

The Financial Impact of a Hospital-Based Care Coordination Program for Children With Special Health Care Needs

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ABSTRACT

Care coordination programs are important in caring for medically complex pediatric patients, particularly for children with special health care needs. This study is a retrospective financial analysis of a hospital-based care coordination program involving one procedural subgroup of children with special health care needs: those receiving pediatric tracheostomy. Hospital records were reviewed for patients who received a tracheostomy at a large Midwestern U.S. hospital from 1999 through 2015. The population was divided into two subgroups: patients who received a tracheostomy before the development of a care coordination program and patients who received a tracheostomy after enrollment in the care coordination program. Patient records were reviewed for length of stay, readmissions related to respiratory and tracheostomy management, and total hospital charges. Enrollment in a care coordination program for the pediatric tracheostomy patient resulted in a decrease in mean length of stay and reduced hospital charges and a slight increase

in readmissions. Further analysis using larger sample sizes and multiple centers is necessary to determine whether such outcomes are the direct result of enrollment in a care coordination program. *J Pediatr Health Care.* (2017) ■, ■-■.

KEY WORDS

Care coordination, children with special health care needs (CSHCN), discharge, hospital charges, pediatric tracheostomy

Increased pressure to reduce length of hospital stays and decrease financial expenditures has resulted in a growing effort to develop care coordination programs, particularly for children with special health care needs (CSHCN). The Maternal and Child Health Bureau has defined CSHCN as those children who have or are at increased risk for a chronic, physical, developmental, behavioral, or emotional condition and who also require health care–related services of a type or amount beyond that required by children generally (McPherson et al., 1998). There are approximately 11.2 million CSHCN in the United States as of 2010, which accounts for 15% of the pediatric population (Data Resource Center for Child & Adolescent Health, 2010). These children often require intense care coordination because of their complex health care needs involving multiple organ systems and requiring care by multiple medical specialists. Centralizing ongoing management and long-term follow-up of CSHCN by integrating primary care providers, specialists, medical equipment suppliers, and home care services helps build strong care

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Conflicts of interest: None to report.

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0891-5245/\$36.00

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<http://dx.doi.org/10.1016/j.pedhc.2017.06.003>

coordination programs that support these CSHCN. Care coordination programs can serve as a central medical access point and educational resource for families of CSHCN. Effective care coordination programs establish continuity of care management that is more comprehensive than traditional discharge planning.

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The development of the Continuity of Care (COC) program for CSHCN was implemented in 2001 at the University of Iowa Children's Hospital. This program was initiated to increase community and hospital communication and decrease fragmented care for CSHCN. The COC program's mission is to facilitate a comprehensive, coordinated, and family-centered system of care through which CSHCN outcomes are enhanced. During the implementation phase, barriers of care coordination were identified by stakeholders and focus groups. These barriers included economic, sociocultural, lack of resource identification, and poor communication among all providers, all of which lead to fragmented care. A strengths–weaknesses–opportunities–threats analysis was initially conducted by the University of Iowa Children's Hospital Referring Physician Advisory Council to assist with evaluating the current state of care coordination. This group found common barriers that were consistent with poor communication to community providers, readmissions, and fragmented care. Along with this strengths–weaknesses–opportunities–threats analysis, the University of Iowa Family Advisory Council validated the same barriers and concluded the need for an overall improvement in care coordination and showed a decrease in communication. Child Health Specialty Clinics Focus group, which is part of the Iowa health care system, completed a statewide needs assessment and continued to identify the same issues. Finally, an interdisciplinary advisory committee was formed that assisted with early program development to include the development of standards and policies, establishment of roles and responsibilities of team members, and identification of metrics for program evaluation. Many of the barriers identified by these stakeholders and focus groups affect quality of life and health. The lack of a single entry point into a complex health care system was also evident, leading to poor linkages to the community once the CSHCN were transitioned to home. The COC program provides the entry point with a focus of increasing access to community-based services, improved communication from inpatient stays

back to the community, less fragmented care, and a standardization of the care coordination process.

Along with the barriers that were identified with the development of the COC program, there were many benefits recognized as well. A number of studies have described benefits of care coordination models: a reduction in hospital readmissions, reduction in length of stay (LOS), reduced emergency department visits, decreased inpatient charges, and improved satisfaction are significantly noted in the literature (Barry, Davis, Meara, & Halvorson, 2002; Criscione, Walsh, & Kastner, 1995; Liptak, Burns, Davidson, & McAnarney, 1998; Walsh, Osber, Nason, Porell, & Ascitutto, 2002). One study used a formal quality improvement initiative to show that implementation of a standardized care coordination process for children who are ventilator dependent have a decrease in length of stay (LOS; Baker et al., 2016). Similar benefit of a care coordination program includes the use of a team approach, which the COC program also incorporates. The COC team takes a multidisciplinary approach and consists of social workers, nurse clinicians, and a nurse practitioner, all with formal responsibilities. The COC program goals are to (a) provide comprehensive, interdisciplinary, and family-centered care coordination; (b) provide a continuous system of care across the continuum; (c) provide psychosocial support including self-advocacy; (d) assist in accessing needed resources and services; (e) facilitate communication among multiple providers; (f) avoid duplication of services and costs; and (g) optimize overall health of the child. Although care coordination can be challenging, complex, and time consuming, it is an efficient and effective way to manage care for CSHCN. Successful care coordination programs result in optimal outcomes for CSHCN and their families and provide fulfillment for providers (American Academy of Pediatrics Council on Children With Disabilities, 2005). The care coordination models described in the literature have common benefits similar to the COC program that are establishing effective communication within the health care system and between the health care system and the community (Bethell et al., 2002).

A retrospective financial analysis was completed at the University of Iowa Children's Hospital, which is a 140-bed tertiary care facility serving rural and urban pediatric patients. A comparison of the impact of care coordination for pediatric patients who have received a surgical procedure (*International Classification of Diseases* [ICD], 9th edition, code 31.1 and ICD-10, code 110F4: tracheostomy; United States Health Care Financing Administration, 1993; World Health Organization, 2009) was studied. This coordinated care is managed by collaboration with the hospital, community medical team, and community services and is illustrated in Figure 1. The COC coordinator helps facilitate organization and communication among these groups to maximize the coordination of care for

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