

# Collaborative Improvement and Innovation Network Improves Pediatric Family-Centered Engagement

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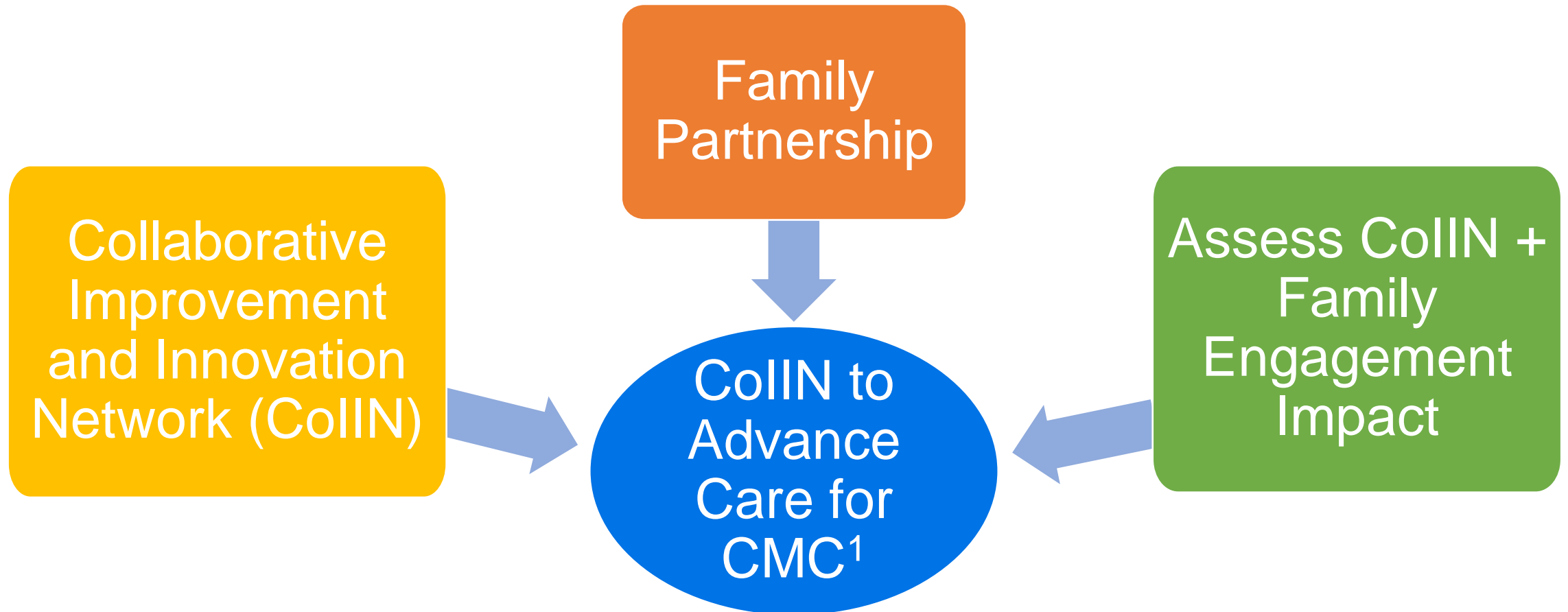
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# LEARNING OBJECTIVES

<b>Examine</b>	Examine CoIIN (Collaborative Improvement and Innovation Network) methodology
<b>Differentiate</b>	Differentiate between patient- and family-centered care and patient- and family-centered engagement
<b>Discuss</b>	Discuss impact of family advisors in designing, implementing and evaluating care delivery innovations within a CoIIN
<b>Apply</b>	Apply lessons learned to current organizational initiatives

# PROJECT OVERVIEW



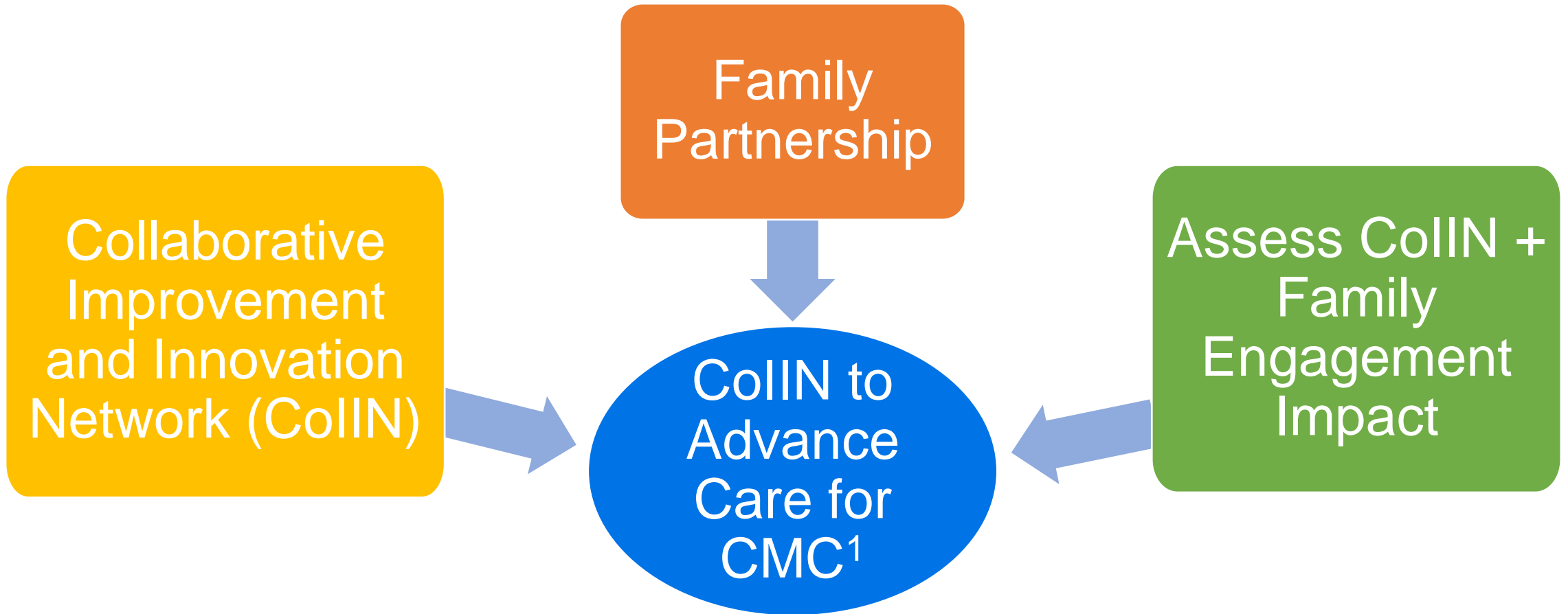
# CMC CoIIN OBJECTIVES & POPULATION

## Objectives

- Improve Quality of Life for Medically Complex Children
- Increase Well-Being of their Families

## Children with Medical Complexity (CMC)<sup>2</sup>

- Multiple complex chronic conditions (Cerebral Palsy, Muscular Dystrophies, Epilepsy, Spina Bifida, Congenital Anomalies)
- Severe functional limitations
- Technology dependence (tracheostomy, feeding tube, ventricular-peritoneal (VP) shunt)
- < 1% of US children but ~ 40% pediatric health resource utilization



# WHAT IS A COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (CoIIN)?<sup>6,7</sup>

Platform & Methodology

Virtual, Collaborative Teams

Common Aim

Quality Improvement Methods

Spread & Scale Innovation

# CMC CoINN COLLABORATORS

**Center for Innovation in Social Work and Health at Boston University**

**National Advisory Committee**

**Family Voices** (Family Partnership)

**American Academy of Pediatrics** (Care Delivery Support, Dissemination)

**Health Management Associates**  
(Medicaid Expertise)

**Association of Maternal Child Health Programs** (CoINN Expertise)

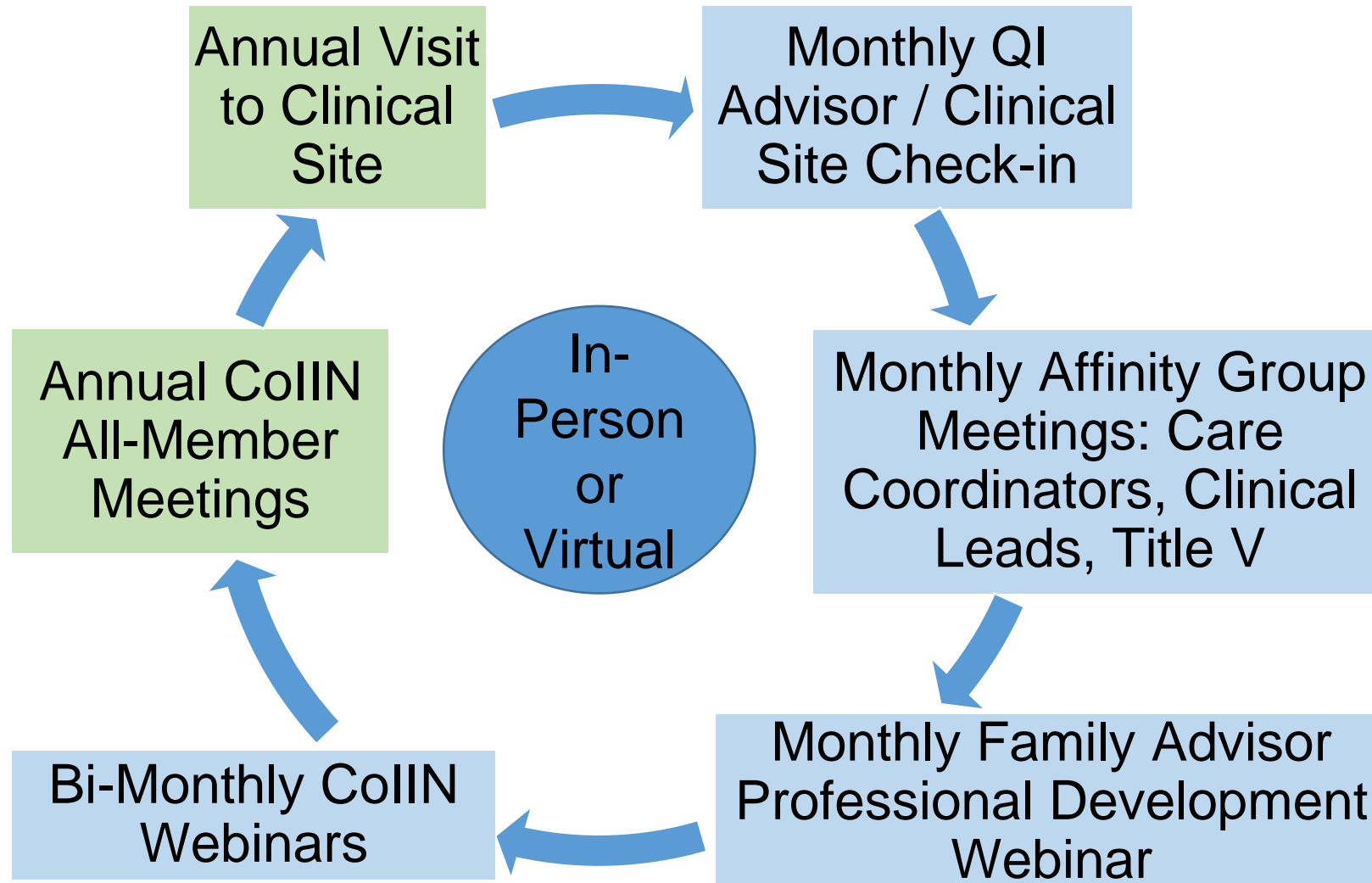
**Population Health Improvement Partners** (QI Expertise)

**10 State Clinical Site Complex Care Teams:**  
**AL, CO, IN, KY, MA, MN, OR, TX, WA, WI**

**Project timeline:** 8/1/2017—7/31/2022

**Enrollment:** 150-300/site → **1500-3000** CMC and their Families

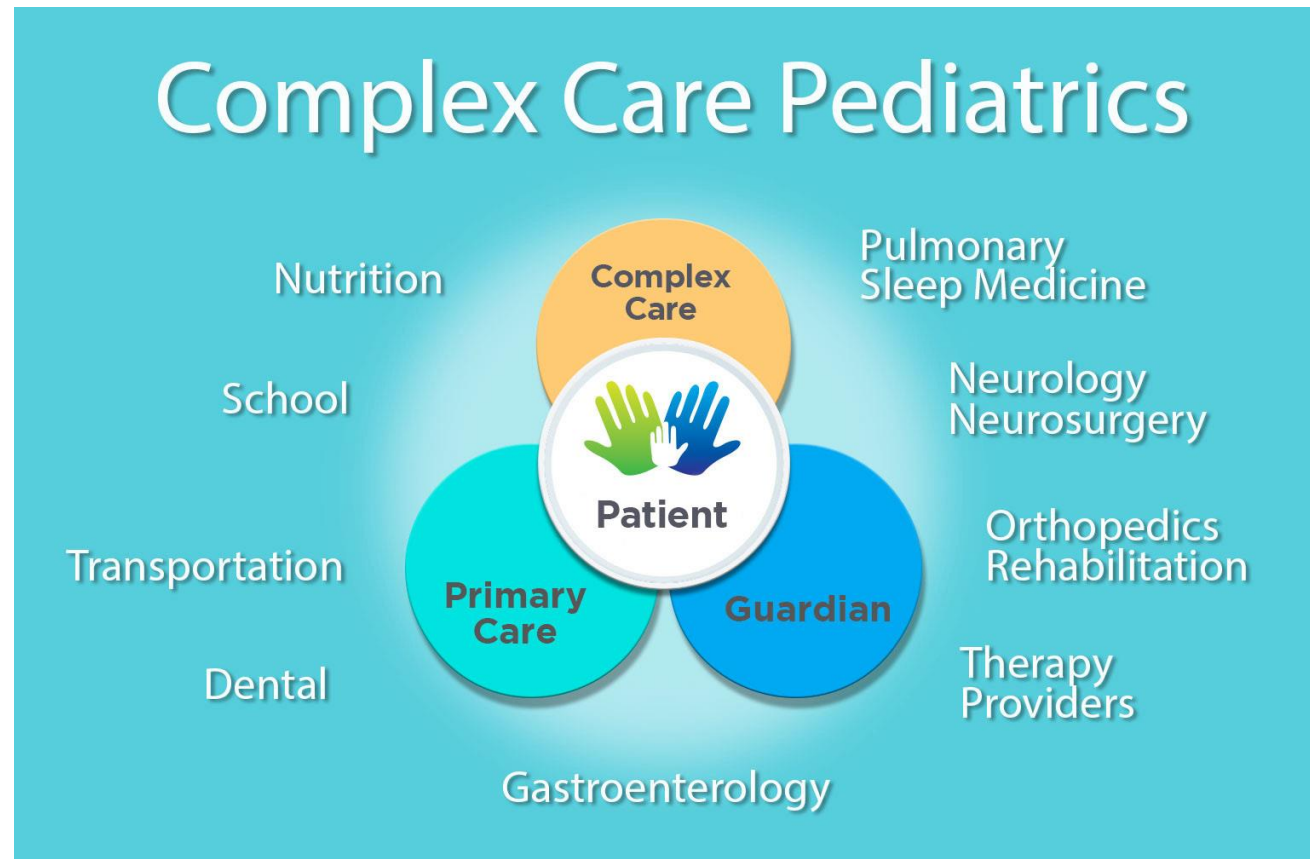
# WHAT MADE THIS A CoIIN?





# CMC CoIIN 'TEAM MN' SETTING

Gillette Children's Specialty Healthcare Complex Care Program<sup>3-5</sup>



# TEAM MN CoIIN IMPLEMENTATION

3 Family Advisors

2 Nurse Care  
Coordinators

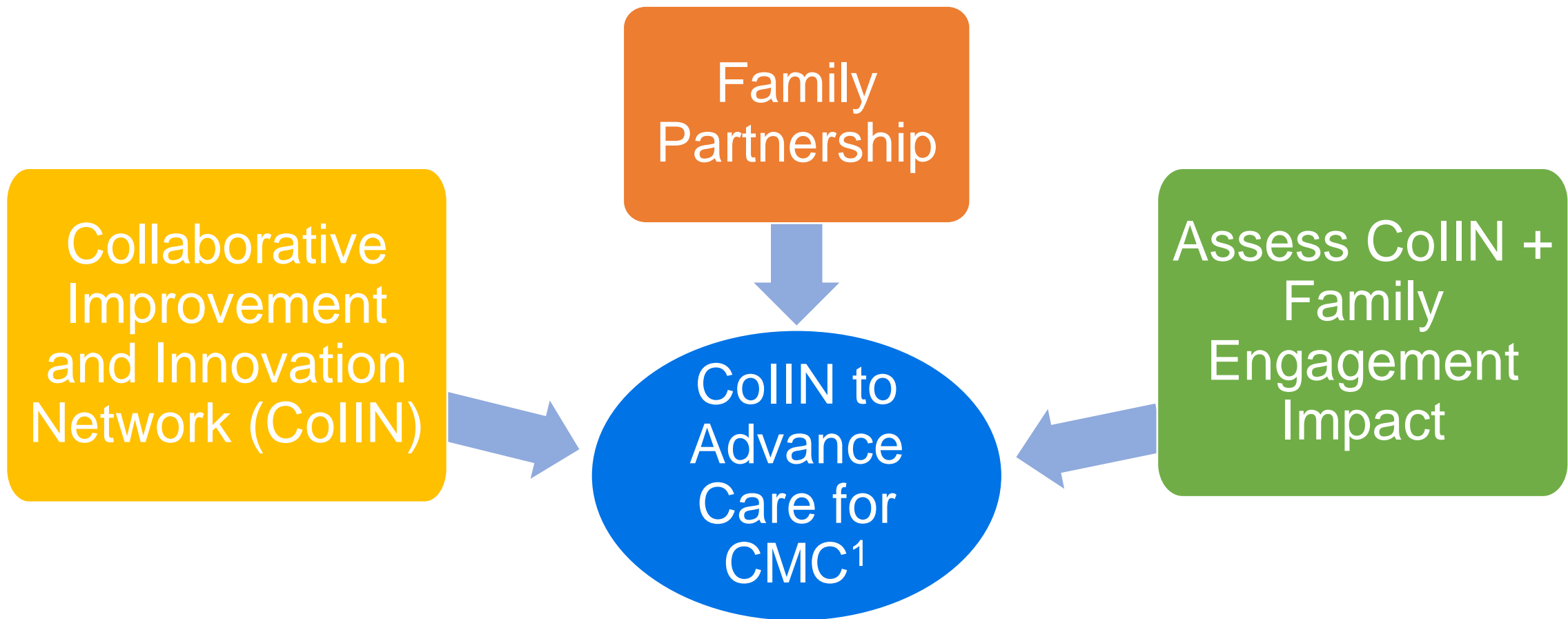
1 Social Worker

2 Physicians, 3 Nurse Practitioners

2 Appointment  
Schedulers

1 Research Specialist, 1 Process Improvement Specialist

- Ground rules for equal inclusion and voice of all members
- Team members trained on process improvement<sup>8</sup> and evidence-based care coordination processes<sup>9</sup>
- All team members paid, including family advisors



# CoIIN FAMILY PARTNERSHIP & ENGAGEMENT PRINCIPLES

## Why

- Family advisors provide expertise and experience to knowledge translation team
- **Evidence-based practice → improved patient and family outcomes**<sup>10-11</sup>

## Who

- Parents/Caregivers of children with medical complexity enrolled in clinical site complex care program

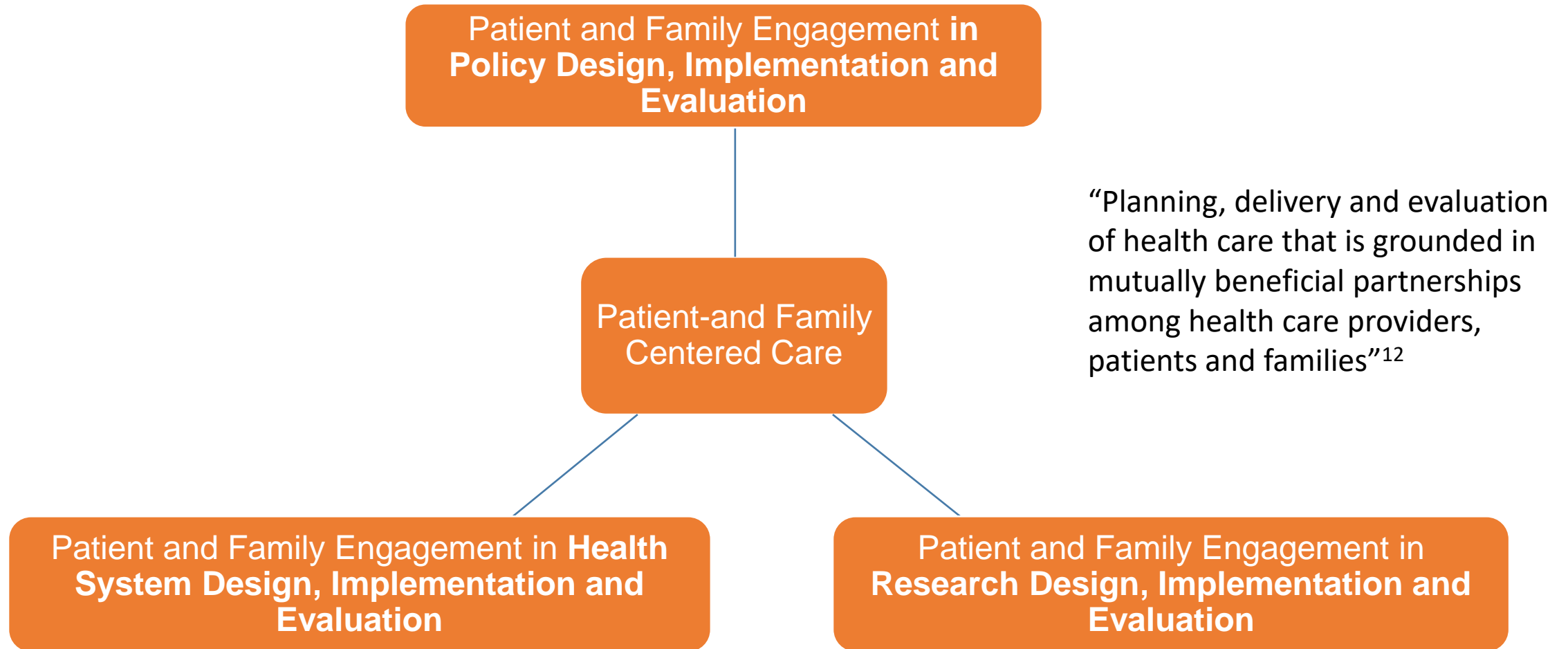
## What

- **Identify** and **implement** evidence-based care coordination processes
- **Evaluate** process uptake and **parent perception of care integration**

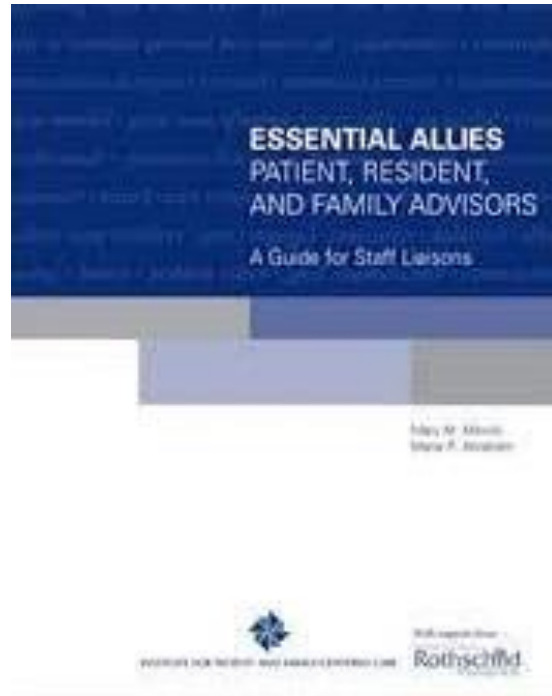
## How

- **Partner** with **Family-Led Organization** (Family Voices, Parent to Parent USA) for **parent leadership training** and **on-going professional development** and mentorship

# FOUNDATION = PATIENT- AND FAMILY-CENTERED CARE



# IMPLICATIONS FOR POLICY AND PRACTICE



- Building *Essential Allies*<sup>13</sup> is a structured approach that requires support, resources and work
- Institute for Patient-and Family Centered Care resources provide expert guidance

## WHAT WE LEARNED

Organizational leadership support for equal and paid family advisors

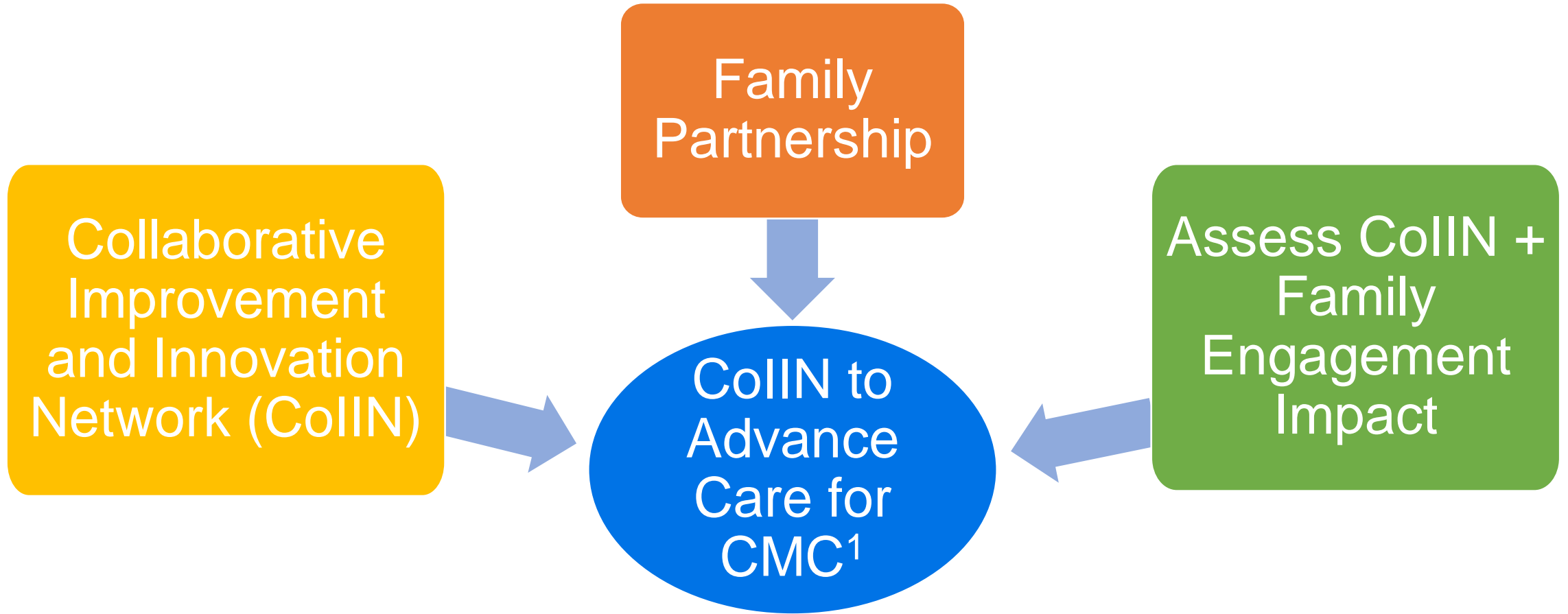
Parent/caregiver readiness to serve and training as a family advisor

Clinical staff readiness to serve and training on working with family advisors

Ground rules for equitable participation established/enforced

Conflicts will happen; address immediately, openly and equitably

Conduct assessment of engagement and build action plans to address deficiencies



# CoIIN Methodology + Family Partnership

Conduct Gemba Walk to Understand Current State

Parent

Care Manager

Provider

Appointment Scheduler



Identify/Prioritize *Missing* Evidence-Based Complex Care Coordination Elements

Patient Registry

Access Plan: Who, How & When for health issues

Care Plan: Family & clinical shared goals

Locus of Care



Initiate PDSA Cycles

New Patient Packet

Peer Support

Access Plan

Care Coordination Needs Assessment



Assess Impact

Standardized Parent Perception of Care Integration Survey

Family Engagement in Systems Assessment Tool



# Family Engagement in Systems Assessment Tool (FESAT)<sup>4</sup>

## Commitment

- Promote engagement as a core value
- Establish engagement at all levels, in all systems of care

## Representation

- Reflect diversity of the community (race, ethnicity, language, income, education level and geography)
- Partner with family-led and community-based organizations

## Transparency

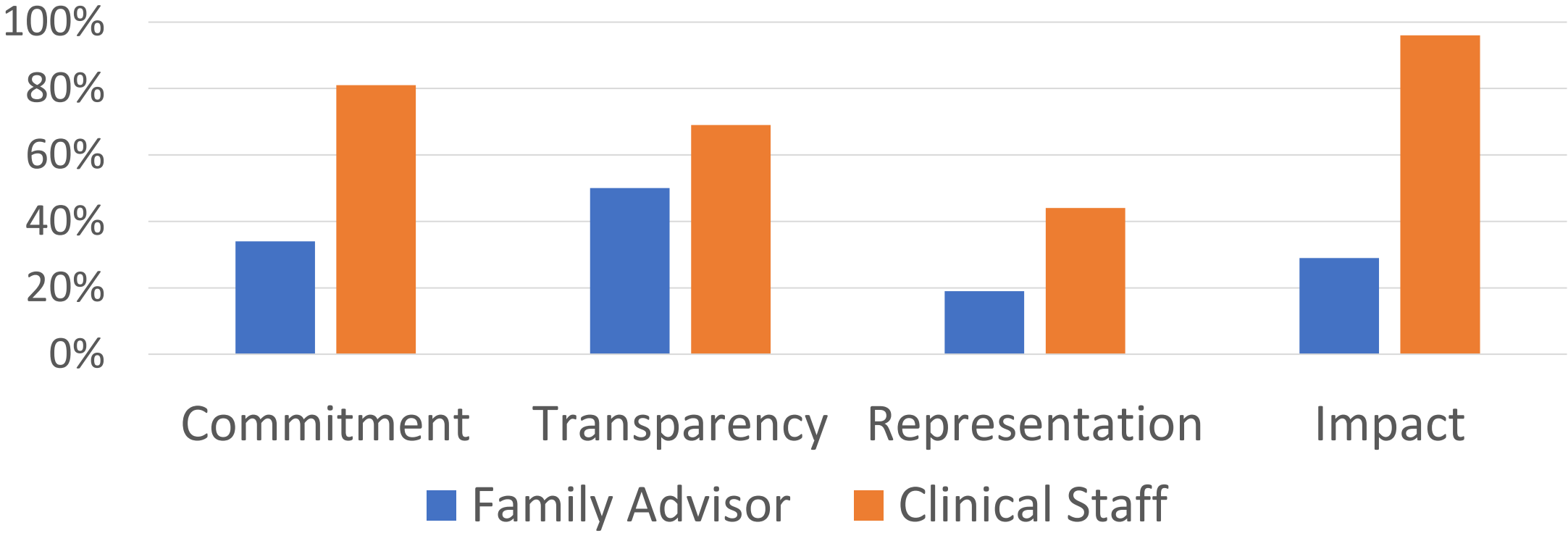
- Provide access to relevant knowledge
- Practice partnership in all parts of the process

## Impact

- Identify what has changed and what the organization or system of care is doing differently because families were involved

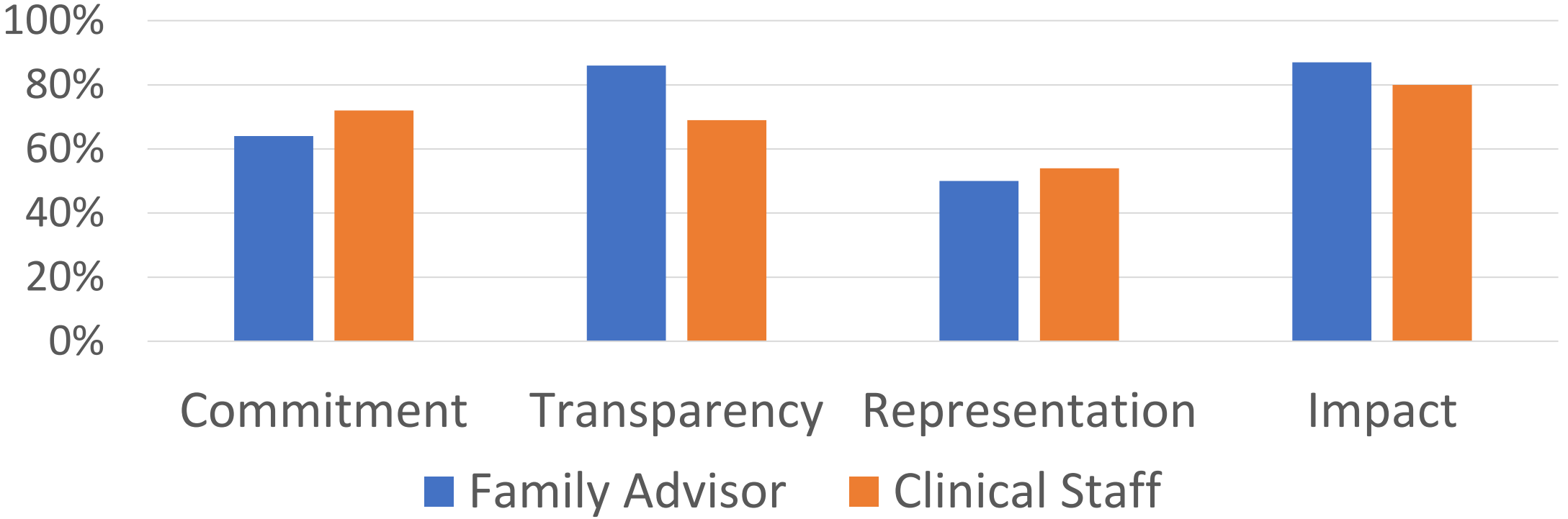
# TEAM MN INITIAL FAMILY ENGAGEMENT ASSESSMENT

2019 - Congruency of Family Advisors and Clinical Staff FESAT<sup>4</sup> Scores



# TEAM MN SECOND FAMILY ENGAGEMENT ASSESSMENT

2020 - Congruency of Family Advisors and Clinical Staff FESAT<sup>4</sup> Scores



# QUESTIONS?

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