Innovative Care Coordination from a Virtual Clinic

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BACKGROUND

Nationwide 3 million children are classified as medically complex--defined as three or more diagnoses or conditions. These pediatric patients represent 6% of children enrolled in Medicaid but 40% of healthcare dollars spent. At one quaternary pediatric hospital only 7.2% of patients were considered to have moderate or high medical complexity but accounted for 80% of total fixed and variable costs.

PROBLEM

This population of patients is characterized by poor coordination across a care continuum that includes subspecialists, general pediatricians and community providers. Poor coordination has resulted in limited and timely access to needed health care services that translates into higher rates of hospitalization and emergency room use.

GOAL

Creation of CORE (Coordinating & Optimizing Resources Effectively), a "virtual" clinic tasked with meeting the care coordination needs of this growing pediatric population. CORE acts as a care coordination "hub", ensuring care coordination and communication amongst subspecialties, home health services, community providers, patients and families.

HOW DID WE ACHIEVE OUR GOAL?

Multi-Disciplinary Team

RNs, MD, Case Manager, Care Coordinator, Parent Mentors, Analytics, Social Worker, Scheduler

Just-in-Time Care Coordination

<u>Implemented CORE Team Standard Work</u>

- Daily Huddles
- Deploying Staff by Need
- Encounter Tracking
- Weekly Inpatient Rounds
- Patient Progression Rounds

Communication Across the Care Continuum

<u>Implemented Cross-Team Communications</u>

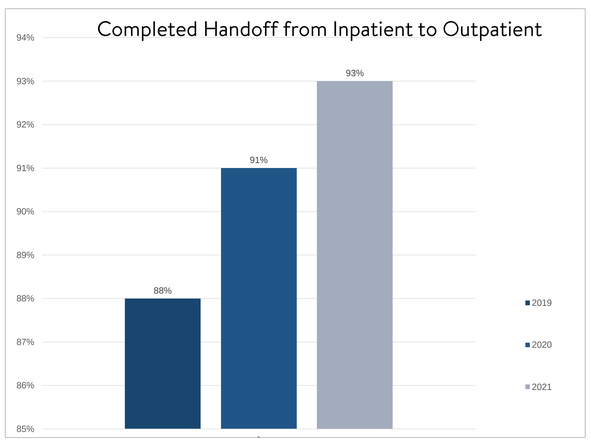
- Attend daily Patient Progression Rounds to ensure a smooth discharge transition from inpatient to outpatient tasks
- Escort families to the hospital unit from the clinic or ED if being admitted
- Inpatient to outpatient care coordination handoff
- Relay admit and discharge status updates to patient's care team members and vendors

Patient/Family Services

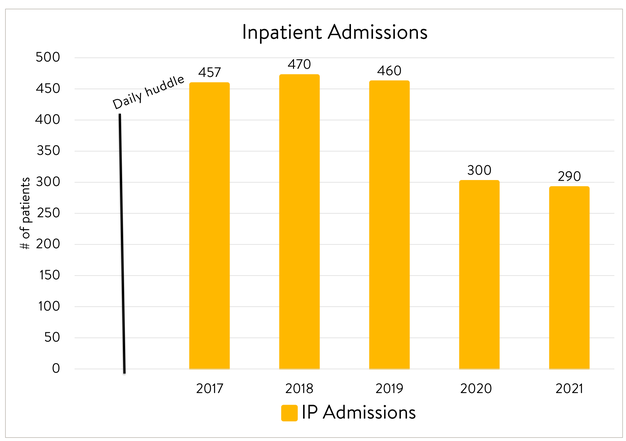
<u>Patient/Family Care Coordination Services</u>

- Spotlight Card (Provider Contact List)
- Parent Self-Management Training
- Post ED Visit Follow up Call
- Quarterly Monitoring
- Transportation and Clinic Access
- Scheduling Services
- Medication Review, Prior Auth's,
- Provider to Provider Communication
- DME needs and/or home nursing
- Insurance Issues, Denials, Appeals

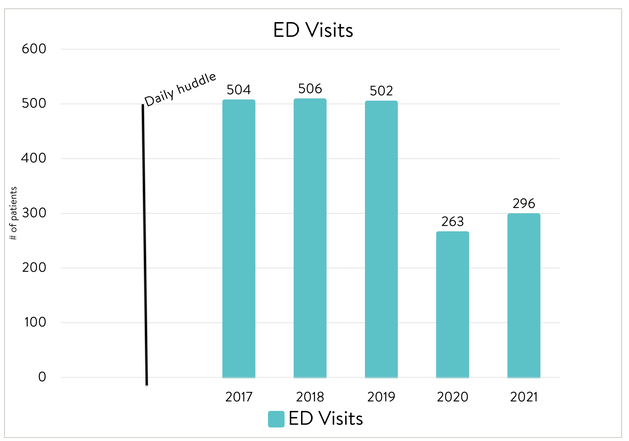
MEASURES



Quality improvement goal to increase handoffs between inpatient and outpatient Case Managers



14% decrease in inpatient admissions after implementation of daily huddles & co-managed clinic visits



10% reduction in ED visits following post-ED parent call to review parent decisions

KEY OUTCOMES

- Standard work improves services to patients and families
- Communication at all levels
- The CORE approach ensures that care isn't siloed by service line
- Parents have a main point of contact for care coordination assistance
- A focus on self-management encourages parents/caretakers to learn how to navigate the healthcare system
- Smoother transition from being inpatient to home