONS?
- NH DHHS RN at 800-897-5323
- CDC Childhood Lead: www.cdc.gov/lead-prevention/hcp/clinical-guidance

Clinical Management of Children with Confirmed Venous Blood Lead Levels

3.5-19 mcg/dL	20-44 mcg/dL *Previous Column AND:*	45-64 mcg/dL *Previous Columns AND:*	65+ mcg/dL *Previous Columns AND:*
• Provide parents three factsheets: - Lead & Children - Lead & Nutrition - Lead Paint in Your Home Available at www.dhhs.nh.gov/leadresources • Explain blood lead level to parents. • Assess for iron deficiency and prescribe iron if needed. Refer to WIC and/or nutritionist. • Refer to Early Intervention and monitor neuro-development (see reverse). • Obtain BLL of other children living in same household. • Encourage parents to work with NH DHHS RN managers. • Follow-up BLL testing as defined above.	• Complete history and physical exam, assessing the child for symptoms related to lead exposure. • Consider performing abdominal x-ray to check for radiopaque foreign bodies. • Contact Poison Control 24/7 at 800-222-1222 for additional guidance.	**URGENT!** • Symptomatic child requires ED evaluation. • Contact Poison Control 24/7 at 800-222-1222 for consultation. • Contact NH DHHS RN at 800-897-5323. • Encourage parents to create a lead-safe environment for child if chelation is required.	**EMERGENCY!** • Child requires an ED evaluation, even if asymptomatic. • Contact Poison Control 24/7 at 800-222-1222.

Quick Reference Clinical Guides for Pediatricians

Quick Guide for POC Testing with Lead Care II Analyzers



Department of HEALTH & HUMAN SERVICES | Division of Public Health

LEAD TESTING QUICK GUIDE FOR LEADCARE® II ANALYZERS

1 Preparing to Test

- ☐ Prepare supplies in a clean work area.
- ☐ Wash site to be punctured (hand or foot) with ***soap and water*** to remove lead from skin. Then swab the skin with alcohol swab and allow to air dry.

2 Collecting the Sample

- ☐ Using the lancet, puncture the finger or heel. Wipe away the first drop of blood.
- ☐ Hold the tube almost horizontally with the green band on top. Make sure the blood reaches the black line without bubbles or gaps.

3 Preparing the Sample

- ☐ Wipe excess blood from the outside of the tube. Avoid wicking blood from the tip.
- ☐ Dispense the specimen into the reagent vial. Mix by inverting the vial between 8 to 10 times.

4 Analyzing the Sample

- ☐ Insert a sensor into the LeadCare® II Analyzer until it beeps.
- ☐ Use a dropper to transfer the specimen from vial to the "X" of the sensor strip until the analyzer beeps.

5 Recording the Results

- ☐ After 3 minutes, the analyzer will beep to indicate the test is done. Be sure to record the result displayed in the window.
- ☐ A "LOW" reading in the display window indicates a result less than 3.3 mcg/dL and must be reported as "<3.3 mcg/dL." A "HIGH" reading in the display window must be reported as ">65 mcg/dL." When reporting results, do not use words.

6 Disposing of the Sample

- ☐ Use 4 drops of the neutralizing solution to lower the pH of the sample. Dispose of the sample in a biohazard container.

Supplies Needed for Testing

- ☑ ***Soap and water for washing the patient's puncture site***
- ☑ Alcohol wipes and gauze pads
- ☑ Disposable gloves
- ☑ Sterile puncture-style lancet
- ☑ Adhesive bandages
- ☑ Capillary tube and plunger
- ☑ LeadCare® II reagent vial
- ☑ Sensor
- ☑ Dropper
- ☑ Neutralizing solution (7.5% sodium bicarbonate, $NaHCO_3$)
- ☑ Biohazard container

For more information

Visit dhhs.nh.gov/cliniclleadinfo or **email** LeadRN@dhhs.nh.gov

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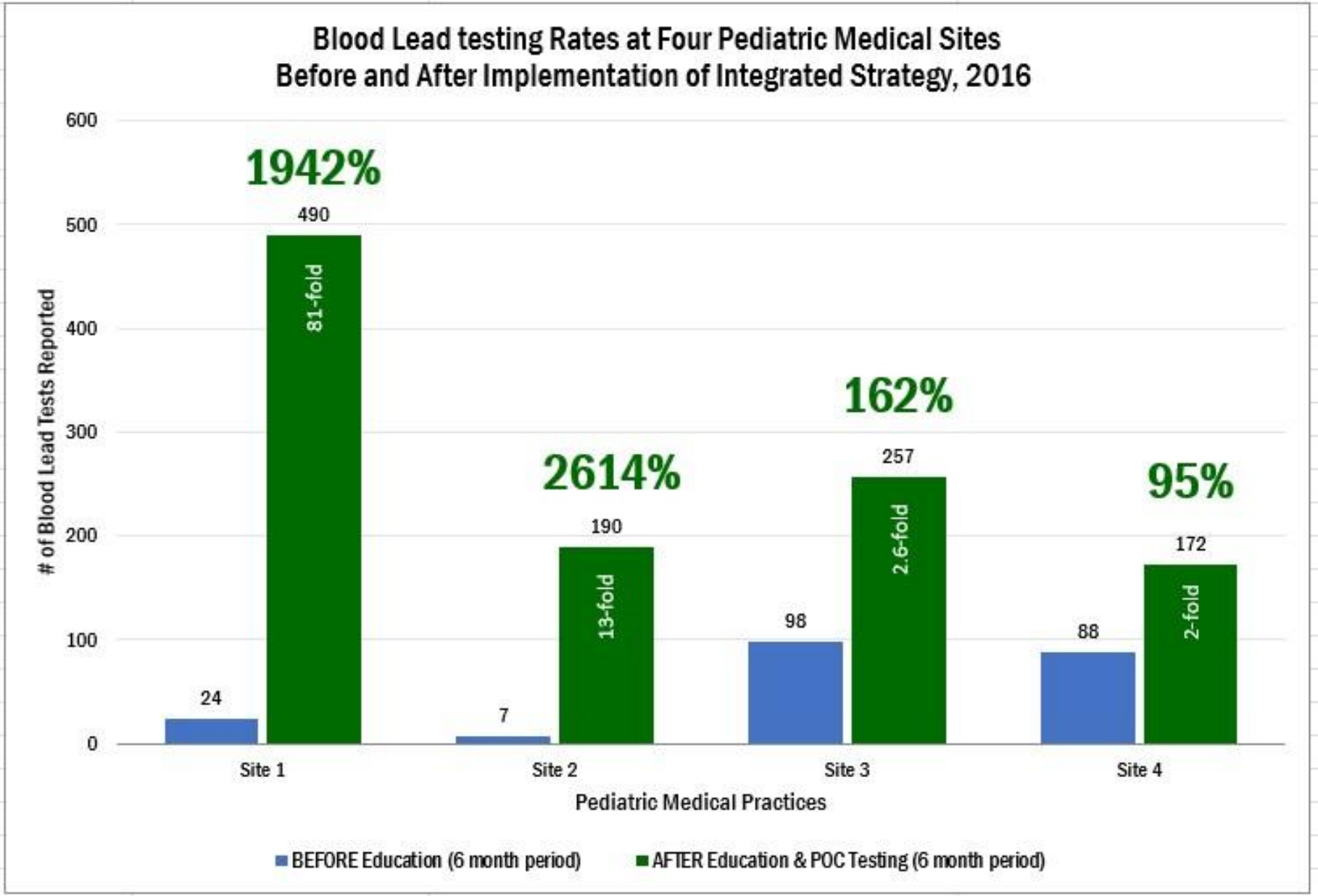
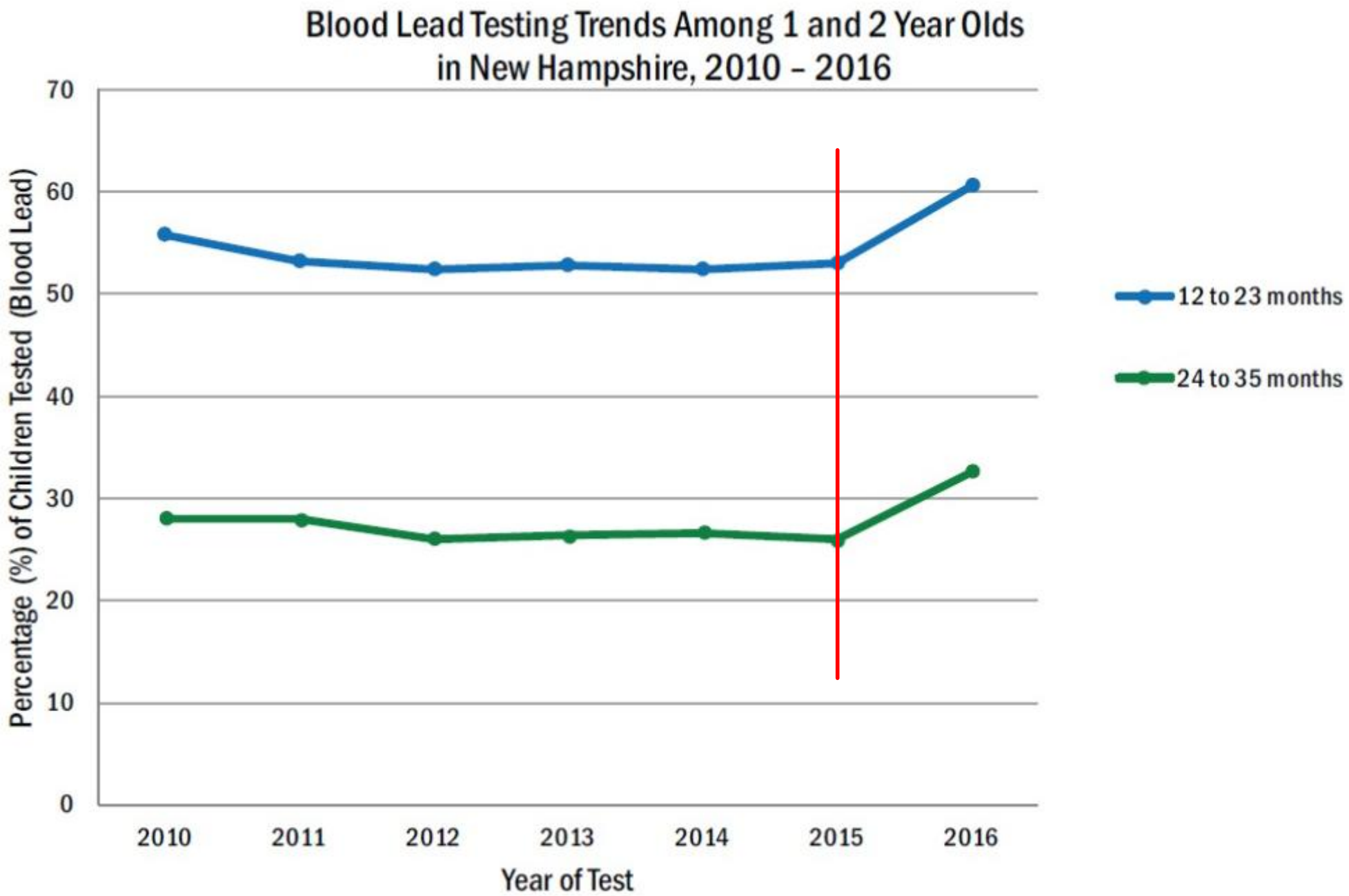
Pilot Project 2016: Impact of Testing Method

Success of POC Testing Equipment and Education 'Grant' Strategy




Blood Lead Testing Trends Among 1 and 2 Year Olds
in New Hampshire, 2010 – 2016
Percentage (%) of Children Tested (Blood Lead)
70
60
50
40
30
20
10
0
2010
2011
2012
2013
2014
2015
2016
Year of Test
12 to 23 months
24 to 35 months

Successful Strategy Published

Journal of Public Health Management and Practice

January/February 2019

Practice Full Report

SDC

Successfully Changing a State's Climate to Increase Blood Lead Level Testing

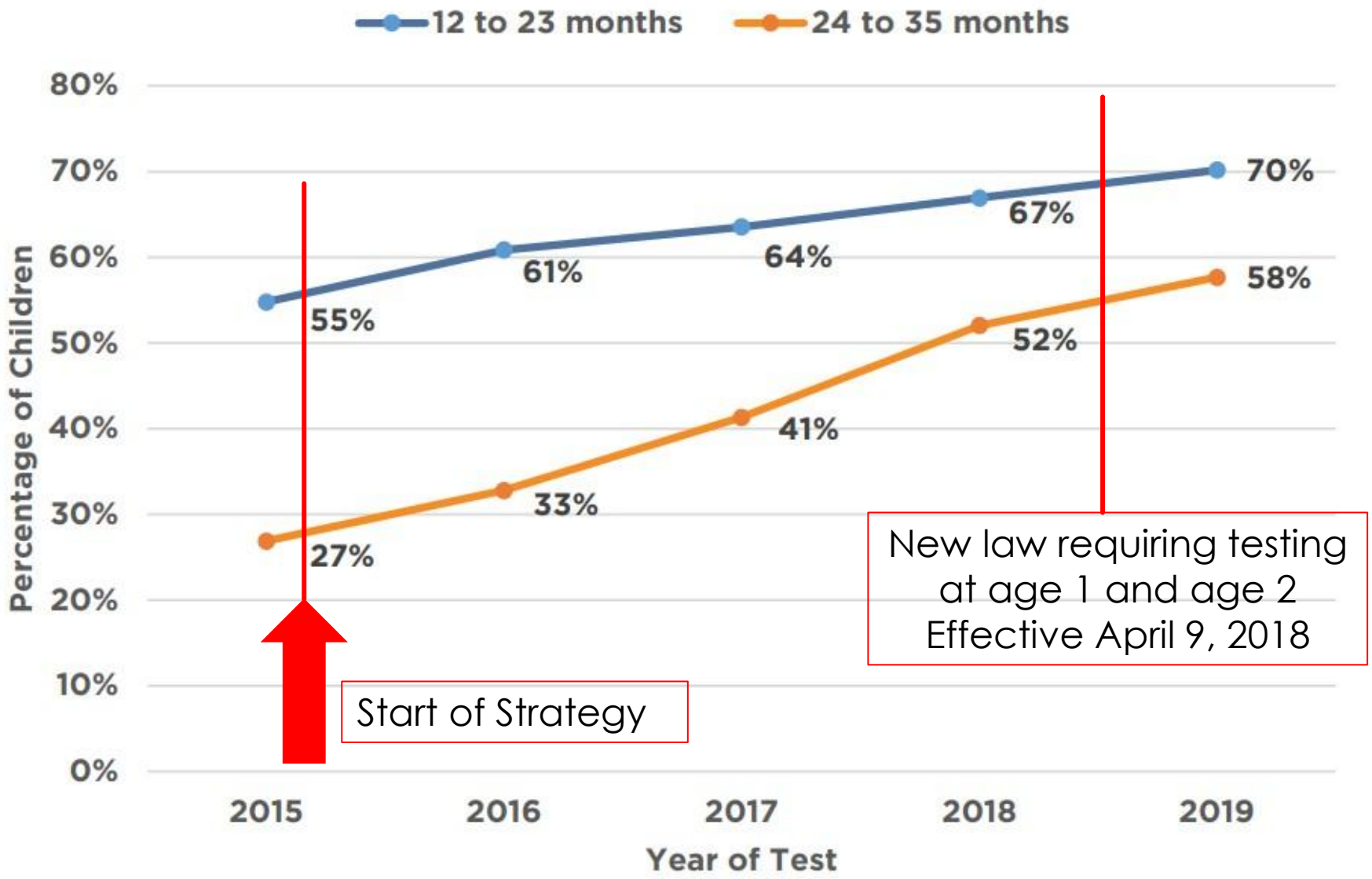
Gail Coppins Gettens, MS; Beverly Baer Drouin, BS

ABSTRACT

Childhood lead poisoning continues to be a persistent environmental pediatric health problem in New Hampshire (NH). In 2015, 660 (4.9%) children younger than 6 years had blood lead levels of 5 μg/dL or more, the Centers for Disease Control and Prevention's recommended level for public health action. Yet, only 16.8% of NH children younger than 6 years were tested. NH's Healthy Homes and Lead Poisoning Prevention Program (HHLPPP) identified 2 barriers to blood lead testing and the opportunities to resolve them: (1) venous testing had lower compliance and resulted in costly follow-up time for providers and (2) lack of understanding in the medical community about the importance of blood lead testing. Strategies to engage pediatric providers needed to recognize the realities of this rural state. In 2016, a strategy with goals of increasing blood lead screening and testing rates statewide with focus on high-risk communities was developed and implemented. The 5-part integrated strategy included the following: (1) implement a medical education program for pediatric providers; (2) increase provider awareness of point-of-care testing equipment; (3) create and distribute medical reference materials; (4) develop parent reminders for blood lead tests; and (5) increase the availability of point-of-care testing equipment. During 2016, NH's HHLPPP presented 25 medical education sessions. Blood lead testing rates improved dramatically, especially at medical sites where both face-to-face education and point-of-care testing were implemented. NH's success serves as a model for other rural areas seeking to improve lead screening rates.

KEY WORD: blood lead level testing rates, childhood lead poisoning, outreach strategy, parent reminder, point-of-care testing, provider education, rural

Figure 2: Percentage of 1-and 2-year-old children tested for blood lead, 2015 - 2019.



Changing Course: Road Map to Increase Pediatric Blood Lead Level Testing Rates

Part I

Effective Pediatrician Engagement:

Quality improvement project utilizing the ECHO® Model for continuing medical education

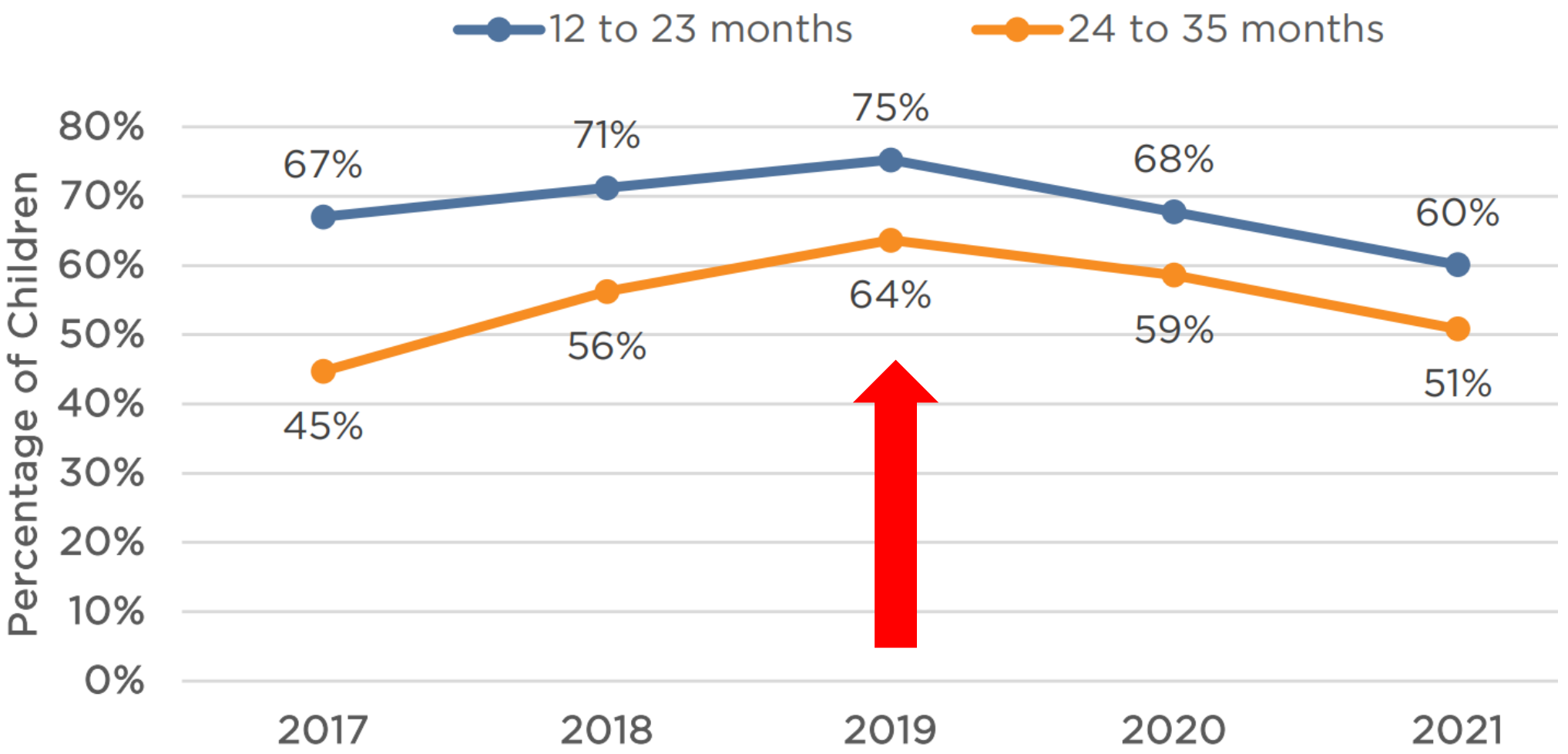
Restarting the Engine After COVID: 2022

Repeat Performance (with updates)

Selected for Plenary Session Presentations
CDC Childhood Lead Poisoning Prevention Grantee Meeting
Global Communications Center – Atlanta, GA

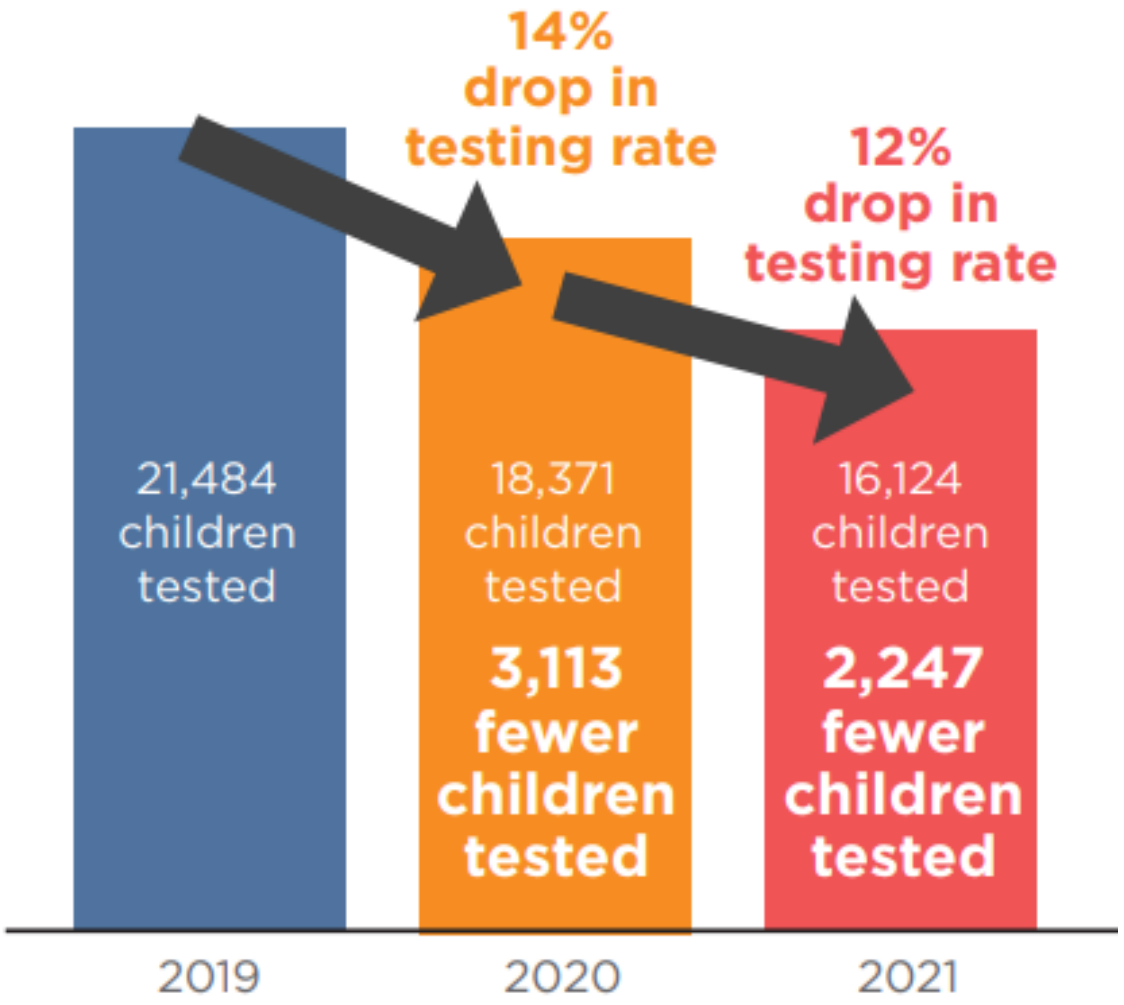
Part I: Story Starts in August 2022

Testing rates had ***crashed and burned***.



25% DROP

in the number of children tested over two years from 2019 to 2021. 5,360 fewer children were tested.



August 2022 – Meeting of NH Statewide Clinical Lead Advisory Committee

NH Lead Quality Improvement Project *combined* CME Training Utilizing ECHO Model®

Collaborative Partnership

NEW HAMPSHIRE DHHS
DEPARTMENT OF HEALTH & HUMAN SERVICES

New Hampshire Chapter
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

AmeriHealth Caritas
Care is the heart of our work

Quality Improvement Consultant

Ruth Gubernick, PhD, MPH

- **November 2023**

  Individual practice on-boarding

- **January - June 2024**

  Six monthly sessions

- **July 2024**

  Last of six data submissions

In a collaborative effort to improve patient care through increased childhood lead screening rates, AmeriHealth Caritas New Hampshire, the NH Division of Public Health Services and the NH Chapter of the AAP are seeking pediatric and primary care practice teams to join the NH Lead QI Project ECHO.

BENEFITS OF PARTICIPATION:

- **Access to a multidisciplinary team of childhood lead screening experts**
- **Connect with a network of professionals**
- **25 MOC Part 4 credits (Physician and Physician Assistant)**
- **Continuing education credits (CME, CNE) (For NP, RN, MA)** (CME, CNE Applications Pending)
- **Expert QI technical assistance and training**

TOPICS WILL INCLUDE:

- Overview of Childhood Lead Exposure in NH (January 16, 2024)
- Neurological Impact of Childhood Lead Exposure (February 20, 2024)
- Assessment and Testing (March 19, 2024)
- An Elevated Blood Lead Level Test Result (April 16, 2024)
- Services for Children with Elevated Blood Lead Levels (May 21, 2024)
- Universal Testing and the Importance of Testing (June 18, 2024)

ELIGIBILITY:

- Practice teams located in New Hampshire
- Commit to engaging in QI planning and implementing discussions or coaching sessions.
- Ability to develop a multidisciplinary team of individuals (2-5 staff) that work together in a practice setting, must include a physician or physician assistant champion.
- Availability of team to attend a one-hour ECHO session every third Tuesday of the month for six months, January 2024–June 2024.

Key: Participation as a Practice Team

- **Minimum** of 1 physician and 1 clinical team member
- **8** Pediatric Practices
- **16** Pediatricians
- **38** Clinical Participants

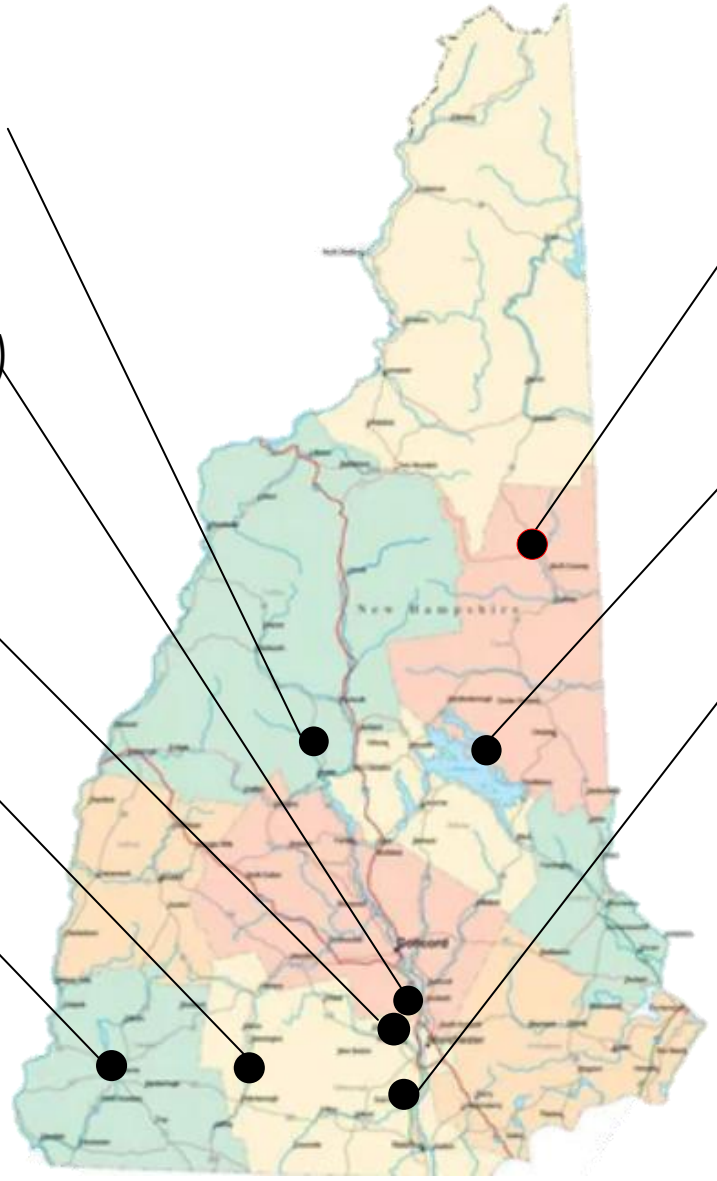
Federally Qualified Health Center
(rural)

Health System Affiliate Practice
(largest city, largest employer in state)

Faith-Based Hospital Affiliate
Practice (330 beds) - largest city

Rural Hospital Affiliate Practice
(25 beds)

Health System Affiliate Practice
Located within a rural hospital
(150 beds)



Independent Practice
Rural Health Center

Rural Hospital Affiliate
Practice (25 beds)

Hospital Affiliated
(188 beds) - 60 affiliated
practices

8 Diverse Practice Teams Participated

A Significant Commitment

6

One-hour sessions with cameras on

1

Individual practice team meeting with QI Coach (minimum)

1

Case study submitted for presentation

7

Monthly data submissions

Individual practice team on-boarding session

Individual and practice MOU

25

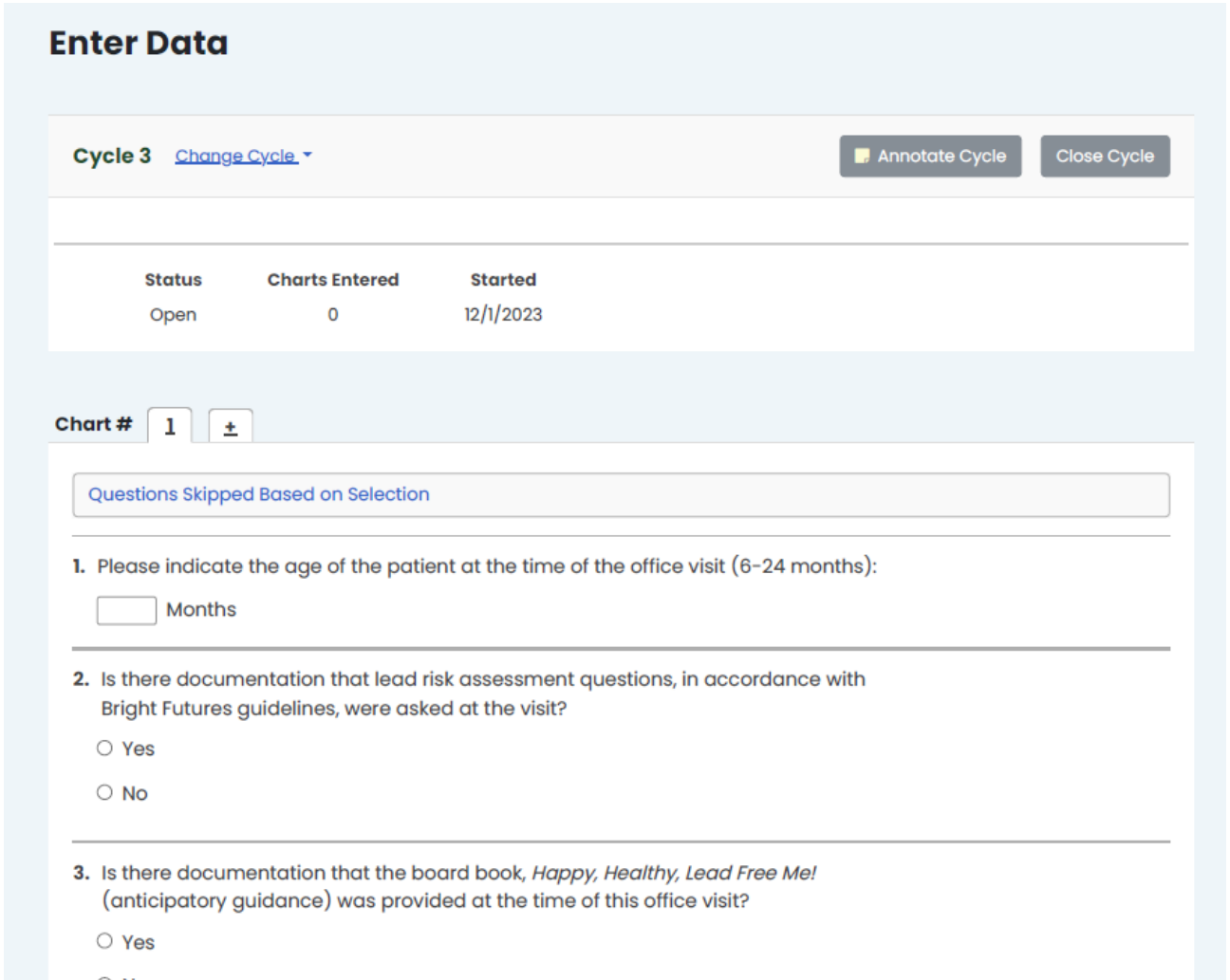
MOC-4 points awarded with CMEs and CNEs

American Academy of Pediatrics (AAP)
Quality Improvement Data Aggregator (QIDA)

- Established **performance measures**
- Developed **data portal**

Source	Definition (Aggregate Chart Entry)	Measure Association	Measure Calculation (via chart tool)	Numerator/Denominator	Goal
ALL	Total number of charts entering data from	N/A	N/A	N/A	N/A
3A*	Of those children who attended a 12-month well visit, how many have documentation of a blood lead level (BLL) test RESULT from the test ordered at this visit?	% of patients who have documentation of a blood lead level test result from a test ordered at their 12-month well-child visit	**Value**(3A) / **Value**(1A)	# patients that attended a 12-month well child visit with documentation of a blood lead level test result from a test ordered at this visit is the numerator (x) in the equation; All patients that attended a 12-month well-child visit is the denominator (y)	90.00
2A*	Of all children who attended a 12-month Well Child visit this month, how many have documentation of an order made at this visit for a blood lead level (BLL) test?				
1A*	How many children attended a 12-month Well Child visit this month?				
3C-A*	How many had an initial elevated blood lead level ≥ 5 ug/dL from a venous specimen?	% of patients who have documentation of an INITIAL elevated venous BLL (>=5 ug/dL) result from a test ordered at their 12-month well-child visit	**Value**(3C-A) / **Value**(3A-A)	# patients that attended a 12-month well child visit with documentation of an INITIAL elevated venous BLL (>=5 ug/dL) result is the numerator (x) in the equation; All patients that attended a 12-month well-child visit who have documentation of an INITIAL venous blood lead level result from a test ordered at this visit is the denominator (y)	90.00
3A-A*	How many children had an INITIAL venous blood lead level result from the test ordered at this visit? ("initial" indicates the child did not have capillary BLL testing as part of this visit.)				
3B-A*	How many children had a capillary blood lead level result from the test ordered at this visit?	% of patients who have documentation of an elevated CAPILLARY BLL (>=5 ug/dL) result from a test ordered at their 12-month well-child visit	**Value**(3D-A) / **Value**(3B-A)	# patients that attended a12-month well child visit with documentation of an elevated CAPILLARY BLL (>=5 ug/dL) result is the numerator (x) in the equation; All patients that attended a 12-month well-child visit who have documentation of a CAPILLARY blood lead level result from a test ordered at this visit is the denominator (y)	90.00
3D-A*	How many children had initial elevated blood lead level (BLL)≥ 5 ug/dL test results from a capillary specimen?				
3E-A*	How many children with elevated capillary blood lead level (BLL)≥ 5 ug/dL test result had a subsequent confirmatory venous blood test? (Confirmatory refers to a venous blood test to confirm the accuracy of a capillary lead test previously obtained.)	% of patients with elevated BLL (>=5 ug/dL) from a capillary specimen at their 12-month well child visit who have documentation in chart that a confirmatory venous blood test was performed	**Value**(3E-A) / **Value**(3D-A)	# patients that attended a 12-month well child visit with elevated BLL (>=5 ug/dL) noted from a capillary specimen with documentation in chart that a confirmatory venous blood test was performed is the numerator (x) in the equation; # patients that attended a 12-month well child visit with elevated BLL (>=5 ug/dL) noted from a capillary specimen is the denominator (y)	90.00
3D-A*	How many children had initial elevated blood lead level (BLL)≥ 5 ug/dL test results from a capillary specimen?				
3F-A*	How many children had an elevated CONFIRMATORY venous blood lead level (BLL) ≥ 5 ug/dL?	% of patients with elevated BLL (>=5 ug/dL) from a capillary specimen at their 12-month well child visit who have elevated BLL (>=5 ug/dL) on CONFIRMATORY venous specimen	**Value**(3F-A) / **Value**(3E-A)	# patients that attended a 12-month well child visit with elevated BLL (>=5 ug/dL) noted from a capillary specimen who have elevated BLL (>=5 ug/dL) on CONFIRMATORY venous specimen is the numerator (x) in the equation; # patients that attended a 12-month well child visit with elevated BLL (>=5 ug/dL) noted from a capillary specimen with documentation in chart that a confirmatory venous blood test was performed is the denominator (y)	90.00
3D-A*	How many children had initial elevated blood lead level (BLL)≥ 5 ug/dL test results from a capillary specimen?				
3E-A*	How many children with elevated capillary blood lead level (BLL)≥ 5 ug/dL test result had a subsequent confirmatory venous blood test? (Confirmatory refers to a venous blood test to confirm the accuracy of a capillary lead test previously obtained.)				
3G-A*	How many of those with INITIAL or CONFIRMATORY venous blood lead levels ≥ 5 ug/dL have documentation of a follow-up order for a venous blood lead level test in 1-3 months' time?	% of patients with elevated BLL (>=5 ug/dL) from an INITIAL or CONFIRMATORY venous specimen at their 12-month well child visit who have documentation in chart that follow-up venous BLL test was ordered	**Value**(3G-A) / **Value**(3C-A) + **Value**(3F-A)	# patients that attended a 12 month well child visit with elevated BLL (>=5 ug/dL) from an INITIAL or CONFIRMATORY venous specimen with documentation in chart that follow-up venous BLL test was ordered is the numerator (x) in the equation; # patients that attended a 12 month well child visit with elevated BLL (>=5 ug/dL) from an INITIAL or CONFIRMATORY venous specimen is the denominator (y)	90.00
3F-A*	How many children had an elevated CONFIRMATORY venous blood lead level (BLL) ≥ 5 ug/dL?				
3C-A*	How many had an initial elevated blood lead level ≥ 5 ug/dL from a venous specimen?				
5A*	Of those children with initial venous (number noted in question 3C) and capillary (number noted in question 3D) with BLL ≥ 5 ug/dL test result, how many have documentation that the patient/parent/caregiver received counseling regarding lead exposure health risks, management, and resources? (Note: Counseling may include a	% of patients with initial elevated BLL (>=5 ug/dL) from a venous or capillary lead test at their 12-month well child visit with documentation	**Value**(5A) / **Value**(3C-A) + **Value**(3D-A)	# patients that attended a 12-month well child visit with initial elevated BLL (>=5 ug/dL) noted from a venous or capillary test with documentation in chart that the patient/parent/caregiver received counseling is the numerator	90.00

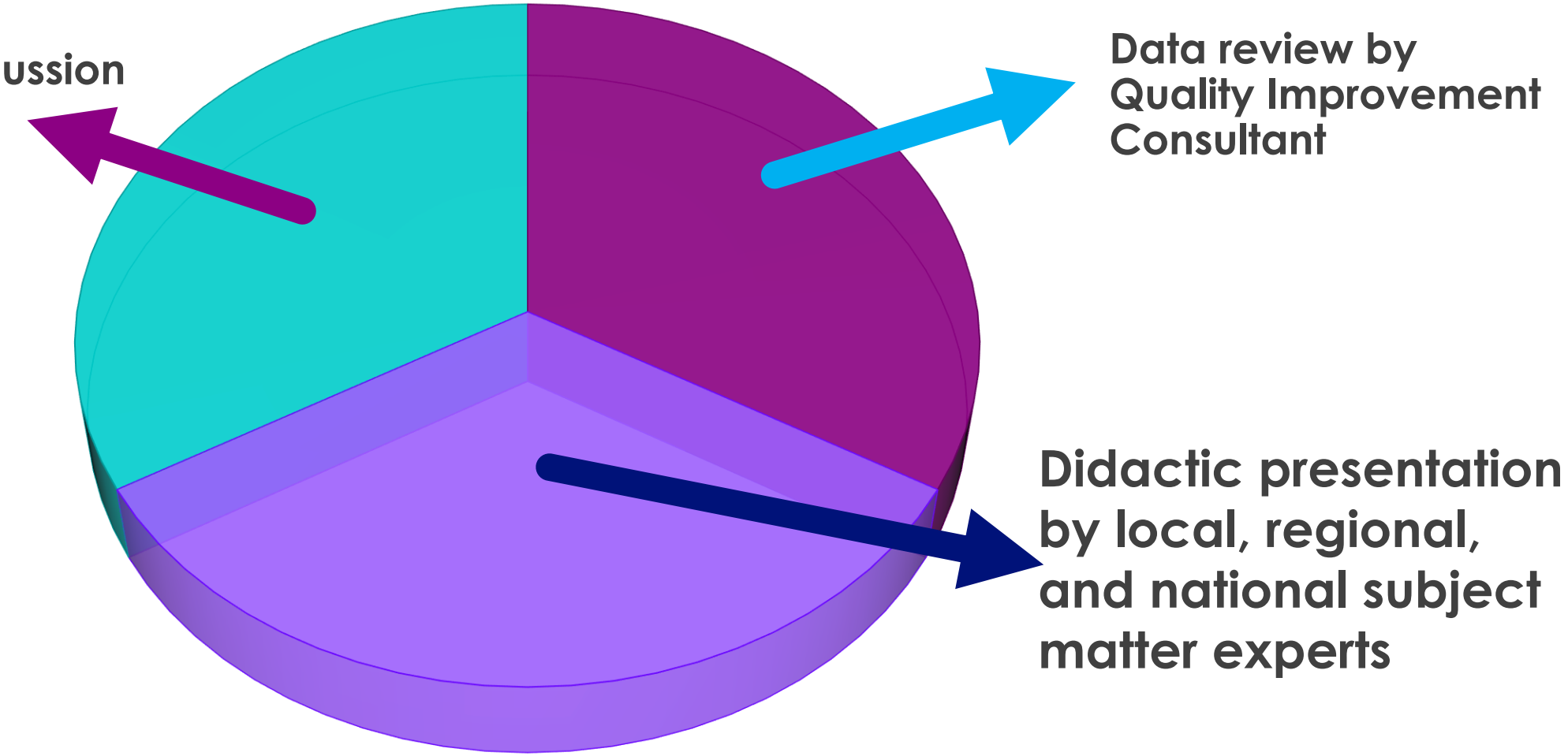
Practice Portal for Data Questions



Monthly Data Submission

Cycle	Data	Due Date
Cycle 1(Baseline) **November**	Patients seen in November 2023	Due January 31, 2024
Cycle 2 **January**	Patients seen in January 2024	Due February 29, 2024
Cycle 3 **February**	Patients seen in February 2024	Due March 31, 2024
Cycle 4 **March**	Patients seen in March 2024	Due April 30, 2024
Cycle 5 **April**	Patients seen in April 2024	Due May 31, 2024
Cycle 6 **May**	Patients seen in May 2024	Due June 30, 2024
Cycle 7 **June**	Patients seen in June 2024	Due July 31, 2024

Components of Six Monthly 1-Hour Sessions

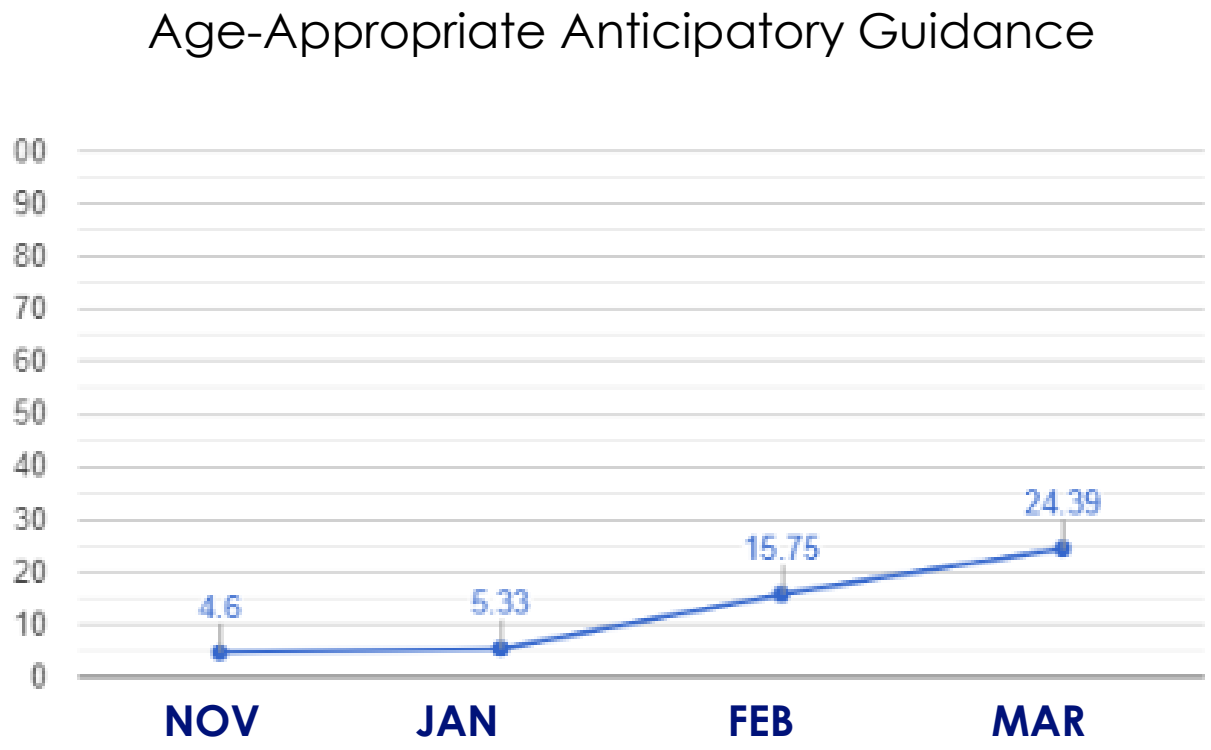


What makes this ECHO™ different?

- Aggregate data run charts for each measure created by QI consultant.
- Aggregate data run charts reviewed during each session.
- Review and discussion facilitated by QI consultant.
- Practice teams required to meet, at least once, with QI consultant to review practice-level data.

All Measures: Tool 1: Single Chart Entry (Practice)

5/13/24



Measurable Outcome Improvements

- Increase in **Lead Risk Assessments** at Well Child Visits (WCV)
- Increase in **Anticipatory Guidance** on lead exposures at WCV
- Increase in **Blood Lead Testing at 12- and 24-month** WCV
- Increase in **'Catch-Up' Blood Lead Testing** at 30mo, 4yo, 5yo WCV

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

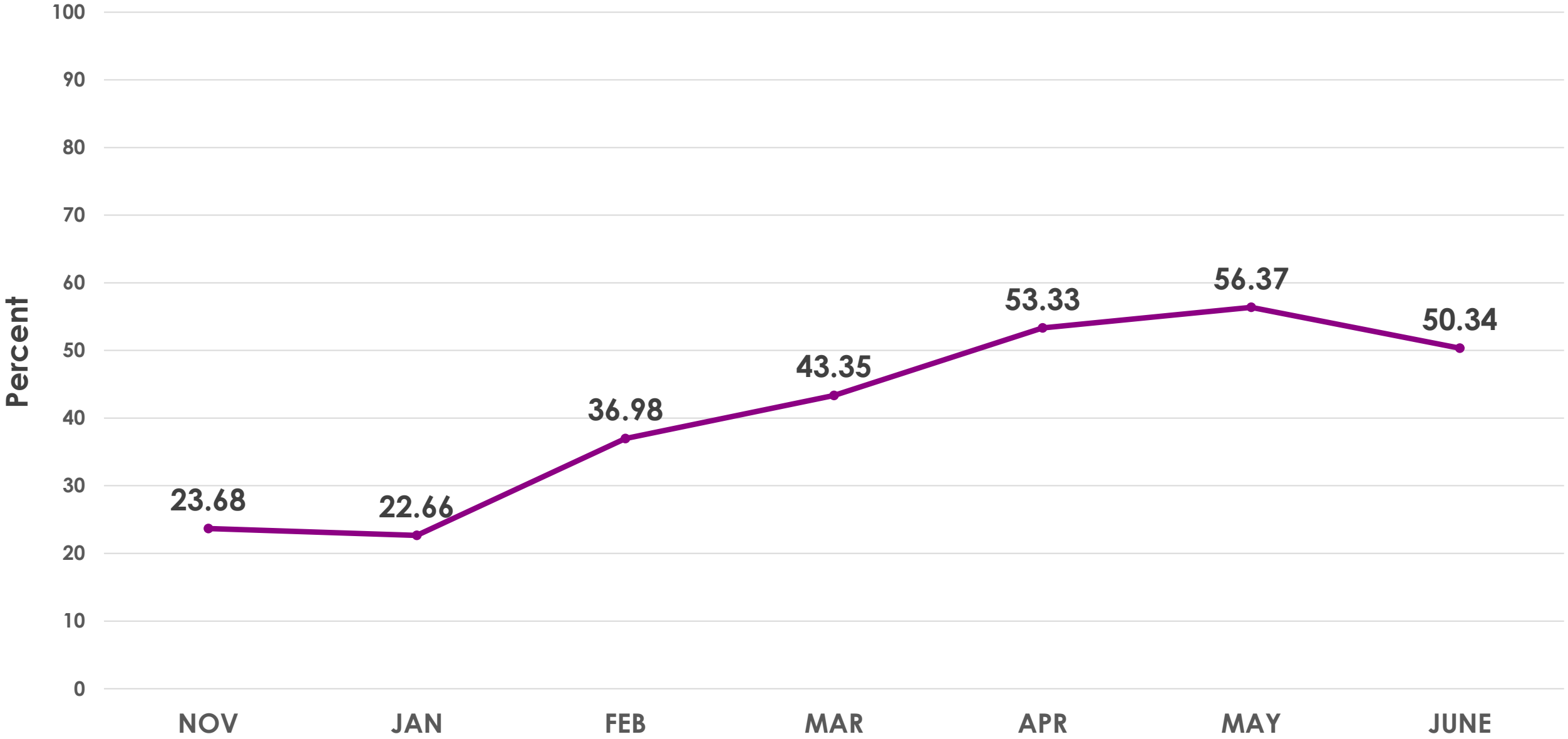
	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9] →	→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	←	●[10] →	←	←	● →	←	←	● →	←	● →
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20] →	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	←			● →	★
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	● →						
Hepatitis B Virus Infection[31]		★ →																														→
Hepatitis C Virus Infection[32]																													● →			→
Sudden Cardiac Arrest/Death[33]																						★ →										→
Cervical Dysplasia[34]																																●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★															
Fluoride Varnish[37]							←	→			●					→																
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Source: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Lead Risk Assessment Questions: Seven Times
Well Child Visits: Ages 6 months to 7 years

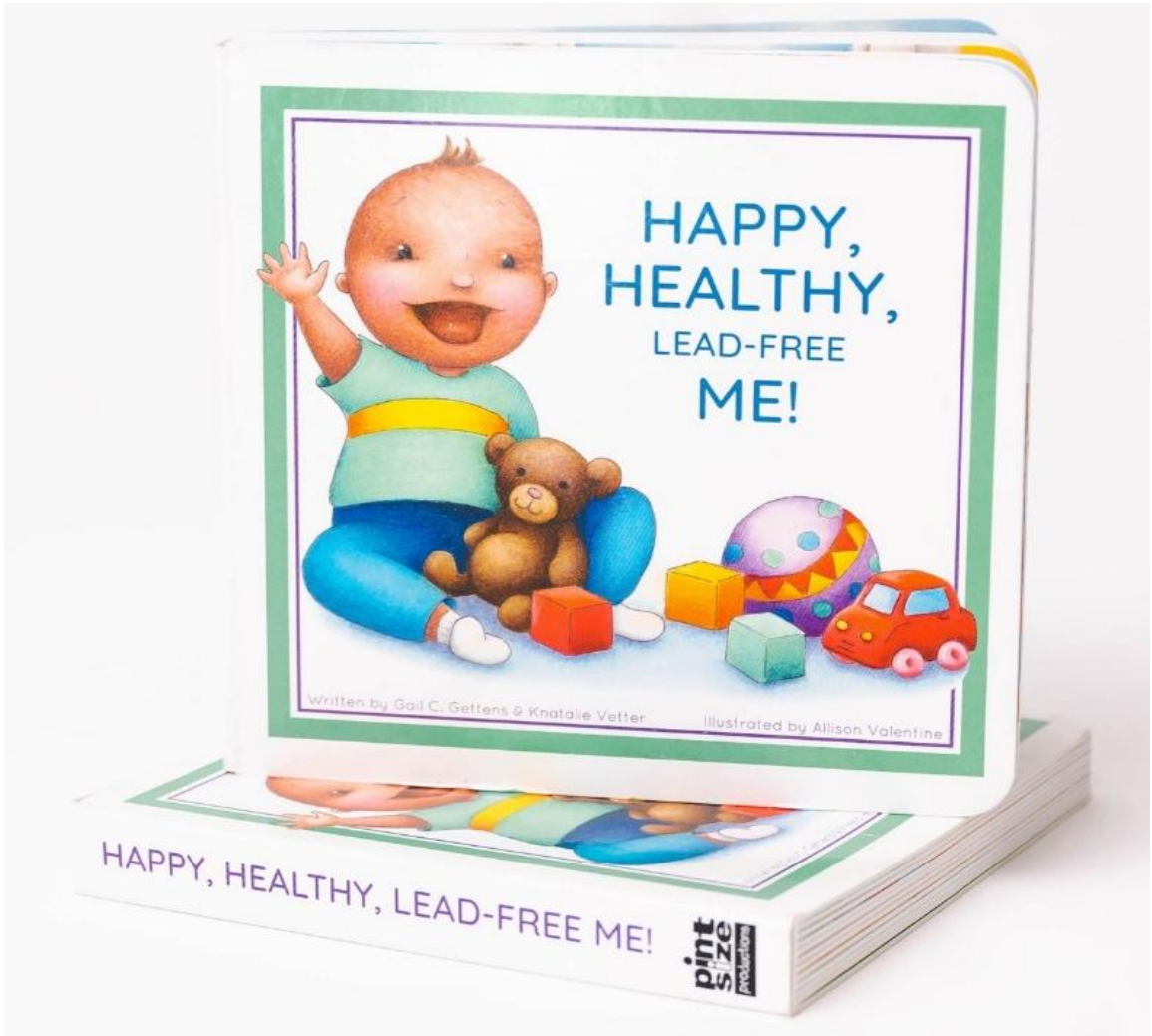
26. Perform risk assessments or screenings as appropriate, based on **universal screening requirements for patients with Medicaid** or in high prevalence areas.

Age Appropriate Risk Assessment



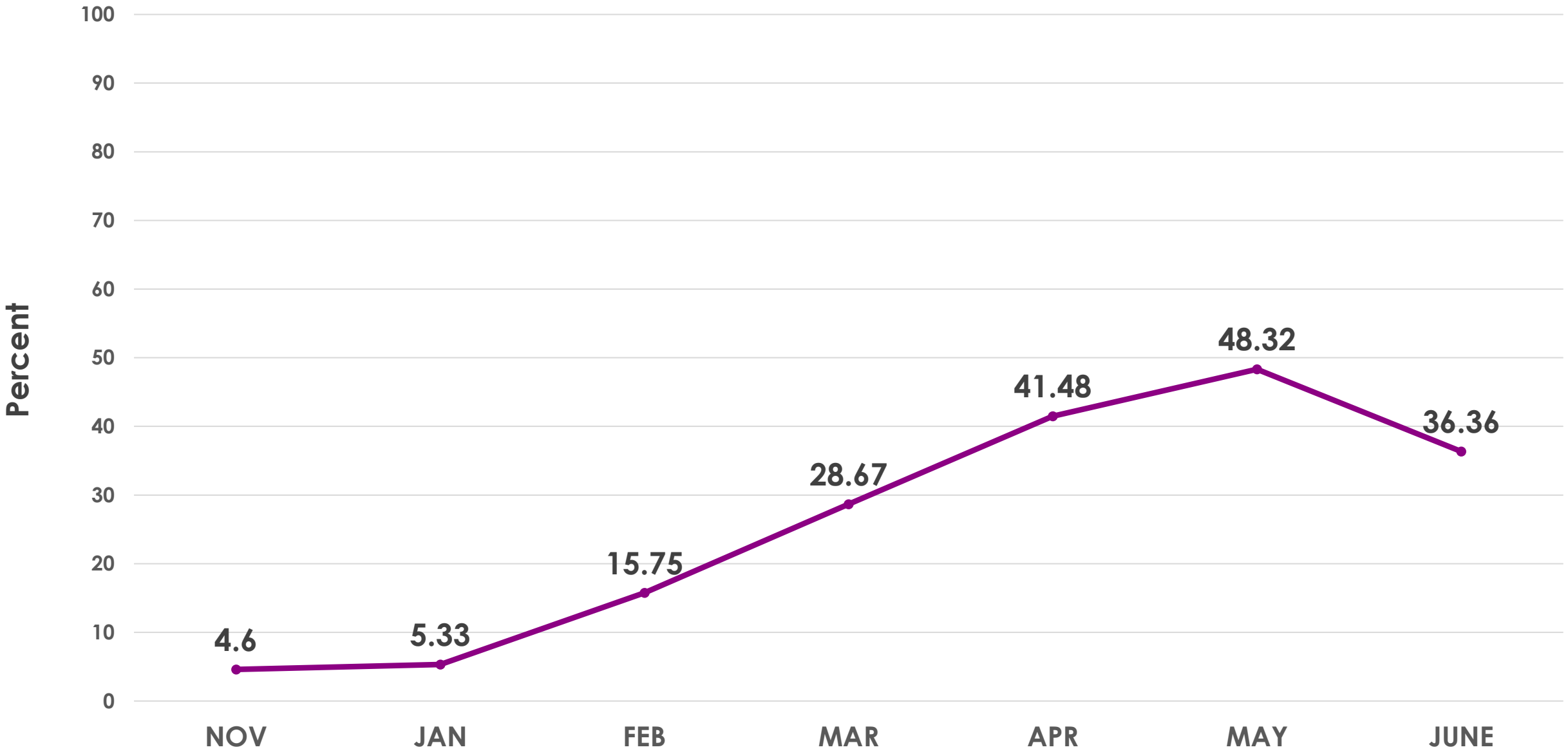
Anticipatory Guidance: Happy, Healthy, Lead-Free Me!

Supporting Early Literacy and Providing Anticipatory Guidance for the Family

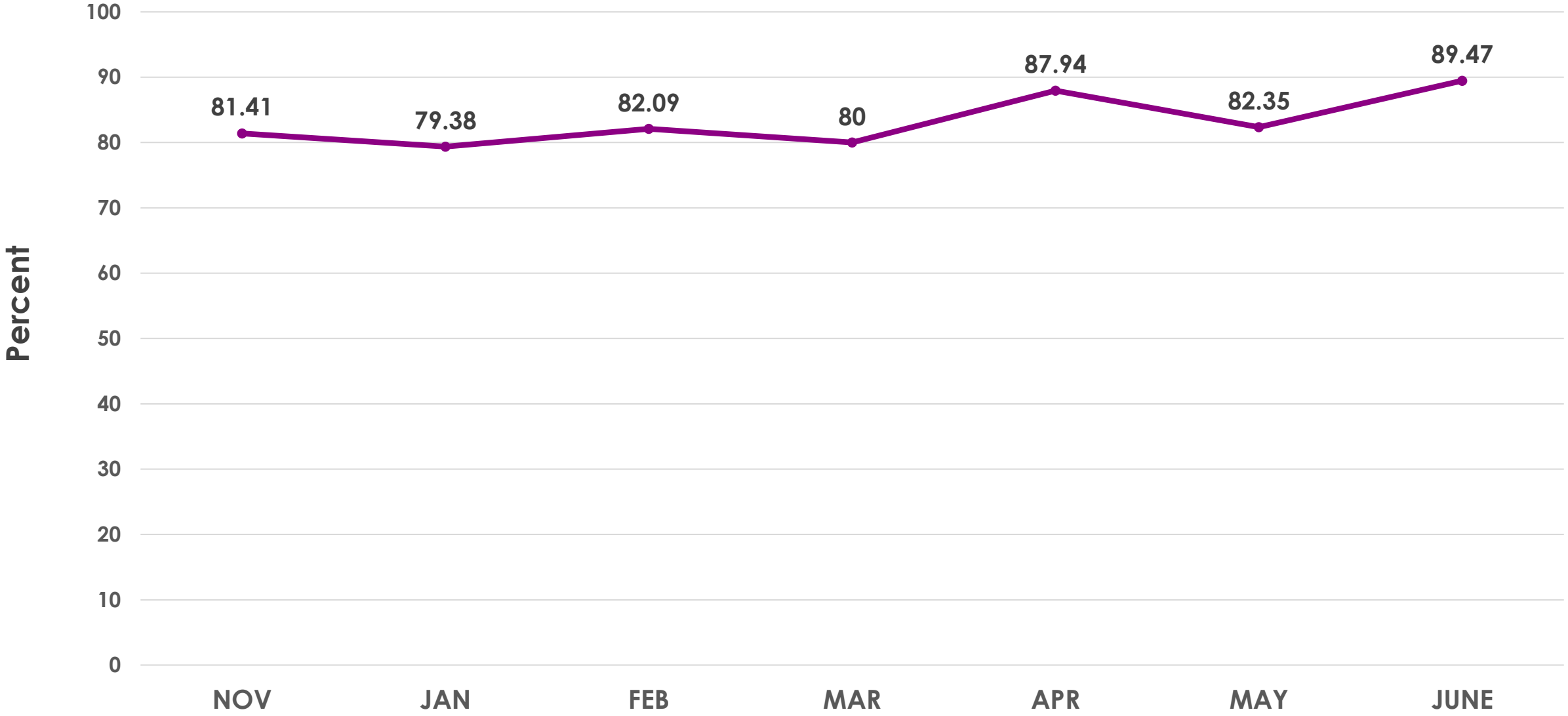


Christine Arsnow, MD
Vice President, NH Chapter of AAP

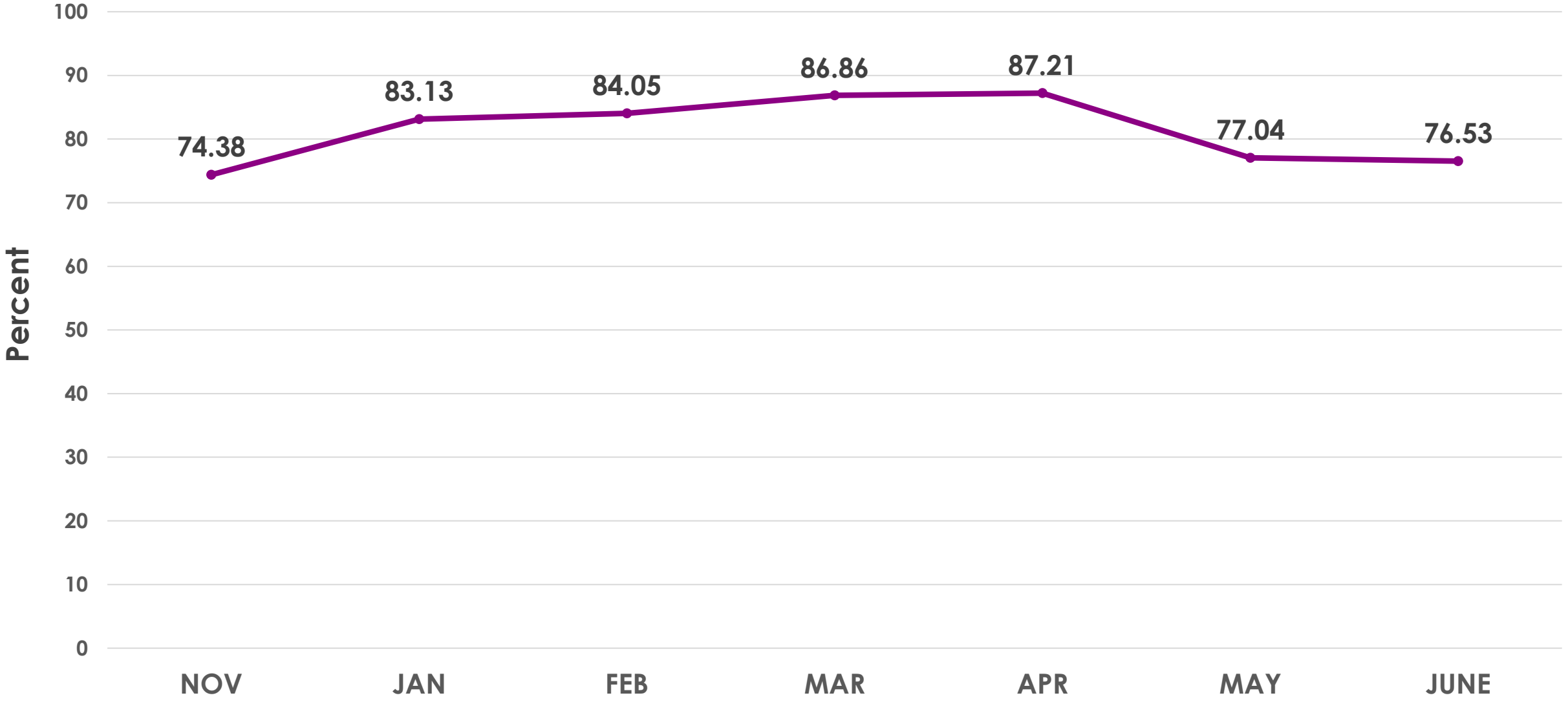
Age Appropriate Anticipatory Guidance



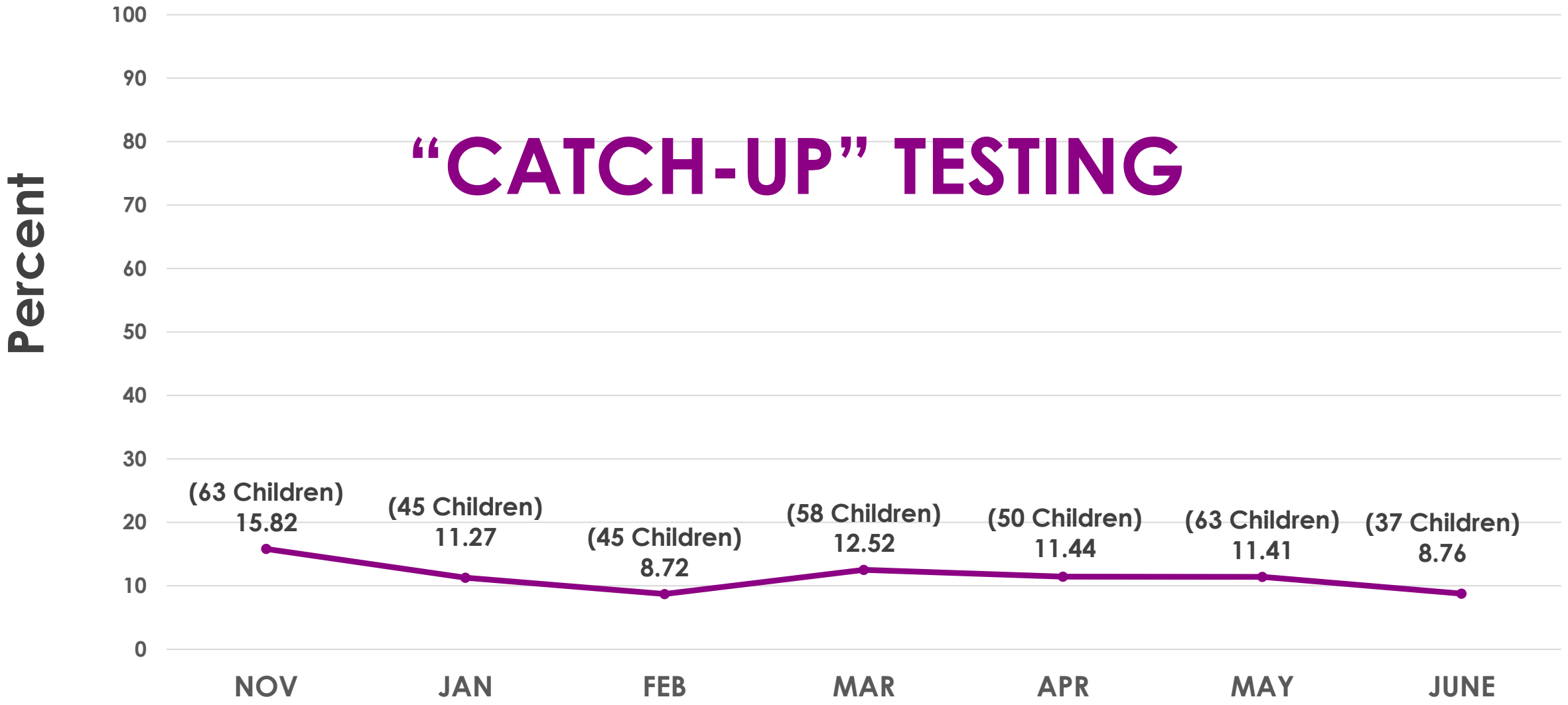
Age Appropriate Lead Testing
All Results 12-Mos.



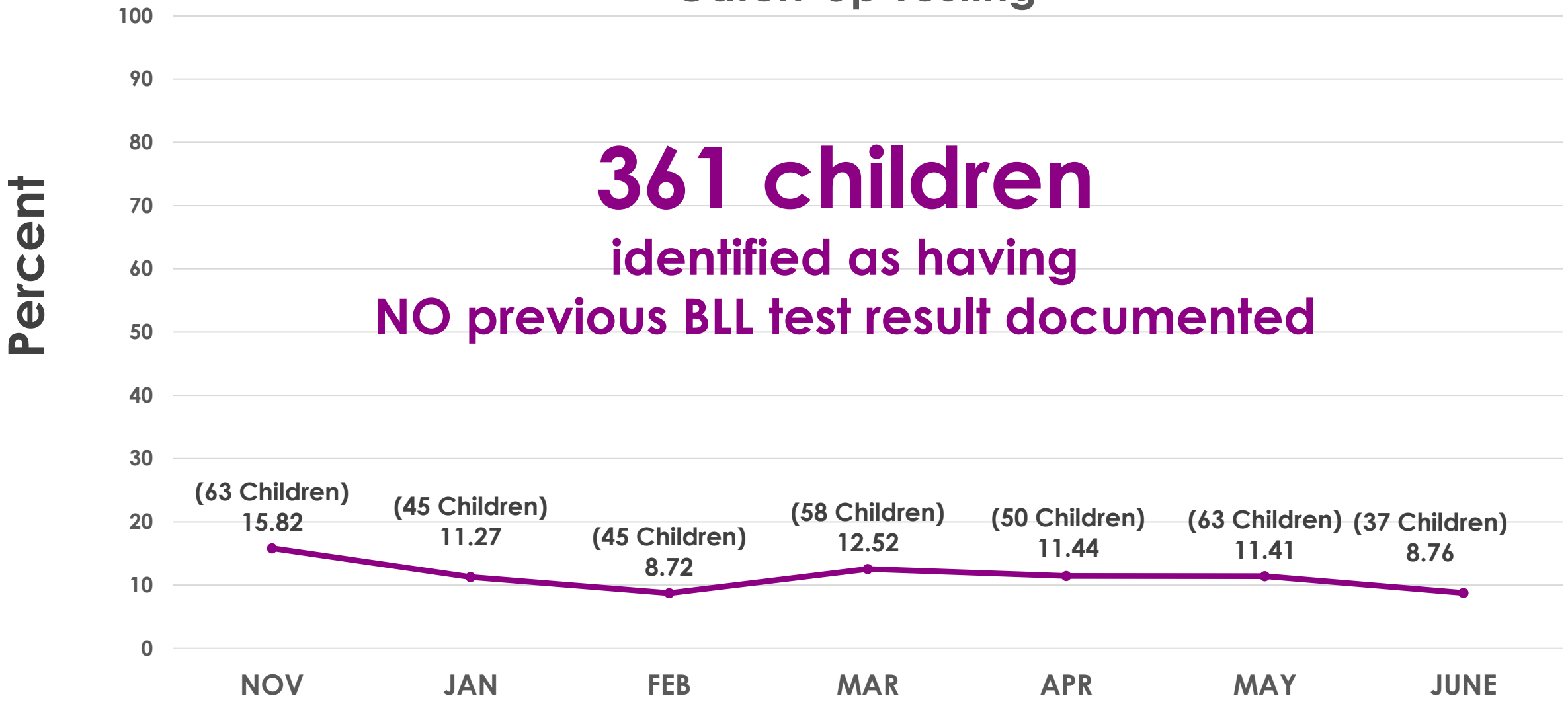
Age Appropriate Lead Testing All Results
24-Mos.



Children with NO Previous Blood Lead Level Test Result Documented Prior to 30-Mos. of Age



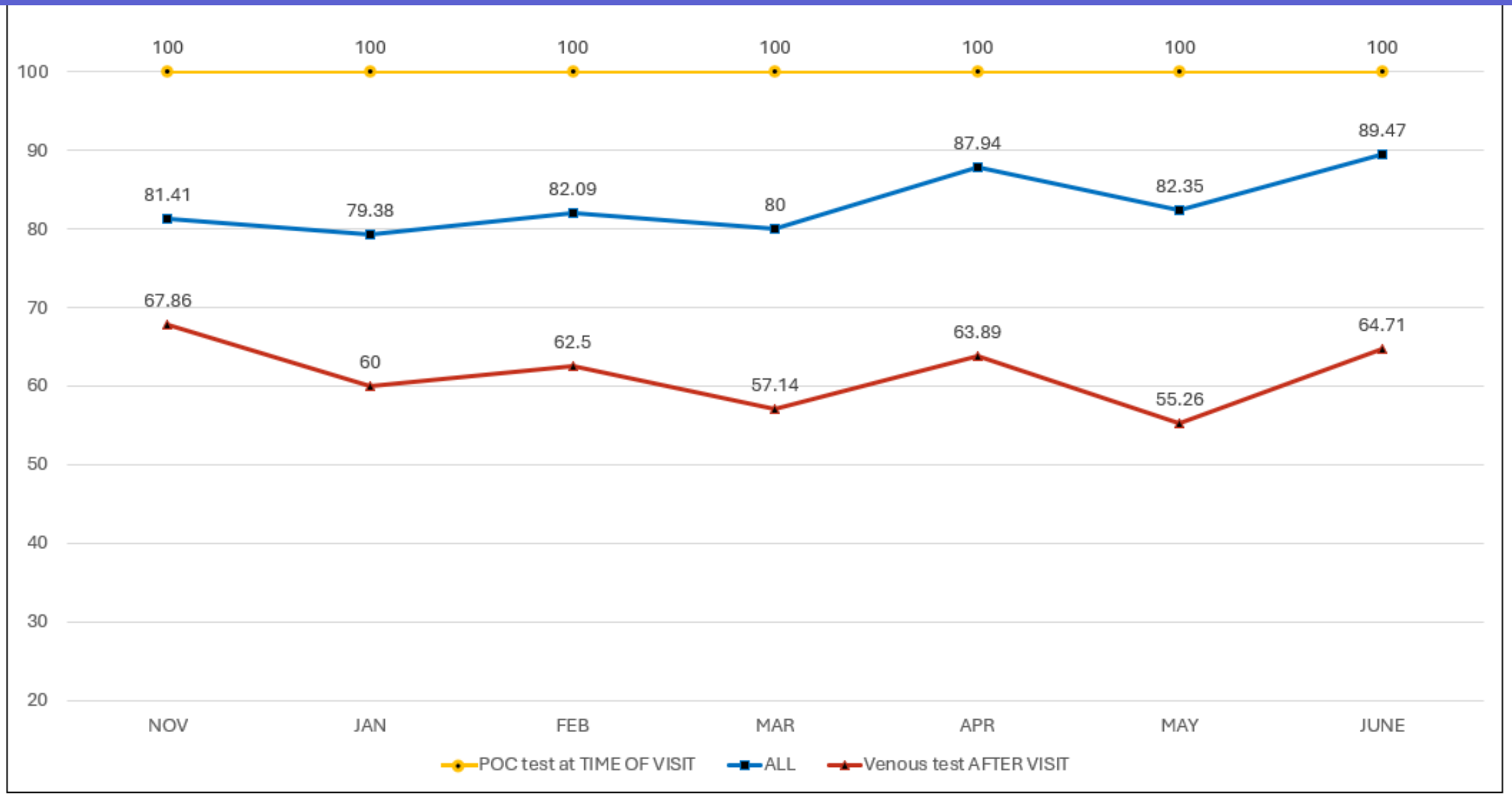
Children with NO Previous Blood Lead Level Test Result Documented Prior to 30-Mos. of Age 'Catch-Up Testing'



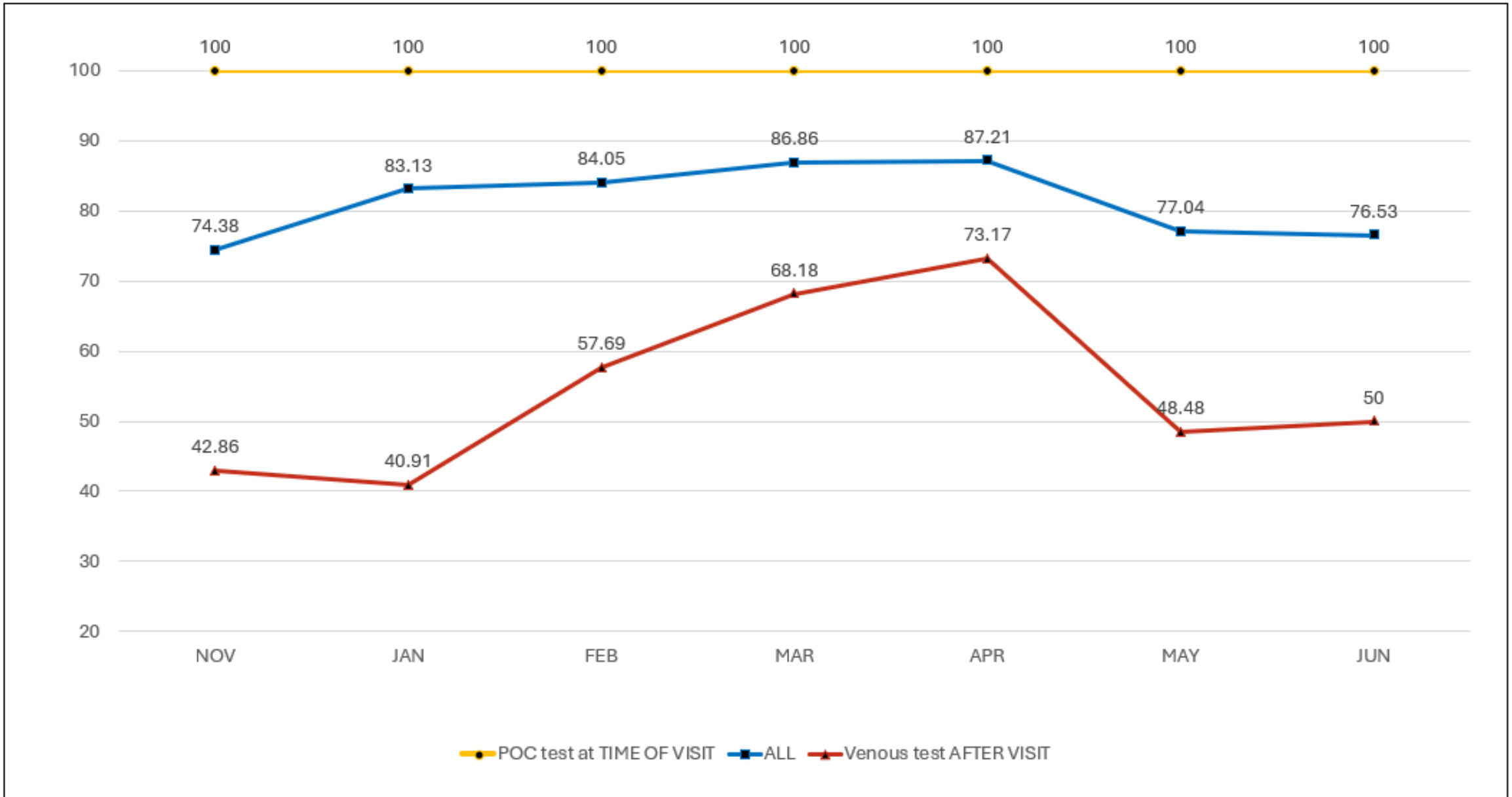
Unexpected and Notable Outcomes

- Overcoming **knowledge gaps**
- **Multi-level changes** in practices
- **Connecting** with public health nurses
- **Point-of-Care** testing success

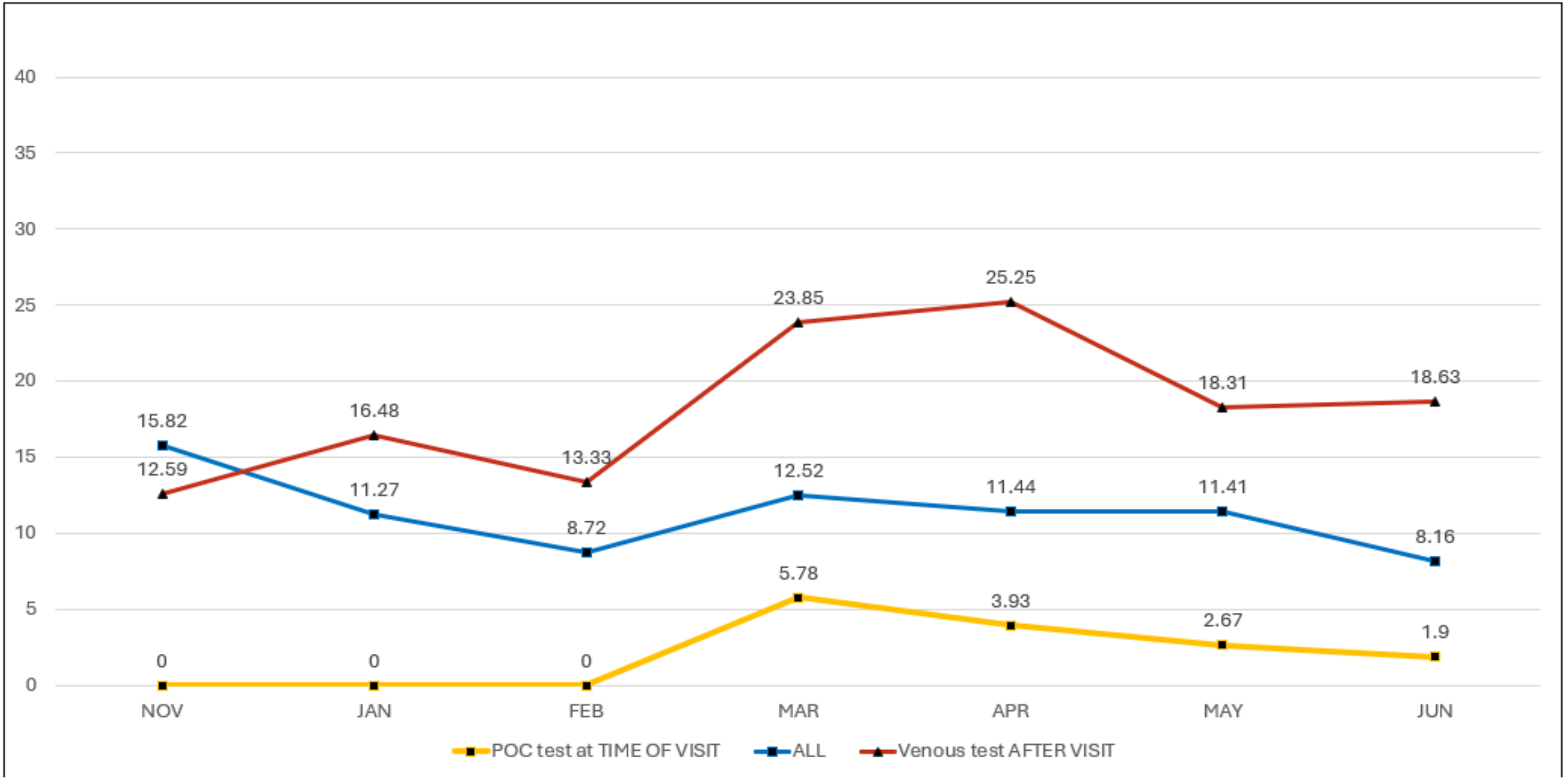
Impact of Testing Method on BLL Testing Rates: 12-mos



Impact of Testing Method on BLL Testing Rates: 24-mos.



Impact of Testing Method on Catch-Up Testing Rates



What We Learned

- Requires **time, funding, and collaboration**. (Worth it!)
- **Incentive** of MOC-4 Points (Huge!)
- Effectiveness of **combining QI project** with CME education/ECHO model.
- **POC testing** = higher testing rates (remove barriers and lab fees)
- High level of practice **team engagement** = multi-level QI changes

What We Learned: Clinical Resources

- Medical Management & Testing 'Quick Guides'
  - Expanded and Updated
- Pediatric Pb Testing CPT/Billing Reference Tool
- Infographic Surveillance Data: Quick Pulse
  - Expand and Added Prevalence
- Clinical Adjuncts for Anticipatory Guidance
  - Happy, Healthy, Lead-Free Me!
  - Information Resource Reboot

Quick Reference Clinical Guides for Pediatricians:

Updated and Expanded

Quick Reference Clinical Guides for Pediatricians:

Lead (Pb) Testing: Billing Coding (CPT) and Medicaid Reimbursement Resource Guide

Department of HEALTH & HUMAN SERVICES | Division of Public Health

Pediatric Blood Lead (Pb) Testing: Coding (CPT) Resource

CPT	NH Medicaid Reimbursement (as of Jan 2025)	Description (see reverse for additional CPT descriptor information)	Reference Page NH Medicaid Fee Schedule (as of Jan 2025)
36416	$13.13	Collection of capillary blood specimen	221
83655(QW)	$10.48	Assay of lead (CLIA-waived test, i.e. performing LeadCare II test)	481
96160	$14.39	Administration of patient-focused Health Risk Assessment instrument (i.e. administer and interpret lead exposure risk assessment)	609
99401 99402 99403 99404	$18.40 (15min) $30.65 (30 min) $49.05 (45 min) $61.32 (60 min)	Preventive medicine counseling, individual (i.e. provide anticipatory guidance/preventive counseling on lead exposure)	649
99426 99427	$49.21 (first 30 min) $37.65 (each add'l 30 min)	Principal Care Management services, first 30 (each add'l 30) minutes of clinical staff time (accumulated per month)	650
99424 99425	$65.49 (first 30 min) $47.62 (each add'l 30 min	Principal Care Management, first 30 (each add'l 30) minutes of personally provided by provider (PA/NP must bill incident-to) (accumulated per month)	650

LEAD EXPOSURE RISK ASSESSMENTS (96160)

- Per Bright Futures Guidelines, administer at 6/9/18 month and 3/4/5/6 year old WCC. See more at: periodicity_schedule.pdf
- Administer at 15/30 month WCC based on clinical judgement. Maximum reimbursement of two (2) Health Risk Assessments/year.

MANDATORY TESTING at 12 and 24 month WCC. Do not perform lead exposure risk assessment. Bill 36416 / 83655 if performing test in office.

ANTICIPATORY GUIDANCE/PREVENTIVE COUNSELING (time based, most are 99401)
Providing anticipatory guidance on lead exposure (i.e., providing *Happy, Healthy, Lead-Free Me*! board book and discussing possible sources/harmful effects of lead exposure for children ages 6 months to 72 months).

Department of HEALTH & HUMAN SERVICES | Division of Public Health

Department of HEALTH & HUMAN SERVICES | Division of Public Health

Pediatric Blood Lead (Pb) Testing: Coding (CPT) Resource

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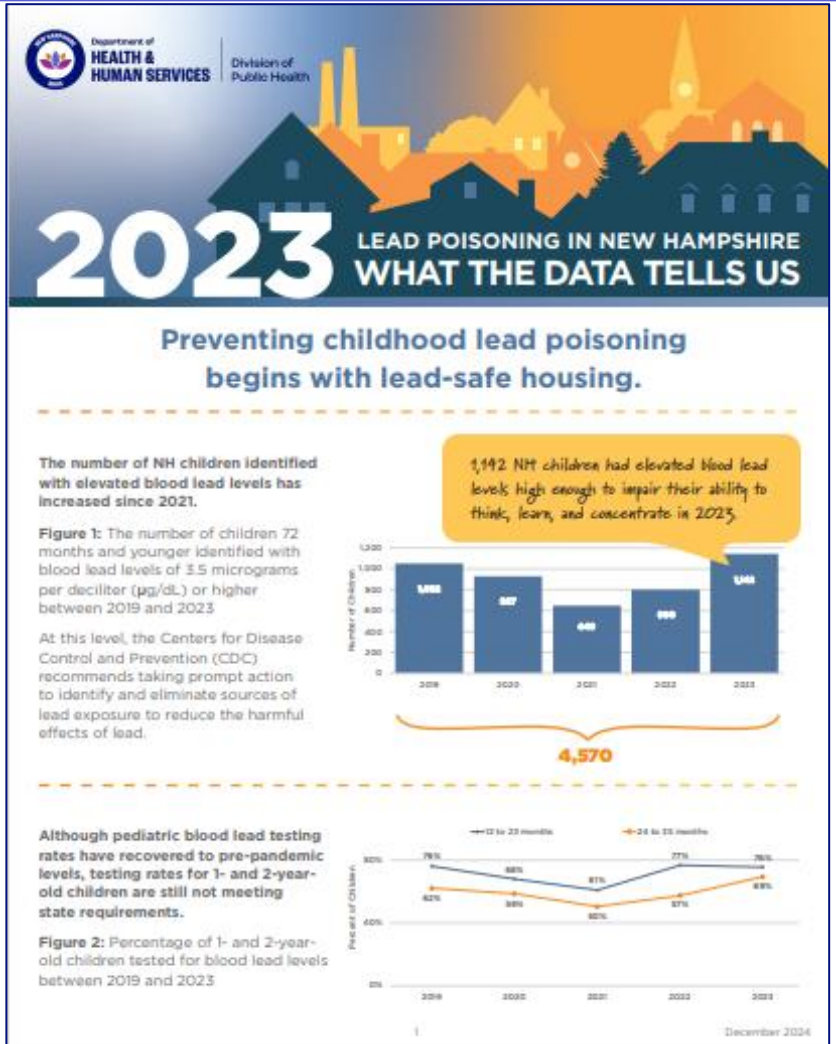
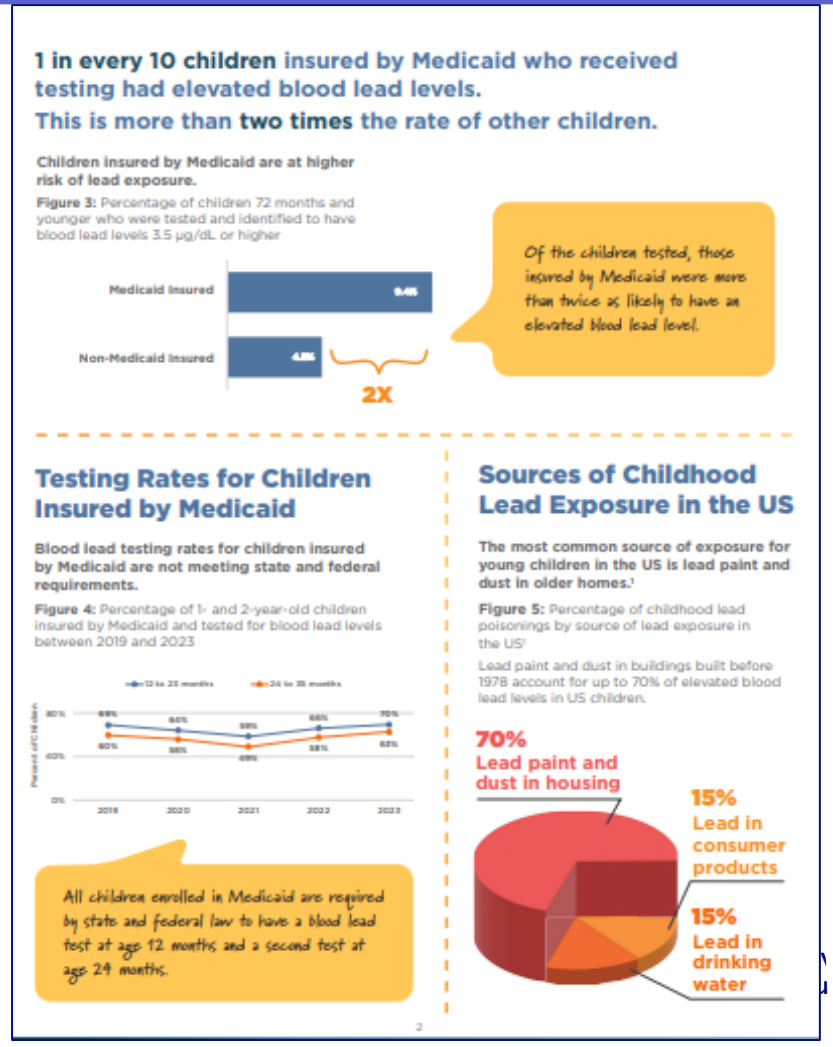
Providing anticipatory guidance on lead exposure (i.e., providing *Happy, Healthy, Lead-Free Me*! board book and discussing possible

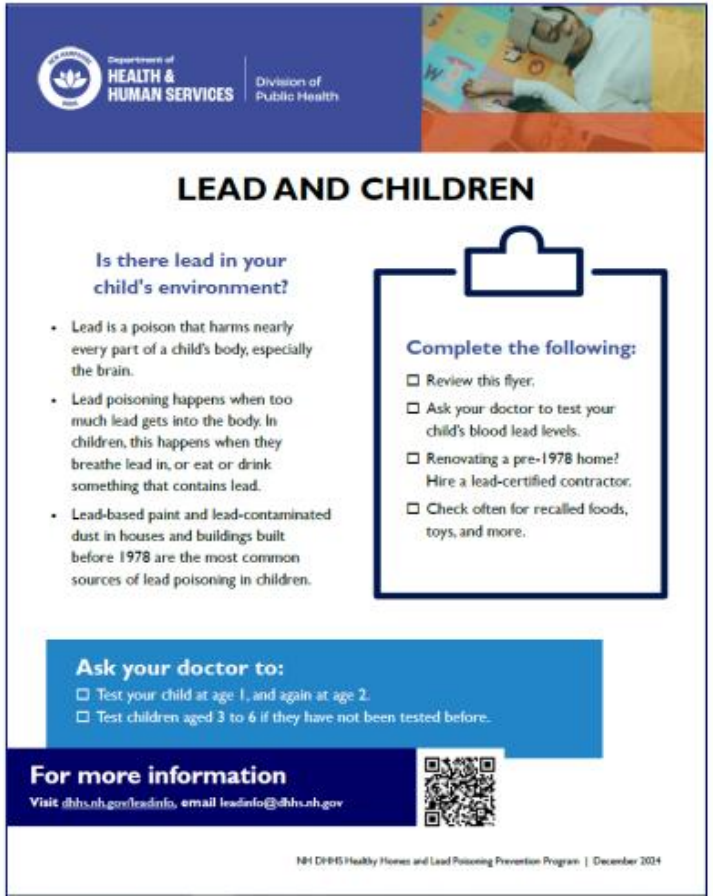
Infographic Format: Easy to Understand **Testing and Exposure Surveillance Data**





Clinical Adjuncts for Anticipatory Guidance

Upgrade Lead Education Resource Sheets



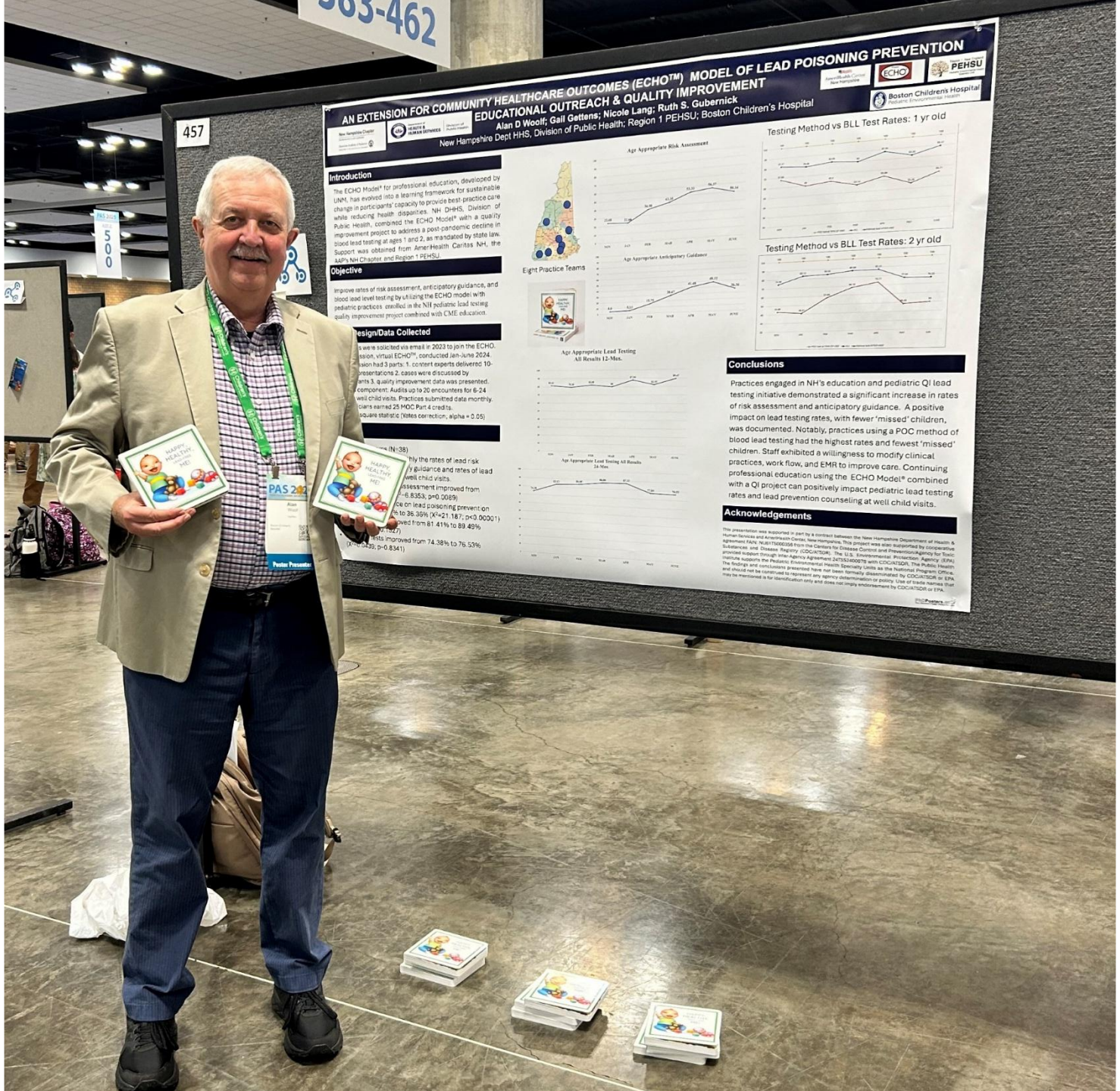
Increase in Providing Anticipatory Guidance:

Providing Happy, Healthy, Lead-Free Me! to *ALL* NH Pediatricians no cost (using NH CLPPP funding) to distribute during WC Visits (optimize 9 months)





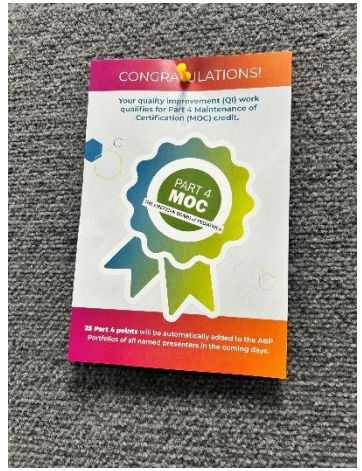

Rich Laracy, MD, Saco River Medical Group, Conway. **Michael Matos, MD**, Wolfeboro Pediatrics. **Sara Currier, PA-C**, Derry Medical Center, Concord **Brian Beals, MD**, Coos County Family Health Center, Berlin. **Christine Arsnow, MD**, Concord Pediatrics, Concord. **Kathryn Hatcher, RN**, Community Health Clinic, Nashua



April 2025

NH Lead Testing QI Project/ECHO

Poster Session



Alan Woolf, MD, MPH, FAAP, FACMT, FAACT
Co-Director, Pediatric Environmental Health Center, BCH
Co-Director, Region 1
New England Pediatric Environment Health Specialty Unit
Professor of Pediatrics, Harvard Medical School
Boston Children's Hospital

Second Cohort

- **November 2025**

  Individual practice on-boarding

- **January - June 2026**

  Six monthly sessions

- **July 2026**

  Last of seven monthly required data submissions

Scan this QR code to complete an interest form, and to ask any questions about participation. Space is limited!
Immediate application is encouraged.

Changing Course: Road Map to Increase Pediatric Blood Lead Level Testing Rates

Part II

The Impact of the HEDIS ® Measure:

Collaborating with state-level Offices of Medicaid Services to Increase BLL Testing Rates

The Last Stretch: Closing the Medicaid Testing Gap

Repeat Performance (with updates)

Selected for Plenary Session Presentations
CDC Childhood Lead Poisoning Prevention Grantee Meeting
Global Communications Center – Atlanta, GA

NH Contracts with Three Insurance Companies To Provide Medicaid Managed Care Plans

Managed Care Organizations = For-Profit Insurance Companies

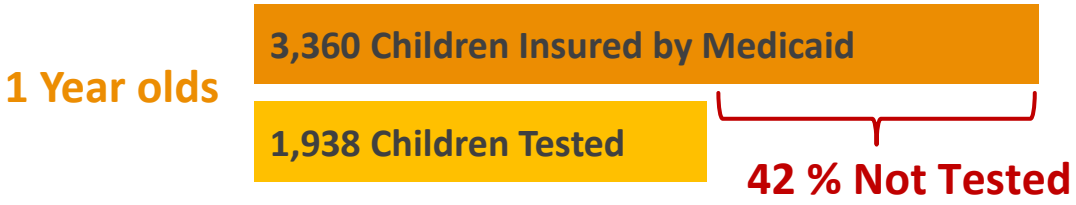
- As of July 2023, **41 states**, including Washington, DC, contract with managed care organizations (MCOs).

- Some of the largest Medicaid MCOs in the country are operated by **Fortune 500 Companies**: CVS Aetna, Centene, Molina, Elevance (Anthem) and United Health Group. Profits in the Billions.

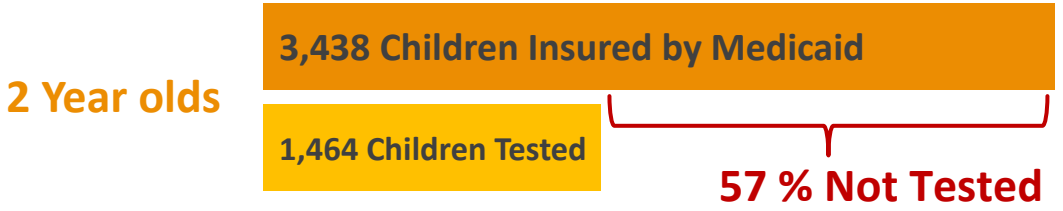
https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/#:~:text=As%20of%20July%202023%2C%2041,)%20on%20April%201%2C%202024.

NH Division of Public Health Services
2018 Annual Lead Surveillance Report

Number of NH one-year olds enrolled in Medicaid tested for blood lead, 2018.



Number of NH two-year-olds enrolled in Medicaid tested for blood lead, 2018.



NH Department Health and Human Services

Division of Public Health Services

We are concerned about NH's low Medicaid lead testing rates.

How do we collaborate for positive change?

Division of Medicaid Services

You must be confused.

NH's testing rates are better than most states.

Is your data incorrect?

NH Department Health and Human Services

Division of Public Health Services

Our surveillance data is accurate.

Two tests required, at 1-yr and, again, at 2-yr olds

Division of Medicaid Services

Our data is accurate.

One test by 2-years of age

New Hampshire Department of
HEALTH AND HUMAN SERVICES

Enter keywords here to search our site...

NH Medicaid Quality

HOME | QUALITY MEASURES A-Z | QUALITY MEASURES BY TOPIC | REPORTS | ABOUT US

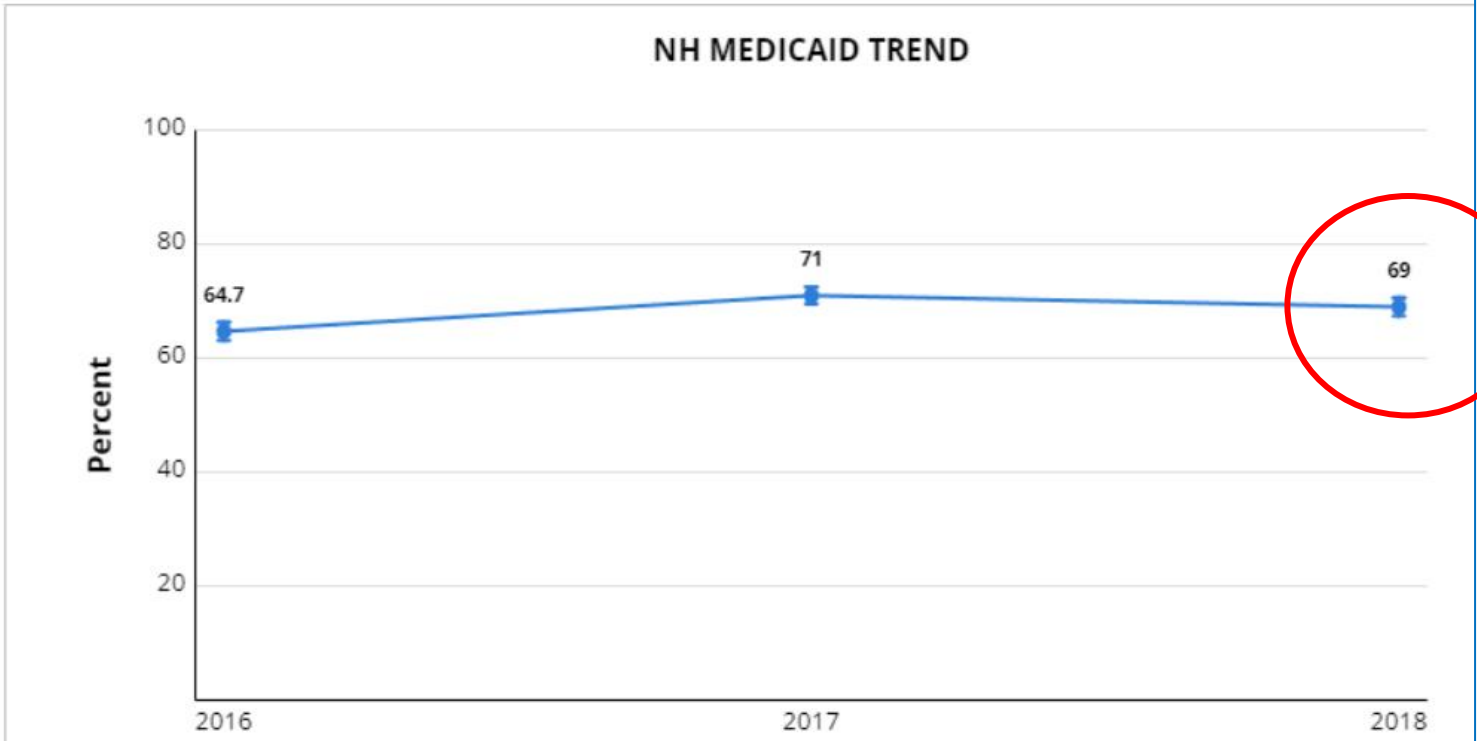
Lead Screening in Children (LSC)

HEDIS® Measurement Definition: The percentage of children 2 years of age who had one or more capillary or ven birthday.

Measure Identifier: HEDIS_LSC

Customize

Trend type: ◉ Line ○ Bar ☐ Hide confidence



69%

What Metrics Are You Using?

Division of Public Health Services

NH Law - Universal Testing

Federal Medicaid Law

American Academy of Pediatrics Recommendations (AAP)

What is a HEDIS Measure?

Division of Medicaid Services

HEDIS® Measure

What do you mean there are two testing requirement?

What Metrics Are You Using?

Division of Medicaid Services

Educate us on requirements for two tests?

NH Law Requires Universal Testing
At Age 1 and, Again, a Second Test, at Age 2

Federal Medicaid Regulations Requires Testing At Age 1 and, Again, a Second Test, at Age 2

Medicaid.gov
Keeping America Healthy

- All children enrolled in Medicaid, regardless of whether coverage is funded through title XIX or XXI, are **required to receive blood lead screening tests at ages 12 months and 24 months**.

- In addition, any **child between 24 and 72 months with no record** of a previous blood lead screening test **must receive one**.

- Completion of a **risk assessment questionnaire does NOT** meet the Medicaid requirement.

American Academy of Pediatrics Periodicity Schedule

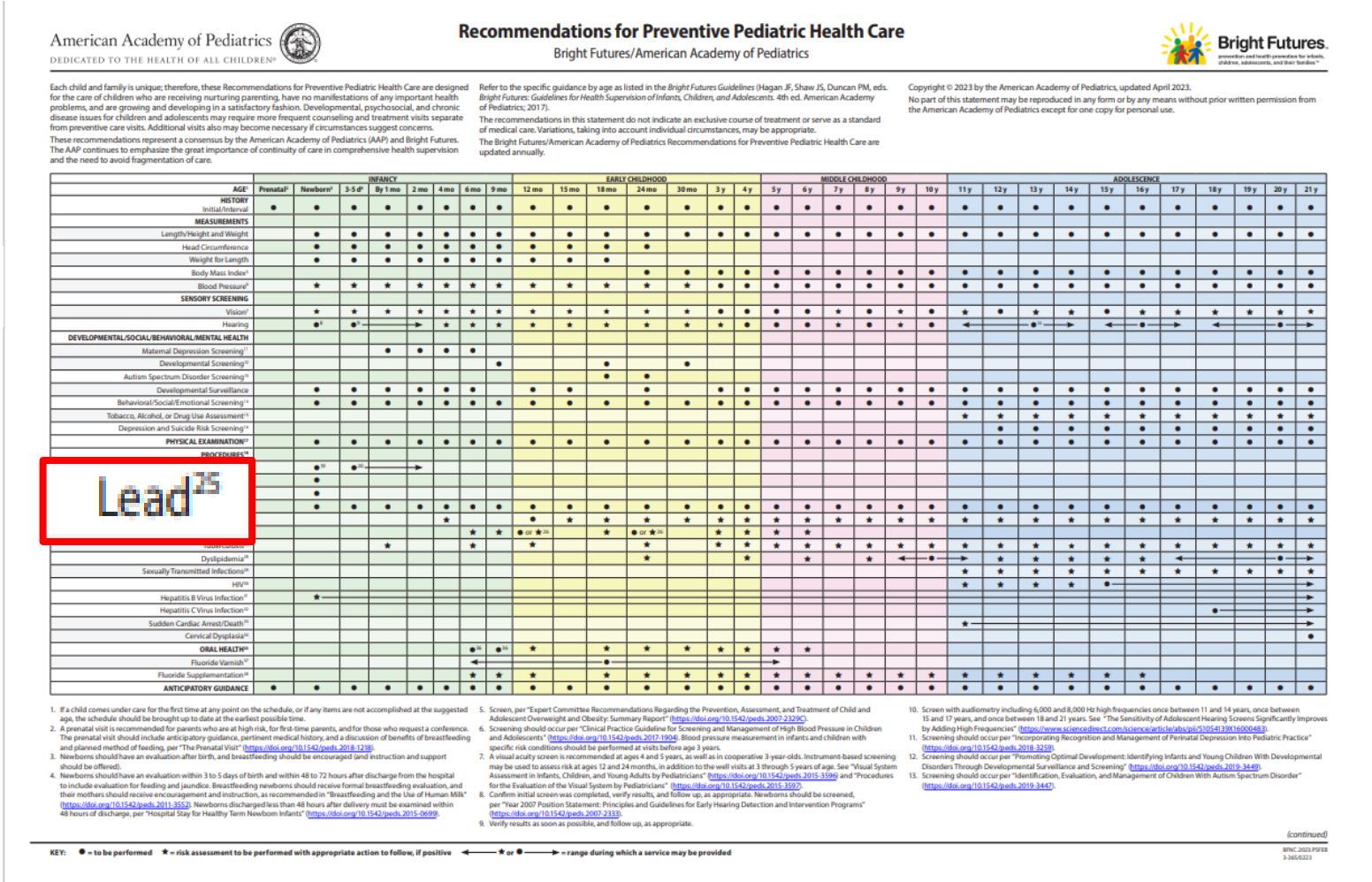
American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Bright Futures

prevention and health promotion for infants, children, adolescents, and their families

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf



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Bright Futures
prevention and health promotion for infants, children, adolescents, and their families

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	INFANCY: By 1 mo	2 mo	4 mo	6 mo	9 mo	EARLY CHILDHOOD: 12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	MIDDLE CHILDHOOD: 5 y	6 y	7 y	8 y	9 y	10 y	ADOLESCENCE: 11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	●	●	★	●	★	●	★	★	★	★
Hearing		●[8]	●[9]	→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	●	[17]	→	←	●	→	←	●	→	
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																															
Maternal Depression Screening[11]				●	●	●	●																								
Developmental Screening[12]								●			●		●																		
Autism Spectrum Disorder Screening[13]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Blood Pressure		●[19]	●[20]	→																											
Lead[25]		●																													
Hematocrit or Hemoglobin		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Urine Culture							★		●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Tuberculosis[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[22]											★			★			★		★	→	●	★	★	★	★	★	←		●	→	
Sexually Transmitted Infections[23]																						★	★	★	★	★	★	★	★	★	★
HIV[24]																						★	★	★	●	→					→
Hepatitis B Virus Infection[7]		★	→																												→
Hepatitis C Virus Infection[25]																													●	→	→
Sudden Cardiac Arrest/Death[26]																						★	→	→	→	→	→	→	→	→	→
Cervical Dysplasia[27]																															●
ORAL HEALTH[28]							●[29]	●[29]	★		★	★	★	★	★	★	★														
Fluoride Varnish[27]							←				●				→																
Fluoride Supplementation[30]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★			
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S305413391630048X).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←★ or ●→ = range during which a service may be provided

BFNC 2023.PSFEB
3-365/0223

Risk Assessment Required at all Well Child Visits

(6 months – 6 years)

Universal Testing Required for Patients with Medicaid

26. Perform risk assessments or lead level testing as appropriate, based on **universal screening requirements for patients with Medicaid** or in high prevalence areas or in accordance with local and state lead level testing madates.

What Metrics Are You Using?

Division of Public Health Services

Educate us about HEDIS® measures?

HEDIS® Measures?
What Are They? Who Establishes Them?

Healthcare Effectiveness Data and Information Set (HEDIS®)

- **90 percent** of health plans, including Medicaid, **use HEDIS® metrics**.
  - Used by both private payers and contracted Medicaid insurance companies.
- **Used to measure performance** on important dimensions of care and service.
- **Used to make comparisons** among plans, health systems, and providers.
- **Established** by the **National Committee for Quality Assurance (NCQA)**, a non-profit, NGO.

How Are HEDIS Measures Used?

- Medicaid MCOs use HEDIS® measures to:
  - Develop **member incentive programs**
  - Develop **physician incentive programs**

- Medicaid MCOs - **financially driven by HEDIS measures**.
  - Paid more and rated based on HEDIS measure performance

What Metrics Are You Using?

Division of Public Health Services

What is the HEDIS® measure for pediatric lead level testing?

HEDIS® Measure Requires Only One Test Lead Screening in Children (LSC)

- The HEDIS® measure for pediatric lead screening is:

  'the **percentage of children who are 2 years old and have had at least one blood test for lead poisoning by their second birthday**.'

https://www.ncqa.org/hedis/measures/lead-screening-in-children/

Member Incentive Programs
$50 Award for ONE test for children ages 0 - 2 years.

WellSense HEALTH PLAN

Extras for kids

OTC

$50 reward for visits and screenings*

Receive a $50 reward for a yearly well visit for children ages 12-17, or a $50 reward for a lead screening for children ages 0-2.

Complete the reimbursement form:
English | Spanish

$50 reward for ONE test.

myhealthpays®

nh healthy families

*It's easy to earn myhealthpays®** reward dollars. And you decide how to use them.*

USE YOUR myhealthpays® REWARDS TO HELP PAY FOR:**

- Utilities
- Transportation
- Telecommunications - Cell Phone Bill
- Childcare Services
- Education
- Rent
- Expenses for Dental, Chiropractic and Other Medical Services

OR, YOU CAN USE THEM TO:

- Shop at Walmart for everyday items**

We will mail your myhealthpays®** Visa® Prepaid Card*** to you upon enrollment. You can keep earning myhealthpays®** rewards by completing more healthy activities. Your rewards will be added to your card once we are notified.

After you complete a healthy activity, we will add the reward dollars you have earned directly to your myhealthpays®** Visa® Prepaid Card***.

Here's what you can earn:

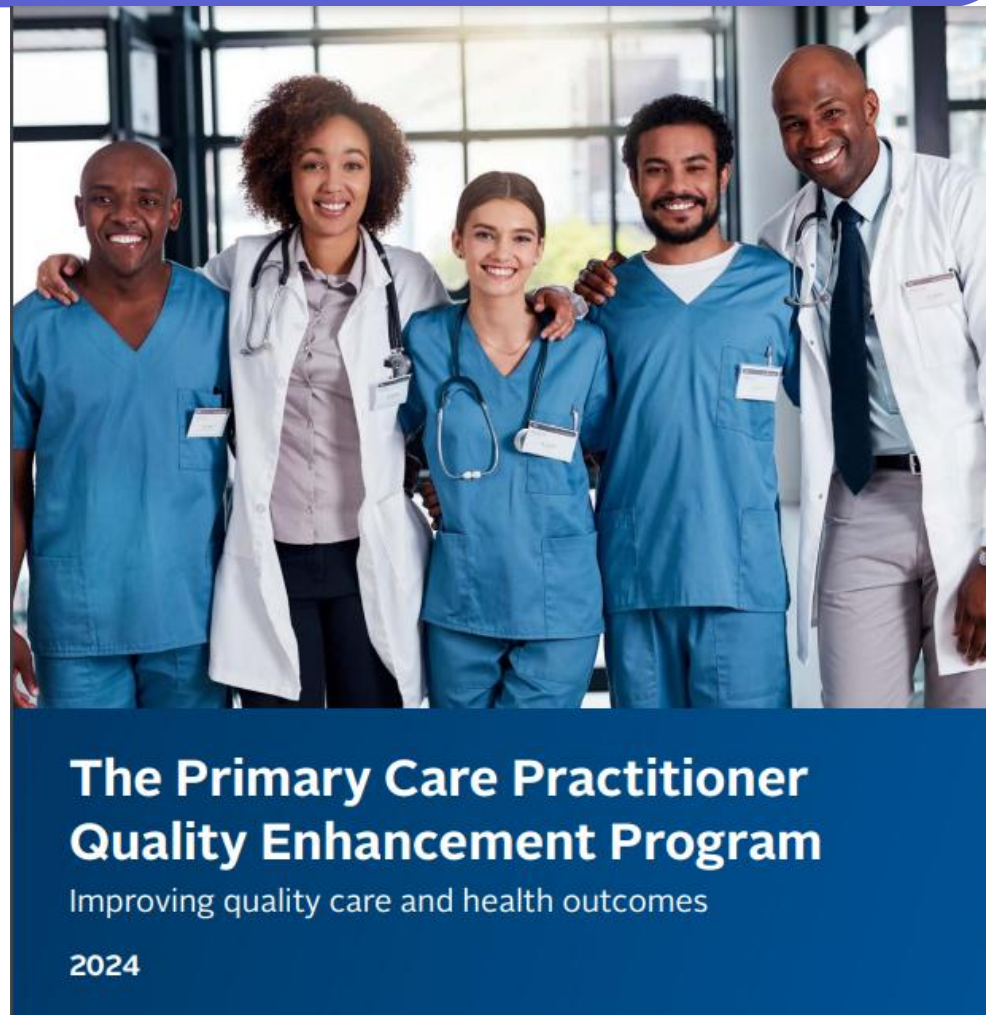
FOR CHILDREN/YOUNG ADULTS		FOR WOMEN		FOR MEN	
Health Risk Assessment Screening Completion	**(Up to $30)** Within 30 days for new members; $15 annually for existing members	Health Risk Assessment Screening Completion	**(Up to $30)** Within 30 days for new members; $15 annually for existing members	Health Risk Assessment Screening Completion	**(Up to $30)** Within 30 days for new members; $15 annually for existing members
Well Baby Visits (15 months or Younger)	**($20 for 6 visits)**	Well Visit	**($20 per year)**	Well Visit	**($20 per year)**
Well Child Visits (24 months-21 years)	**($20 per year)**	Flu Vaccine	**($20 per year)**	Flu Vaccine	**($20 per year)**
Flu Vaccine	**($20 per year)**	Breast Cancer Screening (Ages 40-74)	**($20 per year)**	Prostate Exam (Ages 50 and up)	**($20 per year)**
		Cervical Cancer Screening (Ages 18-65)	**($20)**	Diabetes Care	**($30)**

https://www.nhhealthyfamilies.com/members/medicaid/benefits-services/healthy-rewards-program.html

Physician Incentive Programs
Bonus Payments and Higher Reimbursement Rates

- **Physician** financial incentives include:
  - **Higher reimbursement rates**
  - **Bonus payments.**

- MCOs provide **education and training** for providers on HEDIS® measures
  - Results in provider confusion: BLL testing requirements
  - Medicaid requirements vs. HEDIS



https://www.amerihealthcaritaspa.com/pdf/provider/resources/qep/2024-manual.pdf

Understanding = Reaction = Motivation

Collaboration for Change

Change testing requirements within NH's contracts with insurance companies providing Medicaid managed care plans.

Division of Public Health Services
Division of Medicaid Services

Understanding and agreement that change is needed.

NH, alone, can't change the HEDIS® measure for pediatric lead level testing.

What can WE do?

Lead Testing for 1- and 2-Year-Olds in Alignment with Federal and State Requirements

Required in New Contract Effective 9/1/2024

- In the **first year** of the contract
  - Increase testing rates to **55% for 1-year-olds**
  - Increase testing rates to **44% for 2-year-olds**

- **Each year thereafter** until final year of the contract:
  - Increase testing rates **5% percent <u>each</u> year**

New Contracts Require Reporting on Lead Testing Metrics in Addition to HEDIS® Measure

NEW Metrics

Metric
Pediatric Lead Screening **1-Year-Old Test Completed**
Pediatric Lead Screening **2-Year-Old Test Completed**
Pediatric Lead Screening **Both 1-Year and 2-Year Test Completed**
HEDIS® Lead Screening in Children

State Contract Uses Carrot and Stick Approach

Completion of two pediatric blood lead tests is a selected quality metric

THE CARROT

- **Incentive Program**:
  - Make more money if they increase lead testing rates for 1- & 2-year-olds.
- **Auto Assignment of Members:**
  - Assigned more members if they increase lead testing rates for 1- & 2-year-olds.
- The MCO model is the **more members = more money**.
- **Annual incentive payments** are in the ***millions*** of dollars in New Hampshire

State Contract Uses Carrot and Stick Approach

THE STICK

- **Financial penalties/fines** will be assessed if they **fail to increase lead testing** rates for 1- and 2-year-olds according to the contract requirements.

Per Capitated Approach to MCO Contract Additional Considerations for Some States

- **Per Member Per Month (PMPM):**
  - States Pay MCO insurers flat fix fee per member per month
- **Less Financial Risk for State**
  - Predictable Medicaid budgeting
- **MCO Insurers Assume Risk if Costs Exceed PMPM payments** (they are on the hook)
  - **They <u>Keep the Profits</u> if Costs are Lower than PMPM.**
- **PMPM Approach = Doctors not paid for individual tests or services**
  - MCOs often negotiate discounted rates with commercial laboratories
  - Requiring venous samples or use of testing methods not endorsed by CDC (filter paper)

Per Capitated Approach to MCO Contract
Additional Changes to Consider for Increased Testing

- **Carve Outs: Created by States**
  - Services Not Part of PMPM Fixed
  - Paid Separately through fee-for-service (exist: pharmacy, mental health)
- **Create a "Carve Out" for Lead Level Testing**
  - Reimburse physicians directly (incentive) to test, and test twice.
  - Allow flexibility as to testing method – POC testing
    - in-office, finger-stick only, immediate test results, before family leaves the exam room – no children missed

What We Learned:

- What HEDIS® measures are and who makes them.
- The HEDIS® measure for lead level testing is **one** test by 2 yrs.
- Increasing Medicaid testing rates will only occur with **changes to state-level contracts with insurance companies (MCOs).**
- Importance of **collaborating** with state's Office Medicaid Services
- Need for '**Carve Outs**' in PMPM approach states.
- **Money drives change.**

Update Since Contract Changes: Incentives for Two Tests

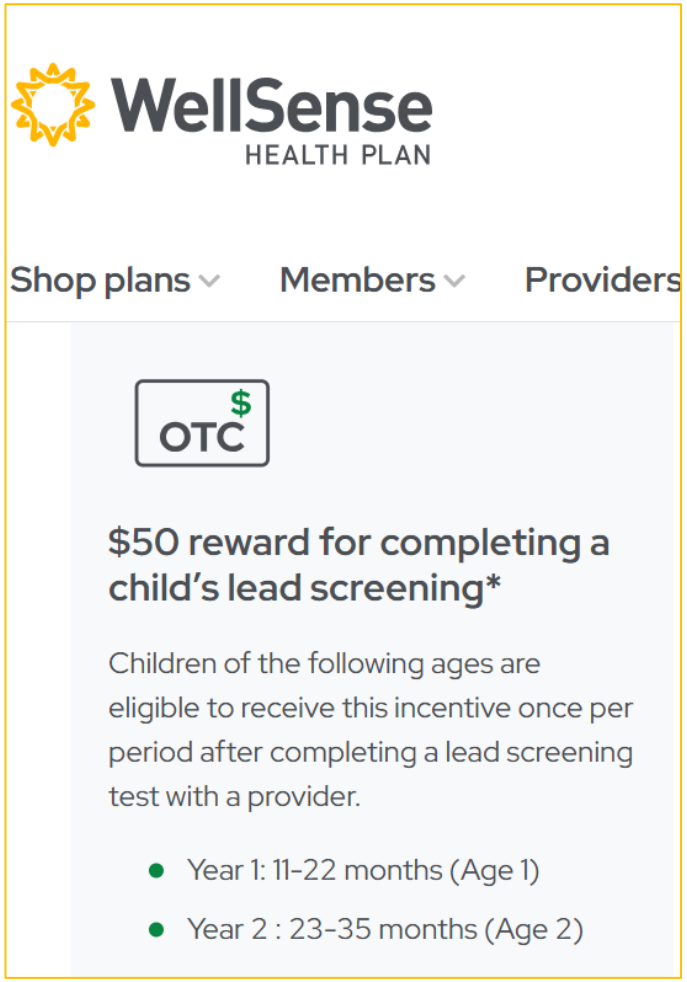
WellSense
https://www.wellsense.org › members › nh › your-extras

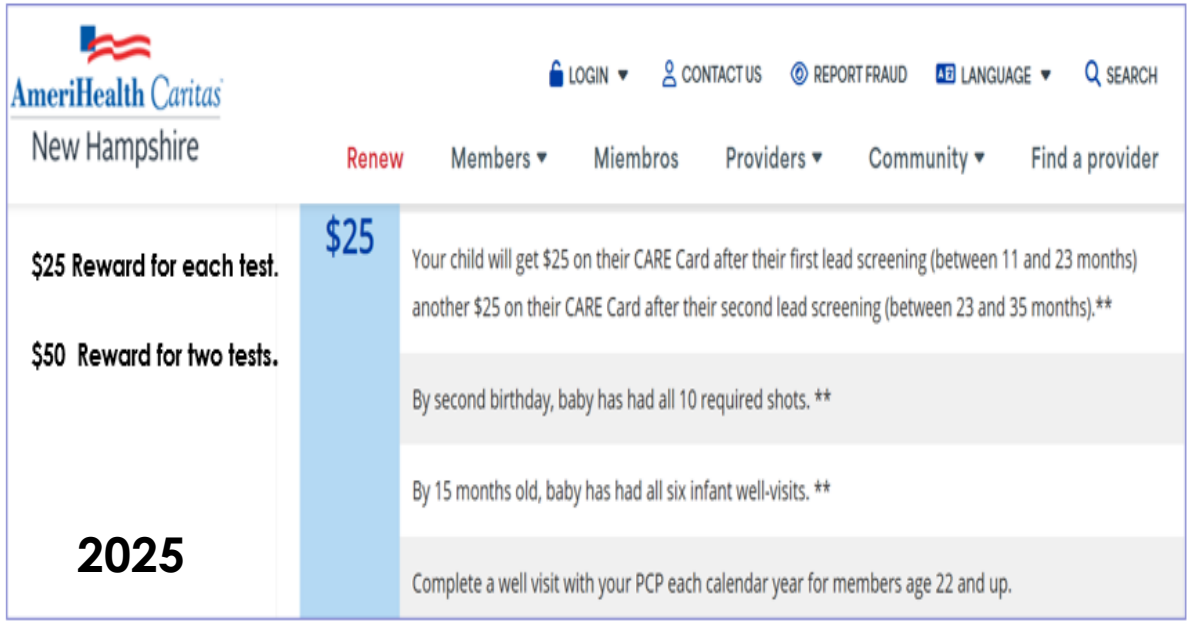
Your Extras | New Hampshire Medicaid

January 2026

$50 Reward for each test.

$100 Reward for two tests.





Changing Course: Road Map to Increase Pediatric Blood Lead Level Testing Rates

Closing:

Tips for An Epic Journey

Road Trip Tips for An Epic Journey:

NH Medicaid Lead Testing Initiatives: 2023 and early 2024

Before Start of New Contract Effective 9/1/2024

- **Annual NH Medicaid Quality Roundtable 2024**
  - One Health Priority – Low Performing Quality Metric
  - Selected Pediatric Lead Testing
  - This is an optional activity that NH does as part of the MCO External Quality Review Organization (EQRO) contract
  - CME/CNE – Subject Matter Expert Speakers
  - Announced upcoming contract changes for lead testing

- **NH Started Incentivizing MCO's to Improve Lead Testing Rates** (1/2024)
  - NH DHHS used unearned "Withhold Money" for $ incentives
  - January 2024 – August 2024 (last 8 months – 'old' NH Medicaid Contracts
  - Announced in Fall of 2023 – $tarted $hift - focus to lead level testing.

NH Road Trip Tips for An Epic Journey

Increasing BLL Testing Rates

- **Collaboration and Partnership:**

  NH Chapter-American Academy of Pediatrics

- **Increasing Point-of-Care (POC) Testing: offering in-office BLL test results**

NH Road Trip Tips for Epic Journey
Increasing Point-of-Care (POC)Testing

- **Increase POC Testing LeadCare II analyzers**
  - NH DPH/CLPPP – actively **endorsed, promoted, granted LeadCare II analyzers**

  to pediatric practices starting 2016. (No lab registration fees, no proficiency testing/CLIA waived
- **Provide site training at deployment on use and reporting**
  - require registration of new LCIIs
- **Set-up and require electronic reporting** (state level DOH - IT)
  - From practice EMR – HL-7 – DPH - for test results

- **Over 75% of NH BLL testing = POC Testing with LeadCare II**
  - All test results come in electronically – POC testing from pediatric offices and commercial labs

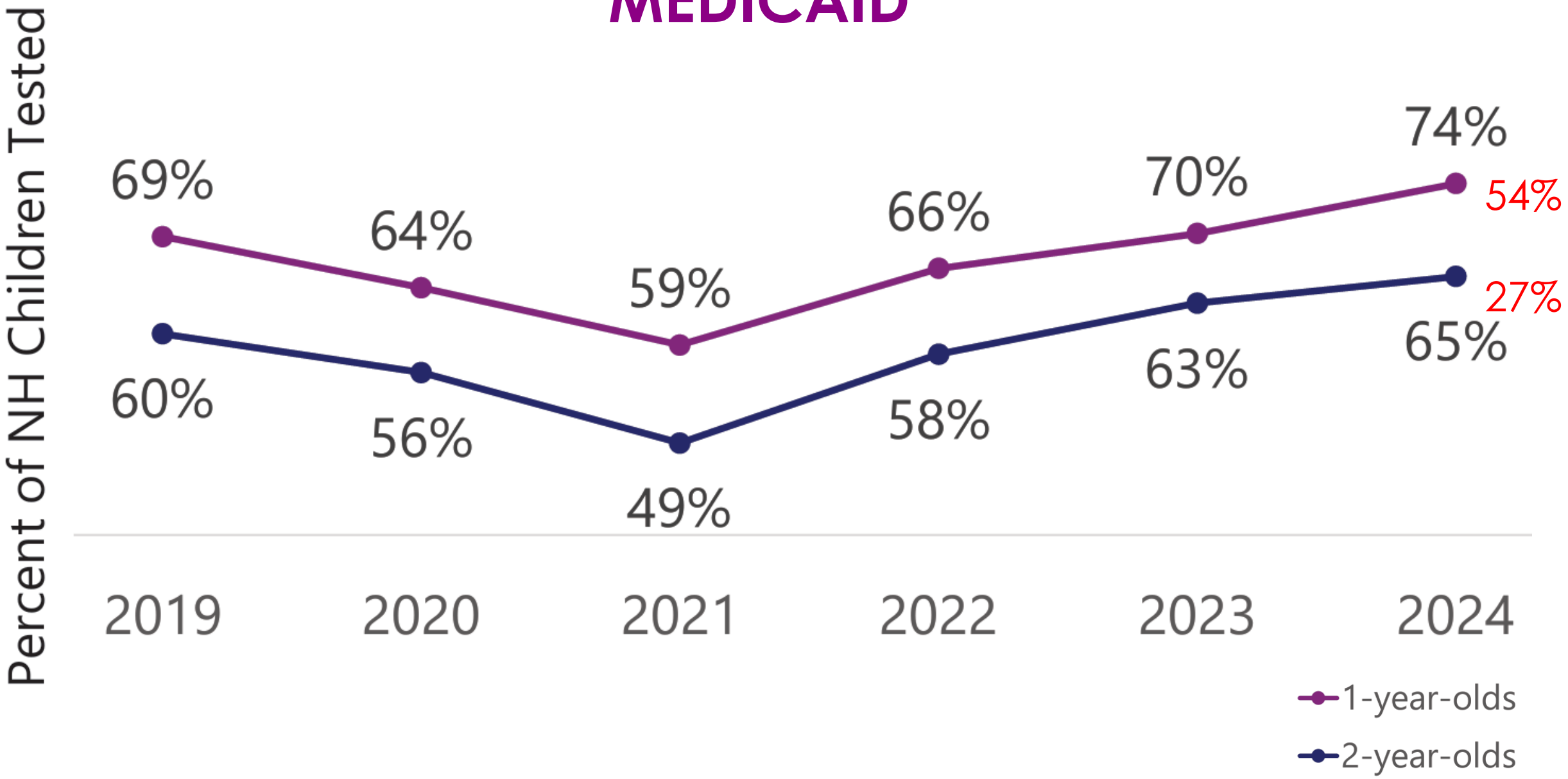
What the Data Tells Us

Impact on Testing Rates

(Did all this work?)

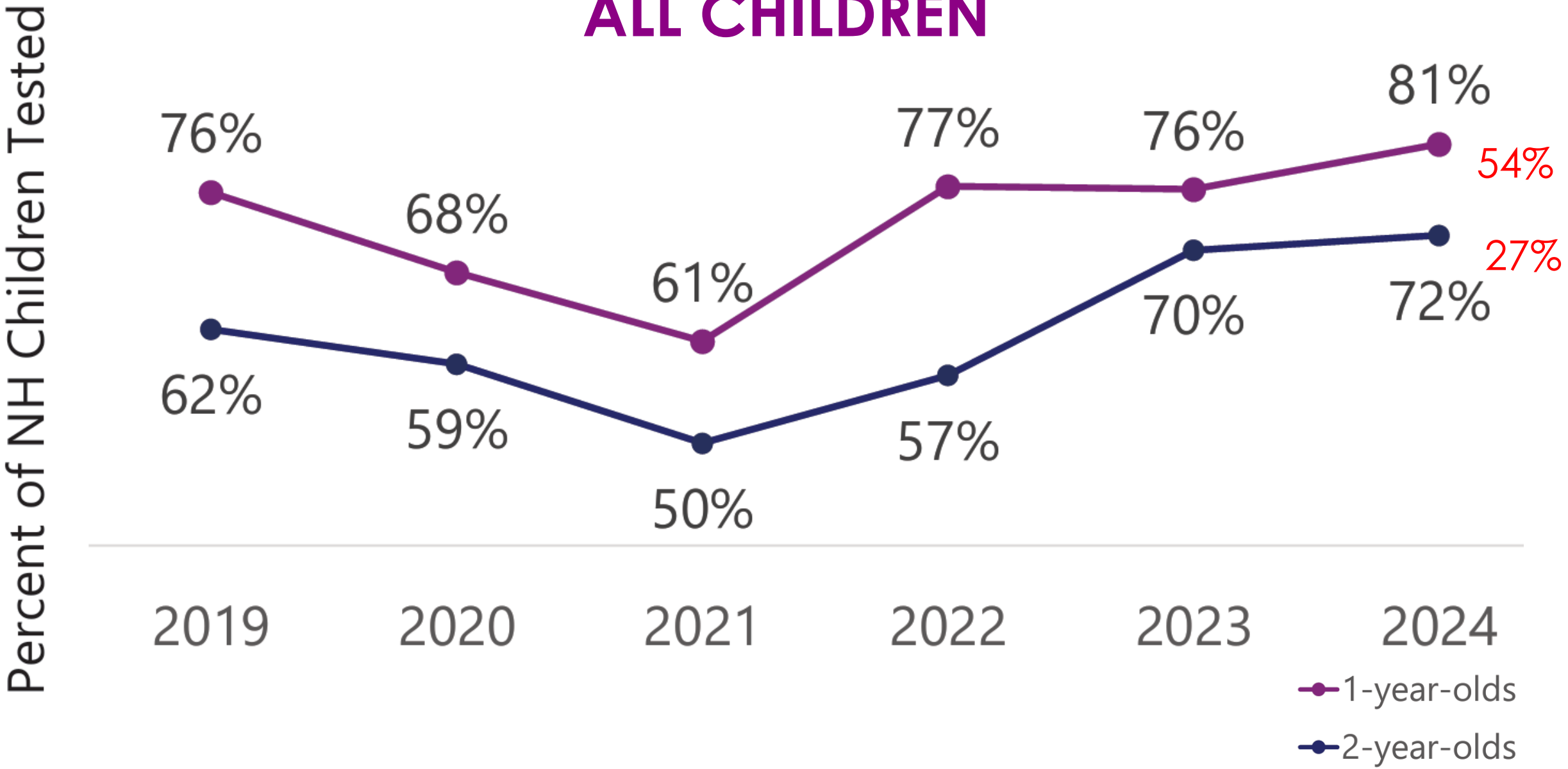
Medicaid Insured Children Tested for Blood Lead Levels

MEDICAID



All NH Children Tested for Blood Lead Levels

ALL CHILDREN



Shout Out to the CDC CLPPP Team

Trina Williams, ScD, MPH, Strategic Communications, Paul Allwood, PhD, MPH, Chief, Cheryl Cornwell, MSPH, Epidemiologist

Questions

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Subject Matter Expert: Point-of-Care Blood Lead Level Testing – CDC's Lead Detect Challenge

Co-Author: Happy, Healthy, Lead-Free Me Learn more: www.leadfree.me

Co-Author: Changing a State's Climate to Increase Blood Lead Level Testing (JPHMP 2019)