Definitions

• What were the specific populations by medical dx, or DRG did you use to prioritize your approach? Was there an overarching top 5% or 10% that you focus on?
  o The Continuity of Care program at University of Iowa Children’s Hospital helps families of children who have special needs. Eligible patients must be 21 years old or younger and have complex health issues that will last at least 12 months and usually are followed by 3 different services at the hospital.

• We are working to define our medically complex population, could you share your definitions for both Tufts and Iowa.
  o At Iowa we have many factors, number of services involved, and primary diagnosis, and secondary diagnosis, duration of diagnosis, high home going needs, and lack of insurance. These are all factors in determining our complex patients.
  o At Tufts, we decided to use the Pediatric Medical Complexity Algorithm to help define and identify patients admitted to the hospital with the highest level of complex disease: Complex- Chronic Disease. In addition we included anyone with a length of stay of greater than or equal to 5 days with the assumption that they would require increased care coordination. Other programs do use specific diagnoses; DRG’s or top percentage of utilizers. As we look to expand into the outpatient and community areas, these other factors may come more into play.

Finance

• Remarkable ROI through improved documentation reported for the Tufts program. For programs moving away from fee-for-service reimbursement, what strategies for financial viability are being considered within a population health model?
  o We recognize that a true population health model resides in an outpatient setting. Our reimbursement was indeed based on the current fee-for-service model in the inpatient setting. The hub described at the end of the presentation notes different aspects of care delivery that need to occur in order to best determine financial viability. The traditional billing for services provided may not provide financial viability looking at a single program within the hospital. However, when looking at the benefits and ROI for such a program within a community, hospital, or health system there are definite opportunities that reflect value-based care. Some initial thoughts include:
- Information exchange databases that can (and must) be instituted and replicated in order to ensure smooth transition of care. This may help reduce overall admissions (value-added for PCPs), readmissions (value added for hospitals) and overall length of stay. Each of these additionally provides value for our patients and families who may not need to miss work for hospitalization, etc.
- Family education on advocacy for health care and medication self-management may help by decreasing medication errors, equipment-related infections, etc. These decrease cost and increase quality specifically for hospitalized children but also may prevent readmission.
- Keeping patients within one medical home (as defined by the patient) can increase quality and referrals to in-network service lines for primary and specialty care.
- Finally, there are also new(ish) billing codes for Complex Care/Coordination of care that should be used. At Tufts, we have not provided outpatient services up until now and are interested in exploring up and coming reimbursements and coding opportunities.

- Can you review the ROI again? What exactly was done to achieve improved ROI and what $ increase over baseline did you achieve?
  - Through documentation audits, missed opportunities were discovered. Clinical Documentation specialists assisted the complex care team with proper documentation that matched the clinical care delivered, so that reimbursement reflected the complexity of care more accurately. For example, a patient who was febrile, hypotensive and had a high white count might be documented as “septic”. CDI specialists were intimately involved in the strategic planning of the inpatient complex care team and attended each complex care meeting. Over 6 months, we saw over $600,000 with proper documentation that would otherwise not have been captured.

**Partners**

- Do any of your teams utilize and pediatric long-term/short-term/sub-acute skilled nursing facilities? (i.e., ChildSErve in Iowa or New England Pediatric Care in MA)?
  - We will use long term placement agencies if /when needed. This need is patient based and assessed individually. In Iowa we are very limited in our pediatric options for such needs. We also do work with short term placement agencies which when we have used it has been for Acute Rehab.
  - Yes, Floating Hospital for Children and Tufts Medical Center have an affiliation with New England Pediatric Care. We are looking to establish other partnerships and preferred referral centers based on quality of care and referral patterns. These include rehab, long-term and community support services.

- Did anyone include a high tech/high acuity home care agency as a partner to improve care coordination and outcomes for CMC?
  - At Iowa we offer the options of care providers in the patient’s area and they chose. We have many different home care providers throughout the State that we work with. Sometimes each agency has a certain skill set in some of the higher needs patients in regards to equipment.
  - No, we have begun discussions in this area and are looking to partner with these agencies.
• Who are some of the newest and unexpected partners outside the hospital walls? How did you engage them?
  - PCPs have always been strong partners. The ever changing home health care field often creates new partnerships. We have also seen an increase in engagement with local hospice agencies, which was established by mutual contact and need.
  - Our PCP referral network approached us and asked to become involved in the strategic planning of our complex care program. This started with an invitation to present our results at a quarterly Pediatric meeting and grew into a partnership to improve care for CMC.

Quality of Life Measures
• Are you looking at Quality of Life measures for these complex patients? What tools are you using to do so?
  - At Iowa we have always considered quality of life for our patients. We are looking into a formal measure for this topic for our patients.
  - This is an area that is also being looked at in the development of the complex care program.

Staffing and Training
• Iowa:
  - What kind of training does the care coordinator have (nursing, social work)?
    - The nurses in COC are all BSN with a strong pediatric medical experience. The social workers all have a MSW and must also possess a strong pediatric hospital based experience. Care Coordination Certification is not mandatory but many of the care coordinators possess additional certifications that enhance care to their service area.
  - How many hours per kid/how many kids per FTE care coordinator are required?
    - Each child has different needs and so an exact or even estimated time commitment is not available. Each care coordinator can have on average anywhere from 8-15 inpatients on a given day. An average caseload is usually around 60-75 at a given point reflecting both inpatient and outpatient needs.
  - How do your hospital case managers fit into this care model, especially related to assessing and helping to arrange for homecare, discharge readiness, etc.?
    - At Iowa, if a care coordinator is involved they do all of the discharge planning this includes arranging the home care, supplies, assessment of discharge needs and readiness. The Care Coordinator then works with the medical team to get the orders and also develop a plan when additional needs are identified.
  - Are the Care Coordinators parts of a specific department? If so, please describe the team and reporting/integration structure.
    - The pediatric care coordinators are all part of the Continuity of Care Department which is overseen by the Nursing Department. Specific supervision is provided by both the nursing department and the social work department for corresponding care coordinators.

• Both Teams:
  - Can you give contact information for the person on your team who has the most direct contact with the school nurses?
• These relationships are being developed as we create the complex care team. At this time, this generally falls to the physicians directly caring for the patient.
  o Do you have a Family Advocate on staff at your hospital?
    ▪ At Iowa we have a patient representative that can serve as needed for patients. We also do have Family Advocates through a state based program that we can refer to.
    ▪ We consider our pediatric social worker and chaplain as family advocates. There is no current role defined as such at Tufts.

Transition to Adult Care
• Tufts mentioned the transition to adult care. Would you comment on what your team is doing to facilitate that?
  o As a pediatric hospital within a larger hospital, we feel that we can provide the complete circle of health from prenatal visits, to perinatal/NICU care through adolescence and adulthood. Maintaining these patients within one medical home should be easy (although it is often not). Several of our pediatric subspecialties have begun these transition programs and partnerships. As we develop our complex care program, we are looking to model those using best practices.

Working with Primary Care Physicians
• It appears as though the entry point to these programs is being admitted. Have you evaluated the perception of the PCPs about these increased services while inpatient and the long-term impact? If so, what did they think?
  o The Tufts program is primarily an inpatient program that has demonstrated decreased length of stay and expenditures. Our primary PCP referral network has been very positive about the initial results and has asked to be a partner in the development of the larger program.
• Is anyone doing complex care coordination in large Primary care practice? My institution is PCP/teaching facility, 12K kids annually, 98% Medicaid.
  o In New England there are several well-developed complex care programs. At this time, Tufts is in the early phases of development.
• Is there any telehealth use in any of these models? Connecting either with PCPs, families or other stakeholder
  o Not at present, but given the large geographic catchment area, this is something that Tufts would like to further investigate and possibly implement.

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