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)
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
- 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
Agenda

• 10 min (Tapia)  Role call and intro
• 15 min (Tapia)  Project updates
• 20 min (Torres) Houston project status
• 15 min (Tapia)  Open forum

Next meeting:  March 18th
Progress

- **Partnerships:** ARC of Texas
  - Jan 14 (Austin) advocate input into system redesign
  - Jan 21 (Houston) panel on impact of ACA
Progress

- Partnerships
  - Wellness Program embedded case management to start Feb 3rd

Questions?

Jana Britton, RN, BSN, MBA
• Provider Relations Manager, Texas Medicaid Wellness Program
• (972) 207-7097

Diana Burbank, RN, BSN
• North/Central Texas – Regions 1, 2, 3, 7
  972-814-7919

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

Beverly Young, RN, BSN, PSF
• West/South Texas/Valley – Regions 8, 9, 19, 11
  281-669-6870
Progress

- Engage family and youth
  - Texas Parent to Parent
  - Pathways to adulthood
  
  http://txp2p.org/

Topics Include

- funding sources
- legal issues: guardianship and alternatives, estate planning
- school transition services & maximizing remaining school years
- medical transition
- opportunities for work

Upcoming

**TxP2P Conferences**
In 2014, we will have 3 1-day Regional Conferences in Port Isabel (3/22/14) and in Hurst (3/28/14) and our Annual Parent 2-day Conference in San Marcos (June 13-14). More information will follow soon.

**TxP2P SPECIAL EVENTS & TRAININGS:**
(click on the titles to read the flyers)

- Pathways to Adulthood Seminar (PDF), Registration Open!
  - Saturday, Feb 8, San Antonio, TX
  - Nellie M. Reidiv Center
- Pathways to Adulthood Seminar (PDF) Español, Registration Open!
  - Tuesday, Feb 18, San Antonio, TX
  - Education Service Center (ESC 20)
- TxP2P 1-day Conference (PDF), Registration open!
  - March 22, 2014, Port Isabel, TX, Call for Exhibitors
    - Port Isabel High School
- TxP2P 1-day Conference (PDF), Registration open!
  - March 29, 2014, Hurst TX, Call for Exhibitors
    - First Baptist Hurst
## Progress

- Regional collaboratives, Y1

| Area         | Lead            | Indicator                                                      | Project                                                                 |
|--------------|-----------------|                                                               |                                                                        |
| Houston      | Dr. Liaw        | Organization of services for easy use                         | Remote social work and care coordination for CYSHCN                     |
| Houston      | Dr. Torres      | Family partnership                                            | Single practitioner, team work and family-centered care                 |
| Dallas       | Dr. Lachman     | Early and continuous screening                                 | Medical neighborhood portal for developmental management                |
| San Antonio  | Dr. Huston      | Comprehensive medical homes                                   | Medical home certification (Sept 27th)                                  |
## Progress

- **Regional collaboratives, Y2**

<table>
<thead>
<tr>
<th>Area</th>
<th>Lead</th>
<th>Indicator</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fort Worth/Dallas</td>
<td>Dr. Hain</td>
<td>Comprehensive medical homes</td>
<td>Medical homes for children with medical complexity</td>
</tr>
<tr>
<td>El Paso</td>
<td>Dr Shokar / Spalding</td>
<td>Comprehensive medical homes</td>
<td>Care coordination in the medical home</td>
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<tr>
<td>Livingston</td>
<td></td>
<td>Organization of services for easy use</td>
<td>Sustainable telepsychiatry</td>
</tr>
<tr>
<td>Beaumont</td>
<td>Dr. Rafiq / Kanniganti</td>
<td>Comprehensive medical homes</td>
<td>Co-management for behavioral &amp; mental health</td>
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</table>

**We are still looking to recruit Y2!**
Progress

• Transition QI
  - (Final analysis) Care Ambassador program to engage youth with diabetes
  - (Planning) Title V Transition partnership
STARHMAC Contacts

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PERCEPTIONS OF PRACTICE & PATIENTS: a medical home pilot

LORA TORRES, M.D.

JANUARY 2014
A Practice Experience in Medical Home Improvement

GOAL:
Improve patient perceptions, operational efficiency and quality care through improving performance across medical home

- Baseline Medical Home Index (MHI) 2012
- TEAMSTEPPSS training for staff
- Family Index Tool
- Results of Family Index Tool
- Family Focus Group
- Comparative MHI Score 2012 - 2014
- Action Plan based on Feedback
- Lessons Learned
The MHI assesses 25 indicators organized under 6 practice domains: organizational capacity, chronic condition management, care coordination, community outreach, data management, and quality improvement. Indicators are measured across 4 levels of achievement using a 8-point Likert scale.


Medical Home Transformation in Pediatric Primary Care - What Drives Change? Authors: Jeanne W. McAllister, BSN, MS, MHA, W. Carl Cooley, MD, Jeanne Van Cleave, MD, Alexy Arauz Boudre, MD, Karen Kuhlthau, PhD., May 2013
Practice Medical Home Index (MHI) results
1/2012

<table>
<thead>
<tr>
<th>Data</th>
<th>Mean</th>
<th>Organizational</th>
<th>Chronic</th>
<th>Care</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHI Management</td>
<td>4.68</td>
<td>4.14</td>
<td>4.33</td>
<td>5.17</td>
<td>6.00</td>
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<tr>
<td>Quality</td>
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<td>Capacity</td>
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<td>Chronic</td>
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<td>Condition</td>
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<td>Care</td>
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<td>Coordination</td>
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<tr>
<td>Outreach</td>
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Practice Overview

- Practitioners: one physician, one nurse practitioner
- Panel Size: 6,687
- Hours of Operation: Monday – Friday 8am – 5 pm
- Years at this location: 12 years
- Insurances seen: Commercial, & Medicaid
TeamStepps for Primary Care Training

- September – November (12 weeks)
  - Opportunity for Staff Insight after watching videos and reading material
  - Time to apply learning between weeks
  - Incorporated skills of active listening, mutual trust, shared decision-making and patient advocacy

- TeamStepps for Primary Care
  - Developed by the Department of Defense (DoD) and Agency for Healthcare Research and Quality (AHRQ)
    - Proven in hospital setting to improve safety and efficiency
    - Based on John Kotter’s Change Theory

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/
Subscales of this 37-item valid and reliable tool represent attributes that enable interprofessional collaboration (shown to promote efficiency and safety as well as improved employee satisfaction).

http://www.researchgate.net/publication/221976426_Assessment_of_Interprofessional_Team_Collaboration_Scale_(AITCS)_development_and_testing_of_the_instrument
CMHI: Medical Home Family Index

- Questions: 37 responses per survey plus demographic information
- Scoring: Uses mix of a 4 point Likert scale, and Yes/No responses
- Time: Completion takes approximately 15 minutes
- Pairs with content seen in the MHI
- Validated Tool
- Given in the Office Setting
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Q23</td>
<td>From my experience, I believe that my PCP and the staff at his/her office have a commitment to provide the quality care and family supports that we need.</td>
<td>98%</td>
</tr>
<tr>
<td>Q14</td>
<td>Office providers or staff who are involved with my child’s care know about their condition, history, and our concerns and priorities.</td>
<td>89%</td>
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<tr>
<td>Q6</td>
<td>My PCP listens to my concerns and questions?</td>
<td>80%</td>
</tr>
<tr>
<td>Q2 b)</td>
<td>Staff respect our needs and requests</td>
<td>74%</td>
</tr>
<tr>
<td>Q4</td>
<td>My PCP asks me to share with him/her my knowledge and expertise as the parent of a child with special health care needs</td>
<td>37%</td>
</tr>
<tr>
<td>Q5</td>
<td>I am asked by our PCP how my child's condition affects our family.</td>
<td>33%</td>
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<tr>
<td>Q8</td>
<td>My PCP and staff work with our family to create a written care plan for my child</td>
<td>36%</td>
</tr>
<tr>
<td>Q10</td>
<td>My PCP and his/her office staff use and follow through with</td>
<td></td>
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Family Advisory Meeting #1

Characteristics of Families Involved:
1) Eight families represented

Setting:
1) The office
2) Provided snacks, giftcard & babysitting

Process:
1) Shared
2) Listened
Family Advisory Board Meeting

Meeting began with introductions and explanation of terms Medical Home and Family-Centered Care

<table>
<thead>
<tr>
<th>Question 1: What are your child’s needs?</th>
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<tr>
<th>Question 2: What Would You like to see in your child’s care plan?</th>
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<tr>
<th>Question 3: Who do I communicate with in the clinic and what is their role?</th>
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- Physician Introduction
- Neutral party (parent partner) facilitated the explanations and questions
- Break /lunch provided by the health plan offered time for thought
- Ended with open comments from families and physician
Results, Actions

- **Needs:** get appointment
  - Get an appointment when sick
  - Phone all returns
  - Teach me

- **Care plan information**
  - Health history
  - Medications, schedule & dosing
  - Other providers/contact info
  - Supply & equipment info

- **Communication**
  - School communication assistance

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1. **Task:** Plan how to facilitate after-hour appointments, phone calls or same day appointments. Special times, special day for visits.

2. **Task:** Develop care plan to share with families and between physicians

3. **Task:** Identify staff if patients with special needs and the need to respond to let families know requests are being worked on
Medical Home Result (2013 compared to 2014)

Quality

Mean Organizational Chronic Care Community Data
MHI Capacity Condition Coordination Outreach Management

1st 2nd

25
1. Empower clinic staff to advocate for identified families with a child with special needs in quick response fashion.

2. Contracting with programming resources for care plan development.

3. Develop form for parents to use to remember questions to ask when in the exam room.

- Identify content needed in shared care plan
- Identify programming needs to efficiently produce a care plan
- Listen to the ‘voice of the customer’ and re-do family survey in 6 months
Lessons Learned

Surprised parents wanted a care plan

Parents want to be taught & informed of State programs and community resources

Teamwork is essential: building trust among internal team helps patient care