

Care Coordination Workgroup Telemeeting
Tuesday, July 28, 2009 ~ 11 am CT/ 12 pm ET
1 866/ 489-0573; *4545164*

Co-Leads: Jennifer Arveson; Kathy Wood	Facilitator: Sally J. Hiner, Region 4 Genetics Collaborative Senior Project Coordinator
Participating: Jennifer Arveson, MN; Anne Weaver, KY; Kathy Wood, IN. Region 4 Staff: Sally Hiner, R4 Collaborative Coordinator; Brianne Dzwonek, R4 Intern; Sarah Wedepohl, R4 Parent Coordinator.	
Meeting Goals <ul style="list-style-type: none"> • Workgroup will be informed of changes in resources available, activities of staff on behalf of workgroup • Workgroup will continue development of a care coordination toolkit <ul style="list-style-type: none"> ○ Consensus on purpose Achieved 07.28.09 ○ Consensus on components ○ Consensus on categories Achieve 07.28.09 ○ Explore moving from comprehensive child and family record to tool for planned, coordinated care ○ Identify next steps 	

Item	Discussion/ Notes	Recommendation/ Action	Follow up (who/ when)
I. State Roll Call – Wood/ Arveson			
II. Meeting			
A. Materials Overview (Hiner/ Dzwonek)	H.O.#1 Meeting Guide H.O.#2 Toolkit Intro H.O.#3 Components H.O.#4 Broad Categories H.O.#5 Working Care Plans H.O.#6 Chronic Condition Management H.O.#7 Care Co-Management	Hiner reviewed the materials provided to support engagement in the team meeting.	
B. Agenda Additions – (Group)	None		
III. Developing the Care Coordination Plan			
A. Staff Activities	Hiner and Dzwonek described activities engaged in since June telemeetings, including <ul style="list-style-type: none"> • Compiled and reviewed all materials 	The CCWG Care Plan Assessment tool included both components that should be available for inclusion in a care plan and	

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	<p>available on the AAP website</p> <ul style="list-style-type: none"> • Compared with Care Coordination plans reviewed by workgroup last fall • Utilized care plan review tool to identify all necessary components and desirable characteristics for usability • Reviewed all workgroup products 	<p>things identified by the workgroup to make careplan implementation more user-friendly and effective. The tool was used to guide formulations for recommendations for the care plan tool that is evolving.</p>	
<p>B. Toolkit Intro (H.O.#2)</p>	<p>Group reviewed the Intro (H.O. #2) presented by Hiner and Dzwonek. Discussion: The current plan is evolving as a menu driven group of tools for initiation by the family member. This is based on the assumption that unless a practice already is a medical home (in which case they should already be using a care plan) or has a paid staff person responsible for care coordination; care plan development be the responsibility of the parents.</p>	<p>Consensus: Intro should include</p> <ul style="list-style-type: none"> • Who this is intended for • Tips for where to start? • Stress that care provider can be particularly helpful with certain information (e.g. special dietary concerns, medications, etc.) • Message to family – how to ask for help, request provider review, etc. 	<p>Group to review and comment</p>
<p>C. Components (H.O.#3)</p>	<p>A comprehensive list of suggested sections was presented by Hiner and Dzwonek. Discussion: What is most important to go into main outline</p>	<p>Consensus: Need to address</p> <ul style="list-style-type: none"> • Duplication of information across forms • Assisting user to identify components to “pull” into different care plans for different audiences/ purposes • Each component should have Tips/ How to use info, as appropriate 	<p>Group to review for completeness of comprehensive list. Is anything missing?</p>
<p>D. Organization (H.O.#4)</p>	<p>A list of broad sections to guide organization of the tools available in the care plan development kit was presented by Hiner and Dzwonek.</p>	<p>Consensus</p> <ul style="list-style-type: none"> • Tips can include types of plans that might include this component • Include a brief intro at beginning of each section – what the forms are intended to collect, who might this information be helpful to? • Sections will be re-ordered based on recommendations received during group discussion 	<p>Dzwonek/ Hiner to revise for next meeting</p>

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		<ul style="list-style-type: none"> • Include narrative describing what can be found in each section 	
<p>E. Using the information for planned, coordinated care (H.O. #5,6,7)</p>	<p>Hiner reviewed the sample plans distributed to the workgroup. Discussion: Moving from a comprehensive health history to utilizing the information for planning, including goal identification and reaching goals. Do you need Rx refills Note when school starts re: special diet</p>	<p>Consensus</p> <ul style="list-style-type: none"> • Explore common goals that kids might share to include in goals worksheet • Plans should include steps for reaching milestones as well as measuring achievement • Plans should include informing/ reflecting agreement re: which provider does what in the child's current situation (medical care coordination) • Assist parents in planning and preparing for "encounters" • Plans should include how to provide the best care for the child in the current situation. • Tips should include things for parents to think about to help proactive planning (do you need Rx refills? When school starts – are there issues with special diet) • Explore incorporating MEMSCIS as the Emergency Component 	
IV. Next Steps			
<p>A. Long Term</p>	<p>Region 4 parent and professional team(s) to "pilot" the tool Incorporate into the Medical Home Guide</p>	<p>K. Wood would be interested in using with a patient and family.</p>	
<p>B. Immediate</p>	<p>Work toward finalizing the Care Coordination Care Plan Tools Explore incorporating MEMSCIS as the Emergency component</p>		
Announcements			
<p>Next Meeting</p>	<p>Tuesday, August 25th Regional Meeting – April 16th and 17th</p>		<p>Notes by Hiner</p>

