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

SUMMER 2021

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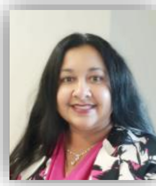
OUR VISION: *The Golisano Children's Hospital Health Home Program aspires to shaping the future of care management by achieving excellence to impact health outcomes for all children.*

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



What a year it has been! I want first to acknowledge our dedicated team. They have tirelessly maintained putting the patient first throughout this past year as our community continues to face barriers due to the pandemic, health disparities, and social determinants of health.

In this issue, we showcase our care managers and care coordinators, their success stories, and their challenges during COVID. We were able to assist several families last year with gifts during the holiday season due to generous donations from members of our community.

Our program has made advancements in the social media world by introducing a new Facebook page and an updated website. Our team has expanded with the addition of new staff, and we are continuing to recruit. As the needs of children become more complex, we are embarking on adding other services to the Center to continue our mission of a patient-centered approach focused on connecting families to resources and encouraging a healthy lifestyle.

I hope you enjoy learning about the milestones we have achieved.

Stay safe and healthy,

Cynthia Korpal
Director, Golisano Children's Hospital Care Management

Children's Health Home- Social Media

We have a new Facebook Page! We are asking patients, providers, and other agencies to find us on Facebook to follow and like our page. The purpose of the page is to share community resources that we find with our followers in order to get the information out to a larger group of people. Upcoming food drives, summer activities, sports, and other community events are some of the links and things we share.

Facebook Page Name: URMC Golisano Children's Health Home Program!

Our Team

Administration
Cynthia Korpal, Director
Andrea Myer, Care Manager Supervisor
Janelle Harris, Billing Administrator
Katie Birge, Administrative Assistant
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
Stephanie Lodato, Care Manager
Cratrina Meeks, Care Manager
Stephanie Neufeglise, Care Manager
Elizabeth Pietrantoni, Care Manager
Claudia Santoya, 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

Holiday Families Program

ANDREA MYER, SENIOR SOCIAL WORKER

Our Holiday Families program had an overwhelming response last holiday season. We had many individuals and agencies adopt families and provide financial donations to give to so many of our families. We were able to assist over 35 families, totaling 135 adults and children. Each year we have been able to grow the program due to the kindness and generosity of those who are able to adopt a family and contribute through donations. If you are interested in being a part of the holiday program for 2021, please contact Andrea Myer at (585) 472-3742.

SUCCESS STORY

RAYNA KENT, CARE MANAGER

The best part of working as a care manager is the person-centered care we provide each and every family. Each family has its own set of strengths and goals that we surround our service around and bridge any gaps in care. A recent family on my caseload was overwhelmed on where to begin and how to engage their child in school enrollment and further community resources. I worked with the family on creating a plan of care in which identified services and goals relating to this child's medical, mental health, educational and financial needs. This mother had shared how overwhelmed she was in enrolling this child into school and not knowing how to get this child enrolled in special education services. This mother suffered from her own extensive health issues that increased her stress in caring for her child's medical and behavioral needs. This mother also shared how stressful it was when I would call or complete home visits due to this child's extensive behaviors. From our generous community donations, I was able to provide this child with coloring books, animal figure toys, and a board game to play with each time this mother needed to speak with providers. This family was extremely appreciative of these donations, and I was able to meet with this family without this child interrupting Mom. I was also able to complete the school application with the family successfully, and our next step will be walking them through the special education process. This is just the beginning of this child's success story, and I feel fortunate to be a part of it.

Serving Patients during COVID

Ayla Johnson, Intake Coordinator

Working with our families during Covid-19 has been both challenging and rewarding. I have found that the majority of the families we work with have been willing to continue to meet with me in-person, while a small number of families have requested that I send the intake packet for them to review at home and complete while discussing it with me via phone.
For families that have been willing to meet with me, a document has been put together to help families know what to expect from the Care Managers and me while meeting with them in person. This document lists the ways the Care Manager will communicate with them (text message, phone calls, Zoom, FaceTime, etc.) as well as the types of PPE a Care Manager might be wearing to their visits (masks, protective eyewear, face shields, etc.). This document also lets the families know that if they need to reschedule appointments with their Care Managers due to illness, it will not affect their status of enrollment with the Children's Health Home Program, and rescheduling can be done. I have found that our families have been appreciative of and responsive to this information and are happy to know what to expect going forward.

Serving Patients during COVID

Donna Heintz, Care Manager Team Lead

COVID has been a difficult time for all, but our families have really stepped up and worked hard to maintain their services. We have been doing many Zoom meetings and FaceTime to see our families and make sure they know we are still here and working for them. In the beginning, we worked on many activities for kids to do at home, whether educational resources or recreational things. Our families have done a great job adapting to the world changes and still maintain their children's needs.
Now we have been able to go back to seeing our families more in person. With the weather changing and vaccination rates increasing, we have been doing many more visits outside with families. We have ensured our families are connected with the supports and services they want and need and still maintain everyone's safety.

OUR STATS AT A GLANCE

304 Enrolled

38 Outreach

My Experience with Children's Health Home

Heather Jones, LMSW, Pediatric Endocrinology and Adolescent Medicine

The Children's Health Home Care Management program is truly an incredible resource for our patients and their families. As the social worker for Pediatric Endocrinology and Adolescent Medicine, I have made my share of referrals to the program since it started. Along with other pediatric divisions within GCH, we work with patients dealing with complex social situations, various chronic illnesses, mental health issues, and limited supports/resources. The support our families receive from this program appears to be extremely beneficial. Some parents have needed extra support adjusting to a new life at home after their child has been diagnosed with type 1 diabetes. Others have needed help figuring out how to fit diabetes management into their daily routine and help with scheduling appointments. Or they've needed help finding resources such as parent support and/or peer support for their child, help with basic needs (food, clothing, etc.), and even assistance with transportation to get to appointments. The list goes on.
Additionally, I appreciate their efforts when it comes to trying to make contact with our families, as this is not always easy. They've also come to appointments with families as needed and have stayed in contact with me while they are involved. Thus far, my experiences with the program have been positive, and I'm grateful to have them as a resource!

A New Pediatric Complex Care (PCC) Program

Neil Herendeen, MD

Specialized Care and Coordination for Children with Medical Complexity

A Program of the Golisano Children's Hospital Christine M. Burns CARES Center

Children with Medical Complexity often experience fragmented care. There is a need to develop a more patient-centered coordinated program that spans the continuum of healthcare services better to serve the needs of our most complex patients and support the efforts of the primary care and specialty teams. We propose to implement a new pediatric complex medical consult and coordination program within the Christine M. Burns CARES Center. This innovative model of centralized care coordination and expert consultation at the local level for children with medical complexity and chronic illness will improve health equity, optimize health outcomes and decrease health care costs in this under-resourced and under-represented population.

Our focus group is children with multi-organ chronic disease, including technology-dependent children living at home with feeding tubes, tracheostomies, ventilators, and private duty nursing. It is challenging to manage this growing population of children with complex medical and psychosocial needs without staff dedicated to this task. Our local experience at Golisano Children's Hospital Pediatric Practice reflects national data showing 30% of our time (and health care dollars) is spent caring for the top 1% of complex children. Modeled after Mercy Virtual's vKIDS program in St Louis, we propose to create a center for children with medical complexity starting this summer to act as a daily care coordination/nurse triage service supported by telemedicine visits as required, and biannual comprehensive interdisciplinary care management service for families as a supplement to the primary care medical home. Children will maintain their primary care pediatrician, and families will have an extra resource to talk about their child, problem solve issues, attain access to care and prevent the need for hospitalization or emergency room care.

The American Academy of Pediatrics encourages more medical centers to provide this specialized pediatric care. As one parent reflects, "I found myself surrounded by more medical equipment, most of which had to be plugged in with a multitude of extension cords and power strips, something I had not thought of when we were in the hospital. With 2 other children walking around, we worried about them tripping. Eventually we had to shift our kids' bedrooms around to accommodate the medical supplies, oxygen tank, blood pressure machine, infusion pumps, wheelchair, and shower chair and create a place for us to sit to make sure our daughter was safe and breathing. Slowly our home began to feel like a medical ICU. Despite our confidence in using the equipment while she was an inpatient, we were dropped into a life that we had no preparation for and no idea how to navigate: a world filled with medical equipment, home care nursing, and so much uncertainty for our child's future. In addition to all the teaching and navigating this new normal, we had to work with multiple supply companies, manage multiple medical appointments, and provide home care nursing, all while being parents to our other children. No hospital teach-back can prepare you for power outages, equipment failure, supply issues, or alarms sounding or providing around-the-clock care or navigating the medically complex world. I quickly realized there is more to home care than just teaching families how to use the equipment. As a parent, we are expected to assess and perform medical interventions at home to the same level as highly trained medical professionals in an ICU. Most of all, we had to figure out how to be a family that included a medically complex child."

We will provide an update when our local CARES center will be able to start enrolling families into this new comprehensive service.

SOCIAL DETERMINANT OF HEALTH-TRANSPORTATION

JACKIE POWELL, LEAD CARE COORDINATOR

Transportation is a Social Determinant of Health for the patients and families that we serve. From experience, on average, 1 in 10 patients have expressed transportation as a barrier. However, traveling to medical appointments is not the only challenge for patients and their families. Finding transportation for basic needs, such as grocery shopping, non-medical appointments, and other needed resources, remains a challenge. Even as the community begins to open up, many are still unsure of public transportation as we are still experiencing the pandemic.

The Care Coordinators can assist patients with transportation, insurance applications through the New York State Marketplace and scheduling many Pediatric appointments. When patients cannot attend their scheduled appointments, Care Coordination staff can reschedule in real-time and provide transportation as needed. In 2020 the Care Coordination team provided outreach to over 1,000 patients for their transportation needs.

As we embark on warmer weather in the Rochester sunshine, our care coordination team in the pediatric practice will continue to assist families with overcoming their transportation barrier. We will continue to be innovative and look for opportunities within our organization and in the community to make reliable transportation accessible for everyone.

PEDS PRACTICE NEWBORN WORKFLOW

KATE MILLER, CARE COORDINATOR

As a new member of the care coordinator team at the start of 2020, I'd had limited experience working through the newborn discharge workflow. The four-person care coordinator team alternated this process by the week. A care coordinator would schedule the newborn discharges at the start of the workweek, and then another care coordinator would take over the following week, and so on. This proved to be difficult for the care coordination and the nursing teams on the strong beginnings birth center and the NICU RN care coordinators. We revised the workflow and determined that the role would be best served if a single care coordinator took on the responsibility of the entire workflow. I became that care coordinator! Over the last year and a half, I've been fortunate enough to work with the wonderful, dynamic teams on the birth center and in the neonatal intensive care units. We've built relationships with these providers that allow us to communicate more efficiently with pending discharges.

The process starts with a referral to Golisano Children's Hospital Pediatric Practice, either by the parents or providers at the birth center. Once the referral is received, I will reach out to the expecting mother prior to the anticipated discharge date and schedule the 3-day newborn appointment and the 14-day appointment. If transportation is requested, I will also assist with securing this service, thanks to grant funding we have received. We've introduced a new program into the practice in February 2021, which provides a video visit service free of cost to the family to discuss lactation, feeding, available resources, and any additional questions with our registered nurses and nurse practitioners. While 2020 proved challenging and required adaptation, I believe something wonderful has blossomed from the struggle!

SUCCESS STORY
CRATRINA MEEKS, CARE MANAGER

"The King will reply, 'Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me.' (Matthew 25:40)

I know everyone does not have religious or spiritual beliefs, but for me, when deciding to go into this field, I had to keep that scripture at the forefront of my thoughts. Most people know that as Social Workers, we chose this field for passion and the love of helping others be successful, not money. I have been working as a Social Worker/Care Manager for about 15 years in different capacities, mostly working with youth. In my current role, we usually have 25-30 clients on our caseload ages 0-21. Each client has different needs. Some need assistance with minor things like appointment reminders or transportation issues, and others may need a lot more. Some families have limited resources, family support, education, and finances. My goal is to meet the family where they are and try to help their youth successfully advance, sometimes taking baby steps.
One client in particular that I have been working with, about 2 years has diabetes and a learning disability. Although my role as a Care Manager here is primarily to work with the child, we almost always work with the family unit as a whole. Mom had recently got custody of her child back, so she was in need of services and resources such as furniture, food, clothes, and appliances. As the care manager, I connected mom to Asbury for the clothing needs. We were able to get mom a refrigerator and beds. I even solicited gently used furniture from my personal friends for the family, which I picked up and delivered to the family. I submitted a requisition to our program to purchase other household needs for the family. We were able to get the child connected with KIRSH. The family relocated during this time but came back to Rochester suddenly due to an emergency situation in which the family had to leave everything and come back and start all over again. When the family arrived back in Rochester, they immediately were reconnected with our program and requested to have me as their Care Manager. Recently, I was able to get mom more furniture and clothing. I am still helping this family reconnect to other services that the child requires for his diabetes and medical needs. Working here at Golisano Children's Health Home program can be challenging at times, especially now during the pandemic. Some of the relationship-building pieces are missing since we have limited face-to-face contact with the family. However, it is rewarding.

SUCCESS STORY
JESSICA HOLLY, CARE MANAGER

One of my younger patients first came to our program with very limited supports. The family struggled with not knowing what they needed to best care for the child or what resources they could utilize within our community to have better developmental growth, emotional well-being, and overall health and happiness. The child was diagnosed with Autism and wasn't receiving the supports that they needed to be successful. The child had difficulty communicating, frustration tolerance, and limited providers other than primary care and school. Through care management services, we were able to assist the family with obtaining some of the basic needs that they were lacking, such as bedding and clothing that fit and helping the family understand the services available in the community how to access those services. I assisted the family in attending informational meeting sessions for OPWDD (Office for People with Developmental Disabilities) and obtaining all the necessary documentation to apply for services. During this process of applying for OPWDD, I also helped them schedule appointments, reminded and accompanied them to the appointments, and helped bridge the communication gap between the providers and the family. I coordinated with the school and assisted with making sure the child received the necessary supports within the school setting to grow and thrive. Throughout the course of the child being in the program, they started to communicate better, have decreased tantrums, and have more loving interactions with family members. As we worked through our care plan, the end goal was ultimately to obtain OPWDD services. The child was accepted and will now have a variety of services they can access to better support their development throughout their lifetime.

CHH Website Gets a Makeover

KATIE BIRGE, ADMINISTRATIVE ASSISTANT

The Christine M. CARES Center has worked diligently on creating a versatile website for our patients, providers, and community alike. We have revamped the website to make a better display and reader experience. The website plays an essential role with extensive knowledge of who we are, the services we provide, and community resources available to the public. We have delivered this in several different ways:

- The Legacy of Christine Burns
- Children's Health Home Program- what a Health Home is and how it can assist with the necessary care
- News & Events- view our newsletter and Adopt-A-Family
- Resources

We are excited about the results and how it will allow us to evolve the site moving forward, creating new topic areas and adding more valuable content. We would love to hear what you think of the new site and hope to improve based on your feedback.

Who Can Refer to Children's Health Home

MICHELLE TUOHEY, REFERRAL COORDINATOR

Children's Health Home is accepting referrals from the community (medical and behavioral health care providers, community organizations, 18 year old young adult and/or family members) for enrollment of eligible individuals. Individuals may also talk with their Managed Care Plan, doctor, specialist, hospital emergency room, and department of social services or contact us at any time to find of if they are eligible to enroll.

Some of the services care managers provide are:

- 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, financial needs

SUCCESS STORY

YAHAIRA VAZQUEZ-VALLE, CARE MANAGER

I have been a care manager for the Children's Health Home Program for almost two years. Being a care manager for the Children's Health Home Program has been fulfilling not only because you have a great team of care managers beside you, being a care manager has given me the opportunity to provide the support and assistance that families are in need of when they become part of our program. Care managers become an ally to the families providing guidance and giving them the tools needed to ensure that the children and the family as a whole become successful. It gives me great satisfaction to know that I can make a difference in someone's life, whether it is calling to schedule a doctor's appointment or connecting the family to community resources. No matter how small the impact is, just knowing that you can make a difference in someone's life is definitely rewarding!

Adopt- A- Family for the Holiday 2021

Many of our families are unable to financially support any additional purchases outside of basic needs. This is why we ask for support from the community to assist with making our families holiday season bright.

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

Children's Health Home – On the Move

- Janelle Harris- Completed her Master's in Business Administration and was promoted to Billing Administrator
- Donna Heintz- Completed her Master's in Social Work
- Stephanie Neufeglise- Completed her Master's in Social Work
- Currently recruiting for newly created Quality Assurance and Training Coordinator

CARES WISH LIST

- Bicycles/Helmets
- Board Games
- Backpacks
- Books
- Amazon Fire Tablets
- Crafts/Coloring Books/Crayons
- Cleaning Supplies/Equipment
- Fans
- Personal Hygiene Products
- Twin Size Bedding
- Pots and Pans
- Microwaves/Hot Plates
- Sport Items
- Diapers
- Recreational Activities

If you are interested in donating, please contact Cynthia Korpal at 585-472-5102 or Cynthia_Korpal@URMC.Rochester.edu

CONTACT US!

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E-Mail: ChildrensHealthHome@URMC.Rochester.edu

To Make a Gift, Click Here!