Model of Complex Care Patient Management

1. Common Elements of Models
2. Gestation to Graduation: fetal, neonatal and surgical patients, in, out and long term follow-up
3. Hospital Based NICU focused Model
4. Outpatient Focused Medical Home and Complex Care High Risk Clinic Models
5. Inpatient, Outpatient, and Homecare Focused Patient Management Model
6. A Medical Home to Decrease Costs and Improve Outcomes: Complex Care Patient Management Clinic with Separate Complex Care Facility
### Who are Medically Complex Children?

<table>
<thead>
<tr>
<th>Category</th>
<th>Common Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically complex</td>
<td>Multiple sub-specialist involvement, polypharmacy, co-morbidities.</td>
</tr>
<tr>
<td>“Frequent flyers”</td>
<td>Functional limitations which are often severe</td>
</tr>
<tr>
<td>Chronic, severe health conditions crossing many specialties</td>
<td>Technology dependence</td>
</tr>
<tr>
<td>High tertiary center and other healthcare use</td>
<td>High cost of care</td>
</tr>
</tbody>
</table>

### What do the Families of Medically Complex Children Want?

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>Primary Care Provider, DME, Pharmacy, Nursing Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and Availability 24/7</td>
<td>Close to Home Resources</td>
</tr>
<tr>
<td>Continuity of Care: Providers who know their child and family goals</td>
<td>Insurance and Benefit Coverage</td>
</tr>
<tr>
<td>Identification of Resources</td>
<td>Care Plan and Emergency Plan</td>
</tr>
</tbody>
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### Why do we need Complex Care Management?

<table>
<thead>
<tr>
<th>Cost of Care</th>
<th>Increase in Complex Care population doubling from 1993-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with 1 or more chronic complex conditions</td>
<td>10% admissions; 26% hospital days; 40% charges</td>
</tr>
<tr>
<td>4.9% of children have chronic catastrophic condition</td>
<td>0.4% of Children’s Hospital of Wisconsin patients have 3 chronic conditions and 2 unplanned admissions over 10 days</td>
</tr>
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### Complex Care Medical Services

**Gestation to Graduation**
- Fetal, Neonatal and Pediatric Surgical Patients
- Inpatient, Outpatient and Long Term Follow-Up

**Lori J. Howell, DNP, MS, RN**
Executive Director of the Center for Fetal Diagnosis and Treatment
Director, Surgical Advance Practice Nurse Program

### Advance Practice Nursing

- Prenatal – 6 FTE 2 Advanced Practice Nurses, CNS (4 BSNs)
- Obstetrics - 9 FTE 3 Perinatal NPs, 6 CNMs-in and outpatient
- NICU – 22 FTE NNPs/PNP dual certified providing 24/7/365 primary coverage for surgical neonates
- General Surgery – 13 FTE PNP (acute and primary) inpatient (7 days/16 hours/365) and outpatient, satellites and lead niche clinics-GERD, PHP, IRP etc.
- APN Manager, Assistant Manager
Role of the Surgery APN

- Advanced Practice Nurse
- Direct patient care
- Education
- Consultation
- Research/evidence based practice/publications
- Administration

Specific Interventions for Continuity

- Mutual respect, collegiality, value of APN
- EMR
- Fetal Force
- Radiant- Fetus to adult
- Surgical Pathways
- Video education
- Anticipatory planning
- Web education

Why is Care Coordination Important?

- Right thing to do
- Increases parent and patient satisfaction
- Improves efficiency and capacity
  - decreases LOS
  - decreases readmissions

Opportunities to Improve Role and Utilization of APN

- Standardize orientation, education and measure level of knowledge
- APNs at different career points, how to treat individually to support and mentor at all levels
- Communication
- Manager role

Outcomes

- Volume is a proxy for surgical Outcomes
- Real time analysis in process
- Discharge planning tool
**Financial Impact**
- No direct billing (yet)
- Incident to billing (clinic)
- ~45 APN FTE financial impact offset by high volume of surgical patients (majority hospital funded)
- Different from Primary Care APN models
- Early Discharge Planning
- Telemedicine

**Challenges and Lessons Learned**
- Vision (not shift nurses, patient ownership, professional model)
- Recruit and Retain the very best and incentivize
- Understand continuity (no silos)
- Role of philanthropy, grants

**Future State**
- 24/7/365 APN coverage for all surgical patients
- Expansion of Long-term multidisciplinary follow-up programs
- Real time outcomes on the web
- Integrated Psychosocial Support Services (psychologist, social worker, child life specialist, chaplain, music therapist)
- App (in process) for surgical guidelines from pathways
- Virtual visits after DC (in process)
- On-line support groups, on-line chat

**Role of APN in Telemedicine**
- Identify inpatients that will benefit from post-discharge telemedicine
- Evaluate outpatient follow-up: identify and resolve any issues
- Collaborate with outpatient clinicians to provide streamlined transition of care from the inpatient setting to the outpatient setting
- Provide support and guidance to parents of children being discharged from the hospital with complex health issues
- Provide education to parents regarding their child’s specific issues (e.g., feeding issues, medication administration, ostomy issues, wound care)
- Assess patient, how home care regimen is being executed, how medications are being administered, safety of sleeping arrangements, surgical wounds, and if applicable, how respiratory equipment is functioning, etc.
- Make recommendations to pediatricians or referrals to specialists, if indicated.

Courtesy of April Willard, 2017
Complex Care Medical Services
Hospital Based NICU focused Model

Erin Keels, DNP, RN, APRN, NNP-BC
Director, Neonatal Practitioner Program
Neonatal Services
Nationwide Children’s Hospital

Complex Care Medical Service Goals

• Improved short and long term outcomes:
  – Decreased variability in approaches to care
  – Evidence based, wholistic care
• Inter-professional, collaborative teamwork
• Complete, accurate and concise communications
• Family integrated and supported care
• Smooth transitions
  – Handoffs
  – Throughput

The Comprehensive Center for Bronchopulmonary Dysplasia (CCBPD)

What does complex care mean at my organization:
– Infants with moderate to severe bronchopulmonary dysplasia (BPD) and multiple co-morbidities:
  • Pulmonary
  • Cardiac
  • Feeding/digestive
  • Neurological/Developmental
– Combination of acute and chronic care
– Ages range from several months to 3 years
– Families with multiple needs

The Problem

• Variable approaches to medical management, nursing care
• Long LOS, older infant population
• Readmissions- to floor, NICU
• Team members working in silos
• Poor and fragmented communications
• Ineffective handoffs
• Families as visitors
• Poorly coordinated discharge planning
• Staff stress

Opportunities to Improve

• Clinical Care
• Throughput
• Communication
• Family care
• Discharge planning
• Staff support
• Ambulatory care

Referral Process

Within the Service Line
– Consultation with CCBPD NP
  • Transfer into the main campus from offsite NICU
  • General management recommendations
  • For entry/transition into CCBPD program
  • Discharge planning
  • Follow up planning

Outside the Service Line
– Consultation with CCBPD NP
  • Appropriateness of transfer
  • Assist with transfer details
  • Teleconsultations for medical management
Enrollment Criteria

- Moderate to severe BPD as primary condition

Services Provided

Inpatient Medical, Advanced Practice (NNP, AC PNP)
- Nursing
- Respiratory Therapy
- Nutrition
- Pharmacy
- Therapies
- Case Management

Outpatient Medical Home Model (AC or PC PNP, NNP)
- Social Work
- Psychology
- Neurodevelopmental team
- Advanced Airway
- Palliative Care
- Pulmonary Hypertension team

Services Provided

- Close follow up of medical needs
- Acute management in clinic
- Developmental assessments
- Social services support
- Collaboration with primary care providers
- Consultation if readmitted

Role of the Nurse Practitioner

Inpatient (NNP, AC PNP)
- Unit based team leader
- Rounds with interprofessional team
- Manages minute to minute details in collaboration with physician
- Supports nursing and other team members
- Educates
- Engages in safety, quality and process improvement initiatives

Outpatient (NNP, AC or PC PNP)
- Provides specialty consultation in NICU and other units
- Independently sees patients in clinic, sick visits
- Develops/expands processes, program
- Educates
- Engages in safety, quality and process improvement initiatives

Specific Interventions

- Diversified APP team to meet needs of older infants
  - Integration of NNP, AC PNP, PA
- Clinical care guidelines
  - Inpatient BPD management
  - Consultation and referral process
- Team based meetings for communication and planning
- Staff support system
- Medical Home model

Lessons Learned

Evolving Population
- Patient and family needs
- Staff support

Role Integration
- Scopes of practice
- Appropriate knowledge base, onboarding, competencies
- Issues with loss, trust

Impact

- 2016 30 day readmission rate= 0%
- Survival overall from BPD unit - 99%
- Survival of outside transferred patients - 96%
- Survival to 2 years of life - 99%
- Tracheostomy rate <5%
- Neurodevelopmental outcomes:
  - Moderate BPD: 10% with composite Bayley less than 70
  - NICHD similar cohort= 26%
  - Severe BPD: 11% with composite Bayley less than 70
  - NICHD similar cohort= 43%
Future State

- Continued program development
  - Refine competency based onboarding
  - Program marketing, external resources
  - Smoother admission and throughput
  - Staff training and support
  - Publish!

References


UTP High Risk Children’s Clinic Goals

- Reduce fragmentation of care of CMC with coordination of care by PCP, specialists in clinic.
- Improve Patient Outcomes as evidenced by reduction in ER visits, hospital admissions and LOS
- Increase family satisfaction as measured with clinic surveys and annual CAHPS

UTP High Risk Children’s Clinic Model

Core Team
- Pediatric Pulmonary Medical Director (.25)
- Pediatrician (1.5)
- PNP (3)
- Social Worker
- Registered Dietician
- Research Nurse
- LVN/MA support staff

Consultative Specialists
- Adolescent Medicine
- GI
- Infectious Disease (ID)
- Nephrology
- Neurology
- Pediatric Surgery
- Physical Medicine and Rehabilitation (PMR)
- Pulmonary
### UTP High Risk Children’s Services Provided

- Medical home for CMC proving outpatient acute and chronic care
- Same day sick visit appointments
- Extended visits (average 2-3 patients per day per provider)
- Care coordination by primary NP or MD: 75-100 pt per template
- After hours: 24/7 on call emergency phone for all patients
- Extended visit (average 2-3 patients per day per provider)
- Specialists in clinic
- Hospital Consult Service (RCT)

### Enrollment Criteria

- Infants and children from birth to 18 years with a chronic illness
- In the past year: ≥2 hospitalizations or ≥1 PICU admissions
- >50% risk for admission in next year based on the patient’s diagnosis and clinical course

### UTP High Risk Children’s Referral Process

- Families, hospitals or outpatient pediatricians or specialists can refer
- Patients must qualify for our clinic
- Transition patients when “healthy”

### Specific Interventions

- 24/7 medical advice from same providers
- Having ‘extra’ or prn medication and or supplies at home – Antibiotics, steroids, back-up G tubes, etc
- Daily screening of hospital records for ER/admissions
- Weekly scrutiny of all health care provided before any ER/admissions to improve care provided

### UTP High Risk Children’s Outcomes

- ER/Admits: Reduced 50-70% both number of ER visits, admissions, PICU admissions and length of stay (LOS)
- Cost-Effective: Total clinic and hospital costs (assessed from a health system perspective) were reduced by $10,258 per child-year
- Improved Parent Satisfaction

### UTP High Risk Children’s Role of the PNP

- Outpatient Clinical Care: provide acute and chronic care and share 24/7 call.
- Care coordination for patient templates
- Provide inpatient consultations in collaboration with MD’s in clinic
- Link between specialists, patients and other providers – Specialty clinic in our medical home: CDH
- Research: Assist in various research projects
- Dissemination of clinical and research results via journal articles, national presentations
### UTP High Risk Children’s Opportunities to Improve

- Hospital care was still costly and discharge transitions were fragmented
- Currently providing an inpatient consult team with same PCP in a RCT study
- Patient diagnosis-based research studies
  - Asthma, BPD, Cystic Fibrosis, Congenital Diaphragmatic Hernia (CDH)
- Patient diagnosis-based specialty clinics
  - CDH, CCHS, CP

### UTP High Risk Children’s Challenges and Lessons Learned

- Create a model that can grow and be sustainable
  - What is feasible for 50 patients, can prove difficult to maintain at 300
- Consider the impact of on-call on emotional well-being of providers
- Use providers to the scope of their license

### Pediatric Medical Home Programs at UCLA

- Accredited Patient Centered Medical Home (URAC)
- Began as the Medical Home Project at UCLA in 2003
- Based on principles from the national AAP model: Medical Home for Children with Special Health Care Needs
- Accessible
  - Family-centered
  - Continuous
  - Comprehensive
  - Coordinated
  - Culturally Sensitive
  - Compassionate

### Medical Home Team

- Care Coordinators (“Family Liaisons”)
- Nurse Practitioner
- Resident Physicians
- Attending Physicians
- Social Worker

### Program Components

- **Pediatric Program**
  - 226 patients; avg age 8.5 yrs (0.4 - 23.9 yrs)
- **Adolescent/Young Adult Program**
  - 70 Patients; avg age 21.5 yrs (12.7 - 29.7 yrs)
- **Parent Advisory Group**
- **Research**
- **Quality Improvement**
- Biweekly team meetings
- Periodic Retreats
Pediatric Medical Home Programs at UCLA

Enrollment Criteria

- Resides in Los Angeles County
- Condition(s) for which patient receives CCS
- At least one other chronic condition requiring ongoing subspecialty services
- Has Medi-caid
- Establish primary care with Resident’s Continuity Clinic

Referral Process

- Referral sources: inpatient providers, NICU/HRIF clinic, specialists, families, community organizations, home health nursing
- Referral form
- Waitlist
- Enroll 1-2 new patients/week

Services Provided

- Primary care
- Same day sick/urgent care visits
- Extended appointments
- A formal patient intake process
- “Social compact”
- Individualized patient “All About Me” binder
- Assigned lay care coordinators
- Direct access
- Advocacy
- Transition to adult specialist and primary care providers

Specific Interventions

- Registry
- Team huddle, pre-visiting planning
- Hospital-to-home transition
  - Post-discharge home visitation, self-care, health coach
- Strategies/interventions to increase parent activation/self management
  - Action plan development

Outcome Measures

- Health, developmental, educational, psychosocial and functional outcomes
- Reduced utilizations
  - Initial cohort of 30 patients who were followed for 5 years: Average number of ED visits per patient decreased from 1.1 +/- 1.7 before enrollment to 0.5 +/- 0.9 after medical home enrollment (P = .02) at Risk; Hrih, Chang, 2010
- Increased patient and family satisfaction/improve patient experience
  (Hamilton, Lerner, Presson, Klitzner, 2013)

ED Rates: Medical Home vs Waitlist Patients

- 1.8 ED visits per pt per year
- 0.9 ED visits per pt per year
Pediatric Medical Home Programs at UCLA
Hospitalization Rates: Medical Home vs. Wait List Patients

- 1.5 admissions per pt per year
- 0.75 admissions per pt per year

Role of PNP

- Primary Care Pediatric NP: Outpatient clinic, outpatient management
- Oversee care coordination
- Quality improvement/research
  - Oversee the implementation of quality improvement initiatives focusing on improving care delivery
  - Research: Aim to enhance family engagement, build family self-management skills, promote family strengths and wellbeing, and improve care while reducing hospital use for children with medical complexity
  - Example: Testing interventions to reduce hospital use through innovative tools that promote family engagement and utilize principles of the Care Transitions Intervention self-management coaching model

Challenges & Lessons Learned

- Care coordinator ratio: 80-100 patients/coordinator
- After hours access to core team
- Local context will influence the program structure/components
- Include parents in planning, ongoing improvement
- Sustainability

38th National Conference on Pediatric Health Care
March 16-19, 2017

Complex Care Medical Services
Inpatient, Outpatient, and Homecare Focused Patient Management Model
Christine Schindler, PhD, RN, CPNP-AC/PC, WCC
College of Nursing Faculty Marquette University
AC-PNP Complex Care
Children’s Hospital of Wisconsin

Key Attributes of CHW Complex Care Team

- Availability
  - 24/7 call
- Continuity
  - Inpatient, Outpatient, ED, Home
- Familiarity
  - Detailed knowledge of patient needs and family goals
- Flexibility
  - Accommodate patient and provider wishes when possible
- Accountability
  - Measure outcomes / Demonstrate value

Children’s Hospital of WI-A Primary Care / Tertiary Care Partnership

- Established in 2002
  - Combined 2 small nurse case management programs and added a part time MD
  - 2017: 4 MDs, 8 PNs, 9 nurse care coordinators, 9 care coordination assistants, 2 social workers
  - 515 patients
- Care Coordination / Co-management Model
  - All patients have a local PCP / Medical Home
  - SNP Complex Care program extends the Medical Home to the Hospital
- Goal
  - Partner with Children & Families, PCPs, Specialists, Community Services, and Insurers to ensure seamless inpatient and outpatient care for CMC with multiple chronic conditions and high tertiary center use
Enrollment Criteria and Process

• Referrals
  – Families, nurses, MDs, community
• Review
  – Weekly intake meeting
• Intake Visit
  – 90 minute appointment
  – Medical Review
  – Coordination Needs
  – Goals of Care
• Outcome
  – Enrollment offered if criteria met
  – Other services sought if criteria are not met

Care Coordination Team

Nurse Care Coordinators

– Intensive Care Coordination
  • Plan of care
  • Advocacy
  • Attend specialty appointments
  • Communication
  • Education
  • Support
  • Coach
  • Single point of contact
  • Access to services
  • Medical triage

Physicians / PNP’s

– Medical Co-Management
  • Review / synthesis
  • “Summary”
  • 24/7 call
  • ED Consultation
  • Inpatient co-management
  • Clinic visits
  • Non face to face tasks
  • Home visits

Rapid Growth with Federal Health Care Innovation Award

The Financial Impact of Nurse Practitioners on Complex Care Teams

Model 1 - 3 MD, 2.2 PNP
Model 2 - 1.5 MD, 5.2 PNP

2016 Family Satisfaction
Children’s Hospital of Wisconsin program, 2016 parent survey

Would you recommend the SNP to other families? (94.5% Yes)

Overall, how satisfied are you with the Special Needs Program? (94.4% Yes)

Would all my child’s health care providers work together (94.2% Often or Always)

CHW Utilization Data

CHW SNP Pre and Post Data for All Patients

PCP Satisfaction Survey 2016 (n = 46)

Amount of Communication:_audio: n = 4, just right: n = 4; no response: n = 2

Amount of SNP involvement: just right: n = 4; no response: n = 2

Future Directions

- Continue to increase research complex care
- Develop clear complex care quality metrics
- Telemedicine
- Working on Reimbursement structure with CMMI

Complex Care Medical Service Goals

- Coordinated, high-quality services across the care continuum for children with complex needs
  - Patient-centered, comprehensive, continuous, and accessible care
  - Proactive management of chronic conditions through the creation of a written, shared comprehensive care plan
- Right care at the right place at the right time
  - Same-day sick visits, telephonic access to a provider
- Decrease unnecessary utilization Emergency Department visits
- Decrease inpatient admissions and actual length of stay
- Improve the patient/family experience within CHST

Complex Care Medical Services
A Medical Home to Decrease Costs and Improve Outcomes
Complex Care Patient Management Clinic with Separate Complex Care Facility

Joe Don Cavender, RN, MSN, CPNP-PC
Vice President & Associate Chief Nursing Officer

Children’s Health – Children’s Medical Center
Referral Process
• Open referrals - accepted from parent, physicians, schools, etc.
• 150 patients currently with about 50 waiting
  — Acceptance pending hiring providers – 2 NP positions open
• Referrals reviewed for:
  — Do they meet the criteria?
  — Matching of patients to provider based upon patient severity of illness /complexity and provider skill set
• Providers each are limited to 1 or 2 new patients per week

Enrollment Criteria
• Major Criteria:
  — ≥ 2 significant chronic conditions
  — ≥ 3 sub-specialists
  — ≥ 1 hospitalization in last 2 years +/- ED visit in past 1 year
• Supplemental Criteria:
  — Age < 17 years at time of enrollment
  — Reside within 30 miles of Children’s Medical Center Dallas (Medical Home Only)

Services Provided
• Two Service Arms:
  — Primary Care Medical Home with Integrated Intensive Care Coordination
  — Complex Care Medical Services assumes the role of the primary care provider
  — Intensive Care Coordination Only
    • Allows community PCPs to retain complex patients while providing them the added benefit of participation in highly coordinated care

Our Children’s House
• Separate, stand-alone facility (42 beds)
• Focused on transitional care and rehabilitation
  — Allows discharge from the hospital acute care setting to a longer term care facility
  — Focus is on convalescence and transition to home care
• Includes an outpatient chronic vent / pulmonary clinic
• ACPNP roles in both the inpatient and outpatient settings

Care Coordination Services
- Care Coordination:
  — Concierge service for eligible patients who remain with their PCP
  — Consolidate appointments and procedures into a more manageable schedule
  — Review and reconcile sub-specialists’ recommendations
  — Medication reconciliation
  — Create a comprehensive care plan
  — Facilitate transition planning
  — Coordinate with insurance and DME companies, schools, and community resources

- Medical Home:
  — Includes care coordination service
  — Primary care model
  — Well child care
  — Screening and surveillance
  — Chronic condition management and co-management
  — Same day sick and urgent visits
  — 24/7/365 telephone availability
- Consultation:
  — Facilitate decision to admit and discharge planning
  — Actively participate in care conferences during admission

Team Members
• Clinic Team
  — RN Care Coordinator
  — MD/NP Primary Care Provider
  — Scheduler
  — Social Worker
  — Clinical Dietician

• Consultative Team
  — Palliative Care
  — Psychology
  — Wound Ostomy
  — School Services
  — Medical Legal Partnership
Role of the Nurse Practitioner

- Each NP (Primary Care) has a panel of approximately 50 patients
- Patients seen at least once every 6 months
  - Most average 8 visits/year (range 4 to 16)
  - Appointments are 90 minutes in length – some as long as 2 to 4 hours, new patients 4 to 8 hours
- NP has two 4 hour sessions/week for care coordination, etc.
  - Form completion and correspondence are a major burden
- NP rotates call with MDs
  - A week at a time every 3 to 4 weeks with MD backup as needed

Specific Interventions

- The families are trained on how to appropriately use the providers and health care system
  - They are taught to call at any time for any emergencies and to not call for refills – to be proactive in meeting their needs
- Some patients arrive to the ED without first calling the on-call provider
  - EPIC system will identify and page the on-call provider at req
  - Can re-educate regarding ED utilization as necessary
  - Avoiding ED visits for issues such as G-tube problems by establishing a plan directly with radiology to avoid going to the ED prior to a G-tube fluoroscopy check

Outcomes

- Patients and families report much higher levels of satisfaction with their care
  - Some were planning to leave our system before this service
- 2015-2016 comparisons of 50 patients:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
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<tbody>
<tr>
<td>Admissions</td>
<td>201</td>
<td>121</td>
</tr>
<tr>
<td>Maximum LOS</td>
<td>289</td>
<td>63</td>
</tr>
<tr>
<td>Average LOS</td>
<td>13.71</td>
<td>8.07</td>
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<tr>
<td>Total ER Visits</td>
<td>141</td>
<td>124</td>
</tr>
<tr>
<td>Acuity Level 3-5 Visits</td>
<td>80</td>
<td>57</td>
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Financial Impact

- Costly services to achieve the desired outcomes
  - Direct revenue does not cover costs
- Costs are recovered through overall reduction in health care costs by improving care coordination and reducing hospital and ED utilization
  - Have achieved reimbursement from payers for care coordination by providing evidence of overall utilization reduction

Challenges and Lessons Learned

- Caregiver fatigue and burn out
  - Burdensome work that can be exhausting and frustrating at times
    - Emotionally taxing, high-touch service
    - Lots of counseling, reassuring
    - Long appointments
    - Families often overwhelmed and exhausted
    - Many social issues
      - In and out of Medicaid eligibility
    - Challenging home settings
      - Loss of utilities due to non-payment
      - Affordable housing is often sub-standard housing
- Some of these patients are so medically complex that the opportunities to reduce utilization are minute
  - They will be admitted, but we have been able to decrease their overall LOS
  - Inpatient services once waited for patients to return completely to baseline before discharge due to poor follow-up, but now with good follow up these patients are being discharged earlier
Future State

- Fulfillment of open provider positions and acceptance of patients on our wait list
- Nurse Practitioner led remote clinics for care coordination beyond 30 miles
- Inpatient admitting service led by our complex care medical service providers

Break up into groups

1. What are the problems you see for patient care need of complex care patients?
2. What are some of the problems you see for the families of complex care patients?
3. Identify Stakeholders: the people <role> you need to talk with to present your plan or discuss your ideas.
4. Establish a Goal: As a <User- patient, NP, Leader>, I want <some goal> so that <some reason>.
5. What are some of the biggest challenges you see to addressing your goal?
6. Who (what are their roles) are some of the champions or supporters of your goal that you can reach out to?
7. What are three talking points or opportunities that you can discuss with your champion to solicit their help to reach your goal.
8. What is 1 thing you can do when you get back to achieve your goal.

UTP High Risk Children’s Clinic

Groups

1. Ask questions of the panel
   - Please stay away from questions specific to your organization
   - Thank you!