NICU to Medical Home Care Management

IHP Conference
Spring 2018
Project Development

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Manager, Case and Disease Management
Priority Health, Medicaid
The baby that started it all …

- Born at 28 weeks
  - Multiple dx
- Discharge after 133 days NICU stay
  - No PCP appts scheduled, no transport scheduled, no show specialty
- Readmitted within 2 months
  - IP Care Conference
Project development

Spectrum Health System – Helen DeVos Children’s Hospital

- Meeting with executives
- Discussion re: population – utilization, costs
- Focus: Academic General Pediatric Residency Clinic
  - Redesign the model of care
  - Embedded care manager

Spectrum Health NICU ➔ Academic General Pediatric Clinic
Project development
Spectrum Health System – Helen DeVos Children’s Hospital

Meeting with executives

Focus: Academic General Pediatric Residency Clinic

Spectrum Health NICU

Discussion re: population – utilization, costs

Redesign the model of care
• Embedded care manager

Academic General Pediatric Clinic
Project goals

*Triple Aim*

1. Quality health outcomes
2. Member experience
3. Lower cost of care
Initial Care Management Role

Jennie Nowak, LMSW
Supervisor, Case and Disease Management
Priority Health, Medicaid
The world of a NICU family
Care Management role initially

- Collaboration With Clinic Staff
- CSHCS Members/First Patient
- Physician Champion Role
- NICU
Growth and development

Kira Sieplinga, MD FAAP
Academic General Pediatric Clinic
Helen DeVos Children’s Hospital

Katie VanderVeen, LMSW
Care Manager, Case & Disease Management
Priority Health, Medicaid
### CMC

**Needs**
- Substantial family-identified service needs
- Significant impact on family (e.g., financial burden)

**Chronic condition(s)**
- Diagnosed (e.g., CCCs) or unknown but suspected
- Severe and/or associated with medical fragility

**Functional limitations**
- Severe
- Often associated with technology dependence

**Health care use**
- High resource utilization
- Necessitating involvement of multiple service providers

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Time is your most precious resource
Who are the “right” patients?

3 or more active subspecialists AND/OR dependence on a life-enabling device

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Ways to Identify Children with Medical Complexity and the Importance of Why

Jay G. Berry, MD, MPH, Matt Hall, PhD, Eyal Cohen, MD, MSc, Margaret O’Neill, BS, and Chris Feudtner, MD, PhD, MPH

Children with medical complexity, although a small fraction of the pediatric population, are important due to their high levels of healthcare spending, unmet healthcare needs, substandard quality of care, and poor health outcomes. Consistent with the Triple Aim, these children are the focus of clinical, research, and policy initiatives seeking to: (1) improve their healthcare experience and limitations, and high health resource utilization. Moving stepwise through this framework, we focus on the advantages and disadvantages of various approaches to identify children with medical complexity.

Identifying the Complex, Chronic Health Problems Endured by Children with Medical
Who is the “right” team?

Smaller team to provide continuous, patient-centered, proactive and available care
What is the “right” approach?

1. Care coordination with the family as the focus
2. Care Planning to fulfill healthcare needs
3. Care planning for future health problems
Care planning for future health problems

✓ Which aspects are likely to get better or worse?
✓ What acute illnesses is the child likely to experience?
✓ What exacerbations of existing conditions likely to experience?
✓ What new comorbid conditions is this child likely to develop?
✓ How can those illnesses be avoided altogether?
✓ If unavoidable, how can one mitigate their severity should they occur?
✓ What major medical needs is the child likely to need in the future?
✓ What decisions about major medical interventions are the child and family likely to face?
✓ What is the likely impact on the family (marriage, employment, etc.)?
✓ What will life be like for this child in 1, 5, 10 years?
Team Dynamics from a Care Manager Point of View

“-It takes a village”

Benefits of being embedded in the clinic

Logistics/details
Care planning to fulfill healthcare needs: in the clinic

Pre-visit work
Patient Visit
Provider post visit work

- “To-do” list
- Family recommendations
- Follow-up
- Goal setting
Care manager role

Typical visit:
- What is the role of the care manager
- Pre- and post-visit follow-up
Care planning to fulfill healthcare needs: across the system
Care manager system collaboration
System collaboration

Collaboration
- Decision-making
- Proactive care

“Care Conferences”
- EMR and technology
- Curbsides

Inpatient
- Care managers
- Relationship building

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The world of a NICU family at AGP
Project outcomes
Project outcomes

1. Quality health outcomes
   - Model that meets member and clinic needs
   - Team huddles/Provider case reviews

2. Member experience
   - Patient satisfaction and more comprehensive care

3. Lower cost of care
   - Spread to other clinics
Questions?
Resources
