Meeting the Needs of Children with Medical Complexity: a Framework for Building a Pediatric Complex Care Program

July 29, 2016
Pediatric Hospital Medicine Workshop
Chicago, IL

Disclosures

• Dr. Ehlenbach & Dr. Cardoso-No relevant financial relationships

• Dr. Thomas has an Honorarium relationship with Children's Medical Center Health Plan.
Welcome and Objectives

• Our objective: share wisdom that we wish we had known when we were starting our programs.
• Your objectives:
  – Formulate a proposal for a complex care program at your institution.
  – Prepare for implementation of a complex care program at your institution.

Roadmap

• Introductions
• Background on CMC and Intersection of Hospital Medicine and Complex Care
• Small groups (choose three of four)
• Next Steps
• Discussion and Questions
Introductions

- Mary Ehlenbach, MD
- Megan Cardoso, MD
- Michelle Thomas, MD
- Small Group Facilitators

Introduce yourselves to others at your table.
CMC 101

Prevalence of CSHCN Among Individuals

Children without special health care needs 84.9%
CMCHN 15.1%

CMC as Subset of CSHCN

“I know it when I see it.”

-- Supreme Court Justice Potter Stewart to describe his threshold test for obscenity in Jacobellis v. Ohio (1964)
DEFINING CMC

Diagnostic Codes

Algorithms using ICD-9 and billing codes (PMCA, CRG)

Past healthcare utilization

# of outpatient/ED/inpatient visits, cost of care, # of subspecialists, etc

Other

# of organ systems affected, parent report/perception, etc

Caregiver surveys

CSHCN and functional limitation Screeners

Small but Mighty

<1% of children

~33% of healthcare spending on children


Child Health Spending and CMC

Slide courtesy of Ryan Coller, MD MPH.


CMC and Hospital Use

- Children’s Hospitals have seen immense growth in numbers of CMC served

- Hospitalization rate for CMC doubled since early 1990s

- In 2006 within US Hospitals, CMC accounted for
  - 10% of all admissions
  - 26% of bed days
  - 41% of all charges

- CMC with severely impairing neurological diseases (e.g. CP)
  = 1/4th total hospital days and nearly 1/3rd inpatient charges
  (and is increasing)

Growing Enthusiasm for Complex Care

- Better Health
- Better Healthcare
- Lower Costs
Why Hospitalists Make Great Complex Care Pediatricians

• System Navigation
• Leadership with a Global Perspective
  – Quarterback
  – Conductor
  – Ringmaster
  – Play nicely in the sandbox
• Bread and Butter
Choose 3 Small Groups

• Group 1 – Criteria for Enrollment & Clinical Services
• Group 2 – Building an Interprofessional Team
• Group 3 – Evaluation Measures
• Group 4 – Business Plan & Engaging Stakeholders

Welcome Back!

• Share themes that emerged from small groups
• Think about your own next steps.
Site Visit Considerations

- Travel planning: your organization may be willing to pay for travel.
- Bring key members of your team.
- Brainstorm your questions and identify your challenges before you go.
- Consider processes: patient flow, patient handling and measuring, team interaction, paperwork, referrals, scheduling, etc
- Evaluate how total FTE translates into daily staffing
- Take time with each member of the team to better understand their role and delegation of tasks
- If out-patient: take note of specialized equipment and room modifications if present
- Inquire about challenges and lessons learned
- Identify questions / clarifications to bring back to your home team
- Identify next steps for your planning process.
- List specific topics that you need to learn more about.

Complex Care Mentorship

- APA Complex Care Special Interest Group
  – Twice yearly meetings
    • PAS
    • AACPDM
  – Google group – contact Rishi Agrawal
  – Website http://www.complexcarehome.com/
- Children’s Hospital Association
- Coming Soon...complex care mentorship program
Questions/Discussion

Thank you for attending!
Meeting the Needs of Children with Medical Complexity: A Framework for Building a Pediatric Complex Care Program
Pediatic Hospital Medicine 2016
Chicago, IL

Agenda

10:45-10:55 Welcome and Introductions

10:55-11:00 Brief Didactic Presentation: Background on Children with Medical Complexity and the intersection of Pediatric Hospital Medicine and the new field of Complex Care

11:00-11:05 Choose 3 of 4 small groups to rotate through:

1) What Is It That You Do?: Enrollment Criteria and Clinical Services

2) Evolving from Hot Mess to Functional Program: Creating Your Multidisciplinary Team  
   - identifying critical members  
   - job descriptions  
   - orientation ideas

3) Prove Your Worth: Defining Quality Measures and Measurement Techniques  
   - common process and outcomes measures  
   - example dashboard

4) Creating the Dreaded Business Plan and Engaging Stakeholders  
   - identifying champions at your institution  
   - making connections with payers  
   - basic “nuts and bolts” of writing a business plan

11:05-11:20 attend first small group session of your choice

11:20-11:35 attend second small group session of your choice

11:35-11:50 attend third small group session of your choice

11:50-12:00 Wrap up, questions, and discussion
Workshop leaders:
Mary Ehlenbach, MD – mehlenbach@pediatrics.wisc.edu
Megan Cardoso, MD – MCardoso@tuftsmedicalcenter.org
Michelle Thomas, MD – Michelle.Thomas@UTSouthwestern.edu

Small group facilitators:
Norah Emara, MD – NEmara@tuftsmedicalcenter.org
Prerna Sinha, MD – psinha@mcw.edu
Mary ("Mitzi") Arbuckle, MSW, CAPSW – MArbuckle@uwhealth.org
Carisa Baker, RN, APNP – CBaker@uwhealth.org
Tamara Simon, MD, MSPH – tamara.simon@seattlechildrens.org
Arti Desai, MD, MSPH – Arti.Desai@seattlechildrens.org
Gemma Warner, MSSW, CCRC – gwarner@pediatrics.wisc.edu
Characteristics of Hospitalizations for Patients Who Utilize a Structured Clinical-Care Program for Children with Medical Complexity

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3138997/

Pediatric complex chronic conditions classification system version 2: updated for ICD-10 and complex medical technology dependence and transplantation


http://pediatrics.aappublications.org/content/pediatrics/106/Supplement_1/205.full.pdf
Table 1. COE4CCN consensus definitions of three levels of medical complexity

<table>
<thead>
<tr>
<th>CONDITION DESCRIPTION</th>
<th>POTENTIAL EXAMPLES *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children with Complex Chronic Disease (C-CD)</strong></td>
<td></td>
</tr>
<tr>
<td>Significant chronic conditions in two or more body systems: <strong>Significant chronic condition</strong> is defined as a physical, mental or developmental condition that can be expected to last at least a year, will use health care resources above the level for a healthy child, require treatment for control of the condition, and the condition can be expected to be episodically or continuously debilitating. <strong>Body systems</strong> include: cardiac, craniofacial, dermatologic, endocrinologic, gastrointestinal, genetic, genitourinary, hematologic, immunologic, mental health, metabolic, musculoskeletal, neurologic, ophthalmologic, otologic, pulmonary/respiratory, and renal.</td>
<td>type 1 diabetes and static encephalopathy; type 1 diabetes and depression; developmental delay and chronic pulmonary conditions</td>
</tr>
<tr>
<td>OR A progressive condition that is associated with deteriorating health with a decreased life expectancy in adulthood.</td>
<td>muscular dystrophy, cystic fibrosis, paraplegia, quadriplegia, malignancy</td>
</tr>
<tr>
<td>OR Continuous dependence on technology for at least six months.</td>
<td>tracheostomy +/- ventilator assistance, renal dialysis, gastrostomy tube, CSF shunt</td>
</tr>
<tr>
<td>OR Malignancies: Progressive or metastatic malignancies that impact life function. Exclude those in remission for more than 5 years.</td>
<td>lymphoma, leukemia, brain tumor</td>
</tr>
<tr>
<td><strong>Children with Non-Complex Chronic Disease (NC-CD)</strong></td>
<td>type 1 diabetes, atrial septal defect, asthma, depression, ADHD</td>
</tr>
<tr>
<td>Chronic Conditions that last at least one year: These conditions are commonly lifelong but can be episodic with periods of good health in between episodes. They include physical, developmental, or mental health conditions that may persist into adulthood but may also resolve either secondary to the natural history of the disease or as a result of surgical intervention. These conditions involve a single body system, are not progressive, can vary widely in severity and result in highly variable health care utilization.</td>
<td>type 1 diabetes, atrial septal defect, asthma, depression, ADHD</td>
</tr>
<tr>
<td><strong>Children without Chronic Disease</strong></td>
<td>ear infection, pneumonia, diarrhea and dehydration, bronchiolitis</td>
</tr>
<tr>
<td>Acute Non-Chronic Conditions: A physical, developmental or mental health condition that is not expected to last more than a year. These children may temporarily (for &lt; 1 year) utilize health care resources above the normal level for a healthy child.</td>
<td>ear infection, pneumonia, diarrhea and dehydration, bronchiolitis</td>
</tr>
<tr>
<td>Healthy: No acute or chronic health conditions. These children do not utilize health care resources above the normal level for a healthy child.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* The examples used in this document to illustrate definitions of medical complexity and chronicity are intended to demonstrate characteristics specified in the definition/descriptions. It is not our intention to imply that specific diseases and conditions are by default linked to the categories that they were used to illustrate.
CAHMI
The Child and Adolescent Health Measurement Initiative

THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SCREENER©

Developed in Collaboration with:

AHRQ  NCQA

FAMILY VOICE

N E S E R V E . O R G
BACKGROUND

The Children with Special Health Care Needs (CSHCN) Screener© was developed through the efforts of the Child and Adolescent Health Measurement Initiative (CAHMI), a national collaboration coordinated by FACCT—The Foundation for Accountability. Beginning in June 1998, the CAHMI brought together federal and state policymakers, health care providers, researchers and consumer organizations into a task force for the purpose of specifying a method to identify children with special health care needs. During the course of this project, the task force met in person six times and more than a dozen times by teleconference.

The CSHCN Screener© is a five item, parent survey-based tool that responds to the need for an efficient and flexible standardized method for identifying CSHCN. The screener is specifically designed to reflect the federal Maternal and Child Health Bureau definition of children with special health care needs:

“Children who have special health care needs are those who have…a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”

The CSHCN Screener© uses non-condition specific, consequences-based criteria to identify children with special health care needs for purposes of quality assessment or other population-based applications. Children are identified on the basis of experiencing one or more current functional limitations or service use needs that are the direct result of an on-going physical, emotional, behavioral, developmental or other health condition.
The non-condition specific approach used by the CSHCN Screener© identifies children across the range and diversity of childhood chronic conditions and special needs, allowing a more comprehensive assessment of health care system performance than is attainable by focusing on a single diagnosis or type of special need. In addition, the relatively low prevalence of most childhood chronic conditions and special health care needs often makes it problematic to find adequate numbers of children with a specific diagnosis or type of special need. A non-condition specific approach makes it possible in many cases to identify enough children to allow statistically robust quality comparisons across health care systems and/or providers.

The CSHCN Screener© is currently being used in several national surveys, including the National Survey of Children with Special Health Care Needs and as part of the CAHPS® survey items in the Medical Expenditure Panel Survey (MEPS). The Agency for Healthcare Research and Quality (AHRQ) has included the screener as an integral part of the new CAHPS 2.0 Child Survey. The Screener is also formally integrated into the CAHPS 2.0H Child Survey to identify the Children with Chronic Conditions Measurement Set, a component of the National Committee for Quality Assurance’s Health Plan Employer Data and Information Set (HEDIS®). The English and Spanish versions of the CSHCN Screener© are available.

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2. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
3. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
For more information on the development, testing & application of the CSHCN Screener:


For scoring programs or other technical support for the CSHCN Screener and its applications:

Christina Bethell, Director
CAHMI—The Child and Adolescent Health Measurement Initiative
Telephone: 503.494.1930
email: cahmi@ohsu.edu

For technical support for the CAHPS 2.0 Child Survey, please contact:
The CAHPS Survey User Network
800.492.9261 or www.cahps-sun.org

For technical support on the CAHPS 2.0H Child Survey*, please contact:
NCQA Policy Clarification Support
hedis@ncqa.org

User’s Form:
There is no cost to use the CSHCN Screener, however, we ask that you complete the enclosed User’s Form. Your input helps us to develop an understanding of our key users and to provide updates.

Please submit the User’s Form via fax (503.494.2475) or email (cahmi@ohsu.edu). We look forward to hearing from you!

*The National Committee for Quality Assurance has incorporated a version of the CAHPS 2.0 survey into the HEDIS measurement set. The version of the survey required for HEDIS is referred to as the "CAHPS 2.0H Survey."
Children with Special Health Care Needs (CSHCN) Screener©
(mail or telephone)

1. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?
   - Yes → Go to Question 1a
   - No → Go to Question 2

   1a. Is this because of ANY medical, behavioral or other health condition?
       - Yes → Go to Question 1b
       - No → Go to Question 2

   1b. Is this a condition that has lasted or is expected to last for at least 12 months?
       - Yes
       - No

2. Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age?
   - Yes → Go to Question 2a
   - No → Go to Question 3

   2a. Is this because of ANY medical, behavioral or other health condition?
       - Yes → Go to Question 2b
       - No → Go to Question 3

   2b. Is this a condition that has lasted or is expected to last for at least 12 months?
       - Yes
       - No

3. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?
   - Yes → Go to Question 3a
   - No → Go to Question 4

   3a. Is this because of ANY medical, behavioral or other health condition?
       - Yes → Go to Question 3b
       - No → Go to Question 4

   3b. Is this a condition that has lasted or is expected to last for at least 12 months?
       - Yes
       - No

4. Does your child need or get special therapy, such as physical, occupational or speech therapy?
   - Yes → Go to Question 4a
   - No → Go to Question 5

   4a. Is this because of ANY medical, behavioral or other health condition?
       - Yes → Go to Question 4b
       - No → Go to Question 5

   4b. Is this a condition that has lasted or is expected to last for at least 12 months?
       - Yes
       - No

5. Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets treatment or counseling?
   - Yes → Go to Question 5a
   - No

   5a. Has this problem lasted or is it expected to last for at least 12 months?
       - Yes
       - No
Scoring the Children with Special Health Care Needs (CSHCN) Screener®

The CSHCN Screener® uses consequences-based criteria to screen for children with chronic or special health care needs. To qualify as having chronic or special health care needs, the following criteria must be met:

a) The child currently experiences a specific consequence.
b) The consequence is due to a medical or other health condition.
c) The duration or expected duration of the condition is 12 months or longer.

The first part of each screener question asks whether a child experiences one of five different health consequences:

1) Use or need of prescription medication.
2) Above average use or need of medical, mental health or educational services.
3) Functional limitations compared with others of same age.
4) Use or need of specialized therapies (OT, PT, speech, etc.).
5) Treatment or counseling for emotional or developmental problems.

The second and third parts* of each screener question ask those responding “yes” to the first part of the question whether the consequence is due to any kind of health condition and if so, whether that condition has lasted or is expected to last for at least 12 months.

*NOTE: CSHCN screener question 5 is a two-part question. Both parts must be answered “yes” to qualify.

All three parts of at least one screener question (or in the case of question 5, the two parts) must be answered “yes” in order for a child to meet CSHCN Screener® criteria for having a chronic condition or special health care need.

The CSHCN Screener® has three “definitional domains:”

1) Dependency on prescription medications.
2) Service use above that considered usual or routine.
3) Functional limitations.

The definitional domains are not mutually exclusive categories. A child identified by the CSHCN Screener® can qualify on one or more definitional domains (see diagram).

Qualifying questions for meeting a CSHCN screener definitional domain

**DEPENDENCY**
Qualify by answering: “YES’ to Questions 1, 1a and 1b

**SERVICE USE**
Qualify by answering: “YES’ to Questions 2, 2a and 2b OR “YES’ to Questions 4, 4a and 4b OR “YES’ to Questions 5 and 5a

**FUNCTIONAL LIMITATIONS**
Qualify by answering: “YES’ to Questions 3, 3a and 3b

Definitional combinations possible for qualifying children to meet

- Dependency ONLY
- Service use ONLY
- Functional Limits ONLY
- Dependency & Service use
- Dependency & Function
- Service use & Function
- Dependency & Service use & Function
ACKNOWLEDGEMENTS

The following people participated in the Child and Adolescent Health Measurement Initiative (CAHMI) Living with Illness Task Force and contributed to the development and/or testing of the Children with Special Health Care Needs (CSHCN) Screener©:

Christina Bethell, CAHMI- The Child and Adolescent Health Measurement Initiative
Stephen Blumberg, *Centers for Disease Control and Prevention*
Julie Brown, *RAND*
Treeby Brown, *Association of Maternal and Child Health Plans*
Paul Cleary, *Harvard Medical School*
Christine Crofton, *Agency for Healthcare Research and Quality*
Susan Epstein, *New England SERVE*
Jack Fowler, *University of Massachusetts*
Shirley Girouard, *Southern Connecticut State University*
Maxine Hayes, *Washington State Department of Health*
John Hochheimer, *formally with the National Committee for Quality Assurance*
Charles Homer, *National Initiative for Child Healthcare Quality, Institute for Healthcare Improvement*
Alice Lind, *Washington State Medical Assistance Administration*
Margaret McManus, *Maternal & Child Health Policy Research Center*
Merle McPherson, *Federal Maternal and Child Health Bureau*
John Neff, *Center for Children with Special Needs*
Paul Newacheck, *University of California, San Francisco*
James Perrin, *Massachusetts General Hospital*
Debra Read, CAHMI- The Child and Adolescent Health Measurement Initiative
Donald Steinwachs, *Johns Hopkins University*
Ruth Stein, *Albert Einstein College of Medicine*
Joe Thompson, *Arkansas Children’s Hospital*
Deborah Klein Walker, *Massachusetts Department of Public Health*
Nora Wells, *Family Voices*
Who are Medically Complex Children?
These children should only be referred to as Medically Complex Children, Children with Medical Complexities, or Children with Medically Complex Conditions.

Children with Medical Complexities require the highest level of services and support from children’s hospitals due to the intensity of care and breadth of pediatric specialists required to care for their conditions. There are approximately 3 million of these children in this country, and almost all of them are cared for in children’s hospitals. And the population is growing.

Children with Medical Complexities are often enrolled in Medicaid. Based on initial estimates of Medicaid data, 6 percent of child enrollees fall into this category, and they represent 40 percent of the Medicaid health care spend for children.

How are they defined?
Using the 3M™ Clinical Risk Group categories, these children can be defined as those that fall into CRG categories 5 through 9* -- a portion of children in Lifelong Chronic, Complex Chronic children, and Children with Malignancies. They are children with significant chronic conditions in two or more body systems or those with a single dominant chronic condition.

<table>
<thead>
<tr>
<th>Non-Chronic (CRGs 1, 2)</th>
<th>Episodic Chronic (CRGs 3, 4)</th>
<th>Lifelong Chronic (CRG 5)</th>
<th>Complex Chronic (CRGs 6, 7, 9)</th>
<th>Malignancies (CRG 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute conditions</td>
<td>Chronic conditions that will last one year and are likely to be episodic in manifestation</td>
<td>More severe primary condition in one body system that is more likely to cause significant long-lasting health impairment</td>
<td>Significant chronic condition in two or more body systems or Progressive or life limiting chronic conditions or Conditions requiring a dependency on technology</td>
<td>Malignancies requiring active treatment</td>
</tr>
<tr>
<td>Example Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fracture, pneumonia, appendicitis, trauma</td>
<td>Asthma, depression, conduct disorders</td>
<td>Type 1 diabetes, congenital heart disease</td>
<td>A child with diabetes, encephalopathy and chronic pulmonary disease. Down syndrome, cerebral palsy, cystic fibrosis.</td>
<td>Leukemia, bone tumors, brain tumors</td>
</tr>
</tbody>
</table>

*Category 5 is further broken into two subcategories by the Children’s Hospital Association - 5a and 5b. The definition of Medically Complex Children includes 5b - Single Dominant Chronic Disease, such as those with Sickle Cell Disease or Congenital Heart Disease.
Breakout Session #1: What is it that you Do? Enrollment criteria and clinical services

PHM 2016 Workshop: Meeting the Needs of Children with Medical Complexity: A Framework for Building a Pediatric Complex Care Program

July 29, 2016  Michelle Thomas, MD / Norah Emara, MD
Clinical Scope

**In-Patient vs Out-patient**

- **In-Patient**
  - Consultation
  - Co-Management
  - Service Line
  - Transition services

- **Out-Patient**
  - Consultation / Co-PCP
  - Medical Home
  - Care coordination only
  - Adolescent transition clinic
Choosing your criteria

• CYSHCNs vs Medically Complex?
  • CYSHCN Screener
  • Pediatric Population Groupers

• “Merit-based”
  • Utilize discharge data: Top spenders vs Top utilizers
  • Diagnoses: Number of chronic conditions, life-sustaining medical technology
  • Utilization: Number of sub-specialists
  • Fragility: Number of ED visits vs Admissions vs Readmissions vs ICU stays vs Total LOS

• May be dependent on payer contracts.
Pediatric Population Groupers

• Pediatric Medical Complexity Algorithm (PMCA)

• Clinical Risk Grouper (CRGs)
  • 3M product, requires 3 years of hospital discharge data; Medical Complex: CRGs 5b-9 (+/-8)
  • CHA’s “Defining Children with Medical Complexity”. https://www.childrenshospitals.org/~media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Children_With_Medical_Complexity/Fact_Sheets/Defining_Children_With_Medical_Complexities_100113.pdf

• Complex Chronic Conditions (CCCs)
    • Resources available on-line in order to implement
## Service Models

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Medically complex service: Children’s Memorial Hospital, Chicago</th>
<th>Medical home program for special needs children: Arkansas Children’s Hospital</th>
<th>Complex-care service: Children’s Hospital Boston</th>
<th>Rainbow initiative: Children’s Hospital Boston</th>
<th>Special needs program: Children’s Hospital, Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service model</strong></td>
<td>Inpatient: Dedicated service</td>
<td>Outpatient: Consultative</td>
<td>Inpatient: Consultative</td>
<td>Outpatient: Primary care</td>
<td>Outpatient: Consultative and dedicated service</td>
</tr>
</tbody>
</table>
| **Patient characteristics considered in selection for program enrollment** | 1. Involvement with 4 or more specialists  
2. Or residence in a chronic care facility  
3. Or 3 or more admissions in the previous 2 years | 1. Involvement of 2 or more specialists  
2. At least 2 chronic conditions | 1. Health problems involving 3 or more organ systems, or significant neurodevelopmental disability  
2. Or significant dependence on medical technology | 1. Health problems involving 2 or more organ systems, or significant dependence on medical technology  
2. Or severe single system disorder, excluding asthma and psychiatric disorders  
3. Or at least 3 hospitalizations in the previous year, or a hospitalization lasting more than 15 days | 1. Health problems involving 3 or more organ systems  
2. Involvement of 5 or more specialists  
3. Two or more hospitalizations, 10 or more hospital days, or 10 or more clinic visits in the previous year  
4. Unmet care coordination needs |
| **Clinician types** | Pediatric hospitalist, social worker, case manager | Neonatologist, developmental/ general pediatrician, nursing care coordinator, social worker, psychologist, speech therapist | Developmental/general pediatrician, social worker, nursing care coordinator | General pediatrician, social worker, nursing care coordinator | General pediatrician, intensivist, nursing care coordinator |
| **Number of patients enrolled in the service** | 234 | 345 | 832 | 500 | 403 |
| **% of children with one or more hospitalizations during the study period** | 71.8% | 73.0% | 84.9% | 37.8% | 59.3% |
Considerations

• Catchment area
• Health system resources and gaps
• Community resources and gaps
• Duplications: Specific comprehensive clinical programs
• Inclusive of behavioral and mental health conditions?
Forward Thinking

• Aligning criteria with national / state initiatives:
  • Advancing Care for Exceptional Kids Act of 2015 (ACEKids Act 2015)
    • Chronic, physical, developmental, behavioral, or emotional conditions that –
      • Affects 2 or more body systems
      • Requires intensive care coordination to avoid excessive hospitalizations or emergency department visits
      • Meets the criteria for medical complexity using risk adjustment methodologies (such as CRGs or another recognized pediatric population grouping system) agreed upon by the Secretary in coordination with a national panel of pediatric experts.

• Complex Chronic Care Management CPT Codes
  • “2 chronic continuous or episodic health conditions that are expected to last at least 12 months or until death of the patient at significant risk of death, acute exacerbation/decompensation, or functional decline”

• State Medicaid Initiatives
Controlling the Floodgates

• Create a Mission, Vision, and Purpose.
• Set achievable goals.
  • FTE and types of support staff available to assist in patient care
  • Other system resources that can be leveraged and gaps to be filled
  • Referral process
  • In-patient: Bed space; define to initial services to whom consultation will be offered (surgical vs medical vs intensive care, ER, pre-op)
  • Out-patient: Estimated visit length and # of sessions to determine capacity
    • Average Panel Sizes
  • Long-term vision: Projected rate of program growth and expansions
Discussion

• What model have you identified would meet the need at your institution?
• Which methods do you find most useful for determining criteria?
• What resources have you or will you leverage at your institution?
• Determine next steps to move forward.
Administrative Specialist/Data Manager

Degree and area of specialization:

BA or BS required. Master's level training (such as MPH) is preferred.

Minimum number of years and type of relevant work experience:

Minimum 2 years of experience in a health care environment preferred, particularly experience in health care research or clinic operations. A successful candidate will demonstrate a history of initiative, flexibility and personal accountability. This position requires administration and time management skills, attention to detail and documentation, ability to problem solve, ability to work as a team member and independently, and strong analytical skills.

Principal duties:

Under the direction and supervision of the Pediatric Complex Care Program Medical and Research Directors, the Pediatric Complex Care Program Administrative Program Specialist will be responsible for providing a comprehensive support system in pediatric clinical and research studies and responsible for the development and implementation of an organizational plan to enhance the workings of the PCCP.

Primary Duties include, but not limited to:

- Apply knowledge of clinical regulation, Good Clinical Practice and program-specific guidelines, prepare IRB submission, including initial reviews, continuing reviews, and protocol changes.

- Understand, interpret, and assist in the creation of complex clinical and research protocols in a variety of therapeutic areas.

- Develop and prepare clinical research applications.

- Monitor operational tasking timelines; provide recommendations for adjustments in schedules based on unexpected variables.

- Manage the collection of data to ensure accuracy and completeness. Assist investigators and PCPP staff in presentation of data analysis.

- Interpret program data to develop clear, concise status reports and summaries for all tasks/projects for the program.
- Validate accuracy of all data and reports to ensure informed decision making process.

- Assist Pediatric Complex Care Program with planning, coordinating, and facilitating operational projects related to the tripartite mission of clinical care, education, and research.

- Administer standardized surveys of patient-reported data for patients enrolled in the program.

- Serve as liaison for the Pediatric Complex Care Program regarding clinical and research related issues to various representatives from the State of WI Department of Human Services, UW Health ACO, Children's Hospital of WI's Special Needs Program, other entities of UW Health, Unity Insurance, community organizations, etc.

- Develop and maintain professional and productive relationships with both internal and external stakeholders.

- Field technical needs, including developing and analyzing reports, creating and managing shared drive content; developing databases, and creating efficiencies with technical advancements.

- Develop and maintain training materials, checklists, spreadsheets, flow charts, work standards, resource materials, process sheets, and other materials to provide consistency and process improvement for program-related activities and support program growth over time.

- Communicate with LEP (limited English proficient) patients/parents of patients via interpreter services or TDD machine as needed.

- Attend and serve on committees as a representative of the Pediatric Complex Care Program as requested.

- Prepare manuscripts for submission to academic journals.

- Prepare reports using program data as requested.

- Maintain proficiency in multiple software programs, including Microsoft Word, Excel, Powerpoint.

- Other duties as assigned.
**Additional Information:**

Ideal candidates will have:

- Excellent knowledge of word processing, spreadsheet, presentation software, and flow diagramming
- Excellent proficiency with Microsoft Word, Excel, Outlook and PowerPoint applications
- Excellent oral and written communication skills
- Ability to create executive-level reports and presentations
- Ability to work effectively with all levels of administration and management within the organization
- Ability to run data reports to support administrative decisions
- Some knowledge of clinic work flows
- Previous exposure to clinical research or quality improvement work
- Ability to work independently, multitask and prioritize workload to complete tasks and operations related projects with limited direction
- Ability to address needs, make improvements, and work proactively
- Attention to detail; thoroughness required
- Excellent organizational and customer service skills
- Ability to take direction well from all members of the Program team
- Excellent teamwork skills and positive attitude
Position Title: Nurse Practitioner/Physician Assistant
Employee Name: 
Reports To: 
Department: Pediatrics – Complex Care Program
Section: 
Date Last Updated: May 2015

Summary: The Nurse Practitioner/Physician Assistant functions as an independent healthcare provider who, working collaboratively within the Pediatric Complex Care Program, is responsible for providing care coordination and medical co-management for patients enrolled in the Pediatric Complex Care Program. The Nurse Practitioner/Physician Assistant, using care coordination as a strategy, will assist in developing and implementing a plan of care in collaboration with the patient/family, members of the Pediatric Complex Care Program, primary care provider, inpatient providers, specialists, and community and other healthcare services in the inpatient and outpatient settings. He/she demonstrates a high degree of clinical expertise in working with patients with acute and chronic illnesses, specifically children with medical complexity who have multiple organ systems affected, are followed by multiple specialists, are often dependent on technology for survival, and are high utilizers of the health care system. He/she delivers maintenance care and acute care, creates and maintains comprehensive patient summary and crisis plans, which include collaboratively determined goals of care, and educates patients and their families on care and treatment plans for health disorders. In addition he/she will help patients, families, and providers navigate the unique needs of patients enrolled in Pediatric Complex Care Program during acute episodes requiring ED visits or inpatient stays, including proactively partnering with patients/families and members of the patient’s healthcare team to ensure seamless transitions within different units in the hospital and between inpatient and outpatient settings. He/she demonstrates excellent knowledge of the inpatient, outpatient, perioperative and operative, radiology, and emergency department systems. He/she develops criteria for and participates in the evaluation of the quality and effectiveness of care. He/she maintains a database of patients enrolled in the Pediatric Complex Care Program for quality benchmarking and research. He/she plans and participates in learning opportunities for nursing students, advance practice provider students, medical students, and resident physicians. He/she works with administrative, nursing, physician, and university faculty to assure quality patient care and to promote education and research. This Nurse Practitioner/Physician Assistant will practice at the Children’s Hospital (inpatient units for consults and Peds Specialty Clinics for outpatient care) with core hours of 8-5 M-F and will have some evening and weekend call responsibilities shared with physicians and other APPs of the Pediatric Complex Care Program.

Qualifications/Requirements:
If Nurse Practitioner:
Master’s or Doctorate’s degree in Nursing **AND**;
Active RN and APNP license, **AND**;
Active board certification as an NP in Pediatrics, Acute Care, or Primary Care, **AND**;
Active DEA license or ability to apply for such license prior to or upon hire.

If Physician Assistant:
Bachelor’s or Master’s degree from accredited PA Program, **AND**;
Active PA board certification; **AND**
Active PA license

**All Nurse Practitioner and Physician Assistant applicants:**
Two years of relevant clinical experience preferred.
CPR certified;
Extensive knowledge of physical assessment, differential diagnosis, pathophysiology, pharmacology and management of acute and chronic patient/family health problems.
Ability to care for acutely and chronically ill patients
Excellent verbal and written communication skills
Professional demeanor
Ability to work as a member of a team
Ability to prioritize tasks

The Nurse Practitioner/Physician Assistant will provide care to a caseload of patients within their scope of practice as outlined by applicable state law, regulations, institutional policy and practice agreements.

The Nurse Practitioner or Physician Assistant is overseen by the division chair/chief for organization and management of the clinical practice. Annual evaluations are performed by collaborating physicians, clinic staff and/or colleagues.

50% Clinic/Outpatient care

1. Conduct comprehensive health history and physical assessment of patients/families with acute, chronic and/or potential health problems as part of the enrollment process for new patients, including the development of the initial care plan.
2. Provide acute care during clinic hours for urgent new health needs, provide post-hospitalization follow-up care, and scheduled maintenance care.
3. Perform preoperative evaluations and communicate effectively with anesthesia and surgical teams to coordinate care in the perioperative setting.
4. Triage acute needs to determine best location for evaluation, such as local emergency department, children’s hospital emergency department, or clinic.
5. Establish medical diagnoses.
6. Create and maintain an accurate electronic medical record and comprehensive patient summary and crisis plans.
7. Accurately and appropriately transcribe or execute standing orders at the direction of the supervising/collaborating physician. Write specific orders within the limits of the practice agreement/scope of practice.
8. Provide telephone or electronic care and care coordination as appropriate.
9. Provide appropriate direction to family and clinic staff regarding patient care issues.
10. Communicate effectively with referring and specialty providers and community and other health care resources; particularly serve as a resource for emergency department or urgent care providers when patients enrolled in Pediatric Complex Care Program need to seek urgent or emergency care. Serve as a liaison to community services (school, therapies, dental care, respite care, etc.).
11. Educate parents about bladder catheterization, ostomy care, oral suctioning, and medical technological devices such as central lines, gastrostomy or other enteral tubes, feeding pumps, intravenous medication pumps, suction machines, and nebulizers, and troubleshoot these devices when they malfunction.
12. Evaluate and treat patients for problems unique to this patient population, such as monitoring skin for pressure wounds related to immobility and orthotics use.
13. Organize, lead, and participate in outpatient care conferences.
14. Maintain and manage databases with quality improvement data and patient care data.
15. Work with other members of the Pediatric Complex Care Program to identify and implement quality improvement initiatives.
16. Participate in weekly Pediatric Complex Care Program meetings to discuss patients and Program initiatives.

50% Inpatient Consultative care

1. Participate in inpatient family-centered rounds for any patient enrolled in the Pediatric Complex Care Program, including during critical illness in the intensive care unit and during non-critical illness hospitalizations on general inpatient units.
2. Work with primary team to establish plan of care for hospitalization.
3. Perform initial admission consult history and physical exam with recommendations for care as needed, particularly conveying the nuances of the patient’s past medical history, recent outpatient medical/surgical interventions, and social situation.
4. Perform consult follow-ups daily during hospitalization.
5. Proactively coordinate care with an eye toward anticipating outpatient needs and facilitating timely discharge.
6. Communicate effectively with patients, families, primary teams, and other consultants, and facilitate communication among various members of the health care team.
7. Perform medication reconciliation upon discharge.
8. Organize, lead, and participate in inpatient care conferences.
9. Create new care plans and crisis plans for use following discharge and create patient education documentation for discharge planning.
10. Evaluate patients in the Emergency room alongside the ER staff to facilitate care coordination and management when able.

11. Perform consults on new patients referred to Pediatric Complex Care Program while in the inpatient setting.

Procedures

Perform routine clinical procedures independently as outlined in the collaborative practice agreement/scope of practice while under the direction and supervision of the responsible physician.

Procedures include, but are not limited to:
- Gastrostomy tube change
- Treatment of gastrostomy granulation tissue
- Bladder catheterization
- Tracheostomy care

Education/Outreach

1. Identify and establish clinical learning opportunities for nursing and medical students, Advance Practice Provider students, resident physicians, and other health science students in conjunction with appropriate faculty. Monitor students’ performance. May act as preceptor in student learning experiences.

2. Participate in formal programs such as clinic and hospital in-services, university and community conferences, CME workshops and courses, and informal education activities such as reviewing current literature, independent study and consultations with health professional and experts in related fields.

3. Develop care pathways, protocols, and guidelines for management of specific problems in collaboration with physicians and other members of the health care team.

4. Support the University’s (Nursing, Med School, PA program) outreach mission through consultations and/or participation in health promotion, health education and specialty requests from community agencies.

5. Act as a resource to healthcare staff and implement educational programs to improve care provided to patients/families. Identify areas of learning need and provide information, refer to information sources and /or assist the individuals or groups to increase skills.

Research

1. Evaluate current research within area of expertise/practice for applicability to the care of patients.

2. Support the planning of and participate in clinical research conducted by students and faculty of the Department and /or other members of the health science disciplines.

3. May perform independent research, acting as principal investigator in research.
General Duties

1. Provide for continuity of care for patients regardless of setting (home, inpatient, outpatient).
2. Analyze clinical practice and identify opportunities to increase effectiveness and efficiency.
3. Meet regularly with appropriate physicians; work collaboratively to effect programmatic changes and develop protocols.
4. Develop, implement, and evaluate comprehensive patient education programs that assure quality and appropriateness of care across settings.
5. Participate in quality assessment and improvement activities. Identify important aspects of care and assure findings are used to improve practice and operations.
6. Serve on clinic/unit based, nursing department, and medical staff committees, as appropriate.
7. Develop state of the art collaborative practice relationships to serve as models for nursing and other students in the health science disciplines.
8. Act as a resource to healthcare staff and implement educations programs to improve care provided to patients/families. Identify areas of learning need and provide information, refer to information sources, and/or assist the individuals or groups to increase skills.
9. Work in collaboration with faculty, residents, fellows, surgeons and nursing staff to provide on-going patient care and management.
10. Is responsible for timely and accurate written documentation or dictation of patient care encounters/procedures.
Care Coordination Assistant/Lay Navigator Position

The Care Coordination Assistant partners with Registered Nurses and other team members to coordinate care and provide support for patients enrolled in the Pediatric Complex Care Program and their families. The Pediatric Complex Care Program (PCCP) provides care coordination and medical management for children with medical complexity who have dysfunction in many organ systems, receive care from many pediatric specialists, and have frequent clinic visits or hospitalizations. The Care Coordination Assistant will work closely with families to ensure that they are appropriately connected to clinical, social, and community resources, and will assist families with navigation of the health care system.

Work Schedule: 100% FTE, 40 hours per week. 8:00 - 5:00, Monday - Friday. Hours may vary based on the operational needs of the department.

Qualifications

<table>
<thead>
<tr>
<th>Education</th>
<th>Minimum</th>
<th>Associate degree in health care or social service related discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Work Experience</td>
<td>Minimum</td>
<td>One year of experience in health care with an emphasis on customer service, including scheduling, registration or insurance focus; or one year of experience in a community setting serving children with special health care needs</td>
</tr>
<tr>
<td></td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Licenses &amp; Certifications</td>
<td>Minimum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Required Skills, Knowledge, and Abilities</td>
<td>• Ability to navigate the health care system and coordinate with multiple services. Ability to be flexible when prioritizing and multi-tasking in order to meet the needs of the patients, parents, physicians and other hospital staff.</td>
<td></td>
</tr>
</tbody>
</table>
• Ability to type a minimum of 50 words per minute. Experience with medical forms, letters and prior authorizations preferred. Experience with data entry and use of the electronic medical record preferred.

• Excellent communication skills (oral and written) are necessary. Experience working with families of diverse ethnic, cultural and socioeconomic backgrounds preferred.

• Possess a positive attitude, excellent teamwork skills, and professional demeanor when interacting with members of the health care team, community organizations/resources, and with patients/families.

• Strong organizational skills. Ability to maintain records, coordinate clinic appointments, and prioritize work independently.

• Ability to concentrate and pay close attention to detail.

• Ability to learn computer and application skills as applicable to role

• Ability to interact with and work around people

• Ability to make judgments in demanding situations

• Ability to react to frequent changes in duties and volume of work

• Effective communication skills
| • Ability to listen empathetically |
| • Ability to logically organize details |
| • Comfortable accepting responsibility for medium to large scale projects involving multiple resources and spanning many months from start to finish |
| • Ability to manage multiple concurrent activities |
COMPLEX CARE RN POSITION DESCRIPTION

Specific Complex Care RN Role (in addition to general RN description below):

-Serve as point of contact at Children’s Hospital for issues that arise for enrolled patients/families.
-Provide telephone-based, electronic, and in-person care coordination services.
-Interface with community resources and ancillary health care-related services such as: school nurse, therapists, DME agencies, in-home nursing, respite care, etc.
-Work with schedulers, other RNs in Peds Specialty Clinic who work with different subspecialty teams, NPs/PAs/subspecialists involved in managing aspects of complex care patients’ care, social workers, and PCP and staff to ensure that the many needs of the complex care patients are addressed in a rational, timely, and patient- and family-centered manner.
-Help families with children with multisystem medical diagnoses navigate the healthcare system.
-If possible and beneficial, accompany complex care patients to subspecialty appointments and/or perform home visits.

Complex Care RN Ideal Qualities

-Knowledge and/or experience with services and resources commonly used by children with developmental disabilities.
-Experience with indwelling technological devices such as central lines, gastrostomy tubes, VP shunts, baclofen pumps, etc.
-Team-oriented outlook, adaptable personality, and willingness to go the extra mile to be able to acutely address patients’ needs.
-Interest in working with children with medical complexity and their families.
-Interests in palliative care a bonus!

<table>
<thead>
<tr>
<th>POSITION SPECIFICS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong> Registered Nurse Clinician</td>
</tr>
<tr>
<td><strong>Reports to:</strong> Clinic Manager</td>
</tr>
<tr>
<td><strong>Job Code:</strong> Varies by Option</td>
</tr>
<tr>
<td><strong>Bargaining Unit:</strong></td>
</tr>
<tr>
<td><strong>Manager Approval:</strong></td>
</tr>
<tr>
<td><strong>HR Approval:</strong></td>
</tr>
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</table>

**POSITION SUMMARY**

Registered Nurse Clinician is responsible for providing direct and indirect patient care ambulatory care areas. He/she is expected to competently perform the patient care responsibilities of the registered nurse within the assigned work setting. Responsibilities include the systematic collection and assessment of data in collaboration with the multidisciplinary team to provide therapeutic care for the patient and/or family. He/she performs all required elements of a nursing assessment including but not limited to physical examination, assessment of readiness to learn, psychosocial assessment, functional assessment and utilization of patient/family specific assessment scales as required. He/she considers factors related to safety, effectiveness and cost in planning and delivering care. The Nurse Clinician decisions and actions with patients and families are determined in an ethical manner. He/she establishes goals and a strategy for meeting the discharge or continuing care needs with the patient, family, and/or other care provider as required or carries out discharge plans as noted on the critical pathway or multidisciplinary plan of care. Care is provided in collaboration with other nursing staff members; he/she delegates and supervises care in accordance with nurse practice acts and the professional nursing role.
The incumbent performs the following job responsibilities:

I. Clinical Practice - Provision of professional nursing care with patients and families.

_The registered nurse systematically collects and assesses data in collaboration with the multidisciplinary team to provide therapeutic care with the patient and family, follows the prescribed plan of care and documents progress towards achieving defined outcomes. Continuity in patient care is achieved through concise communication with the Care Team Leader._

1. Systematically assesses the needs with the patient through interview (including history taking), observation, and physical examination (may be selective or total examination).

2. Secures information about the medical plan of care and previous health care experiences.

3. Notes progress in meeting defined outcomes.

4. Plans and organizes individual nursing care for an identified group of patients.

5. Administers individual nursing care, independently applying both simple and complex techniques and processes that are specific to the needs of the patient.


7. Evaluates and documents patient response to prescribed interventions.

8. Completes delegated patient and family teaching including providing patient and family with information about clinic and hospital policies, procedures, and participation in decision-making.


10. Instructs the patient and/or family on subjects such as disease process, risk factors, and prevention of complications to help them plan for care.

11. Anticipates from present evidence, nursing and/or medical problems which may arise and initiates preventive measures.

12. Reports patient and family progress in meeting defined outcomes to physicians and members of other health care disciplines.

13. Skillfully uses the range of equipment, medicines, and other modalities, such as CPR, as well as the procedural and educational resources pertinent to assigned work area. Demonstrates knowledge of purpose and expected outcomes.

14. Provides support and assistance to the patient during physical examinations, and surgical and
**COMPLEX CARE RN POSITION DESCRIPTION**

medical procedures completed in the clinic.

15. Provides concise communication regarding the patient's progress to other nursing staff members, and other health care practitioners. Examples: intra- and inter-unit; inpatient unit to clinic, or operating room, hospital to home or other health care facility.

16. Possesses knowledge of the principles of growth and development for the appropriate age group(s).

17. Demonstrates the ability to assess data reflective of the patient's status in relation to the appropriate age group(s).

18. Demonstrates the ability to interpret relevant information needed to identify each patient's nursing care requirements relative to his/her age specific needs.

19. Demonstrates the ability to provide nursing care relative to the patient's age specific needs.

*Performance measures:*

- Performs systematic nursing assessment, recognizes abnormalities and documents findings. Critical elements include physical examination, assessment of readiness to learn, psychosocial assessment, functional assessment, and (depending on setting) utilization of specific assessment scales including the Braden scale, pain assessment and functional assessment, developmental level scales.
- Possesses knowledge of the principles of growth and development for the appropriate age group(s).
- Interprets overt and subtle data to determine physiologic or psychosocial risk.
- Provides for each patient's nursing care requirements relative to his/her age specific needs as established on the plan of care.
- Teaches patient, family and/or other care provider critical knowledge and skill necessary to accomplish self-care regimes and manage decision-making of continuing care needs according to prescribed teaching plan.
- Documents information, which leads to insights or the solutions of usual patient problems, the response to, and the outcome of care, provided. Documents in accordance with UWHC polices and procedures.
- Safely and competently executes technical skills required for practice.

**II. Resource Utilization**

*The registered nurse considers factors related to safety, effectiveness, and cost in delivering care*

1. Acts to facilitate cost control in use of material resources.

2. Adapts focus of assessment and intervention techniques in responding to changing patient care needs during scheduled shift.

3. Schedules and arranges for patient participation in the many hospital services affecting patient care for scheduled work shift.
COMPLEX CARE RN POSITION DESCRIPTION

4. Observes hospital policies and procedures that ensure the security and safety of patients, e.g., medication administration procedures, etc.

5. Takes assigned action (per policy manual) in emergency situations, such as fire, tornado, disaster, etc; may act as a lead person in emergency activities.

6. Judges which data needs to be reported to staff or managers, and organizes accurate, efficient, and timely reports.

Performance measures:

- Consults with Clinic Manager or Clinic Coordinator to implement practice protocols competently and consistently dependent on practice setting.

Evaluates and reports patient response based on expected outcomes

III. Collaboration

1. Initiates communication with patient and family to determine individual needs of patients and families.

2. Initiates communication with co-workers and colleagues in other disciplines and departments to share and exchange ideas and information about related activities and needs.

3. Provides detailed patient education with patient and family members during their visit, using prescribed teaching plans.

4. Responds effectively, both verbally and non-verbally, to communications from patients, families and significant others as well as subordinates, colleagues, department heads, supervisors, physicians, etc.

Performance measures

- Maintains patient privacy and confidentiality.
- Develops a therapeutic relationship by establishing trust and enabling patient and/or family to verbalize his/her requirements for help comfortably and clearly.

IV. Ethics

The registered nurse’s decisions and actions with patients and families are determined in an ethical manner.

1. Demonstrates sensitivity to the values of self and others.

2. Involves patient/family in plan of care incorporating their cultural, spiritual and other belief systems.

Performance measures:
COMPLEX CARE RN POSITION DESCRIPTION

• Demonstrates trust, respect, honesty, and caring attitudes with patient/families and other members of the health care team.
• Demonstrates commitment to patient/family cultural beliefs and practices.

All duties and requirements must be performed consistent with the Organizational Performance Standards.

<table>
<thead>
<tr>
<th>POSITION REQUIREMENTS</th>
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<tbody>
<tr>
<td><strong>Education</strong></td>
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<tr>
<td>Minimum</td>
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<tr>
<td><strong>Work Experience</strong></td>
</tr>
</tbody>
</table>
| Minimum               | Preferred | • One (1) year relevant clinical experience.  
                                      • Recent/current inpatient or outpatient pediatric experience. |
| **Licenses & Certifications** |
| Minimum               | Preferred | • Registration as a professional nurse in the State.  
                                      • CPR certification.  
                                      • Chemotherapy certification may be required based upon clinic assignment. |
| **Required Skills, Knowledge, and Abilities** |
|                       | 1. Knowledge regarding quality improvement and standards of care within practice area.  
                                      2. Experience in teaching patients and families.  
                                      3. Excellent communication skills.  
                                      4. Ability to effectively delegate and supervise the work of other nursing team members. |

AGE – SPECIFIC COMPETENCY

Identify age-specific competencies for direct and indirect patient care providers who regularly assess, manage and treat patients.

**Instructions:** Indicate the age groups of patients served either by direct or indirect patient care by checking the appropriate boxes below. Next,

| Infants (Birth – 11 months) | Adolescent (13 – 19 years) |
| Toddlers (1 – 3 years)     | Young Adult (20 – 40 years) |
| Preschool (4 – 5 years)    | Middle Adult (41 – 65 years) |
| School Age (6 – 12 years)  | Older Adult (Over 65 years) |

**Job Function**

Review the employee’s job description, and identify each essential function that is performed differently based on the age group of the patient.

**PHYSICAL REQUIREMENTS**

Indicate the appropriate physical requirements of this job in the course of a shift. *Note: reasonable accommodations may be made available for individuals with disabilities to perform the essential functions of this position.*

<table>
<thead>
<tr>
<th>Physical Demand Level</th>
<th>Occasional</th>
<th>Frequent</th>
<th>Constant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up to 33% of the</td>
<td>34%-66% of the</td>
<td>67%-100% of the</td>
</tr>
<tr>
<td>Category</td>
<td>Maximum Weight</td>
<td>Time Required</td>
<td>Additional Requirements</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Sedentary:</td>
<td>Up to 10#</td>
<td>Negligible</td>
<td>Occasional lifting and/or carrying of small tools.</td>
</tr>
<tr>
<td>Light:</td>
<td>Up to 20#</td>
<td>Up to 10# or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>requires</td>
<td>significant walking or standing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>significant</td>
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<td></td>
<td></td>
<td>weight</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>X Medium:</td>
<td>20-50#</td>
<td>10-25#</td>
<td>Negligible-10#</td>
</tr>
<tr>
<td>Heavy:</td>
<td>50-100#</td>
<td>25-50#</td>
<td>10-20#</td>
</tr>
<tr>
<td>Very Heavy:</td>
<td>Over 100#</td>
<td>Over 50#</td>
<td>Over 20#</td>
</tr>
</tbody>
</table>

List any other physical requirements or bona fide occupational qualifications:

- 

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**Sedentary:** Ability to lift up to 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one, which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

**Light:** Ability to lift up to 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only be a negligible amount, a job is in this category when it requires walking or standing to a significant degree.

**Medium:** Ability to lift up to 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.

**Heavy:** Ability to lift up to 100 pounds maximum with frequent lifting and/or carrying objects weighing up to 50 pounds.

**Very Heavy:** Ability to lift over 100 pounds with frequent lifting and/or carrying objects weighing over 50 pounds.
Peds Complex Care Social Worker PD

1. Perform assessment for all patients to identify resources for which patient/family might be eligible (secondary Medicaid, county family support dollars, therapies, WIC, etc) and facilitate the process of getting the patient/family enrolled.

2. Work in conjunction with the rest of the team to facilitate obtaining home equipment, personal care workers, home nursing, and other necessary items, including writing letters of medical necessity and completing other paperwork.

3. Create long-term supportive therapeutic relationships with patients/families, and act as a point person for social needs.

4. Provide emotional support to families.

5. Prepare patients and families for transition to adulthood through education about and assistance with guardianship, community resources, out of home placement, planning for the future, advance directives, etc.

6. Create educational materials for learners and patients/families about commonly utilized resources for children with medical complexity.

7. Create and maintain list of commonly accessed support groups, equipment websites, equipment exchange, etc.

8. Establish relationships with community organizations to facilitate connections and optimal care coordination for our population.

9. Work with families to proactively prevent crises (financial, emotional, etc) and intervene when such crises inevitably occur.

10. Provide family education and support to encourage parental advocacy, organization, systems navigation, and teamwork skills for families new to caring for children with medical complexity.

11. Participate in grant-related provider-level and patient-level data capture, such as time tracking, gathering family impact data, and comply with grant requirements.

12. Communicate clinical info to complex care program staff.

13. Develop positive relationships with social workers in subspecialty disciplines so as to maximize efficiency in meeting the needs of this population.
Evolving from Hot Mess to Functional Program: Creating your Multi-disciplinary Team

Interprofessional Education and Practice (IPEC, 2011)

a. **Interprofessional collaborative practice**: “When multiple health workers from different professional backgrounds work together with patients, families, carers [sic], and communities to deliver the highest quality of care” (WHO, 2010)

b. **Interprofessional team-based care**: Care delivered by intentionally created, usually relatively small work groups in health care, who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients, e.g., rapid response team, palliative care team, primary care team, operating room team

I. **Identifying Critical Members Worksheet**

<table>
<thead>
<tr>
<th>Organizational Factors</th>
<th>1. Who will lead your team?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Who needs to be on your team (shares your mission, vision, values)?</td>
</tr>
<tr>
<td></td>
<td>3. Who would make your team more timely and efficient? (ex. Admin support)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal Factors</th>
<th>1. Who do you trust to be on your team/Who do you know?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Who speaks the same language (complex care)?</td>
</tr>
</tbody>
</table>
| **Professional-Related Factors** | 1. What groups/practioners have skills or competencies that you might need on your team?  
2. Who would be motivated to be on your team? |
|----------------------------------|--------------------------------------------------------------------------------------------------|
| **External Factors**             | 1. Who will help with education/competencies?  
2. Who will help with finances, billing and/or strategic planning?  
3. Who will help with laws and regulations?  
4. Who will ensure that IT and Communications will support your program? |
| **Patient-Related Factors**      | 1. How active will the role of your patients/families be? How do you envision the patients/families being part of your team?  
2. Are there Patients and Families who might support the strategic planning and development of your program? |

(Adapted from van Dongen, et al BMJ Fam Prac 2016)
**Team Members to Consider**

- Team Composition will depend on patient population, type of clinical services being offered

<table>
<thead>
<tr>
<th>Complex Care Pediatrician</th>
<th>Pediatric Subspecialists</th>
<th>Care Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Pediatrician</td>
<td>GI</td>
<td>Case Management</td>
</tr>
<tr>
<td>Pediatric Hospitalist</td>
<td>Neurology</td>
<td>Social Work</td>
</tr>
<tr>
<td>Primary Care Pediatrician</td>
<td>Orthopedics</td>
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<tr>
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<td>Quality Department (Metrics)</td>
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References:


## UW Peds Complex Care Program Dashboard – data through June 2016

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<td>Total ineligible referrals to date</td>
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<td>Average days, referred to enrollment (median)</td>
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<tr>
<td>% of referrals who enrolled, to date</td>
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<td>Number of patients enrolled each month</td>
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<td>11</td>
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<td>9</td>
<td>8</td>
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<td>117</td>
<td>128</td>
<td>136</td>
<td>145</td>
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<td>109</td>
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<td>130</td>
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<td>9</td>
<td>9</td>
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<tr>
<td>Total projected # of patients enrolled by month</td>
<td></td>
<td>200 (Yr2)</td>
<td>121</td>
<td>128</td>
<td>137</td>
<td>146</td>
<td>155</td>
<td>164</td>
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<td>34 total</td>
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<td>0</td>
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<td>% of completed Enrollment Forms by month</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>15</td>
<td>18</td>
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<td>-</td>
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<td>20</td>
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<td>% of completed biannual visits (M6/12, etc.) by month</td>
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<td>100%</td>
<td>20%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
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<td>% of completed Mon 2 F/U visits by month</td>
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<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>77%</td>
<td>40%</td>
<td>50%</td>
<td>44%</td>
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<td>100%</td>
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<tr>
<td>% of discharged calls completed within 72 hours</td>
<td></td>
<td>100%</td>
<td>64%</td>
<td>73%</td>
<td>63%</td>
<td>60%</td>
<td>62%</td>
<td>44%</td>
<td>22%</td>
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<tr>
<td>% of post discharge follow-up visits scheduled w/in 30 days</td>
<td></td>
<td>100%</td>
<td>91%</td>
<td>91%</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>80%</td>
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<td>% of med reconciliations within 72 hours of discharge</td>
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<td>100%</td>
<td>64%</td>
<td>77%</td>
<td>63%</td>
<td>60%</td>
<td>62%</td>
<td>44%</td>
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<td>Number of after-hours phone calls</td>
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<td>4</td>
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<td>Year 2 FTE actual</td>
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<td>7.3</td>
<td>6.8</td>
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<td>Year 2 FTE projected</td>
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</table>
Mangione-Smith Lab

Measurement Tools

Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN)

Family Experiences with Coordination of Care (FECC) measurement set
- Family Experiences with Coordination of Care (FECC) Details and Information (PDF)
- FECC Fact Sheet (DOC)
- FECC Survey: Telephone Interview English Version (DOC)
- FECC Survey: Mailed English Version (DOC)
- FECC Survey: Telephone Interview Spanish Version (DOCX)
- FECC Survey: Mailed Spanish Version (DOCX)
- FECC Detailed Measure Specifications (PDF)
- FECC Research Evidence (PDF)
- FECC Construct Measurement Reliability Testing for Multi-Part Indicators (PDF)

Hospital-to-home transition quality measures

Survey-based transition quality measures
- Quality of Pediatric Hospital-to-Home Transitions Survey English Version (PDF)
- Quality of Pediatric Emergency Department-to-Home Transitions Survey English Version (PDF)
- Quality of Pediatric Hospital-to-Home Transitions Survey Spanish Version (PDF)
- Quality of Pediatric Emergency Department-to-Home Transitions Survey Spanish Version (PDF)

Medical records–based transition quality measures

- Transition Measures MR Abstraction Tool Guidelines (DOC)
- Transition Measures MR List of Questions (DOC)
- Transition Measures MR Abstraction Tool (DOC)
- Transition Measures MR Scoring Specifications (DOCX)
- Transition Measures MR Electronic Abstraction and Scoring Tool (XLSM in ZIP)

Mental healthcare quality measures

Survey-based mental health quality measures

- Quality of Mental Healthcare Survey ED English Version (DOCX)
- Quality of Mental Healthcare Survey ED Spanish Version (DOCX)
- Quality of Mental Healthcare Survey Inpatient English Version (DOCX)
- Quality of Mental Healthcare Survey Inpatient Spanish Version (DOCX)
- Mental Health Survey Measures Detailed Specifications Emergency Department (XLSX)
- Mental Health Survey Measures Detailed Specifications Inpatient (XLSX)

Medical records-based mental health quality measures

- Mental Health Measures MR Abstraction Tool Guidelines (DOC)
- Mental Health Measures MR Data Abstraction Tool with Programming (DOC)
- Mental Health Measures MR Scoring Specifications (DOCX)
- Mental Health Measures MR Electronic Abstraction and Scoring Tool (XLSM in ZIP)

Pediatric Medical Complexity Algorithm (PMCA)

- PMCA Fact Sheet (DOC)
- Consensus Definitions for Medical Complexity (PDF)
- PMCA Tables (PDF)
- Statistical Analysis System (SAS) Instructions and Code (PDF)
SAS Programming Code for the PMCA (SAS in ZIP)

Article: Pediatric Medical Complexity Algorithm: A New Method to Stratify Children by Medical Complexity; Tamara D. Simon, Mary Lawrence Cawthon, Susan Stanford, Jean Popalisky, Dorothy Lyons, Peter Woodcox, Margaret Hood, Alex Y. Chen and Rita Mangione-Smith, Pediatrics; originally published online May 12, 2014; DOI: 10.1542/peds.2013-3875

Quality of Pre- and Post-Specialty Referral Communication for Children with Medical Complexity

- Specialty Referral Guidelines (DOC)
- Specialty Referral List of Questions (DOCX)
- Specialty Referral Abstraction Form (DOCX)
- Specialty Referral Measure Scoring (DOCX)
- Specialty Referral Electronic Abstraction and Scoring Tool (XLSM in ZIP)

Seattle Children's provides healthcare without regard to race, color, religion (creed), sex, gender identity or expression, sexual orientation, national origin (ancestry) or disability. Financial assistance for medically necessary services is based on family income and hospital resources and is provided to children under age 21 whose primary residence is in Washington, Alaska, Montana or Idaho.

© 1995–2016 Seattle Children’s Hospital
4800 Sand Point Way NE Seattle WA 98105
Dear Medical Director,

I am writing to tell you about the Pediatric Complex Care Program, a new program at UW Health-American Family Children’s Hospital that I believe will be of benefit to some children with medical complexity who are insured by you.

The Pediatric Complex Care Program is designed to provide enhanced care coordination for children with medical complexity (CMCs) who have many different organ systems affected, see many subspecialists, and who are high utilizers of the health care system. Children with medical complexity are a subset of the population of children and youths with special healthcare needs1-3 (CSHCN), and are the most complex and fragile pediatric patients.4 They constitute a very small proportion of the population but account for a very large amount of healthcare spending.5 They often have functional limitations, are dependent on technology to survive, and have needs well beyond those of typical children and even other children with special health care needs.4 Because of their complexity and fragility, they require care at pediatric tertiary care centers.4-6

The goal of the Pediatric Complex Care Program is to partner with the patient and family, PCP, specialists, and community resources to provide care to children with medical complexity that is coordinated, proactive, non-duplicative, and rational. By doing so, we hope to prevent hospitalizations whenever possible, decrease hospital length of stay, and avoid unnecessary ED visits, thereby reducing cost. It is challenging for busy PCPs in the community to play this role in a tertiary care center due to time, distance, and resource constraints.7,8 I and the other members of the Pediatric Complex Care Program team can provide the global perspective of the general pediatrician and work in partnership with the PCP to ensure that the care AFCH provides to patients enrolled in our program is maximally efficient and in line with the patient’s and family’s goals of care. We will also work closely with the patient and the PCP to keep care based out of the PCP’s office whenever possible, which is generally more convenient for the family and more cost-effective.

Programs of intense care coordination for children with medical complexity have been developed over the last several years at many pediatric tertiary care centers, generally with excellent results from a cost-savings standpoint.9-13 I am attaching a list of references for your review.

Criteria for enrollment in the Pediatric Complex Care Program include: 1) dysfunction in three or more organ systems, 2) care by three or more specialty providers, and 3) hospitalizations or ED visits within the last year. We are currently not enrolling patients who meet these criteria whose care is already coordinated through a different venue. Services that we provide include outpatient visits in the AFCH Pediatric Specialty Clinic for enrollment, routine follow up (roughly every 3 months depending on the patient), and unplanned urgent needs; inpatient consultation and rounding with the primary inpatient team when the patient is hospitalized to provide historical perspective and to be as proactive as possible about care coordination issues that may prolong hospitalization; and frequent telephone or electronic communication with the patient/family so small issues can be addressed proactively before they become larger issues requiring ED evaluation or hospitalization. For every patient we will write a comprehensive patient care summary for all providers caring for the patient to use as a
reference, as well as a crisis plan specific to the patient for addressing issue that we predict may arise that could result in increased healthcare utilization. The codes for the services we would potentially be billing include:
- inpatient consult (99251-5)
- inpatient subsequent hospital service (99231-3)
- prolonged physician service (direct) inpatient (99356-7)
- prolonged physician service without direct contact (99358-9)
- observation (99217-20, 99224-6)
- new outpatient visit (99201-5)
- established outpatient visit (99211-5)
- outpatient consult service (99241-5), sometimes for surgical clearance purposes (V72.83)
- prolonged physician service (direct) outpatient (99354-5)
- complex chronic care coordination services (99487-9)

Please consider authorizing clinic visits with me and other members of the Pediatric Complex Care Program at American Family Children’s Hospital for those who you insure who may benefit from our services.

I am happy to discuss the Pediatric Complex Care Program further, and answer any questions you may have. Please feel free to contact me at any time.

Sincerely,

Mary L. Ehlenbach, MD
Medical Director, AFCH Complex Care Program
Assistant Professor of Pediatrics (CHS)
University of WI School of Medicine and Public Health
Department of Pediatrics
600 Highland Avenue
Madison, WI 53792-4108
mehlenbach@pediatrics.wisc.edu

References


# SECTION A: PROJECT OUTLINE

A.1. Briefly describe the proposed business development project.

Children with medical complexity are a growing subset of the population of children and youths with special health care needs (CYSHCN), and are a group that requires special attention due to their complex medical needs and high utilization of healthcare resources. Although comprising <1% of the population of children in the United States, this group of children accounts for as much as 1/3 of healthcare spending on children. Due to increased survival of premature infants and older children who have suffered critical illness, as well as children with genetic abnormalities and other syndromes that were previously not compatible with long-term survival, there exists a population of children who have chronic conditions with high health care needs, who are often dependent on technology for survival, and have significant functional limitations.

The Pediatric Complex Care Program hopes to proactively coordinate care for children with medical complexity who see multiple specialists at UW Health (but do not have a particular subspecialty service who manages their overall care), who have three or more organ systems affected, and who frequently visit the emergency department or require admission to the hospital. While some of our potential patients have PCPs within the UW Health system, many potential patients come from other parts of the state of WI or northern IL and have PCPs who are outside the UW Health system and do not have the time, resources, familiarity with our system, and sometimes pediatric expertise needed to coordinate care for this complex population. We will look at the patient with a global pediatric perspective and partner with the family, PCP, specialists, and community resources to make sure that the care of these vulnerable patients is proactive, rational, cost-effective, patient- and family-centered, and in line with the family’s goals of care. We will provide outpatient, inpatient consultative, and electronic/telephone-based services to ensure that transitions are seamless, and that care is effective, efficient, and not duplicative. The team composition will be a registered nurse, a pediatric nurse practitioner, and two pediatricians who all have expertise in caring for children with medical complexity and are devoted to improving the quality of care for this population at AFCH.
A.2. Identify the most important objectives of the project. What will the project enhance, improve, or create? How will the project generate incremental value for patients & their families, purchasers, and our community?

Objective One: Improve outcomes through enhanced care coordination for children with medical complexity at AFCH. Children with medical complexity are generally followed by multiple specialists at tertiary care children’s hospitals. The specialists (appropriately) focus on their areas of expertise but usually cannot manage the patients with a global pediatric perspective in mind. PCPs generally do not have the time and resources necessary to coordinate care for this complex population, particularly those who are located a great distance from AFCH. Parents, specialists, and PCPs have expressed a desire for a “point person” at AFCH who can evaluate the patient with a global pediatric perspective, weigh the risks and benefits of the recommendations of the specialists, and help the family navigate their experience within the daunting health care system. Some examples of improved care coordination include: coordinating multiple visits or procedures into one day or one hospital stay, fostering communication between different specialists whose recommendations may have unintended consequences on other organ systems or patient functionality, and ensuring that care is efficient and not duplicative.

Objective Two: Provide proactive, not reactive, care for children with medical complexity at AFCH. Too often, due to the complexities of both the patients and the healthcare system, a problem (the proverbial molehill) that could have been addressed over the telephone or in an acute care clinic visit is not addressed until it becomes an emergency (the proverbial mountain), requiring a visit to the costly emergency department and/or an inpatient hospital stay. The Pediatric Complex Care Program will have the resources to proactively prevent the molehill from becoming the mountain. Our current system is not designed to provide proactive care well; however, a complex care program would create the infrastructure and resources necessary to proactively manage this population of children with medical complexity.

Objective Three: Improve the “patient experience” and the “provider experience” at AFCH for children with medical complexity. A dedicated team who views children with medical complexity with a global perspective will allow for enhanced communication, improved system navigation, and attention to detail at times of transition. Patients and their families, subspecialty providers, and PCPs all stand to benefit from the services of the Pediatric Complex Care Program.

Objective Four: Decrease the cost of care for children with medical complexity at AFCH. With proactive, coordinated care, healthcare resource utilization (and therefore costs) will decrease. Payers and patients/families, as well as society at large, will benefit from this in our current model. In the future as the healthcare market transitions from volume-based to value-based, UW Health may benefit from shared-savings or other innovative payment models that develop.
A.3. Describe how the project will foster or bring about new or innovative models of patient care. Cite any related supporting references to evidence-based best practice, research, successful implementations at other organizations, etc.

Case management for high-risk populations is a concept that is gaining favor as a means of controlling cost and improving outcomes. The Pediatric Complex Care Program will provide the infrastructure for such services for children with medical complexity, a small but very costly population, at AFCH. Complex care programs are already in existence at many tertiary care children’s hospitals, and the concept was recently endorsed by the Children’s Hospital Association in report entitled “Optimizing Health Care for Children with Medical Complexity” available at [http://www.childrenshospitals.net/AM/Template.cfm?Section=Children_with_Medical_Complexity&template=/CM/ContentDisplay.cfm&ContentID=68420](http://www.childrenshospitals.net/AM/Template.cfm?Section=Children_with_Medical_Complexity&template=/CM/ContentDisplay.cfm&ContentID=68420). Included below is a summary of the relevant existing literature on children with medical complexity and complex care programs.

A.4. Describe how the project will create services or additional value that represent meaningful market differentiators for UW Health. What other organizations provide this service within UW Health's markets? What alternatives to this service are currently available in the marketplace? What currently happens to the patient population that will use this service?

While care coordination for some complex pediatric populations occurs at AFCH for certain disease processes or diagnoses, there is a large void in these services for the population of children with medical complexity who do not fit neatly into one particular diagnosis or subspecialty group. The Pediatric Complex Care Program aims to serve those patients who are followed by many specialists but whose care is not primarily managed by one subspecialty group. In the inpatient setting these patients are often cared for on the pediatric hospitalist service. Care is coordinated for that particular hospitalization, but there is currently no outpatient corollary, and the likelihood that an individual hospitalist will have a pre-existing relationship with or historical perspective on an individual patient is low. At discharge care is transitioned to a variety of subspecialists and/or the PCP, and transitions are fraught with the potential for details to “fall through the cracks.” Most of the other tertiary care children’s hospitals in the Midwest already have care coordination programs for children with medical complexity in place, and referring providers have provided specific feedback that “Milwaukee (Children’s Hospital of WI) does ‘this’ better.” No other organizations or alternatives to this service exist in our community. Currently, the care of children with medical complexity is often neither coordinated nor proactive.

A.5. What patient populations are directly affected by the proposal? Roughly how many patients will be affected by the project on an annual basis?

Children with medical complexity who meet the following criteria are directly affected by this proposal: 1) three or more organ systems involved, 2) 4 or more specialists are involved in care, and 3) hospitalization or multiple emergency department visits in the last 12 months. (Specific patient populations, such as those with tracheostomies and/or home ventilators, will be excluded as their care is already coordinated through a designated service.) We estimate that there are at least 200, if not substantially more, patients who could benefit from the Pediatric Complex Care Program’s services, and this population is only growing as NICU and PICU survival increases. Given the relatively small number of staff included in this proposal, we hope to enroll between 50 and 100 patients by the end of the first year.

A.6. Who else does the project materially affect, and how? (Payors, Staff, Researchers, Students, Community)

- Payors are likely to benefit because we anticipate a decrease in the cost of care.
- Research is a mission of our program; children with medical complexity is a new population and we hope to contribute scholarly work that enhances understanding of the unique needs of this population.
- Education is a mission of our program; we intend to have medical, nursing, and other allied health professional students spend time with us, as well as resident physicians and advanced practice provider students.
- The community served by AFCH will benefit from this program, as there is no other venue for these services in Madison or the surrounding area.
- UW Health and AFCH will benefit from this program, as it will fill the void that currently exists and make us competitive with other tertiary care children’s hospitals in our region.

A.7. Describe any new or changed relationships, partnerships, or collaborations with external entities or organizations that are required by this project. Will this create new contractual relationships or materially alter existing ones?

In order for this program to cover its costs, we will need to engage payors in innovative payment models, such as shared savings or per-member-per-month payments for care coordination.
A.8. What are the key measurable outcomes of successful execution of the project?

<table>
<thead>
<tr>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>Cost of patient care (anticipate overall decrease)</td>
</tr>
<tr>
<td>Utilization of inpatient and ED services (anticipate decrease)</td>
</tr>
<tr>
<td>Patient/family experience with process of care (anticipate improvement)</td>
</tr>
<tr>
<td>Referring provider and subspecialist satisfaction (anticipate increase)</td>
</tr>
<tr>
<td>Quality of life (unclear how/if this will change)</td>
</tr>
<tr>
<td>Adherence to general pediatric primary care measures of quality (vaccination rates, BMI screening, etc.)</td>
</tr>
<tr>
<td>Program-level measures (number/rate of enrollment, duration of time in the program, no-show rates, etc.)</td>
</tr>
</tbody>
</table>
### SECTION B: INCREMENTAL RESOURCES for PROJECT PLANNING and EXECUTION

**B.1.** To the best of your ability, approximate INCREMENTAL resources needed to execute the project. If precise amounts are not known, that's not a problem. Please give your best estimate.

<table>
<thead>
<tr>
<th>Incremental (New) Resource</th>
<th>Amount: One Time Investment</th>
<th>Amount: Ongoing Per Year</th>
<th>Your Comments</th>
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</thead>
<tbody>
<tr>
<td>New Capital $ (for new equipment or technology)</td>
<td></td>
<td>(Dollars)</td>
<td>Telemedicine equipment – pilot program</td>
</tr>
<tr>
<td>New Clinical Space (procedure rooms, ORs, clinic, etc)</td>
<td></td>
<td>(Sq Ft)</td>
<td>Anticipate needing approximately 0.5-1 clinic day/week; can use existing space</td>
</tr>
</tbody>
</table>
| New Non-Clinical Space (offices, other)             |                            | (Sq Ft)                  | -RN: desk, chair, telephone, computer in a reasonably quiet workspace (shared office or team room)  
|                                                     |                            |                           | -NP desk, chair, telephone, computer in a reasonably quiet workspace (shared office)  
|                                                     |                            |                           | -An interdisciplinary complex care team room would be ideal for communication. |
| New Staffing: Provider FTEs                        |                            | (FTE)                    |               |
| New Staffing: Non-Provider FTEs                     |                            | (FTE)                    |               |
| Marketing support                                   |                            | (Dollars)                |               |
| Other incremental costs (describe)                  |                            | (Dollars)                |               |

**B.2.** Briefly describe any new IT support needed.

- Creation of a database to track patients/outcomes
- Website development and maintenance
- Support for developing interfaces with HealthLink

**B.3.** Elaborate on any material project impacts and needs with respect to the physical environment and space.

- The RN and NP ideally will be housed in close proximity to foster communication. An office space and/or dedicated team room in AFCH would be ideal.

**B.4.** Does the project involve the implementation of technology new to UW Health? If so, briefly describe.

- No, although we would be interested in exploring the use of telemedicine with this population.
B.5. Please describe any other material assumptions about resource needs, including the re-assignment of existing resources to support this project.

When enrollment reaches a critical point, adding social worker, dietician, and pharmacist support to the program would be ideal.
## SECTION C: ALIGNMENT WITH UW HEALTH PRIORITIES

### C.1. If the project were NOT to be done, would UW Health's regulatory compliance risk materially increase? Please describe if so.

No.

### C.2. Succinctly describe how the project directly, and materially, furthers the achievement of UW Health's strategic goals:

*Click here to go to the UW Health Strategic Plan page on UConnect.*
*Click the name of each strategic goal below to go to the UConnect page for that goal.*

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Best Work and Academic Environment</strong></td>
<td>The Pediatric Complex Care Program can increase quality of care for this patient population, and can potentially improve access for some subspecialty services who currently are left to provide some care coordination for children with medical complexity by diverting resources within their own programs that could be devoted to increasing access for new patients.</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>This program serves the clinical, research, and educational missions of UW Health in one setting. Its existence will allow for streamlined communication with referring providers.</td>
</tr>
<tr>
<td><strong>Patient &amp; Family Experience</strong></td>
<td>At the heart of this program is a mission to improve the patient/family experience for children with medical complexity. The Pediatric Complex Care Program team is committed to family-centered rounds in the inpatient setting and will participate in rounds with the primary service when enrolled patients are inpatients. Our current model of caring for this population is not particularly patient-centered, and the Pediatric Complex Care Program will hopefully improve the patient/family’s perception of care as being patient-centered.</td>
</tr>
<tr>
<td><strong>Quality Distinction</strong></td>
<td>One measure of quality of inpatient care is readmission rate. Children with medical complexity not infrequently experience readmissions to the hospital, some of which are likely preventable and potentially related to rocky transitions. The Pediatric Complex Care Program can serve as a “safety-net” during transitions, and we anticipate that our involvement may decrease readmission rates for this population.</td>
</tr>
<tr>
<td><strong>Clinical Model of Care</strong></td>
<td>The Pediatric Complex Care Program aligns well with the UW Health Clinical Model of Care Five-Year Aim. The program is interdisciplinary and team-based. We will improve clinical outcomes. Our program is innovative and would provide a new and needed service to children with medical complexity and their families served at AFCH. The physicians in the program are faculty known for and committed to academic excellence in all manners.</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>While the program will not provide primary care services, we will work closely with PCPs to ensure quality measures for pediatric primary care can be more easily accomplished in this population.</td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
<td>The population of children with medical complexity is small but costly. We anticipate that, like other programs have demonstrated, enhanced care coordination can improve outcomes and decrease costs.</td>
</tr>
<tr>
<td><strong>Market Focus</strong></td>
<td>Complex care services are provided at other children’s hospitals in the Midwest and nationally, and referring providers have asked for such services at UW Health.</td>
</tr>
</tbody>
</table>
C.3. Does the project reduce the cost of care for the population affected? How?
Yes, other programs have demonstrated that proactive care coordination can improve outcomes and decrease cost.

C.4. Does the project expand the patient population base, market share, or revenue base of UW Health? How?
Yes, this service is offered at other children’s hospitals in the region and has been requested by referring providers.

C.5. Does the project directly improve quality performance on publicly reported performance measures? How?
Few measures on pediatric populations are reported, so likely our program would not have an impact in this area.
D.1. Who is the administrative Executive Sponsor who will provide actively engaged leadership for the project?

D.2. Who is the clinical Executive Sponsor who will provide actively engaged leadership for the project?

D.3. Identify the Primary Operational Owner and other key leaders who will provide day to day clinical or administrative project direction and support:

D.4. Who is the Project Manager responsible for tracking, driving and supporting the details of project execution?

D.5. Identify proposed project milestone dates. Describe any material contingencies.

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Notes on Contingencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Planning- completion date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Implementation- initiation date</td>
<td>3/1/14</td>
<td></td>
</tr>
<tr>
<td>Project Implementation- completion date</td>
<td>ongoing</td>
<td></td>
</tr>
</tbody>
</table>

D.6. Describe any known material risks to the project planning or execution phases, or other contingencies we should be aware of.

None

D.7. Describe any cultural changes required to support success of this project.

The global pediatric perspective on many children with medical complexity served at AFCH is often missing. While many specialists and referring providers have requested the development of a complex care program at AFCH, there may be some services or referring providers who feel like the existence of a complex care program is intrusive or unnecessary. We will make an effort to tread lightly with these groups. Given that the number of children with medical complexity is only increasing, there are plenty of patients to care for and we will work collaboratively with other groups to identify the most appropriate patients.
Ideas for Engaging Stakeholders When Developing a Pediatric Complex Care Program

Recommendations Before Getting Started:
1. Make sure you have support of division head, department chair, hospital medical director, &/or other important leaders.
2. Consider discussing with those whose toes might feel “stepped on” such as PCPs and specialists who do significant care coordination to set the stage for collaboration.
3. Think about how the outcomes of a complex care program align with your institution’s priorities and emphasize this!

- Competition/Institution Reputation
  - Have referring docs or patients/families asked for these services at your institution?
  - Do other institutions in your region have complex care programs?

- Patient experience
  - Who in your institution cares about satisfaction surveys?
  - Who in your institution manages complaints from families?
  - What does the patient/family advisory council think?

- Patient safety
  - Med errors
  - “Transition” errors

- Interview some eloquent families

- Provider experience
  - Medical subspecialists
  - Surgical subspecialists
  - Referring providers
  - ED providers

- Capacity management
  - Shorter hospitalizations: increased capacity > fewer surgeries cancelled > increased revenue
  - Increased efficiency & therefore capacity in outpatient specialty clinic with someone else to do care coordination and address other medical issues

- Health care reform
  - Medicare population
  - Population health / ACO

- Payers (via your institution’s administration)
  - Medicaid
  - Private payers
Tips For Connecting With Medicaid (and Private Payers)

Start with senior leadership at your own institution. Someone probably has a connection to someone at Medicaid, and introductions can be made. Leaders within Population Health at your organization are likely to have some connections.

If that route is a dead end, identifying leadership within the contracting division of your institution (specifically Medicaid contracting) could be helpful. Someone there likely has some pre-existing relationships with folks at Medicaid and could help you make a connection.

Most institutions have government affairs teams who interface with state government on a variety of issues. Identifying this group at your institution could lead to some introductions.

If the dead ends continue, find out the name of your state Medicaid medical director, and reach out to that person on guidance for how to “get a foot in the door.” In general, public officials will/should be receptive to meeting and listening to constituents.

Connecting with your state hospital association might be helpful. Leaders of this organization often know people who work in policy at Medicaid.

Once you get a “foot in the door” you can introduce your program and start networking. Before making an “ask” it is good to have some relationships with folks who work in Medicaid and have some knowledge of workflows, reporting structure, etc.
UW Health Business Development Program – SHORT PROPOSAL

Project Name:  
ProjectSubmitter:  
Submission Date:  

Please include documentation of any analysis or research that you cite in your answers. You may provide internet links within your answers or submit additional documents along with the Short Proposal.

SECTION A: PROJECT OUTLINE

A.1. Executive Summary: Briefly describe the proposed business development project, including purpose, general design and impact. If this proposal is a test or pilot, also indicate the potential scale and breadth of a full implementation. Note that your answer to this question may be pulled out as an Executive Summary to be shared with senior leadership.

A.2. Key Objectives: Identify the most important objectives of the project. What will the project enhance, improve, or create? How will the project generate incremental value for patients and their families, purchasers, and our community?

A.3. Innovations in Care: Describe how the project will foster or bring about new or innovative models of patient care. Cite any related supporting references to evidence-based best practice, research, successful implementations at other organizations, etc.

A.4. Market Differentiation: Describe how the project will create additional value or services that represent meaningful market differentiators for UW Health. What other organizations provide this service within UW Health’s markets? What alternatives to this service are currently available in the marketplace? What currently happens to the patient population that will use this service?

A.5. Population Served: What patient populations are directly affected by the proposal? Please describe the population in the following terms: clinical, demographic, market share, or geography. What UW Health services do they currently access? Roughly how many patients will be affected by the project on an annual basis?
A.6. **Stakeholders Affected:** What other non-patient groups does the project materially affect, and how? (For example, how would payors, staff, researchers, students, community, other UW Health programs or strategic initiatives be affected?)

A.7. **External Relationships:** Describe any new or changed relationships, partnerships, or collaborations with external entities or organizations that could be developed as part of this project. Will this create new contractual or operational relationships, or will it materially alter existing ones?

A.8. **Vision:** What is the long-term vision for this program? Where do you see it three years after implementation? Five years after implementation?
SECTION B: INCREMENTAL RESOURCES for PROJECT PLANNING and EXECUTION

B.1. To the best of your ability, approximate INCREMENTAL (i.e., new) resources needed to execute the project. If precise amounts are not known, please give your best estimate.

<table>
<thead>
<tr>
<th>Incremental (New) Resource</th>
<th>Amount: One Time Investment</th>
<th>Amount: Ongoing Per Year</th>
<th>Your Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Capital $ (for new equipment or technology)</td>
<td></td>
<td>(Dollars)</td>
<td></td>
</tr>
<tr>
<td>New Clinical Space (procedure rooms, ORs, clinic, etc.)</td>
<td>(Sq Ft)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Non-Clinical Space (offices, other)</td>
<td>(Sq Ft)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Staffing: MD FTEs</td>
<td></td>
<td>(FTE)</td>
<td></td>
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<tr>
<td>New Staffing: NP or PA FTEs</td>
<td></td>
<td>(FTE)</td>
<td></td>
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<tr>
<td>New Staffing: Non-Provider FTEs</td>
<td></td>
<td>(FTE)</td>
<td></td>
</tr>
<tr>
<td>Marketing support</td>
<td></td>
<td>(Dollars)</td>
<td></td>
</tr>
<tr>
<td>Other incremental costs (describe)</td>
<td></td>
<td>(Dollars)</td>
<td></td>
</tr>
</tbody>
</table>

B.2. Briefly describe the kind and number of clinical and non-clinical spaces that will be needed (for example, will the space require procedure rooms, ORs, clinics, offices, etc.? Specify whether this is new or existing space. If existing facilities will be used or modified, then be specific about location and timeframe.

B.3. Elaborate on any other material project impacts and needs with respect to the physical environment and space. (This could include furniture, remodeling, etc.)

B.4. Briefly describe any new IT support needed (for example, technology, applications, education, metrics or reporting).

B.5. Does the project involve the implementation of technology new to UW Health? If so, or if you are uncertain, briefly describe.
B.6. Please describe any other material assumptions about resource needs. Identify specific examples where existing resources will be reassigned or reprioritized to support this project, over short- and long-term periods.
SECTION C: ALIGNMENT WITH UW HEALTH PRIORITIES

C.1. **Strategic Impact:** Please identify three of UW Health’s Strategic Goals with which this proposal is most aligned. Describe.

UW Health’s Eight Strategic Goals

(See [UW Health Strategic Goals on UConnent](https://workspaces.uconnect.wisc.edu/display/BDP))

Create the **Best Work and Academic Environment**

Follow a consistent, patient and family-centered **Model of Care**

Pursue **Integration** to work as one enterprise for patients

Serve Wisconsin and beyond through strategic **Market Focus**

Provide a **Patient and Family Experience** of compassion and excellent clinical quality

Promote healthy communities through **Population Health**

Serve patients in a **Primary Care** medical home

Perform in the top 10 percent of health systems on **Quality**

C.2. **Outcome Measures of Success:** What are the key measurable outcomes of successful execution of the project? Be sure to identify, as appropriate, how you will measure impact on stakeholder satisfaction, patient experience, quality, or financial and business metrics. Wherever possible use specific measures reported publicly or on the UW Health Strategic Dashboard.
SECTION D: PROJECT MANAGEMENT, OVERSIGHT and LOGISTICS

The Business Development Team will assume you have support from anyone listed here, prior to submitting the proposal. The individual you indicate in D.1. will be contacted by the Business Development Ops Team prior to any materials being sent to the Feasibility Team. All individuals indicated in Section D will be included in an email notification when the proposal has been scheduled with the Feasibility Team. The email will contain the materials you have submitted during this process.

D.1. Who is the administrative Executive Sponsor who will provide actively engaged leadership for the project? (VP or above)

D.2. Who is the clinical Executive Sponsor who will provide actively engaged leadership for the project? (Department Chair, Vice-Chair or Division Chief, Clinical Executive)

D.3. Who is the physician or clinical champion that will own the day-to-day clinical operational and management responsibilities?

D.4. Identify the Primary Operational Owner and other key leaders who will provide day-to-day clinical or administrative project direction and support:

D.5. Identify proposed project milestone dates. Describe any material contingencies.

| Date                     | Notes on Contingencies
<table>
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<tbody>
<tr>
<td>Project Planning – Completion Date</td>
<td>What factors could cause these dates to change?</td>
</tr>
<tr>
<td>Project Implementation – Initiation Date</td>
<td></td>
</tr>
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<td>Project Implementation – Completion Date</td>
<td></td>
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</tbody>
</table>

D.6. Describe any known material risks to the project planning or execution phases, or other contingencies of which we should be aware.

D.7. Please include any other information that would be helpful in understanding this proposal.