Advancing Family-Centered Care Coordination
QI Project

Learning Community

February 26, 2019
# Agenda

<table>
<thead>
<tr>
<th>Welcome &amp; Introductions</th>
<th>12-12:10</th>
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<tbody>
<tr>
<td><strong>Using QI Framework to Advance Use of Shared Plans of Care (SPoS)</strong></td>
<td>12:10-12:35</td>
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<tr>
<td>- Learning Communities</td>
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<tr>
<td>- <a href="#">Driver Diagram</a></td>
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<tr>
<td><strong>Life QI Platform</strong></td>
<td>12:35-12:55</td>
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<tr>
<td>- Overview</td>
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<td>- PDSA Sample</td>
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<td><strong>Wrap up &amp; Next Steps</strong></td>
<td>12:55-1:00</td>
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<tr>
<td>- Mar 5: Family Representative Call</td>
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<td>- Week of March 4: Q1 surveys distributed to teams</td>
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<td>- Apr 5: Q1 surveys due</td>
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<tr>
<td>- April 23: In-person Summit meeting (Crowne Plaza, Madison) (registration available soon)</td>
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<tr>
<td>Health Center</td>
<td>Population</td>
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<tr>
<td>Amery Hospital and Clinic</td>
<td>Children with emotional/behavioral challenges</td>
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<td>Bad River Tribal Health Center</td>
<td>Youth in foster care due to opiate-addicted parents</td>
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<td>Children’s Hospital of WI-Complex Care Clinic</td>
<td>Children with medical complexity who are 12 yrs old or older</td>
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<td>Children’s Hospital of WI-Rheumatology Clinic</td>
<td>Children/adolescents with chronic rheumatic disease</td>
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<td>Forest Co Potawatomi Health and Wellness Center</td>
<td>Children/youth diagnosed with global developmental delays and/or Autism Spectrum Disorder</td>
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<td>Gerald L. Ignace Indian Health Center</td>
<td>Children with ADHD</td>
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<td>Peter Christensen Health Center</td>
<td>Children with chronic special health care needs including behavioral health</td>
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<tr>
<td>Health Center</td>
<td>Population</td>
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<tr>
<td>St. Croix Tribal Health Clinic</td>
<td>Children with special health care needs including emotional or behavioral health</td>
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<td>Sokaogon Chippewa Health Clinic</td>
<td>Children with medical complexity/behavioral health</td>
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<td>Stockbridge Munsee Health and Wellness Center</td>
<td>Children with asthma (0-18 yrs old)</td>
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<td>UW Health AFCH – Pediatric Complex Care Program (Ehlenbach)</td>
<td>Children with medical complexity</td>
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<tr>
<td>UW Health AFCH – Pediatric Complex Care Program (Sodergren)</td>
<td>Children with medical complexity (ages 12-21)</td>
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<tr>
<td>Waisman Center – Newborn Follow-up Clinic</td>
<td>Children less than 36 mo of age who spent time in neonatal intensive care units</td>
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Aim to Improve Family Centered Care Coordination for CYSHCN

USING SHARED PLANS OF CARE
AIM:
85% of families will agree or strongly agree that the Shared Plan of Care helps ensure more of their child’s needs are met.
What is a Shared Plan of Care?

Essential Elements:

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.
Why SPoC? For Whom?

- >20% of WI children and youth have some type of special health care need anticipated to last at least a year and requiring services and supports beyond those of other children.
- Fragmentation of care is common, and families often shoulder a disproportionate share of the care coordination burden.
- Care plans developed with families may help reduce hierarchical relationships between health care providers and parents, improve reciprocal information exchange, and strengthen relationships.

Wisconsin report from the 2001/12 National Survey of Children’s Health.
Approach

• Learning Community = cohort of clinical care teams (including families) using quality improvement (QI) methods to reach aim
  – Facilitated by WISMHI

• Over 12 months, teams participate in learning community calls and in-person event

• Participating pediatricians earn Maintenance of Certification credit

• FOCUS: Developing SPoC that help ensure more of child’s needs are met
Learning Community Roles

WISMHI
- Implements all phases of the project
- Establishes and facilitates calls and in-person event
- Communicates updates and results to teams
- Offers targeted, as needed coaching

CYSHCN Program
- Provides grant funding to SPoC projects and WISMHI
- Directs focus of work
- Integrates work into broader CYSHCN programming
- Communicates what has been learned to national partners

Care Teams
- Participate in learning community
- Attend calls and in-person meeting
- Actively involve families in project
- Receive feedback reports & coaching
- Earn professional certification
Why QI to Improve Clinical Care?

Less effective

• Educational materials for health professionals
• Didactic educational meetings

More effective

• Multifaceted interventions/QI
• Academic detailing
• Interactive educational workshops

LA Bero, R Grilli, J Grimshaw, E Harvey, A Oxman, MA Thomson. Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. BMJ1998;317:465-468.
What is a Learning Community?

- Modeled on the Institute for Healthcare Improvement’s *Breakthrough Series*
- Short-term (months) learning system that brings together teams seeking improvement in a focused topic area
- Components
  - **Shared learning**: face-to-face and/or virtual Learning Sessions
  - Structured goals, tests of change, data collection/analysis with feedback to teams
- Based upon the **Model for Improvement**
- Excellent track record of achieving dramatic results
The Model for Improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

AIM
MEASUREMENT
TESTS of CHANGE
Repeated Use of the PDSA Cycle

Hunches, Theories, Ideas → Data → Changes That Result in Improvement
Clinical Practice-Based Improvement

Measures of care and outcomes

Shared learning among teams through meetings and calls

Results back to teams showing comparison with other sites

Improved levels of performance

Provide topic-specific improvement materials and tools

Coaching on improvement goals and implementing change
Clinical Practice-Based Improvement

Measures of care and outcomes

Shared learning among teams through meetings and calls

Results back to teams showing comparison with other sites

Provide topic-specific improvement materials and tools

Coaching on improvement goals and implementing change

Improved levels of performance
# Family of Measures

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<tr>
<th>MEASURE</th>
<th>GOAL</th>
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<tr>
<td>Families agree/strongly agree SPoC helps ensure more of their child’s needs are met</td>
<td>85%</td>
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<td>Care team meetings including family member</td>
<td>75%</td>
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<tr>
<td>Families agree/strongly agree that SPoC helps them tell other service providers (schools, child care providers) about their child’s needs</td>
<td>60%</td>
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<tr>
<td>Teams neutral/disagree/strongly disagree use of SPoC helps their team communicate more efficiently</td>
<td>&lt;20%</td>
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# 2019 Advancing Family-Centered Care Coordination using a Shared Plan of Care Learning Community QI Project

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<tr>
<th>AIM</th>
<th>Drivers</th>
<th>Tests of Change Ideas</th>
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| By December 31, 2019, 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                                                                                   | • Different versions of shared plans of care (previous vs plans containing 3 essential elements)  
• Use of SPoC with different groups within selected population (different levels of education, different economic resources, different condition severity)  
• 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."  
• Partner with Family Voices, Regional Centers, Parent 2 Parent to provide support and resources for families                                                                                                                                                                                                                         |
| 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 |
| SPoC improves the quality of communication                           |                                                                                                                                            | • Use strategies to empower families to communicate with other health systems, agencies about the SPoC (test scripted language)  
• Share SPoC with emergency department clinicians and care team members, hospitalists, other clinical care providers  
• Share SPoC with school professionals, child care providers, early intervention  
• Develop and pilot a consent form to share the SPoC                                                                                                                                                                                                                               |
| 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)  
• Families are engaged to provide feedback about SPoC clinic activities                                                                                                                                                                                                                  |
https://us.lifeqisystem.com/login/
# Programmes

## 2019 NPM Developmental Screening
By December 31, 2019, 69% of sites listed in RedCap will be conducting developmental screening.
- Geeta Wadhwani, Children's Health Alliance of Wisconsin

## 2018 Local Public Health Department Data
By December 31, 2019, 69% of sites listed in REDCap will be conducting developmental screening.
- Geeta Wadhwani, Children's Health Alliance of Wisconsin

## Shared Plans of Care Project 2019
By December 31, 2019, 85% of families will agree/strongly agree that the SPoC helps ensure more of their child's needs are met.
- Geeta Wadhwani, Children's Health Alliance of Wisconsin
Project Teams

Shared Plans of Care Project 2019

Member projects:
- Amery Hospital and Clinic
  - Amery, Wisconsin
  - Children's Health Alliance of Wisconsin
- Children's Hospital of Wisconsin: Complex Care Program
  - Milwaukee, Wisconsin
  - Megan Teed
- Children's Hospital of Wisconsin/MCW: Rheumatology Clinic
  - Milwaukee, Wisconsin
- Provea Pediatrics
  - Green Bay, Wisconsin
PDSA Ramp

1. Define the scope of this ramp
   - Change Idea

2. Define this ramp’s first PDSA Cycle
   - Title
   - Aim

3. Who is responsible for this cycle?
   - Who: Alissa Martin
   - When: 25/03/2019
Discussion Posting and Resource Sharing
New Discussion

1. What is this discussion going to be about?

Title

2. Who’s involved?

Privacy
Everyone can view and post

Members

- Geeta Wadhwani
  Lead User - Admin
  Confirmed

- Children’s Health Alliance of Wisconsin
  Lead Organisation - Admin
  Confirmed
Reminders

- **Mar 5**: Family Representative Call
- **Week of Mar 4**: Q1 surveys sent to teams
- **Apr 23**: In-person Summit, Crowne Plaza, Madison (registration available this week)
- **Sign up for Life QI!**
Thank you!

Colleen Lane (clane@chw.org)