



VCHIP Care Coordination Summit #2

Vision: The Care Coordination Summits will bring together healthcare professionals, organizations, patients, families, and other interested parties around a shared vision for improving and uniting care coordination efforts for children and youth with special health needs.

Goals for Summit #2:

- Share priority areas with Summit participants
- Identify initial improvement opportunities
- Communicate plan for continued engagement

Selecting Priority Areas

Priority areas and improvement opportunities were identified by participants (Appendix A) from the Care Coordination Summit #1, held virtually on March 22, 2022. Participants were randomly selected to join a smaller group, where they were lead through a facilitated discussion designed to answer the following questions:

- What areas related to care coordination resonate with you, or are already being addressed by stakeholders?
- What areas related to care coordination are not already being addressed? What is missing?

The project team then organized the ideas, opinions, and issues generated by the groups into a table (Appendix B). The visualization highlights key priority areas across the top and opportunities for improvement under each area. Additional strategies may be added as participation and engagement evolves.

Family Partnerships and **Health Equity** are foundational to our work and have been integrated across the domains. Our work will support and encourage input from those with lived experience. Improvement strategies will aim to reduce barriers to accessing care and encompass a variety of supports to acknowledge the diversity among families.

Call to Action

Our work will begin with the convening of the Care Coordination Summits and will continue with ongoing meetings bringing together stakeholders and partners to advance the collaborative work optimizing care coordination services for children. We acknowledge and thank the stakeholders, partners, and families that have committed their time to this endeavor. Your guidance and participation are valued



Appendix

Appendix A

Care Coordination Summit Priorities for Improving and Uniting Care Coordination Efforts for Children and Youth with Special Health Needs

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VCHIP Care Coordination Summit Priorities for Improving and Uniting Care Coordination Efforts for Children and Youth with Special Health Needs

Workforce	Technology	Communication	Systems Integration
Develop clearly defined roles and responsibility for care teams	Identify common communication platforms	Develop and provide Shared Plans of Care	Improve understanding of the many funding sources to support care coordination
Identify a process to match care teams to patient needs during episodes of care (crisis, acute illness, chronic illness, maintenance)	Leverage telemedicine to improve access to care	Improve communication between cross state care teams	Align resources and care coordination efforts
Integrate behavioral health providers to address family stress	Utilize informatics to capture outcome data	Streamline communication within an organization	Promote use of 211, Help Me Grow, Vermont Family Network as central hubs for resources
Identify efficiencies to avoid redundancies or duplication among care teams	Leverage VITL to improve timely access to health information	Streamline communication across different organizations	Integrate with schools & early education centers
Facilitate collaboration and partnerships between care teams (“coordinate the coordinators”)		Utilize care conferences to improve communication between families, care teams, and others	Address gaps in current care coordination models
Develop clear expectations for care teams and families		Enhance communication systems within care teams	Engage insurers and payors to help navigate insurance system
Develop and socialize standardized definitions for: -care coordination -case management -care management		Identify a point person for families	Increase networking & shared learning opportunities with care coordinators and stakeholders
Provide job skills training and support to care coordinators		Offer several different communication modalities based on family preference	Integrate with public health
Assess family needs to align services and resources with current family need		Provide information in several different modalities based on patient and family preference	Share quality metrics and outcome data
Diversify workforce so all patient populations are represented		Increase access to interpreters and other communication supports	Curate resource that describes different care coordination models
Provide cultural humility training to care teams		Develop materials or guidebooks for families to help navigate complex systems or access services	Provide flexibility and choices for families to access care coordination services (“no wrong door”)
Incorporate cultural humility into services provided		Provide scheduled check-ins based on families’ preferred method – email, phone, in person, telehealth, (proactive vs. reactive)	Provide statewide access to high quality care coordination
Develop systems to identify and monitor vulnerable patients			Provide opportunities for marginalized areas to be represented

Family Partnerships and Health Equity Integrated Across Domains