High Risk Pediatrics:
Making a Meaningful Difference

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Lakewood Health System
Medical Home Team
Introduction: Lakewood Health System
Clinics

• 5 Primary Care Clinics
  – Medical Home Certified
  – Including…

• Main Campus
  – Multiple specialties offered
  – Integrated with Primary Care
  – Behavioral Health Program and Providers
  – Awaiting certification for Behavioral Health Home
  – Maturity of Medical Home Program
Inter-Disciplinary Grant Team

- Providers
- Case Managers
- Social Work
- Population Health
- Informatics
- Grant Coordinator
- Patients and Parents
- Community Members
Population

- High Risk Pediatric patients
- Medical Home Patients
- Rising Risk patients
Initial Plan…

• Identify gaps that exist for high-risk children living in our primary service area, receiving specialty care within and outside of our system

• Improve the communication between families, LHS and other agencies
Initiating the Plan

• Have patients and families participate with us
• Partnership with CentraCare, Gillette and Children’s
• Identify new processes and workflows
Initial Findings…

• **From Parents:**
  • Few gaps existed
  • Individual communication was not an issue

• **From EPIC:**
  • High-Risk identification analysis

• **From Medical Home:**
  • Identify Care Coordination in process

• **From Referral Centers**
  • Opened referral and care coordination channels
Change of Focus...

- We decided to change the focus from identification of gaps in communication to identification of unmet *specific needs* of LHS high-risk pediatric patients.
Criteria for High Risk List

• Data from EPIC utilized to assist in prioritizing high-risk patients based on the Johns Hopkins ACG risk score methodology

• Patients ages 0-17 with a risk score greater than 3
Working the High Risk Patient List

1. Ongoing monitoring and evaluation of high risk pediatric patients and enrolled to Medical Home when appropriate

2. Chart scrubbing to verify risk and needs

3. Broadened focus to include all Medical Home Pediatric Patients

4. Deeper Dive: Found 3 emerging risk categories
Three Categories Emerged…

- Socioeconomic
- Medical
- Behavioral Health
Socioeconomic Focus

- Food Insecurity
- Community Health Initiatives
- Resource Connection
Medical Focus

- Raise Provider Awareness of when and how to refer rising risk patients
- Use expertise of RN/SW team to assure connections with community resources
Behavioral Health Focus

- Application for BHH Certification
- Focus on Collaboration for Pediatric Interventions for 5-15 year-olds through Learning Community grant
Challenges with Project

- Admitting Patients to Medical Home
- As needed Social Services model within the clinic
Wins

- PEP Group
- Parent Advisory Group
- Increased provider awareness
- Care Team function in EPIC
- Dedicated social services within the clinic
Case Study 1: Inpatient Infant

Three-month old admitted to hospital for Failure to Thrive
- Special needs – Low birth weight, g-tube feedings, cleft palate
- Significant social needs
- Children’s Hospital involved with care as well

Referral made by provider to Medical Home
- Post discharge – daily calls to MH RN for daily weights
- Coordination with MH and Public Health nurse visits – with updates
- MH, RN coordinating communication between LHS and specialty providers – U of M and Gillette Children’s
- SW for MH making referrals to Early Childhood Special Education – birth to three programs.
- SW assisting with housing applications – family homeless at the time of hospitalization
- SW assisting with coordination of domestic violence advocate for support
Parent Testimonial

https://youtu.be/LO24TaEuTXQ
Questions?
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