Houston Special Needs Primary Care Clinic

STAR Kids Advisory Committee
Sept 10, 2014

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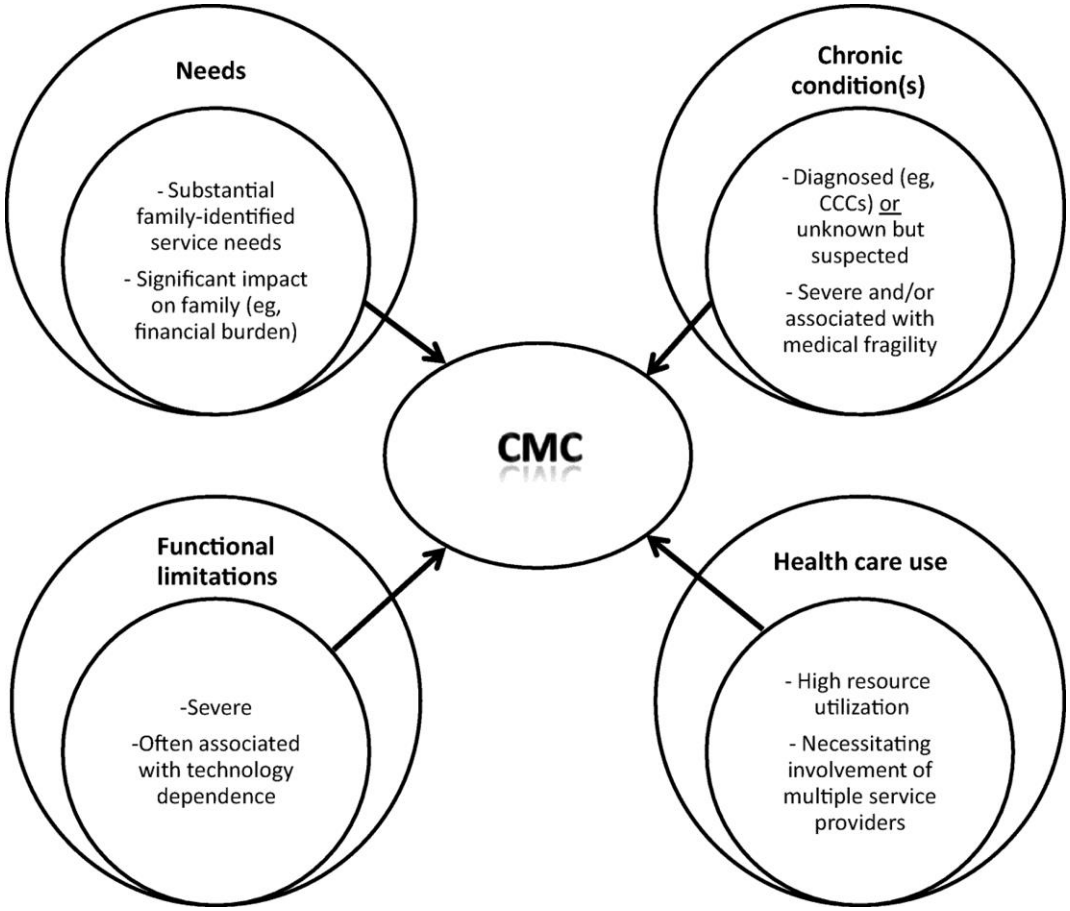
Objectives

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

CMC

- Children with medical complexity = the sickest of the sick



Cohen E, et al. Children with medical complexity: An emerging population for clinical and research initatives. Pediatrics. 2011;127(3):529-538

From: **A National Profile of Caregiver Challenges Among More Medically Complex Children With Special Health Care Needs**

Arch Pediatr Adolesc Med. 2011;165(11):1020-1026. doi:10.1001/archpediatrics.2011.172

Table 3. Medical Care Use of Children With Special Health Care Needs by Complexity[a]

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

[a]All data are weighted. $P<.001$ for all variables (χ^2 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.

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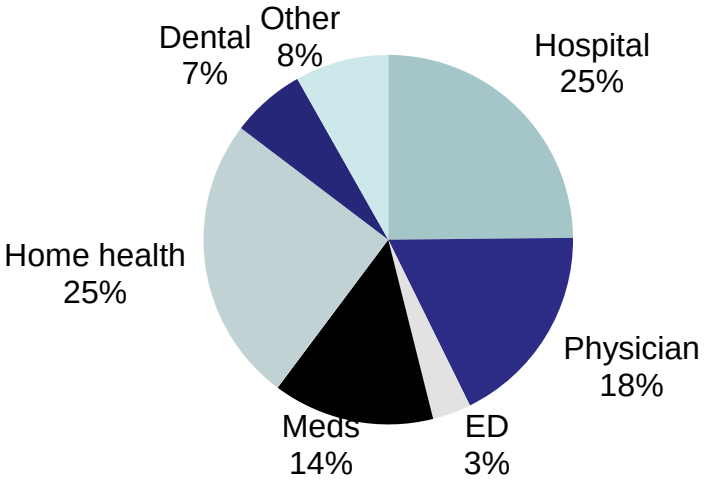
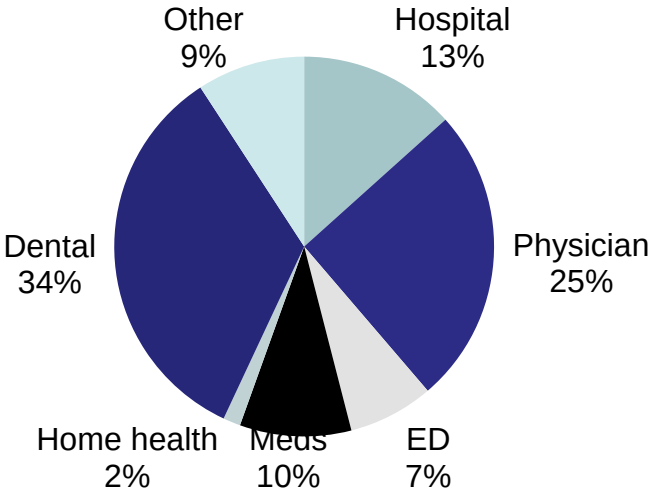
Children with disabilities spending



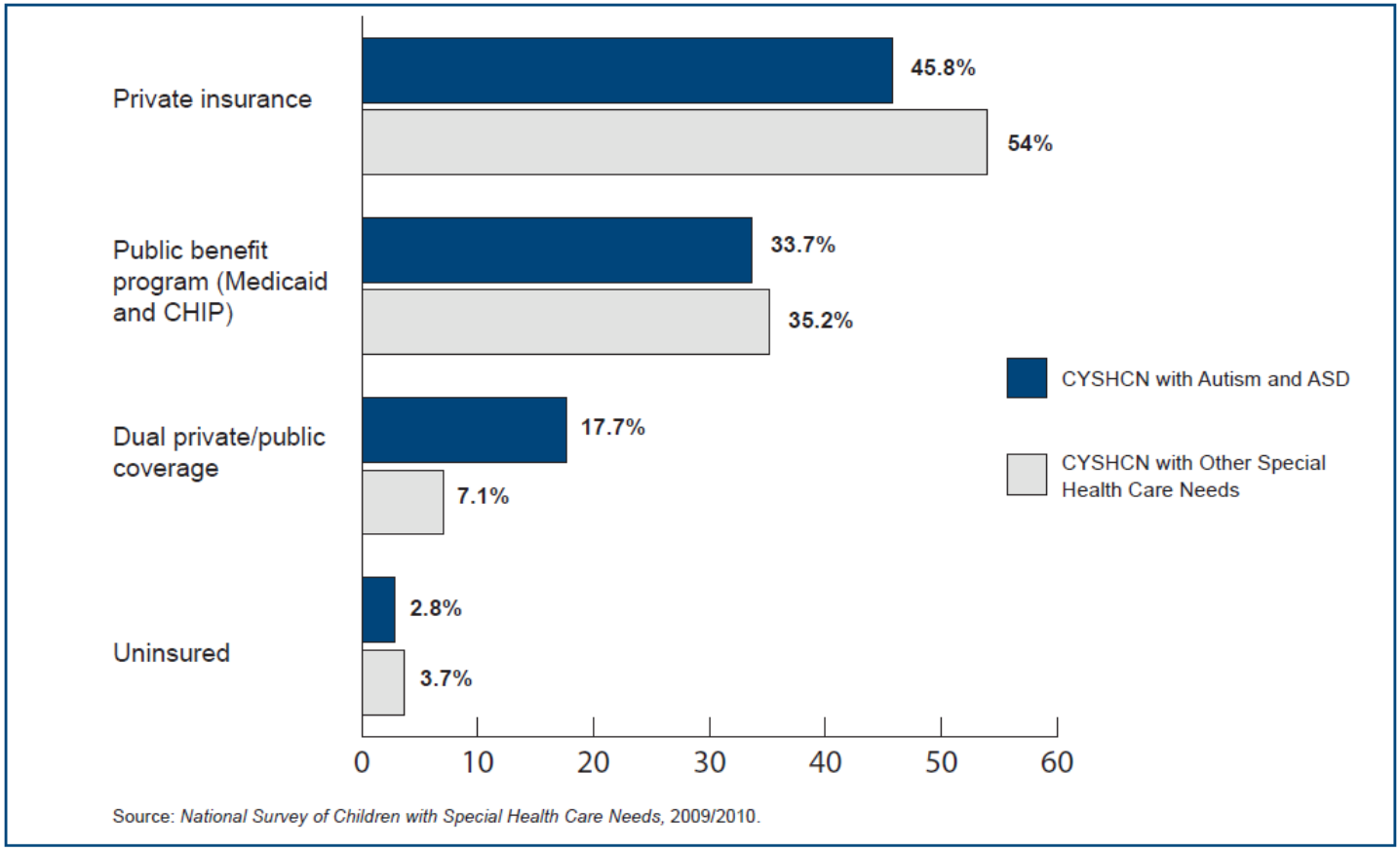
Children without disabilities spending



Newacheck P,et al. Pediatrics. 2004;114;79

How are CMC covered for insurance?

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



Source: *National Survey of Children with Special Health Care Needs*, 2009/2010.

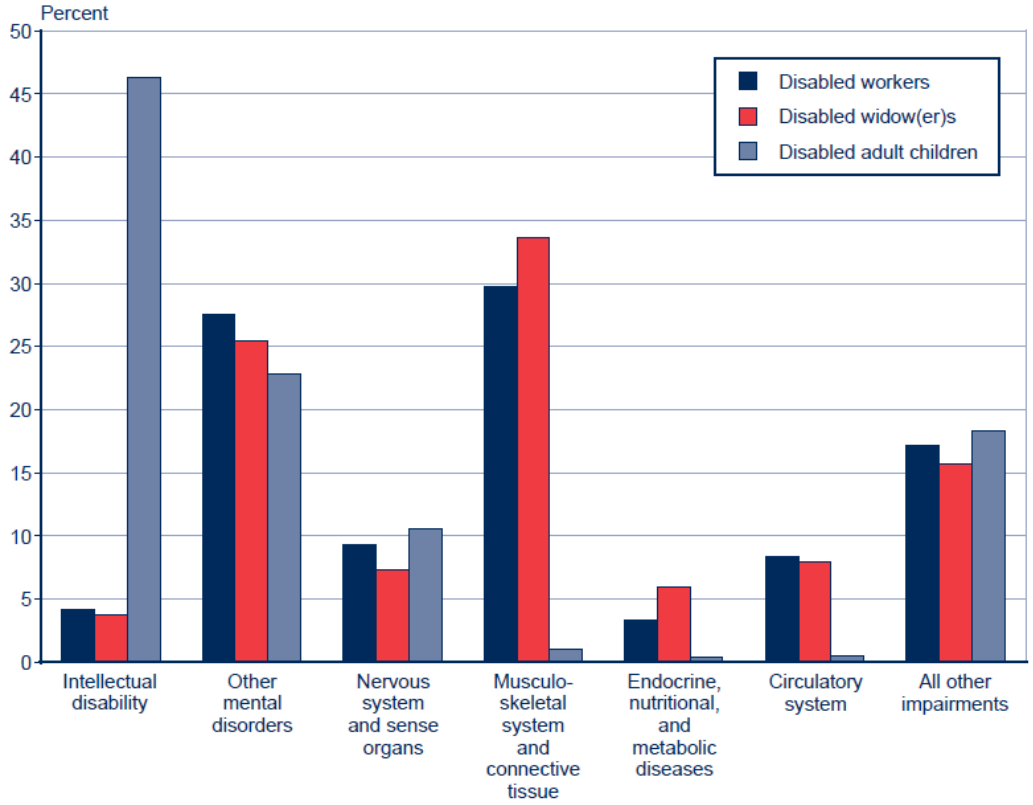
http://www.amchp.org/Policy-Advocacy/health-reform/resources/Documents/ACA_AutismFactSheet_5-3-12.pdf

CMC and IDD

Beneficiaries in Current-Payment Status

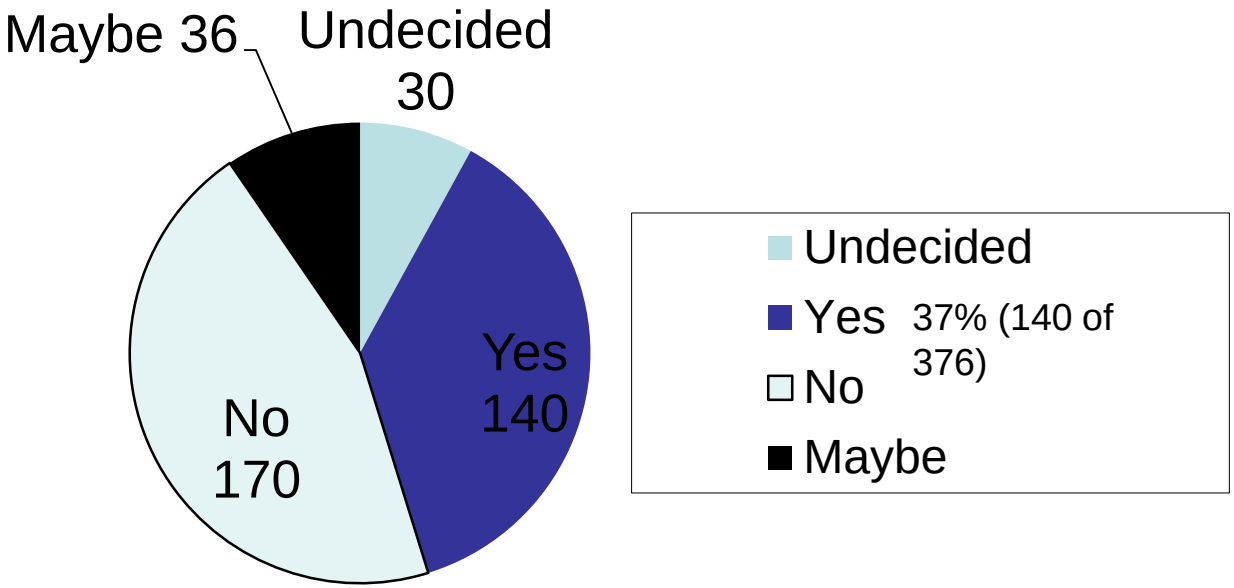
Chart 6.
Disabled beneficiaries in current-payment status, by diagnostic group, December 2012

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.



http://www.ssa.gov/policy/docs/statcomps/di_asr/2012/sect01.pdf

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%).

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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

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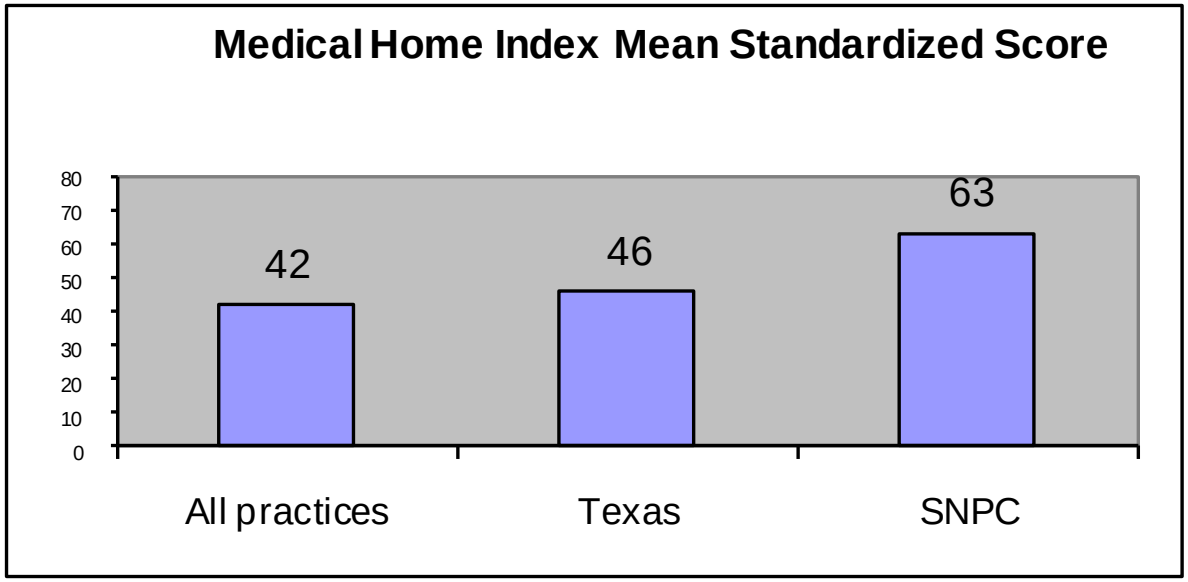
Special Needs Primary Care Clinic

- 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)

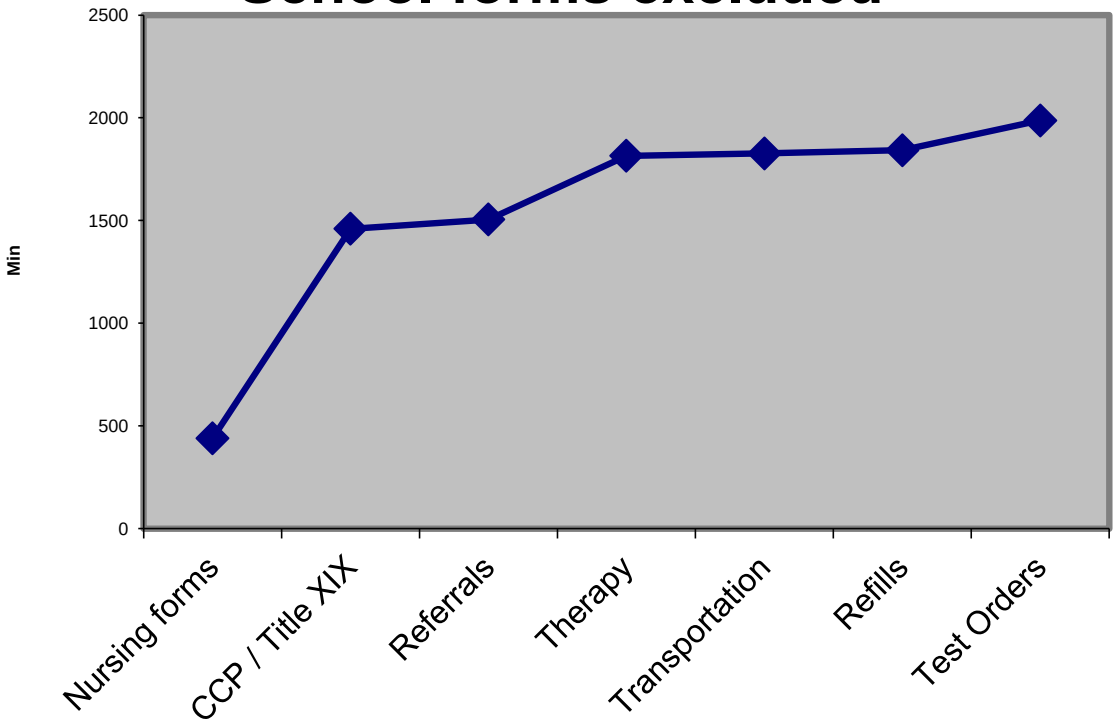
II. Chronic condition management (patient registry, strong community partnerships, co-management with specialists in the system, transition policy and partnership, 24/7 provider access)

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

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

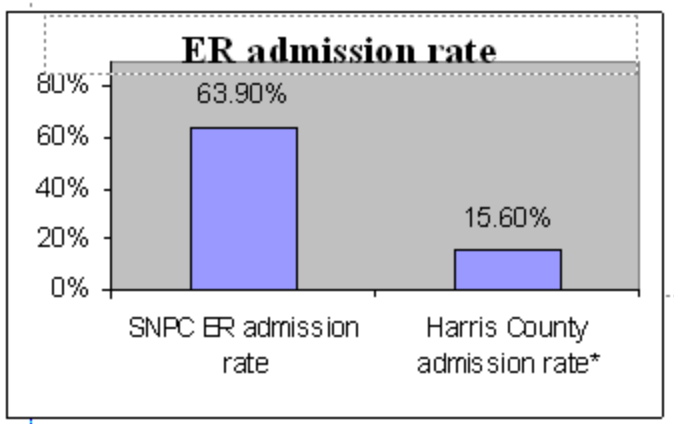
Complexity

Case Management Time (faxes), week of 8/15 to 8/21/2010 School forms excluded



Outcomes

5. **Effective care.** Of triaged calls, 75-86% resulted in a clinic visits versus an ER visit. Of patients seen in the ER, 42—66% required admission (much greater than the average local ER admission rate).



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

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Patient access

Weekly summaries						
	Patient Volume				No shows	
June	Total	Average	Min	Max	Number	%
Summary	222	12			28	12
July						
Summary	191	11			24	13%
Aug						
Week 1	56	11	5	15	8	14%
Week 2	49	10	4	13	5	10%
Week 3	74	15	6	22	8	11%
Week 4	66	13	5	18	13	20%

<u>No show initiative</u>
-Automated and personal calls
-McKesson embedded case managers

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Care coordination

Number patients in case management	
Genevieve	52

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

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Staff satisfaction

- Staff turnover: 98% over the past 2 years

- <u>Initiatives</u>
  - Weekly teambuilding sessions
  - Shared leadership model (Baylor – TCH)
  - Wellness emphasis

Medical Home

June	Transition Number	% days missed
Week 1	4	100%
Week 2	2	100%
Week 3	3	67%
Week 4	2	100%
July		
Week 1	1	100%
Week 2	3	67%
Week 3	3	0%
Week 4	1	0%
Aug		
Week 1	2	0
Week 2	3	67%
Week 3	5	80%
Week 4	4	100%

Transition QI

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

Other projects

- Nutrition QI
- NCQA certification

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

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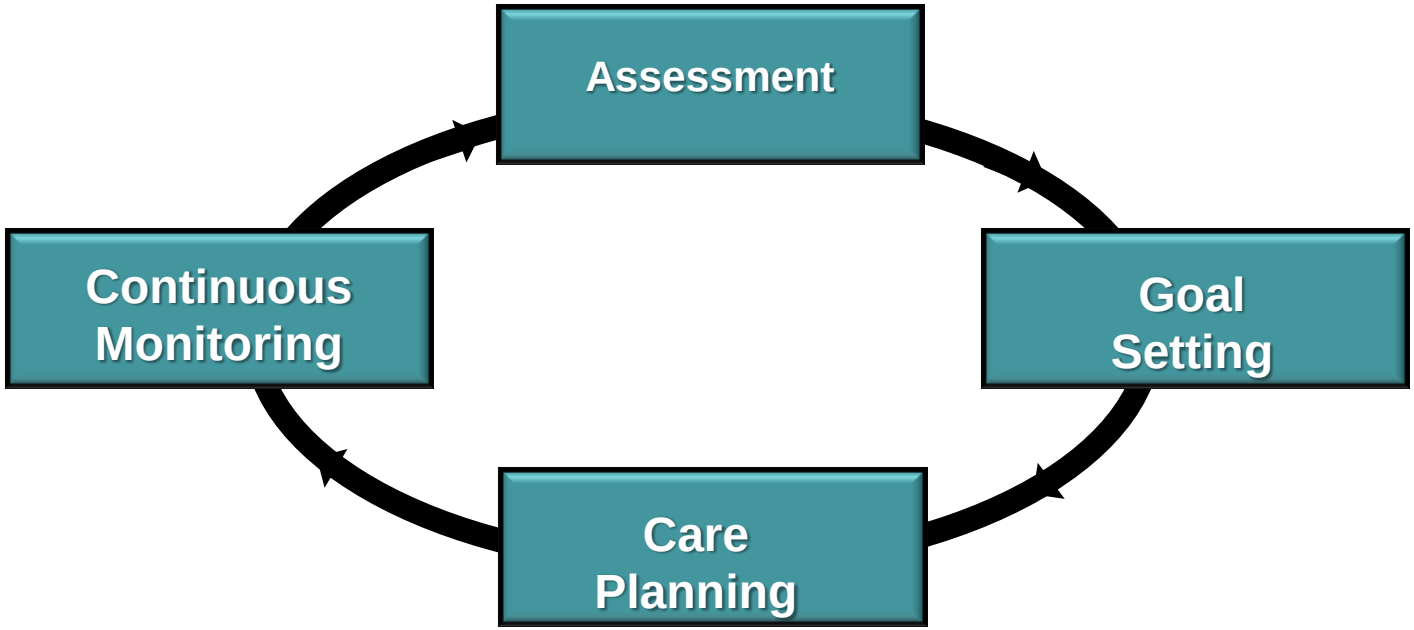
System Integration



Patients Across All Settings

Texas Children's Hospital®

System Integration

Medicine

Texas Children's Hospital®

Care Coordinator

1:70

Patient Navigator

1:500

Vulnerable Transition

Behavioral Health

1:200

Care Managing Assistant

Non-Traditional Patient Care Approach

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System Integration

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

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Other Regional Primary Care Providers

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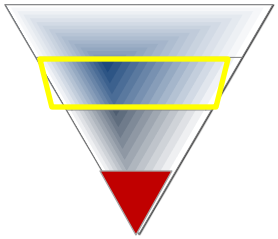
System Integration

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



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System Integration

- Care Coordination
- Transition Support
- Education
- Advocacy
- Data Analytics
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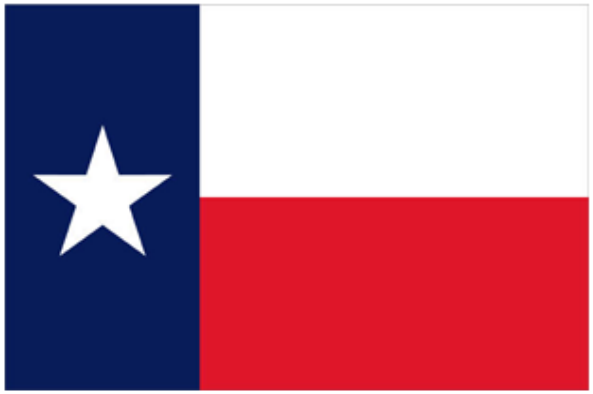

Class of 2015

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

Texas Children's Hospital Outpatient

Texas Children's Pediatrics and The Center

Other Regional Primary Care Providers

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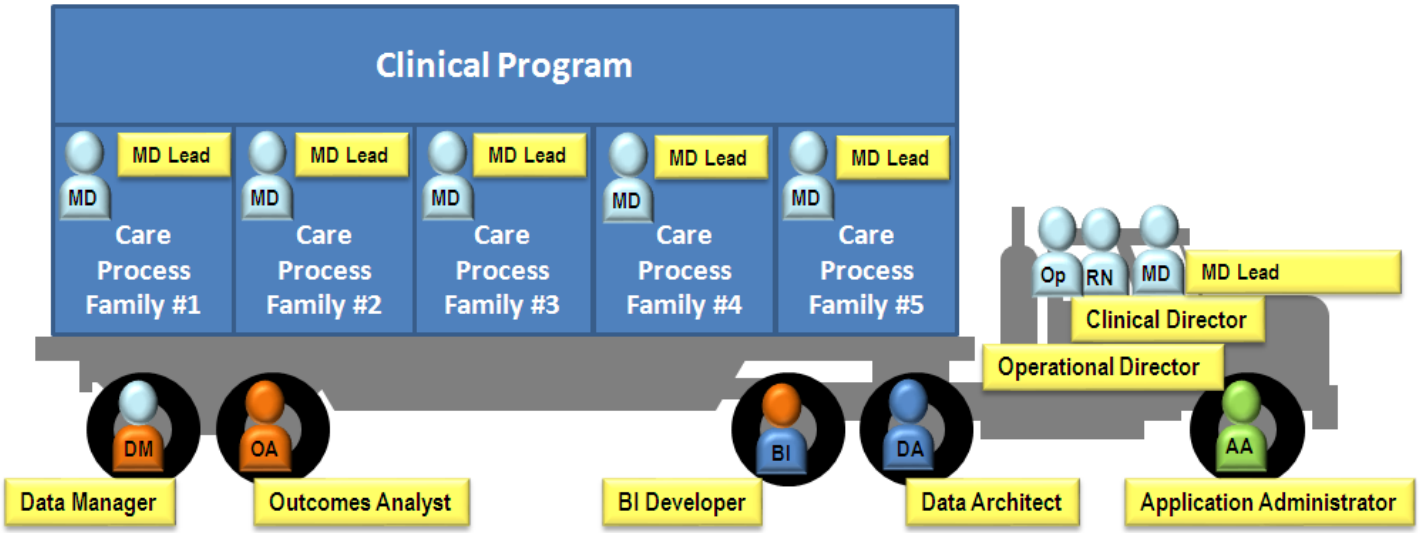
System integration



Children with Medical Complexities Balanced Scorecard			
Venue of Care	Metric	Donabedian Classification	IOM Domains
All	Compliance with routine check-up and follow-up visits with either the primary care physician or referral (numerator: number of completed visits & denominator: number of all anticipated visits)	Outcome	Access to Care, Care Coordination, Timely, Efficient
All	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.	Process	Care Coordination, Equitable, Patient-Centered
All	Patient experiences (coordination of care / communication) with services delivered by TCH IDS.	Outcome	Patient-Centered
Critical Care	Number of antibiotics used and duration	Outcome	Effective
EC	Emergency center utilization rates	Outcome	Effective, Efficient
IP/OBS	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.	Process	Access to Care, Care Coordination, Patient-Centered, Safe
IP/OBS	Median length of stay and mean annual admissions for CMC cases	Outcome	Efficient, Effective, Patient-Centered

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