**ASHEW Learning Session 3 Team Time | Complex Needs Planning**

**1. Assign Planning Roles (2 minutes)**

Scribe Facilitator: Timekeeper:

**2. Plan to Identify and Support Families with Complex Needs (40 minutes)**

**Step 1: Consensus on risk criteria for identifying families with complex needs** (10 minutes)

* Start with all families with positive response to ASHEW screenings/assessments
* Spread practice-wide after testing with QI team
* Consider other criteria: children with a mental health concerns, significant chronic/complex medical conditions, and families challenged with navigating the health care system

**Step 2: Identify, flag, and track patients** (20 minutes)

* Create a complex needs tracking system

Option A: Use the [ASHEW Referral Tracking Sheet](https://3.basecamp.com/3131512/buckets/17290193/uploads/3117882379), either add a new tab or use referral tracking data to build a new complex care tracking sheet

Option B: Use existing or create a custom tracking system

* Consider engaging IT staff if available
* How will you flag a child/family in your system for positive screens/assessments?

* Will you use [Z Codes](https://3.basecamp.com/3131512/buckets/17290193/uploads/3516271455), ICD-10, or other codes to run reports?

**BREAK:** Please take a 10-minute break. Stay on webinar in your breakout room.

**Step 3: Select one strategy to support families** (10 minutes)

* Seek input from your practice or chapter family advisor
* Think about implementing in phases with the first phase between now and end of June

Option A: Foundational, start here if you do not have a way to flag patients

* Flag for complex patients in scheduling system
* Adjust schedule blocks to allow extra time for patients with flag
* Ensure established provider/care team sees family for each appointment
* Assure follow up at intervals the team determined (see “Protocols for patients with complex needs” under Option B)

Option B: If you already have a way to flag patients, consider adding one of these supports

* Pre-visit planning
	+ Assign one staff as a complex care coordinator to schedule, identify needs, and prepare for visit
	+ Daily huddles to review list of families with complex needs and make a plan
* Protocols for patients with complex needs
* Develop protocols for follow up visit intervals, include telehealth
* Determine frequency of re-screenings
* Establish proactive reminders for follow-up visits
* Integrate behavioral health, social worker, and/or family navigator
* Optimize billing and [coding](https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Coding-Tips-for-Pediatricians-Evaluation-and-Management-Coding-Strategies.aspx) for complex needs

**Please Use This Activity Sheet to Document Planning**

|  |  |  |  |
| --- | --- | --- | --- |
| Step or Activity | Responsible  | Timeline  | Notes  |
| *Example:**Step 1: Run list of patients with positive screenings for SE, PD, and SDOH* | *Jan (QI Team)request to Ian (IT)* | *March 16-20* |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**3. Prepare for Report Out (2 min)**

Identify a team member who will report out for the team

* Step 1: What risk criteria did you select?
* Step 2: Which option did you chose? ASHEW Tracking Sheet or Custom Tracking Sheet

* Step 3: Which strategy did you choose to support families?