

Plan a Test of Change

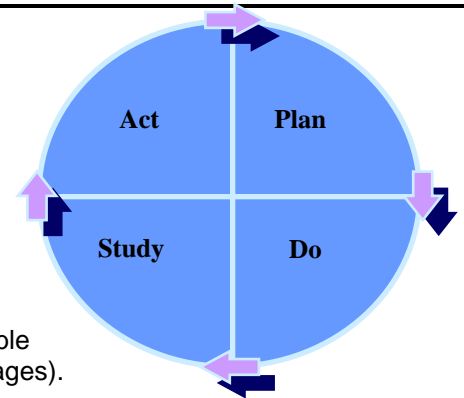
Cycle #:_1_ Start Date: 7/1/16 End Date: 7/1/16

Objective for this PDSA Cycle (Aim):

By July 1, 2016, our practice will test a care plan that includes elements needed by healthcare professionals, patients and parents/caregivers to ensure seamless planned care.

PLAN:

QUESTIONS What elements can currently be populated from our EHR?
 What elements do the physicians and other clinicians in our practice want included?
 What elements do patients and parents/caregivers want/need?



PREDICTIONS This will require an iterative process but, over time, we will be able to create a balance between the practice and patient/family needs (and not be >4-pages).

PLAN FOR CHANGE OR TEST: WHO, WHAT, WHEN, WHERE

Tasks: By June 10th, Alice (N Manager) will export to Excel a list of all of the care plan elements included as possible choices in the NICHQ Care Plan Template which she downloaded from <https://www.nichq.org/resource/nichqs-care-plan-template>. She will cross-walk it with data fields currently in our EHR. She will also share the file via email with all of the physicians and clinicians, as well as the 15 members of our Parent/Family Advisory Group, asking them by June 17th to place an “X” in the appropriate column for each element which is a “must include” and for each element viewed as a “could include.” Alice will tally the results to share with our core QI team, including our parent partner, when they meet on June 24th to identify the initial care plan elements to be included and tested by Dr. Green.

On July 1, this initial care plan template will be tested by Dr. Green with the last patient with special healthcare needs he is scheduled to see that day.

PLAN FOR COLLECTION OF DATA: WHO, WHAT, WHEN, WHERE

Feedback will be collected from Dr. Green about the ease in creating, sharing and reviewing the care plan with the patient/family. Feedback will also be collected from the patient and/or parent/caregiver about the usefulness of the information provided and ease in understanding the plan, based on format and organization. Both physician and parent/caregiver will be asked what else is needed or should be changed.



DO: CARRY OUT THE CHANGE OR TEST; COLLECT DATA AND BEGIN ANALYSIS.
REPORT THE RESULTS OF YOUR TEST HERE. Describe observations, problems encountered, and special circumstances.

STUDY: COMPLETE ANALYSIS OF DATA; SUMMARIZE WHAT WAS LEARNED

**ACT: ARE WE READY TO MAKE A CHANGE? Modifications or refinements to the test?
 PLAN FOR THE NEXT CYCLE**

Plan a Test of Change

Cycle #: 1 Start Date: 7/1/16 End Date: 7/1/16

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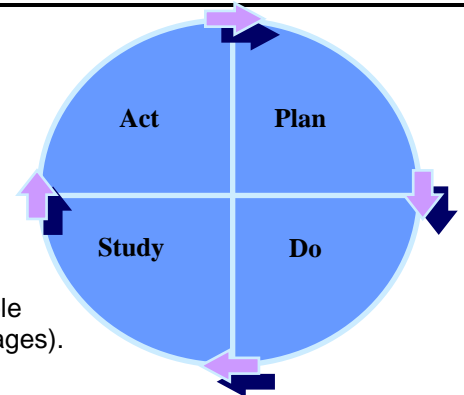
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Tasks were completed as described in Plan. Dr. Green was able to create, print out, share and review the care plan with the last patient with special healthcare needs that he saw today. Many fields were populated with data from our EHR which was helpful but that did not include information recorded as a “Note.” It was “tested” with a 5 yrs. old child whose mom has been good advocate for her at her school. She reported that she likes the information about her child’s strengths and favorite activities but doesn’t like that it includes the fact that she has trouble paying for her daughter’s medications, since she shares this plan with the school nurse.

STUDY: COMPLETE ANALYSIS OF DATA; SUMMARIZE WHAT WAS LEARNED

The feedback was shared with the QI team. Since the printed care plan was only 3 pages long, there is an opportunity to add some additional elements, preferably one or two “could include” that are already being collected in the EHR. The QI team is reconsidering including social risks which the physicians/clinicians wanted but not the parents/caregivers. Need to prioritize “must have” elements that currently require typing the information into the template, to see which could be created as data fields in the EHR that could then populate the care plan electronically.

ACT: ARE WE READY TO MAKE A CHANGE? Modifications or refinements to the test?

PLAN FOR THE NEXT CYCLE: Care plan template was tweaked, to remove social risks and add list of “primary” school team members and community-based providers engaged with the child/youth (daycare, Early Intervention, Head Start, transportation providers, etc.), and contact information. Dr. Green will test the use, sharing and review of care plan with patients/families with CSHCNs seen tomorrow and will gather and give feedback to the QI team. Findings of these cycles will also be shared and discussed at the full staff meeting next week.