Care Coordination Quality Improvement Grants

April 9, 2019
Health Care Home Pre-Conference Session

Wendy Berghorst MS, RN, PHN
Coordinated Care Systems Specialist
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter/Location</th>
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<tbody>
<tr>
<td>1:00 – 1:10</td>
<td>Welcome &amp; Background</td>
<td>Wendy Berghorst</td>
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<td>1:10 – 1:35</td>
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<td>1:40 – 2:05</td>
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<td>2:10 – 2:35</td>
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<td>West Side</td>
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<td>2:35 – 3:00</td>
<td>BREAK</td>
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<tr>
<td>3:00 – 3:25</td>
<td>4</td>
<td>CHI – St. Gabriel’s</td>
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<td>3:30 – 4:00</td>
<td>5</td>
<td>Essentia Health</td>
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<td>4:00 – 4:30</td>
<td>Round robin/networking/Q &amp;A</td>
<td>Each team has a Station</td>
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Mission:
Protecting, maintaining, and improving the health of all Minnesotans

Vision:
The MDH vision is for health equity in Minnesota, where all communities are thriving and all people have what they need to be healthy.
Protect, promote, and improve the health of children and youth with special health needs and their families.
Responsibilities:

**ASSESS:** Monitor and report on the health and well-being of CYSHN.

**ASSURE:** Engage in the development, coordination, and support of state and local systems for CYSHN.

**POLICY DEVELOPMENT:** Serve in an advisory capacity to a variety of policy-making bodies to assure the interests of CYSHN are considered.
Minnesota CYSHN Strategic Plan / Core Outcomes

Overarching Themes

Family-Centered Care

1. Ongoing, coordinated, comprehensive care within a health care home
2. Adequate private and/or public insurance
3. Screened early and continuously
4. Organized services families can easily navigate
5. Families are partners in decision-making
6. Transition services to adult health care, work, and community

Vision Elements
Implement strategies to advance the provision of effective, high performing care coordination for MN children & young adults

Grant Period:
Dec 1, 2017 – May 31, 2019
Care Coordination Key Elements : Focus Area Options

1. Needs assessment/continuing care coordination engagement
2. Care planning and communication
3. Facilitating care transition
4. Connecting with community resources and schools
5. Transition to adult care
• Support implementation of best practices of care coordination services across the state

• Funding for primary and specialty care practices

• Plan & implement QI projects related to care coordination

• Pediatric and young adult population
Objectives

Participants will

1. Identify QI activities that support children with special health care needs by improving coordination of care.
2. Review tools & strategies to consider implementing in their own setting.
3. Network and share learnings with others in MN.
Upcoming Conference:
Transforming Care and Experience for Children with Health Complexity

Thursday, June 20, 2019
9:00 a.m. – 5:30 p.m.
317 on Rice Park
Event Center

Register Now!
Gillettechildrens.org/carecoordination

Transforming Care and Experience for Children with Health Complexity

This conference is for all persons caring for children with complex conditions including care coordinators, specialists, parents, pediatricians, primary care physicians, advanced practice providers and nurses as well as other health care professionals. Our overall conference goal is to advance the system of comprehensive, family-centered care coordination that supports families of children who have complex conditions.

Course Objectives
At the completion of the course, participants should be able to:
• Promote shared plans of care as a tool to increase coordination of care across the child’s providers and family
• Identify how to support families and providers to work as colleagues in the child’s care
• Recognize services and support that families need to successfully care for child in the home

For full conference details and to register, visit our website: gillettechildrens.org/carecoordination
Questions: cme@gillettechildrens.com