

Technical Assistance for Medical Home & Health Care Transition Performance Measures]

Webinar Presentation

March 28, 2016

**Prevention and Health Promotion Administration
Office of Genetics and People with Special Health Care Needs**

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HRSA Title V Transformation 3.0

- An essential component of Transformation 3.0 is the development of Performance Measure Framework.
- Performance measures
 - generally accepted, objective standard of measurement against which a grantee's level of performance can be compared
 - describe specific, tangible processes and outcomes that need to be accomplished. They contribute to the achievement of overarching goals
 - provide a framework to guide applicants and funded grantees in their proposed projects.



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Webinar Aim:

1. Provide background information on OGPSHCN selected priorities areas-Medical Home & HCT
2. Provide definitions and clarity to focus areas and components of Medical Home and HCT
3. Assist potential grantees in selecting appropriate performance measures that will allow grantees to measure their programs performance and progress



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Medical Home

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Maryland Department of Health & Mental Hygiene

Prevention and Health Promotion Administration

Definitions, Suggested Strategies, and
Performance Measures



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Definition of Children and Youth with Special Health Care Needs

Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally



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National Performance Measure: Medical Homes

The National Survey of Children with Special Health Care Needs (NS-CSHCN) is designed to provide information on the CYSHCN population and to assist in the measurement of its core outcomes. Outcome #2 assesses if CYSHCN receive care within a medical home, a key American Academy of Pediatrics priority. Nationally, 43.0% of CYSHCN meet this outcome, with states ranging from 34.2% - 50.7%, as measured in the 2009/10 NS-CSHCN. In Maryland, 44.2% of CYSHCN meet this outcome. Maryland ranks 28th in the nation.



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The Pediatric Medical Home



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In practice, this basic notion has been operationalized in at least two different ways:

- One way is that care coordination has been included as one of the pillars of the “medical home”. Medical home serves as a point of entry for CSHCN and helps coordinate care in an otherwise decentralized system of health care delivery.
- Care coordination programs that stand alone without being part of a medical home represent a second way that the basic notion of ‘a process that facilitates linkage’ has been implemented nationwide.



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Care Coordination

- Sophisticated way of organizing the systems of care. Care for the chronically ill needs to be a collaborative, multidisciplinary process. Integrated healthcare delivery systems represent an important step towards addressing the coordination needs of those with chronic health conditions.



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Case Management is NOT care Coordination!

AAP Definition:

care coordination as “a process that facilitates the linkage of children and their families with appropriate services and resources in a coordinated effort to achieve good health”

The basic notion of ‘a process that facilitates linkage’ constitutes the core of care coordination activities.



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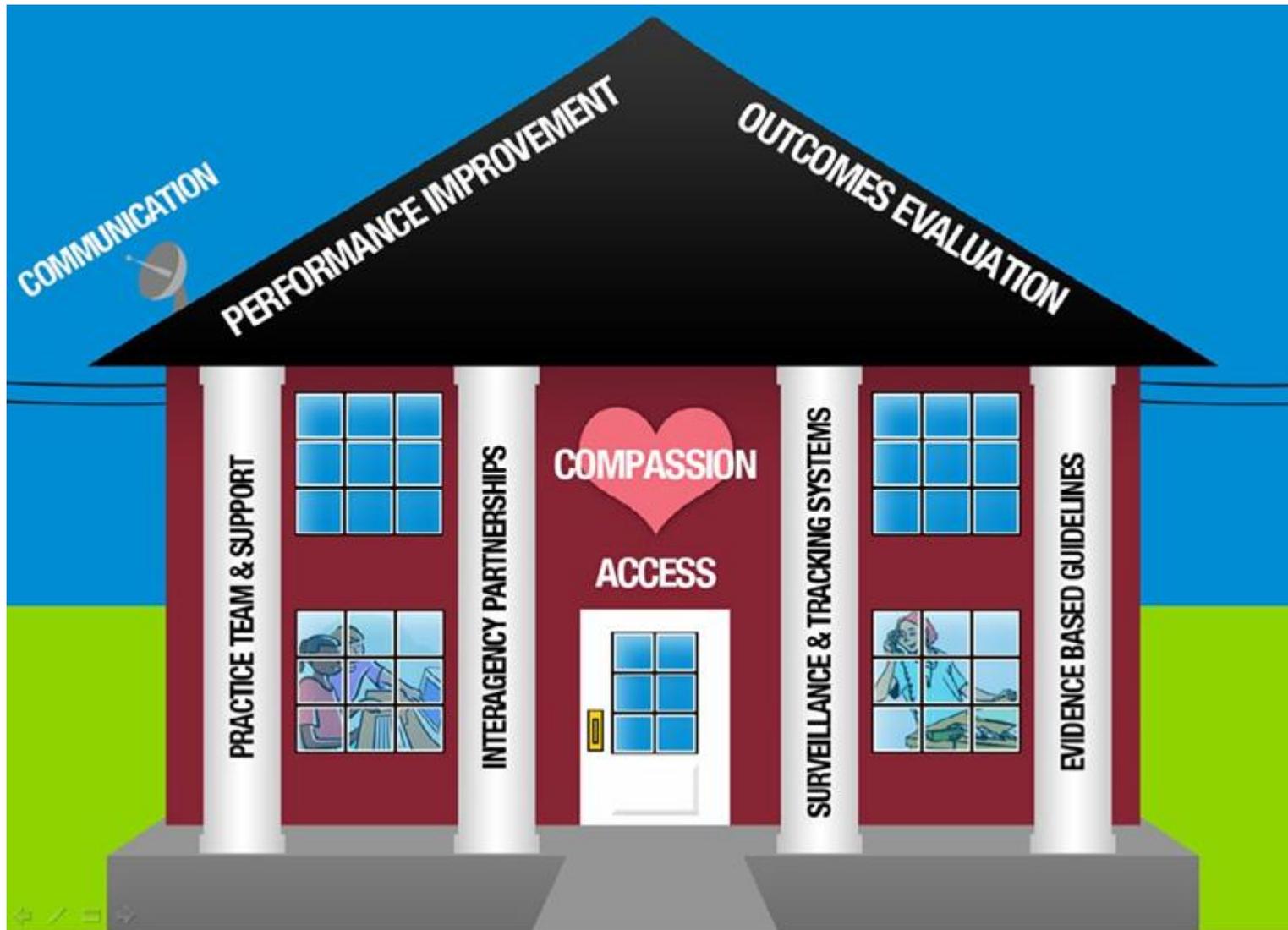
What are the similarities and differences?

- Case management
- Disease management
- Comprehensive, high performing pediatric care coordination



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Care Coordination: Heart of the Medical Home

- Transforms a house into a home 
- Promotes efficiency and continuity of care
- Focuses on helping those in the home get their needs met (immediate and ongoing)
- Makes coming in and going out easier
- Creates a friendly, supportive environment for patients and families and each other
- Prepares patients and families for the future

Defining Characteristics of Care Coordination

- Patient- and family-centered
- Proactive, planned, and comprehensive
- Promotes self-care skills and independence
- Emphasizes cross-organizational relationships



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Care coordination programs that stand alone without being part of a medical home represent a second way that the basic notion of ‘a process that facilitates linkage’ has been implemented nationwide.

The next section describes the focus of care coordination as a primary focus and actionable component of many partners of the Medical Home and so called “medical neighborhood.”



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Focus Measures

ACCESS TO MEDICAL HOME, HEALTH CARE, AND OTHER RESOURCES

- Identify and register the CYSHCN population
- Establish with families effective means for medical home/office access
- Provide accessible office contact for family and community agencies
- Catalog resources to link families to appropriate educational, information and referral sources
- Promote and “market” practice-based care coordination to families and others (e.g. brochures, posters, outreach efforts)

COMMUNITY CONNECTIONS & IMPROVING AND SUSTAINING QUALITY FOR CYSHCN

- Establish alliances with community partners
- Facilitate practice & family linkages with agencies (e.g. family support, schools, early intervention, home care, day care & agencies offering respite, housing, & transportation)
- Align transition support activities with schools & other groups
- Collaborate to improve systems of care for CYSHCN (families, payers, providers, and agencies)



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Focus Measures

PROACTIVE CARE PLANNING FOR CYSHCN

- Help to maintain health and wellness & prevent secondary disease complications
- Maximize outcomes (e.g. alleviation of the burden of illness, effective communication across organizations, enrollment in needed services, and school attendance/success)
- Listen, counsel, educate, & foster family skill building
- Screen for unmet family needs
- Develop written care plans; implement, monitor and update regularly
- Plan for future transition needs; incorporate into plan of care
- Facilitate sub speciality referrals, communication & help family integrate recommendations of specialists
- Link family, staff to educational/financial resources



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FUNCTIONS OF CARE COORDINATION:

1. Establish relationships with children, youth, and families through introductory visits dedicated to setting expectations for care coordination
2. Promote communication with families and among professional partners, and define minimal intervals between communications.
3. Complete a child/youth and family assessment
4. Working with the family, develop a written care plan, including a medical summary, action plan, and, if needed, an emergency plan, that reflects mutual goals.
5. Arrange for, set up, and coordinate referrals, and track referrals and test results.



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FUNCTIONS OF CARE COORDINATION

6. Provide condition-specific and related medical, financial, educational, and social supportive resource information, while coaching for the transfer of skills supportive of partnerships with families to care for their children and youth
7. Ensure the health care team integrates multiple sources of health care information; communicate this summary, thereby building caregiver skills and fostering relationships between the health care team and families
8. Support and facilitate all care transitions from practice to practice and from the pediatric to adult systems of care.
9. Coordinate family-centered team meetings (across organizations as needed).
10. Use health information technology to effectively deliver and continually monitor care coordination and the effectiveness of service delivery.



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Now that we understand functions and strategies of care coordination:

Measures and Goals or Outcomes



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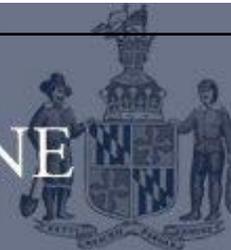
<p>Costs of care</p>	<p>Reduced emergency department visits Increase in measures of health</p>	<p>Baseline of emergency or urgent care usage % decrease in usage of emergency or urgent care</p>	<p>activity log, or Care Coordination Measurement Tool)</p>
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<p>Function(addressing the improved function of the CYSHCN or the family of CYSHCN)</p>	<ol style="list-style-type: none"> 1. Ease of access to resource information 2.Achieve self-management skills 3.Enhance communication among providers/family/ community partners 4.Increase functional abilities 5.Support achievement of optimal developmental trajectory 	<p>Baseline Family Reports (CMHI Family Survey)</p> <p>% Increase in family and professional access to information about resources</p> <p>% Increase in documentation of care plan or medical summary use</p> <p>Establish baseline and compare % increase in any of following: improved functional assessment, increase in and number of care plans developed and shared; improved school attendance and or school success; improved ability to perform activities of daily living.</p>	<ol style="list-style-type: none"> 1.Patient, family, PCP, and specialist report 2.Patient, family, PCP, and specialist report 3.Care plans 4.Functional assessments 5.Standardized screening <p>Family report, plan report, school reports.</p> <p>CMHI survey tools</p>
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Performance Measures Medical Home: Non –clinical

The number of locally identified resources

The patients level at the point of entry to care coordination services.

Family Satisfaction-decrease in worry and frustration, increased sense of partnership with professionals, improved satisfaction with team communication

The number of Trainings on Medical Home conducted to providers and partners

The number of Trainings on Cultural Competency/family Sensitivity

The number of parent/caregivers that receive education on advocacy, family and patient rights and guardianship.

The number of parent/caregiver education workshops conducted

The educational opportunities offered to collaborative partners

The number of providers (primary, adult or specialty) that were identified and received training

The number of identified collaborative partners

The number of linkages established between health care and community providers



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Medical Home Care Coordination Measurement Tool©

Site Code: _____

Form # _____ of _____

Date	Patient Study Code	III CSHCN Without Complication	Focus	Care Coordination Needs	Activity Code(s)	Outcome(s) Prevented Occurred	Time Spent*							Staff	Clinical Comp.	Initials
							1	2	3	4	5	6	7			

Patient Level
 Level Description
I Non-CSHCN, **Without** Complicating Family or Social Issues
II Non-CSHCN, **With** Complicating Family or Social Issues
III CSHCN, **Without** Complicating Family or Social Issues
IV CSHCN, **With** Complicating Family or Social Issues

Focus of Encounter (choose ONE)
 1. Mental Health
 2. Developmental / Behavioral
 3. Educational / School
 4. Legal / Judicial
 5. Growth / Nutrition
 6. Referral Management
 7. Clinical / Medical Management
 8. Social Services (ie. housing, food, clothing, ins, trans.)
 Rev-09/10

Care Coordination Needs
 (choose **all that apply**)
 1. Make Appointments
 2. Follow-Up Referrals
 3. Order Prescriptions, Supplies, Services, etc.
 4. Reconcile Discrepancies
 5. Coordination Services (schools, agencies, payers etc.)

Time Spent
 1 - less than 5 minutes
 2 - 5 to 9 minutes
 3 - 10 to 19 minutes
 4 - 20 to 29 minutes
 5 - 30 to 39 minutes
 6 - 40 to 49 minutes
 7 - 50 minutes and greater*
 (*Please NOTE actual minutes if greater than 50)

Staff
 RN, LPN, MD, NP, PA, MA, SW, Cler

Clinical Competence
 C= Clinical Competence required NC= Clinical Competence not Required

Activity to Fulfill Needs
 (choose **all that apply**)
1. Telephone discussion with:
 a. Patient e. Hospital/Clinic
 b. Parent/family f. Payer
 c. School g. Voc. / training
 d. Agency h. Pharmacy
2. Electronic (E-Mail) Contact with:
 a. Patient e. Hospital/Clinic
 b. Parent f. Payer
 c. School g. Voc. / training
 d. Agency h. Pharmacy
3. Contact with Consultant
 a. Telephone c. Letter
 b. Meeting d. E-Mail
4. Form Processing (eg. school, camp, or complex record release)
5. Confer with Primary Care Physician
6. Written Report to Agency: (eg. SSD)
7. Written Communication
 a. E-Mail
 b. Letter
8. Chart Review
9. Patient-focused Research
10. Contact with Home Care Personnel
 a. Telephone c. Letter
 b. Meeting d. E-Mail

Outcome(s)
 As a result of this care coordination activity, the following was **PREVENTED**
 (choose **ONLY ONE**, if applicable): 1a. ER visit
 1b. Subspecialist visit 1c. Hospitalization
 1d. Visit to Pediatric Office/Clinic 1e. Lab / X-ray
 1f. Specialized Therapies (PT, OT, etc)
 2. As a result of this care coordination activity, the following **OC CURRED** (choose **all that apply**):
 2a. Advised family/patient on home management 2b. Referral to ER
 2c. Referral to subspecialist 2d. Referral for hospitalization
 2e. Referral for pediatric sick office visit 2f. Referral to lab / X-ray
 2g. Referral to community agency 2h. Referral to Specialized Therapies
 2i. Ordered prescription, equipment, diapers, taxi, etc. 2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
 2k. Reviewed labs, specialist reports, IEP's, etc. 2l. Advocacy for family/patient
 2m. Met family's immediate needs, questions, concerns 2n. Unmet needs **(PLEASE SPECIFY)**
 2o. Not Applicable / Don't Know 2p. Outcome Pending
 Supported by grant HRSA-02-MCHB-25A-AB



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Health Care Transition

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Maryland Department of Health & Mental Hygiene

Prevention and Health Promotion Administration

Definitions, Suggested Strategies, and
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Health Care Transition

Health care transition is the process of changing from a pediatric to an adult model of health care.

The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.



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Overall Measure: The percentage of Maryland families of youth with special health care needs (YSHCN) reporting that they have participated in health care transition planning for their youth according to the annual Maryland Transitioning Youth Parent Survey (baseline measurement for 2011 is 17%). There are disparities noted by the presence of one or more Emotional/Behavioral Disorders with only 28% of these children achieving this outcome, compared to 42.5% of CYSHCN without however whites achieve this outcome at more than 1.5 times the rate of non- Hispanic Blacks.



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Health Care Transition Performance Measurement Goals

- A. For the **families** of transition age youth to improve their understanding of the health care transition policy(proposed); and the skills needed for successful transition to adult medical care.

- A. For the **clinicians** to improve in their knowledge of the skills necessary for successful transition from pediatric to adult care. To Include the six core elements in care plans.



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6 Core Elements

1. Transition Policy
2. Transition tracking and monitoring
3. Transition readiness
4. Transition planning
5. Transfer of care
6. Transfer completion



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Performance Measures: SFY 2017

- Increase the number of presentations to staff and partners on health care transition. CME's.
- Number of outreach events/activities (families/youth/community base).
- Number of families receiving information on health care transition.
- Number of group education activities (youth/families).
- Number of staff training hours on health care transition policy and care plans and transfer for care plans.
- Number of care plans ready for adult transfer.
- Number of care plans transferred to adult care.



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Performance Measures: SFY 2016

- Percentage of activities developed to capture health care transition data.
- Percentage of partners publicizing survey for youth/parent **collection**.
- Percentage of Partners publicizing findings for youth/parent **findings**.
- Percentage of CYSHN given a HCT policy, prepared readiness/self-assessment, and care plan.
- Percentage of (All) youth given a policy, prepared readiness/self-assessment, and care plan.
- Percentage of (All) youth transferred into adult care, using the Six Core Element's Tool.
- Percentage of CYSHN transferred into adult care, using the Six Core Elements.



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Options for Tracking and Reporting

Client Service Bills
Meeting(s) Attendance records
Client Appointments
Client Records
Material purchases/invoices
Data reports
Surveys



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IMPORTANT DATES TO REMEMBER:

- **APPLICATION DUE DATES** **May 13, 2016**
- **TA CALL FOR LHD** **APRIL 15, 2016 (10 AM TO 11AM)**
- **TA CALL FOR SYSTEM GRANTS** **APRIL 19, 2016 (10AM TO 11AM)**
- **START DATE FOR FY 17 GRANTS** **JULY 1, 2016**
- **END DATE FOR FY 17 GRANTS** **JUNE 30, 2017**



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Thank
You



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