STARMHAC Regional Learning Collaborative

Tuesday, May 28th
12:00 – 1:00 PM
Agenda

• Introductions
• Background and announcements
• Case example D70: Georgia
• Medical Home Certification Program
• Texas Medical Home Initiative
• UT Chosen Clinic QI Project
• 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
5. Transition QI
Progress

• Partnerships
  – CATCH grants
  – Texas Medical Home Initiative
Progress

• Engage family as partners
Progress

- Regional collaboratives

<table>
<thead>
<tr>
<th>Location</th>
<th>Name</th>
<th>Project Description</th>
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<tbody>
<tr>
<td>Houston</td>
<td>Dr. Liaw</td>
<td>Remote social work and care coordination for CSHCN</td>
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<td>Houston</td>
<td>Dr. Torres</td>
<td>Systematic family feedback and family advisory group</td>
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<td>Dallas</td>
<td>Dr. Lachman</td>
<td>Medical neighborhood portal for developmental management</td>
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<tr>
<td>San Antonio</td>
<td>Dr. Huston</td>
<td>Medical home certification</td>
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Progress

• Transition QI

• GLOBAL AIM: Establish an ongoing relationship with a Care Ambassador to improve engagement of diabetic youth aged 14-19 in own care to improve health outcomes

• PARTNERS: Texas Children’s Hospital Diabetes and Endocrinology clinic, Texas Children’s Health Plan

• TARGET: Nonadherent (no visit in six months, no HbA1c in six months, HbA1c >= 9)
Progress

• System measures for intervention
  – Improvement in adherence to visits
  – Number enrolled
  – Improved burden of disease scores
  – Improved perceived relationship / satisfaction
  – Improvement in HgA1c documentation
  – Transition readiness
CASE EXAMPLE
Examples from other states

Georgia
- Transition Toolkit with AFP and AAP chapters
- Teen peer transition trainers

http://health.state.ga.us/programs/specialneeds/index.asp
MEDICAL HOME CERTIFICATION PROGRAM
PCMH in Texas &
The Impact on Your Practice

Vicki Graham, RN
Beverly Young, RN
Diana Burbank, RN

Practice Support Facilitators
Texas Medicaid Wellness Program
The Patient Centered Medical Home

The TransforMED Patient-Centered Model
A Medical Home for All

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: trust, respect, shared decision-making
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care
Access to Care & Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice-Based Services
- Comprehensive care for both acute and chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic & support services
- Ancillary diagnostic services

Care Management
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Care Coordination
- Community-based services
- Collaborative relationships
  - Emergency room
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management
- Care transition

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Case Coordination
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Health Information Technology
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Care Coordination: A continuous relationship with a personal physician coordinating care for both wellness and illness
- Mindful clinician-patient communication:
  - Trust, respect, shared decision-making
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

The TransforMED Patient-Centered Model
A Medical Home for All

15 Texas Medicaid Wellness Program
Provider Outreach

Patient Centered Medical Home Initiative

Objectives

• Educate practices on PCMH model components
• Enhance awareness of PCMH among Medicaid Tier 1 and Tier 2 practices
• Create opportunities for networking and collaboration via TransforMed’s Delta Exchange
• Lead activities at learning collaboratives to encourage implementing PCMH components in practices
Provider Outreach

Overview

226
Providers invited to engage in PCMH model

8
Conference Exhibits at Key Stakeholder Meetings

310
Visits to Tier 1 and Tier 2 Providers

10
Practices currently engaged in PCMH Model

Texas providers have embraced the Wellness Program seeing the value in assisting them with the care of their patients
PCMH Data: Two Year Outcomes Data

Improved Practice Revenue:
• Average annual growth in revenue for practices that participated in the transformation to a medical home pilot increased 11% on average

Improved Physician Salaries:
• 14% increase in salaries with no new money from outside sources

Improved Efficiencies/Quality:
• Average reduction in cycle time of 12 minutes over the course of being transformed to a medical home

Improved Provider/Staff Satisfaction:
• Overall provider satisfaction increased 58%
• Staff satisfaction increased 66% with 82% indicating that they prefer the patient centered medical home
Additional data reported: Improved Financial Outcomes

Average Net Revenue per practice
- 24% to 36% increase
- Average increase = 30%

Decreased total practice overhead
- 2% to 48% decrease
- Average decrease in practice overhead = 22%

Decreased staff costs as a percentage of net revenue
- 3% to 79% decrease in staffing costs
- Average decrease in staff overhead = 31%
# Why PCMH Matters

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<thead>
<tr>
<th>Physicians &amp; Staff</th>
<th>Patients</th>
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<tbody>
<tr>
<td>Happier staff</td>
<td>Improved satisfaction</td>
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<tr>
<td>Happier physicians</td>
<td>Improved preventive care</td>
</tr>
<tr>
<td>Increased net revenue</td>
<td>Improved quality measures</td>
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<tr>
<td>Increased take-home pay in today’s environment</td>
<td>Reduced ED utilization</td>
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<td>Team-based care</td>
<td>Reduced readmissions</td>
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<td>Relatively rapid returns from transformation</td>
<td>Reduced hospitalizations</td>
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<td>Increased standardization of care</td>
<td>Longer team-based appointments; enhanced communication</td>
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<td>Reduced per capita cost for certain chronic conditions</td>
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Why Become a PCMH?

Improved Outcomes!

• Quality
• Chronic Disease
• Satisfaction
• Efficiency (cost savings)
• Practice Financials
Questions?

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Vicki Graham, RN, BSN 832-516-1242
• Northeast & Southeast Texas – Regions 4, 5, 6

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• West/South Texas/Valley – Regions 8, 9, 19, 11
TEXAS MEDICAL HOME INITIATIVE
SUE BORNSSTEIN
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