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.)
Need for Complex Care Management Identified
1) Patient being discharged from home health or declining home health services or...
2) Patient is receiving home health services but would benefit from wraparound services and...
3) Pediatric patient meets complex care criteria (see definition of complex) and...
4) Caregiver provides verbal consent to Complex Care Management Intervention Services

Patient Education
Home Health educates patient that a Care Manager Nurse will call them to schedule a home visit

Referral
Home Health team notifies Central Navigation by phone (207-482-7089), fax (207-761-3078), or email ctiliaison@mmc.org

For MMP Practices, send the referral through the MMP Care Transitions Clinical Pool “940900” in Epic, or call MMP CM at (207) 661-7906

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

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

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?
Yes
Discharge
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)

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