Mississippi Partnership for Continuous Quality Improvement Project Implementation Summary

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Mississippi Continuous Quality Improvement
Project Implementation Summary

I. Introduction

This project was established by the Mississippi Partnership for Continuous Quality Improvement Team (MSPCQI) in response to the training workshop provided by the National Initiative for Children's Healthcare Quality (NICHQ) in June 2010. The project was sponsored by the U.S. Department of Health and Human Services, Maternal and Children Health Bureau (Grant D70).

The MSPCQI team members are professionals from the Children’s Medical Program at the Mississippi State Department of Health (state Title V agency), the Institute for Disability Studies (IDS) at The University of Southern Mississippi, the Mississippi Division of Medicaid, the Mississippi Chapter of American Academy of Pediatrics, and the state family representative.

During the training, the MSPCQI developed the Care Quality Improvement Plan (Appendix) based on the priorities identified by the team members. The project was implemented during the period of July through December 2010. Implementation data were collected monthly by CMP/MSDH and entered and annotated by IDS to the database created by the Institute for Health Improvement (IHI).

II. Project Goal (Aim Statement)

By December 31, 2010, at least 32 or more children graduating from the Children's Medical Program (CMP) (from July 1, 2010 to December 31, 2010) will receive ongoing primary care in a Medical Home. (Baseline: 43 would graduate by December 2010. During the six-month period, one case was deceased and one case moved out of the state. The amended baseline is 41).

III. Outcomes and Process Measures (Indicators)

1. Number of CYSHCNs with adult Medical Home (for their primary care needs)
2. Number of families contacted
3. Number of families that have plans for ongoing care
4. Number of CYSHCNs who received coordination to create a transition plan

Definition of Medical Home

Medical Home is an ongoing source of primary care through a physician or nurse practitioner seeing the children at least once a year for check-ups and treatment of acute and chronic conditions and/or illnesses (MSDH, 2010)

IV. Performance Summary

Based on the final data collected on January 24, 2011, the status of project implementation was summarized as follows. It should be noted that the data collection efforts were a continuous process during the six-month period. Data changes after respective monthly report dates were not reflected in the figures.
Indicator 1. Number of CYSHCNs who received coordination to create a transition plan to Medical Home

Figure 1 presents the changes in number of CYSHCNs with Medical Home (coordinated) care plan in the six-month period:

Figure 1.

The final data collected in January 2011 showed 36 of 41 CYSHCNs (88%) whose birth dates reached 21 years old had Medical Homes.

Table 1 shows the Medical Home status of CYSHCNs whose birth dates were in the respected months. Additionally, specific actions were taken to contact the CYSHCNs who did not have the Medical Homes:

Table 1.

<table>
<thead>
<tr>
<th>Number of Children with 21st Birth Date</th>
<th>Medical Home Status</th>
<th>Barriers and Insurance Type(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No MH (Action Taken)</td>
</tr>
<tr>
<td>11 (July)</td>
<td>10</td>
<td>1 (Family Seeking and Referred)</td>
</tr>
<tr>
<td>8 (August)</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>7 (September)</td>
<td>6</td>
<td>1 (Deceased)</td>
</tr>
<tr>
<td>5 (October)</td>
<td>3</td>
<td>1 (Referred) 1 (Moved out of the state)</td>
</tr>
<tr>
<td>8 (November)</td>
<td>6</td>
<td>1 (Lost to follow-up) 1 (Not interest)</td>
</tr>
<tr>
<td>4 (December)</td>
<td>3</td>
<td>1 (Not contacted)</td>
</tr>
<tr>
<td><strong>Total: 43-2=41 (100%)</strong></td>
<td><strong>36 (88%)</strong></td>
<td><strong>5 (12%)</strong></td>
</tr>
</tbody>
</table>
Indicator 2. Number of families of CYSHCN transitioning who are contacted

Figure 2 indicates the progression in the number of families with transitioning CYSHCNs who were contacted during the project implementation period. Thirty-nine of 41 families of CYSHCNs were contacted (95%):

MSDH/CMP district and central office staff contacted families with CYSHCNs transitioning (whose birth dates reached 21 years old) regarding the status of forthcoming/continuous care to be received by the patients. Most families were contacted by phone, followed by certified letters and home-visits or clinic encounters. Table 2 shows the number of families who were contacted by various methods.

Table 2.

<table>
<thead>
<tr>
<th>Number of Families</th>
<th>Contact Methods &amp; Number of Contact(s)</th>
<th>Number of Families Not Contacted &amp; Reason(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Phone</td>
<td>Mail</td>
</tr>
<tr>
<td>11 (July)</td>
<td>× 19</td>
<td>× 2</td>
</tr>
<tr>
<td>8 (August)</td>
<td>× 12</td>
<td>× 0</td>
</tr>
<tr>
<td>6 (September)</td>
<td>× 8</td>
<td>× 2</td>
</tr>
<tr>
<td>4 (October)</td>
<td>× 9</td>
<td>× 4</td>
</tr>
<tr>
<td>7 (November)</td>
<td>× 12</td>
<td>× 2</td>
</tr>
<tr>
<td>3 (December)</td>
<td>× 8</td>
<td>× 3</td>
</tr>
<tr>
<td><strong>Total: 39 (95%)</strong></td>
<td>68</td>
<td>13</td>
</tr>
</tbody>
</table>
One family did not respond to the contacts made by the staff and then lost follow-up status. Another family was not contacted by the staff members due to unknown reasons.

**Indicator 3. Number of families who have plans for ongoing care**

Families of CYSHCNs were progressively contacted by the CMP district staff members in terms of seamlessly transitioning from current pediatric care to adult care. Based on the information provided by the families of CYSHCNs and MSDH database, 36 of 41 families had plans of ongoing care as of January 2011, which accounted for 88% of families in the project. This data are illustrated in the following figure.

![Figure 3.](image)

**Indicator 4. Number of YSHCN with transition provider identified**

Thirty-seven of 41 patients (90%) had transition providers identified. Thirty-six of them had providers as within Medical Homes. One would use the ER as a provider since the family was not interested in having a Medical Home. The following figure indicates number changes in identified transition providers in the six-month project period:

![Figure 4.](image)
V. Conclusion

The project goal proposed by the MS CQI team was that at least 32 or more of the 41 children whose 21st birth dates were from July 1 to December 31, 2010, would graduate from the Children's Medical Program with ongoing primary care in a Medical Home.

1. Findings

- Thirty-six (88%) of CYSHCNs have Medical Homes for their continuous care.
- Thirty-nine (95%) families of CYSHCNs were effectively or responsively contacted.
- Thirty-six (88%) families had plans of ongoing care.
- Thirty-seven (90%) had transition providers identified. Thirty-six of them had providers as within Medical Homes. One would use the ER as a provider since the family was not interested in having a Medical Home.
- Seven CYSHCNs (17%) had no insurance.
- Two families with CYSHCNs (5%) had no home/working phone access.
- Only four children had private insurance coverage (10%) and two (5%) had both Medicaid and private insurance services. One (2%) had Medicaid and Tri-care. Twenty-four CYSHCNs (59%) relied on Medicaid for their care.
- One family indicated no interest in having a Medical Home for the care and would use the ER for their medical needs.

2. Major barriers

- The process of collecting and sharing data was very labor-intensive during the project implementation period, particularly in getting feedback from the district staff members who have multiple other duties and priorities.
- Leadership changes for CMP/MSDH program have been a significant barrier to implementing and completing this project.
- It is challenging to get buy-in for the importance of having a medical home from families of CYSHCNs, field staff members, MS CQI team organizations, and primary health care providers.

3. Comments and Suggestions

- Provide education to district staff members, families and primary health care providers on the concept of Medical Home.
- Establish transition database to ensure each child who reaches 21st birth date will have (or continue to have) primary health care providers.
- Set up strategies and action plan to follow-up on the tough cases (e.g. not interested in Medical Home and rely on an ER for care) to switch to Medical Home for the care instead of an ER.
- Increase partnership involvement amongst stakeholders. CMP will take the leadership role for the initiative on state Maternal and Children's Health.
VI. Reference

VII. Appendix

Mississippi Transition/Medical Home Plan for Continuous Quality Improvement (CQI)

The National Survey of Children with Special Health Care Needs conducted in 2005-2006 shows that 13.9% of children in the United States have special health care needs, and 21.8% of households with children include at least one child with a special health care need.

In Mississippi, the families of children with special health care needs served by the Children’s Medical Program (CMP) often find it difficult to maintain or transition to a medical home by the age of 21. Endorsed by more than 70 professional and voluntary organizations, the national agenda calls for the development of systems of care for CSHCNs, which should be family-centered, community-based, coordinated and culturally competent.

The Mississippi Continuous Quality Improvement (CQI) team is focusing on assisting the children currently enrolled in the CMP who will reach the age of 21 between July 1 and December 31, 2010, to maintain or transition to an appropriate medical home. The effort will be achieved by education, outreach, one-on-one consultation, tracking and follow-up.

CQI Team Organizations and Projects/Program

- Mississippi State Department of Health, Children Health Program (Title V Program)
- Mississippi Institute for Disability Studies
  - Mississippi Integrated Community System (MICS) Project
  - Mississippi Family to Family Project
- Mississippi Office of the Governor, Division of Medicaid
- American Academy of Pediatrics, Mississippi Chapter

Aim Statement

By December 31, 2010, at least 32 or more children graduating from the Children’s Medical Program (from July 1, 2010 to December 31, 2010) will receive ongoing primary care in a Medical Home.

Process

- **Step 1 – Responsible Party: MSDH/CMP**
  Baseline assessment – CMP will provide birth dates and locations for children whose age will be 21 years within the period of July 1, 2010 to December 31, 2010.

- **Step 2 – Responsible Party: MSDH/CMP**
  CYSHCN with Medical Home assessment – MSDH/CMP will conduct a short survey to assess existing CYSHCN with Medical Homes.

- **Step 3 – Responsible Party: MSDH/CMP, District Social Workers**
  Follow Up – MSDH Social workers from nine Public Health Districts will contact identified children from Step 1 and provide one-on-one consultation, share resources based on the results received from the survey stated in Step 2.

- **Step 4 – Responsible Party: MSDH/CMP, District Social Workers**
Weekly Evaluation – MSDH/CMP and social workers will conduct weekly PDSA to share accomplishments, identify barriers and challenges, and set up the work plan for the following week.

- **Plan** – Objective, questions and predictions (why?). Plan to carry out the cycle (who, what, where, when?).
- **Do** (Small Scale) – Carry out the plan. Document problems and unexpected observations. Begin analysis of the data.
- **Study** – Complete the analysis of the data. Compare data to predictions. Summarize what was learned.
- **Act** – What changes are to be made? Next cycle – Adapt, adopt, and abandon?

**Outcomes and Process Measures** – Responsible Party: IDS

- Number of Children and Youth with Special Health Care Needs (CYSHCN) with adult Medical Home (Primary Care).
- Number of families contacted.
- Number of families that have plans for ongoing care.
- Number of CYSHCNs who received coordination to create a transition plan.

**Methodology**

- Process measure – Responsible Party: IDS
  Annotated Run Chart – to show the progress of the process:
  - Horizontal Line = Time (Month)
  - Vertical Line = Number Children Contacted
  - Plot data in time sequence
  - Annotate changes

- Outcome measure – Responsible Party: IDS
  Annotated Run Chart – to show the completion of the Aim Statement:
  - Horizontal Line = Time (Month)
  - Vertical Line = Percentage of Children Who Have Medical Homes
  - Annotate changes

**Definition**

- Medical Home – an ongoing source of primary care through a physician or nurse practitioner seeing the children at least once a year for check-ups and treatment of acute and/or illnesses (MSDH, 2010).
### CMP/MSDH Children Turn to Age of 21 (Birthday) from July 1 to December 31, 2010

<table>
<thead>
<tr>
<th></th>
<th>District I</th>
<th>District II</th>
<th>District III</th>
<th>District IV</th>
<th>District V</th>
<th>District VI</th>
<th>District VII</th>
<th>District VIII</th>
<th>District IX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010</strong></td>
<td><strong>July</strong></td>
<td>7/29</td>
<td>7/2</td>
<td>7/12</td>
<td>7/17</td>
<td>7/14</td>
<td>7/16</td>
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<td>7/22</td>
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<td></td>
<td><strong>August</strong></td>
<td>8/18</td>
<td>8/31</td>
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<td>8/24</td>
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<td><strong>October</strong></td>
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<td></td>
<td><strong>November</strong></td>
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<td><strong>December</strong></td>
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<td><strong>Total 43</strong></td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>