The model relies on effective care.

Families reported positive impact to quality.

Our new and innovative model demonstrated.

Post Enrollment

monitoring technology

Program Goals:

- Over 34% of all pediatric healthcare costs ($110 billion).
- Less than 1% of all U.S. children
- Children with medical complexity (CMC) represent
- Virtually diagnose, treat, and manage acute and chronic
- Provide parental reassurance, guidance, and education
- Advocate for approval and delivery of necessary medical
- Plan for compliance with ACE Kids Act
- Federal funding opportunity through Medicaid for
- Disease-specific states: Asthma Program
- Further collaboration with Mercy Kids Palliative
- NICU, PICU, and hospital discharge
- Disease-specific states: Arkansas, Illinois, Springfield
- New Patient Populations
- • NICU, PICU, and hospital discharge
- • Further collaboration with Mercy Kids Palliative
- Phase 1
- Phase 2

Conclusion

- Our new and innovative model demonstrated a decrease in ED utilization and hospitalizations for program participants compared to 12 months prior to enrollment.
- Families reported positive impact to quality of life for themselves and their children.
- The model relies on effective care coordination with multidisciplinary team interventions.
- This unique model holds promise to help address a nationally recognized need in pediatric healthcare.

Next Steps

- Geographic Expansion
- • Arkansas, Illinois, Springfield
- • New Patient Populations
- • NICU, PICU, and hospital discharge
- • Further collaboration with Mercy Kids Palliative Care team, Mercy Clinic PCPs, and Pediatric specialists
- • Disease-specific states: Asthma Program
- • Payer Partnerships
- • Plan for compliance with ACE Kids Act
TH-7 Telehealth for Complex Pediatric Patients at Home

Abstract

- **Background:** Children with medical complexity (CMC) represent less than 1% of all U.S. children but account for over 34% of all pediatric healthcare costs ($110 billion) and 47% of Medicaid’s total spending on pediatric hospital care. These children are now living longer and surviving many previously lethal conditions, and this population is expected to double by 2025. The purpose of the vKids at Home program is to manage medically complex ambulatory pediatric patients with a virtual physician-led multidisciplinary clinical team, utilizing home monitoring technology.

- **Methods:** vKids at Home is a multidisciplinary virtual care program designed to improve quality of life for children with medical complexity and decrease unnecessary hospital utilization. Patients complete a daily, proactive, digital touchpoint with the ability to escalate to text message, phone, or video visit with the care team of nurses, nurse practitioner, social worker, and physicians. vKids at Home provides preventative and acute visits and coordination for all chronic medical and social needs.

- **Outcomes:** In the first year, the vKids team enrolled 89 patients in the program. This population had an average of 4.3 ED visits and 2.5 hospitalizations per patient in the 12 months prior to enrollment. Since enrollment, our patients had a 42% reduction in ED visits per patient per month and a 26% reduction in inpatient admissions. At the one-year analysis, there were 86 documented instances that the vKids team helped a patient to avoid an unnecessary ED visit. The program has a 91.4% patient satisfaction rating. The vKids team helped support four medically complex children in their transition into foster care, provided support and direction in a critical situation by giving life-saving care via video and facilitating safe transition to the hospital.

- **Discussion:** Children with medical complexity require additional resources to navigate the healthcare system and help facilitate team-based, patient-centered, collaborative care. Our model of a physician-led multidisciplinary virtual team allows every member to build trust with the families and home nurses caring for complex kids. This relationship leads to significant opportunity to provide support by engaging through digital surveys, texting, phone and video visits. This model has been effective at improving patient and family quality of life as well, reducing unnecessary ED visits and hospitalizations, and improving transitions in care. Next steps include expansion to other regions within our hospital system, expansion to other disease states, and transition to a bring-your-own-device (BYOD) model to appropriate patient populations.

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