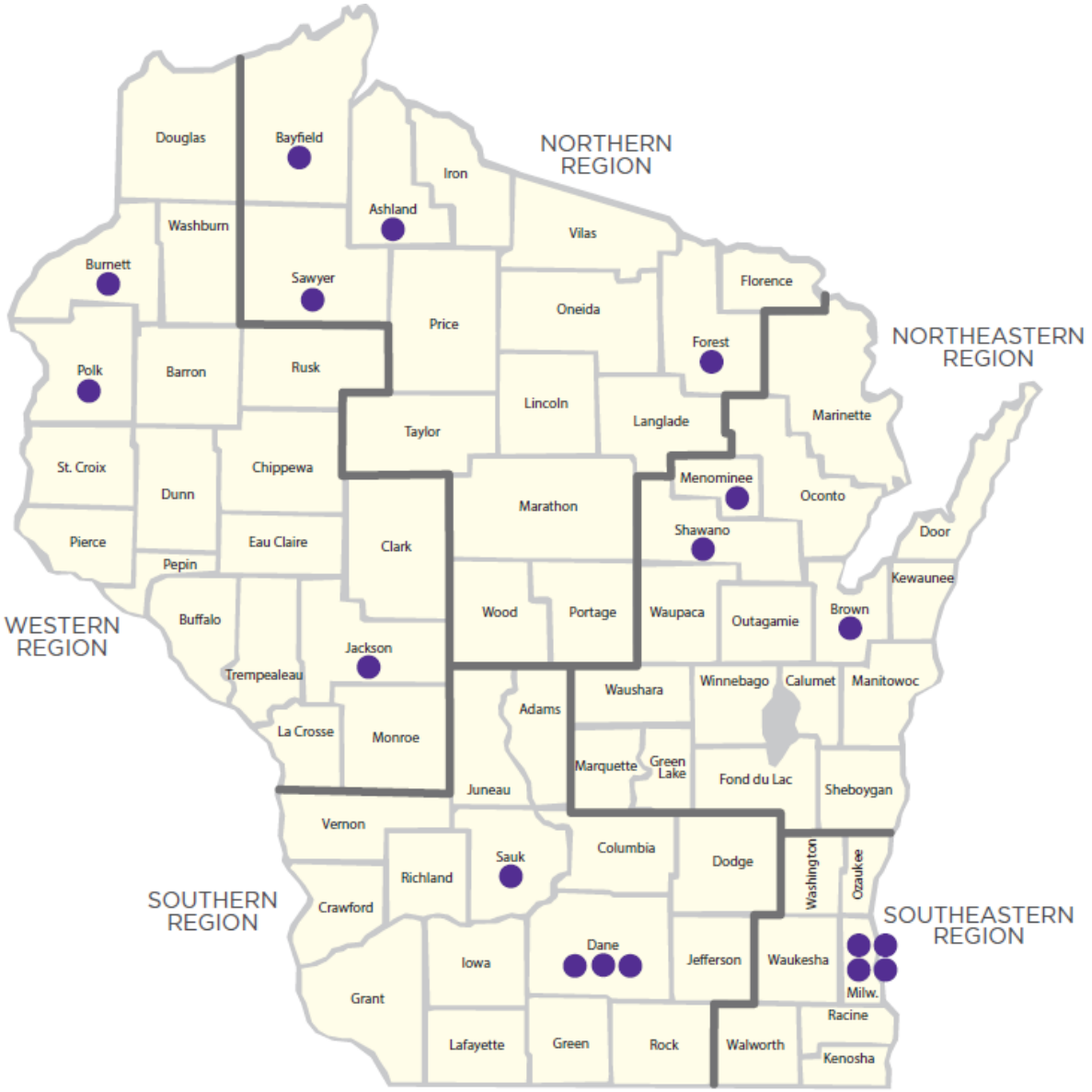
2018 Advancing Family-Centered Care Coordination for CYSHCN QI Project

Learning Community Call

February 27, 2018


NORTHERN REGION
NORTHEASTERN REGION
WESTERN REGION
SOUTHERN REGION
SOUTHEASTERN REGION
Douglas
Bayfield
Iron
Ashland
Washburn
Vilas
Florence
Burnett
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Dunn
Chippewa
Menominee
Oconto
Marathon
Shawano
Door
Pierce
Pepin
Eau Claire
Clark
Kewaunee
Wood
Portage
Waupaca
Outagamie
Brown
Buffalo
Jackson
Trempealeau
Waushara
Winnebago
Calumet
Manitowoc
Adams
La Crosse
Monroe
Marquette
Green Lake
Fond du Lac
Sheboygan
Juneau
Vernon
Columbia
Dodge
Washington
Ozaukee
Sauk
Richland
Crawford
Dane
Iowa
Jefferson
Waukesha
Milw.
Grant
Racine
Lafayette
Green
Rock
Walworth
Kenosha

Northern Region Teams

Health Center	Population
Bad River Tribal Health Center	Children with emotional/behavioral challenges
Lac Courtes Oreilles Community Health Center	Children with asthma
Red Cliff Community Health Center	Children with emotional/behavioral challenges
Sokaogon Chippewa Health Clinic	Children with medical complexity

Northeast Region Teams

Health Center	Population
Prevea Health Clinic	Children with rheumatologic diseases
Menominee Tribal Clinic	Children with ADHD
Stockbridge Munsee Health and Wellness Center	Children with ADHD

Southeast Region Teams

Health Center	Population
Children's Hospital of WI – Downs Syndrome Clinic	Children with Down Syndrome
Children's Hospital of WI – Renal/Dialysis/Transplant Clinic	Children with kidney disease
Gerald L. Ignace Indian Health Center	Children with ADHD
Medical College of WI – Rheumatology Clinic	Children with Systemic Lupus Erythematosus

Southern Region Teams

Health Center	Population
Ho-Chunk Nation Dept of Health (*Baraboo & Black River Falls*)	Children with ADHD
UW Health AFCH – Pediatric Complex Care Program	Children with medical complexity
UW Health – Primary Care Pediatrics Clinics	Children with ADHD
Waisman Center – Newborn Follow-up Clinic	Children less than 36 mo of age who spent time in neonatal intensive care units

Western Region Teams

Health Center	Population
Amery Hospital and Clinic	Children with emotional/behavioral challenges
Ho-Chunk Nation Dept of Health (*Baraboo & Black River Falls*)	Children with ADHD
St. Croix Tribal Health Clinic	Children with emotional/behavioral challenges

Essentials Elements of a Shared Plan of Care

1. Medical summary, including providers involved in care
2. Family strengths and preferences
3. Negotiated actions – family goals and clinical goals, timelines, and persons responsible

Other necessary attachments – may include emergency plans, chronic condition protocols, other relevant legal documents such as IEPs or 504 plans.

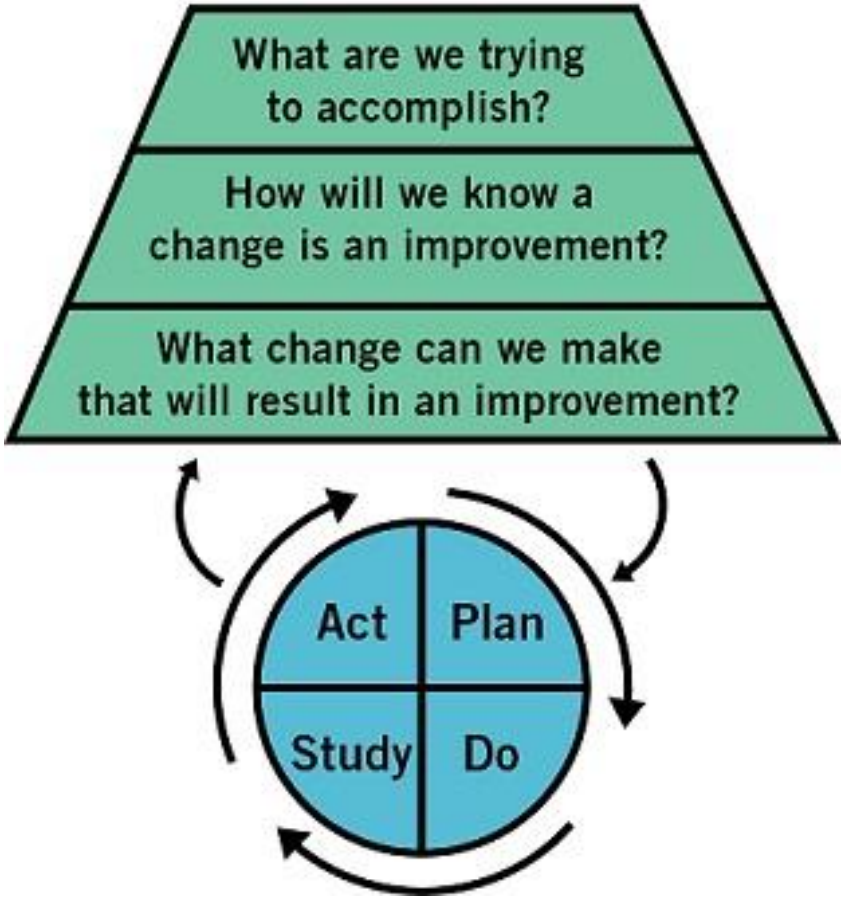
Continuous Quality Improvement

A systematic approach to improving processes and outcomes through

- Regular data collection,
- Examination of performance relative to pre-determined targets,
- Review of practices that promote or impede improvement, and
- Application of changes in practices that may lead to improvements in performance.

Source: Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program. Retrieved, 4/5/2013 from http://www.hrsa.gov/grants/manage/homevisiting/sir02082011.pdf.

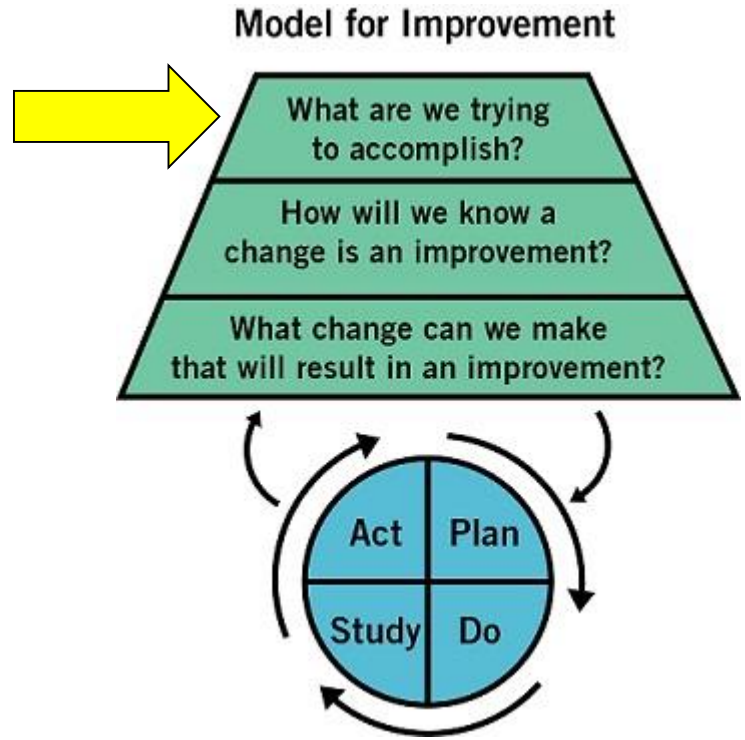
Model for Improvement



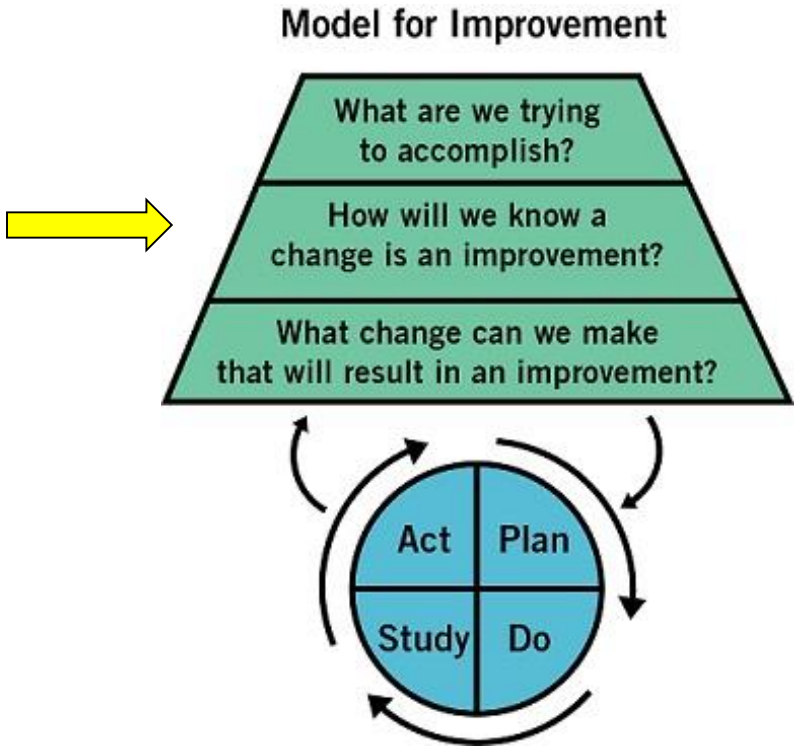
Aim

By December 31, 2018,

255 Shared Plans of Care (SPoC) will be in use by teams involved in the Care Coordination Learning Community.

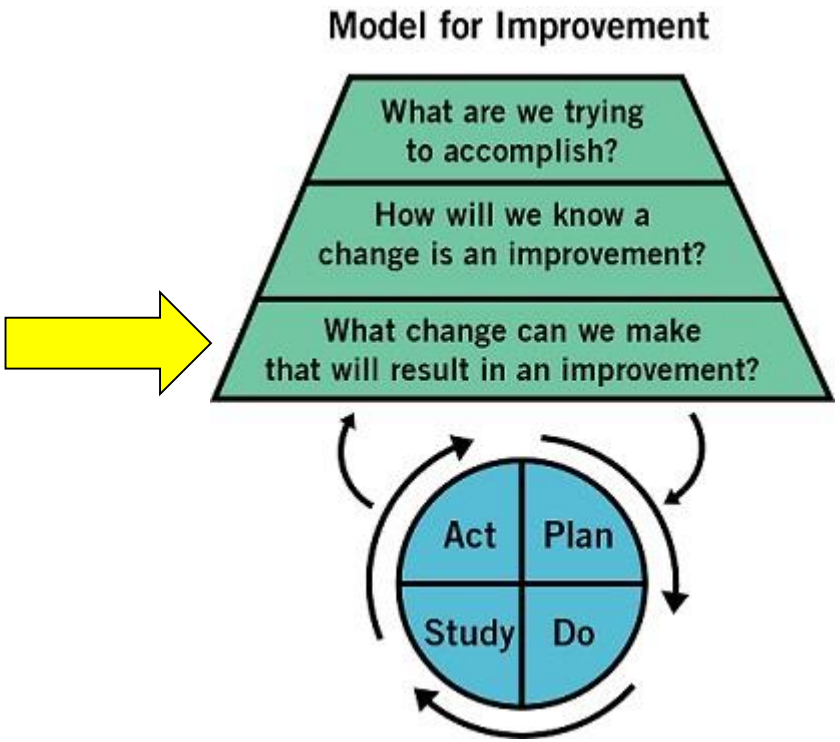


Measures


Model for Improvement
What are we trying to accomplish?
How will we know a change is an improvement?
What change can we make that will result in an improvement?
Act
Plan
Study
Do

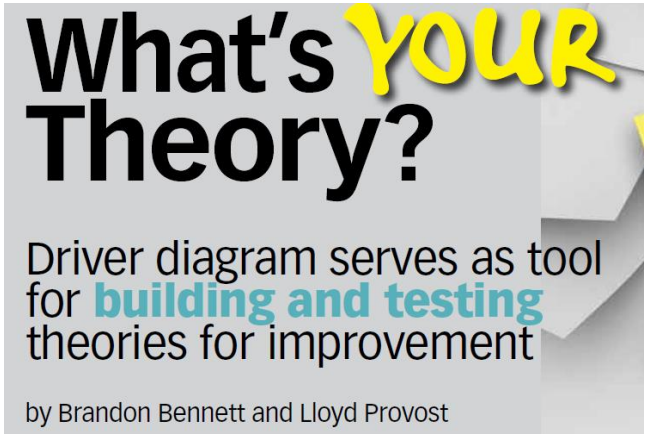
Measure	Measure Type	Source
Number of SPoC in use by teams	Outcome	Care team quarterly survey
Percent of families agreeing/strongly agreeing the SPoC helps ensure more of their child's needs are met	Process	Family quarterly survey
Percent of teams agreeing/strongly agreeing use of SPoC helps them better communicate with, partner with, and engage families	Process	Care team quarterly survey
Percent of teams agreeing/strongly agreeing use of SPoC helps them better coordinate care with health care system counterparts	Process	Care team quarterly survey
Number of teams participating in learning community calls, in-person meeting	Process	WISMHI attendance sheet
Percent of teams neutral/disagreeing/strongly disagreeing use of SPoC helps their team communicate more efficiently	Balancing	Care team quarterly survey

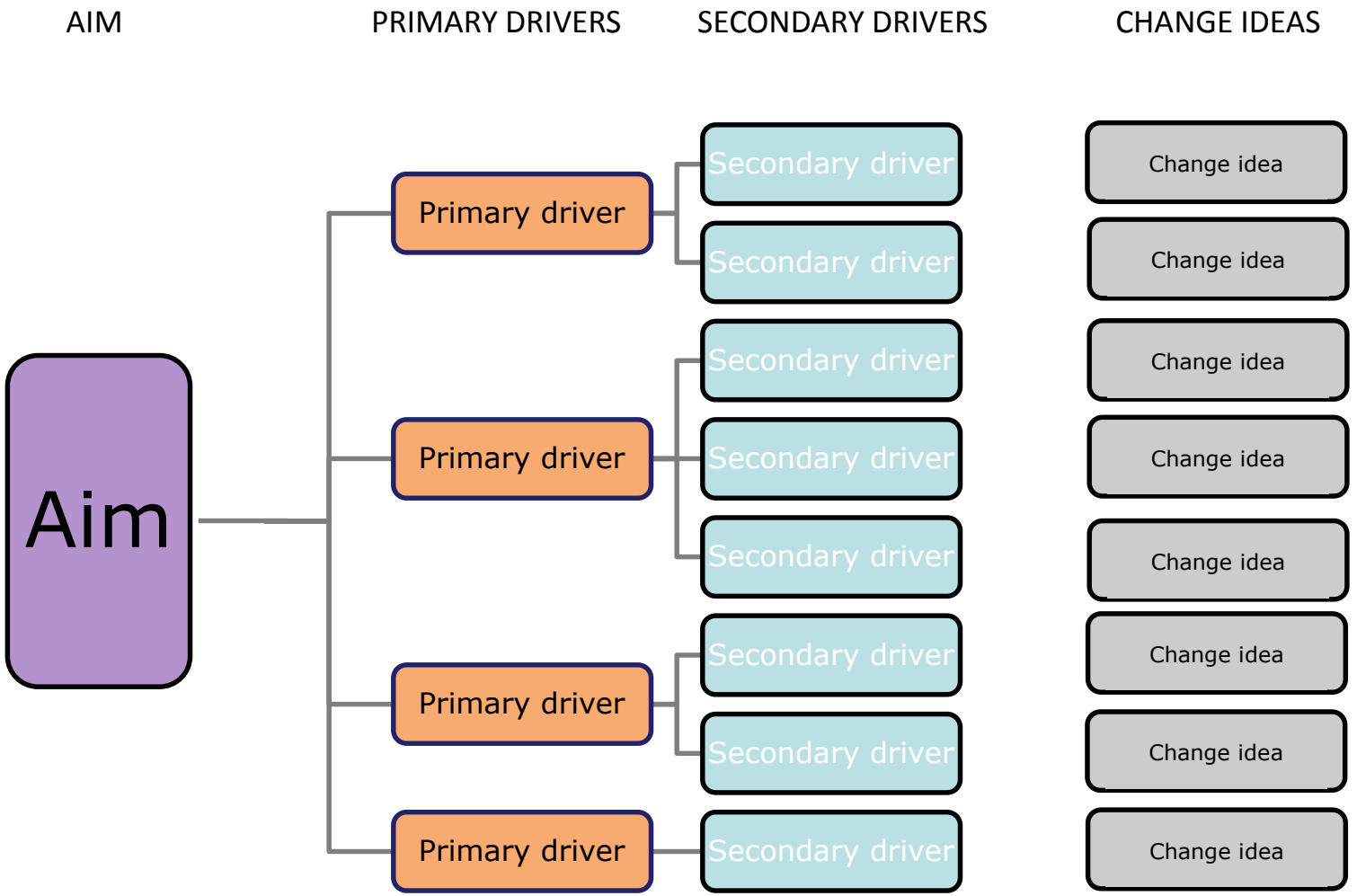
Testing Changes



Driver Diagram

Visual of theory behind what will result in desired improvement




AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE IDEAS
Aim
Primary driver
Primary driver
Primary driver
Primary driver
Secondary driver
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Secondary driver
Secondary driver
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Change idea
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AIM	Drivers	Tests of Change
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) • 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) • 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)

Drivers	Tests of Change
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Drivers	Tests of Change
4. 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
5. 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) • Gather data using care coordination time-tracking tool (such as *CCMT)*
6. 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)

Testing Changes

- Plan
  - Questions & predictions
  - Who/what/where/when?
- Do
  - Observe the test
  - Document results
- Study
  - Analyze the data
- Act
  - Refine the change and plan for the next cycle

PDSA PLANNING WORKSHEET

Project Name:	PDSA Name:
Specific question addressed:	
What is the objective of the test?	
Planned timeline: Start date:	Completion date:

PLAN:

Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What do you predict will happen?

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.			
2.			
3.			
4.			
5.			
6.			

Plan for collection of data:

DO: Test the changes.

Was the cycle carried out as planned? ☐ ☐ Yes ☐ ☐ No

If not, why not?

Record data and observations.

What did you observe that was not part of our plan?

STUDY:

Did the results match your predictions? ☐ ☐ Yes ☐ No

Compare the result of your test to your previous performance:

What did you learn?

ACT: Decide to Adopt, Adapt, or Abandon.

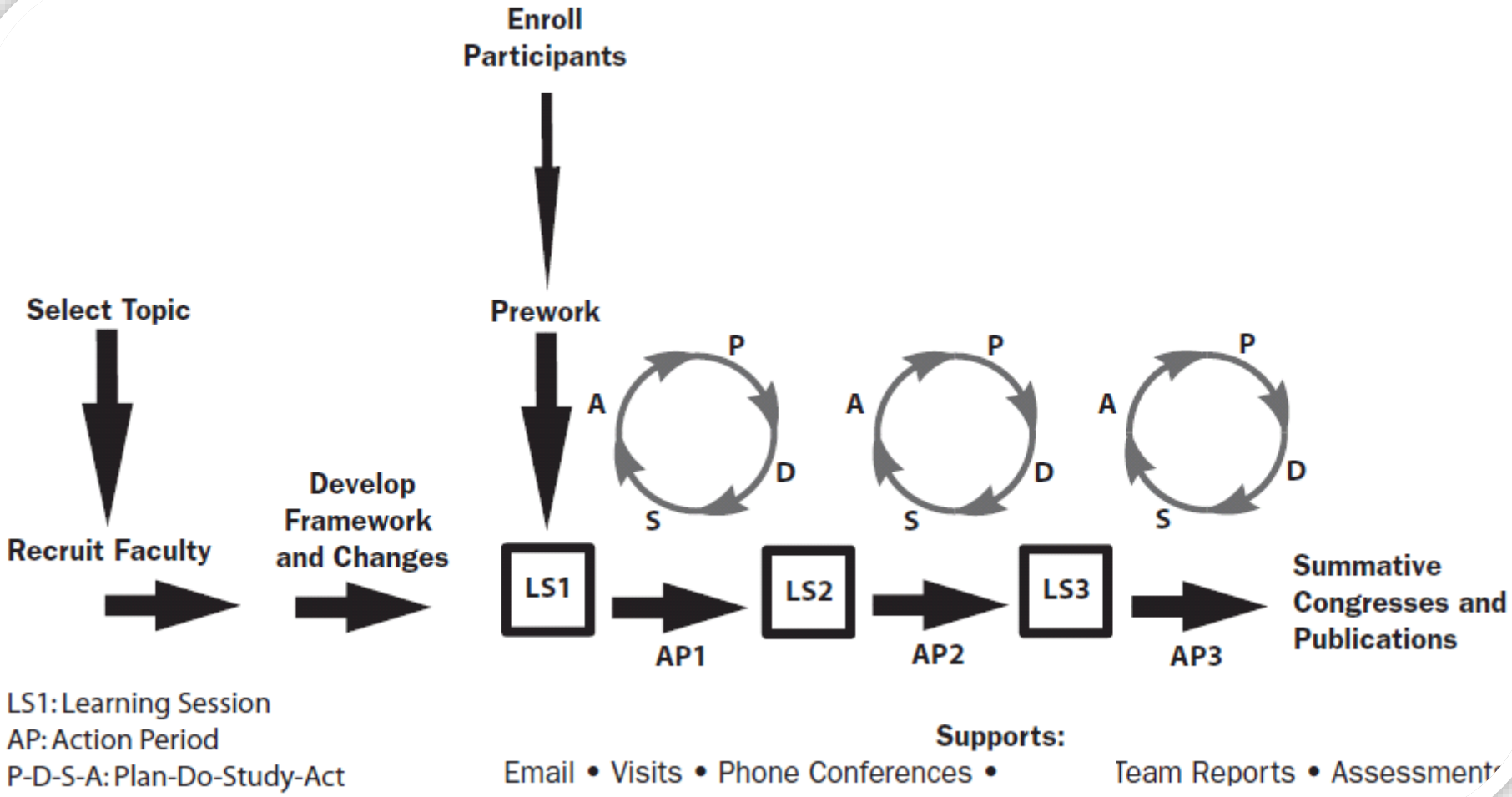
☐ Adapt: Improve the change and continue testing plan.
Plans/changes for next test:/PDSA cycle

☐ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

☐ Abandon: Discard this change idea and try a different one

Next Steps

- Identify one "test of change" you'd like to try out related to your project
- Run at least one PDSA cycle on this test of change before June 26
- Come to June call ready to share about your test of change, and what you learned!


Enroll Participants
Select Topic
Prework
P
A
D
S
Recruit Faculty
Develop Framework and Changes
LS1
LS2
LS3
AP1
AP2
AP3
Summative Congresses and Publications
LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act
Supports:
Email • Visits • Phone Conferences •
Team Reports • Assessment

Learning Community Dates

- Calls
  - June 26 12-1 pm
  - Oct 23 12-1 pm

- In-person meeting (WI Dells)
  - April 24 8 am – 3 pm

Your web page

https://www.wismhi.org/wismhi/Resources/Resources-for-Care-Coordination-Project-Teams

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WISCONSIN Medical Home

Children's Health Alliance of Wisconsin