### Driver Diagram: Advancing Family-Centered Care Coordination Learning Community QI Project

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<thead>
<tr>
<th>AIM</th>
<th>Drivers</th>
<th>Tests of Change</th>
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| By December 31, 2018, 255 Shared Plans of Care (SPoC) will be in use by teams involved in the Care Coordination Learning Community. | Clinicians and care team members understand value of SPoC               | • Review best practice [literature on SPoC development and use](#)  
• Participate in learning community calls, April 24 in-person event  
• Review WISMHI website with [care coordination resources](#) |
|                                                                     | Families and youth understand value of SPoC                             | • Use of strategies for communicating with families when enrolling in pilot, developing SPoC (such as [letters of introduction](#) or recruitment, scripts for in-person conversations, [cover pages on SPoC](#) to explain how families might choose to use document)  
• Pre-visit planning call – introduce SPoC  
• Explain “personal goals” section of SPoC using accessible language (“What matters to you?”/“What’s important to you?” versus “What are your goals?”)  
• Dedicated staff member to explain and develop SPoC  
• Promote WI Family Voices’ [Coordinating your Child’s Health Care](#) training among enrolled families |
|                                                                     | Partners involved in the child’s care understand value of SPoC         | • Share SPoC with emergency department clinicians and care team members, hospitalists, other clinical care providers  
• Share SPoC with school professionals  
• Share SPoC with early intervention |
|                                                                     | SPoC improves quality of care coordination                              | • Involve families in SPoC development  
• Share SPoC with other partners caring for child (hard copy vs EMR availability)  
• Update SPoC at regularly scheduled intervals |
|                                                                     | Clinic has established processes for SPoC development, implementation and updating | • Hold regular team meetings  
• Clearly define roles for care team members in SPoC process  
• Explore scheduling flexibility (appointment length)  
• Expand enrollment criteria  
• Gather data using care coordination time-tracking tool (such as CCMT) |
|                                                                     | SPoC accessible to all partners                                         | • Make SPoC available within EMR (“letters” section vs. other areas)  
• Make SPoC available within EMR as fillable document (vs. scanned form)  
• Share hard copy SPoC with families (+ patient portal access as well) |
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Measures
1. Number of SPoC in use by teams (Outcome)
   - Care team quarterly survey
2. Percent of families agreeing/strongly agreeing the SPoC helps ensure more of their child’s needs are met (Process)
   - Family quarterly survey
3. Percent of teams agreeing/strongly agreeing use of SPoC helps them better communicate with, partner with, and engage families (Process)
   - Care team quarterly survey
4. Percent of teams agreeing/strongly agreeing use of SPoC helps them better coordinate care with health care system counterparts (Process)
   - Care team quarterly survey
5. Number of teams participating in learning community calls, in-person meeting (Process)
   - WISMHI attendance sheet
6. Percent of teams neutral/disagreeing/strongly disagreeing use of SPoC helps their team communicate more efficiently (Balancing)
   - Care team quarterly survey

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