Driver Diagram: Advancing Family-Centered Care Coordination Learning Community QI Project (St. Croix Tribal Health Center)

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) • 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)

PDSA on Team Meetings for Role Definition
(St. Croix Tribal Health Clinic)

Plan: Team meeting with role definition

- Question to be answered: Will having a team meeting with each member's role defined clarify expectations for their involvement in the SPoC project?

- Prediction: Team meetings with defined roles will result in greater understanding of the SPoC and each person's role in facilitating the process. Greater understanding will also result in more willingness to explain SPoC to families, and ultimately recruit more families into the project.

Do: Team meeting was held, and roles for nurses, behavioral health, and other clinic professionals in the SPoC project was discussed. This brainstorming led to rich conversation and identification of specific populations of patients who might benefit from SPoC.

Study: Test met prediction of participants having a greater understanding of their role in SPoC project. Participants left the meeting knowing project expectations and to contact project lead if they need assistance signing families up. The team is now on the same page and understands the benefit of this program to the clinic and the communities it serves.

Act: Future meetings for July and August to discuss what is working, what is not and what can be done to make the SPoC project better. Consider gathering information at that time on whether initial meeting resulted in SPoC being explained to more families.

Driver Diagram: Advancing Family-Centered Care Coordination Learning Community QI Project (Waisman Center)

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) • 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
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	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)

	PLAN			DO	STUDY		ACT	
PDSA Cycle #	What change will you test?	What question are you trying to answer?	What do you predict will happen (1 per question)? Predict time and accuracy score	What did you discover while testing? What did you note that was expected/ unexpected?	Go back to your measures and questions in your plan. What are the results of your test for each?	What did you learn in this test cycle?	Adopt (how?) Adopt, Abandon	Was anything uncovered that could be an alternative change to test?
1	Expand enrollment to include children over age of 12 months and with less social complexity	Will expanding the potential pool of candidates increase overall enrollment?	Enrollment will increase	Families are interested in participating even when home/family is more stable	Expanding criteria to include families without complicating social factors increased enrollment. Expanding criteria by age had no impact	Continue to offer participation to any families that could benefit from care coordination regardless of complicating factors	Adopt	Introduce idea during pre-visit planning call
2	Introduce the concept of the grant during the pre-visit planning call for 1st time visits to clinic for families attending at 3, 9, or 18 month visit	Will parents be more receptive to participation if they have time to think before their visit?	Enrollment will increase. Additional 10 families in the next 2.5 months (end of June – August)					
3	Second meeting with NICU Social Workers at AFCH and Meriter	Are families more interested in enrolling when the project is introduced by a trusted source?	Enrollment will increase. Additional 3 families in the next 2 months (end of June – August)					

Example from UW Health-Waisman Center Newborn Follow-up Clinic (June 2018)