STARMHAC Regional Learning Collaborative

Wednesday, March 27th
12:00 – 1:00 PM
Agenda

• Introductions
• Background and announcements
• The care and feeding of your regional collaborative
• Example of building a medical home project
• Discussion
What is STARMHAC?

• Health Resources and Services Administration for inclusive community-based systems of services for CSHCN

• Tx: Statewide Association for Regional Medical Home Advancement

• Partnership with Title V, Texas Children’s Health Plan, Texas Pediatric Society, and Texas Parent2Parent
Components of STARMHAC?

1. Build partnerships
2. Engage family and youth
3. Recruit teams to use continuous quality improvement techniques to increase access to a medical home
4. Promote change and sustainability
Progress

• Partnerships
  – TX Health Home Summit
  – CATCH program
  – Doctors for Change (Houston)
  – Upcoming QI project on engaging teens in transition
Progress

• Engage family as partners
  – Transition Workshops – Plano, San Benito, Austin, New Braunfels, Elgin, San Antonio, & Waco – trained over 140 parents and professionals; upcoming trainings in Lubbock, Amarillo, San Marcos, Corpus Christi, El Paso
  – Supporting 25 parents in transition issues
  – Transition Action Groups (TAGs)- small groups of parents banded together to assist each other create quality lives for their children after graduation; currently have 4 active groups and a facilitator listserv
  – Presented on transition at the statewide Autism and Transition conferences
  – Created a brochure and welcome packet for parents; working on how-to guides, a transition inventory and a webpage
Progress

• Regional collaboratives
  – Training series
  – Identify project to increase access to medical homes
  – Technical assistance available
Examples from other states

• Arkansas
  – A state strategic plan
  – pilot project with Little Rock schools that is generating direct referrals of Hispanic families to the bilingual Arkansas Family-2-Family Health Information Center specialist
  – health care transitions tools piloted by both Title V care coordinators and Children's Hospital services
  – two web sites (by the F2F and the Arkansas AAP) well under development
  – planning a state transitions conference for Year 3
So you want to start a regional collaborative...

- Expectations
- Suggested elements
- Ideas for change
Expectations

• Build a multidisciplinary coalition
• Do a simple QI project designed to improve an element of the medical home
• Collect some basic baseline information about the practices
• Share your results
Suggested elements

1. Establish your coalition
   – Who do you need to be successful?
   – Who are the “players” in your area?
   – Payors are nice for sustainability

Ex: CATCH grants most successful when considering previous relationships and all partners have a stake in the outcome

Obesity initiative with grandparents not successful until partnered with the YMCA
Suggested elements

2. Baseline assessment

- Can be tailored to your project
- Medical home index
- CSHCN screener
- Survey of participants
Suggested elements

3. Consensus on aims
   – What is important to your coalition?
   – What is important to Title V?

Ex: Beware mission drift

CATCH grant on transportation almost derailed by lack of consensus on goal (bus tokens, help understanding schedules, etc)
Suggested elements

4. Quality improvement training
   – Do you have an internal primer?
   – We can provide links and suggestions

5. PDSA
   – What are you trying to change?
   – How will you know a change is an improvement?
   – What changes can result in an improvement?
   – Plan, do, study, act
Suggested elements

6. Sustainability

– Share your results in a meaningful way
– Continue your project

Ex: consider sustainability in picking your outcomes/metrics

Healthy grandfamilies – partnership with grocery store chain led to funding, included grocery store visit and confidence in shopping
Ideas for change

• Transition
• Family feedback
• Care plans
• Open access
• Community outreach
• CSHCN identification and registry
Baylor Transition Medicine Clinic Quality Improvement Project

• Adolescent/young adults with chronic childhood conditions e.g. spina bifida, Down syndrome, cerebral palsy
  – Increase unmeet needs
  – Increase cost
  – Increase ER/hospital stays
  – Disengagement
  – Increase change
Cynthia Peacock, MD

One Example of QI Project
## Comparison of health care expenditures and utilization between CYSHCNs and children without disabilities

<table>
<thead>
<tr>
<th>Category</th>
<th>CYSHCN</th>
<th>Children without disabilities</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days</td>
<td>464 days/1,000</td>
<td>55 days/1,000</td>
<td>8 times higher</td>
</tr>
<tr>
<td>Physician visits</td>
<td>4.6 visits/year</td>
<td>1.9 visits/year</td>
<td>2 times more visits</td>
</tr>
<tr>
<td>Nonphysician professional visits</td>
<td>3 visits/year</td>
<td>0.6 visits/year</td>
<td>5 times more visits</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>6.2 medications/year</td>
<td>1.8 medications/year</td>
<td>3 times the number of prescriptions</td>
</tr>
<tr>
<td>Home health provider days</td>
<td>3.8 days/year</td>
<td>0.04 days/year</td>
<td>95 times more days</td>
</tr>
<tr>
<td>Health care expenditures</td>
<td>$2,669/year</td>
<td>$676/year</td>
<td>4 times the cost</td>
</tr>
<tr>
<td>Out-of-pocket expenditures</td>
<td>$297/year</td>
<td>$189/year</td>
<td>1.5 times the cost</td>
</tr>
</tbody>
</table>

Newacheck, Inkelas, and Kim (2004). Secondary data analysis of 1999 and 2000 Medical Expenditure Panel Survey, with total sample of 13,792 children younger than 18 years of age and overall response rate of 65.5%. All comparisons are statistically significant.
# Medical Home Evaluations – Children With Special Healthcare Needs (CSHCN)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Population Served</th>
<th>Areas of Savings</th>
<th>% of Savings (Reduction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas Children's Hospital, Little Rock, Arkansas</td>
<td>CSHCN: 67.01% Medicaid, 32.94% Commercial, 0.06% Self Pay</td>
<td>Hospital Admissions</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Per child cost</td>
<td>30%</td>
</tr>
<tr>
<td>Colorado Medical Homes for Children*</td>
<td>Medicaid/CHIP</td>
<td>Hospital Admissions</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings per patient</td>
<td>$169-530</td>
</tr>
<tr>
<td>St. Joseph's Children's Hospital, Tampa, Florida</td>
<td>CSHCN: 85% Medicaid, Commercial, Self Pay</td>
<td>Hospital Days</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER Visits</td>
<td>33%</td>
</tr>
</tbody>
</table>

* PCMH site

---


National Association of Children's Hospitals. November 2010 presentation


AIM: Goal To Achieve

• Decrease ER visits and hospital stays
  – Team meeting to agree on plan
  – Define what each team member will do
  – Define ways to ensure success - Huddle
Plan: Proactive Care Coordination

- All patients leaving the office had a return appointment – Front Desk
- All patients who missed their appointment received a call from nurse – MA or RN
- All patients who were advised to follow up with subspecialists were called in-between visits - MA or RN
- The clinic has a reminder system in place for appointments.
How to Measure

- The six vital sign - MA
  - Have you been in the ER or had a hospital stay since your last visit????
  - Recorded with the chief complaint
  - Given a release of information form that is faxed during the appointment
DO: Describe What Happen

• It helped to remind everyone at the weekly team meeting what everyone’s job roles were for the project
• Waiting for one year of data is not rewarding
• The call reminder system doesn’t work well for adolescents/young adults/Medicaid population?
• EHR’s don’t have friendly tickler systems
Study: Results (#of patients visits/ER visits & #of patient visits/unplanned hospital stays)

<table>
<thead>
<tr>
<th></th>
<th>ER Rate</th>
<th>Hospital Visit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-2011</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>2011-2012</td>
<td>7%</td>
<td>11%</td>
</tr>
</tbody>
</table>
ACT: Modifications to the Plan

- Patients lost to follow up before the study started ending up in the hospital and/or ER
- New patients with acute issues needed more hospitalization/ER visits
- Another Clinic similar to ours in Florida found their 3rd year had increase in hospital stays/ER visits
- Patients forget visits scheduled months ahead of time