Houston Special Needs Primary Care Clinic

STAR Kids Advisory Committee
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Objectives

- Define children with medical complexity (CMC)
- Clinic characteristics
- Key challenges and solutions
CMC

- Children with medical complexity = the sickest of the sick

# Table 3. Medical Care Use of Children With Special Health Care Needs by Complexity

<table>
<thead>
<tr>
<th>Variable</th>
<th>Less Complex (n=9 897 116)</th>
<th>More Complex (n=324 323)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s health care needs, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change all the time</td>
<td>5.4</td>
<td>32.0</td>
</tr>
<tr>
<td>Change sometimes</td>
<td>27.9</td>
<td>33.0</td>
</tr>
<tr>
<td>Are usually stable</td>
<td>66.9</td>
<td>35.0</td>
</tr>
<tr>
<td>No. in the last 12 mo. median (interquartile range)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School days missed</td>
<td>3 (1-8)</td>
<td>10 (5 to 16-20)</td>
</tr>
<tr>
<td>Physician visits</td>
<td>4 (2-7)</td>
<td>11-15 (6-&gt;21)</td>
</tr>
<tr>
<td>Emergency department visits</td>
<td>0 (0-1)</td>
<td>1 (0-3)</td>
</tr>
<tr>
<td>Receipt of, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early intervention services at age &lt;3 y</td>
<td>19.0</td>
<td>82.2</td>
</tr>
<tr>
<td>Special education services at age range of 3-17 y</td>
<td>27.0</td>
<td>76.9</td>
</tr>
</tbody>
</table>

*a* All data are weighted. *P* < .001 for all variables (χ² test for proportions and Mann-Whitney test for nonparametric variables).

*b* More complex is defined as positive response to “need for more medical care” than usual item and 3 of the remaining 4 items on the complex children with special health care needs screener; medical equipment use; and seeing 2 or more specialists in the last 12 months.
Children with disabilities spending

- Hospital: 25%
- Physician: 18%
- ED: 3%
- Meds: 14%
- Home health: 25%
- Dental: 7%
- Other: 8%

Children without disabilities spending

- Hospital: 13%
- Physician: 25%
- ED: 7%
- Meds: 10%
- Home health: 2%
- Dental: 34%
- Other: 9%

How are CMC covered for insurance?

**FIGURE 1. Distribution of Insurance Coverage for CYSHCN with ASD/DD Compared with Other CYSHCN**

- **Private insurance**
  - CYSHCN with Autism and ASD: 45.8%
  - CYSHCN with Other Special Health Care Needs: 54%

- **Public benefit program (Medicaid and CHIP)**
  - CYSHCN with Autism and ASD: 33.7%
  - CYSHCN with Other Special Health Care Needs: 35.2%

- **Dual private/public coverage**
  - CYSHCN with Autism and ASD: 17.7%
  - CYSHCN with Other Special Health Care Needs: 7.1%

- **Uninsured**
  - CYSHCN with Autism and ASD: 2.8%
  - CYSHCN with Other Special Health Care Needs: 3.7%


http://www.amchp.org/Policy-Advocacy/health-reform/resources/Documents/ACA_AutismFactSheet_5-3-12.pdf
CMC and IDD

Chart 6.
Disabled beneficiaries in current-payment status, by diagnostic group, December 2012

The impairment on which disability is based varies with the type of beneficiary. In December 2012, diseases of the musculoskeletal system and connective tissue were the primary reason disabled workers and disabled widow(er)s received benefits; intellectual disability was the predominant reason for disability among disabled adult children.

Houston community providers response to “would you be willing to take care of CYSHCN, if supported?”

Repeat survey one year later 131 of 407 ‘Yes’ (32%).
Special Needs Primary Care

• Resident clinic crisis 2008

• Key drivers
  – Faculty expertise in complexity, intellectual disability, public insurance
  – Medical home model: more time and access for families, lead plan of care with TCH specialists, work to increase capacity with community providers
Objectives

- Define children with medical complexity (CMC)
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Special Needs Primary Care Clinic

- Primary care and care coordination
- Over 700 patients
- Patient population
  - Technology-dependent
  - Intractable seizures
  - Terminal conditions
- Exclusions
  - Live over 100 miles away
  - Not willing to switch medical homes
  - Solely behavioral health
I. Organizational capacity (family feedback and advisory group, regular visits, special rooms, in-person interpreters, regular education)

II. Chronic condition management (patient registry, strong community partnerships, co-management with specialists in the system, transition policy and partnership, 24/7 provider access)

III. Care coordination (care plans, case managers, expertise in community resources, advocacy)

IV. Community outreach (community & state outreach, EMR support)
Complexity

Case Management Time (faxes),
week of 8/15 to 8/21/2010
School forms excluded
5. **Effective care.** Of triaged calls, 75-86% resulted in a clinic visit versus an ER visit. Of patients seen in the ER, 42—66% required admission (much greater than the average local ER admission rate).

<table>
<thead>
<tr>
<th></th>
<th>Jan-10</th>
<th>Feb-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triaged Calls</td>
<td>174.00</td>
<td>167.00</td>
</tr>
<tr>
<td>Patients Seen in ER</td>
<td>44.00</td>
<td>24.00</td>
</tr>
<tr>
<td>ER Avoided</td>
<td>130.00</td>
<td>143.00</td>
</tr>
<tr>
<td>Avoidance Rate</td>
<td>74.7%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Admitted</td>
<td>29.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Sent home from ER</td>
<td>15.00</td>
<td>14.00</td>
</tr>
<tr>
<td>ER admission rate</td>
<td>65.9%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>159</td>
<td>45</td>
</tr>
<tr>
<td>Average LOS</td>
<td>5.48</td>
<td>4.50</td>
</tr>
</tbody>
</table>
Objectives

- Define children with medical complexity (CMC)
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## Patient access

<table>
<thead>
<tr>
<th>Weekly summaries</th>
<th>Patient Volume</th>
<th>No shows</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Average</td>
<td>Min</td>
</tr>
<tr>
<td>June Summary</td>
<td>222</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>July Summary</td>
<td>191</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Aug</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 1</td>
<td>56</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Week 2</td>
<td>49</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Week 3</td>
<td>74</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Week 4</td>
<td>66</td>
<td>13</td>
<td>5</td>
</tr>
</tbody>
</table>

*No show initiative*
- Automated and personal calls
- McKesson embedded case managers
## Care coordination

### Number patients in case management

<table>
<thead>
<tr>
<th>Number patients in case management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Genevieve</td>
<td>52</td>
</tr>
</tbody>
</table>

### Initiatives

- Vulnerable transition service (NICU, PICU)
- Weekly team huddles
- DME providers: improve paperwork turnover, ambulance expectations
- Nursing providers: standardize nursing expectations
- Curriculum for case manager training
- Validating case management severity tool

### Barriers

- Lack of real time data from health plans
- Lack of integrated communication with health plans
- No capitation or care coordination payments or incentives
Staff satisfaction

• Staff turnover: 98% over the past 2 years

• Initiatives
  – Weekly teambuilding sessions
  – Shared leadership model (Baylor – TCH)
  – Wellness emphasis
## Medical Home

### Transition QI
- Tracking transition policy to ages 14 +
- Next step: transition effectiveness

### Other projects
- Nutrition QI
- NCQA certification

<table>
<thead>
<tr>
<th></th>
<th>Transition</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>June</td>
<td></td>
<td>Number</td>
<td>% days</td>
</tr>
<tr>
<td>Week 1</td>
<td></td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Week 2</td>
<td></td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Week 3</td>
<td></td>
<td>3</td>
<td>67%</td>
</tr>
<tr>
<td>Week 4</td>
<td></td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>July</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 1</td>
<td></td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Week 2</td>
<td></td>
<td>3</td>
<td>67%</td>
</tr>
<tr>
<td>Week 3</td>
<td></td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>Week 4</td>
<td></td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Aug</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 1</td>
<td></td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Week 2</td>
<td></td>
<td>3</td>
<td>67%</td>
</tr>
<tr>
<td>Week 3</td>
<td></td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Week 4</td>
<td></td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>
System Integration

- Care Coordination
- Transition Support
- Education
- Advocacy
- Data Analytics
- Funding/Scholarship
- Texas Children's Hospital Inpatient
- Texas Children's Hospital Outpatient
- Texas Children's Pediatrics and The Center
- Other Regional Primary Care Providers
System Integration

Assessment

Continuous Monitoring

Goal Setting

Care Planning

Patients Across All Settings
System Integration

- Care Coordinator: 1:70
- Patient Navigator: 1:500
- Vulnerable Transition: 1:200
- Behavioral Health: 1:200
- Care Managing Assistant

Non-Traditional Patient Care Approach
System Integration

- Care Coordination
- Transition Support
- Education
- Advocacy
- Data Analytics
- Funding/Scholarship

- Texas Children’s Hospital Inpatient
- Texas Children’s Hospital Outpatient
- Texas Children’s Pediatrics and The Center
- Other Regional Primary Care Providers
System Integration

- Consultation Service
- Education for Community PCPs
  - Formal CME
  - Just in Time Coaching
  - Fellowship (i.e. CHoSA)
- Telemedicine / TeleHealth
System Integration

- Care Coordination
- Transition Support
- Education
- Advocacy
- Data Analytics
- Funding/Scholarship

- Texas Children’s Hospital Inpatient
- Texas Children’s Hospital Outpatient
- Texas Children’s Pediatrics and The Center
- Other Regional Primary Care Providers
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)
System Integration

- Care Coordination
- Transition Support
- Education
- Advocacy
- Data Analytics
- Funding/Scholarship

Texas Children’s Hospital
- Inpatient
- Outpatient

Texas Children’s Pediatrics and The Center

Other Regional Primary Care Providers
System integration

Clinical Program

Children with Medical Complexities Balanced Scorecard

<table>
<thead>
<tr>
<th>Venue of Care</th>
<th>Metric</th>
<th>Donabedian Classification</th>
<th>IOM Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Compliance with routine check-up and follow-up visits with either the primary care physician or referral (numerator: number of completed visits &amp; denominator: number of all anticipated visits)</td>
<td>Outcome</td>
<td>Access to Care, Care Coordination, Timely, Efficient</td>
</tr>
<tr>
<td>All</td>
<td>Percentage of patients with an up-to-date proactive care plan that takes into consideration the patient's and family's preferences and is culturally-sensitive.</td>
<td>Process</td>
<td>Care Coordination, Equitable, Patient-Centered</td>
</tr>
<tr>
<td>All</td>
<td>Patient experiences (coordination of care / communication) with services delivered by TCH ID.</td>
<td>Outcome</td>
<td>Patient-Centered</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Number of antibiotics used and duration</td>
<td>Outcome</td>
<td>Effective</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency center utilization rates</td>
<td>Outcome</td>
<td>Effective, Efficient</td>
</tr>
<tr>
<td>IP/OBS</td>
<td>Percentage of patients that received a reconciled medication list and whose discharge summary was transmitted to the primary physician or other health care professional for follow-up care within 24 hours of discharge.</td>
<td>Process</td>
<td>Access to Care, Care Coordination, Patient-Centered, Safe</td>
</tr>
<tr>
<td>IP/OBS</td>
<td>Median length of stay and mean annual admissions for CMC cases</td>
<td>Outcome</td>
<td>Efficient, Effective, Patient-Centered</td>
</tr>
</tbody>
</table>