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 [Updated: June 6, 2018]

- 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.)

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

Inpatient Referral to CM Complex Care Management Intervention

Discharge Plan

Need for Complex Care Management Identified

Refer to "Criteria" on

Page 1

1) Pediatric patient meets complex care criteria

and

2) Is not being discharged to another facility or discharged with home health services,

and

Caregiver provides verbal consent to
Complex Care Management Intervention
 Services

Patient Education

Provider adds "Complex Care Management" to the discharge summary, which is provided to the patient.

Care Team educates patient that a Care Manager Nurse will call the patient

Referral

Epic Hospitals: Provider enters a referral in Epic for "MHACO Care Management"
Non-Epic Hospitals: Provider notifies
Central Navigation by phone (207-482-7089), fax (207-761-3078), or email ctiliaison@mmc.org

For MMP patients, Central Navigation will send the referral through the MMP Care Transitions Clinical Pool "940900" in Epic

Care Manager Nurse Outreach

MHACO Care Manager Nurse calls patient to set up an initial home visit.

MMP Care Manager Nurse will contact patient and set up initial meeting (i.e. at practice)

MHACO Complex Care Management

"6 Pillars" model of coaching
Home visit within 48-72 hours
Follow-up telephone calls weeks 1, 2 & 4
Additional home visit (if appropriate)
Expected discharge? Around 30 days

Care Manager Nurse engages Social Worker/Health Guide, Behavioral Health, Med Access, Health Plans, etc.

Refer to "Best

Practices" on

Page 1

MMP Care Management

After initial evaluation & assessment, patient/caregiver and Care Manager will develop plan of care and patient goals

Self Managing Is patient self managing?

No ▼ Complex Care Management Continued

"6 Pillars" model of coaching
Follow-up telephone calls every 1-2 weeks

Expected discharge? Around 2-6 months, depending upon patient's level of engagement and ability to self manage

MMP Care Management

MMP Care Management will continue to work on plan of care and patient goals

Discharge

END

Discharge patient (i.e. patient goals completed, patient is self managing, connected with a community resource, or a warm hand-off to their practice has occurred)