Bridging Complex Medical Care from Hospital to Home
Disclosures

- We will discuss no off-label products
- We have not received money or other gifts from any industry
- No relevant financial relationship exists
- Almost Home Kids is an affiliate of Ann & Robert H. Lurie Children’s Hospital of Chicago
Objectives

• Almost Home Kids Journey
• Medically Complex Pediatric Population
• Almost Home Kids Approach
• Obstacles and Barriers for Transitional Care
• Proactive and Aligned Care Management Best Practices
• Understanding the Financial Impact of Delivering Transitional Care
• Expanding our Approach
• Questions and Answers
AHK Concept conceived by two mothers of children with complex medical conditions

1992

AHK Naperville Opens
- Alternative Healthcare Delivery Act (210 ILCS 3)
- Licensed by the Illinois Department of Public Health
- Children’s Community-Based Health Center

1999

2004

AHK Chicago Opens on the 6th Floor of the Ronald McDonald House

2009

Alternative Healthcare Delivery Act amended
- include Chicago facility
- Certificate of Need relief

2012

2013

Ann & Robert H. Lurie Children’s Hospital of Chicago Affiliation

2014

2016

Children’s Hospital of Illinois Letter of Intent (LOI) signed

JCAR Accepts Illinois Administrative Codes updates

Alternative Healthcare Delivery Act amended
- include Chicago facility
- Certificate of Need relief
Recognized for Excellent Health Outcomes

An extraordinary place for healing and family-centered care, evidence-based design and advanced technology:

• Ranked 11th over-all in the nation with 5 specialties in the top 10 in 2015-16 *US News & World Report Survey*

• First children’s hospital in country to earn Magnet Award for Nursing Excellence – Received 4th re-designation in September, 2015

• *Almost Home Kids program received Magnet Exemplar 2015*

• 9 out of 10 parents would recommend Lurie Children’s
Mission: At Almost Home Kids our mission is to provide transitional care in a home-like setting for children with complicated health needs, as well as training for their families and respite care.

Transitional Care
- Bridge from Hospital to Home
- Parent/Caregiver training
- Up to 120 day stay
- Community Supports – Home Nursing, DMEs, Foster Care
- Implement and revise Hospital Discharge Plan
- Subspecialty & PCP Community Coordination
- Newborn – age 22
Respite Care
• Mission driven program keeping families whole
• Planned or Emergency Short Term stay (up to 2 weeks)
• 24/7 Nursing care and recreational volunteers
• Opportunity to review Home Medical Plan and DME
• Newborn – age 22

Respite Transportation
• Safe transport from home to Almost Home Kids
• Nurse accompanies child
• Supplies and back up equipment
• Provides an easy way for families to more effectively utilize respite services at Almost Home Kids.
Medically Complex Pediatric Population

There are 3 million children in the US with medically complex conditions:

- 6% of the children on Medicaid, 40% of Medicaid spending on children**
- Accrue 10 times the cost per year compared to other children in Medicaid**
- Account for 15–33% of health care spending for all children (about $50–$110 billion annually).*
- 5% annual growth; among the most rapidly growing pediatric population**

At Lurie Children’s, of the 174,000 children served in 2014, children with medical complexities represented 6% of children cared for and 42% of payments.

**Children’s Hospital Association 2012
*http://content.healthaffairs.org/content/33/12/2199.full?ijkey=62dN2g7uEPvbs&keytype=ref&siteid=healthaff
Snapshot of Diagnosis

• Neuromuscular Disease
• Spinal Muscular Atrophy (Type 0, I & II)
• Premature Birth
• Central Hypoventilation Syndrome
• Metabolic Disorders
• Cerebral Palsy
• Spina Bifida
• Oncology
• Chromosomal Disorders
• Cardiac Anomalies
• Traumatic Brain & Spinal Cord Injury
• Gastric Anomalies - Short Gut Syndrome
• Palliative Care
• Hospice
• Neonatal Withdrawal Syndrome
AHK Team

- On Site Medical Directors
- Director of Nursing Services
- Advanced Nurse Practitioners
- Clinical Educator
- Social Workers
- Case Management Team
- Clinical Managers
- Direct Care RN’s 3-1 ratio
- Certified Nurses Aides
- Physical Therapist
- Child Life Specialist
- Nutritionists
- Pediatric Surgery APN Consultations
- Dental Consults
- Sleep Medicine Consults
- Volunteers (1-2.5 FTE)
AHK Medical Directors

Peter J. Smith, MD, MA
AHK Chicago
Medical Director

Christopher Bender, MD
AHK Naperville
Medical Director

Ann Karch, MD
AHK Chicago/Naperville
Associate Medical Director

Mike Hoffman, MD,
AHK Naperville
Associate Medical Director
Clinical Capabilities

- Ventilators
- Tracheostomies
- CPap and BiPap
- Remodulin pumps
- PICC lines (IV antibiotics, TPN)
- Feeding tubes (GT, GJT, NGT, NJT)
- Urinary catheters (In-dwelling, straight cath, suprapubic)
- Ostomies
- Orthopedic external fixation devices
- Oxygen therapies
- Spica cast
- Peritoneal Dialysis
- Blood Draws
Chronic respiratory disease arising in the perinatal period: 29%

Infantile cerebral palsy, unspecified: 24%

Anoxic brain damage: 8%

Other conditions due to autosomal anomalies: 8%

Chronic respiratory failure: 6%

Hypoxic-ischemic encephalopathy (HIE): 5%

Other specified anomalies: 5%

Dyspnea and respiratory abnormalities: 3%

Tetralogy of Fallot: 3%

Spina bifida: 3%

Malignant neoplasm of brain: 3%

Other and unspecified postsurgical nonabsorption: 3%

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Primary Diagnosis for Children in Transitional Care (2013-2014)
2010-2015 Service Days by Site

2012 data includes both Naperville and Chicago, which opened Sept. 2012.
National & International Children’s Healthcare Centers
New Programs Responding to Children’s Needs

**Epic Care Everywhere, Added Consult button**

**Sleep Medicine: AHK Chicago**
- Improve the quality of life for children who have sleep difficulties or have outgrown the need for medical technology.
- Significant cost savings over the child’s life.
- Free up ICU beds
- Increase quality of life
- In 2015 24 children received sleep studies at Almost Home Kids

**Pediatric Surgery APN Consultations:**
- G-Tube Stoma’s and trach’s
- Frees up clinical space and time
- Billed as outpatient
- Transportation costs reduced

**Telemedicine – for ED Coordination, 3 subspecialties being piloted**

**Nutrition Consults**

**Medical Education**
- Partnered with 5 Medical Centers, 60 Residents and Medical Students enrolled in first year of program
Obstacles and Barriers for Transitional Care

Reimbursement Barriers (out of state)
- Medicaid Payments
- Lack of Legislation outside Illinois
- Reimbursement for Community-based care settings needs to be created

Parent/Caregiver Perceptions
- Overwhelmed
- Punitive
- Concerned about level of care
- Not able to stay bedside
- Hospital Conveniences (diapers, single dosage, feeding, etc.)

Clinician Perceptions
- Lack Understanding – what it is, how it’s different, benefits for the families
- Traditional practices
- Controlling outcomes
- Convenience of Hospital Setting
- Trust

Discharge Delay’s
- Staffing home nursing
- DCFS
- Translating social needs to social supports
- Home Modifications
- Supplies and medication delivery
- Correct equipment delivery
Proactive and Aligned Care Management Best Practices

• Weekly rounds (NICU, PICU, Complex Case) at three hospitals
• Child Identification - 15 identifiers
  • Initial review: demographics and clinical assessment
  • Milestones tracked – every 30 days at AHK
  • Caregiver counseling
  • Follow through:
    • coordinating social supports in the community
    • caregiver competencies for each skill x 3 plus 2 overnight stays
    • discharge planning and respite plan established
• Follow-up post discharge from AHK 30 days, 90 days and 6 months
Caregiver Timeline

- Pediatric Hospital admit identified as Child with Medical Complexities
- Parent’s visit AHK and meet with AHK Case management team onsite
- Parents engage in a signed agreement with AHK to learn the necessary care within 120 days. Child is transported to AHK via ambulance or medi-van
- Child stays at AHK for up to 120 days while parents are trained on the child’s own home technology, home-health nursing is staffed, DME (durable medical equipment) supplier identified and Government Agencies and Services are secured
- Child safely transitions home

Caregiver Timeline

- Child is stabilized in hospital and is ready to transfer home, but factors exist that prevent a safe transition home
- Parents engage in a signed agreement with AHK to learn the necessary care within 120 days. Child is transported to AHK via ambulance or medi-van
- Child stays at AHK for up to 120 days while parents are trained on the child’s own home technology, home-health nursing is staffed, DME (durable medical equipment) supplier identified and Government Agencies and Services are secured
- Child safely transitions home

Caregiver Timeline

- Parent’s view AHK video and Hospital Case Management Team introduces parents to AHK Case Management Team
- Child is stabilized in hospital and is ready to transfer home, but factors exist that prevent a safe transition home
- Child stays at AHK for up to 120 days while parents are trained on the child’s own home technology, home-health nursing is staffed, DME (durable medical equipment) supplier identified and Government Agencies and Services are secured

Caregiver Timeline

- Child is able to return to AHK for Respite (2 days to up to 2 week stay) – giving parents a much needed rest
Ruthie is a 2 year old girl
- skeletal dysplasia
- chronic respiratory failure
- chromosome anomaly
- cerebral ventriculomegaly
- Trach
- G-tube
- Ventilator Dependent

Discharged to AHK but readmitted to a second Hospital as it was determined she required further respiratory stabilization prior to discharge to a community setting

Transferred from Lurie Children's Hospital to Almost Home Kids for Transitional Care

AHK Social Work worked closely with the family and outside agencies

Readmitted to AHK when home nursing was lost

Transitioned home again following re-staffing of home nursing

11 months $850 vs. $3,300 ~$816,000

Still home today
Reducing Costs & Improving Care

• Less than 2% of our children were re-admitted the hospital within 30 days of being discharged for failed home-health plan from AHK. Family members receive extensive training to care for their child reducing the need for unnecessary hospitalizations and emergency department visits.

• 75% of parents report a reduction of stress completion of the transitional care program reducing the potential for them to develop stress related health conditions.

• Longitudinal follow-up study of children and caregivers – Describing the caregiver experience of transitional care – measuring caregiver competency and stress levels
Lowering the Hospital Length of Stay

Hospital stays for children with complex medical conditions can exceed APR-DRG National Average Length of Stay (ALOS).

- Kylie: 232.6 excess days ($1,024,835)
- Gabe: 108.9 excess days ($304,484)
- Jamri: 142.4 excess days ($395,160)
- Alexis: 198.6 excess days ($609,702)

(Nationally)
Reduction of Potential Preventable Re-admits and Associated Penalties

Example:
300 PPRs FY2014
65% AHK APR DRGs
$16,560 penalty per case
Reduce those fines by half (300 x 0.65)
\[ x \times 16,540 \times 0.5 = \$1.6M \]
Reducing ED Utilization

Our study showed that 8% of children with medical complexities returned for an ED visit within 6 months after completing the AHK program versus 16% of the same population discharged directly home.

Aligns with the 2013 Dobson DaVanzo analysis

“Coordinated Care Models for children with medical complexity can produce savings and improve quality.”

“Children with medical complexities in a coordinated care program demonstrated a 40% reduction in ED visits.”

“Medical home model for children with medical complexities decreased hospital/clinic costs 38% including decreased ED utilization.”

*2013 Dobson DaVanzo analysis
Expanding Our Model

Almost Home Kids intends to partner with pediatric care providers across the country to bring up new sites and provide Transitional and Respite Care to communities in need.
Affiliating with Almost Home Kids

1. The Intellectual Property - The Program

The Playbooks - Documented processes and workflows for all clinical care, case management coordination, polices, procedures, financial, EMR and operational business practices (financial, development, volunteer)

The Architectural Prototype - Optimized 12 bedroom home-like transitional care building, incorporating best practices and optimized work flows for all key functions.

2. The Services Package - Implementation of the IP

Affiliation Project Management, Staffing, Clinical and Case Management Coordination Training and Support, Volunteer, Fund Development and Marketing expertise Consulting, Billings and Collection Consulting, EMR work Flows, Information systems and data sharing support and on going support.
Our Consulting Services

5 Pillars of Success
Assess readiness across the five pillars. Identify barriers and gaps to overcome. Develop the necessary roadmap to build a sustainable Transitional and Respite Care Model.

- Program Model, Quality and Outcomes
- Culture, Structure and Governance
- Government Support
- Service-area Hospitals Medical Community Commitment
- Service Area Need Business Case
Q & A
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