Wisconsin Children and Youth with Special Health Care Needs

Advancing Family-Centered Care Coordination for Children and Youth with Special Health Care Needs using a Shared Plan of Care (SPoC) Grant Project Guidance 2020

Thank you for your interest in the Wisconsin Medical Home Initiative (WISMHI) Advancing Family-Centered Care Coordination for Children and Youth with Special Health Care Needs (CYSHCN) using a Shared Plan of Care (SPoC) Grant project opportunity. Children and youth with special health care needs are defined as those who have a chronic (lasting or expected to last one year or longer) physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally (such as asthma, ADHD, diabetes, autism spectrum disorder or those with medical complexity). Nearly one in five or 19.1% of Wisconsin children have a special health care need.[1]

The Medical Home Initiative of Children's Health Alliance of Wisconsin is releasing a Request for Applications (RFA) to support implementation of medical home quality improvement (QI) processes at the practice level. Based on available funds of $125,000, organizations may choose to apply for a grant in an amount up to $25,000 to support work to advance family-centered care coordination for children and youth with special health care needs. Funds for the QI grants are provided to the Wisconsin Medical Home Initiative (WISMHI) through a grant from the Wisconsin Department of Health Services, Division of Public Health, Bureau of Community Health Promotion, Family Health Section, Children and Youth with Special Health Care Needs (CYSHCN) Program. WISMHI staff will provide support and technical assistance to the grantees.

CRITICAL DATES

- October 7, 2019: Grant project Request for Applications released
- October 28, 2019: Grant project informational call, 12:00-1:00 PM (register for call by Oct 24, 2019): Register here
- December 2, 2019: Completed applications due electronically (must submit online using SurveyMonkey link): https://www.surveymonkey.com/r/2020SPOCQIapplication
- December 20, 2019: Award notifications released
- January 1, 2020: Practice teams begin grant project work
- February 25; June 23; October 27, 2020: Learning Community Calls, 12:00-1:00 PM
- April 21, 2020: In-person, full-day project meeting (location TBD)
- December 31, 2020: Project completion
- January 31, 2021: Final project report due

BACKGROUND INFORMATION

There is growing evidence that care provided within the medical home model supports the Institute for Healthcare Improvement's Triple Aim, including improved patient and family experience, overall improvement in population health, and reduced cost of care. Although a medical home is important for all children, it is especially important for children and youth with chronic diseases, developmental disabilities and medically complex conditions. High-quality, family-centered care coordination is an essential function of medical homes.

According to the American Academy of Pediatrics' policy statement, *Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems (2014)*, care within a medical home, and specifically care coordination, has shown to positively impact family-reported receipt of family-centered care, decrease unnecessary office and emergency department visits, and reduce unplanned hospitalizations. Shared care planning is a central component of coordinated care.

The shared plan of care (SPoC) is a tool designed to support enhanced communication and coordination within your clinic and across organizations. Coordinating care means working with a team to meet the needs of children and youth while enhancing the family's caregiving capabilities. It addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health and wellness. It is grounded in partnerships across health care providers, children, youth, families and community and is essential to assure safe and quality care.[3] A brief summary of this work in Wisconsin is available on the Children's Health Alliance website.

WHAT IS A SHARED PLAN OF CARE?

A SPoC is a living document that identifies clinical and social information impacting a child's and youth's health. The plan is developed in collaboration with families (including youth), clinicians and other team members. It documents activities and accountabilities with the goal of being accessible and shared across systems. It serves as a communication tool to focus and coordinate care as well as reduce fragmentation. Key components include: [5]

- Medical summary (including providers involved in care)
- Family strengths and preferences (including social needs and supports)
- Negotiated plan of action (including clinical and family goals, actions to address goals, responsible partners, and timeline)
- Other necessary attachments (such as emergency plans, chronic condition protocols, and relevant legal documents such as IEPs or 504 plans)

Evidence-base: Research[2-7] has shown that the use of a shared plan of care can improve family-clinician relationships; support provision of family-centered care; and provide information that enhances the planning and delivery of health care services that meet the medical and social needs of children, youth, and their families.

ELIGIBLE APPLICANTS

To be eligible, applicants must satisfy all of the requirements:

- Include Wisconsin health care providers in clinical settings serving children and youth with special health care needs.
- Develop a team of key stakeholders which must include: at least one health care clinician (such as pediatrician, family physician, nurse practitioner or physician assistant), one care team member, and at least one family representative (parent and/or youth).
    - Teams are encouraged to include personnel from different areas of their health system or community: social work, information technology, quality improvement, behavioral health, pharmacy and/or community organizations with shared goals.
- Teams will partner with staff from the nearest Regional Center for Children and Youth with Special Health Care Needs, who can provide information, resources and support for teams and families. Grantees may also consider connecting with Family Voices of Wisconsin to learn about resources to engage with and support families.
- Support from administration is strongly encouraged.
- A designated project lead must commit to spending an average of 2-4 hours per week on project-related work.
- **Pediatricians who can attest to meaningful participation in the project are eligible for 25 Maintenance of Certification (MOC) Part 4 credits through the American Board of Pediatrics upon project completion.**

ADVANCING FAMILY-CENTERED CARE COORDINATION FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS GRANT PROJECTS

The SPoC grant projects are designed to support quality improvement efforts within Wisconsin health care teams to advance medical home provision for children and youth with special health care needs. Applying teams will be required to pilot shared plans of care, promote family engagement, partner with family representatives in QI project work, participate in the ongoing learning community, and coordinate a Care Mapping workshop. An additional option of implementing strategies supporting youth health transition is available.

Role of the Children and Youth with Special Health Care Needs (CYSHCN) Network:

The purpose of the award is to offer teams' access to technical assistance and funds to build the capacity of healthcare professionals and families to create systems of care coordination. These changes are to be responsive to what families indicate they need. Technical assistance is intended to:

- Build skills and capacity at the health system level to use a QI approach to (a) promote youth and family engagement in the QI activities of the project including the development of the SPoC and participating on the QI project team and (b) test and implement SPoC as a tool to enhance communication within and across systems working with children and youth.
- Promote relationships across clinical and community systems and with the CYSHCN Network team to advance care coordination.

Available Funding:
Funding options are dependent on whether your site is New or Returning/Experienced. Additional funding is available for both New and Returning teams for selecting the optional Youth Health Transition focus:

- **New Teams (teams who have not previously participated in the project or do not currently utilize shared plans of care with their patients):**
    - There are two funding tracks available: **up to $10,000 and up to $20,000**. For the $10,000 grant amount, project teams are required to pilot use of a shared plan of care with at least 10 children or youth with special health care needs in their practice. For the $20,000 grant amount, project teams are required to pilot use of a shared plan of care with at least 20 children or youth with special health care needs in their practice.

- **Returning or Experienced Teams (teams who have previously participated in the project and/or currently utilize shared plans of care with their patients):**
    - There is one funding tracking available: **up to $20,000**. Returning or experienced project teams are required to enroll a minimum of an additional 10-20 children or youth beyond the currently enrolled children/youth in the project.

- **Additional funding for selecting the optional Youth Health Transition focus (see page 6 for further information):**
    - Funding of an additional **$5,000** is available to teams selecting the option to support youth health transition with youth 12-21 years of age. Teams will focus on piloting the SPoC and implementing strategies to support the transition processes.

See Addendum C for a table summarizing the primary grant options and activities for new and returning applicants.

THE FOLLOWING FIVE ACTIVITIES ARE REQUIRED FOR ALL AWARDED PROJECTS

1. Clinic Activities with the Shared Plan of Care

Project teams may pilot a Shared Plan of Care (SPoC) already available within their electronic medical record (EMR) or another SPoC document that meets the needs of their practice and families. The SPoC must include the referenced key components. Care plan examples include the American Academy of Pediatrics's shared plan of care, Indiana University's Riley Children's Hospital and NICHQ.

- **Quarterly surveys to measure care team's perceptions of SPoC and its impact** are to be completed by the care team. Surveys will be provided in an electronic format and take less than 15 minutes to complete. *See Appendix D for samples of the 2019 care team survey.*
- **Each quarter, submit at least one completed Plan-Do-Study-Act cycle** reflecting project-specific tests of change. A PDSA worksheet template is available or sites may choose to submit a PDSA planning worksheet specific to their organization. Teams will also be offered the option to submit PDSA cycles using Life QI, an online quality improvement platform. *See Appendix F for a sample PDSA tracking form.*

2. Family and Youth Engagement with the Shared Plans of Care

- **Quarterly surveys to measure family's perceptions and experience with their child's SPOC and its impact on care** are to be completed by the families. Surveys in English and Spanish will be provided in electronic and/or hard copy format and take less than 15 minutes to complete. Please encourage families to participate. *See Appendix E for samples of the 2019 family survey.*

3. Quality Improvement Efforts in Partnership with Family Representatives

Engaging family, children and youth in healthcare quality improvement and system redesign is a key component of advancing care coordination. It is also an active process of ensuring that the family and youth's experience, wisdom, and insight are infused into individual care and improvement of care systems.[4]

- **This required activity is designed to ensure family involvement in your QI project, including having a family member on your project team**. Family representation on your QI team is a critical element of this work. "Family" includes parents, caregivers, guardians, and youth. Family engagement is an integral part of work serving children and youth with special health care needs and is built on trusting relationships with families. It means inviting families to join your project team, including them in project design and decisions, asking for feedback, and much more.

- Identify at least one family representative to be a supported member of your QI team. Your CYSHCN Regional Center staff will be available to assist you in identifying and understanding the roles and responsibilities of family representatives.
    - Family representatives will have the opportunity to participate in three video conferencing calls (Mar. 5, Jun. 12, Oct. 10) with other family representatives of health care teams throughout the state to learn about the family voice on QI teams and to problem solve any challenges. These calls will be hosted by Family Voices of Wisconsin.
    - Family representatives will participate in the April in-person meeting with the goal of project teams and families sharing what they have learned and make plans to refine their work.

Learn more about strategies for family engagement and its importance, listen to Sarah Davis, JD, MPA, Associate Director, Center for Patient Partnerships presentation of the Patient Engagement In Quality Improvement Toolkit and link to the toolkit. The booklet, Team Engagement for Quality Improvement Welcome Booklet, provides an introduction for families and health care teams working together to improve care for children and youth with special health care needs. This booklet contains tips from health care team members and family representative team members to help your team in the quality improvement work.

4. Learning Community Participation

- Teams will participate in three Learning Community Calls (Feb. 26, Jun. 12, Oct. 23) with other health care teams throughout the state to learn about successful strategies for implementing, promoting and supporting family-centered care coordination for children and youth with special health care needs through a variety of activities.
- Team will participate in the April in-person meeting (April 21, 2020) with the goal of project teams and families sharing what they have learned and make plans to refine the work.

5. Care Mapping

A Care Map is a visual diagram to support and guide a family and their care teams to all the care a child requires in the wide variety of settings. According to the National Center for Care Coordination Technical Assistance "care mapping is a process which guides and supports the ability of families and care professionals to work together to achieve the best possible health outcomes. A care map provides a comprehensive snapshot of a family's needs, and enables the care team to appreciate how each of these aspects relates to each other." The Regional Center for CYSHCN staff will support the work by coaching the team on completing a care map with families and/or coordinating a *Care Mapping* workshop for families. The goal of this is to promote understanding for both care teams and families of how a SPoC may be used as a communication tool to assist and coordinate care among the many individuals or organizations involved in the child and family's care. Potential partners with whom to share the SPoC may be identified. Additional information about Care Mapping is available at: http://www.childrenshospital.org/integrated-care-program/care-mapping. We will work with your team to determine the best approach to meet the needs of your team and the families you serve. In collaboration with your Regional Center and WISMHI team:

- Conduct a workshop titled Care Mapping for parents, caregivers, guardians, providers, or community partners on the concepts of care mapping. *(Note: This workshop can occur as part of other planned family gatherings, activities or conferences).*

OPTIONAL ADD-ON:

Youth Health Transition (additional $5,000 funding provided)

Youth between the ages of 12 and 21 years of age and their families will participate in the planning and/or completion of the transition from pediatric to adult care. Clinic teams focusing on youth health transition to adult care processes will implement the strategies below. The Wisconsin Youth Health Transition Initiative staff will provide support and technical assistance. The goal of this focus is described by the American Academy of Pediatrics' policy statement, *"Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home (2018),"* which highlights the critical roles for health care

providers in pediatrics, family medicine, med-peds, and adult care as they support adolescents in their growth towards increased independence and self-management of their own health care:

- *Got Transition*'s Current Assessment of Health Care Transition Activities to be completed by the project team within the first month of the project, by January 31, 2020 (baseline data), and complete again in the fourth quarter to reflect on project impact.
- Complete a youth readiness assessment with each youth of transition age (12-21 years old) enrolled in the project. This will be a single assessment for transition readiness using an appropriate tool for youth and/or their family, either currently in use by the clinic/health system, or adapted from Got Transition, a national initiative, with assistance from the Youth Health Transition Initiative.
- In collaboration with your Regional Center for CYSHCN and the Youth Health Transition Initiative, complete a *Build Your Bridge* or similar youth health transition training for families. This training could be conducted in conjunction with other family learning events. Depending on the age and abilities of participating youth, it might also be appropriate to plan a youth education event. We will work with your team to determine the best approach and training to meet the needs of your team and the families you serve.
- Teams will participate in four Youth Health Transition Learning Communications Calls (Mar. 19, May 21, Sep. 17, Nov. 19).

ADDITIONAL REQUIREMENT FOR RETURNING OR EXPERIENCED TEAMS

Teams will engage in activities that build upon or enhance existing quality improvement efforts with children, youth and families, and improve the quality of the SPoC. Goal setting is an important part of creating a shared plan of care and is centered on family priorities and concerns. It can also be challenging to set meaningful, actionable goals. Possible activities that offer opportunities to dive deeper into the goal-setting and goal-reaching journey with families may include, but is not limited to:

- Develop strategies and specific action steps for family members to reach their short and long term goals.
- Identify the stressors that may impact family success.
- Determine what agencies or services children and families are currently receiving and what goals they are working on.
- Identify and connect families to organizations/support that families may need to achieve certain goals while building their network of support.
- Aggregate and analyze data of families who have documented goals in their SPoC to support building partnerships.
- Share the SPoC (or relevant portions of it) as a strategy to ensure that community supports may be aware of a family's identified goals, strengths, and needs AND who can help the family to reach their goals.

GRANT FUNDS

Grant funds can be used to pay for a portion of the project leader's time, supplies, resources, meetings, and travel. A portion of the grant funds should be used to support the time and expertise of family and youth representation as well as family engagement strategies. This may include mileage, meal reimbursement, time spent working with the project team or other costs associated with the project initiatives including an allocation for teams and family representatives to attend the April in-person meeting. Funds cannot be used to purchase capital equipment.

INFORMATION ON GRANT PROJECT PROPOSAL PROCESS

An informational call is scheduled for **October 28, 2019** from **12:00-1:00 PM**. This call will provide background information and address questions regarding this opportunity. Please register and submit questions for the call by 5:00 PM, October 24, 2019. Register here.

Informational call information:

October 28, 2019 (12:00-1:00 PM)
Zoom Meeting Room: https://zoom.us/j/3933567720
To join by phone: 1-408-638-0968
Meeting ID #: 393-356-7720, then enter Participant ID (shown on screen)

Timeline of Expected Activities		
Timeline	**Lead**	**Activity**
Pre-application (2019)		
October-December	Practice Site Medical Home Champion(s)	• Complete and submit proposal online by Dec. 2, 2019
Grant Period (2020)		
January	Project Lead	• Participate in introductory call with WISMHI team and your Regional Center partner
January	Team	• Technical assistance from WISMHI as team plans work • Begin regular team meetings • Begin to identify children with special health care needs in your practice with whom you will pilot SPoC
January 31	Team	• Teams focusing on Youth Health Transition population, complete Got Transition's Current Assessment of Health Care Transition Activities
February 25, 12-1p	Team	• Shared Plan of Care Learning Community Call (1 of 3)
March 4, 7-8p	Family Member(s) on Project Team	• Family Representative Call (1 of 3)
March 19, 12-1p	Team	• Youth Health Transition Learning Community Call (1 of 4)
March-April	Project Lead	• Complete quarterly electronic survey on care team's perception of impact of shared plans of care • Distribute family surveys on perception of impact of shared plan of care

		• Submit PDSA cycles
April 21	Team	• In-person, full-day project meeting (location TBD)
May 21	Team	• Youth Health Transition Learning Community Call (2 of 4)
June-July	Project Lead	• Complete quarterly electronic survey on care team's perception of impact of shared plans of care • Distribute family surveys on perception of impact of shared plan of care • Submit PDSA cycles
June 11, 7-8p	Family Member(s) on Project Team	• Family Representative Call (2 of 3)
June 23, 12-1p	Team	• Shared Plan of Care Learning Community Call (2 of 3)
September 17, 12-1p	Team	• Youth Health Transition Learning Community Call (3 of 4)
September-October	Project Lead	• Complete quarterly electronic survey on care team's perception of impact of shared plans of care • Distribute family surveys on perception of impact of shared plan of care • Submit PDSA cycles
October 9, 7-8p	Family Member(s) on Project Team	• Family Representative Call (3 of 3)
October 27, 12-1p	Team	• Shared Plan of Care Learning Community Call (3 of 3)
November 19, 12-1p	Team	• Youth Health Transition Learning Community Call (4 of 4)
December	Team	• Implement plans to continue and sustain efforts
December	Project Lead	• Participate in a final call with WISMHI staff
December 31	Team	• Teams focusing on Youth Health Transition population (12 to 21 years old), complete Got Transition's Current Assessment of Health Care Transition Activities
December-January 2021	Project Lead	• Complete quarterly electronic survey on care team's perception of impact of shared plans of care • Distribute family surveys on perception of impact of shared plan of care • Submit PDSA cycles
Ongoing	Project Lead	• Ongoing collaboration with partners from Regional Center for CYSHCN to learn about family engagement and community resources
Ongoing	Team	• Practice team meets regularly, guided by family input • Team members encouraged to participate in Shared Plan of Care Learning Community Calls • If focusing on youth health transition, team members encouraged to participate in Youth Health Transition Learning Community Calls • Ongoing collaboration with partners from Regional

		Center for CYSHCN to learn about family engagement and community resources
Post Grant Project (2021)		
January 31, 2021	Project Lead	• Final project report due
Ongoing	Team	• Sustain and spread project outcomes

SELECTION PROCESS

Applications will be reviewed by a committee and ranked based on the following review criteria:

Criteria	Points Possible
Focus of Project Project focuses on advancing medical home care provisions for children and youth with special health care needs. Project must include piloting a shared plan of care, promoting family engagement, participating in the ongoing learning community, coordinating a Care Mapping workshop, and, if selected, implementing strategies to support youth health transition.	**10**
Staffing Multidisciplinary team has been identified, which includes project lead. Senior leadership support is in place.	**10**
Family Engagement Strategies have been identified to involve families of children or youth with chronic special health care needs. Project team includes at least 1 family representative.	**10**
Activities and Outcomes (work plan) Applicant has outlined activities that can be implemented during grant period and for which outcomes can be evaluated. Activities must include piloting a shared plan of care, promoting family engagement, participating in the ongoing learning community, coordinating a Care Mapping workshop, and, if selected, implementing strategies to support youth health transition. Returning/experienced teams must describe specific activities that can be tested with families to address goal setting.	**40**
Sustainability and Dissemination Applicant has outlined a plan for sustaining and spreading medical home quality improvement efforts after funding has ended, and for aligning them with other practice initiatives.	**20**
Budget The budget outlines a plan for spending during the grant period, meets grant criteria, and includes justification for allocations.	**10**
Total Score	**100**

PLEASE NOTE:

- Following Appendix F, there is a sample application. You may use this sample to draft your application responses, this form is not designed to be submitted.
- Final applications must be submitted online using the link provided. Submit application online using the SurveyMonkey link: https://www.surveymonkey.com/r/2020SPOCQIapplication
- Complete and submit the proposed budget worksheet. This worksheet is available on the Children's Health Alliance of Wisconsin website: Budget worksheet
- The final submission process has three parts. Please submit all parts no later than **December 2, 2019 (11:59pm)**:
    - Complete the online application
    - Submit the completed budget worksheet
    - Submit a sample of your selected Shared Plan of Care

    Send budget worksheet and Shared Plan of Care as email attachments to Colleen Lane (clane@chw.org).

For questions, contact:

Colleen Lane
Wisconsin Medical Home Initiative
1716 Fordem Ave
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608-442-4177

APPENDIX A

Wisconsin Children and Youth with Special Health Care Needs

Advancing Family-Centered Care Coordination for Children and Youth with Special Health Care Needs using a Shared Plan of Care Grant Project 2020

Role Expectations

Project Lead

- Spend an average of 2-4 hours per week on project-related work
- Convene regular meetings of team members
- Participate in introductory and final calls with WISMHI team and your Regional Center contact
- Participate in three, one-hour Shared Plan of Care Learning Community Calls
- If focusing on the youth health transition population, participate in four, one-hour Youth Health Transition Learning Community Calls
- Submit required quarterly care team data to WISMHI team
- Distribute required surveys to families
- Communicate any questions or concerns to the WISMHI team
- Monitor progress on work plan activities and outcomes
- Attend an April 21, 2020 in-person meeting and share work
- Complete final project report and submit to WISMHI team
- Sustain and spread quality improvement after the funding ends

Administration

- Support team efforts with organizational resources
- Recognize improvements within organization
- Facilitate opportunities for team to share project results within organization and promote sustainability and spread

Team Members

- Attend team meetings
- Encouraged to participate in three, one-hour Shared Plan of Care Learning Community Calls and the in-person meeting on April 21, 2020. If focusing on the youth health transition population, encouraged to participate in four, one-hour Youth Health Transition Learning Community Calls
- Complete required action items between meetings
- Sustain and share quality improvement work

WISMHI Team

- Administer project grants
- Connect grantee teams to Regional Center for CYSHCN professionals
- Provide technical assistance as needed to sites in partnership with Regional Center staff
- Coordinate Learning Community Calls
- Organize in-person meeting on April 21, 2020

APPENDIX B

Wisconsin Children and Youth with Special Health Care Needs

**Advancing Family-Centered Care Coordination for
Children and Youth with Special Health Care Needs using a Shared Plan of Care
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References

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3. Institute of Patient and Family Centered Care. What is PFCC? Retrieved on July 26, 2018 from (n.d.) http://www.ipfcc.org/about/pfcc.html

4. Davis S, Gaines ME, Pandhi N. Patient Engagement in Redesigning Care Toolkit, Version 2.0. Center for Patient Partnerships, UW Health, Primary Care Academics Transforming Healthcare, and UW Health Innovation Program; 2017. Available at: http://www.hipxchange.org/PatientEngagement

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6. Association of Maternal Child Health Programs. Standards for Systems of Care for Children and Youth with Special Health Care Needs. Lucile Packard Foundation for Children's Health. 2014. Retrieved on September 21, 2017 from http://www.amchp.org/AboutTitleV/Resources/Documents/Standards%20Charts%20FINAL.pdf

7. Adams S, Cohen, E, Mahant S, et al. Exploring the usefulness of comprehensive care plans for children with medical complexity (CMC): A qualitative study. *BMC Pediatrics*. 2013; 13:10. Retrieved on February 16, 2017 from http://bmcpediatr.biomedcentral.com/articles/10.1186/1471-2431-13-10

<u>APPENDIX C</u> – Summary Table for Primary Grant Options and Activities

	Eligibility	Funding Amounts	Focus Population	Required Activities
<u>New Teams</u>	Clinical practices serving children and youth with special health care needs who have **not** participated in the project or do not currently utilize shared plans of care with their patients	A. Up to $10,000 B. Up to $20,000 Optional: • Additional $5,000 (youth health transition focus)	A. Pilot <u>family-friendly</u> SPoC with at least 10 children and youth with special health care needs B. Pilot a <u>family-friendly</u> SPoC with at least 20 children and youth with special health care needs Optional: • Pilot the SPoC with youth 12-21 years of age and implement strategies to support the transition process	1. Clinic Activities with SPoC 2. Family and Youth Engagement with the SPoC 3. QI Efforts in Partnership with Family Representatives 4. Learning Community Participation 5. Care Mapping Optional: • Implement youth health transition strategies
<u>Returning/Experienced Teams</u>	Clinical practices serving children and youth with special healthcare needs who have previously participated in this project **and/or** currently utilize SPoC with their patients (SPoC must include the key components referenced in the grant guidance)	A. Up to $20,000 Optional: • Additional $5,000 (youth health transition focus)	A. Enroll a minimum of an additional 10-20 children or youth beyond currently enrolled children/youth Optional: • Utilize the SPoC with youth 12-21 years of age and implement strategies to support the transition process	In addition to above, engage in activities that build upon or enhance existing QI efforts with children, youth and families, and improve upon the quality of the SPoC such as: • Dive deeper into goal-setting and goal-reaching with families

APPENDIX D – Sample 2019 Care Team Survey

SPoC Care Team Survey

2019 Sample

Your name: ________

Your title: ________

Please select your clinic: ________ ▼

Please select the time frame for which you are submitting data: quarter 1 ▼

Overall, how many patients in your clinic have an implemented SPoC (in use by care team and family)?
Enter in number format only. ________

How many implemented SPoCs were developed jointly with family/patient and care team at the end of the most recently completed quarter? (Start count of patients since January 1, 2019)
Enter in number format only. ________

How many patients are currently enrolled in this project at the end of the most recently completed quarter? (start count of patients enrolled since January 1, 2019)
Enter in number format only. ________

Is the SPoC accessible in paper format for:

	Yes	No
Families/Patient	○	○
Your healthcare team	○	○
Healthcare teams across your organization	○	○
Non-clinical community services (such as early intervention or schools)	○	○

APPENDIX D continued – Sample 2019 Care Team Survey

2019 Sample

Is the SPoC accessible electronically for:

	Yes	No
Families/Patient	○	○
Your healthcare team	○	○
Healthcare teams across your organization	○	○
Non-clinical community services (such as early intervention or schools)	○	○

With what frequency are the SPoCs updated? (select all that apply)

- ☐ Every 3 months
- ☐ Every 6 months
- ☐ With a change in current health status (i.e. hospitalization, ER visit, new diagnosis)
- ☐ Other

Using shared plans of care helps our team communicate with the entire care team:

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1a.	More frequently	○	○	○	○	○
1b.	In a more timely manner	○	○	○	○	○
1c.	With better accuracy	○	○	○	○	○
1d.	More efficiently	○	○	○	○	○

Using shared plans of care helps our team to:

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
2.	Better communicate with families.	○	○	○	○	○

Using shared plans of care helps our team better coordinate care with:

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	N/A
3a.	Counterparts across health care systems or organizations.	○	○	○	○	○	○
3b.	Community partners from early intervention, schools, or other agencies.	○	○	○	○	○	○

4. Please share other thoughts or examples of how, if at all, using shared plans of care has affected the care your team provides.

APPENDIX D continued – Sample 2019 Care Team Survey

Family Engagement in the SPoC QI Project Team

How many family representatives are members of the 2019 SPoC QI project team?
Enter in number format only.

How many SPoC project team meetings were held this quarter?
Enter in number format only.

How many SPoC project team meetings held this quarter included at least one family representative?
Enter in number format only.

Please briefly describe how family representatives participated in SPoC project team efforts this quarter. (this may include orienting family representative(s) to the team, discussion of roles and responsibilities of each team member, gathering input about the SPoC design or others).

Expand

Briefly describe what has changed (in the SPoC project work) as a result of partnering with family representatives on the project team.

Expand

Briefly describe how your team plans to engage family representatives as members of your project team during the upcoming quarter.

Expand

2019 Sample

APPENDIX D continued – Sample 2019 Care Team Survey

To what extent do you agree with the following:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The project team mentor has actively shared relevant information about SPoC team project activities with family representative(s) this quarter. (a mentor is the point person(s) on the project team working with family representatives.	○	○	○	○	○
Family representatives are valued partners on the Shared Plan of Care project team.	○	○	○	○	○
Family representatives have been compensated for their time spent in meetings or consultation for the SPoC project work.	○	○	○	○	○
The level of family engagement with the SPoC during the quarter met our SPoC project needs:	○	○	○	○	○

reset

Progress on additional Focus Areas

Select the additional focus area(s) your team worked on during the most recently completed quarter.

- ☐ Pilot the use of the Care Coordination Measurement Tool
- ☐ Promote the understanding of medical home with parents using available communication tools (customizable brochure for parents on the topic of medical home and a training available for parents titled Partnering with your Child's Doctor, or Care Mapping)
- ☐ Promote the understanding of care coordination with parents in a training on care coordination (Coordinating Your Child's Health Care offered by Families Voices of Wisconsin)
- ☐ Promote the understanding of youth transitioning with parents in a training on youth health transition (Build Your Bridge)
- ☐ Support youth of transition age (12-21 years old) in completing an assessment for transition readiness

Submit

2019 Sample

APPENDIX E – Sample 2019 Family Survey

Resize font: + | −

Enable speech

Shared Plan of Care: Family Survey

Survey instructions: These questions are about a "shared plan of care." A shared plan of care is a form filled out by parents and the health care providers. It is meant to make sure that everyone caring for your child knows about his/her medical condition, and that next steps in his/her care are outlined.

2019 Sample

	Question	Response
	Today's date:	[ ] Today M-D-Y
1.	**Please select your child's clinic:**	[dropdown]
2.	**How old is your child?**	○ 0-5 years ○ 6-10 years ○ 11-15 years ○ 16-20 years ○ 21-25 years reset
3.	**Does your child currently have a shared plan of care?**	● Yes ○ No ○ Not sure reset
4.	**How long has your child had a shared plan of care?**	○ Less than 1 month ○ 1-3 months ○ 4-6 months ○ More than 6 months reset
5.	**Do you have access to your child's shared plan of care?**	○ Yes ○ No reset

APPENDIX E continued – Sample 2019 Family Survey

6. I helped develop my child's shared plan of care.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

res

7. My likes and dislikes as to how my child is cared for are included in the shared plan of care.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

res

Using my child's shared plan of care has:

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not applicab
8a.	Helped me tell other health care providers (such as other doctors or therapists) about my child's needs						
8b.	Helped me tell other service providers (such as school or home visiting staff) about my child's needs						
8c.	Helped me better understand my role in managing my child's care						
8d.	Helped me spend less time coordinating his/her care						
8e.	Helped make sure more of my child's needs are met						

9. Let us know any other ways that having a shared plan of care has made a difference for your child or family.

Expar

Submit

2019 Sample

APPENDIX F – Sample PDSA Tracking Form

PDSA Tracking Form

	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?	Adapt (how?) Adopt, Abandon	Was anything uncovered that could be an alternative change to test?
Ex.	During the pre-visit call with the family, RN will introduce the SPoC using a standard script.	Will adding introduction of the SPoC to the call script result in more families enrolling in the project?	The SPoC will be introduced at 10 pre-visit calls conducted Jan 1-Mar 31. Five additional families will enroll by the end of quarter 1.	SPoC introduction script developed. Nurse used script during 7 pre-visit calls with families.	An additional 3 families were enrolled during quarter 1.	Although the script was used with fewer families than expected (7 vs 10 predicted) and fewer families enrolled (3 vs 5 predicted), adding the introduction of the SPoC to the pre-visit call appears valuable.	Adopt – edit script to emphasize value of SPoC to families.	Some families expressed interest in reviewing the SPoC before enrolling. Consider mailing a hard copy SPoC example as a possible subsequent test of change.
1								
2								
3								
4								

2020 Advancing Family-Centered Care Coordination for Children and Youth with Special Health Care Needs using a Shared Plan of Care Grant Project Application

Introduction

Thank you for your interest in the Wisconsin Medical Home Initiative (WISMHI) Advancing Family-Centered Care Coordination for Children and Youth with Special Health Care Needs (CYSHCN) using a Shared Plan of Care (SPoC) Grant project opportunity. Based on available funds up to $125,000, health care organizations may choose to apply for a grant in the amount of up to $25,000 to support work within Wisconsin pediatric health care teams to advance family-centered care coordination for children and youth with special health care needs. Projects will run from January 1 through December 31, 2020, including a one-day event at which grantees will share their experiences.

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.

Prior to beginning your proposal, please review the grant guidance located on the Children's Health Alliance of Wisconsin website.

Application Instructions

You may access your responses and work on your application until the deadline (December 2, 11:59 pm). Information entered in the online submission form may be saved or returned to at a later time. To access your existing application to complete or edit responses, you must use the same device and web browser you used to start the application. Responses are saved as you navigate through the application. To save your responses on a page, click "Next" and navigate to the next page.

Sample

2020 Advancing Family-Centered Care Coordination for Children and Youth with Special Health Care Needs using a Shared Plan of Care Grant Project Application

Applicant Information

1. Applicant information:

Project Lead:

Clinic Name:

Health System Name:

Address:

City/Town:

State: -- select state --

ZIP:

Email Address:

Phone Number:

2. Team:

Teams must include at least one health care clinician (pediatrician, family physician, family physician, nurse practitioner or physician assistant), one care team member (i.e. nurse, medical assistant), and at least one family or youth member. Support from administration is strongly encouraged.

Health Care Clinician Name & Credentials:

Care Team Member Name & Credentials:

Family Member(s) Name:

Administration Name:

Other Team Members and their role:

Sample

3. Project teams will partner with professionals from their Regional Center for Children and Youth with Special Healthcare Needs (CYSHCN). Please select the Regional Center with which you will be partnering. If you are not familiar with the Regional Centers for CYSHCN, please refer to this map for additional information.

- ◯ Northern Regional Center
- ◯ Northeast Regional Center
- ◯ Southern Regional Center
- ◯ Southeast Regional Center
- ◯ Western Regional Center

Available Funding Information

Funding options and activities are dependent on whether your site is New or Returning/Experienced. Additional funding is available for both New and Returning teams for selecting the optional Youth Health Transition focus:

- **New Teams (teams who have not previously participated in the project or do not currently utilize shared plans of care with their patients):**
  - **There are two funding tracks available: up to $10,000 and up to $20,000. For the $10,000 grant amount, project teams are required to pilot use of a shared plan of care with at least 10 children and youth with special health care needs in their practice. For the $20,000 grant amount, project teams are required to pilot use of a shared plan of care with at least 20 children and youth with special health care needs in their practice.**
- **Returning or Experienced Teams (teams who have previously participated in the project and/or currently utilize shared plans of care with their patients):**
  - **There is one funding tracking available: up to $20,000. Returning or experienced project teams are required to enroll a minimum of an additional 10-20 children beyond the currently enrolled children/youth in the project.**
- **Additional Youth Health Transition Option:**
  - **Funding of an additional $5,000 is available to teams selecting the option to support youth health transition with youth 12-21 years of age. Teams will focus on piloting the SPoC and implementing strategies to support the transition processes.**

Sample

* 4. Are you a New or Returning/Experienced Team?

◯ New Team

◯ Returning/Experienced Team

2020 Advancing Family-Centered Care Coordination
for Children and Youth with Special Health Care Needs using a Shared Plan of Care
Grant Project Application

New Teams

There are two funding tracks available for new teams: up to $10,000 and up to $20,000.

* 5. Indicate which funding track you are seeking:

- ◯ up to $10,000
- ◯ up to $20,000

2020 Advancing Family-Centered Care Coordination for Children and Youth with Special Health Care Needs using a Shared Plan of Care Grant Project Application

Returning/Experienced Teams

There is one funding track available for returning/experienced teams: up to $20,000.

Returning/Experienced teams will engage in activities that build upon or enhance existing quality improvement efforts with children, youth and families, and improve the quality of the SPoC.

Setting goals with families is an essential part of making the SPoC meaningful and actionable.

Sample

6. Briefly describe specific strategies/activities you plan to test to improve goal setting with families. Please include the following elements:

- Proposed plans or predictions of what your team will test and how you will know if the predictions are successful throughout the year. Possible tests of change may include (additional examples are included in the grant guidance):
    - Collaborative goal setting (if you may be working with other agencies such as schools, Head Starts etc. please briefly describe how they may be involved in the efforts)
    - Hopes and dreams vs actionable goals
    - Discussion of goals earlier in the clinic visit
- Describe any barriers that you anticipate
- Include a brief description of your current efforts and any technical assistance you may need (not scored)

Sample

2020 Advancing Family-Centered Care Coordination
for Children and Youth with Special Health Care Needs using a Shared Plan of Care
Grant Project Application

Shared Plan of Care (Required)

A shared plan of care is a living document that identifies clinical and social information impacting a child's and youth's health. The plan should be developed in collaboration with families (including youth), clinicians and other team members. It serves as a communication tool to focus and coordinate care as well as to reduce fragmentation of care for children and youth with special health care needs.

Key components include:
• Medical summary (including providers involved in care)
• Family strengths and preferences
• Negotiated plan of action (including clinical and family goals, actions to address goals,

responsible partners, and timeline)

• Other necessary attachments (such as emergency plans, chronic condition protocols, and relevant legal documents such as IEPs or 504 plans)

7. Selected Population Data (Required)

Identify the population with whom you plan to pilot the shared plan of care:

The number of children in your practice in the selected population:
(For example, if you plan to pilot the form with children with asthma, this is an estimate of all the children in your practice with asthma).

The number of children in selected population who currently have a shared plan of care implemented (may be 0):

Why was this population selected?

8. Select a shared plan of care to be piloted.

Documents may NOT be uploaded to this survey. Please provide a web address where it can be found or send your selected plan of care as an email attachment to Colleen Lane at clane@chw.org.

(note: if you are a returning team, please forward a copy of your current SPoC)

Sample

2020 Advancing Family-Centered Care Coordination
for Children and Youth with Special Health Care Needs using a Shared Plan of Care
Grant Project Application

Shared Plan of Care (Required)

Clinic Activities with the Shared Plan of Care (SPoC)

9. Briefly describe your activities and timelines to address the following expected outcomes:

- The clinic has established workflow processes for the development, implementation and routine updates of the SPoC
- The SPoC is accessible to the care team
- The SPoC is utilized as a communication tool with clinical and non-clinical community providers

For teams who have been previously funded, briefly describe specific strategies you plan to test to improve upon the clinic activities described above.

Family and Youth Engagement with the Shared Plan of Care (Required)

Family and Youth Engagement with the Shared Plan of Care (SPoC)

Sample

10. Briefly describe your activities and timelines to address the following expected outcomes:

- Families and youth are identified, recruited, and enrolled in the SPoC pilot project
- Families and youth are actively involved in the ongoing development and use of their SPoC
- Families and youth have access to the SPoC
- Families and youth identify strategies to utilize the SPoC as a communication tool with clinical and non-clinical community providers

For teams who have been previously funded, briefly describe specific strategies you plan to test to improve upon the clinic activities described above.

Sample

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Quality Improvement Efforts in Partnership with Family Representatives (Required)

Quality Improvement Focused Efforts in Partnership with Family Representatives

Family representation on your QI team is a critical element of this work and frequently results in improved outcomes and greater staff and family satisfaction. “Family” includes parents, care givers, guardians, and youth. Family representation with your QI project work may take on many different forms. Below is a table that describes the many ways families can be engaged with QI work at the clinic level.

11. Briefly describe your activities and timelines to address the following expected outcomes:

- Families are identified and recruited at clinic level QI activities focused on care coordination
- Family involvement in project work (this may include agenda development, setting up a conference line for family participation, dedicated time and space for family feedback, or others)

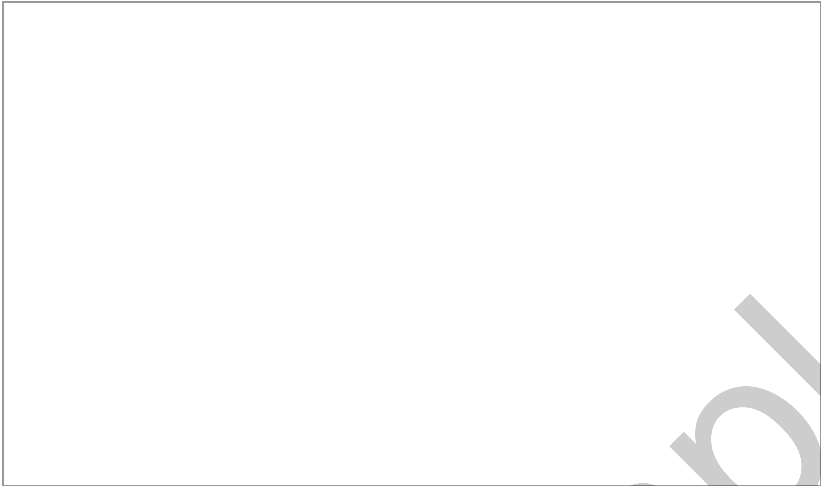
For teams who have been previously funded, briefly describe specific strategies you plan to test to improve upon the activities that engage families in your clinic's QI project work.

Sustainability

Sample

12. Describe how the implementation of the Shared Plan of Care (SPoC) will be sustained beyond the duration of the project. Please include how youth and families will be involved. Include a minimum of one activity or strategy your team will use to track and measure. For example:

- Development of family engagement policy
- Relationship development with partners to identify ways to share relevant parts of the SPoC
- Promotion of the tool with administrators and/or other departments
- Ensuring that the SPoC is accessible across your health system



Sample

2020 Advancing Family-Centered Care Coordination
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Care Mapping (Required)

Care Mapping
A Care Map is a visual diagram to support and guide a family and their care teams to all the care a child requires in the wide variety of settings. The goal behind this is to promote understanding for both care teams and families of how a SPoC may be used as a communication tool to assist and coordinate care among the many individuals and organizations involved in the child's and family's care. In collaboration with your Regional Center team and WISMHI team:

- **Conduct a Care Mapping workshop for parents, caregivers, guardians, providers, or community partners on the concepts of care mapping (Note: this workshop can occur as part of other planned family gatherings, activities or conferences).**

13. Briefly describe your activities to address the Care Mapping workshop. Include proposed outcomes, activities, and timelines.

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Youth Health Transition (Optional)

Sample

Youth Health Transition (available to both new and returning/experienced teams)
Funding of an additional $5,000 is available to teams selecting the option to support youth health transition with youth 12-21 years of age. Teams will focus on piloting the SPoC and implementing strategies to support the transition processes. The Wisconsin Youth Health Transition Initiative will provide support and technical assistance.

* 14. Please indicate if you are selecting the Youth Health Transition option:

- Yes
- No

2020 Advancing Family-Centered Care Coordination
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Grant Project Application

Youth Health Transition

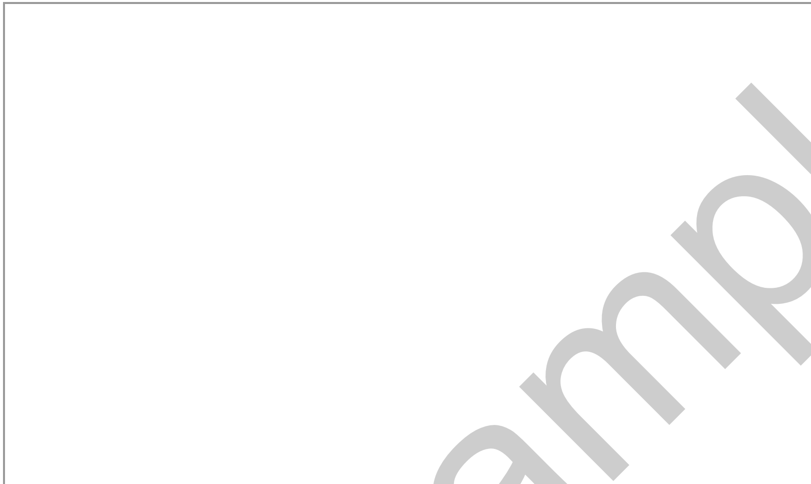
Clinic teams focusing on youth health transition to adult care processes will implement the strategies below:

- **Got Transition's *Current Assessment of Health Care Transition Activities* to be completed by the project team within the first month of the project, by January 31, 2020 (baseline data), and**

complete again in the fourth quarter to reflect on project impact.

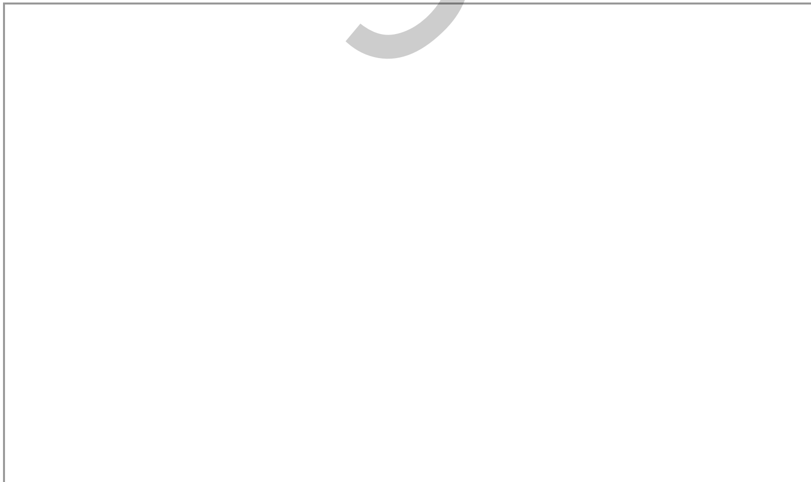
- **Complete a youth readiness assessment with each youth of transition age (12-21 years old) enrolled in the project. This will be a single assessment for transition readiness using an appropriate tool for youth and/or their family, either currently in use by the clinic/health system, or adapted from *Got Transition*, a national initiative, with assistance from the Youth Health Transition Initiative.**
- **In collaboration with your Regional Center for CYSHCN and the Youth Health Transition Initiative, complete a *Build Your Bridge* or similar youth health transition training for families. This training could be conducted in conjunction with other family learning events. Depending on the age and abilities of participating youth, it might also be appropriate to plan a youth education event. We will work with your team to determine the best approach and training to meet the needs of your team and the families you serve.**

15. Briefly describe your activities to address the Youth Health Transition strategies. Include proposed outcomes, activities, and timelines.



Sample

16. Sustainability Plans: Identify and include a minimum of one activity or strategy your team will use to track and measure implementing the Youth Health Transition strategies.



Proposed Budget and Application Completion

Budget Worksheet
Complete and submit the proposed budget worksheet. The worksheet is available on the Children's Health Alliance of Wisconsin website: Budget worksheet

Application Completion
The final submission process has three parts. Please submit all parts no later thanDecember 2, 2019 (11:59pm):

1. **Complete the online application**
2. **Submit your selected Shared Plan of Care**
3. **Submit the completed budget worksheet**

Send your Shared Plan of Care and budget worksheet as email attachments to Colleen Lane (clane@chw.org).

Thank you for submitting your application. Award notifications will be released December 20, 2019. If there are questions regarding the application, the process, or if you would like a copy of your submitted application, please contact Colleen (clane@chw.org).

Sample