Care Coordination Toolkit

Proper Use of Coordination of Care Codes with Children and youth with Special Health Care Needs (CYSHCN)

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Developed by the Center for Infants and Children with Special Needs.
Cincinnati Children's Hospital Medical Center.
&
The National Center of Medical Home Initiatives for CSHCN

Proper use of Coordination of Care Codes with CYSHCN

Billing for the *Coordination of Care* codes requires an understanding of the individual codes, proper documentation, and an easy to follow billing slip.

Coordination of Care - Physician Management Codes:

These codes are for *physician time only* and, ideally, should not be used until verifying that the patient's insurer will cover them and the diagnoses that the care was provided for. For example, Ohio only reimburses for these codes through their Title V Program (BCMH) and will not cover these services if they are provided for a developmental or mental health diagnosis.

Prolonged Services (with direct patient contact)

These are used when a physician provides prolonged service in an inpatient or outpatient setting that is beyond the usual service provided. They can be billed in addition to the E/M code.

Inpatient	
99354	first 74 min
99355	each additional 30 min
Outpatient	
99356	first 74 min
99357	each additional 30 min

Prolonged Services (without direct patient contact)

This refers to such services as reviewing records, communication with other providers or the patient &/or family in either the inpatient or outpatient setting.

99358	first 74 min
99359	each additional 30 min

Case Management Services

This refers to *Team Conferences* needed to coordinate the activities of patient care. They may occur during a hospitalization or after discharge and the patient or family need not be present. **Each physician present can bill this code separately.

99361	approximately 30 min
99362	approximately 60 min

There are additional codes for *phone calls* which involve active management of a problem over the phone, i.e. the after hours call that prevents an ER visit. They can also be used when management or coordination involves phone communication with a pharmacy, lab, social worker, home care provider, therapist, or other physician.

99371	brief call (<10 Min)
99372	intermediate call (10-20 min)
99373	complex call (>20 min)

Please note: since the current telephone care codes do not have times assigned to them, the times included above are suggestions only.

To bill for *special reports* such as such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. This code is not an add on code (i.e., it does not have to be reported in conjunction with a face-to-face E/M visit) and it does not require face-to-face contact with the patient/parent. Medicare does not assign any relative value units to this code.

99080

Modifiers

The *modifier 25* should be used when symptoms requiring significant amounts of physician work beyond preventive care are encountered during a preventive medicine visit (checkups) of a child with special health care needs. This would be added to the end of E/M code and billed with the preventive medicine code. Thus, a 5yo with chronic lung disease, seizures, and feeding problems comes in for his yearly WCC and the physicians spends additional time evaluating and treating his chronic problems… The physician can then bill;

99393	5yo preventive care visit
99214-25	E/M code for the additional time spent on the child's special needs.

Care Plan Oversight

These codes refer to the *physician* *work spent over a 30 day period* to supervise the care plan for patients, i.e. development and review of care plans; review patient status reports, test results, and correspondence from other health care professionals. These codes do not signify the work done to initially set up the care plan.

99339 Home, domiciliary, rest home care 15-29 min
99340 Home, domiciliary, rest home care >30 min

99374 Home care when patient under the care of home health agency 15-29 min
99375 Home care when patient under the care of home health agency >30 min

99377 Hospice care 15-29 min
99378 Hospice care >30 min

99379 Nursing home 15-29 min
99380 Nursing home >30 min

Coordination of Care Non-physician Provider Codes

These codes cannot be reported by a physician nor can they be reported on the same day as Preventive Medicine Counseling codes (99401-99412).

CPT Health and Behavior Assessment/Intervention Codes

The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
96151	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment

The focus of the intervention is to improve the patient's health and well being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate the specific hearing-related problems.

96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with patient present)
96155	Health and behavior intervention, each 15 minutes, face-to-face; family (without patient present)

CPT Education and Training for Patient Self-Management Codes

- Used to report services provided by *non-physician* *providers*. If physicians provide these services, report evaluation and management codes or 99078
- Used to report educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional using a standardized curriculum for treatment of established illness(s)/disease(s) or to delay comorbidity(s)
- Standardized curriculum must be used in order to report these codes but can be modified as necessary for the clinical needs, cultural norms, and health literacy of the patient(s)
- For health and behavior assessment/intervention that is not part of a standardized curriculum, see codes 96105-96155
- Purpose is to each the patient/caregiver how to effectively self-manage the patient's illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient's professional healthcare team
- Education and training related to subsequent reinforcement or due to changes in the patient's condition or treatment plan are reported in the same manner as the original education and training

- The type of education and training provided for the patient's clinical condition will be identified by the appropriate diagnosis code(s) reported
- The qualifications of the non-physician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, non-physician healthcare professional society/association, or other appropriate source

98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
98962	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients

Healthcare Common Procedural Coding System (HCPCS Level II Codes

HCPCS "S" Codes (Temporary National Non-Medicare Codes)

S9441	Asthma education, non-physician provider, per session
S9445	Patient education, NEC, non-physician provider (NPP), individual, per session
S9446	Patient education, NEC, non-physician provider, group, per session
S9447	Infant safety (including CPR) classes, non-physician provider, per session
S9460	Diabetic management program, nurse visit
S9465	Diabetic management program, dietician visit

HCPCS "T" Codes (Established for state Medicaid agencies)

T1001	Nursing assessment/evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1004	Services of a qualified nursing aide, up to 15 minutes

Proper Documentation:
The *managing physician* must document all phone calls, care conferences, review of old records, subspecialty letters, test results, etc. as well as the time spent on each. Office staff who interact with the patient, family, other offices, &/or the physician must also document what they do but must also indicate the *time spent discussing and getting direction for the encounter with the managing physician*. Thus a nurse may spend 1 hour on the phone with the family dealing with a new problem and calling in new meds but the office can only bill for the time the nurse spent discussing and being directed by the managing physician which might only be 10 minutes.

Billing Form
This form should be easily accessible and can be placed in the front of the patient's chart and all staff involved in the patients care should fill it out **but remember it is only for physician time**. Per CPT Guidelines, "the complexity and approximate physician time of the care plan oversight services provided within a 30 day period determine code selection." Note: depending on the diagnosis/ICD-9-CM you enter can determine your eligibility to get reimbursed.

		PLAN of CARE	PHONE CALLS	CARE CONF	REVIEW RECORDS, LABS,TESTS			BILL TO:	
DATE	INITIALS	TIME	TIME	TIME	TIME	DIAGNOSIS	COMMENTS	INSURANCE	INSURANCE

Office Tips:

- Identify eligible patients, if billing to state programs (Appendix I)
- Label charts (Appendix I)
- Keep billing form in front of chart
- Train all staff to document care coordination activities
- Meet with your billing department to discuss strategies on how to bill for these codes. (For example, Title V may not be the payer of last resort in this situation and may be the first designated payer for these codes. Some systems are set up to bill private insurance and then Medicaid and then Title V and you may need to work on a new system to bill this properly.)
- Design a system for your practice on how to tally and submit billing information

Disclaimer: As codes change every year, please refer to the CPT and ICD-9-CM Manuals for final verification.

Appendices:

I. **Identification of CYSHCN: Tools and Strategies**
How to Label / Flag the Chart: Tools and Strategies

II. **Forms**

III. **How to Negotiate with Public and Private Insurers: Tools and Strategies**

IV. **Selected Vignettes**

Appendix I
Identification of CYSHCN: Tools and Strategies:
How to Label / Flag the Chart: Tools and Strategies

1. The Center for Medical Home Improvement Domain of Chronic Condition Management (CCM). This information is part of the medical home index tool kit and encompasses several issues relating to the extra layers of care and care continuity necessary for each child with special health care needs. Each of the six themes associated with this domain relates to a specific care and care continuity concern.
   1. Identification of Children in the Practice with Special Health Care Needs
   2. Care Continuity
   3. Continuity across Settings
   4. Cooperative Management Between Primary Care Provider and Specialist
   5. Supporting the Transition to Adult Health Care Services
   6. Family Support

   For the purposes of the toolkit, we have extracted the information only related to identification of children in the practice with special needs. For more information on the medical home index tool kit, go to:
   http://www.medicalhomeimprovment.org

2. **Responses from the Medical Home Listserv posted on March 1, 2004**

   Request: For practices involved in a quality improvement process to increase their *medical homeness* for children and youth with special needs and their families.

   > How did you start to identify children and youth with special needs in your practice/clinic? and how did you flag or label the chart once you identified your group? Please include any tools you used or developed.

DOMAIN 2: CHRONIC CONDITION MANAGEMENT

The domain of Chronic Condition Management (CCM) encompasses several issues relating to the extra layers of care and care continuity necessary for each child with special health care needs. Each of the six themes associated with this domain relates to a specific care and care continuity concern. CCM involves a set of special services for children whose chronic condition represents a significant impact upon their lives and upon the lives of their families (see CCM protocol on page 160, a more in-depth article is contained within the references in Section VI).

CHRONIC CONDITION MANAGEMENT:

2.1 Identification of children with special health care needs (CSHCN) in the practice

A *CSHCN* list is generated by applying a definition, the list is used to enhance care and/or define practice activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups). Diagnostic codes for *CSHCN* are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible practice database (see definitions and code lists pages 168-170).

Tangible Examples:

- After the practice chooses a definition of special health care needs, children fitting that definition have their files marked with an indicator (sticker, "CSHCN" or other electronic identifier or prompt) to identify them as having special needs.
- A complexity score indicating the level of care, care coordination and follow-up a child's condition is assigned to each CSHCN (see complexity scoring examples from Phoenix Pediatrics and the HOMES complexity score from the Center for Medical Home Improvements, pages 172-174).

Scenario #1

An identifier, such as "CSHCN" or "Special Needs" is used on the patient's computer file; this may be printed out on the "day sheet" and highlighted to help staff prepare for the visit. Staff will see this "flag" and be alerted to note modifications or plan for any family requests or accommodations during that child's appointment.

Scenario #2

ABC Pediatrics identifies children and families according to an applied definition; they ask for parent permission to "sticker" the chart and then provide a description of their medical home efforts to improve the quality of care. They then add the child to a "population list" and assign a HOMES complexity score to the child. This allows them to quantify and qualify their population, plan for care coordination needs and staffing, and demonstrate their efforts toward providing a medical home (see Exeter CSHCN definition, their medical home explanation, and the HOMES complexity scoring tool on pages 169, 171 and 173).

CHRONIC CONDITION MANAGEMENT:

2.2 Care Continuity

The team (including *PCP*, family, and staff) develops a plan of care for CSHCN which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up or cross coverage providers are informed by these plans. The practice/teams use condition protocols; they include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes and protocols which support children and families with these protocols.

Tangible Examples:

- Parents meet with their physician and care coordinator (every 6 months or at agreed upon intervals) to review their child's progress and to discuss goals and services for the next 6 months. The decisions are documented in the child's care plan that is copied and given to the parents before they leave the office (see Chronic Condition Management protocols pages 160-167 and sample care plans pages 139-146).
- Care plans include goals, services, interventions, and referral contacts. Tools and other standardized office processes which support these protocols (see Today's Concerns, Care Coordination Visit, a Family Journal, and Medical Care Plan examples on pages 139-146).

Scenario:

ABC Pediatrics meets with parents of CSHCH every 6 months to review their child's care plan. The practice has given each parent a family journal so they can monitor and track the medical needs of each their child. For parents of CSHCN the journal is the place where they keep information about their child's services – who is doing what and how often; they jot down questions and priorities for their next visit. At the end of each meeting the team reviews what has been discussed, who is responsible for which task and the timeframes by which to monitor and communicate with one another.

CHRONIC CONDITION MANAGEMENT:

2.3 Continuity Across Settings

Systematic practice activities foster communication among the practice, family, and external providers such as specialists, schools, and other community professionals for CSHCN; these methods are documented and may include information exchange forms or ad hoc meetings with external providers. A method is used to convene the family and key professionals on behalf of children with more complex health concerns; specific issues are brought to this group and they all share and use a written plan of care.

Tangible Examples:

- The pediatrician and care coordinator have regular meetings with parents, teachers, and school administrators to discuss the plans of care for children with special health care needs. Other social service agencies attend as needed.
- Tool supports include medical care plans, a patient education checklist, or forms designed for information exchange (see Gifford Pediatrics' Family/Practice School Information Exchange Form on page 175 and medical care plan examples on pages 139-146).

Scenario:

ABC Pediatrics has set up a regular protocol to meet with parents and school administrators, teachers or other providers at the school at intervals during the school year to assess a child's progress and to review goals and services.

CHRONIC CONDITION MANAGEMENT:

2.4 Cooperative Management Among Primary Care Provider and Specialist

The PCP and family set goals for referrals and communicate these to specialists; together they clarify co-management roles among family, PCP and specialists and determine how specialty feedback to the family and PCP is expressed, used, and shared. The family has the option of using the practice in a strong coordinating role; parents as partners with the practice manage their child's care, using specialists for consultations and information (unless they decide it is prudent for the specialist to manage the majority of their child's care).

Tangible Examples:

Parents and their PCP outline goals and define the roles they want the specialists to take; together they work with the specialists as a team to benefit their child (see specialist letter template, page 179).

- The specialist continues to provide treatments and communicates each time with the family and PCP; written, phone, and e-mail and Internet activity support this input.
- The PCP helps interpret medical information, including specialist information, with and for the parents, s/he connects parents to supports within the community.

Scenario:

> At ABC Pediatrics parents discuss with their primary care provider how they would like care to be coordinated among the various providers involved with their child. Parents may agree that their primary care provider will be responsible for the coordination of services and inform and interpret specialty care with and for the families.

CHRONIC CONDITION MANAGEMENT:

2.5 Supporting the Transition to Adult Health Care Services

Providers anticipate transition issues in advance, promoting children's self-competence; using a developed transition timetable they take an active role in identifying an adult primary care provider and in transferring care. As the transition age approaches, providers, family, and children include adult transition needs in the health care plan; specific actions may include maintaining the pediatric provider as a consultant to the new adult primary care provider or including the adult provider in the development of a transitional health care plan.

Tangible Examples:

- As a child/young adult approaches a transition, the provider supports them with anticipatory guidance; in adolescence they prepare parents and young adults by discussing options for future health care access (see transition tool/timetable, available 2002).
- The PCP and parents meet with adult care providers to discuss care plans and roles for each member of the child's health care team to take; knowledge of "what works best" is transferred
- Parents and providers communicate over the use of an office staff person or someone in a "Care Coordination" role being available to assist them with transitions.

Scenario:

ABC Pediatrics wants to help make pending transitions as smooth as possible. The practice follows a transition timetable which anticipates children and family needs at transition from pre-school to school, elementary to junior high, junior high to senior high, and transitions to college, work and adult health care. Attention to transition issues is evident in patient care plans and documentation. The practice promotes appropriate self-care and independence for teenagers and orients the adolescent and family to adult care providers. They each try to meet together with the adult providers to transfer knowledge and expertise about the child and to support the family in the adjustment to new providers. These transitions and methods to approach them are necessarily flexible.

CHRONIC CONDITION MANAGEMENT:

2.6 Family Support

The practice actively takes into account the overall family impact when a child has a chronic health condition by considering all family members in care; when families request it, staff will assist them to set up family support connections. The practice sponsors family support activities (e.g. skills building for parents of CSHCN on how to become a supporting parent); they have current knowledge of community or state support organizations and connect parents to them.

Tangible Examples:

- The role of an office care coordinator is developed; as a part of that role the care coordinator learns about and collects information on resources for families. The care coordinator then becomes a support for families and an educator to providers and staff.
- Knowledgeable of state programs and various types of supports the practice can better connect families to family support and to offer opportunities for families to connect with one another (see VT Parent to Parent and Family Voices) contact information on pages 205 and 206.

Scenario #1

ABC Pediatrics invites in a Parent-to-Parent resource person to attend their core team medical home improvement meetings; s/he is able to bring resources information to the group and identify gaps in practices knowledge that s/he can research and fill.

Scenario #2

XYZ Pediatrics invites existing state resource persons to their improvement meetings for in-services and for knowledge sharing.

CHRONIC CONDITION MANAGEMENT IN THE PRIMARY CARE SETTING

Chronic Condition Management in the primary care setting is a specific primary care practice which acknowledges that children with chronic conditions and their families may require more than the usual well child preventive care and acute condition interventions. Incorporating the Elements of Family-centered Care and founded on a belief in community-based services, CCM involves explicit changes in the roles of the primary health care provider and the office staff which are aimed at improving access to needed services, improving communication with specialists, schools, and other resources, and improving outcomes for children and families.

Chronic Condition Management may be initiated if a child's chronic medical condition meets one or more of the following criteria:

- impacts significantly on daily living and family life
- impacts on school performance
- impacts on development
- involves significant, on-going specialty care
- involves multiple agencies or professionals
- causes a new crisis (due to hospitalization, accelerating office or ERvisits, or major family stress)

Chronic Condition Management involves the following steps:

I. <u>Explicit</u> decision to shift from routine pediatric care to Chronic Condition Management based on the above criteria for CCM

II. Chronic Condition Management blends monitoring of a child's chronic condition with the other primary pediatric care services usually provided by the office such as well child care and acute condition care

III. Discuss initiating CCM with parents and with child
   A. Describe CCM in office (priority care; monitoring visits; etc.)
   B. Describe family support services in community
   C. Discuss roles and expectations of/by physician and parent
   D. Discuss child's participation in care/office visits
   E. Set initial agendas with parents/child
   F. Provide "Parent Notebook" and other educational materials

IV. Initiate CCM in office
- A. Flag child's record for CCM
- B. Add child's name to receptionist's CCM "priority list"
- C. Identify primary office contact person for family

V. Begin CCM monitoring process
- A. Periodic monitoring visits at primary care level
  - 1. Begin with family's/child's main issue "right now"
  - 2. Health provider's main issue "right now"
  - 3. Assess accomplishments since last visit
  - 4. Assess health/condition status (better/worse; meds; acute episodes)
  - 5. Incorporate scheduled general health maintenance needs*
  - 6. Review any subspecialty/special clinic contacts
  - 7. Review impact of chronic condition on:
    - a. School (absences, gym, meds at school, academics)
    - b. Child's life (sleep, social life/recreation)
    - c. Family life (changes in family life; siblings)
    - d. Financial (work, insurance, extra expenses)
    - e. Emotional impact (coping for child; parents)
  - 8. Review need for information or educational materials
  - 9. Promote/support condition self-management by child
  - 10. Review/revise care priorities; reset agendas
- B. Monitoring and management by specialists
  - 1. New referrals or involvement of specialists
  - 2. Review/revise planned visits
  - 3. Explicitly review roles/care responsibilities with specialists and discuss/review with parents
- C. Deal directly with challenges and frustrations
  - 1. Use direct parent/physician communication to get back on track
  - 2. Say "you don't know," but have ideas about how to find out
  - 3. Identify conflicts in perceived needs, roles, and expectations

VI. Beyond the office visit
- A. Develop system for priority scheduling
- B. Alert billing person/department to child's CCM status
- C. Initiate communication with school setting (letter to school)
- D. Initiate communication with specialists (referral letter)
- E. Provide "priority" method for parent/office communication

* For some children, one of the chronic condition monitoring visits might be designated an annual health maintenance visit to cover a broader health agenda (e.g. immunizations, lead screening, anticipatory guidance); for other children it may be appropriate to blend health maintenance throughout the chronic condition monitoring process.

Healthwatch for the person with cerebral palsy

Adapted from Crocker and Rubin (1989)

CONCERN	CLINICAL EXPRESSION	PREVALENCE	MANAGEMENT
Central nervous system	Infancy: altered muscle tone; delay in motor milestones; asymmetry; persistent primitive reflexes Preschool: development of motor, posture, gait patterns; prognosis about ambulatory level; need for assistive devices; watch hips Childhood: typical motor tasks more challenging; watch for deformities; scoliosis; hips Motor presentation may include hypotonia (which may progress to spasticity); athetosis; ataxia; dystonia; mixed tone/movements	All	Early intervention referral; physical therapy Pediatric orthopedics consultation Neuromotor clinic – Bureau of Special Medical Services
Altered muscle function	Weakness, slower movements	All	Physical therapy: stretching; positioning
	Extremities involved: diplegia; hemiplegia; quadraplegia		Pediatric orthopedics: bracing; surgery
	Muscle imbalance leads to contractures; dislocations; leg-length discrepancy; scoliosis		Other: intrathecal Baclofen; rhizotomy
Associated concerns	Cognitive impairments (MR, increased risk LD)	50% MR	Assessment; beware of assumptions about MR
	Visual impairments	>50%	Pediatric ophthalmologic consultation in all
	Hearing impairment (sensorineural)	5 – 15%	Audiologic consultation in all
	Seizures–all types (common in quadraplegia & hemiplegia)	30%	Neurologic consult; EEG; anticonvulsant
	Communication disorders	Common	Speech/language evaluation and intervention; augmentative communication evaluation
	Swallowing, feeding, GE reflux problems (caloric/fluid needs may be higher due to movement disorder)	Common	Pediatric GI evaluation; nutrition consultation; modified Barium swallow; gastrostomy tube
	Urinary tract problems (bladder dysfunction; infections)	Common	Pediatric urologic consultation
	Constipation	Common	Dietary or medical intervention
Emotional/coping issues	Adjustment/self-esteem issues	Common	Anticipatory guidance; encourage activity and involvement; inclusive education; psychosocial interventions
	Loss of function in some adults		Rehabilitation; physiatry

RESOURCES ON PERVASIVE DEVELOPMENTAL DISORDER

National Organizations:

Autism Society of America
7910 Woodmont Ave., Suite 300
Bethesda, MD 20814-3015
(301) 657-0881 or
1-800-3-AUTISM (information/referral)
(301) 657-0869 (Fax)

State Organizations:

Autism Society of New Hampshire
PO Box 68
Concord, NH 03302-0068
(603) 898-0916

Electronic mailing list on autism issues:

www.autism-society.org

Recommended Readings:

Denckla, M., & James, L.S. (Eds.). (May, 1991). An Update on Autism: A Developmental Disorder. (Supplement). Pediatrics, 87 (5).

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 4th edition). (1994). American Psychiatric Association: 1400 K. St. NW, Washington, DC 20005; pp 66-78.

Hart, C.A. (1993). A Parent's Guide to Autism-Answers to the Most Frequent Questions. Pocket Books: New York.

Powers, M.D. (Eds.) (1989). Children with Autism-A Parent's Guide. Woodbine Press: Baltimore.

Healthwatch for the person with pervasive developmental disorder*

Adapted after Crocker and Rubin (1989)

CONCERN	CLINICAL EXPRESSION	PREVALENCE	MANAGEMENT
Central nervous system Hallmarks: 1. Language disorder 2. Altered social interaction 3. Altered play and behavior	Infancy: PDD usually not identified until later; in retrospect some may have decreased eye contact, absent social smile, lack of "cuddliness;" motor delays present in some due to hypotonia or dyspraxia; prelanguage and early language acquisition may seem normal Preschool: Onset is nearly always before age 3; altered verbal/nonverbal, receptive/expressive language skills are evident by age 2 - 2 1/2; altered sociability; altered or narrowed repertoire of play interests; "odd" or idiosyncratic fascinations and behaviors; each of "hallmark" behaviors may be present on a continuum from mild to severe; many children have altered sensory responses including hyper- and hypoacusis or sound, visual stimuli, touch, smell, or pain Childhood: some children improve considerably by age 7 or 8; better initial language and/or social attachment forecast better prognosis; early intervention and preschool programs contribute noticeably to improved outcomes	All	Early intervention or preschool special education referral Audiologic evaluation in all to rule out hearing impairment as alternative cause for language delay Brain imaging is of minimal value at this point See "associated concerns" below
Altered muscle function	Normal to moderate involvement; many dyspraxic or "clumsy" for fine motor or gross motor; some are hypotonic	Many	Occupational therapy; rarely need physical therapy or pediatric orthopedics
Associated concerns	Cognitive impairments; often dramatic pattern of strengths and weaknesses; some children "hyperlexic" sight reading by age 2 1/2 or 3; others have computational or visual reasoning skills; musicality, precise imitative ability	Most	Skilled assessment; beware of assumptions of MR; many with PDD are "untestable;" helpful to look for cognitive strengths, e.g. visual processing to identify best educational methods
	Seizures—all types; Landau-Kleffner (aphasic epilepsy)	20-25%	Pediatric neurologic consultation; EEG
	Associated genetic conditions—e.g. Fragile X syndrome, neurofibromatosis, tuberous sclerosis, etc.; siblings at higher risk; high incidence of positive family history for PDD, learning disability, language disorders or delays, social awkwardness, mental illness; many have large head circ. and some have relatively large stature and/or large birth weight	10-15%	Genetics consultation; chromosomes, DNA tests
	Communication disorder	Universal	Augmentative communication consultation
	Behavioral issues; frustration, anger, anxiety; may be most significant stressor for family and other caregivers	Common	Respite care/other family supports; skilled behavioral consultation and planning; variety of psychopharmacologic approaches

*Pervasive Developmental Disorder (PDD) is a broad category which includes children with autism; other terms may also be found, e.g. autistic spectrum disorder, Asperger syndrome, Kanner syndrome, multisystem developmental disorder (MSDD), PDD-NOS (not otherwise specified)5/95

RESOURCES ON PERVASIVE DEVELOPMENTAL DISORDER

National Organizations:

Autism Society of America
7910 Woodmont Ave., Suite 300
Bethesda, MD 20814-3015
(301) 657-0881 or
1-800-3-AUTISM (information/referral)
(301) 657-0869 (Fax)

State Organizations:

Autism Society of New Hampshire
PO Box 68
Concord, NH 03302-0068
(603) 898-0916

Electronic mailing list on autism issues:

www.autism-society.org

Recommended Readings:

Denckla, M., & James, L.S. (Eds.). (May, 1991). An Update on Autism: A Developmental Disorder. (Supplement). Pediatrics, 87 (5).

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 4th edition). (1994). American Psychiatric Association: 1400 K. St. NW, Washington, DC 20005; pp 66-78.

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Powers, M.D. (Eds.) (1989). Children with Autism-A Parent's Guide. Woodbine Press: Baltimore.

Healthwatch for the Person with Down Syndrome

CONCERN	CLINICAL EXPRESSION	WHEN SEEN	PREVALENCE	MANAGEMENT
Congenital heart disease	Complete AV canal Septal defects Mitral prolapse	Newborn or first six weeks; later for mitral prolapse	40 - 50%;	Pediatric cardiology consultation; echocardiogram; surgery; dental prophylaxis
Hypotonia	Reduced muscle tone; increased range of joint movement; motor function problems	Throughout life; tends to improve with age	100%	Guidance by physical therapy early intervention program
Delayed growth	Usually near or below third percentile of general population for height	Throughout life	100%	Nutritional support; DS growth charts check heart/thyroid
Developmental delays	Some global delay, degree varies; specific processing problems; specific language delay	First year; monitor throughout life	100%	Early intervention Individual educational plan Language interventions
Hearing problems	Middle ear problems (fluid and infections) Sensorineural hearing loss	Audiology consult every six months until age 2, then annually	50-70%	Audiology, tympanometry ENT consultation Myringotomy tubes if needed
Vision problems	Refractive errors Strabismus Cataracts	Eye exam in 1st month; then annually	50% 35% 15%	Pediatric ophthalmologic consultation and appropriate treatment
Cervical spine problems	Atlanto-axial instability Skeletal anomalies May cause spinal cord injury	Initial x-ray screen at age 3 for AAI	15%	Orthopedic; neurology; neuro-surgery; avoid high risk activity; surgery if spinal cord compression
Thyroid disease	Hypothyroidism (rarely hyper-)	Some congenital; check annually	15%	Endocrinology consultation; replacement therapy
Overweight	Excessive weight gain	Late preschool; adolescence/adult life	common	Life style changes around food/exercise; check thyroid function; ?depression
Seizure disorder	Generalized or myoclonic; hypsarrhythmia	Any time	5-10%	Neurology consultation, EEG, medication
Emotional problems	Behavioral changes; depression	Adolescence; young adult	common	Inclusive education; counseling; support during transition from school to work
Dementia	Loss of adaptive skills; seizures; mood lability; rapid decline common	After age 40	20%	Neuropsychologic testing; neurology consultation; psychopharmacologic management (NSAID, anticholinergic)

Variable occurrence of: celiac disease; gastrointestinal anomalies; Hirschsprungs; leukemia; alopecia areata; diabetes; sleep apnea; hip dysplasia

RESOURCES ON DOWN SYNDROME:

National Organizations:

National Down Syndrome Society
666 Broadway
New York, NY 10012
1-800-221-4602 or (212) 460-9330

State Organizations:

Northern New England
Down Syndrome Congress
P.O. Box 617
Hudson, NH 03051
(603) 622-6904

Parent to Parent of New Hampshire
12 Flynn Street
Lebanon, NH 03766
1-800-698-5465 or 448-6393

Granite State Independent Living Foundation
P.O. Box 7268
Concord, NH 03301-7268
1-800- 826-3700 or (603) 228-9680

Recommended Reading:

Batshaw, M. L. & Perret, Y. M. Children with Disabilities: A Medical Primer (3rd ed.). Baltimore, MD: Paul H. Brookes Pubs. 1992.

Cooley, W.C. & Graham Jr., J.M. (1991). Down syndrome – an update and review for the primary pediatrician. Clinical Pediatrics, 30(4), 233-253.

Hanson, M. J. Teaching the Infant with Down Syndrome: A Guide for Parents and Professionals. Austin, TX: PRO-ED, Inc. 1987.

Pueschel, S. M. A Parent's Guide to Down Syndrome: Toward a Brighter Future. Baltimore, MD: Paul H. Brookes Pubs. 1990.

Pueschel, S. M. The Young Person with Down Syndrome: Transition from Adolescence to Adulthood. Baltimore, MD: Paul H. Brookes, Pubs. 1988.

Stray-Gunderson, K., ed. Babies with Down Syndrome: A New Parents Guide. Washington DC: Woodbine House, Inc. 1986.

DEFINITIONS OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

US Maternal and Child Health Bureau

Children with special health care needs as defined by the US Maternal and Child Health Bureau are those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997). Statistics show that this definition includes between 16-18% of all children.

Ruth Stein, et al (1993)

A chronic health condition must: 1) have a biologic, psychologic or cognitive basis, 2) have lasted or is expected to last at least one year, and 3) produces one or more sequelae including: limitation of function, activities, or social role; dependency upon medications, special diets, medical technology, assistive devices, or personal assistance to compensate for limitations; the need for related medical, psychologic, educational or other services over and above the usual for the child's age; or require ongoing treatments, interventions or accommodations at home or in school.

Foundation for Accountability (FACCT) screener identifies population of CSHCNs

The Children With Special Health Care Needs (CSHCN) screener was developed by FACCT in response to the need for a brief, standard, parent self-administered method to validly identify a denominator of children with chronic or special health care needs for the purpose of assessing health plan and provider quality. The results of the CSHCN screener can be used to stratify performance measures for children with and without special health care needs and to estimate the prevalence of CSHCN in health plans and other settings.

- The screener contains 5 questions, each with follow up parts asking about the presence and duration of any health conditions.
- There are 7 ways to qualify as a child with chronic or special health needs on the CSHCN screener
- The screener may be parent self-administered or telephone interviewer administered.
- The screener questions uses health consequences-based, rather than diagnosis-specific criteria, to identify children.
- The CSHCN screener takes 1-2 minutes to administer.
- The CSHCN screener has been field-tested by FACCT in sixteen different samples: 16-20% children in population-based samples were identified has having chronic or special health care needs, 50-65% were identified in samples prescreened using diagnostic criteria and over 95% identified in a population of children receiving SSI benefits.
- The CSHCN screener is not intended for in-depth, clinical assessment of a child’s health needs and should not be used for such.
- For more information about the screener: www.facct.org

EXETER PEDIATRICS

Children with Special Health Care Needs Identification Criteri

(Please place a pink sticker on the chart of any child/adolescent identified or at risk for a special health care need).

Chronic health conditions in children may:

- Last at least one year
- impact family and school life
- impact development
- Result in limited function/
- & involve dependence upon: activities, services, treatments, and special programs at distant centers, in the community, at home and/or in school.

Examples of chronic health conditions include but are not limited to:

BIOLOGICAL	PSYCHOLOGICAL	COGNITIVE	OTHERS WHO ARE "AT RISK" OR GENERATE CONCERN
asthma diabetes seizure disorders autism/PDD Down Syndrome bee sting/food allergies recurrent UTIs recurrent otitis media cerebral palsy hearing/serious vision impairments some pre-term infants developmental delay	depression eating disorders abuse/neglect substance abuse attachment disorder temperament disorder suicidal ideation or suicide attempt	ADD ADHD learning disabilities mental retardation language disorders processing disorders	Children/adolescents living: in poverty, in a foster home, with alcohol or drug dependent parents or guardians, with a depressed or ill parent(s), or amidst domestic violence. Pregnant teens or teens who demonstrate risky behaviors.

This definition is meant to provide guidance in identifying children with special health care needs. It is not meant to represent inclusion or exclusion criteria.
If you have a question about a particular child, please check with Greg Prazar, MD or Jody Couillard, Care Coordinator.

CENTER FOR MEDICAL HOME IMPROVEMENT
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)
Common ICD-9 Codes

ACNE	706.1
ADD	314.00
ADHD	314.01
ALLERGIC RHINITIS	477.9
ALLERGIES	995.3
ANXIETY DISORDER	300.00
ASTHMA	493.90
AUTISM	299.0
BEE-STING ALLERGY	989.5
BIPOLAR DISORDER	296.80
BRONCHOPULMON DYSPLASIA	770.7
CARCINOMA	140-239
CARDIO NEUROGENIC SYNCOPE	780.2
CEREBRAL PALSY	343.9
CHILD ABUSE	995.5
CHRONIC LIVER DISORDER	571.9
CHRONIC RENAL DISORDER	582.9
CHRONIC RESPIRATORY ORDER	519.9
CHRONIC SERIOUS OTITIS MEDIA	381.1
CHROHNS DISEASE	555.9
COLOBOMA	743.49
CONG.DACRYOSTENOSIS	743.65
CONGENITAL ANOMALIES	740-759
CONSTIPATION	564.0
CYSTIC FIBROSIS	277
DEPRESSION	311
DEPRESSION (ACUTE)	296.2
DEPRESSION (RECURRENT)	296.30
DEVELOPMENTAL DELAY	783.4
DIABETES	250.0
DYSLEXIA	784.61
DEVELOPMENTAL	315.02
ECZEMA	692.9
ENCORPESIS	787.6
ENCORPRESIS (NON-ORG. ORIGIN)	307.7
EPILEPSY	345.9
(GENERAL.NON-CONCLUSIVE)	345.0
EPILEPTIC CONVULSIONS	345.10-345.91
EXPRESSIVE SPEECH DELAY	315.39
FAILURE TO THRIVE	783.4
FEBRILE SEIZURE	780.31
FETAL ALCOHOL SYNDROME	760.71
FOSTER CARE	V61.29
FRACTURE	800-829
FRAGILE X	789.83
GASTROESOPHAGEAL REFLUX	530.1
GROSS MOTOR DELAY	783.4
HEAD TRAUMA	959.01
HEARING LOSS (SEVERE)	389
HEMPOHILIA	286.0
HIV	042
HYPERTHYROIDISM	242.9
HYPOLASTIC LEFT HEART	746.7
HYPOTHYROIDISM	244.9
IMMUNODEFICIENCY DISORDERS	279.3
JUVENILE RHEUMATOID ARTHRITIS	714.30
LEAD POISONING	984.9
LEARNING DIFFICULTIES	315.2
MENTAL DISORDERS	300.9
MUSCULAR DYSTROPHY	359
NYSTAGMUS	379.50
OBESITY	278.00
OBSESSIVE COMPULSIVE DISORDER	300.3
CHROHNS DISEASE	555.9
PANIC DISORDER	300.01
PKU	270.1
PREMATURITY	765.1
SCOLIOSIS (CONGENITAL)	754.2
(ACQUIRED POSTURAL)	737.30
CYSTIC FIBROSIS	277
SEXUAL ABUSE	995.53
SICKLE CELL DISEASE	282.6
SEIZURE NOS	780.39
SPECIFIC LEARNING DISABILITY	315.2
SPEECH/LANGUAGE DISORDER	315.31
STRABISMUS	378.9
TIC	333.3
TOURETTE DISEASE	307.2
TRAUMATIC BRAIN INJURY	850-854
UTI	599.0
VISION LOSS (SEVERE)	369.9
WERNIG-HOFFMAN	335.0
WITNESS TO VIOLENCE	V62.8

Add:

CSHCN CHART IDENTIFICATION & WHO NEEDS A MEDICAL HOME - EXPLANATION

Parent Permission to sticker/identify the chart as a CSHCN

We are trying to find a better way to give care to patients who have a condition lasting longer than a year by identifying the chart with a sticker (provide a medical home). Is that all right with you?
Explanation (this is printed on nice handout paper):

Who Needs a Medical Home?

There are over 200 different kinds of health conditions in children that may cause physical, emotional or learning challenges. Some examples of these health issues are: cancer, diabetes, depression, addictions, learning and developmental challenges, and living with adults who have physical or emotional health concerns.

We have formed a Caregiver/Parent team at Exeter Pediatrics as part of a project linked with The Hood Center for Children and Families at the Children's Hospital at Dartmouth. This partnership will promote quality care for children and families with health care issues. We would appreciate hearing your comments and suggestions to help us in this effort.

Many families want a central place where their children can receive medical care from knowledgeable and supportive professionals. They want medical "partners" who will work with them to keep their children healthy and to help them find needed supports and resources. This idea is called a "Medical Home".

At Exeter Pediatrics we are working hard to become an effective Medical Home for families we serve. We believe that supporting families not only promotes healthy children but also promotes healthy families.

If you would like to learn more about this project or have questions regarding your child's care, ask your health care provider or our Care Coordinator, Jody Couillard, at 772-8900 Ext. 175.

Complexity Index (Phoenix Pediatrics) David Hirsch, MD

Complexity	Description	Example
0	Well, no medical problems	Well Child
1	One moderate medical problem, involving one organ system with complications	Moderate asthma
2	One moderate or severe medical problem, involving one organ system with complications	CP, contractures
3	Two or more moderate or severe medical problems involving two or more organ systems	CP, epilepsy, MR
4	Two or more moderate or severe medical problems involving two or more organ systems with complications	Epilepsy, BPD, Tracheotomy, vent dependent

EXETER PEDIATRIC ASSOCIATES
"HOMES" COMPLEXITY INDEX

The purpose of this index is to identify the level of complexity/intensity involved in supporting children with special health care needs in our practice. See reverse side for explanation of terms.

Score each category 0, 1, or 2 (0 means no service, activity or concern)

Category	Criteria	Score
Hospitalizations, ER Usage & Specialty Visits (in last year)	1 = 1 hospitalization, ER or specialist visit for complex condition 2 = 2 or > hospitalizations, ER or specialist visits for complex condition	
Office Visits and/or Phone Calls (in last year, over and above well child visits, +/- extra charges).	1 = 1-2 office visits or MD/RN/care coordinator phone calls related to complex condition 2 = 3 or more office visits or MD phone calls for complex condition	
Medical Condition(s): One or more diagnoses	1 = 1-2 conditions, no complications related to diagnosis 2 = 1 or 2 conditions with complications or 3 or more conditions	
Extra Care & Services at PCP office, home, school, or community setting (see *Services*)	1 = One service from the list below 2 = Two or more services from the list below *Services*: Medications, medical technologies, therapeutic assessments/treatments/procedures, & care coordination activities.	
Social Concerns	1 = "At risk" family/school/social circumstances are present 2 = Current/urgent complex family/school/social circumstances are present	

Complexity Scores will range from 0-10 (0-3 low, 4-6 medium, 7-10 high).

Name ______________________________ Date __________ Total Score = _____

6/18/01

“HOMES” COMPLEXITY INDEX
GLOSSARY

A complexity score for each identified child will help providers/staff prepare and budget time more effectively for each child. It will also help administrators justify essential extra time spent by the practice in the care and support of the children and their families.

Medical Home: Community-based primary care provided by the practice which is: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent (American Academy of Pediatrics definition).

Children with Special Health Care Needs (CSHCN)/(Complex Condition): Children with special health care needs are defined by the US Maternal and Child Health Bureau as those children who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. The condition must be present for at least one year. These children require health and related services of a type or amount beyond that generally required by children.

Specialist Visit: Includes visits to MD’s, audiologists, feeding specialists and similar others.

MD Phone Calls: Includes time on phone with family, physicians, agencies/organizations, schools & others.

Complications: Medical, emotional, or social concerns related to the complex condition. For example, conditions which prove particularly difficult to manage, like depression or behavioral issues secondary to the complex condition, or learning difficulties and/or falling behind in school as a result of the condition (missed school or missed parent work days).

Medical Technologies: Some examples include G-tubes, infusions, tracheotomies, communication devices, or the need for other medial equipment and supportive technologies.

Therapeutic Treatments: Some examples include physical, occupational or speech therapies, respiratory treatments such as postural drainage or regular nebulizer use, counseling or other therapeutic interventions.

Care Coordination Activity Examples:
- Providing assessments and monitoring of child and family needs
- Participating in parent/professional practice improvement activities
- Offering supportive services including counseling, education and listening
- Facilitating communication among PCP, family and others
- Developing, monitoring, updating and following up with care planning and care plans organizing wrap around teams with families
- Supporting meeting recommendations and follow-up
- Coordinating inter-organizationally
- Advocating with and for the family (e.g. to school, daycare, or health care settings)
- Finding, coordinating and promoting effective and efficient use of current resources
- Monitoring outcomes for child, family and practice and other activities needed and/or requested by the child and family.

“At risk” circumstances: Children/adolescents living in poverty, in a foster home, with parents or guardians who are alcohol or drug dependent, depressed or ill, or living with domestic violence. Also at risk are pregnant teenagers and teens who demonstrate health risk behaviors (e.g. smoking, drugs, alcohol, firearms, dangerous driving habits, etc.).

GIFFORD PEDIATRICS
A MEDICAL HOME* FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCNS)

The purpose of this document is to enable parents/guardians, medical providers and appropriate school personnel to exchange information regarding a child's special health and educational needs and related services. While this document belongs to the child's parent or guardian, one copy will reside with the child's health care provider ____(Name/Practice), and one copy with the child's school____________________________(School Name).

Information Exchange for:____
Female______Male_______Date of Birth_______Grade_______School Year________

Parents/Guardian:_____________________________Phone Number:_______________
Preferred Method/Time of Contact:
____

Primary Medical Provider:______________________Phone Number:_______________
Preferred Method/Time of Contact:
____

Medical Care Coordinator: ______________________Phone Number:_______________
Preferred Method/Time of Contact:
____

School Contact(s) :___________________________Phone Number:_______________
Preferred Method/Time of Contact:____
____

Other Key/Medical Providers:
____Phone Number:_______________
____Phone Number:_______________

Permission Releases

I _____________________________________(parent/guardian) give permission to ___________________________(health care provider) to share *the information on this form* with my child's school___________________________(school name) via the named school primary contact. I give permission for my child's school to share *the information on this form* back to my child's provider____.

Signature:____Date:______________

When *this information* is discussed via phone, in person, or otherwise I would like:
___It to be documented in my child's chart where I may see it.
___A phone call informing me of said communication (within 24-36 hours).
___Other:____

Document created (date)_________Updated__________Next update due__________

Medical Information for Schools

To Be Filled Out By Provider and Parents/Guardian

Information Exchange for:______________________________

HEALTH INFORMATION AND MEDICAL NEEDS

I. Medical Data

Primary Diagnosis(es):______________________________

Secondary Diagnosis(es):______________________________

Other Specialties Involved:______________________________

____

Medications:______________ Medical Therapies/Treatments:______________

______________ / ______________

______________ / ______________

Special Instructions (and/or staff training):

____

____

This child's condition, illness symptoms, and/or medications/treatments may affect the following:

- ☐ Attendance
- ☐ Memory
- ☐ Attention
- ☐ Learning
- ☐ Fire drills
- ☐ Vision
- ☐ Hearing
- ☐ Triggers
- ☐ Thirst/Appetite
- ☐ Mobility/motor skills
- ☐ Peer Interactions
- ☐ Personality
- ☐ Toileting/Hygiene
- ☐ Continuity/Stability
- ☐ Participation
- ☐ Other______________
- ☐ Stamina/Fatigue
- ☐ Meals/ Foods/Feeding
- ☐ Transportation
- ☐ Academic testing
- ☐ Physical education
- ☐ Field Trips/ Events
- ☐ Playground/Recess
- ☐ Other______________
- ☐ Oral expression
- ☐ Articulation
- ☐ Written expression
- ☐ Listening comprehension
- ☐ Reading comprehension
- ☐ Math reasoning
- ☐ Sensori-motor integration
- ☐ Other______________

If a box is checked, please comment explicitly below:

____

____

____

____

____

____

____

NEEDS AND GOALS

The Individual Child/Family: Assets &Needs, Goals & Actions

____

____

____

____

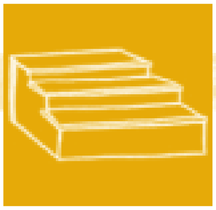
____

____

____

Parent/Guardian Signature: ______________________________ Date:______________

Provider Signature:______________________________ Date:______________ Next update:______



School Information for Provider:

To Be Filled Out By Provider and Parents/Guardian

Information Exchange for:____

SCHOOL SERVICES AND THERAPIES

I. The Child At School

Individualized Education Program (IEP): ☐ YES ☐ NO

Created (date):__________Last Review (date):______/______Next Review (date):_____/______/

Other Accommodations: ☐ YES ☐ NO

Describe:____

____

Related Services	✓	From an assistant?	Goals being met? Yes/No	Comments:
Occupational Therapy (OT)		Yes/No	Yes/No	
Physical Therapy (PT)		Yes/No	Yes/No	
Speech/Language		Yes/No	Yes/No	
Assistive Technology		Yes/No	Yes/No	
Other:		Yes/No	Yes/No	

Please comment on other related services (e.g. accommodations, assistive technology, school health/social/or counseling services, adaptive PE, etc). See the note section on back.

____

____

Concerns: This child's condition, illness symptoms, and/or medications/treatments may affect the following:

- ☐ Attendance
- ☐ Memory
- ☐ Attention
- ☐ Learning
- ☐ Fire drills
- ☐ Vision
- ☐ Hearing
- ☐ Triggers
- ☐ Thirst/Appetite
- ☐ Mobility/motor skills
- ☐ Peer Interactions
- ☐ Personality
- ☐ Toileting/Hygiene
- ☐ Continuity/Stability
- ☐ Participation
- ☐ Other______________
- ☐ Stamina/Fatigue
- ☐ Meals/ Foods/Feeding
- ☐ Transportation
- ☐ Academic testing
- ☐ Physical education
- ☐ Field Trips/ Events
- ☐ Playground/Recess
- ☐ Other______________
- ☐ Oral expression
- ☐ Articulation
- ☐ Written expression
- ☐ Listening comprehension
- ☐ Reading comprehension
- ☐ Math reasoning
- ☐ Sensori-motor integration
- ☐ Other______________

If a box is checked, please comment explicitly below:

____

____

NEEDS AND GOALS

Summary of School Goals, IEP, or Other Services:

____

____

____

____

Parent/Guardian Signature: ________________________________Date:________________

Provider Signature:______________________________________Date:________________Next update:______

GIFFORD PEDIATRICS
A MEDICAL HOME* FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCNs)

"Information Exchange" Notes

Medical/Family → Information for Schools

School/Family → Information for Provider

According to the American Academy of Pediatrics a medical home provides care that is accessible, family-centered, continuous, coordinated, compassionate and comprehensive. Parents and providers in partnership, working collaboratively with school professionals on behalf of their children are a part of a medical home.

11/16/99

REFERRAL FOR SPECIALTY CONSULTATION

Child's Name: ____________________________________ DOB: ________________________

Date: ___________________ Specialist referred to:_____________________________________

Date & Time of Appointment:____

Clinical Problem:

Specific Questions I need answered:

Parent/Child Concerns:

Ongoing Care desired:

______ Consultation without ongoing subspecialty care
______ Phone discussion about specific shared roles in disease management
______ Chronic condition management locally between subspecialty visits
______ Subspecialty management of all aspects of the chronic condition with acute and primary care locally.

Easiest time to contact me:

I would appreciate receiving a recent update or review article on:

____

Doctor's Name:
Clinic Title:
Street Address:
Town, State, Zip
Telephone/Fax/E-mail

Enclosed: ____ office/ hospital progress notes
____ lab results
____ X rays (____ family will hand carry)

Center for Medical Home Improvement, 2001

Responses from the Medical Home Listserv posted on March 1, 2004

Request: For practices involved in a quality improvement process to increase their *medical homeness* for children and youth with special needs and their families.

How did you start to identify children and youth with special needs in your practice/clinic? and how did you flag or label the chart once you identified your group? Please include any tools you used or developed.

Responses:

Getting Started | Identification Examples and Tools | Flagging the Chart | Lessons Learned | More Tools

Getting Started

The Center for Medical Home Improvement (CMHI) has put together recommended guidelines and information in their medical home tool kit on pages 168-172. It goes through how to facilitate the process of identifying CYSHCN with a practice and how to get started. The first suggestion is to figure out what is possible. Here is a brief outline of the process:

1) Determine to identify, flag and quantify their population
2) Pick a definition
3) Identify in real time, prospectively and add CSHCN to the problem list so that they can be pulled up by computer
4) Use natural opportunities to help them (flu shot clinics for example)
5) Identify and apply a complexity score
6) Develop the mentality of whenever a child is brought to their attention asking if they are identified
7) Being prepared to respond with why are you asking this/or doing this/or labeling my child and what is a medical home anyway.

Physician Recall and Computer Report by Diagnosis and Identification while in the Process of Care

▸ We originally started identifying CSHCN by recall and easily had a list of over 100 kids. We than ran computer reports for specific diagnoses to ID additional patients. Now new patients are referred by our MDs as they are identified (usually at a rate of 3-4 per week)
-Palmetto Pediatric and Adolescent Clinic. Columbia, SC

▸ We printed out a list of all of our patients, by primary care physician, and asked each doctor to highlight the patients that met criteria (their own criteria). We then got in a supply of sturdier charts and have been migrating the patients records to those charts as they come in or we have time. We continue to identify patients not picked up in the initial process as we see them - docs, nurses, even the occasional patient, has helped in this process.
-Utah Medical Home Project

▸ Doctors identify the patients and place them in order of importance for the care coordinator to contact. The practice has prioritized the list as all are not able to be served with/ the care coordinators limited number of work hours.
-Red Rock Pediatrics, AZ

▸ Referrals from PHN and observations within the clinic setting.
-Waianae Coast Comprehensive Health Center. Kaneohe, HI

▸ We've identified over 300 kids by 1) physician recall, 2) computer recall by diagnosis, such as Down Syndrome, autism, cerebral palsy, seizure disorder, prematurity, bipolar disorder, childhood malignancy, etc. and 3) identification while in the process of care (usually when you have gotten way behind taking care of a special needs child!) Our docs are starting to be more proactive in identification, especially after being given a list of kids they've already identified.
-Chapel Hill Pediatrics and Adolescents, P.A. Chapel Hill, NC

CSHCN Screener

▸ We conducted a study of the use of the CSHCN screener© (Bethell, Read, Stein et al., 2002) to identify this group of children in primary care settings. It shows potential for helping primary care providers identify this group. The reference for this paper is below.
-University of Missouri, Department of Health Psychology

The CSHCN Screener© is a five item, parent survey-based tool that responds to the need for an efficient and flexible standardized method for identifying CSHCN. The survey can be administered in person or by telephone. The screener is specifically designed to reflect the federal Maternal and Child Health Bureau definition of children with special health care needs. (4 pages).

Farmer, J.E., Marien, W.E., & Frasier, L. (2003). *Quality improvements in primary care for children with special health care needs: Use of a brief screening measure*. Children's Health Care, 32 (4), 273-285.

Title V list to start and then develop office criteria

We started by getting a list from our title V agency. It turned out to have about half of the kids we were seeing with complex health care needs, but gave us a start. But, lots of our Title V patients did not really need the care coordination services we are providing as part of our medical home project. So we came up with the following criteria for doing care coordination:

To be enrolled as a medical home project participant, a patient must have a chronic medical condition that would make them CRS (Title V) eligible AND

- 2 or more regular consultants
- Frequent ER visits
- Frequent hospitalizations
- Family support problems
- School problems
- Financial problems impacting access
- Mental health problems

-Beaufort Pediatrics, South Carolina

County and State Collaboration with Practices to Identify CSHCN

The Alameda County Medical Home Project in California has assisted their local primary care providers to identify CSHCN in their practices in several ways:

1. Provide practices with a list of their patients enrolled in CA's Title V program for CSHCN (called CCS). These data unfortunately often are out of date, but it's a start (few PCPs already have these children noted in any accessible way), and they take corrections from the PCPs and forward them to CCS program staff so they can correct their database.

2. Facilitate Primary Care Physicians (PCP) getting a list of their patients who are active CCS clients from the county Medicaid managed care plan; this list will include only those children who are members of that plan (the alternate plan is private and statewide and does not share its data by county), but it's another way to expand PCP knowledge. Also, as in above, we forward to the local CCS program any changes noted in PCP for CCS kids based on the plan's list so CCS can correct its database.

3. Our project's parent body, the Alameda County Committee on Children with Special Needs, developed a Special Needs Risk Factor Scale (Guidelines) a number of years ago specifically to identify those children who need more assistance in the primary care setting. The Scale was explicitly designed to include psychosocial risks since our experiences indicated that for many providers, the psychosocial issues were more difficult to handle in the primary care setting than the medical conditions. Five years ago we negotiated an agreement with our county Medicaid managed care plan to pay a risk-adjusted primary care capitation rate to pediatricians (and now family physicians) serving children who reach a threshold score of 4 points on the Scale. Our Medical Home Project encourages medical home practices to attend the Risk Factor Scale training and to participate in the risk-adjusted capitation program. It's a win-win: PCPs identify both medical and psycho-social risks in their patients, which enhances their ability to serve as medical homes to these kids and their families, and PCPs serving children with moderate or high needs (as determined by the Scale) get more money from the plan. We have responded to PCP feedback (through surveys we've conducted over the years) and made some changes in the Scale, and we collaborate with the plan to analyze the data from the Scales to determine what other steps we should take to assist PCPs and families.

Flagging the Chart

▸ We changed the plain manila charts to bright blue charts for each of the identified patients. We also changed the patient's status in are computer to read "CSHCN" and added an audible notification whenever the account is accessed. EVERYONE in our offices knows that a blue chart means CSHCN.

We then developed a "Care Plan" which is posted in the front of the chart as well as shared with each of the child's providers from schools to other MDs and therapists. The family is also given a copy of the care plan along with a letter to keep handy if they should ever need to call EMS, be seen out of town, etc.
-Palmetto Pediatric and Adolescent Clinic. Columbia, SC

- We put a * behind the name in the computer. This will then come up whenever they call for an appointment or with questions. There also is a list of diagnosis, medications, specialists, etc that this triggers at each encounter.
  -Reading Pediatrics – Wyomissing, PA

- By placing a MEDICAL ALERT label on the outside of patient's chart and by placing a comment in our computer system which, when the patient was pulled up, would tell the operator to allow more time for appointments.
  -Pediatricians of West Houston

- We use a computerized scheduling system, and all my special needs patients have notes attached to their names as "extra-time" patients. The schedulers know to book them differently, roughly twice the time of an otherwise healthy child. There are occasional glitches, but in general it works for me.
  -The Everett Clinic - Mukilteo, WA

- We have an electronic medical system called Encounter Pro from JMJ technologies which allows alerts to be placed on the patient's chart so the alert is the first thing you see when you enter the chart. We put our special needs children's diagnoses there. It is also easy to see the diagnoses from previous visits when scrolling through the chart.
  -Growing Up Pediatrics - Cornelius, NC

- Once the child is identified, their chart is marked with a non-stigmatizing green sticker, and marked as "Special" in Medical manager to alert the schedulers to give more time for that appointment.
  -Chapel Hill Pediatrics and Adolescents, P.A. Chapel Hill, NC

- We marked the charts with a piece of colored tape, and have been adding other children as they come into the office. Since the charts are marked, it's easy to tell when the patients come in if we have already added them to our registry.
  -Beaufort Pediatrics, South Carolina

- Once I've contacted the patient and they choose to be part of the Medical Home program, their file is change to another color. Because of the color of the chart, the staff knows when any information comes in about this patient, the chart goes to me. When I meet with the patients, the notes are in the chart so everyone can review them.
  -Red Rock Pediatrics, AZ

- Our front office staff have a list of Highly special need patients that are provided with longer appointment times and not made waiting for prolonged periods in the waiting area.
  -Waianae Coast Comprehensive Health Center. Kaneohe, HI

A three step approach to identifying CYSHCN and providing comprehensive, coordinated care:

1. We have a front summary sheet where we list all " encounters" and a "problem list". The front summary sheet also has all the "well child" periodicity components with a blank indicated for result or action. On a monthly basis when we have our clinic meeting, 5-10 charts are pulled for each pediatrician and the physicians, assistants, nurses and we do a 10 minute audit of a particular item. Examples; review last encounter and determine if is was recorded; look for referrals and see if result is present etc and acknowledged. Continuing quality improvement, quality assurance-it has a lot of names but as pediatricians we know behavior changes in small steps.
2. Most helpful , however, is that the staff pulls all charts the day before a visit and we review them the day before as mini teams-nurse, assistant, front office-we have work sheets on the each chart with notes as what is to be done. Sure , many patients are scheduled the same day but the staff "looks" for the sheet and reviews. It creates an office "culture" of all caring for the patient. We also call mom, dad, and family and include them in the team process by asking that they bring in info-school report, audiology report etc if we do not have it in the chart. It improves our care and also improves our efficiency. We are not continually looking for charts; attempting to secure a referral result while the child and family are in the clinic. Our care is also more comprehensive - less likely to miss a routine immunization on a patient with many other needs.

3. Once a month we invite an agency in our area to have lunch with our staff. Community health services, early intervention, homes for runaway teens, children's protective services, school personnel, home infusion etc. We realize that there are many others in the community that participate in the health of children and we like to get to know one another.

   -Portland, OR

Lessons Learned

There are lists on chronic diseases, lists on conditions considered special healthcare needs, however, I find it the most practical to have each practice define who or what conditions they want to track and benefit from the medical home model understanding that then ideal is "for every child to have a medical home" and not only those with special needs. The way you define this group defines the volume of the program which is an important consideration. For instance we do not include in the list all children with chronic OM. We include some of them if they have an associated problem such as delayed speech or hearing loss. In other words start small and try it out; then include other conditions once the program is running with some degree of efficiency.
-New Mexico Medical Home Project

The National Center has compiled a list of formal assessment tools to identify children and youth with special needs that are available at: http://www.medicalhomeinfo.org/tools/identify.html

Appendix II: Forms

1. Medical Home Care Coordination Tool Physician Care Management Billing Office Form: A form to record care coordination activities by all staff. Developed by the Center for Infants and Children with Special Needs at Cincinnati Children's Hospital Medical Center.

2. Medical Home Care Coordination Measurement Tool: A form to record care coordination activities by all staff. Recommendations and guidelines on scoring the measurement tool included. Developed for the National Study of Care Coordination Costs in Medical Homes by Nashaway Pediatrics, University of Massachusetts Memorial Community Medical Group and the Department of Pediatrics, University of Massachusetts Medical School.

3. Billing Office Form. This form will allow you to consolidate all of the care coordination activities by patient, diagnosis, and activity.

It is recommended that the care coordination tools be placed in the front of the patient chart for easy access which will improve on time documentation. These forms will most likely need to be adapted to fit your practice and billing needs.

PHYSICIAN CARE MANAGEMENT BILLING
MONTH(S)/YEAR:

NAME: ______________________________ MR#: ____________ DOB: __________
INSURANCE: (NEEDS SPECIFIC DX) ______________________ BCMH: ______________

		POC	CALLS	CONF	REVIEW			BILL TO:	
DATE	INITIALS	TIME	TIME	TIME	TIME	DIAGNOSIS	COMMENTS	INSURANCE	INSURANCE

* POC (Plan of Care) | Calls (Phone Calls) | Conf (Care Conference) | Review (Review records, labs tests)

Medical Home Care Coordination Measurement Tool©

Patient Name	Date	Patient Study Code And Age	Patient Level	Focus	Care Coordination Needs	Activity Code(s)	Outcome(s)		Time Spent*							Staff	Clinical Comp.	Initials
							Prevented	Occurred	1	2	3	4	5	6	7			

Patient Level

Level	Description
I	Non-CSHCN, **Without** Complicating Family or Social Issues
II	Non-CSHCN, **With** Complicating Family or Social Issues
III	CSHCN, **Without** Complicating Family or Social Issues
IV	CSHCN, **With** Complicating Family or Social Issues

Focus of Encounter (choose **ONLY ONE**)

1. Mental Health
2. Developmental / Behavioral
3. Educational / School
4. Legal / Judicial
5. Growth / Nutrition
6. Referral Management
7. Clinical / Medical Management
8. Social Services (ie. housing, food, clothing, ins., trans.)

Rev-03/20/03

Care Coordination Needs
(choose **all that apply**)

1. Make Appointments
2. Follow-Up Referrals
3. Order Prescriptions, Supplies, Services, etc.
4. Reconcile Discrepancies
5. Coordination Services (schools, agencies, payers etc.)

Time Spent

1 – less than **5** minutes
2 – **5 to 9** minutes
3 – **10 to 19** minutes
4 – **20 to 29** minutes
5 – **30 to 39** minutes
6 – **40 to 49** minutes
7 – **50** minutes and greater*
(*Please NOTE **actual minutes** if greater than 50)

Staff

RN, LPN, MD, NP, PA, MA, SW, Cler

Clinical Competence

C= Clinical Competence required
NC= Clinical Competence not Required

Activity to Fulfill Needs
(choose **all that apply**)

1. **Telephone discussion with:**
   - a. Patient
   - b. Parent/family
   - c. School
   - d. Agency
   - e. Hospital/Clinic
   - f. Payer
   - g. Voc. / training
   - h. Pharmacy
2. **Electronic (E-Mail) Contact with:**
   - a. Patient
   - b. Parent
   - c. School
   - d. Agency
   - e. Hospital/Clinic
   - f. Payer
   - g. Voc. / training
   - h. Pharmacy
3. **Contact with Consultant**
   - a. Telephone
   - b. Meeting
   - c. Letter
   - d. E-Mail
4. **Form Processing**: (eg. school, camp, or complex record release)
5. **Confer with Primary Care Physician**
6. **Written Report to Agency**: (eg. SSI)
7. **Written Communication**
   - a. E-Mail
   - b. Letter
8. **Chart Review**
9. **Patient-focused Research**
10. **Contact with Home Care Personnel**
    - a. Telephone
    - b. Meeting
    - c. Letter
    - d. E-Mail
11. **Develop / Modify Written Care Plan**
12. **Meeting/Case Conference**

Outcome(s)

1. As a result of this care coordination activity, the following was **PREVENTED** (choose **ONLY ONE**, if applicable):
   - 1a. ER visit
   - 1b. Subspecialist visit
   - 1c. Hospitalization
   - 1d. Visit to Pediatric Office/Clinic
   - 1e. Lab / X-ray
   - 1f. Specialized Therapies (PT, OT, etc)

2. As a result of this care coordination activity, the following **OCCURRED** (choose **all that apply**):
   - 2a. Advised family/patient on home management
   - 2b. Referral to ER
   - 2c. Referral to subspecialist
   - 2d. Referral for hospitalization
   - 2e. Referral for pediatric sick office visit
   - 2f. Referral to lab / X-ray
   - 2g. Referral to community agency
   - 2h. Referral to Specialized Therapies
   - 2i. Ordered prescription, equipment, diapers, taxi, etc.
   - 2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
   - 2k. Reviewed labs, specialist reports, IEP's, etc.
   - 2l. Advocacy for family/patient
   - 2m. Met family's immediate needs, questions, concerns
   - 2n. Unmet needs (**PLEASE SPECIFY**)
   - 2o. Not Applicable / Don't Know
   - 2p. Outcome Pending

R. Antonelli, MD, FAAP

Supported by grant HRSA-02-MCHB-25A-AB

Scoring the Medical Home Care Coordination Measurement Tool Guidelines and Recommendations

(Developed for the National Study of Care Coordination Costs in Medical Homes)

(Supported by MCHB grant HRSA-02-MCHB-25A-AB)

Patient Name	**This part of the form is for your internal use only. You should write the patient's name in this box.**

Date	**Record the date of the care coordination encounter. Be certain to document activities each day. <u>Recommendation:</u> If you don't have an outcome by the end of the day, but you've spent 40 minutes trying to coordinate home care for a patient (for example), document the 40 minute care coordination activity for that day and code the Outcome as "2p" or "Outcome Pending". If you pick up the task the next day, and complete it in 10 minutes, you would enter a 10 minute care coordination encounter for the new day, and code the outcome "2g" or "Referral to a Community Agency".**

Patient Level	**Patient Level** <u>Level</u> <u>Description</u> **I** Non-CSHCN, **Without** Complicating Family or Social Issues **II** Non-CSHCN, **With** Complicating Family or Social Issues **III** CSHCN, **Without** Complicating Family or Social Issues **IV** CSHCN, **With** Complicating Family or Social Issues	**If the clinical staff person who codes the complexity has any question as to the correct Patient Level, the patient's Primary Physician should be consulted.**

Checklist for Determination of CSHCN

1. Does this child HAVE a physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months? Yes ___ No ___
   (If "No" or Don't Know, continue to #2)

2. Is this child AT RISK FOR HAVING a physical, developmental, behavioral, or emotional condition that is expected to last at least 12 months? Yes ___ No ___
   (If "No" or Don't Know, continue to #3)

3. Does this child require health and related services of a **type** OR **amount** beyond that required by children generally? Yes ___ No ___
   Includes: Medicines prescribed by a doctor (other than vitamins)
   Medical Care
   Mental Health Services
   Educational Services
   Specialized Therapies (PT, OT, Speech)
   Treatment or Counseling for emotional, developmental or behavioral problems
   (If "No" or Don't Know, continue to #4)

4. Is the child limited or prevented in any way in his or her ability to do the things most children of the same age can do, due to a **chronic** medical, behavioral or other health condition?
Yes ___ No ___

(Checking "Yes" to any of the four questions places the child in either Level III or IV, depending on the presence of complicating family or social issues)

Some examples of "Complicating Family or Social Issues":

- Single Parent Home
- Divorce
- Language Barrier
- Drug / Alcohol Abuse in home
- Homelessness
- Loss of Job
- Undocumented Immigration Status
- Mental Illness in home

Focus	**Focus of Encounter**	**Decide how to document this section**
       	1. Mental Health 2. Developmental / Behavioral 3. Educational 4. Legal / Judicial 5. Growth / Nutrition 6. Referral Management 7. Clinical / Medical Management 8. Social Services (ie. housing, food, clothing, ins., transportation)	**Do you want staff to document ONE area of focus per CC encounter or all that apply? It is recommended to list all, with the primary focus first.** **If there are several areas of focus, you may decide to document them on separate lines as distinct CC encounters.**

This tool will assist you to breakdown a care coordination encounter into four components.

- The **FOCUS OF THE ENCOUNTER**, list the primary focus area first.
- The **CARE COORDINATION NEEDS**, which documents all the areas of need to satisfy the care coordination encounter. You should document ALL THAT APPLY.
- The **ACTIVITY TO FULFILL the NEEDS**, which records precisely what you did and for which you document the amount of time it took you to complete the activities. You should document ALL THAT APPLY.
- The last component is the **OUTCOME(S)**. Outcome is divided into two parts – what was PREVENTED (choose ONLY ONE) and what OCCURRED (choose ALL THAT APPLY).

Care Coordination Needs	**Care Coordination Needs** (choose **all that apply**)	**<u>Recommendation:</u> Write in all Needs that apply for that CC encounter.**
      	1. Make Appointments 2. Follow-Up Referrals 3. Order Prescriptions, Supplies, Services, etc. 4. Reconcile Discrepancies 5. Coordination Services (schools, agencies, payers etc.)	**Reconciling discrepancies refers to such needs as hunting down missing data, miscommunications between family/specialists/agencies/etc, and compliance issues.**

NOTE:

- There are FOUR boxes on the entire CCMT that can contain multiple entries (if the CC encounter included more than one)
  - Focus of Encounter
  - Needs
  - Activity to Fulfill Needs
  - Outcome – Occurred

All other boxes can contain ONLY A SINGLE ENTRY.

Recommendation:
Decide on entry standards – what areas must be completed and what sections are "if applicable."

Activity Code(s)	**Activity to Fulfill Needs** (choose **all that apply**)	
	1. Telephone discussion with: a. Patient e. Hospital/Clinic b. Parent/family f. Payer c. School g. Voc. / training d. Agency h. Pharmacy **2. Electronic (E-Mail) Contact with:** a. Patient e. Hospital/Clinic b. Parent f. Payer c. School g. Voc. / training d. Agency h. Pharmacy **3. Contact with Consultant** a. Telephone c. Letter b. Meeting d. E-Mail **4. Form Processing**: (eg. school, camp, or complex record release) **5. Confer with Primary Care Physician** **6. Written Report to Agency**: (eg. SSI) **7. Written Communication** a. E-Mail b. Letter **8. Chart Review** **9. Patient-focused Research** **10. Contact with Home Care Personnel** a. Telephone c. Letter b. Meeting d. E-Mail **11. Develop / Modify Written Care Plan** **12. Meeting/Case Conference**	**How does a staff person decide whether an activity they are performing is recordable for the study?** **Recommendation:** **If in doubt, RECORD IT!**

If it is necessary to perform several activities in the process of performing the care coordination encounter, you should list all the activities on this line and enter the combined total number of minutes required to complete these activities.

For example, you are trying to assist a family in refining an educational plan (IEP) for their learning disabled child at school.
As mentioned on the previous page,

- The **Focus** of the Encounter is (3) Educational.
- The Care Coordination **Needs** are primarily (5) Coordination of Services.

The **Activities** you perform may include:

- (1b) Telephone discussion with Parent/family,
- (1c) Telephone discussion with School,
- (12) Setting up a Meeting,
- (3c) Sending out a Letter to the Specialist/Consultant and
- (7b) Sending a confirmatory letter to the School.

All of these Care Coordination Activities are required to fulfill the Needs of the encounter, and their combined time should be recorded.

There is likely not an **Outcome – Prevented**, however if the family had needed to book a visit with the Specialist in order to sort out the problems, you would code (1b) as outcome prevented.

The **Outcomes – Occurred** might include:

- (2j) Reconciled discrepancies between the School, the family and the Specialist
- (2k) Reviewed reports and proposed IEP's
- (2m) Met family's needs, questions and concerns

<table>
<tr><th colspan="2">Outcomes(s)</th><th rowspan="2">Outcome(s)</th></tr>
<tr><th>Prevented</th><th>Occurred</th></tr>
<tr><td></td><td></td><td rowspan="8">1. As a result of this care coordination activity, the following was PREVENTED (choose ONLY ONE, if applicable):
1a. ER visit
1b. Subspecialist visit
1c. Hospitalization
1d. Visit to Pediatric Office/Clinic
1e. Lab / X-ray
1f. Specialized Therapies (PT, OT, etc)

2. As a result of this care coordination activity, the following
OCCURRED (choose all that apply):
2a. Advised family/patient on home management
2b. Referral to ER
2c. Referral to subspecialist
2d. Referral for hospitalization
2e. Referral for pediatric sick office visit
2f. Referral to lab / X-ray
2g. Referral to community agency
2h. Referral to Specialized Therapies
2i. Ordered prescription, equipment, diapers, taxi, etc.
2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
2k. Reviewed labs, specialist reports, IEP's, etc.
2l. Advocacy for family/patient
2m. Met family's immediate needs, questions, concerns
2n. Unmet needs (PLEASE SPECIFY)
2o. Not Applicable / Don't Know
2p. Outcome Pending</td></tr>
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</table>

It is often the case that nothing is “Prevented” as an outcome of the care coordination activity. In this case, enter “0”. However, if your efforts in care coordination prevented a child from needing to go to the emergency room, for example, please enter “1a” under Outcome – Prevented. If your careful care coordination resulted in a child avoiding a duplicate or perhaps unnecessary X-ray or Lab procedure, please code “1e”.

Every care coordination encounter should have an outcome that “Occurred”. Some encounters may have several outcomes that occurred. If you are uncertain how to code the outcome of the encounter, you can code “2o”.

IMPORTANT: If, after all your time and effort spent in CC activities, there remains an unmet need, it is recommended that you list under <u>Outcomes – Occurred</u> as “2n” or “Unmet Needs”, and briefly document, ie:

- **Unable to obtain mental health services**
- **Insurance denied durable equipment request**

Time Spent*							**Time Spent**
1	**2**	**3**	**4**	**5**	**6**	**7**	
							1 – less than **5** minutes **2** – **5 to 9** minutes **3** – **10 to 19** minutes **4** – **20 to 29** minutes **5** – **30 to 39** minutes **6** – **40 to 49** minutes **7** – **50** minutes and greater (***Please NOTE **actual minutes** if greater than 50) **Check ONLY ONE Time Spent Box**

Staff	**Staff**	
	RN, LPN, MD, NP, PA, MA, SW, Cler	**Please document the staff category of the person who completed the Care Coordination activity.** **It is essential that ALL staff who perform care coordination activities document their work on the CCMT.**

Clinical Comp.	**Clinical Competence**	
	C= Clinical Competence required NC= Clinical Competence not required	**In the opinion of the person filling out each CCMT encounter, did this activity require clinical knowledge or training to complete?**

Initials	**Finally, you should put your initials as the last entry for each CC encounter. If the other staff or the billing office, have any questions about your entry, they will know whom to contact for clarification.**

Monthly
Charge: Month ______
Day ______
Year ______

		Dx		Care Plan Oversight		Phone Calls			Care Conf		Review Records	
Acct #	Patient	Code	MR#	99993743	99993750	99993719	99993727	99993735	99993610	99993628	99993586	99993594

Appendix III: How to Negotiate with Public and Private Insurers
Tools and Strategies

1. The Shared Responsibilities Toolkit: Tools for Improving Quality of Care for Children with Special Health Care Needs (CSHCN) is available on the New England SERVE website www.neserve.org . This publication (2002, 75pages) is designed to focus the attention of health plans on CSHCN. The Toolkit includes an 8-page introductory booklet, and fifteen additional tools that can help plans identify CSHCN and collaborate with families, providers and Title V programs to improve systems of care.

The Shared Responsibilities tools are designed to be easily adapted for use by: any health plan; provider group; purchaser; or state agency working in partnership with health plans.

The Identify section of the Toolkit includes a rationale for why health plans should invest in identifying this population. Four sample tools for identifying children with special health care needs are included, as well as references on how to get additional information and support in using these tools.

The Collaborate section of the Toolkit includes survey formats and resources designed to assist health plans to build partnerships with families, providers, and state organizations that are also involved in providing care for this group of children.

The Improve section of the Toolkit includes examples of best practices at the health plan level, a checklist for health plan policies and procedures that can support serving CSHCN, and a set of measures that can be used to assess a health plan's readiness to focus on this population.

2. **A Pediatrician's Guide to Managed Care, 2nd Edition**
The recent, rapid growth of HMOs, PPOs, and other managed care systems makes it imperative that physicians stay abreast of current issues and policies as this health care delivery model becomes more dominant. This 2001 edition contains new and updated information to assist the pediatrician in understanding how managed care works, how it impacts the pediatrics practice, and how to develop a strategic approach to managed care that is consistent with the physician's own professional goals. You can order this guide on line at: www.aap.org/bst/index.cfm?did=15

3. **Coding Resources**

- **Coding Hotline:** 800-433-9016 extension 4022 or aapcodinghotline@aap.org
- **AAP** Coding Publications:
    - Coding for Pediatrics (manual)
    - Quick Reference Guide to Pediatric Coding and Documentation for Children with Special Health Care Needs. A Companion to Coding for Pediatrics.
    - New Quick Reference Guide to Pediatric Coding and Documentation
      ICD-9-CMFlipchart
- **AAP News Coding Corner** (monthly column) aapnews.aappublications.org/cgi/collection/coding_corner
- **Newsletter:** AAP Pediatric Coding Companion - **Free Sample Issue** available at: http://coding.aap.org/
  Developed by the AAP, with careful review by the AAP Committee on Coding and Nomenclature, this NEW monthly newsletter provides broad coverage of coding for both pediatric primary care and subspecialty services. Look here for peer-reviewed, AAP-endorsed coding solutions, alerts on upcoming coding developments, exclusive insights from experienced practitioners, all custom-built for ready access and easy comprehension by physicians and office staff alike.
- **Online Resources:**
    - PediaLink Coding Clues
      Top ten underutilized pediatrics codes
      CPT Coding Change Request Form (instructions)
      ICD-9-CM Coding Change Online Request Form
    - CMS Web site: Medicare Learning Network (Medlearn)
      Documentation Guidelines - Evaluation and Management Services
- **AAP Committee on Coding and Nomenclature (COCN):** www.aap.org/visit/coding.htm
  2003 RBRVS Brochure: RBRVS: What Is It and How Does It Affect Pediatrics?
- **Private Sector Advocacy** (an area within the AAP Members Center)
- CPT Coding Change Request Form http://www.ama-assn.org/ama/pub/article/3866-3864.html
  ICD-9-CM Coding Change Online Request Form http://www.aap.org/visit/icd-9form.htm
  CMS Web site: Medicare Learning Network (Medlearn) Documentation Guidelines - Evaluation and Management Services http://cms.hhs.gov/medlearn/emdoc.asp
- AAP Committee on Coding and Nomenclature (COCN): http://www.aap.org/visit/coding.htm

Appendix IV:
Coding Vignettes

You attend an Individualized Education Plan (IEP) meeting for one of your patients. Total time spent in the team conference is 2 ½ hours.

CODE: 99362 – Team conference (1st 60 minutes)
99358 – Prolonged services without patient contact (1st hour)
99359 – Prolonged services without patient contact (each additional 30 minutes)

A mother calls to discuss the possibility of her child having ADHD due to ongoing school problems and the fact that this diagnosis was raised by the teacher who said to see "your pediatrician" about it. Mom is concerned, and the call lasts 35 minutes.

CODE: 99373 – Telephone call (complex or lengthy)

A mother brings her child with Down syndrome for a 12-month checkup. She is an established patient. In addition to a comprehensive and age-appropriate history and physical examination with anticipatory guidance, the physician discusses issues related to Down Syndrome. This counseling lasts 35 minutes. Consultation reports from the cardiologist and the Individual Family Service Plan from the early intervention program are reviewed. Family requests contact with another family with child with Down syndrome and seeks information about total communication for child to develop skills in sign language, speech, and audition. The visit lasts 55 minutes.

CODE: 99392 – Periodic comprehensive preventive medicine services visit, established patient, age 1-4 years (while this part of the visit takes up the 1st 20 minutes, time is never a factor for preventive medicine services). Link to ICD-9-CM code for routine infant or child health check (V20.2)
99214-25[5] – Office or other outpatient visit, level 4, established patient, appended with modifier 25 (35 minutes of counseling). Link to ICD-9-CM code for Down Syndrome (758.0)

Vignettes adapted from the 2003 Crosswalk to Reimbursement
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Developed by Margaret McManus, Alan Kohrt, Joel Bradley, and Linda Walsh in collaboration with the Center for Medical Home Improvement, the American Academy of Pediatrics, and the National Institute for Children's Healthcare Quality. Funded by the Maternal and Child Health Bureau, U.S. Department of Health and Human Services through the Maternal and Child Health Policy Research Center. To access the *Crosswalk* go to:
http://www.medicalhomeinfo.org/tools/Coding/Crosswalk%20-%20Final.doc

The following Vignettes are for the 2006 Care Plan Oversight Codes

99339 Individual physician supervision of patient (patient not present) in home, domiciliary, or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) in involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99340 Individual physician supervision of patient (patient not present) in home, domiciliary, or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) in involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

A 21-year old with Down Syndrome who is transitioning from home care and public special education to a sheltered work program operated by the community service agency. He is moderately mentally retarded, and ongoing medical problems include hypothyroidism and sensorineural hearing loss. Over the past two months his behavior his become progressively disruptive. His previously developed care plan includes the active medical and educational/ vocational problems with ongoing adjustments being made based on feedback from the family and other health care professionals and service providers. The primary care physician (internal medicine, family physician, pediatrician) delivers primary care services, and manages and coordinates care plan activities.

Typical ongoing care plan oversight activities include:

- Review of reports including a new audiology assessment and endocrine consultation report
- Telephone call to the audiologist about results of the most recent hearing assessment and recommendations to provide hearing amplification to the patient
- Completion of medical forms for the vocational program listing medical problems, general cognitive and physical abilities, and recommendations for behavior management
- Discussion by phone with the family of recent appetite and weight gain noted by the family after beginning a new behavior medication, and subsequent call to the psychiatric nurse practitioner at the mental health center who recommends a dose change and a dietary consultation
- Review of endocrine recommendations to increase the thyroid dosage, with ensuing phone call to family and the pharmacy to prescribe a different dose form of Synthroid

The physician documents the relevant information in the record that summarizes the above activities.

A six-month-old established patient who was born at 25 weeks gestational age is now two months from hospital discharge from the NICU. Ongoing problems include chronic lung disease of prematurity, hypertonia, retinopathy of prematurity and failure to gain weight secondary to gastroesophogeal reflux and increased caloric expenditures. Services are coordinated by the primary care physician and provided by several health care professionals to include the primary care pediatrician in the infant's medical home, the pediatric pulmonologist, and gastroenterologist in the regional Children's Hospital. The patient is newly enrolled in a regional infant rehabilitation program, with services provided in the local daycare setting to include occupational and physical therapy. Ongoing activities to support his care include the work of care coordination and maintenance of an individualized and family-centered plan of care.

Typical ongoing care plan oversight activities include:

- Regular telephone calls to the family to discuss feedings, work of breathing and oximetry readings. Multiple reports are reviewed and entered into the medical record.
- Telephone calls to subspecialists to review findings and recommendations from consultations and to relay new problems or progress with ongoing treatment
- Regular review of reports from other providers with resulting alterations or amendments to the patient's plan of care. These typically include progress reports from all providers, requests for orders for needed rehabilitation services.
- Team teleconference with the infant rehabilitation team and social worker who supports the family
- Completion of forms for the patient's developmental day care listing medical service needs (bronchodilator treatment, rescue plan for medical emergencies), and a Family Medical Leave Act form for the mother
- Development, discovery and provision of educational and instructional information and resources to the family

The physician documents the pertinent information from the above activities in the medical record.

The existing Care Plan Oversight codes include:

99339 Individual physician supervision of patient (patient not present) in home, domiciliary, or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) in involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99340 Individual physician supervision of patient (patient not present) in home, domiciliary, or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) in involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

99374 Physician supervision of a patient under care of home health agency (patient not present), in home, domiciliary, or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment of care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99375 Physician supervision of a patient under care of home health agency (patient not present), in home, domiciliary, or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment of care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

99377 Physician supervision of hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment of care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99378 Physician supervision of hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment of care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more