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
Progress

• Partnerships
  - Title V Medical home and transition workgroup
  - Dr. Rapheal, Aetna Medical home project
  - McKesson and Medicaid Wellness program
Progress

• Partnerships
  -Texas Health Steps On-line Provider Training: Health home and medical society promotion
  http://www.txhealthsteps.com/cms/

  -ECI and Dr. Adams: Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best Outcomes

Resource
The AAP Early Intervention Program Referral Form is available at
http://www.medicalhomeinfo.org/downloads/pdfs/EIReferralForm_1.pdf
Progress

- Engage family and youth
  - Texas Parent to Parent Pathways to adulthood

**Topics Include**

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

**When:** Tuesday, December 3, 2013
**Time:** 9am-2pm (lunch will be provided)
**Where:** Comal ISD
  1404 IH 35 N.
  New Braunfels, TX 78130

For questions, please contact:
- Jamie Ezell
  Parent Community Specialist
  Comal ISD
  830-221-2169
  Jamie.Ezell@comalsd.org

To register please go to [www.txp2p.org](http://www.txp2p.org), or to learn more about the Texas Parent to Parent Pathways to Adulthood program please contact, Cynda Green at 512-458-8600 or cynda.green@txp2p.org
## Progress

- Regional collaboratives, Y1

<table>
<thead>
<tr>
<th>Area</th>
<th>Lead</th>
<th>Indicator</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston</td>
<td>Dr. Liaw</td>
<td>Organization of services for easy use</td>
<td>Remote social work and care coordination for CYSHCN</td>
</tr>
<tr>
<td>Houston</td>
<td>Dr. Torres</td>
<td>Family partnership</td>
<td>Single practitioner, team work and family-centered care</td>
</tr>
<tr>
<td>Dallas</td>
<td>Dr. Lachman</td>
<td>Early and continuous screening</td>
<td>Medical neighborhood portal for developmental management</td>
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<tr>
<td>San Antonio</td>
<td>Dr. Huston</td>
<td>Comprehensive medical homes</td>
<td>Medical home certification (Sept 27th)</td>
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We are still looking to recruit Y2!
Progress

• Regional collaboratives, Y2

<table>
<thead>
<tr>
<th>Area</th>
<th>Lead</th>
<th>Indicator</th>
<th>Project</th>
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<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>UTMB</td>
<td>Organization of services for easy use</td>
<td>Sustainable telepsychiatry</td>
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<tr>
<td>Beaumont</td>
<td>Dr. Kanniganti</td>
<td>Comprehensive medical homes</td>
<td>Co-management for behavioral &amp; mental health</td>
</tr>
</tbody>
</table>

We are still looking to recruit Y2!
Progress

- Transition QI
  - Youth transition to adult health care, work, and independence
AIM Statement

• By Oct 2013, the Care Ambassador will enroll 50 youth to establish an on-going relationship* designed to improve outcomes by March 2014, defined in terms of:
  – Improve attendance (show rate) from 70% to 95%
  – Low perceived burden of disease score (<= 2 for youth; >=3 for parent)
  – High satisfaction rating with provider (score >=3)

*relationship = face-to-face clinic visits / monthly phone contact
STARHMAC Contacts

Contact
**Carl Tapia, MD, MPH**
Associate Medical Director, Pediatrics
Texas Children’s Health Plan
Technical Assistance
cdtapia@texaschildrens.org
832.828.1292

Contact
**Xuan G. Tran, MHA**
Manager, Health Services Research & CME
Texas Children’s Health Plan
General inquiries
XGTran@texaschildrens.org
832.828.1292
Impact of Medical Home Care on Children with Special Health Care Needs

Jean L. Raphael, MD, MPH
Baylor College of Medicine
November 19, 2013

Promoting Wellness, Health and Access to High-Quality Health Care
Specific Aims/Project Goals

Aim 1
• To assess whether having a patient centered medical home (PCMH) is associated with health care utilization among children with special health care needs (CSHCN)

Aim 2
• To determine whether PCMH care is associated with patient satisfaction with medical care

Aim 3
• To determine the relationship between PCMH care and the perception of health system bias
Background and Rationale

CSHCN are characterized by medical fragility, high resource utilization, and substantial economic consequences

- Higher number of hospitalizations and physician visits

- Higher medical expenditures and out-of-pocket expenditures

- 66 million restricted activity days and 27 million days lost from school annually

- Families experience higher rates of marital stress, divorce, and unemployment
Background and Rationale

PCMH has the potential to innovate and transform the primary care delivery system for CSHCN

- Defined by American Academy of Pediatrics as care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective

- PCMH improves health status, timeliness of care, family functioning

- Recent demonstration projects primarily focus on adults

- Continued need for framework of PCMH that will improve care for CSHCN and families
Clinical Value Compass for Medical Home

Functional:
↓ Parental Stress
↓ Perception of health system bias
↑ Health-related quality of life

Clinical:
↑ Increase preventive service use
↓ Illness episodes
↓ Acute encounters

Satisfaction:
↑ General satisfaction
↑ Ease of use of health care

Cost:
↓ ER, hospital visits
↓ Unnecessary specialty and office visits
↓ Lost parental work time
↑ Care coordination activities received

Adapted from Center for Medical Home Improvement
Methods

Study Design
• Retrospective cohort study

Target Population
• Low income CSHCN according to 8 conditions

Exposure
• Medical home according to patient experience
• Medical home according to practice structure and function

Outcome Measures
• Health care utilization according to administrative claims
• Medical Expenditures according to administrative claims
• Parent reported satisfaction with care
• Parent reported experience with health system bias
Methods

Study Site

• Texas Children’s Health Plan, Houston, TX

Survey Instrument

• Medical home measure, National Survey of Children’s Health for patient experience
• Medical Home Index (MHI) for practice structure
Project Overview And Algorithm

Member Identification by ICD-9 codes and continuous enrollment for 12 months

Does not meet criteria

Recruitment by research team

Does not meet criteria

Refuses to participate

Could not be contacted

Survey instrument completion
Administrative claims review

Primary care practice completion of Medical Home Index
Enrollment Conditions

Asthma
Attention deficit hyperactivity disorder
Autism
Cerebral Palsy
Cystic Fibrosis
Diabetes
Seizure Disorder
Sickle Cell Disease
Miscellaneous
Results
Response Rate

Patients
- 452 households contacted
- 193 could not be reached
- 93% of those contacted (240/249) agreed to participate

Practices
- 122 practices accounted for 240 children enrolled
- 51 (n=135 children) agreed to participate
- 71 practices (n=105 children) refused to participate
## Subject Demographics (n=240)

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>(%)</th>
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</thead>
<tbody>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
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<tr>
<td>White</td>
<td>27</td>
<td>11.3</td>
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<tr>
<td>Black</td>
<td>47</td>
<td>19.6</td>
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<tr>
<td>Hispanic</td>
<td>164</td>
<td>68.3</td>
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<tr>
<td>Other</td>
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<td>0.8</td>
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<tr>
<td><strong>Primary Language</strong></td>
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<tr>
<td>English</td>
<td>119</td>
<td>49.6</td>
</tr>
<tr>
<td>Spanish</td>
<td>119</td>
<td>49.6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.8</td>
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</tbody>
</table>
Practice Demographics (n=51)

Number of Practice Providers
• 29 of 51 were multi-provider practices
• 23 of 51 were single provider practices

Panel Size of Practices
• Mean panel size 1496 (range 1300-2000)
# Preliminary Findings

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
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<tbody>
<tr>
<td><strong>Comprehensive Care</strong></td>
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<tr>
<td>Usual Source of Care</td>
<td>90%</td>
</tr>
<tr>
<td>No Problems Getting Referrals</td>
<td>88%</td>
</tr>
<tr>
<td><strong>Family-Centered Care</strong></td>
<td></td>
</tr>
<tr>
<td>Spends enough time</td>
<td>81.3</td>
</tr>
<tr>
<td>Listens carefully</td>
<td>87.9</td>
</tr>
<tr>
<td>Provides needed information</td>
<td>87.9</td>
</tr>
<tr>
<td><strong>Coordinated Care</strong></td>
<td></td>
</tr>
<tr>
<td>Gets help with coordination</td>
<td>52</td>
</tr>
<tr>
<td>Satisfaction -provider communication</td>
<td>55.8</td>
</tr>
<tr>
<td>Satisfaction –provider communication</td>
<td></td>
</tr>
<tr>
<td>with non-medical providers</td>
<td>51.7</td>
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</tbody>
</table>
Preliminary Findings

Patient Experience
• Usual Source of Care associated with lower ER and hospitalization rates
• No associations between patient-reported experience and outpatient urgent visits, subspecialty visits, costs

Practice Structure and Self-Assessment
• Higher organizational capacity associated with lower rates of ER and hospitalization rates
• Higher chronic disease management associated with higher rates of ER encounters
Implications for the Field

• What matters most- patient experience or practice structural achievement?

• How to overcome practical challenges to obtaining both patient and practice input?
SAN ANTONIO COALITION FOR MEDICAL HOME ADVANCEMENT
November 19, 2013
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

Children’s Health Center, UTHSCSA/UT PEDS

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

Children’s Hospital of San Antonio™

Baylor College of Medicine
TRANSFORMED

Nonprofit 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
FIRST CONFERENCE- SEPTEMBER 27, 2013 AT CHILDREN’S HOSPITAL OF SAN ANTONIO

Participants:

12 Physicians and 1 medical student

12 Clinic Staff

4 Other professionals

5 conference faculty

Total: 34 participants

10 different clinical sites represented
CONFERENCE SCHEDULE

8:00-8:30  Sign in, Continental Breakfast

8:30-12:30  TransforMed Presentation

12:30-1:30  Lunch

1:30-2:00  Dr. Ballesteros, Practicing Medicine in a PCMH

2:00-2:30  The Medical Home Index

2:30-3:30  Debbie Wiederhold, Texas Parent to Parent

3:30-4:00  Beverly Young, Texas Medical Wellness Program
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 RESULTS

7 sites completed the MHI-RSF

Number of providers per site: 1.5-15

Care Coordinators: 2 of the 7 sites

Accept Medicaid Patients: 5 of the 7 sites
THE MEDICAL HOME INDEX: REVISED SHORT FORM: PEDIATRIC (MHI-RSF)- SAN ANTONIO RESULTS

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Reference</th>
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</thead>
<tbody>
<tr>
<td>Standardized Total Score</td>
<td>41.5</td>
<td>30.4</td>
<td>52.7</td>
<td>56.1</td>
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<tr>
<td>Overall Mean Score</td>
<td>3.0</td>
<td>2.3</td>
<td>4.0</td>
<td>4.5</td>
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## THE MEDICAL HOME INDEX: REVISED SHORT FORM: PEDIATRIC (MHI-RSF)- SAN ANTONIO RESULTS

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Reference</th>
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</thead>
<tbody>
<tr>
<td>Organizational Capacity</td>
<td>3.2</td>
<td>1.7</td>
<td>5.0</td>
<td>4.5</td>
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<tr>
<td>Chronic Condition Management</td>
<td>3.4</td>
<td>2.5</td>
<td>4.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>4.0</td>
<td>3.0</td>
<td>6.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Community Outreach</td>
<td>2.4</td>
<td>1</td>
<td>4</td>
<td>4.0</td>
</tr>
<tr>
<td>Data Management</td>
<td>3.3</td>
<td>2.0</td>
<td>6.0</td>
<td>5.0</td>
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<tr>
<td>Quality Improvement</td>
<td>1.4</td>
<td>1.0</td>
<td>2.0</td>
<td>3.9</td>
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NEXT STEPS

Sites are being encouraged to:

1. Form PCMH Leadership Teams
2. Become familiar with PCMH resources
3. Request site visit by Beverly Young of the Texas Medicaid Wellness Program
AAP DIGITAL NAVIGATOR

Interactive, web-based software application

Provides tools, documents, templates and interactive reports

Guides practices through the PCMH process

Available soon
NEXT CONFERENCE - JANUARY 17, 2014

TransforMed presentation in the morning

Presentation by community agency

Presentations by sites, sharing successes and challenges