### 2020 Advancing Family-Centered Care Coordination using a Shared Plan of Care Learning Community QI Project

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| By December 31, 2020, 85% of families will agree/strongly agree that the SPoC helps ensure more of their child’s needs are met | Clinicians and care team members understand value of SPoC               | • Review best practice literature on development and use such as “Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs”  
• Use of strategies for communicating with other staff members defining and explain a SPoC and how it may be used (such as developing a “What is a Shared Plan of Care” flyer)  
• Use of SPoC with different groups within selected population (different diagnoses or condition severity, different levels of education, different economic resources) |
| Families and youth understand value of SPoC                         |                                                                       | • Use of strategies for communicating with families defining and explaining a SPoC and how it may be used (such as developing a “What is a Shared Plan of Care” flyer)  
• Dedicated staff member to explain and develop SPoC  
• Explain “personal goals” section of SPoC using accessible language (“What matters to you?”/“What’s important to you?”)  
• In collaboration with your Regional Center, conduct a Care Mapping workshop |
| SPoC improves the quality of communication                           |                                                                       | • Use strategies to empower families to communicate with other health systems, agencies about the SPoC (test scripted language or develop a SPoC cover page)  
• Use SPoC with care team members, hospitalists, emergency department clinicians and other clinical care providers to communicate about family/child  
• If working with youth between 12-21 years of age, implement transition strategies for planning the transition from pediatric to adult care |
| Building a network of community supports for families, children and youth |                                                                       | • Develop action steps for family members to reach their short and long term goals  
• Identify the stressors that may impact family success  
• Identify and connect families to organizations/support that families may need  
• Aggregate and analyze data of families who have documented goals in their SPoC to support building partnerships  
• Share the SPoC (or relevant portions of it) to ensure community supports may be aware of a family’s identified goals, strengths, and needs AND who can help the family reach their goals (i.e. school professionals, child care providers, early intervention) |
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| Clinic has established processes for SPoC development, implementation and updating | • Frequency of regular team meetings (Q2 wk. vs Q mo. vs other)  
• Team meetings are scheduled at convenient times/locations for families  
• Frequency of SPoC updates (Q3 mo. vs Q6 mo. vs other)  
• Roles for care team members in SPoC process (test different members leading different parts of process) |
|---|---|
| SPoC accessible to all partners | • Family-friendly format  
• Share hard copy SPoC with families (and patient portal if available)  
• Make SPoC available within EMR |
| Family Representatives/Partners are valued project team members | • Family partners have an identified and accessible ‘buddy’ or mentor  
• Families are included in decisions about SPoC design/revisions/project activities  
• Meeting materials are available in formats that families can access, at an appropriate language and literacy level, and in a timely manner  
• Family members are invited and participate in the Family Representative Calls and April in-person event.  
• Families are compensated for their time, expertise, and costs of participation such as childcare or travel expenses. |
| Participate in learning community opportunities on Shared Plan of Care work | • Initiate discussions with other project teams (available in Life QI)  
• Share resources and best practices (available in Life QI)  
• Document your Plan-Do-Study-Act (PDSA) cycles in Life QI or available form |

### Measures

1. Percent of families agreeing/strongly agreeing the SPoC helps ensure more of their child’s needs are met (Outcome)  
   - Family quarterly survey (goal 85%)

2. Percent of team meetings that include a family member (Process)  
   - Care Team quarterly survey (goal 75%)

3. Percent of families agreeing/strongly agreeing that the SPoC helps them tell other service providers (schools, childcare providers, others) about their child’s needs. (Process)  
   - Family quarterly survey (goal 60%)

4. Percent of teams neutral/disagreeing/strongly disagreeing use of SPoC helps their team communicate more efficiently (Balancing)  
   - Care team quarterly survey (goal 20%)