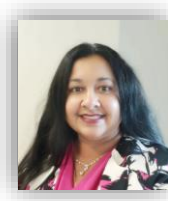
UR MEDICINE
GOLISANO CHILDREN'S HOSPITAL
CHRISTINE M. BURNS CARES CENTER
CARE MANAGEMENT PROGRAM

WINTER 2020

IN THIS EDITION…

OUR VISION: *The Golisano Children's Hospital Health Home Program aspires to shaping the future of care management by achieving excellence to impact health outcomes for all children.*

OUR MISSION: *The Golisano Children's Health Home Program is dedicated to connecting families to community resources and strengthening their ability to maintain a safe and healthy lifestyle.*



FROM THE DIRECTOR

Welcome to the first edition of the Christine M. Burns CARES Center Newsletter. Our program started in late 2016, and we have spent the past few years building our team and infrastructure to provide care management services to the children in our community.

In this initial edition, you will be taken on a journey, learning about our program and the dedicated team doing the work. You will read about their experiences with our patients and families and how the delivery of comprehensive patient-centered care has impacted them. No program is successful without an administrative component; this group of individuals works behind the scenes to complement our direct care services.

In echoing the work done by Christine Burns during her time at Golisano Children's Hospital, we will continue her goal of providing our patients and families with exceptional care. We strive to reach that goal by connecting community resources and sharing the work we do with others.

I hope you enjoy learning about the CARES Center and all the uniqueness it provides to patients, families, and health care professionals. We continue to work together to take care of our communities' most vulnerable children during these unprecedented times.

Stay safe and healthy,

Cynthia Korpal
Director, Golisano Children's Hospital Care Management

WHAT IS A HEALTH HOME?

In New York State, many people get their health benefits through the Medicaid Program. Some children have chronic health problems, developmental delays, or mental health needs and can't always manage their medical and day to day needs. New York State's Health Home program was created with these people in mind. The goal of the Health Home program is to make sure its members get the care and services needed.
Started in 2017, Golisano Children's Health Home has received 1,400 referrals to date. Our program receives referrals from within our system, community providers, and agencies including, Center for Youth, Monroe County CPS, Rochester City School District, and the Refugee Center. Our program has established positive relationships with community organizations such as Goodwill, Metro Mattress, Department of Social Services, Asbury Storehouse, and the Wease Cares Children's Fund.

Our Team

Administration
Cynthia Korpal, Director
Andrea Myer, Care Manager Supervisor
Katie Birge, Administrative Assistant
Janelle Harris, Information Analyst
Michelle Tuohey, Referral Coordinator
Ayla Johnson, Intake Coordinator

Care Managers
Donna Heintz, Care Manager Team Lead
Dana Cromheecke, Care Manager
Alysha Dias, Care Manager
Brittany Gnage, Care Manager
Jessica Holly, Care Manager
Lisa Hounshell, Care Manager
Lena Katafiaz, Care Manger
Rayna Kent, Care Manager
Cratrina Meeks, Care Manager
Andrew Miller, Care Manager
Stephanie Neufeglise, Care Manager
Elizabeth Pietrantoni, Care Manager
Yahaira Vazquez-Valle, Care Manager
Dominique Wilcox, Care Manager

Care Coordination
Jackie Powell, Team Lead, Green Team
Cheryl Gordon-Barr, Yellow Team
Kate Miller, Orange Team
Melissa Horton, Blue Team
Allison Preteroti, Complex Care

CONNECTIONS TO THE COMMUNITY

ANDREA MYER, SENIOR SOCIAL WORKER

The Golisano Children's Hospital Health Home Program has been working very hard to connect with people and agencies in the community. The program feels it is essential to have those relationships to grow our program and to be able to meet the needs of the families we serve. We have done numerous community presentations and attended stakeholder meetings to gain knowledge and understanding of other programs available in the community. We want to ensure that we know everything we can about the best choices for the children and families that we work with and what will suit them best. Our program has positive working relationships with mental health agencies, schools, provider offices, and community agencies providing food and clothing. We are always looking to grow and develop relationships with any provider or agency that offers the Rochester community services.

SUCCESS STORY

ELIZABETH PIETRANTONI, CARE MANAGER

The family had a history of missed medical appointments and struggled to follow through with care team recommendations. The client's mother also expressed frustration and concerns regarding her own mental health that she stated impacted her parenting skills. With assistance from the client's medical team, we completed referrals for in-home supports and therapy. This client is currently connected with in-home skill-building and in-home therapy and attends routine medical appointments with compliance. Mental health providers report positive engagement as this client develops coping skills and anger management to use in the home and school setting. The client has stabilized on medication and has monthly sessions with his pediatrician office to ensure the medication remains effective. The client's in-home service worker states he is very engaged with services and will continue to work with this client and family to continue coping skills and anger management skills weekly in the home. I also completed a referral for adult health home care management for this client's mother, who is now connected with her own services and mental health treatment. Overall, the family feels they now have the support and services to continue to move forward in a positive direction for the client's mental health and behaviors.

Finding Resources for Families in Need

Janelle Harris, Information Analyst

Acquiring resources to assist our patients and their families with their basic needs can be a challenge. Often, community organizations either have a limited supply of the items requested or cannot supply the items at all. When resources are available, there is an application process to be placed on a waiting list. When placed on a list, it is not a guarantee that patients and their families will receive assistance. Navigating the process to receive support can be a daunting experience for families in crisis. Many of them are left feeling overwhelmed and don't know where to turn.

Through the CARES Center, our patients and their families have received the assistance they need, due to our staff's hard work and funded by the generosity of our private contributors. The care managers at the CARES Center have established an amazing rapport with the families and have developed an intimate knowledge of their needs. The families feel comfortable asking for assistance to receive beds, educational equipment, personal hygiene items, and even the funds to pay for college application fees. Our most requested item has been beds. From 2017 to 2020, we have provided 35 beds for some of our patients. Having the opportunity to provide much-needed resources is an incredible feeling. In most cases, the families cannot purchase some of the items they need due to financial constraints.

Outreach for Vulnerable Children

Ayla Johnson, Outreach Intake Coordinator

Though the challenges of community-based outreach and engagement exist, the benefits have proven to be far greater. Over the past year, I have connected with families in their homes and provided a service that has been missing from patient care. We often find that the families we work with have limited resources. Because of this, phone calls, letters, and MyChart can only be successful if the family has the resources necessary to make this connection. I have been able to bridge this gap by going to the patient's homes and having the tools to assist with scheduling appointments, transportation, as well as completing documents required by providers. This has helped to take away the barrier that the lack of resources presents.

I have found families receptive to face-to-face outreach and appreciative of the efforts being made on behalf of their children's care. By performing this type of outreach, I have successfully gotten patients to be seen who were previously lost to contact. I have also provided access to much-needed services such as the Children's Health Home Program by offering more information and completing enrollment while meeting with these families. This type of face-to-face outreach shows families that, we as a health care team, value not only the wellbeing

SUCCESS STORY

ANDREW MILLER, CARE MANAGER

I had a client who was a 7th grader in the RCSD school district. He was being bullied at his previous school. This treatment was causing him to feel depressed and not comfortable while attending school. I worked with the patient's mother and brought her and the patient to the school board. We were able to solve this issue quickly. The patient switched schools and has a more positive outlook on attending school.

PEDIATRIC PRACTICE
REMOTE ACCESSIBILITY AND TRANSPORTATION

JACKIE POWELL, LEAD CARE COORDINATOR

The Care Coordination staff have been working remotely since March 2020 due to the COVID-19 pandemic. However, they remain accessible to our patients, AC6 staff, and Children's Health Home Care Managers. The Care Coordinators can assist patients with transportation, insurance applications through the New York State Marketplace, and schedule all medical appointments. While in their remote setting, Care Coordination staff are able to focus their efforts on calling and scheduling all essential patients. When patients are unable to attend their scheduled appointments, Care Coordination staff are able to reschedule in real-time and provide transportation as needed.

During the COVID-19 Pandemic, Community Hospitals, along with local doctors' offices, partnered with Regional Transit Service (RTS) to provide free rides to patients in need of essential well-child visits. RTS assisted with 44 free trips for patients who otherwise would not have received medical care. The success of this partnership was paramount as detailed in the following patient experience:

Positive Patient Experience:

A 19-month-old well-child visit was scheduled. The patient's mother requested help with transportation for this appointment. The request was sent to Care Coordination. The Care Coordination staff contacted the parent and discussed the method of transportation to which the mother agreed. Regional Transit Service (RTS) confirmed the trip. The Care Coordinator called Mom the morning of the scheduled appointment and confirmed that she would bring the patient in for the appointment. The patient's mother shared her experience after the visit with a Care Coordinator. Mom stated, "The flow of this appointment was perfect. I was checked in, went back to the room, the doctor came in, I got all my questions answered, I went down to x-ray and called you (Care Coordinator) to let you know that I was ready, and as I went down to the front, the bus was waiting. It was perfect because my husband had to go back to work. He was at home with the other children. I made it home in enough time."

Children's Health Home – What to Expect

When a child is enrolled into our program, our care managers will work with your family to set up a care plan, schedule appointments and help you obtain the services necessary to better meet your child's needs. Some of the services care manages provide include: linking to community programs, scheduling appointments, obtaining transportation to medical and non-medical appointments, assisting with housing needs, attending medical appointments for your child, communicating with all providers involved with the child's care, locating resources for food, clothing, social services and financial needs.

Our staff also reaches out to pediatricians when a patient of theirs is admitted into our hospital and meets the eligibility requirements of the Children's Health Home Program. Referrals are then submitted to our Health Home Program and our staff will review the referral for eligibility and reach out to the family to begin the process.

Referrals! Referrals! Referrals!

Anyone can complete a Health Home referral. They may be submitted via fax, email, phone, mail, and eRecord. Most of our referrals are received via fax and email. Our program receives referrals from within our system, community providers, and agencies including Center for Youth, Monroe County CPS, Rochester City School District, and the Refugee Center.

OUR STATS AT A GLANCE

283 Enrolled

22 Outreach

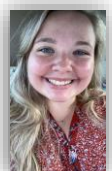
Success Story

STEPHANIE NEUFEGLISE, CARE MANAGER

I received a referral for a youth who was young and expecting. After she had the baby, she lost herself for a while and ended up in the hospital. Once she was discharged from the hospital, her team worked together to get her into school, therapy, and in-home supports. Since her discharge, she has been doing great and is even on the high honor roll.

Complex Care

ALLISON PRETEROTI, COMPLEX CARE



Throughout the past year, I have had the privilege to work under the FLPPS grant and alongside the AC6 complex care team as the new complex care coordinator. Under the FLPPS grant, we have created and strengthened interpersonal connections with over 120 children with medical complexities. With each patient, we have made it a priority to acknowledge and address all aspects of their lives, including family dynamics, their relationship with the social determinants of health, and their connection to the health care system. As this position has strengthened the relationship between the patient and their medical team, it has also strengthened the connection between the medical team members. I have been able to pay special attention to the relationships within the URMC system and our relationship with hospitals outside of Rochester, including Boston Children's Hospital and Children's Hospital of Philadelphia. The connections made within this past year have resulted in effective and vital communication between providers. In March 2020, COVID-19 began to impact the health care system. The complex care team was able to readily adapt and implement new ways to address our medically complex patients' needs. Our providers were often able to see these patients virtually to renew nursing orders and conduct follow up visits while maintaining the highest level of care. We have received a great deal of positive feedback from our patients and caregivers regarding our virtual visits. The AC6 complex care team has provided patient-centered care while adapting to and promoting new ideas and will continue to do so after the FLPPS grant has ended.

SUCCESS STORY

DOMINIQUE WILCOX, CARE MANAGER

This client has been on my caseload for three years now. Mom has been struggling with the client's behaviors on her own, and we have enrolled her into therapy and started medication management. The client was a well-behaved child in school for kindergarten, and during that time, mom noticed she was behind in her learning goals. As the patient's Care Manager, I went down to the board of education with my patient's mother and applied for a CES- committee education services meeting to obtain an IEP- individualized education plan. The IEP would offer special education services to the client if needed. Months went by, and the CES- committee education services meeting was denied. My patient's mother was disappointed but was receptive to trying again. The client went to first grade and started to show some school behaviors and missed school due to morning behaviors at home. As the family's Care Manager, I encouraged mom to apply two more times during first grade for a CSE meeting, which was denied due to attendance and the client not having her glasses in school. Mom applied again at the Rochester City School Board District, and this time a meeting was granted. After three more months of testing, the client was granted an IEP in May 2020.

Holiday Adopt- A- Family

The Children's Health Home Program works with the families that we serve during the holidays' exciting times. Holidays can bring a range of emotions for families in need. Many of our families cannot afford to provide any gifts for their children during the holiday season. We have been very fortunate to have received donations and had other companies and individuals in the community "adopt" one of our families to purchase gifts for them for the holidays. We feel that this is very important because the parents/guardians of the children we work with want to provide for their kids but cannot always make that happen. It brings the community and us a lot of joy to shop and give a lovely holiday to one of our families in need. We try and reach as many families as we can but that all depends on donations and those who can "adopt" our families. We are always looking for new ways to provide an exciting and cheerful holiday season for the families that we serve.

Adopt- A- Family for the Holiday 2020

If you are interested in adopting a family this holiday season, please contact:

Andrea Myer at 585-472-3742 or

Andrea_Myer@URMC.Rochester.edu

CONTACT US!

Address: 601 Elmwood Ave
Box 777
Rochester, NY 14642
Phone:
585-275-4242
Fax:
585-341-9430
E-Mail: ChildrensHealthHome@URMC.Rochester.edu

IN THE NEXT EDITION….

Holiday Adopt-a-Family Update
Social Media Presence
Community Connections

Children's Health Home - Out and About

Children's Health Home Staff have participated in many presentations and conferences over the past several years. We have showcased the uniqueness of our program, its connection to the Golisano Children's Hospital and the community based pediatricians. Our staff have presented both locally and nationally at the Monroe County Medical Society, Rochester City School District, and a variety of pediatric practices.

URMC Social Work Department – January 2020
Poster on Children's Health Home Program

Children's Hospital Association – November 2019 Children's Health Home and Ambulatory Hospital Services Making It Work

World Congress Care Coordination and Transitions Conference – January 2019
Examine the Unique Needs for Children within Health Home Care Management

NYS Care Management Coalition - April 2018
Collaboration between PCMH Care Coordinators and Children's Health Home Care Managers

Pediatric Nursing Conference- May 2018

At Golisano Children's Hospital we do everything in our power to help every child reach their fullest potential.