Neonatal Social Work Care Coordination in the NICU and NICU Follow-up Programs

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Background: According to the Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee, "Care Coordination is an essential element of a transformed American health care delivery system that emphasizes optimal quality and cost outcomes, addresses family-centered care, and calls for partnerships across various settings and communities." The NICU Follow-up Program at Nationwide Children's Hospital monitors the developmental progress of eligible NICU graduates until the age of 3 years, but retention rates have been variable. The need for education and guidance to NICU families regarding recommendations for their child's follow-up and a process to identify and problem-solve barriers to care was much needed. This led to the development of Neonatal Social Work Care Coordination Services (NEOSWCCS). This specialized social work program specifically addresses the transition from hospital to home and provides partnership with families to help them better understand the goals of developmental surveillance and intervention as well as problem solve practical barriers to care which may interfere with program retention.

Content/Action: The poster will showcase this specialized program, Neonatal Social Work Care Coordination Services (NEOSWCCS), which was initiated in October of 2016. Patients discharged from the NICU are eligible for NEOSWCCS if they meet specific criteria potentially associated with non-adherence (e.g. parents with cognitive limitations, mental health issues, language barriers) or if the child's healthcare needs are especially complex. Once a patient is identified as eligible for NEOSWCCS, attempts are made by the Neonatal Social Work Care Coordinator (Neo SWCC) to meet families referred to the NICU Follow-up Program prior to their discharge from the NICU. The Neo SWCC provides parent education about the clinic their child will be attending and the importance of developmental monitoring and intervention. Barriers to follow-up care are also explored during this initial face-to-face intake and the Neo SWCC then links families with available resources to mitigate these barriers. In addition, the Neo SWCC completes a phone call approximately one week after discharge to asses for post-discharge needs and during the week prior to the initial developmental evaluation (typically at 3-4 months corrected age) to provide information regarding what to expect for the evaluation and explore barriers to care. The Neo SWCC has also led an initiative developing systems to follow up on non-compliance in

the clinics which includes a triage process for high risk patients. This has been a multidisciplinary effort rolled into standard operating procedures for the clinics.

Lessons Learned: Developing clear criteria for patient eligibility and having pre-existing clinical relationships with the multidisciplinary team in the NICU was essential. Both helped to identify patients, facilitate communication with the families, and for identification of barriers to care. Challenges during the implementation of this program include slower or missed identification of eligible families for NEOSWCCS during planned and unplanned absences of the Neo SWCC as well as an insufficient tracking system to evaluate circumstances affecting data.

Implications of Practice: The implementation of NEOSWCCS allows for targeted interventions specific to helping families transition from their NICU care to outpatient follow-up thus increasing the retention rates and developmental follow-up. The NICU Follow-up Program at Nationwide Children's Hospital averages 5,000 completed visits each year. Average completion rate of the D1 developmental evaluation (3-4 months corrected age) in the NICU Follow-up Program in 2016 was 52%. In 2018, the rate increased to 89% (for completion of initial developmental evaluation) for patients eligible for NEOSWCCS. Results will be illustrated through tables and will include data from 2019.