

The Primary Care Medical Home for the Chronically Ill Child

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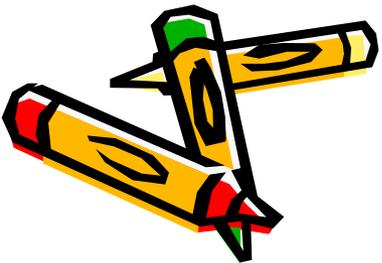
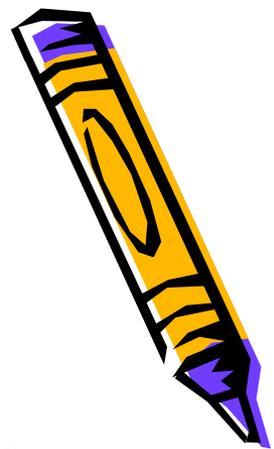
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Su Clinica Familiar, Harlingen, TX



April 2007

Objectives

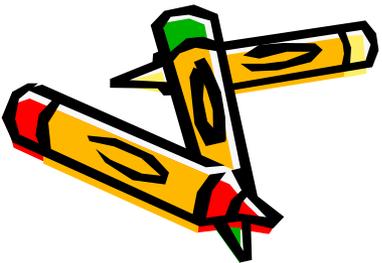
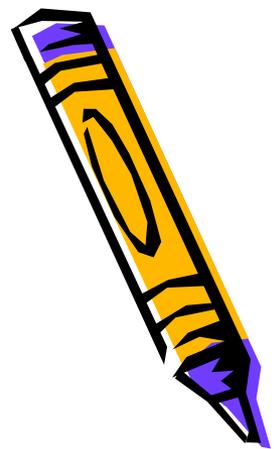
1. Review the rationale for medical homes for children with special health care needs (CSHCN), and the central role of the Primary Care Physician.
2. Discuss “real world” PCP implementation of the CSHCN medical home: strategies for success:
 - practice management tools
 - coding for appropriate reimbursement



Children with Special Health Care Needs (CSHCN)

CSHCN “are those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”

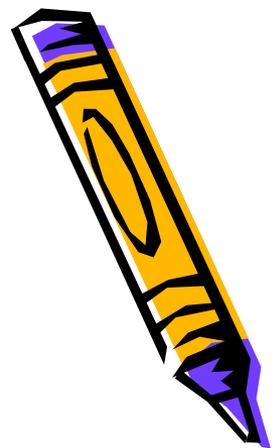
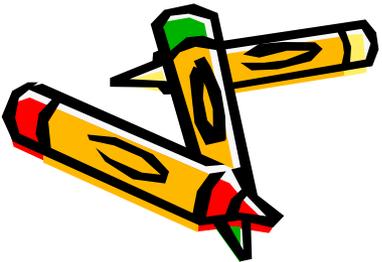
*Maternal and Child Health Bureau, accepted
by American Academy of Pediatrics*



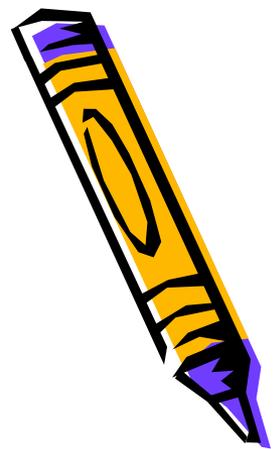
The CSHCN Data

- CSHCN are 13-18% of children, accounting for 80% of pediatric healthcare expenditures.
Compared to other children ...
- Average annual school absences: 7.4 vs 2.8 days
- Parents unsatisfied with care: 18% vs 14%
- Unmet health needs: 13% vs 6%
- Annual physician contacts: 6.4 vs 2.6
- Annual hospital days: 0.7 vs 0.1 days

Newacheck et al. Pediatrics. 1998;July:102



What Services do CSHCN Families Need ?



Ranking

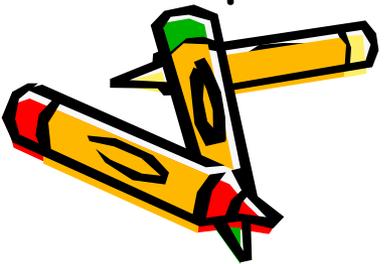
By Parents

By Physicians

- Info on community resources
- Financial information
- Parent support groups
- Recreational opportunities
- Psychological services
- Vocational counseling
- Summer camps
- Dental treatment
- Respite
- Help with behavior problems

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

- Respite
- Day care
- Parent support groups
- Help with behavior problems
- Financial information
- After school child care
- Environmental adaptation
- Vocational counseling
- Psychological services
- Homemaker services

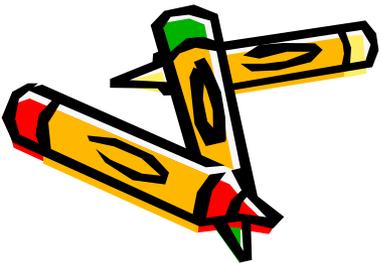
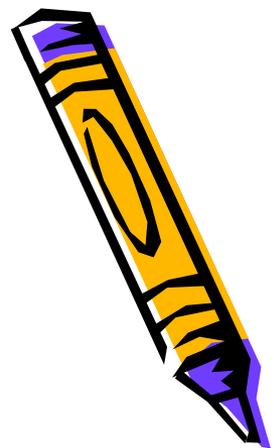


Liptak and Revell, 1989



Healthy People 2010: CSHCN and The US Health Care Agenda

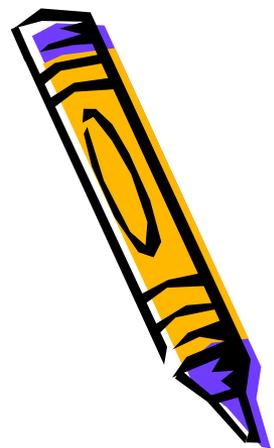
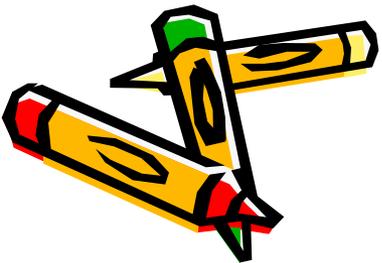
- Family participation in decision-making
- Ongoing, comprehensive care in a medical home
- Adequate health care insurance
- Early and continuous screening for special health care needs
- Services organized for ease of use
- Services for transition to adult life

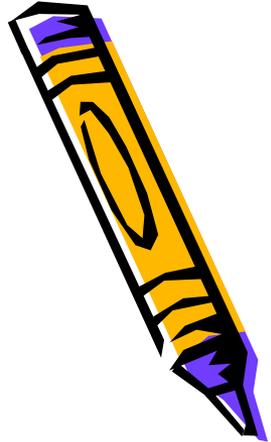


What is a Medical Home?

A process of care offered by primary care providers in partnership with families of CSHCN. The concept of a medical home is about practice-wide improvement.

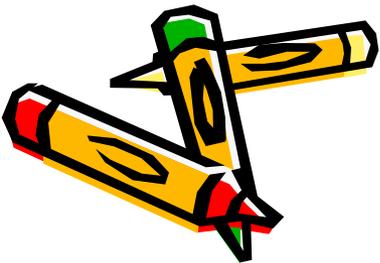
The Center for Medical Home Improvement



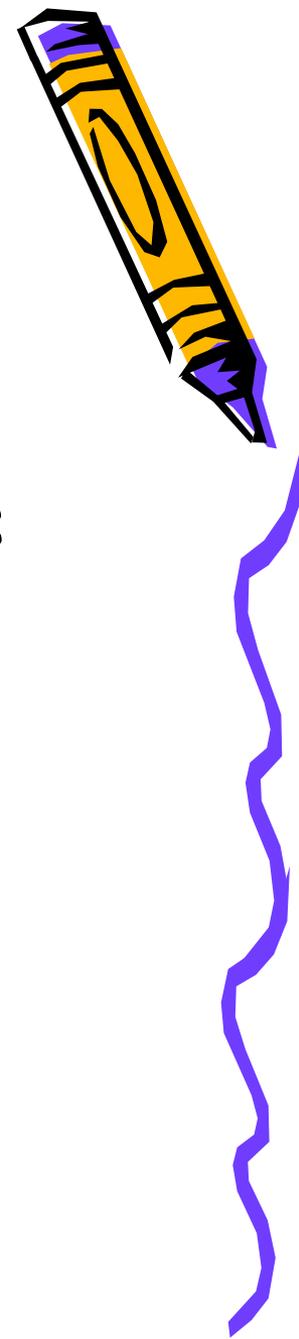


“Our medical home is a place where they know my story, they listen to my son, and they respect us. They facilitate our services and recognize these service needs beyond medicine. They talk to us.”

Judie Walker, whose 18-year old son has cerebral palsy and asthma



The Medical Home for CSHCN

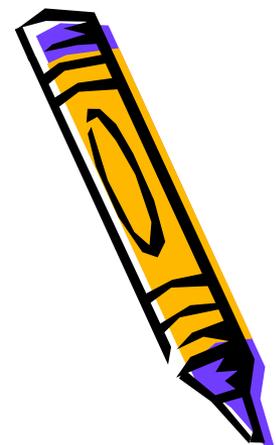


The American Academy of Pediatrics describes care in a Medical Home as:

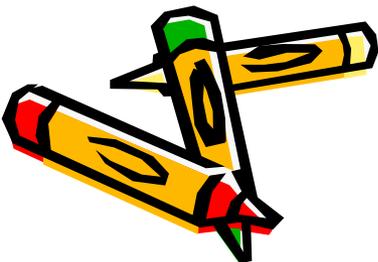
- Accessible - location; time; payors
- Family Centered - family as expert partners
- Continuous - same providers; facilitated transitions
- Comprehensive - preventive, primary, consultative
- Coordinated - health care with school, community
- Compassionate - concern for child and family
- Culturally Effective - respectful of culture, religion



Medical Homes for CSHCN mean ...

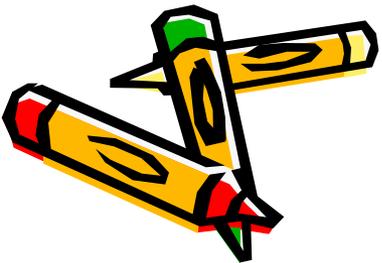
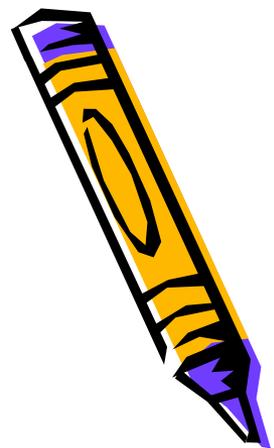


- Increased preventive health care
- Fewer unmet health care needs (2.0x) and fewer delays in care
- Fewer unmet needs for family support services (2.8x)



Medical Homes for CSHCN mean Decreased ER Visits

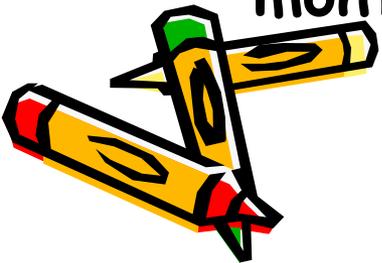
- NICHQ MHLC-II: Percent of CSHCN with at least one ER visit in previous 3 months decreased from 36% to 20%.



Medical Homes for CSHCN mean Decreased Hospitalizations



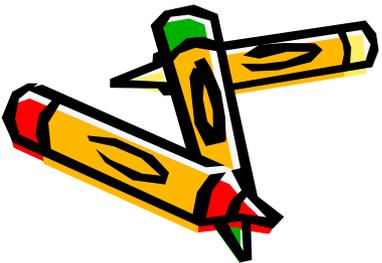
- Palfrey: Drop from 58% to 43% percent of CSHCN hospitalized/yr with primary care medical home implementation
[*Pediatrics*. 2004;113:1507]
- NICHQ MHLC-I: Unplanned hospitalizations for CSHCN decreased 13-18% across practices implementing medical homes
- NICHQ MHLC-II: Percent of CSHCN with one or more unplanned hospitalizations in previous 3 months dropped from 19% to 7%.



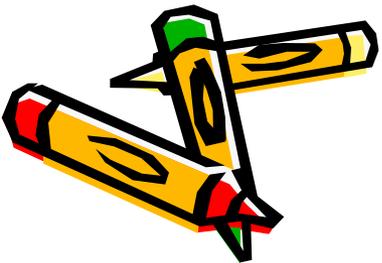
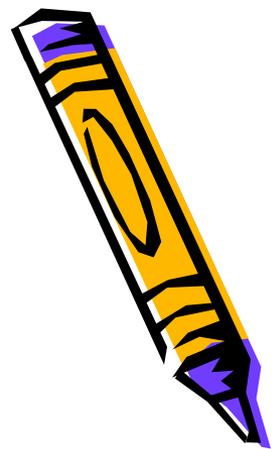
Medical Homes for CSHCN mean Fewer Missed Work/School Days



- Palfrey: Percent of parents missing >20 days of work/yr decreased from 26% to 14%. [*Pediatrics*. 2004;113:1507]
- NICHQ MHLC-II: Percent of parents/CSHCN with a missed work/school day in previous 3 months decreased from 58% to 30%



The Medical Home at
Su Clinica Familiar
Harlingen, TX





Su Clinica Familiar

Harlingen, Texas



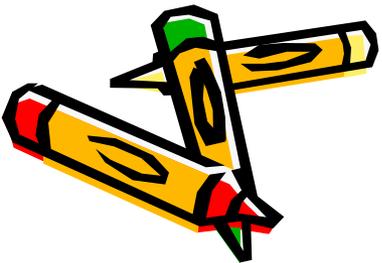
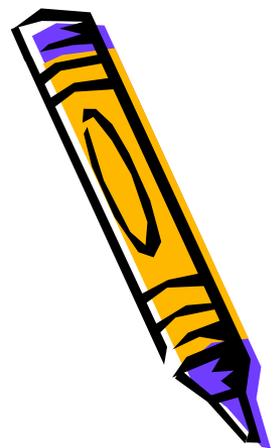
Su Clinica Familiar is a Federally-funded Multi-Specialty Community Health Center located in the Rio Grande Valley along the U.S. –Mexico border. We serve a largely Hispanic population and most of our Pediatric patients qualify for Medicaid or SCHIP. Some of our most challenging patients are children of Migrant Farm Workers and undocumented immigrants from Mexico and Central America. Currently our seven pediatricians, one physician assistant and one nurse practitioner see approximately 700 children per week, 11% of whom are CSHCN.

Building a Medical Home

- Identify committed team members, and meet regularly.

Multidisciplinary: clinician, nursing staff, administrative staff (office manager, front desk, medical records, Information technology), social worker (s), one or more parents.

- Plan a walk-through to identify barriers and barriers as well as gaps in care.



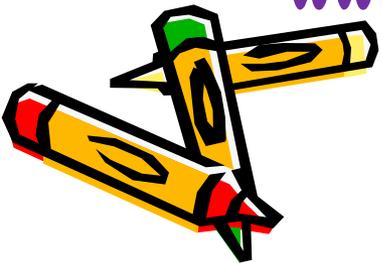
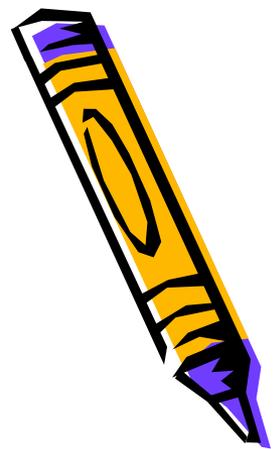
Building a Medical Home

- Educate yourselves!
 - The Center for Medical Home Improvement has all Medical Home Learning Collaborative II resources:

www.medicalhomeimprovement.org

- AAP Medical Home website has a wealth of materials:

www.medicalhomeinfo.org

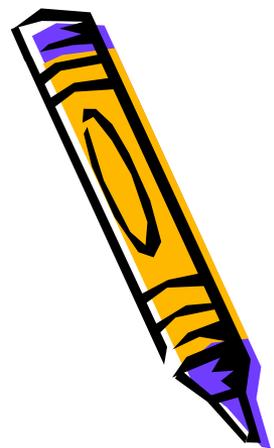


Building a Medical Home

- Evaluate yourselves!

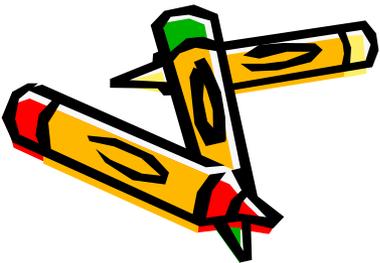
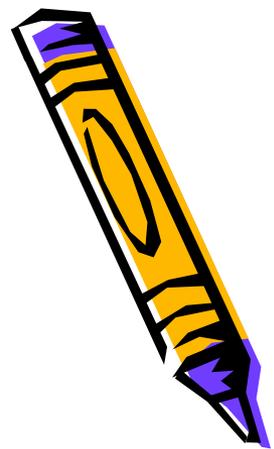
The Medical Home Index* is a measurement tool which has six domains including organization capacity, chronic condition management, care coordination, community outreach, data management, and quality improvement. You can rate your practice's level of care for CSHCN. Repeat it after several months of working on a Medical Home in order to track your progress.

*© Medical Home Improvement Programs, 2001. Hood Center for Children and Families



Building a Medical Home

- Set short and long-term goals.
 - Establish a method of identifying CSHCN
 - Reduce the number of missed school days by 30% for all CSHCN
 - 75% of families will be able to name one Pediatrician from the practice as their PCP provider

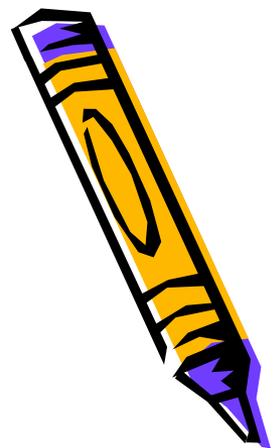
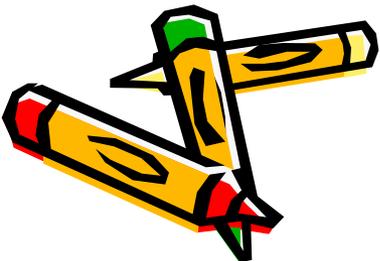


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Building a Medical Home

- Obtain medical records from specialists and previous PCPs (for new patients) within two weeks of request
- Define which CSHCN need a care plan and develop care plans for 90% of our population using applicable guidelines
- Develop case management services to coordinate specialty care for high risk families and CSHCN

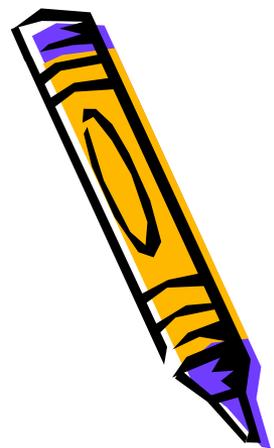
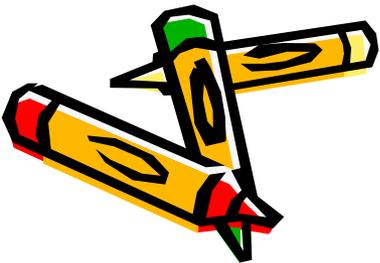
Su Clinica Familiar



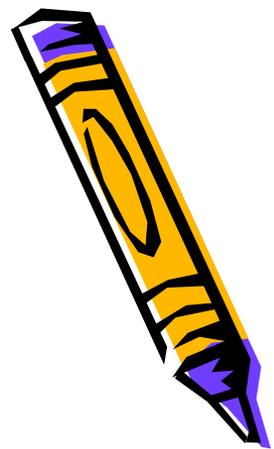
Building a Medical Home

- Provide a written summary of the relevant health history to 90% of CSHCN with complex chronic conditions
- 70% of families will rate satisfaction with care coordination as very satisfied
- 50% reduction in the number of CYSHCN who visit other local clinics or ED for non-emergent care

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How are you going to accomplish your goals?



Model for Improvement*

Plan - What is the question you want to answer?

Make a prediction.

Plan for change or test: Who, What, When, Where

Plan for Collection of Data: Who, What, When, Where

Do - Carry out the Change or test; collect Data and Begin analysis

Study - Complete Analysis of Data; summarize what was learned

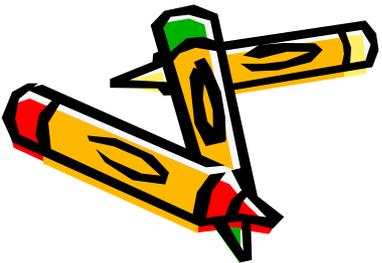
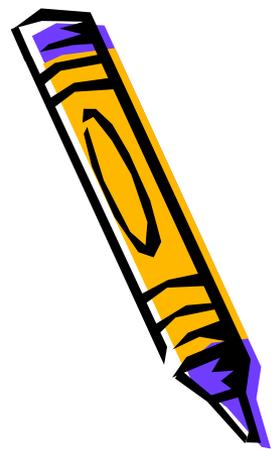
Act - Are we ready to make a Change?

*Adapted from 2001 National Initiative for Children's Healthcare Quality



Building a Medical Home

The Experience at Su Clinica Familiar

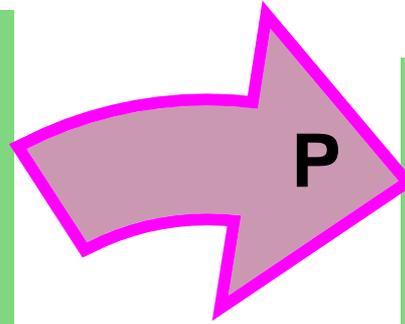


Example of PDSA Cycle

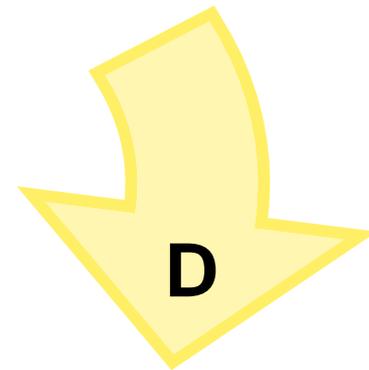
Identification of CSHCN



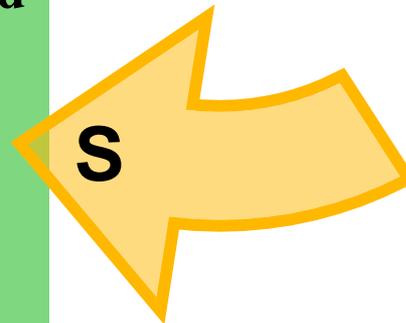
All practitioners became involved in developing their own list of CSHCN and along with the children identified through the survey – to date we have identified about 320 CSHCN @ SCF



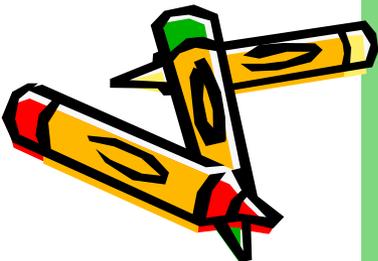
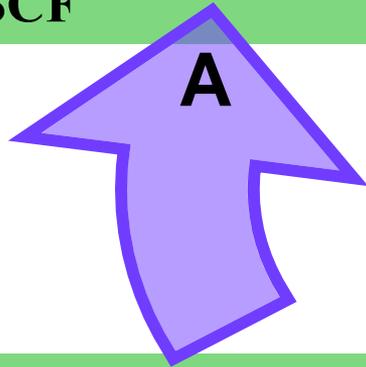
Dr. Lopez to review patient list and charts of appointments to identify CSHCN



Dr. Lopez used one day's list of appointments and charts to identify a small # of CSHCN through memory recall



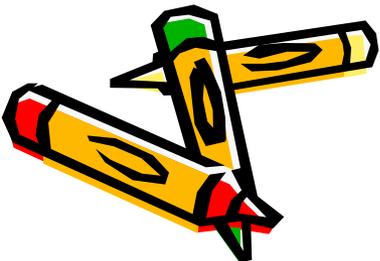
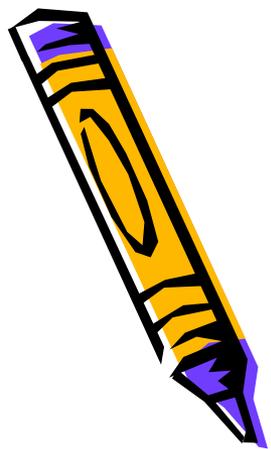
Dr. Lopez identified 25% of CSHCN with this method and more were identified after the visit



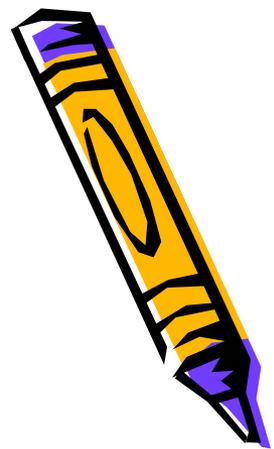
CAHMI Screener

Children with Special Health Care Needs (CSHCN) Screener©
Children and Adolescent Health Measurement Initiative

- Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?
 - 1a. Is this because of ANY medical, behavioral or other health condition?
 - 1b. Is this a condition that has lasted or is expected to last for at least 12 months?
- Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age?



CAHMI Screener



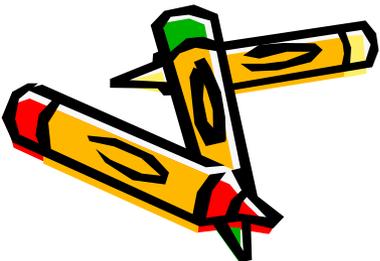
2a. Is this because of ANY medical, behavioral or other health condition?

2b. Is this a condition that has lasted or is expected to last for at least 12 months?

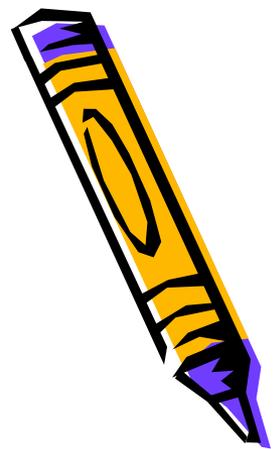
- Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

3a. Is this because of ANY medical, behavioral or other health condition?

3b. Is this a condition that has lasted or is expected to last for at least 12 months?



CAHMI Screener



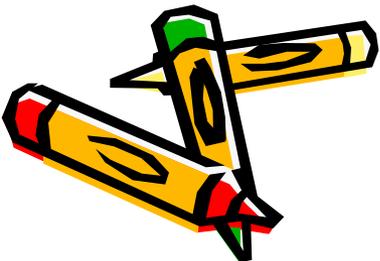
Does your child need or get special therapy, such as physical, occupational or speech therapy?

4a. Is this because of ANY medical, behavioral or other health condition?

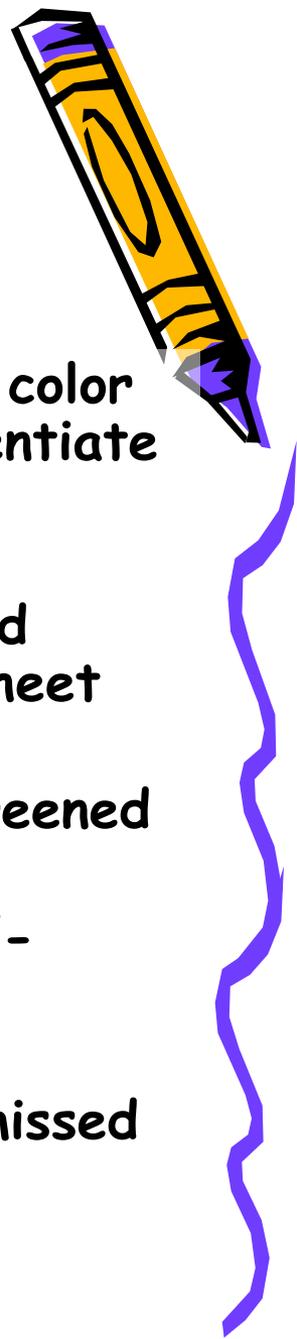
4b. Is this a condition that has lasted or is expected to last for at least 12 months?

- Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets treatment or counseling?

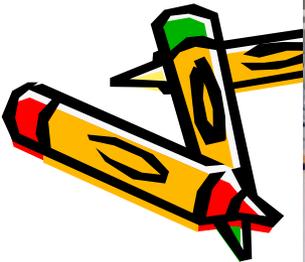
5a. Has this problem lasted or is it expected to last for at least 12 months?



Survey Collection

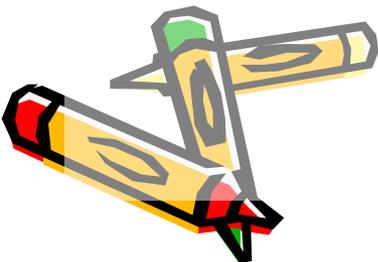


- Front Desk Staff used color coding to easily differentiate English/Spanish Screeners/Surveys
- Patients were coded and entered into a spreadsheet for tracking
- 1018 patients were screened over five months
- Approximately 100 self-identified as CSHCN
- Drawbacks of CAHMI: several children were missed (parent perception?)



Improved Communication: Fax-Back Form

- Our clinic already had a fax-back form, which was updated.
- Consultants have a space at bottom of form to give brief reply and fax back on the day patient is seen.



Name _____ _____		Su Clinica Familiar Family Health Services Program PATIENT REFERRAL	
Address _____		<input type="checkbox"/> 1706 TREASURE HILLS BLVD. HARLINGEN, TEXAS 78550 TELEPHONE: 365-6000 MEDICAL RECORDS FAX: 365-6773	<input type="checkbox"/> 131 FM 3168 RAYMONDVILLE, TEXAS 78580 TELEPHONE: 689-2196 MEDICAL RECORDS FAX: 689-5937
DOB _____	Phone _____		
Chart # _____	Acct # _____		
OR PLACE PATIENT LABEL HERE			

Screening Test Diagnostic Test Consult Treatment

URGENCY: Routine Within _____ days/weeks STAT

TYPE OF SERVICE: _____

REFERRED TO: _____

ADDRESS: _____ PHONE: _____

APPT DATE: _____ APPT TIME: _____

Referral is for one consultation. (Valid for 3 months) MEDICAID MEDICARE PVT INS. _____

Future consultations require a new referral. Please help us to expedite payment by submitting a copy of this form with your bill.

SCF will pay _____% of charge for consultation only. (Patient is responsible for all other charges including lab, x-ray, etc.)

DIAGNOSIS: _____ ICD 9 CODE: _____

REASON FOR REFERRAL: _____

I have explained the benefits of this test/consult/treatment and the risks of declining service.

Please notify me if the patient declines this recommendation.

Reason patient declined _____

SIGNATURE: _____ DATE: _____

Printed Name: _____ UPIN: _____ FAXED TO: _____

REPLY/RECOMMENDATIONS: _____

Please forward complete consultation report to SCF Medical Records.

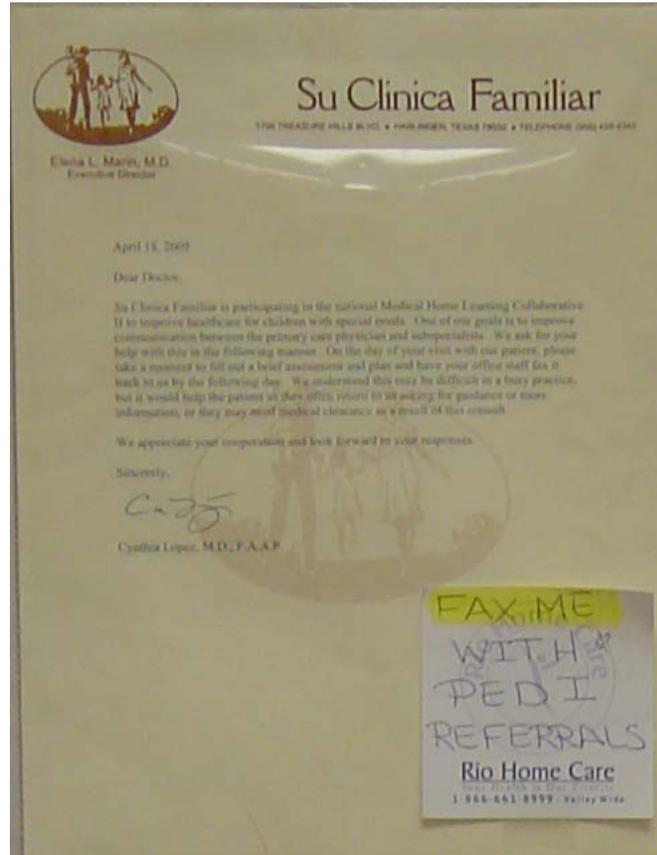
REFERRAL PROCESSED BY: _____ DATE: _____

APPOINTMENT KEPT: YES NO CONTACT PERSON: _____

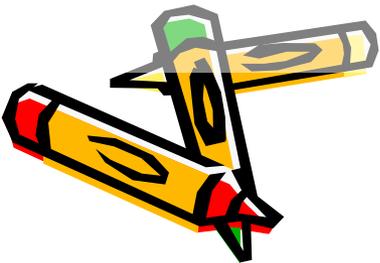
Original: Medical Records Copy: Patient

Fax Back Form

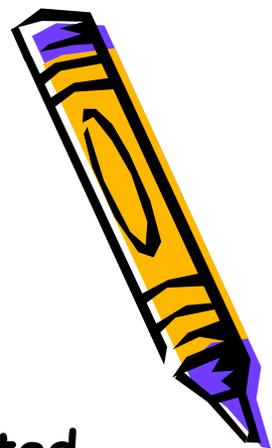
- A letter explaining Medical Home goals is faxed with referral to Specialist at the time appointment is scheduled
- The physicians noted a quicker turnaround time in correspondence:
1-2 Months → 1-2 weeks often 1-2 days



Social Workers



CSHCN Bulletin Board



- Approved by Management/Executive Director 5/1/05
- 5/26/05 First Installation of Parent Information Posted

Does your child have a Medical Home? ¿Tiene su hijo un Hogar Médico?

FAMILY-CENTERED
 RECOGNITION THAT THE FAMILY IS THE PRINCIPAL CAREGIVER AND THE CENTER OF STRENGTH AND SUPPORT FOR CHILDREN
 UNBIASED AND COMPLETE INFORMATION IS SHARED ON ONGOING BASIS
 THE FAMILY IS RECOGNIZED AS THE EXPERT IN THEIR CHILD'S CARE, AND YOUTH ARE RECOGNIZED AS EXPERTS IN THEIR OWN CARE

COORDINATED
 A PLAN OF CARE IS DEVELOPED BY THE PHYSICIAN, CHILD OR YOUTH, AND PROVIDERS, AGENCIES, AND ORGANIZATIONS INVOLVED IN THE CARE OF THE PATIENT
 A CENTRAL RECORD CONTAINING ALL PERTINENT MEDICAL INFORMATION, INCLUDING HOSPITALIZATIONS AND SPECIALTY CARE, IS MAINTAINED AT THE EDUCATIONAL AND COMMUNITY BASED SERVICES

EMPATHIC
 LA PREOCUPACIÓN POR EL BIENESTAR DEL NIÑO O JOVEN Y DE LA FAMILIA SE EXPRESA Y SE DEMUESTRA
 MANTENIENDO UNA APERTURA CON LOS FAMILIARES Y LAS PERSPECTIVAS DE LA FAMILIA ASÍ COMO DEL NIÑO O JOVEN

COMPREHENSIVE
 HEALTH CARE IS AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK, 52 WEEKS A YEAR
 PREVENTIVE, PRIMARY, AND TERTIARY CARE NEEDS ARE ADDRESSED
 INFORMATION IS MADE AVAILABLE ABOUT PRIVATE INSURANCE AND PUBLIC RESOURCES

ACCESSIBLE
 CARE IS PROVIDED IN THE CHILD'S OR YOUTH'S COMMUNITY
 ALL INSURANCE, INCLUDING MEDICAID, IS ACCEPTED
 FAMILIES OR YOUTH ARE ABLE TO SPEAK DIRECTLY TO THE PHYSICIAN WHEN NEEDED

CONTINUOUS
 CARE PRIMARY PEDIATRIC HEALTH CARE PROFESSIONALS ARE AVAILABLE FROM YOUNG ADULTHOOD INCLUDING THOSE WITH TRANSITIONING INTO THE ADULT HEALTH CARE SYSTEM, AND PLANNED AND ANTICIPATED

COMPASSIONATE
 CONCERN FOR WELL BEING OF CHILD AND FAMILY IS EXPRESSED AND DEMONSTRATED
 EFFORTS ARE MADE TO UNDERSTAND AND EMPATHIZE WITH THE FAMILIES AND PERSPECTIVES OF YOUTH WELL AS THE CHILD OR YOUTH

**LA ATENCIÓN SE BRINDA DENTRO DE LA COMUNIDAD DEL NIÑO O DE JOVEN
 SE ACEPTAN TODOS LOS SEGUROS, INCLUIDO MEDICAID, Y SE CONCILIAN LOS CAMBIOS DE SEGURO
 LAS FAMILIAS O LOS JOVENES SON CAPACES DE HABLAR DIRECTAMENTE CON EL MÉDICO CUANDO ES NECESARIO**

ACCESSIBLE
 LA ATENCIÓN DE CALIDAD SE BRINDA 24 HORAS AL DÍA, 7 DÍAS A LA SEMANA, 52 SEMANAS AL AÑO
 SE CUBREN LAS NECESIDADES DE ATENCIÓN PREVENTIVA, PRIMARIA Y TERCIARIA
 SE BRINDA INFORMACIÓN ACERCA DE SEGUROS PRIVADOS O DE SEGUROS PÚBLICOS

INTEGRAL
 LOS MIEMBROS PROFESIONALES DE LA SALUD DE ATENCIÓN PEDIÁTRICA PRIMARIA ESTÁN DISPONIBLES DESDE LA PRIMERA INFANCIA, HACIA LA ADOLESCENCIA Y LA EDAD ADULTA, JOVEN Y FAMILIA
 LA ATENCIÓN EN LAS TRANSICIONES A O A LOS SISTEMAS DE ATENCIÓN PEDIÁTRICA ADULTOS

CULTURALLY EFFECTIVE
 FAMILIES CULTURAL BACKGROUND, LANGUAGE, BELIEFS, ATTITUDES AND CUSTOMS ARE RESPECTED AND TAKEN INTO ACCOUNT
 CULTURAL INFORMATION IS SHARED AND INTERPRETED AS NECESSARY
 INTERCULTURAL AND BILINGUAL CARE IS PROVIDED
 INTERCULTURAL AND BILINGUAL CARE IS PROVIDED
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CULTURALMENTE EFICAZ
 SE OFERCE ATENCIÓN DE CALIDAD 24 HORAS AL DÍA, 7 DÍAS A LA SEMANA, 52 SEMANAS AL AÑO
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 SE BRINDA INFORMACIÓN ACERCA DE SEGUROS PRIVADOS O DE SEGUROS PÚBLICOS

¿Tiene su hijo un Hogar Médico?

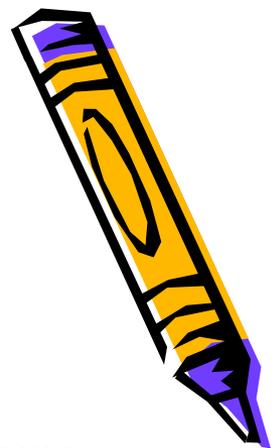
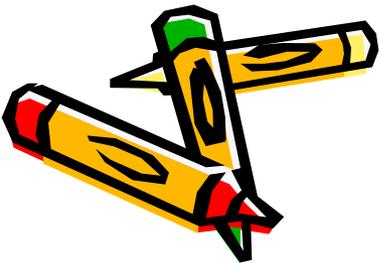
PARA MÁS INFORMACIÓN, HABLE CON BRANDY STONCER, TRABAJADORA SOCIAL EN EXTENSION 1801
 FOR MORE INFORMATION, CONTACT BRANDY STONCER, SOCIAL WORKER AT EXTENSION 1801



Parents as Partners

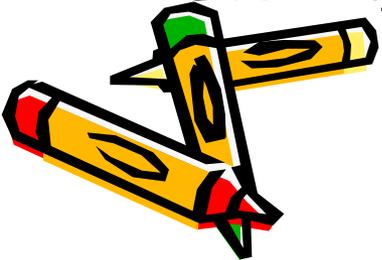
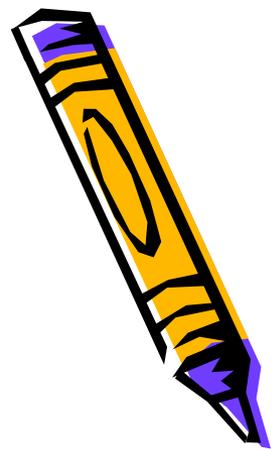


- A few parents were involved in every process starting with the walk-through of our clinic and one attended every conference during the Medical Home Learning Collaborative
- One parent partner met regularly with our local Title V representative and involved him in a large School District meeting and our Healthfair for families to explain the CSHCN Program!!!
- Parent support group started Nov 05
- Goal is to involve more parents in our monthly Medical Home Committee meetings



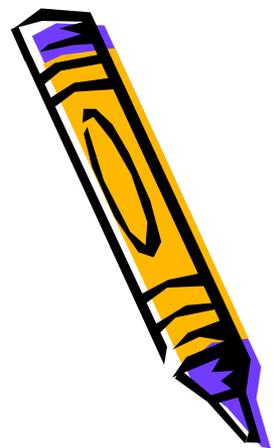
Other Accomplishments

- Identified over 300 CSHCN
- Converted over 175 medical charts of CSHCN to Burgundy colored charts
- Pediatric Health Fair, August 05 & 06
- Care Plans Initiated
- Additional Weekend Hours (Saturday mornings)
- Identified a PCP for over 100 CSHCN
- Improved knowledge of struggles of families with CSHCN
- Improved follow up on specialist referrals via stamps
- Los Angeles de Su Clinica Familiar



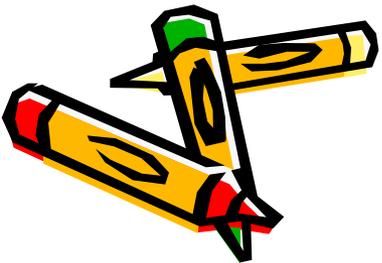
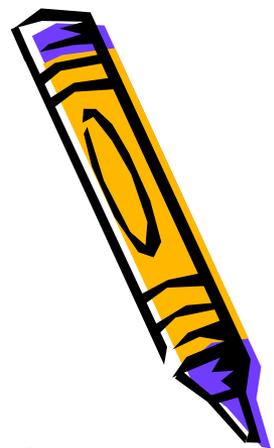
Ideas in Progress at Su Clinica

- Code Burgundy for longer appointments
- More Care Plans
- Identify a PCP for EACH CSHCN
- Easy identifier in computer system for CSHCN
- Transition Protocol
- Parent Advisory Group
- Health summaries for families once electronic medical records available next year



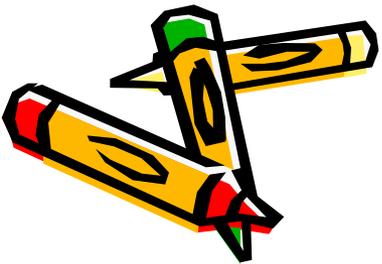
Lessons learned at Su Clinica

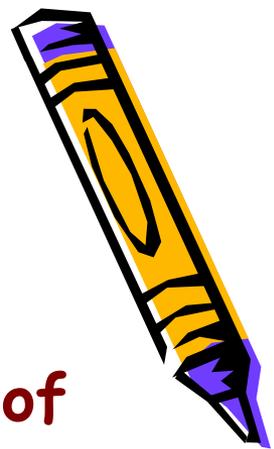
- You will need the support of colleagues and administration; get “buy in” early on.
- You will need different methods for identifying CSHCN.
- When making a change, start small.
- Borrow what you can.
- The person organizing the team will need to be the Medical Home “Champion” who should strive to maintain the gains achieved.





Ok. All this is really terrific.
But ...





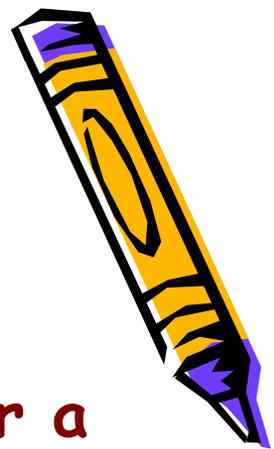
- **A CSHCN medical home will take too much of my time.**

I've got a *very* busy practice. [You're ALREADY seeing these children. Improved care coordination should mean decreased hospitalizations and ER visits, and improve your productivity.]

- **I don't have a care coordinator.**

[Maybe not a social worker, but someone's now arranging referrals, DME, school and ECI contacts. Consider the efficiency of the process; give that person expertise and tools. Also, consider collaborative coordination resources OUTSIDE your practice, including HMO, State, and family-to-family organizations.]

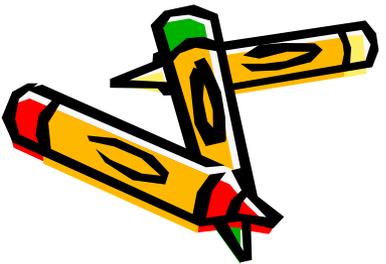




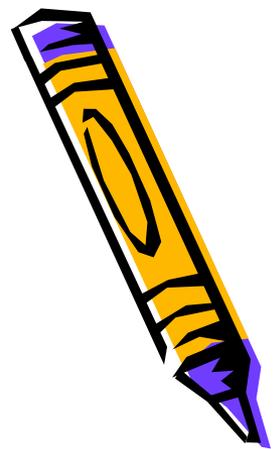
- I can't knowledgeablely be a medical home for a child with _____.

[Consider knowledge and complexity of child's condition and family situation; define your role as primary manager, or co-manager with specialist. Consider developing individualized health care plans with families and collaborating providers: medical summary, emergency care, and action-based care plan]

- I won't get paid for the work I (and my staff) do.



Coding for Medical Home Services



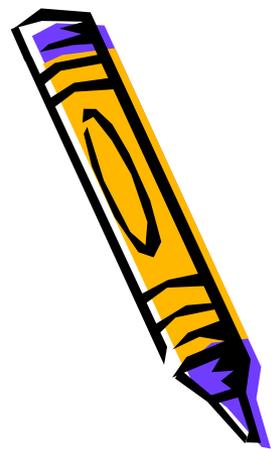
- Index of CPT Codes for Medical Home

<http://www.pafp.com/MMS/coding/medical-home-code-index.doc>

- Code by elements of history, exam, and medical decision-making. But when counseling and/or coordination of care are >50% of face to face encounter, TIME controls coding. Counseling is education of and discussion with a patient and/or family about diagnostic studies, prognosis, management.



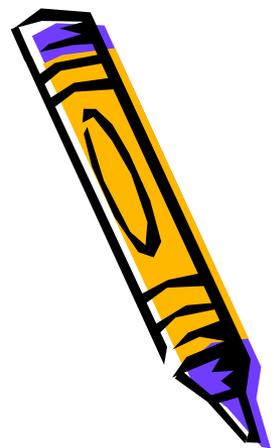
Coding for Medical Home Services



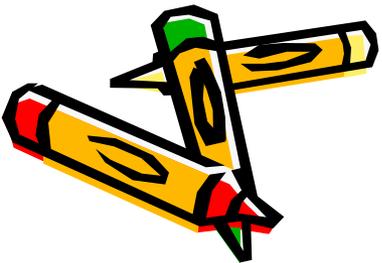
- So, published (minimum) times for established patient visit codes 99214 and 99215 are 25 and 40 minutes, respectively. Expected maximum time for 99215 is 55 minutes. If a 25 minute visit includes 13 minutes of counseling/ coordination, it should be coded as 99214, regardless of elements; and a 40 minute visit with 21 minutes of counseling as a 99215.
- DOCUMENTATION OF ELEMENTS AND TIME, AND WHAT IS DISCUSSED IS CRITICAL. OTHERWISE, IT DIDN'T HAPPEN.



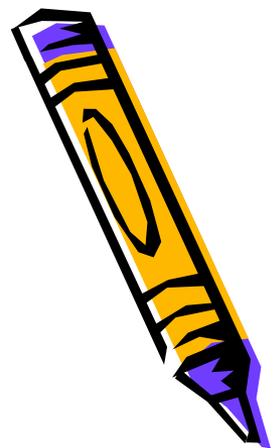
Coding for Medical Home Services



- Presume a PCP practice of 500 visits/month, with 350 non-preventative care visits, currently billing 5% 99214 and no 99215.
- Presume reimbursement of
 - \$50.32 for 99213
 - \$78.91 for 99214
 - \$115.84 for 99215



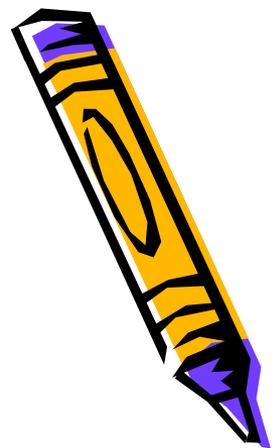
Coding for Medical Home Services



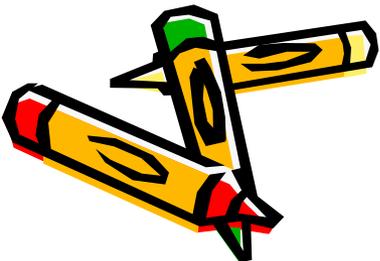
- Presume increase 99214 to 15% and 99215 to 2% of 350 visits/month. Net increase in revenue is \$17,504/year.
- Use prolonged services code 99354: *in addition* to the E/M code, for face to face contact exceeding the maximum by 30-74 minutes



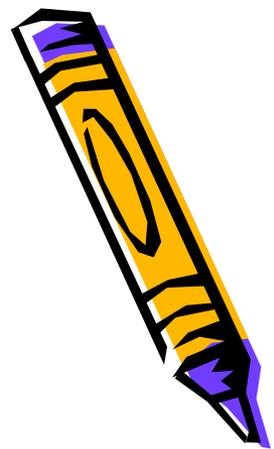
Coding for Medical Home Services



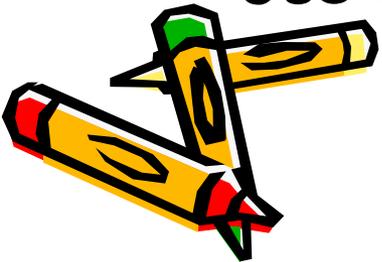
- Similar rules for time and prolonged service coding apply for new outpatient and inpatient visits.
- Code for procedures: e.g. inhalation therapy (94640), nebulizer/mdi teaching (94644), limited developmental testing (96110).
- Use increased reimbursement codes if consultation requested by another physician: always document reason, request and report.



Coding for Medical Home Services



- Code for team conferences, when patient/family not present: 30 minutes (99361); 60 minutes (99362)
- (Telephone-based care and coding is rarely reimbursed.)
- Code for home health care plan oversight: 15-29 minutes/mo (99374); 30 minutes or more/mo (99375)
- Use modifier coding when appropriate

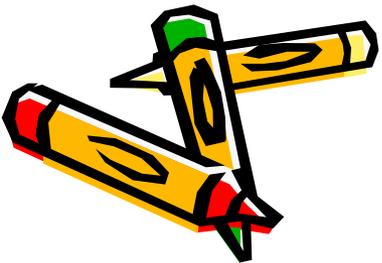


Summary:

Designing the Medical Home

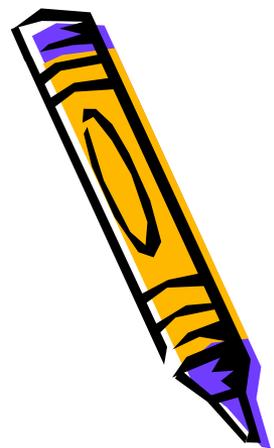


- Engage parents as partners !
- Create a CSHCN office registry (use med and diagnostic lists, memory, CSHCN screener and flag charts) and categorize the complexity of patient/family issues.
- Develop practice strategy for care coordination, including intra-office role development, co-management with other providers, and communication methodologies, AAP Emergency Information Form.
- Facilitate preplanning of CSHCN office encounters: Collect pre-visit data from families and other involved providers, including physicians and therapists; schedule longer visits, including time with office care coordinator.
- Develop practice tools for appropriate and rapid coding.



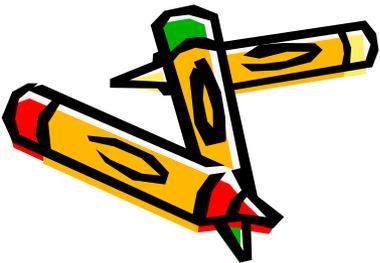
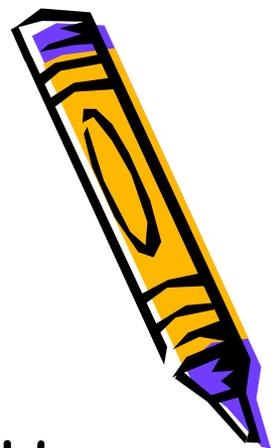
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- Ireys HT, Anderson GF, Shaffer TJ, Neff JM, Expenditures for care of children with chronic illnesses enrolled in the Washington State Medicaid Program, Fiscal Year 1993, *Pediatrics*. 1997;100:197-204.
- U.S. Dept. of Health and Human Services. Health People 2010. 2nd ed. Washington, D.C.: U.S. Dept. of Health and Human Services, 2000.



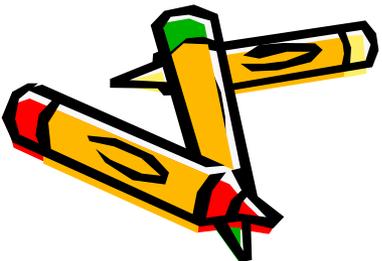
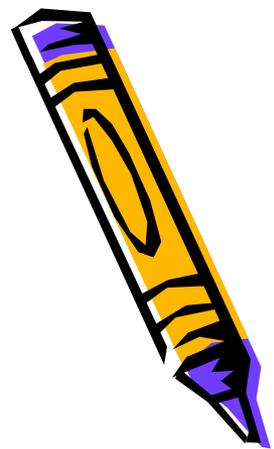
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<http://www.pediatrics.org/cgi/content/full/110/1/184>
- Cooley WC and McAllister JW, Building Medical Homes: Improvement Strategies in Primary Care for Children With Special Health Care Needs. *Pediatrics*. 2004;113:1499-1506.
<http://www.pediatrics.org/cgi/content/full/113/5/S1/1499>



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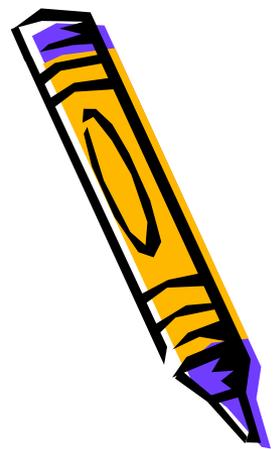
- General information, including Medical Home Index
<http://www.medicalhomeimprovement.org>
- Texas Department of State Health Services
<http://www.dshs.state.tx.us/cshcn/medhome.shtm>
- The Children with Special Health Care Needs (CSHCN) Screener <http://www.cahmi.org/>
- Coding Resources
www.medicalhomeinfo.org/tools/coding.html



Sources

- Medical Management Series
<http://www.pafp.com/MMS/coding/medicalhome.htm>
- Su Clinica Familiar
 - Su Clinica Familiar Pediatric Care Plan form
 - CSHCN office registry
 - Patient Referral and Response form (FAXback)

Contact Dr. Lopez at 956-365-6000 for more information



Sources

- American Academy of Pediatrics, Emergency Information Form for Children with Special Needs
<http://www.aap.org/advocacy/blankform.pdf>
- General information and NICHQ sponsored CSHCN Medical Home Learning Collaboratives (MHLC)
<http://www.nichq.org/NICHQ/Topics/ChronicConditions/MedicalHome/>

