**Background**

The Children’s Health Center is a hospital-based, Level 3 NCQA-certified academic medical home at Children's National. We provide care to approximately 18,000 children per year including more than 1100 children with complex, multi-system medical needs. In 2011, we integrated the consultative Complex Care Program (CCP) at Children’s National into the Children's Health Center to combine resources and create a medical home for children with medical complexity (CMC).

**Key Activities for Integration**

- **Space & Equipment:**
  - Redesign to create three large exam rooms
  - Bed & wheelchair scales
  - Wall oxygen/suction

- **Inter-professional Training for Staff:**
  - Mobility and Accessibility
  - Feeding Tubes (including Simulation Center)
  - Tracheostomies and Emergency Preparedness
  - Augmentative Communication Devices
  - Cerebral Palsy
  - Supporting Grieving Families

- **Patient Registry:**
  - Creation of ICD-9/10-based CMC registry
  - Care delivery & population health functionality

- **Team-Based Care:**
  - Role Definition for Case Management, Social Work, Clinical Nurses & Parent Navigators

- **Coordination Across the Care Continuum:**
  - New Nurse Practitioner Role – part-time in Medical Home & part-time with HELP team

- **Pediatric Resident Training:**
  - Complex Care sessions during Outpatient Block

**Primary Care vs Consultative**

Families of CMC have option of primary care or consultative care coordination (maintaining a primary care provider in the community). The same range of services is provided to all children and families of CMC.

**Current Staffing**

- 0.7 Dedicated Provider FTE for Complex Care visits
- 7.8 Total Provider FTE (all providers with CMC as a portion of primary care patient panel)
- 2 RN Case Managers
- 2 MSW social workers
- 6 Parent Navigators
- 1 Case Management Liaison

**Reflections & Next Steps**

- **Benefits of Integration:** Full medical home resource availability & consolidation; cost offset for Complex Care Program by larger primary care practice; enhanced skill sets for all team members/providers; resident training opportunities; family centered care (ability to care for siblings at same visit).
- **Limitations of Integration:** Challenges for patient flow (especially urgent visits); confusing to external stakeholders; continuity of care in academic setting
- **Next Steps:** Introduction of Telemedicine for care coordination visits, enhanced use of data for health outreach and patient outcome tracking