



**Enhancing Child Health in Oregon
Learning Session #2 Agenda
May 19th, 2012: 8AM to 4PM
World Forestry Center
4033 SW Canyon Rd
Portland, OR 97221**

- 8:00-8:15** Welcome and Introductions
- 8:15-8:30** Overview of Learning Session Activities
- 8:30-9:30** Report Back from Practices and PDSA Cycles
- 9:30-9:45** Break
- 9:45-12:00** Keynote: The What, Why, Who and How of Care Coordination: A Symphony in B flat by Dr. Robert Nickel
- 12:00-1:00** Working Lunch – Applying Complexity Scales to Determine Care Coordination Needs for CYSHN; Reimbursement Strategies
- 1:00-2:00** PDSA Cycle planning
- 2:00-3:00** Teamness
- 3:00-3:45** Report Back: Planning for Next Action Period
- 3:45-4:00** Next Steps



Context for Care Coordination Learning Session

Functional definition of care coordination (from J McAllister and C Cooley):

Practice-based care coordination within the medical home is a direct, family/youth-centered, team oriented, outcomes focused process designed to:

- Facilitate the provision of comprehensive health promotion and chronic condition care;
- Ensure a locus of ongoing, proactive, planned care activities;
- Build and use effective communication strategies among family, the medical home, schools, specialists, and community professionals and community connections; and
- Help improve, measure, monitor and sustain quality outcomes (clinical, functional, satisfaction and cost)

From the PCPCH Standards:

Care coordination functions can include but are not limited to:

- *tracking of ordered tests and result notification,*
- *tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians,*
- *and direct collaboration or co-management of patients with specialty mental health, substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long term care services and supports.*

Goals and Objectives:

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1. To provide an overview of care coordination functions for primary care providers, both within the health care system and across other systems of care.
2. To share patient and family perspectives in the experience of navigating the health care system for children with special health care needs
3. To help practices assess their current level of functioning as a team, and to help practices consider how Care Coordinators can be integrated into clinical practice.



Objectives:

By the end of this session, participants will be able to:

- Implement a family needs assessment into the workflow for care coordination of CYSHN.
- Understand the content of care coordination toolkits, and how the content of these toolkits can be incorporated into clinical practice.
- Describe the use and utility of shared care plans in managing CYSHN.
- Incorporate techniques for setting shared goals with patients.
- Describe the process of pre-visit planning for CYSHN.
- Incorporate transition plans into clinical workflows for CYSHN.