

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

AIM	Drivers	Tests of Change Ideas
<p>By December 31, 2020, 85% of families will agree/strongly agree that the SPoC helps ensure more of their child's needs are met</p>	<p>Clinicians and care team members understand value of SPoC</p>	<ul style="list-style-type: none"> <li>Review best practice literature on development and use such as <a href="#">“Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs”</a></li> <li>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)</li> <li>Use of SPoC with different groups within selected population (different diagnoses or condition severity, different levels of education, different economic resources)</li> </ul>
	<p>Families and youth understand value of SPoC</p>	<ul style="list-style-type: none"> <li>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)</li> <li>Dedicated staff member to explain and develop SPoC</li> <li>Explain “personal goals” section of SPoC using accessible language (“What matters to you?”/“What’s important to you?”)</li> <li>In collaboration with your Regional Center, conduct a Care Mapping workshop</li> </ul>
	<p>SPoC improves the quality of communication</p>	<ul style="list-style-type: none"> <li>Use strategies to empower families to communicate with other health systems, agencies about the SPoC (test scripted language or develop a SPoC cover page)</li> <li>Use SPoC with care team members, hospitalists, emergency department clinicians and other clinical care providers to communicate about family/child</li> <li>If working with youth between 12-21 years of age, implement transition strategies for planning the transition from pediatric to adult care</li> </ul>
	<p>Building a network of community supports for families, children and youth</p>	<ul style="list-style-type: none"> <li>Develop action steps for family members to reach their short and long term goals</li> <li>Identify the stressors that may impact family success</li> <li>Identify and connect families to organizations/support that families may need</li> <li>Aggregate and analyze data of families who have documented goals in their SPoC to support building partnerships</li> <li>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)</li> </ul>

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	Clinic has established processes for SPoC development, implementation and updating	<ul style="list-style-type: none"> <li>• Frequency of regular team meetings (Q2 wk. vs Q mo. vs other)</li> <li>• Team meetings are scheduled at convenient times/locations for families</li> <li>• Frequency of SPoC updates (Q3 mo. vs Q6 mo. vs other)</li> <li>• Roles for care team members in SPoC process (test different members leading different parts of process)</li> </ul>
	SPoC accessible to all partners	<ul style="list-style-type: none"> <li>• Family-friendly format</li> <li>• Share hard copy SPoC with families (and patient portal if available)</li> <li>• Make SPoC available within EMR</li> </ul>
	Family Representatives/Partners are valued project team members	<ul style="list-style-type: none"> <li>• Family partners have an identified and accessible 'buddy' or mentor</li> <li>• Families are included in decisions about SPoC design/revisions/project activities</li> <li>• Meeting materials are available in formats that families can access, at an appropriate language and literacy level, and in a timely manner</li> <li>• Family members are invited and participate in the Family Representative Calls and April in-person event.</li> <li>• Families are compensated for their time, expertise, and costs of participation such as childcare or travel expenses.</li> </ul>
	Participate in learning community opportunities on Shared Plan of Care work	<ul style="list-style-type: none"> <li>• Initiate discussions with other project teams (available in Life QI)</li> <li>• Share resources and best practices (available in Life QI)</li> <li>• Document your Plan-Do-Study-Act (PDSA) cycles in Life QI or available form</li> </ul>

### 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%)