Complex Care Management Criteria for Pediatric Patients
[Updated: June 6, 2018]

Note: Patients who do not have a PCP that is part of the ACO should be referred to their Primary Care Provider, rather than to an ACO or MMP Complex Care Manager. This includes Intermed patients, Martin's Point patients, etc.

Criteria for pediatric patients who are candidates for complex care management:

Example include, but not limited to:

- New diagnosis of a chronic or complex condition
- Chronic disease that begins to worsen
- Uncontrolled/poorly managed disease
- Psychosocial challenges, coupled with a complex medical condition
- Mental health challenges, coupled with a complex medical condition
- Financial instability
- Missed a lot of appointments
- Multiple providers
- High utilization (i.e. multiple office visits; multiple ED visits; multiple IP visits; etc.)

Complex Care Management Best Practices for Pediatric Patients
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1) Assess understanding of post-discharge instructions
2) Teach back use of medications, inhalers, etc.
3) Coordinate follow up visits with providers, if needed (i.e. cardiologist, lab work, PCP, etc.)
4) Assess medication affordability
5) Assess transportation needs
6) Assess food insecurity
7) Assess financial status and provide assistance with applying for financial support programs
8) Connect to case management for long term support

Note: Additional home visits will be set up if appropriate (i.e. after follow up appointment with provider, discuss changes to medications, care plan, etc.)

Home Health: Pediatric Patient Referrals to Care Managers [Updated: June 6, 2018]