Chronic Care Management:
Helping your child get the care they need

Managing a chronic (long term) health concern can be hard. Patients, parents, and caregivers often have questions about the future and how to best care for their child's unique needs. Intermountain's Chronic Care Management (CCM) program provides families with strategies and tools to better manage a chronic condition, helping your child — and you — live a fuller, more enjoyable life.

What is chronic care management?

CCM services are available to patients who have multiple chronic conditions. Some of those conditions are:

- Heart disease
- Chronic lung disease
- Genetic (inherited) diseases
- Autism
- Developmental delay
- Depression

How can CCM help my child?

You and your child's care team will work together on:

- Improving or maintaining your child's health
- Care goals that are important to you and your family
- Avoiding trips to the emergency department or unplanned hospital stays
- Coordinating care with your child's providers
- Following up on care recommendations

Who is on a care management team?

Studies show that a team approach to care provides the greatest benefit. Your pediatric CCM team may include the following care professionals:

- **Pediatrician** [pee-dee-ah-TRISH-hun] (a doctor who specializes in children's health) or an **advanced practice provider (APP)** (a specially trained nurse or physician's assistant). They will examine your child, order tests, prescribe medication, and check on their progress.
- **Registered nurse (RN)**. The RN will answer and prioritize patient phone calls and give medications in the clinic.
- **Medical assistant (MA).** The MA will check a patient's vital signs (temperature, weight, etc.) and perform any other needed checks and measures before you meet with the provider.

Care management team, continued

- **Patient service representative (PSR).** The PSR will schedule your appointment and check to make sure your insurance and personal information are accurate in the system.
- **Care manager.** The care manager may be a nurse or social worker, or both. The care manager will work with you to create a care plan that helps you meet your goals. They can also help identify and overcome issues that keep you from reaching your goals.
- **Care coordinator.** The care coordinator will check on patients who are due for well visits with their provider. They also direct patients to community resources as needed, and coordinate with the care manager to support individual patients.

How do I get started?

1. You (or your adult child) must agree to take part in CCM services. You may stop using the program at any time.
2. You (or your adult child) will get a bill for the regular insurance co-payment, co-insurance, or deductible at the end of each month (contact your insurance for price). The amount will be based on how much time the chronic care management team spends doing these activities:
   - Communicating with you and other providers
   - Providing education for you or your child
   - Setting up treatment plans and managing medications
   - Working on a plan of care
   - Connecting you and your child to organizations or other assistance

Talk with your insurance plan about the cost of chronic care management (codes 99490 and 99439).

Notes

Agreement to Receive Chronic Care Management Services

Your Rights

As part of the chronic care management services, you will receive a copy of your care plan. You have the right to stop chronic care management services at any time (effective the end of a calendar month). To stop, please contact your care management team at ____________________.

Agreement and Consent

By signing this form, you agree to the following:

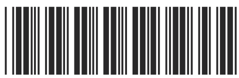
- Intermountain Healthcare may provide chronic care management services to you or your child.
- Intermountain Healthcare is allowed to bill your insurance for these services during any month that they provide at least 20 minutes of chronic care management services to you or your child.
- You understand that only one (1) provider or hospital can provide and bill for chronic care management services for you during a calendar month. You agree to let us know if you receive these services from any other provider during any month.
- You will have 24/7 access to a member of the care team (on-call provider) who is familiar with the plan.
- You agree to allow ______________________________ to share your care information electronically with other providers delivering care to you.
- You understand that standard coinsurance, copays, and deductibles apply to chronic care management services. This means you may be billed for these services up to once a month, even if there is not face-to-face meeting with your provider. You may stop these services at any time, effective at the end of the calendar month.

I, ____________________________________, parent/guardian of ______________________________,

agree to participate in Chronic Care Management (CCM) Services and pay the associated fees. All of my questions about CCM services have been answered.

____ (Parent or Guardian signature)

________________________ (Today's Date)



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