Advancing Family-Centered Care Coordination using a Shared Plan of Care

More than 20% of Wisconsin children have a health care condition needing supports and services beyond their same-aged peers, and expected to last at least a year. Care plans developed with families can assist in promoting care that is coordinated and family-centered. Early evidence suggests that Shared Plans of Care with three essential elements help to ensure more of children's needs are met, and increase families' understanding of their role in their child's care.

The three essential elements of Shared Plans of Care are:

- Medical summary
- Family strengths and preferences
- Negotiated actions, where clinical goals and family goals are identified, along with timelines and people responsible for the goals

Since 2016, over 20 clinics in Wisconsin serving children with chronic conditions have participated in pilot projects to use Shared Plans of Care. Teams receive funding provided to the Wisconsin Medical Home Initiative through a grant from the Department of Health Services' Children and Youth with Special Health Care Needs Program, and use quality improvement approaches to accelerate their learning. Shared Plans of Care have been piloted among families of children with ADHD, JRA and medical complexity, among others.

Pediatricians who can attest to meaningful participation in the project are eligible for 25 MOC Part 4 credits through the American Board of Pediatrics upon project completion.

Grant opportunities are made available in the fall of each year to fund work in the subsequent year.

To learn more:

- Visit the Wisconsin Medical Home Initiative (https://www.chawisconsin.org/medical-home/) or contact Colleen Lane (clane@chw.org)

- Contact your Regional Center for Children and Youth with Special Health Care Needs https://www.dhs.wisconsin.gov/cyshcn/regionalcenters.htm

Feb 2019