HealthLinks

Care Conference Facilitator Quick Guide

Pre-Conference

- Meet with the patient to understand their strengths, priorities and unmet needs. Work with the patient to identify key supports (current or proposed) and potential goals.
- In partnership with the patient determine the care conference modality required (virtual or face to face as well as the location) and clarify areas of focus for the care conference.
- Talk with the Primary Care Provider (PCP) and review the Health Links approach to care, roles and responsibilities, the patient's health status and issues discussed with the patient. Gather information about the PCP's perspective. Request their preferred method of input into the care planning process (discuss care conference options-telephone, teleconference, face to face and various places in which this meeting may take place such as the patient's home or the physician's office).
- Set a time and place for a care conference which best meets the needs of various parties including the patient, family, PCP and others as appropriate.
- Call other members of the care team individually to review the need for a collaborative care plan and conference. Outline the goals of the meeting and the reason their input is requested.

During the Conference

- Welcome participants, introduce yourself and describe your role.
- Invite all participants to introduce themselves and their role.
- Explain the purpose of the conference and briefly describe the process which will be followed.
- Discuss the patient's overall medical history and their current challenges. Invite further comment or clarification from the patient/family.
- Summarize comments into specific actionable goals.
- With each specific goal, invite participants to share their perspectives on how, given their individual expertise, the patient can achieve these goals and the resources which can be provided to support success. Document points of agreement and/or disagreement.
- Once each goal has been discussed, summarize the discussion and check for accuracy/understanding, noting the agreed upon actions.

- For each action item identify the individual who take the lead responsibility and the timeline for implementation of actions.

- Invite patient/family to provide feedback about the conference outcomes and discuss the next steps related to the completion and sharing of the coordinated care plan (CCP).

- Provide contact information and encourage participants to circle back to the care coordinator, the single point of care if any concerns arise.

Post Care Conference

- Document conference, complete CCP and send a copy to each conference participant.

- Meet with patient to review the CCP, including action items, and provide them with a copy.

- Share the CCP and document its completion. Proceed to monitoring the success of the CCP.