National Standards for Systems of Care for Children and Youth with Special Health Care Needs

**What:** the consensus of national experts across multiple systems

**Why:** designed to help communities and states build and improve systems of care for CYSHCN

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**Screening, Assessment and Referral**

**Eligibility and Enrollment**

**Access to Care**

**Medical Home:**
- Pediatric Preventive and Primary Care; Care Coordination; Pediatric Subspecialty Care

**Community-based Services and Supports:**
- Respite Care; Palliative and Hospice Care; Home-based Services

**Family Professional Partnerships**

**Transition to Adulthood**

**Health Information Technology**

**Quality Assurance and Improvement**

**Insurance and Financing**

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*Disclaimer:* The National Standards are meant to supplement, not substitute, federal statute and regulatory requirements under Medicaid, the ACA and other relevant laws and are intended for use or adaptation by a wide range of stakeholders at the national, state and local levels.
8 Standards focus on:
- Early identification including newborn screening
- Needs identified by insurance plans
- EPSDT and Bright Futures
- Documented, transportable plans of care

Relevant System Partners:
- Health Plans/Insurers
- Primary Care
- State
- Families
Screening, Assessment and Referral (8 Standards)

**Health Plans/Insurers**
- SA1. Consistent identification mechanism for CYSHCN upon enrollment and transfer
- SA2. Prompt initial assessment of CYSHCN after enrollment; conducted with family or caregiver
- SA4. Documented plan and process for follow-up with state and/or hospital when newborn screening results are not received
- SA5. Periodic screening for physical, oral, mental, developmental and psychosocial needs in accordance with Bright Futures Guidelines

**Primary Care**
- SA4. Documented plan and process for follow-up with state and/or hospital when newborn screening results are not received
- SA5. Periodic screening for physical, oral, mental, developmental and psychosocial needs in accordance with Bright Futures Guidelines
- SA6. Coordination and sharing of periodic screening and results
- R1. Referrals are made to all needed services and agencies and follow-up provided to ensure connections and coordination
- R2. Screening, referral and follow-up protocols and documentation methods in place

**State**
- SA3. Timely sharing of Newborn Screening information with providers and parents; follow-up services are arranged and documented
- SA5. Periodic screening for physical, oral, mental, developmental and psychosocial needs in accordance with Bright Futures Guidelines
Relevant System Partners:
• Health Plans/Insurers
• Health care providers
• State
• Families

6 Standards focus on:
• Outreach & coordination with community organizations
• Policies for transitions between plans and for gaps in coverage
• Comprehensive member services with specialty staff

Eligibility and Enrollment
Percentage of CYSHCN who have adequate insurance to pay for the services they need
Medical Home Index: Care coordination
Access to health services
# Eligibility and Enrollment (6 Standards)

## Health Plans/Insurers

1. Enrollment outreach includes CYSHCN-specific strategies and coordinate with family organizations
2. Continuity of care ensured during periods of enrollment and transition
3. Written policies and procedures for transitioning between non-network and network providers
4. Written policies and procedures for newly enrolled CYSHCN to continue to see out-of-network providers for up to 6 months
5. Comprehensive member services with specialized staff and linkages to family organizations
6. Culturally and linguistically appropriate written and oral information regarding eligibility and enrollment at state and/or hospital when newborn screening results are not received

## State

1. Enrollment outreach includes CYSHCN-specific strategies and coordinate with family organizations
2. Continuity of care ensured during periods of enrollment and transition
3. Written policies and procedures for transitioning between non-network and network providers
4. Written policies and procedures for newly enrolled CYSHCN to continue to see out-of-network providers for up to 6 months
Relevant System Partners:
- Health Plans/Insurers
- Primary Care
- State
- Families

5 Standards focus on:
- Statewide access
- Physical, mental health, dental and specialty care - with provider choice
- Transportation and interpreter supports

Access to Care
- Percentage of CYSHCN who have adequate private and/or public insurance
- NCQA: Track and coordinate care
- Medical Home Index: Chronic condition management
- Access to health services
Health Plans/Insurers
• 2. Pediatric specialists who are the demonstrated clinical coordinator of care, are able to serve as a PCP for CYSHCN.
• 3. Freedom of choice to select PCP and written policies and procedures re: choice/assignment of PCP in place.
• 4. Access to pediatric subspecialists specified in a child’s plan of care is provided without prior authorization from child’s PCP or health plan whether or not such specialists participate in a health plan’s provider network.
• 5. Transportation assistance is provided to families with difficulties accessing needed medical services.

Primary Care
• 4. Access to pediatric subspecialists specified in a child’s plan of care is provided without prior authorization from child’s PCP or health plan whether or not such specialists participate in a health plan’s provider network.
• 5. Transportation assistance is provided to families with difficulties accessing needed medical services.

State
• 1. The system has the capacity to ensure CYSHCN geographical and timely access to appropriate primary and specialty services, including in- and out-of-network providers and referrals.
• 5. Transportation assistance is provided to families with difficulties accessing needed medical services.
Relevant System Partners:
- Health Plans/Insurers
- Primary Care
- State
- Families

29 Standards focus on:
- Medical team; care coordination
- 24-7 access; additional time for visits
- Prevention and Treatment
- Routine, emergent and urgent needs are met

Percentage of CYSHCN who receive coordinated, ongoing, comprehensive care within a medical home

NCQA: Plan and manage care
Medical Home Index: Chronic condition management

Access to health services
<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1. Provide access to health care services 24 hours, seven days a week</td>
<td>• 2. Provide health care services that encourage the family to share in decision making, and provide feedback</td>
</tr>
<tr>
<td>• 2. Provide health care services that encourage the family to share in decision making, and provide feedback</td>
<td>• 5. Develop, maintain, and update a comprehensive, integrated plan of care that has been developed with the family and is shared with families and providers</td>
</tr>
<tr>
<td>• 3. Perform comprehensive health assessments</td>
<td>• 6. Support self-management of CYSHCN’s health and health care</td>
</tr>
<tr>
<td>• 4. Promote an integrated, team-based model of care coordination</td>
<td>• 8. Integrate care with other providers; effective info sharing with families and providers</td>
</tr>
<tr>
<td>• 5. Develop, maintain, and update a comprehensive, integrated plan of care that has been developed with the family and is shared with families and providers</td>
<td>• 9. Active care tracking that includes proactive reminders to families and clinicians of services needed via a registry or other mechanism</td>
</tr>
<tr>
<td>• 7. Promote quality of life, health development and behaviors across all life stages</td>
<td></td>
</tr>
<tr>
<td>• 8. Integrate care with other providers; effective info sharing with families and providers</td>
<td></td>
</tr>
<tr>
<td>• 9. Active care tracking that includes proactive reminders to families and clinicians of services needed via a registry or other mechanism</td>
<td></td>
</tr>
<tr>
<td>• 10. Provide effective, evidence-based care</td>
<td></td>
</tr>
</tbody>
</table>
Medical Home: Pediatric Preventive and Primary Care (9 Standards)

Health Plans/Insurers

- 3. All children, including CYSHCN, have access to medically necessary and preventive services to promote optimal health
- 5. Reasonable access to routine, episodic, urgent and emergent health care are provided

Health Care Providers

- 1. (PCP) Bright Futures Guidelines for screening and well care including oral and mental health are followed
- 2. (PCP) Care focuses on overall health, wellness and prevention of secondary conditions
- 3. All children, including CYSHCN, have access to medically necessary and preventive services to promote optimal health
- 4. (PCP) All children, including CYSHCN, receive recommended immunizations
- 5. Reasonable access to routine, episodic, urgent and emergent health care are provided
- 6. Reasonable wait times and same day appointments are available for physical, oral and mental health care
- 7. Accommodations for special needs (i.e. home vs. office visits) are available
- 8. Scheduling systems that recognize additional time in caring for CYSHCN
- 9. Pre-visit assessments are completed with family to ensure provision of family-centered care and needed referrals

State

- 3. All children, including CYSHCN, have access to medically necessary and preventive services to promote optimal health
- 5. Reasonable access to routine, episodic, urgent and emergent health care are provided
<table>
<thead>
<tr>
<th>Health Plans/Insurers</th>
<th>Health Care Providers</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All CYSHCN have access to patient and family-centered care coordination.</td>
<td>1. All CYSHCN have access to patient and family-centered care coordination.</td>
<td>1. All CYSHCN have access to patient and family-centered care coordination.</td>
</tr>
<tr>
<td>3. A plan of care* is jointly developed, shared and implemented among PCP, specialists, family and CYSHCN, and others as needed.</td>
<td>2. Care Coordinators serve as member of medical home team; assist in managing CYSHCN transitions; and provide appropriate resources to CYSHCN and families.</td>
<td></td>
</tr>
<tr>
<td>3. A plan of care* is jointly developed, shared and implemented among PCP, specialists, family and CYSHCN, and others as needed.</td>
<td>3. A plan of care* is jointly developed, shared and implemented among PCP, specialists, family and CYSHCN, and others as needed.</td>
<td></td>
</tr>
<tr>
<td>*addresses health problems; identifies strengths and needs of child and family; routinely evaluated and updated; delineates roles of all participating entities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Medical Home: Pediatric Specialty Care (7 Standards)

## Health Plans/Insurers
- 1. Shared management of CYSHCN between pediatric primary care and specialty providers is permitted.
- 4. Pediatric centers of care are available to CYSHCN and their families when needed.
- 6. Durable medical equipment and home health services are customized for CYSHCN.
- 7. A full continuum of children’s behavioral health services are provided.

## Health Care Providers
- 2. Systems such as satellite programs, electronic communications, and telemedicine are used to enhance access to specialty care and multidisciplinary teams of pediatric specialty providers.
- 3. Physical, oral and mental health are coordinated and integrated.
- 4. Pediatric centers of care are available to CYSHCN and their families when needed.
- 7. A full continuum of children’s behavioral health services are provided.

## State
- 2. Systems such as satellite programs, electronic communications, and telemedicine are used to enhance access to specialty care and multidisciplinary teams of pediatric specialty providers.
- 5. The system serving CYSHCN includes Title V CYSHCN programs, LENDs and UCEDDs, where available.
- 7. A full continuum of children’s behavioral health services are provided.
10 Standards focus on:
• Patient and family centeredness
• Respite services; home-based services
• Palliative and hospice care
• Transportation and interpreter supports

Relevant System Partners:
• Health Plans/Insurers
• Primary Care
• State
• Families
• 1. Agreements are in place between the health systems and various community agencies and programs serving CYSHCN and are structured to:
  • Promote family support through linkages to family organizations and other services
  • Promote shared financing
  • Establish systems for timely communications and appropriate data sharing
  • Ensure access and coordination of services for individual children and their families
  • Promote collaboration between families and community-based providers, agencies, organizations, and health care systems
  • Specify responsibilities across various providers and agencies serving children and their families
Community-Based Services and Supports: Respite Care (5 Standards)

**Health Plans/Insurers**
- 1. Respite services are available to all families and caregivers of CYSHCN
- 2. Families are informed about available respite services and helped to access them.
- 3. When out-of-home respite services are needed, transportation is available.
- 4. Health providers and plans screen families and caregivers of CYSHCN for respite care needs and provide referrals to qualified providers.
- 5. Health providers and plans have a system in place for ensuring timely referrals for emergency respite needs.

**Health Care Providers**
- 2. Families are informed about available respite services and helped to access them.
- 4. Health providers and plans screen families and caregivers of CYSHCN for respite care needs and provide referrals to qualified providers.
- 5. Health providers and plans have a system in place for ensuring timely referrals for emergency respite needs.

**State**
- 1. Respite services are available to all families and caregivers of CYSHCN
- 2. Families are informed about available respite services and helped to access them.
- 3. When out-of-home respite services are needed, transportation is available.
Health Plans/Insurers

1. Curative and palliative care (also known as concurrent care) is available and offered at the same time.
2. Palliative and hospice care utilizes family-centered models of care that respect individual’s preferences and provide family access to psychosocial screening and referrals to needed supports and services.

Health Care Providers

1. Curative and palliative care (also known as concurrent care) is available and offered at the same time.
2. Palliative and hospice care utilizes family-centered models of care that respect individual’s preferences and provide family access to psychosocial screening and referrals to needed supports and services.
3. The child and family plays an active role in decision making regarding goals and plans of care.

Families

3. The child and family plays an active role in decision making regarding goals and plans of care.
1. Home health care is a covered benefit for CYSHCN that includes health care for the child and supportive care for the family, and is provided in the family’s home by licensed professionals who have experience in pediatric care.

1. Home health care is a covered benefit for CYSHCN that includes health care for the child and supportive care for the family, and is provided in the family’s home by licensed professionals who have experience in pediatric care.
9 Standards focus on:
• Families are active members of the team
• Connection with family organizations, peer support
• Strength-based; Informed
• Culturally and linguistically appropriate

Relevant System Partners:
• Health Plans/Insurers
• Primary Care
• State
• Families

MCH Performance
Medical home
Healthy People 2020

Family Professional Partnerships
Percentage of CYSHCN whose families partner in decision making at all levels and are satisfied with services
NCQA: Measure and improve performance
Medical Home Index: Organizational capacity
Disability and health
### Family Professional Partnerships (9 Standards)

#### State
- 1. Families' priorities and concerns are central to care planning and management.
- 3. Families are connected to family and peer support organizations.
- 5. Care is delivered in culturally appropriate ways.
- 6. Families get information in family-chosen methods.
- 7. All written materials provided to CYSHCN and their families are culturally, linguistically, and literacy-level appropriate.
- 8. Health systems that serve CYSHCN solicit feedback from the family and children.
- 9. Health systems that serve CYSHCN have a family advisory board of committee, inclusive of families of CYSHCN.

#### Health Care Providers
- 1. Families are active, core members of the medical home team.
- 2. Families' priorities and concerns are central to care planning and management.
- 3. Families are connected to family and peer support organizations.
- 4. Family strengths are respected in the delivery of care.
- 5. Care is delivered in culturally appropriate ways.
- 6. Families get information in family-chosen methods.
- 7. All written materials provided to CYSHCN and their families are culturally, linguistically, and literacy-level appropriate.

#### Families
- 1. Families are active, core members of the medical home team.
- 3. Families are connected to family and peer support organizations.
- 6. Families get information in family-chosen methods.
- 8. Health systems that serve CYSHCN solicit feedback from the family and children.
- 9. Health systems that serve CYSHCN have a family advisory board of committee, inclusive of families of CYSHCN.
12 Standards focus on:
• Youth engagement
• Transition and transfer of care policies and processes
• Transition assessment and plan in place and current
• Coordination between pediatric and adult providers

Relevant System Partners:
• Health Plans/Insurers
• Primary Care
• State
• Families
• YSHCN

Transition to Adulthood
Percentage of YSHCN who receive the services necessary to make transitions to all aspects of adult life
Medical Home Index: Chronic condition management
Access to health services
<table>
<thead>
<tr>
<th>Health Plans</th>
<th>Pediatric Primary Care</th>
<th>Adult Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PS1.</strong> Transition prep and planning policies/ processes are in place in health plan and medical home for YSHCN and families moving between pediatric and adult care systems; youth involvement is encouraged.</td>
<td><strong>PS1.</strong> Transition prep and planning policies/ processes are in place in health plan and medical home for YSHCN and families moving between pediatric and adult care systems; youth involvement is encouraged.</td>
<td><strong>AS1.</strong> A policy describing the adult medical home approach to YSHCN is in place</td>
</tr>
<tr>
<td><strong>P/AS2.</strong> An individual flow sheet or registry for IDing and tracking transitioning YSHCN is maintained by the health plan and medical home.</td>
<td><strong>PS2.</strong> An individual flow sheet or registry for IDing and tracking transitioning YSHCN is maintained by the health plan and medical home.</td>
<td><strong>AS2.</strong> An individual flow sheet or registry for IDing and tracking transitioning YSHCN is maintained by the health plan and medical home.</td>
</tr>
<tr>
<td><strong>AS3.</strong> A process for IDing providers who are interested in caring for YSHCN exists at the adult medical home and health plan levels.</td>
<td><strong>PS3-6.</strong> Transition readiness assessment, plan of care are developed starting at age 14; transfer package is prepared and communicated with new adult medical home; pediatric medical home is available to consult as needed and follow-up process is in place.</td>
<td><strong>AS3.</strong> A process for IDing providers who are interested in caring for YSHCN exists at the adult medical home and health plan levels.</td>
</tr>
<tr>
<td></td>
<td><strong>PS7.</strong> Transition QI includes collaboration and co-management.</td>
<td><strong>AS4.</strong> A process for welcoming and orienting young adults exists within the adult medical home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>AS5.</strong> A process for confirming the transfer between pediatric and adult medical homes is in place to assist YSHCN with ongoing care management.</td>
</tr>
</tbody>
</table>
5 Standards focus on:

- Use of electronic health record systems; meaningful use
- Families are partners in electronic health information (EHI)
- HIT incorporates CMS health policy priorities
- EHI is accessible and shared across care settings

Relevant System Partners:
- Health Plans/Insurers
- Health care providers
- State
- Families

Percentage of CYSHCN who receive coordinated, ongoing, comprehensive care within a medical home

NCQA: Identify and manage patient populations
Medical Home Index: Data management

Health information technology
Health Information Technology (5 Standards)

**Health Plans/Insurers**
- 1. Electronic health record systems meet meaningful use requirements.
- 5. To promote care coordination across providers and systems, electronic health info should be accessible; retrievable; available; use documented process for exchanging info across care settings.

**Health Care Providers**
- 1. Electronic health record systems meet meaningful use requirements.
- 2. Medical homes have capacity for electronic health info and exchange, including maintenance of clinical info.
- 3. Families have easy access to their electronic health info and the opportunity to contribute to the record.
- 4. HIT systems incorporate the five specific health policy priorities of CMMS
- 5. To promote care coordination across providers and systems, electronic health info should be accessible; retrievable; available; use documented process for exchanging info across care settings.

**State**
- 1. Electronic health record systems meet meaningful use requirements.
- 3. Families have easy access to their electronic health info and the opportunity to contribute to the record.
- 4. HIT systems incorporate the five specific health policy priorities of CMMS
- 5. To promote care coordination across providers and systems, electronic health info should be accessible; retrievable; available; use documented process for exchanging info across care settings.
3 Standards focus on:
- Quality assurance and improvement processes for CYSHCN
- Child medical record reviews include sample of CYSHCN
- Utilization review/appeals for CYSHCN include integrated care team

Relevant System Partners:
- Health Plans/Insurers
- Health care providers
- State
- Families
### Quality Assurance and Improvement (3 Standards)

<table>
<thead>
<tr>
<th>Health Plans/Insurers</th>
<th>State/Medicaid</th>
<th>Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health plans and insurers have specific, ongoing QA and QI process for CYSHCN and families that includes families; monitors network capacity, utilization of care; uses experience of care surveys; assesses out of pocket costs and lost work burden on families; and assesses child outcomes.</td>
<td>1. Health plans and insurers have specific, ongoing QA and QI process for CYSHCN and families that includes families; monitors network capacity, utilization of care; uses experience of care surveys; assesses out of pocket costs and lost work burden on families; and assesses child outcomes.</td>
<td>1. Health plans and insurers have specific, ongoing QA and QI process for CYSHCN and families that includes families; monitors network capacity, utilization of care; uses experience of care surveys; assesses out of pocket costs and lost work burden on families; and assesses child outcomes.</td>
</tr>
<tr>
<td>2. Child medical record reviews include a sample of CYSHCN.</td>
<td>2. Child medical record reviews include a sample of CYSHCN.</td>
<td></td>
</tr>
<tr>
<td>3. Utilization review and appeals processes for CYSHCN include members of a child’s integrated care team.</td>
<td>3. Utilization review and appeals processes for CYSHCN include members of a child’s integrated care team.</td>
<td></td>
</tr>
</tbody>
</table>
9 Standards focus on:
• Plans are affordable and no risk for loss of benefits
• Coverage/payment facilitates access to needed providers
• Comprehensive habilitative services coverage
• Promote care coordination and medical homes

Relevant System Partners:
• Health Plans/Insurers
• Health care providers
• State
• Families
Insurance and Financing (9 Standards)

Health Plans/Insurers

1. Insurance plans for CYSHCN are affordable; cost-sharing policies protect families from financial strain; without risk or loss of benefits.
2-3. Coverage/payment adequate for access to all needed primary and specialty health services and supports medical home model and optimal growth and development.
4-5. Comprehensive habilitative services are a covered benefit; offered in addition to rehabilitative services; and include therapies, services and devices based upon individual needs.
6. Provider payment policies promote recruitment and retention of primary care providers and specialists and incentivize providers.
7. Authorization processes are flexible to unique aspects of CYSHCN and simplified to promote access to services.
8. Families may seek second opinions without restrictions.
9. Performance or financial incentives are in place to promote medical homes, care coordination and quality and enhance access to services.

Health Care Providers

3. All children, including CYSHCN, have access to medically necessary services to promote optimal growth and development...
4. Comprehensive habilitative services include therapies, services and devices based on individual needs, to prevent and avert deterioration of functioning or attain a skill or function never learned or acquired due to a chronic condition, including those services specified in IFSPs or IEPs.

State

1. Insurance plans for CYSHCN are affordable; cost-sharing policies protect families from financial strain; without risk or loss of benefits.
2-3. Coverage/payment adequate for access to all needed primary and specialty health services and supports medical home model and optimal growth and development.
4-5. Comprehensive habilitative services are a covered benefit; offered in addition to rehabilitative services; and include therapies, services and devices based upon individual needs.
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9. Performance or financial incentives are in place to promote medical homes, care coordination and quality and enhance access to services.
Next steps

Use data

Courageous conversations

Relationships and learning

Define the goal

MCH Performance
Medical home
National Standard
Healthy People 2020

Define the goal
Care coordination
• Texas is below average in receiving effective care coordination
• Just over half of families get care coordination when needed
• Only 22% got any help arranging or coordinating care

Use data
Medical Home

Texas Medical homes
- Analysis of 57 NCQA-certified providers vs 5,568 non-certified providers caring for CYSHCN in Medicaid fee-for-service
- NCQA-certified practices had more well-child visits and ER follow-ups
- Authors summarized no effect on utilization/cost, but perhaps better care coordination

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Adjusted odds ratio NCQA vs non-certified</th>
<th>Confidence interval</th>
<th>Significant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child</td>
<td>1.73</td>
<td>(1.19 - 2.53)</td>
<td>Yes</td>
</tr>
<tr>
<td>30 day ER follow-up</td>
<td>2.42</td>
<td>(1.63 – 3.61)</td>
<td>Yes</td>
</tr>
<tr>
<td>Any ER visit</td>
<td>0.87</td>
<td>(0.69 – 1.10)</td>
<td>No</td>
</tr>
<tr>
<td>Avoidable ER visit</td>
<td>0.85</td>
<td>(0.65 – 1.10)</td>
<td>No</td>
</tr>
<tr>
<td>Inpatient admission</td>
<td>0.88</td>
<td>(0.61 – 1.26)</td>
<td>No</td>
</tr>
<tr>
<td>ACS admission</td>
<td>0.85</td>
<td>(0.35 – 2.08)</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical Home Workgroup: Formed in 2003 to promote person-centered medical homes
Wellness Program: Since Oct 2011, 75 practices trained, 40 practices individual coaching
Texas Medical Home Initiative: Since 2008, North Texas adult patient-centered medical home demonstration projects
STARMHAC: Since 2012, statewide pediatric demonstration projects

Texas medical home improvement projects
• Medical home workgroup
• Texas Wellness Program
• TMHI
• STARMHAC regional collaboratives

Class of 2015
TEXAS STARMHAC
Statewide Association for Regional Medical Home Advancement
(Title V, Texas Children’s Health Plan, Texas Pediatric Society, and Texas Parent2Parent)

Source:
• 70 DSRIP projects increase medical homes

• 24 DSRIP projects provide care coordination

• 21 DSRIP projects include children

http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml
Use data

Family Professional Partnerships

The Maternal and Child Health Federal-State Partnership

**Texas**

**MATERNAL & CHILD HEALTH (MCH) MEASURES**

<table>
<thead>
<tr>
<th>Title V - Maternal Child Health National Performance Measures</th>
<th>State 2013 Results</th>
<th>State 2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)</td>
<td>70.3%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Family Professional partnerships

• Texas meets the national average from the NS-CSHCN 09/10
• Are we on track to meet our 2018 state goal?

What can you share about your experience with care coordination and/or family partnering?
What should our goal as a group/state be with regard to care coordination and family partnerships?

What is your next step?

What is our next step?
OBJECTIVES

1. Define team-based care and relate rationale for use to current health environment

2. Apply five effective team based strategies in their practice across disciplines

3. Analyze practice to derive pertinent outcomes monitoring and sustainment strategies
Team-Based Care

**TEAM BASED CARE**

- services to individuals, families and/or communities
- work collaboratively with patients and their caregivers
- accomplish shared goals within and across settings
- achieve coordinated high-quality care


**TEAM BUILDING**

- Organize and Nurture group
- Develop Synergy
- Focus on Goals
- Understand Roles
- Link Perceptions of Status to Role Competence
Why Team-Based Health Care?

Safety

Unnecessary waste and cost

Continuity - number of professionals ‘touching a patient with chronic care

Institute of Medicine, 2010
Importance of Team Based Care

1. Improved Work Environment
2. Increased Quality of Care
3. Open Communication / Patient Safety
4. Improved Patient Care Coordination
5. Improved Role Satisfaction

Brown, R. The Promise of Care Coordination, 2009
Team Strategies and Tools to Enhance Performance and Patient Safety (Team STEPPS)
TeamSTEPPS Primary Care Version

- Developed by the Agency for Healthcare Quality & the Department of Defense
- Dr. John Kotter’s Theory of Change supports curriculum
- Supports clear communication, mutual trust, shared decision making, professional accountability – all attributes of interprofessional collaboration
TeamSTEPPS Content Areas

- Leadership
- Communication
- Mutual Support
Random selection of 25 intervention & 25 attention control sites

Group intervention
Individual measurement
Group analysis

6 weeks education
6 weeks skill application
Evidenced based curriculum
The AITCS has been tested across various roles and settings (including primary care staff).
Comparison of AITCS Total Scores

Demographics

- 90% female
- 45% medical assistant role
- 39% in present role less than 3 years

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Total</th>
</tr>
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(*p = .000*)
Subscale Comparison

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Team Skills

Five Skill Sets to Support Effective Teams
#1 Briefing Checklist

- Clarifies who will be leading the team
- Open lines of communication among team members,
- Discusses protocols & responsibilities to decrease misunderstandings
- Prepares the team for the flow of the day’s patients, & means for resolving any unusual circumstances
- Sets expectations, increases understanding
#2 Feedback

- Fosters improvement in work performance
- Meets the team’s and individual’s need for growth
- Promotes better working relationships
- Helps the team set goals for ongoing improvement
#3 Mutual Support

- Referred to as “backup behavior” in teamwork literature
- Suggests a degree of task interchangeability among members as they must fully understand what each of the other team members does
• Short, informal information exchange used as a process improvement tool

• Occurs after an event

• Designed to improve teamwork skills.

• Answers the question…Did we achieve our plan?
#5 Huddles

- A huddle is a quick, reactive, “touch base” meeting
- Used to regain situation awareness
- Quickly allows team members to discuss critical issues, anticipate outcomes and likely contingencies, assign resources, and express concerns
Collaboration involves full and open communication—team members respectful & open to each other

(LISTENING!)
Team STEPPS for Primary Care Version

- Instructor guide with wording for facilitator to support fidelity to program content and
- Participant handouts (individual and group activities)
- Videos for download or online viewing (8)

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/
Assessment of Interprofessional Team Collaboration Scale (AITCS)
http://www.ipe.uwo.ca/Administration/aitcs.html
(measure across all roles)

Teamwork Perceptions Questionnaire
http://teamstepps.ahrq.gov/teamwork_perceptions_questionnaire.pdf
(ahrq tool)
Actions for Medical Home!

- Increase Awareness
- Communicate Clearly
- Build Trust across Team
Effective Teams = a tool to deliver patient-centered, coordinated, quality health care
THANK YOU!
References

Partnership for Patients, Centers for Medicare and Medicaid Services


Teamwork Perceptions Questionnaire
http://teamstepps.ahrq.gov/teamwork_perception_questionnaire.pdf
MISSION STATEMENT

Our practices will provide an excellent, patient-centered medical home for all children in our care, particularly for those children with special health care needs.
PARTNERS

Texas Medicaid Wellness Program

Children’s Hospital of San Antonio (CHofSA)

Pediatric Primary Care Clinic (CHofSA)

CentroMed

University Children’s Clinic/ UTHSCSA

Texas Parent to Parent

Community First Health Plan
STARMHAC GRANT

Four One Day Conferences- Catering and Materials

One Year Subscription to AAP Digital Navigator

Providing subscription for 10 clinical sites

STARMHAC (Statewide Association for Regional Medical Home Advancement) through HRSA Grant #D70MC24126-01-00
TEXAS MEDICAID WELLNESS PROGRAM

Administered by McKesson Health Solutions on behalf of HHSC

Comprehensive care management to high risk Medicaid fee-for-service patients

Educates providers about PCMH - collaborates with TransforMed, hosting learning collaboratives throughout Texas

Assist Medicaid providers through the PCMH process
TRANSFORMED

TransforMed is a non-profit subsidiary of the American Academy of Family Physicians

Provides consultation, support, tools and resources to physicians and practice leaders to enable them transform their practices and obtain PCMH recognition
34 Participants, representing 10 different clinical sites

Presentations:

TransforMed

Practicing in a PCMH: Dr. Diana Ballesteros

Texas Parent to Parent: Debbie Wiederhold

Texas Medicaid Wellness Program: Beverly Young

Medical Home Index
SECOND CONFERENCE- JANUARY 17, 2014 AT CHILDREN’S HOSPITAL OF SAN ANTONIO

42 Participants, representing 10 different clinical sites

Presentations:

TransforMed

Any Baby Can: Stephanie Kubanda

Reports from each clinical site
THIRD CONFERENCE- MAY 29, 2014 AT CHILDREN’S HOSPITAL OF SAN ANTONIO

35 Participants, representing 10 different clinical sites

Presentations:

  TransforMed

  What’s New With Texas Health Steps: Kathe Barrett

  Autism Community Network: Loree A Primeau
FOURTH CONFERENCE- SEPTEMBER 5, 2014 AT CENTRO MED

36 Participants, representing 13 different clinical sites

Presentations:

Transformed

Boys Town Texas: Janie Cook

Brighton ECI: Holly Grogan
FIFTH CONFERENCE- JANUARY 30, 2015 AT CENTRO MED

Presentations:

  TransforMed

  Update on the Texas Medicaid Transportation Program: Starlite Folley
  of LeFleur Transportation

  Networking Lunch and Updates from the Clinical Sites
THE MEDICAL HOME INDEX: REVISED SHORT FORM: PEDIATRIC (MHI-RSF)

For the National Evaluation of the CHIPRA Quality Demonstration Grant Program

Adaptation of the short version of the Medical Home Index

Low burden option for collecting valid and reliable information on “medical homeness” for child-serving practices

Estimated to take 2 people 20-30 minutes to complete

AHRQ Evaluation Highlight No. 2, May 2013
THE MEDICAL HOME INDEX: REVISED SHORT FORM: PEDIATRIC (MHI-RSF)

Two pages: clinic demographics

14 questions covering 6 domains

Each question describes 4 levels of care

Each level has option of “partial” (some activity within that level) or “complete” (all activity within that level)
THE MEDICAL HOME INDEX: REVISED SHORT FORM: PEDIATRIC (MHI-RSF)- SAN ANTONIO BASELINE RESULTS

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THE MEDICAL HOME INDEX: REVISED SHORT FORM: PEDIATRIC (MHI-RSF)- PEDIATRIC PRIMARY CARE CLINIC RESULTS

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## THE MEDICAL HOME INDEX: REVISED SHORT FORM: PEDIATRIC (MHI-RSF)- SAN ANTONIO BASELINE RESULTS

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AAP DIGITAL NAVIGATOR

Interactive, web-based software application

Provides tools, documents, templates and interactive reports

Guides practices through the PCMH process

15 Subscriptions purchased

Current version is based upon 2011 NCQA Criteria