STARMHAC
Regional Learning Collaborative Webinar
Dec 20, 2012
Agenda

- Introductions
- Background
- Medical homes examples
  - Current models
  - Embedded case management
  - TX P2P transitions project
  - Parent navigators
- 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
  - Engaging community-based health plans
  - Children’s Policy Council
  - Medical Home Workgroup
- Engage family as partners
  - TxP2P creating Pathways to Adulthood Transition Center
Progress

- Regional collaboratives
  - Training series
  - Identify project to increase access to medical homes
  - Technical assistance available
Current models: Medical homes
20% of children account for almost 70% of spending

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Chronic conditions</th>
<th>Complex &amp; chronic</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy kids with acute conditions</td>
<td>Single, low acuity condition</td>
<td>Complex and multiple conditions</td>
<td>Life-threatening</td>
</tr>
<tr>
<td>Pneumonia, UTI</td>
<td>Asthma, ADHD</td>
<td>Heart disease, cancer, cystic fibrosis</td>
<td>Vent-dependent, transplant</td>
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Face of CSHCN
## What works?

<table>
<thead>
<tr>
<th>Author</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criscione et al (1995)</td>
<td>RCT NP case management</td>
<td>N=115 Over $200,000 savings in hospital charges</td>
</tr>
<tr>
<td>Liptak et al (1998)</td>
<td>Case management by 11 FTE for “wraparound” services</td>
<td>N=10, 715 $77.7 million savings</td>
</tr>
<tr>
<td>Antonelli et al (2008)</td>
<td>Care coordination measurement tool in primary care</td>
<td>N=3172 26% decrease in ER visits</td>
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</table>
What works?

- Baseline / Chronic conditions
  - Standardize care (identification, registries)
  - Medical summary
  - Improved access to medical home
What works?

- **Complex**
  - Care coordinator / key contact
    - Familiar with the patient
    - Elicit family goals
    - Facilitate prior authorization
    - Assist family in accessing community resources
  - Medical home
    - Facilitate communication among medical professionals
    - Avoid duplication and unnecessary costs
What works?

- Critical
  - High intensity, “complex” care coordination
    - Face–to–face (hospital, in practice, in home)
    - Facilitate transitions (new diagnosis, hospitalizations, school changes, change in health status)
    - Care plan focus of care
## Tiered care coordination

<table>
<thead>
<tr>
<th></th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient</strong></td>
<td>Low complexity Episodic needs</td>
<td>Moderate complexity Chronic needs</td>
<td>High intensity High needs</td>
</tr>
<tr>
<td><strong>Supports</strong></td>
<td>Information</td>
<td>Service contracts</td>
<td>Home visits</td>
</tr>
<tr>
<td></td>
<td>Appointment coordination</td>
<td>Care plan</td>
<td>Complex case management</td>
</tr>
<tr>
<td></td>
<td>Care summaries</td>
<td>Self-management supports</td>
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Care coordination now

- NSCHSCH (childhealthdata.org)
  - 17% of families spent 5–10 hours a week
  - 60% of families have cut back or stopped work

  - Most families get care coordination with PCP
  - Only 23% include school
  - Only 41% always assessed family needs
Care coordination potential – Level 1

- Comprehensive health assessment via standardized screening
- High risk patients automatically flagged for outreach
- Automatic flags for missed referrals and labs
- Care summaries generated at every encounter
- EMR used and shared to track progress toward goals
Care coordination potential – Level 2

- High risk patients automatically flagged for outreach
- Care plans drive care
- Seamless access to specialists when needed
- Patient education material is accessible
Care coordination potential – Level 3

- Specialty care coordination by experienced team
- Home visits
- Family experience and quality of life frequently measured
Partners

- Level 1: lay navigators, office staff
- Level 2: dedicated staff, health plan
- Level 3: tertiary center
Example of embedded care coordination

Janet Treadwell
TCHP MEDICAL HOME PILOT CASE MANAGER ROLE

1. Population management
   - Identify patients with care gaps
   - Facilitate patient access [call, mailings]

2. Care coordination
   - Build relationships with families & with care team
   - Conduct assessments of needs & strength
   - Develop care plan
   - Support specialty/PCP communication
3. Quality improvement

- Medical home index
- Collaborate with families, engaging for input & satisfaction
- Encourage quality improvement within the practice setting
# MEDICAL HOME INDEX OVERVIEW

<table>
<thead>
<tr>
<th>Domain 1: Organizational Capacity: For CSHCN and Their Families</th>
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<tbody>
<tr>
<td><strong>THEME:</strong></td>
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<tr>
<td>#1.1 The Mission of the Practice</td>
</tr>
<tr>
<td>#1.2 Communication/Access</td>
</tr>
<tr>
<td>#1.3 Access to the Medical Record</td>
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**Source:** [http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Full-Version.pdf](http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Full-Version.pdf)
USE OF THE MEDICAL HOME INDEX AS A BASELINE ACROSS FIVE NETWORK SITES (TCHP)
### ADMISSIONS PER THOUSAND COMPARISON OF CHANGE ACROSS FIVE MEDICAL HOMES (TCHP)

<table>
<thead>
<tr>
<th>SITE</th>
<th>BEFORE adm/1000</th>
<th>AFTER adm/1000</th>
<th>P</th>
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<tbody>
<tr>
<td>H</td>
<td>36.06</td>
<td>19.30</td>
<td>p=.0056</td>
</tr>
<tr>
<td>I</td>
<td>159.96</td>
<td>76.98</td>
<td>p=.0000</td>
</tr>
<tr>
<td>J</td>
<td>43.13</td>
<td>29.82</td>
<td>p=.1101</td>
</tr>
<tr>
<td>K</td>
<td>57.26</td>
<td>27.88</td>
<td>p=.0001</td>
</tr>
<tr>
<td>L</td>
<td>81.12</td>
<td>47.62</td>
<td>p=.0028</td>
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DAYS PER THOUSAND CARE COORDINATION IMPACT IN MEDICAL HOMES
Example: Medical Home H (TCHP, Houston)
DAYS PER THOUSAND CARE COORDINATION
IMPACT IN MEDICAL HOMES
Example: Medical Home K (TCHP, Houston)

![Graph showing before and after days/1000 Dr. K](image)

- Individual Value
  - \( X = 93.5 \)
  - UCL = 187.7
  - LCL = -0.7

- Moving Range
  - MR = 35.4
  - UCL = 115.7
  - LCL = 0
DAYS PER THOUSAND CARE COORDINATION IMPACT IN MEDICAL HOMES
Example: Medical Home L (TCHP, Houston)
How to Start

1. Identify practices with large CSHCN volume
2. Hold meeting with PCP & Office Manager explaining concept – human and information capital to support their practice
3. Meet with all staff, explaining roles
4. Conduct Medical Home Index using information with team to select quality project
5. Provide registries and pharmacy fill data
6. Conduct call and mail outreach, teaming with scheduler
Value Add to Practice

- Developmental screen completion (ASQ)
- Explanation of Asthma action plan/inhaler use
- Attend visit to provide later support to family of adherence to prescribed treatment
- Co–develop care plan after patient visit
- Outreach to obtain specialty assessments
Texas Parent to Parent
Texas HRSA Grant
Laura Warren & Rosemary Alexander, PhD
Texas Parent to Parent is a state-wide non-profit that provides support, information and education to families of children/youth with disabilities, chronic illness and other special health care needs. We help families build a community through connections with other parents. We do this through one-on-one peer support (referred to as a “match” and based on evidence-based best practices), trainings, quarterly newsletters, listservs, an annual conference, and any other way we can identify. The majority of our staff and Board of Directors are parents or family members of a child with a disability.
TxC2P’s Pathways to Adulthood

- Statewide transition program for CYSHCN, their families, and the professionals who work with their children
With this grant, TXP2P will

- Give parents the emotional support and information needed to build high quality lives for their children after public school ends
- Disseminate information on transition via mail, email, website, calls to TXP2P office and 1–day workshops around the state
With this grant, TXP2P will

- Offer 1–1 matches for transition support
- Create local Transition Action Groups (TAGs)
- Help parents answer the question, where will my child live, work and make friends after graduation?
Parent Navigator

Elaine Hime
The Center Sub-Activation Committee on Patient Education – Draft Work Flow for Appointment for Children with Chronic Health Care Needs

**Arrival and Check-In – education starts here**

- **Front Desk Clerk** – checks family in and provides family with 1) required forms, 2) disease specific forms, 3) Healthcare Survey, 4) Social Needs Survey and explains process to family (educational piece).
- **Family completes required forms in waiting area and returns to Front Desk Clerk, keeps Disease Specific Forms, Healthcare and Social Needs Surveys Survey**
- **Required forms are placed in chart for PCP.**
- **Medical Assistant (M.A.) escorts family to Exam room.**

**Pre-Exam**

- **M.A. checks family into exam room and assists the family to complete Healthcare and Social Needs Survey if needed, explains process to family (educational piece) and completes vital signs with any modifications for child’s special needs with guidance from the family.**
- **M.A. places Healthcare Survey in chart for PCP. Gives Case Manager (C.M.) and Parent Navigator (P.N.) Social Services Survey.**
- **C.M. and P.N. enter and discuss Social Services Survey with family to access preliminary needs (education piece).**
- **With PCP and Nurse entering, C.M. and P.N. leave to research family’s social needs to add to Plan of Care.**

**Exam**

- **PCP and Nurse reviews disease, address family’s concerns from Healthcare Survey, completes exam and discusses Plan of Care with family.**
- **C.M. enters exam room towards the end of exam for assisting with Plan of Care.**
- **Outside exam room, PCP or Nurse confers with C.M. and P.N. about Family’s needs.**
Post-Exam - area outside exam room

Nurse and PCP finalizes Plan of Care

Nurse with P.N. discuss with family finalized Plan of Care and initiates "Teach Back" working with family to teach back the plan to check that family understands when explaining to other family members and to discover any barriers to adherence. Nurse with family schedules follow-up appointment.

C.M. and P.N. finalized Plan of Care with the social needs with family as Nurse gathers doctor’s orders, prescriptions, excuse for school, follow-up appt. scheduled.

Check-out

With coordinating scheduling with other families of children with chronic health care needs, P.N. facilitates a parent group for networking and sharing.

P.N. follows up with a home visit with family to see process and discuss subsequent needs and any barriers. Discusses subsequent family’s needs with the C. M.
Examples of Parent Navigators

Rhode Island Pediatric Practice Enhancement Project (PPEP) – trained Parent Consultants in pediatric primary and specialty care practices.

- assisting families and providers in accessing community-based resources and specialty services.
- help identify barriers to effective care coordination
- Cost effective for CSHCN – reduction in use of in-patient and ER use as their care in coordinated
- Parent Consultants in 24 sites, serving 4,200 families over a 5 year period
- http://www.hdwg.org/catalyst/ParentConsultant Video
Examples of Parent Navigators

Stone Soap Group, Alaska – provide Parent Navigators in various types of pediatric clinics such as Neurodevelopmental, Long-term Infant Follow-up and Evaluation Clinic, and the Sub-Specialty Clinics at Children’s Hospital at Providence Hospital

- Assist the family in identifying and prioritizing their needs
- Provide referrals to community programs designed to enhance the lives of all family members
- Provide emotional support including before, during and after evaluations or assessments
- Act as a liaison between a clinic and the family, developing the child’s medical home
Examples of Parent Navigators

- Nebraska – Project Launch with 6 Parent to Parent Consultants. Developing with consults with the Hali Project’s Brad Thompson of North Texas and the Rhode Island PPEP Program model.

- Utah – through Utah’s New Freedom Initiative, Parent Partners are hired to provide information and support to families of CYSHCN and are recognized as equal members of the medical home practice teams.
Expansion of Family Partner in Texas

Family Partners Recommendation, *Texas Children’s Policy Council Legislative Recommendations for Children’s with Disabilities for 2012* – “Utilize the Balancing Incentive Program to expand the Medicaid State Plan Family Partner Certification process for children with special needs and developmental disabilities, similar to the current Family Partner certification program designed to serve families of children and adolescents receiving mental/behavioral health services.” Currently Family Partners who are trained and certified through Via Hope become qualified providers of rehabilitative services as employees or contractors of a Medicaid enrolled provider.
Discussion

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