STARMHAC Regional Learning Collaborative

Tuesday, April 23rd
12:00 – 1:00 PM
Agenda

• Introductions
• Background and announcements
• Case example D70: New Mexico
• Care coordination overview (Janet)
• Care coordination primer (Carl)
• Discussion
What is STARMHAC?

• Health Resources and Services Administration for inclusive community-based systems of services for CSHCN (D70)
• 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
  – TMHI: TX Health Home Summit
  – TPS: Annual Leadership Planning Summit
  – Endocrine/TCH: Upcoming QI project on engaging teens in transition
Progress

• Engage family as partners
## Progress

### Regional collaboratives

<table>
<thead>
<tr>
<th>Location</th>
<th>Leader</th>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston</td>
<td>Dr. Liaw</td>
<td>Remove social work and care coordination for CSHCN</td>
</tr>
<tr>
<td>Houston</td>
<td>Dr. Torres</td>
<td>Systematic family feedback and family advisory group</td>
</tr>
<tr>
<td>Dallas</td>
<td>Dr. Lachman</td>
<td>Medical neighborhood portal for developmental management</td>
</tr>
<tr>
<td>San Antonio</td>
<td>Dr. Huston</td>
<td>Medical home certification</td>
</tr>
</tbody>
</table>
Examples from other states

New Mexico
- Telemedicine
- Overweight
- Nutrition
- Psychiatry
- Asthma

-MOC QI
- Dev screening
- Overweight

http://www.envisionnm.org/index.php/about/
Current QI Projects by Topic

*Note that some of the QI projects fall into more than one topic

Data self-reported for 12 states as of 5/2012 within last 2 years

http://www.uvm.edu/medicine/nipn/?Page=states.html
Models and Best Practice in Care Coordination

Janet Treadwell, RN, PhD
Tuesday April 23, 2013
1. Provide baseline care coordination definition

2. Identify proven care coordination interventions for members with chronic illness
   • Transitional Care
   • Comprehensive Care Coordination

3. Describe key distinguishing features
CARE COORDINATION

A person-centered, assessment based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator.
The majority of healthcare expense occurs in a small percentage of members, primarily with complex chronic conditions.

Therefore, care coordination problems need to be addressed in areas such as:

- Likely situation of continuity gaps (transition, multiple specialties)
- Early intervention (education & self-management plan)
- Psychosocial comorbidities
- Risk of care gaps (chronic care)

Through interventions with rigorous evidence!
TRANSITIONAL CARE MODELS

Care Transitions Intervention (Coleman)

- Patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across care settings.

Transitional Care Intervention (Moyer)

- Neonatal intensive care intervention designed to improve quality of life, and reduce hospital readmissions for NICU graduates.

Adolescent Transition (Gottransition.org)

- Resource support model beginning at age14 designed to promote self-management, satisfaction, and reduce preventable hospitalizations and ED visits.
Integrated Care Management (Holtze, Fallon Community Health Plan)

- Intensive Care Management services are provided to complex, high-risk individuals (1% of patients) with the highest cost, highest ED visits and hospital admissions.

Automated Telephone Self-Management (Ratanawongsa)

- Diabetes management combination of phone technology clinical data sharing and case management showed improved engagement in goal setting with practitioners.
Readmission Risk (Boult)

- Predictive modeling used to identify individuals as being high cost and high risk for future hospital admission. Focus targets on high prediction of admission through home visits. (15% lower ED, 9% more specialists)

Geisinger Care Coordination (Allen)

- Comprehensive teaming of practice and case manager developing shared care plan using predictive modeling for target.
## DISTINGUISHING SUCCESSFUL MODELS

<table>
<thead>
<tr>
<th>MODEL SYNTHESIS</th>
<th>LITERATURE REVIEW</th>
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</thead>
<tbody>
<tr>
<td><strong>Targeting</strong></td>
<td></td>
</tr>
<tr>
<td>• Patients with select chronic conditions including co-occurring behavioral health</td>
<td>• Program targeting to identify the population who can most benefit from a given intervention</td>
</tr>
<tr>
<td>• Those who were hospitalized in previous year or at time of enrollment</td>
<td></td>
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<tr>
<td><strong>Intervention</strong></td>
<td></td>
</tr>
<tr>
<td>• Conduct comprehensive in-home initial assessment</td>
<td>• Baseline and ongoing assessment of health and social needs</td>
</tr>
<tr>
<td>• Develop a mutually agreed upon care plan with goal</td>
<td>• Interdisciplinary approach to allow providers to address a spectrum of health and social service needs</td>
</tr>
<tr>
<td>• Frequent face-to-face contact (home, office) with patients (~1/month)</td>
<td>• Flexible provision of services and service intensity</td>
</tr>
<tr>
<td><strong>Primary Care Provider</strong></td>
<td></td>
</tr>
<tr>
<td>• Strong rapport with practitioners</td>
<td>• Enhanced communication among providers, frequently including the primary care physician</td>
</tr>
<tr>
<td>• Face-to-face contact in rounding</td>
<td></td>
</tr>
<tr>
<td>• Assign all of a physician’s patients to the same care coordinator when possible</td>
<td></td>
</tr>
</tbody>
</table>

## Distinctive Practice Recommendations

<table>
<thead>
<tr>
<th>Patient Education</th>
<th>Training</th>
<th>Community Link</th>
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<tbody>
<tr>
<td>• Providing a strong, evidence based patient education/coaching intervention for managing health, symptoms, medications</td>
<td>• Initial comprehensive training of CCs</td>
<td>• Coordinate communication among physicians, health/community providers and patient/family</td>
</tr>
<tr>
<td></td>
<td>• Performance feedback to CCs</td>
<td></td>
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References


Antonelli, R., Antonelli, D., Providing a Medical Home: The Cost of Care Coordination: Services in a Community-Based, General Pediatric Practice. Pediatrics (Supplement) 2004; Vol. 113: 1522-1528


References


Care coordination primer

Carl Tapia, MD, MPH
Care coordination definition

• Central care to overcome fragmentation

• Multidisciplinary
  – Family-centered
  – Assessment driven
  – Achieve optimal health and wellness

Care coordination

- Models for children with medical complexity?
  - Variety
  - Tiered approach
  - Value different outcomes
Care coordination functions

1. Reconciliation
   - Diagnoses
   - Medications
   - Equipment

2. Goal setting

3. Proactive
   - Follow-up
   - Tracking

4. Written care plan
Care coordination roles

- Written, defined roles for team members
- Written expectations for patients
- Resources
- Outcomes
Dashboard
Baseline data

Family-Centered

Clinic Goals
- Clinical care
- Respect for learners

Outcomes
- Quality Care

Medical Home
- Accessible
- Family centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally effective

TCH Clinic for CYSHCN
Principles of the medical home provide the foundation for a three-tiered approach to quality (patient, clinical, and research domains). Outreach should drive recognized leadership in clinical care, education, and research.

Table of contents
- Inputs: 2
- Outputs: 2
- Outcomes: 3

Texas Children's Hospital

BCM
Becker College of Medicine
Case Management Time (faxes), week of 8/15 to 8/21/2010
School forms excluded
4. **Family-centered care.** A random sample of 30 English and Spanish-speaking patients were selected for a telephone survey. Questions from the CAHMI family survey were used. Up to 4 attempts were made to reach family. The response rate was 60%. In an evaluation using the Medical Home Index, the clinic surpassed average scores for national and local clinics using this scale.

“In the last 12 months, how often did your child’s doctors or other health care providers...”

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take time to understand the specific needs of your child</td>
<td>3.7</td>
</tr>
<tr>
<td>Respect you as an expert about your child</td>
<td>4.0</td>
</tr>
<tr>
<td>Help you feel like a partner in your child’s care</td>
<td>3.6</td>
</tr>
<tr>
<td>Explain things in a way that you can understand</td>
<td>4.0</td>
</tr>
<tr>
<td>Show respect for your family’s values, customs, and how you raise your child</td>
<td>4.0</td>
</tr>
</tbody>
</table>
Medical Home Index Mean Standardized Score

- All practices: 42
- Texas: 46
- SNPC: 63
Outcomes

5. Effective care. Of triaged calls, 75-86% resulted in a clinic visits versus an ER visit. Of patients seen in the ER, 42—66% required admission (much greater than the average local ER admission rate).

<table>
<thead>
<tr>
<th></th>
<th>Jan-10</th>
<th>Feb-10</th>
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</thead>
<tbody>
<tr>
<td>Triaged Calls</td>
<td>174.00</td>
<td>167.00</td>
</tr>
<tr>
<td>Patients Seen in ER</td>
<td>44.00</td>
<td>24.00</td>
</tr>
<tr>
<td>ER Avoided</td>
<td>130.00</td>
<td>143.00</td>
</tr>
<tr>
<td>Avoidance Rate</td>
<td>74.7%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Admitted</td>
<td>29.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Sent home from ER</td>
<td>15.00</td>
<td>14.00</td>
</tr>
<tr>
<td>ER admission rate</td>
<td>65.9%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>159</td>
<td>45</td>
</tr>
<tr>
<td>Average LOS</td>
<td>5.48</td>
<td>4.50</td>
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</table>
### BCM Academic General Pediatrics
#### Care Coordination Documentation

<table>
<thead>
<tr>
<th>Faculty Name___________________________</th>
<th>Date of Service / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name___________________________</td>
<td>MR # _________________________________</td>
</tr>
<tr>
<td>Circle one TCH HCHD</td>
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</table>

#### Primary Diagnosis

<table>
<thead>
<tr>
<th>ICD 9</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

#### Secondary Diagnoses

<table>
<thead>
<tr>
<th>ICD 9</th>
<th>Description</th>
</tr>
</thead>
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</tr>
</tbody>
</table>

#### Care Coordination Activity (Circle one)

- Pt location
  - 0-29min: 99339, 99340
  - >=30min: 99374, 99375
- Home health: 99377, 99378
- Hospice: 99379, 99380
- Nursing home: 99379, 99380

#### Pre-/Post-Care

- 15-29 min: 99358, 99359
- >=30 min: 99358, 99359

#### Team

- 0-59 min: 99361, 99362
- >=60 min: 99361, 99362

#### Telephone calls

- Simple/brief: 99371
- Intermediate: 99372
- Complex/long: 99373

#### Other

- Medical testimony: 99075
- Analysis of clinical data: 99090

#### Outcome (Circle all that apply)

- Prevented
  - Office visit
  - Subspecialist visit
- Resulted in
  - ER visit
  - Hospitalization
- Lab/x-ray
- Other __________________________________________
Today

- EPIC template
- Care manager assistant
- Pilot with McKesson for on-site case manager
- Negotiating care coordination reimbursement
Wrap up: Rate yourself

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**Domain 3: Care Coordination For CSHCN and Their Families**

<table>
<thead>
<tr>
<th>THEME:</th>
<th><strong>Level 1</strong></th>
<th><strong>Level 2</strong></th>
<th><strong>Level 3</strong></th>
<th><strong>Level 4</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>#3.1 Care Coordination /Role Definition</td>
<td>The family coordinates care without specific support; they integrate office recommendations into their child's care.</td>
<td>The primary care provider (PCP) or a staff member engages in care support activities as needed; involvement with the family is variable.</td>
<td>Care coordination activities are based upon ongoing assessments of child and family needs; the practice partners with the family (and older child) to accomplish care coordination goals.</td>
<td>Practice staff offer a set of care coordination activities (<em>see page 16</em>), their level of involvement fluctuates according to family needs/wishes. A designated care coordinator ensures the availability of these activities including written care plans with ongoing monitoring.</td>
</tr>
<tr>
<td></td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
</tr>
</tbody>
</table>

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Wrap-up

• What do you want to do better?