August 7, 2018

Q&A: A Conversation on Models of Care Delivery for Children with Medical Complexity

Below are responses to questions the panel was unable to answer during the webinar.

Respondents

- **Elisabeth S. Pordes, MD, MPH** - Assistant Professor, Pediatrics, Children's Hospital of Wisconsin
- **Maria Brenner, PhD, MSc** - Associate Professor, School of Nursing & Midwifery, Trinity College Dublin
- **David Bergman, MD** - Associate Professor of Pediatrics, Lucile Salter Packard Children's Hospital

Q&A

Can you share more on the care management service line that is being experimented on at Cincinnati Children's and CHOP?

David: Cincinnati Children's Medical Center has implemented a care management service line that covers the population of children cared for in their primary care network. Children with medical complexity are included in this network. They use the Pediatric Medical Complexity Algorithms and a social risk survey to segment their pediatric patient population into 9 categories. The appropriate mix of care management professionals and services are then mapped to each of the categories. As part of the service line development they have established role definitions for both licensed and non-licensed health professionals. They have also established a set of practice guidelines which delineate their care management activities. CHOP has contracted with their local Medicaid Managed Care Organization to support a care management team of 7 FTE's consisting of RN's, MSW's, and community health workers to provide care management services. Continuing support of the team will depend on the increased value provided through care management services. I suggest that you contact the individual programs for more details.

Any tips on how to integrate community resources (community health care workers, school nurses, pharmacists, etc.) into the care delivery system?

Elisabeth: Face to face meetings have always been helpful. One of the best relationships our program has developed has been with pharmacists - both inpatient and outpatient. The impetus for this relationship really came from the pharmacists who wanted to assist families with multiple medications. We have weekly meetings with our outpatient pharmacist at the Children's Hospital to go over issues and upcoming discharges. This has helped tremendously for our patients and staff. Finding a champion at a community resource is key - and ensuring there is something that also benefits that community resource (i.e. with the pharmacists that can present findings/research/novel care delivery at conferences).

Is there a 'best model' for those who are currently trying to provide care in primary care within a tertiary care children's hospital?

David: It depends on a number of factors. If your hospital has a large catchment area for referrals you may want to consider a consultative service for children who are too far away to provide a medical home at the hospital. If most of CMC are drawn from your local community, you may want to consider providing a clinic that serves as a medical home for these children. Your payment model will also play a role. Unless you can negotiate a way to support needed care coordination services with your health plan, it will be difficult to support a primary care program for CMC on clinical revenues. In this case it may be more financially viable to provide consultation services and charge as a specialty clinic. However, it is still

difficult to support a consultation model in a strict fee for service environment. Some hospitals provide both a medical home and consultative services. On a personal level I have found it most satisfying to be able to provide a medical home for CMC who want all their care in the children's hospital and their well siblings.

Elisabeth: One of the hard parts about any model is determining what the scope of the practice is. I find with our co-management model being able to see families/patients while they are inpatient lets us, as providers, understand more about the medical issue. I believe this helps families by having a familiar face. How often and in what capacity (social/consultation only, care conference attendance) is a very difficult question given limited staff resources.

In Dublin, is the pay rate a challenge as well for in home care? We need to have a competitive rate for staff that's trained.

Maria: There is no standardised payment method system across the EU as in many countries there are no standardised methods of assessing care needs.