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Practice Summary & Implementation Guidance

Family Centered Shared Care Planning Assessment Tool

The Family-Centered Shared Care Planning Assessment (FCSCPA) tool is a self-scoring electronic assessment that prompts Shared Care Planning teams to facilitate quality improvement and reflect upon their values and processes.

Cutting-Edge → Emerging → Promising → Best

Location	Topic Area	Setting
Oregon	Service Coordination/Integration	Community

Population Focus	NPM	Date Added
CYSHCN, Families/Consumers, Care Coordinators, Case Managers, and Others in similar roles	NPM 11: Medical Home NPM 12: Transition	July 2023

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Section 1: Practice Summary

PRACTICE DESCRIPTION

The Family-Centered Shared Care Planning Assessment (FCSCPA) tool is a self-scoring electronic assessment that prompts Shared Care Planning teams to facilitate quality improvement and reflect upon their values and processes. For teams who prefer it, a paper version is available. The tool asks teams to explore ten core values of patient/family-centered shared care planning by scoring items correlated to these values. This provides opportunity for shared care planning teams to reflect on how they operationalize core values of family-centered care and score themselves by consensus. Resulting scores provide feedback to teams that they can use to prioritize their quality improvement efforts. The assessment tool is meant to be completed by at least two experienced or long-term professional members of a shared care planning team. The FCSCPA tool elevates the shared care planning process by taking it beyond the process of shared care planning and shifting the paradigm to ensure families are truly at the center of shared care planning and are full partners in their child's care.

The primary beneficiaries of the FCSCPA tool are the public health workforce that facilitate shared care planning and their professional partners. The secondary beneficiaries of the assessment tool are children and youth with special health care needs and their families. The FCSCPA tool intends to support local public health authorities and home visitors across Oregon to improve their shared care planning practices and celebrate their strengths in shared care planning. Utilization of the tool may improve these practices, CYSHCN and their families may be positively and supported through an improved quality of life and access to equitable care and services. Ultimately, it is children and families who benefit from the tool. According to *Jeanne McAllister's Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs*, children and their families benefit the most from improved and elevated shared care planning practices. Additionally, *NASHP's National Care Coordination Standards for Children and Youth with Special Health Care Needs*, outlines the importance of strengthening care coordination to better serve families. The families and their children or youth with special health care needs are impacted by the improved shared care planning processes resulting from the assessment tool. Through evaluation of the tool, OCCYSHN hopes to better understand the populations that will benefit from it.

The purpose of this tool is for team members to reflect on their Shared Care Planning process through a family-centered lens. The results of the tool provide insight on team strengths and areas for improvement, and helps teams set goals for quality improvement. The process of completing the tool builds the skills of the workforce that implements shared care planning. Teams who successfully engage in using the FCSCPA may experience improved satisfaction in providing care and support to CYSHCN.

CORE COMPONENTS & PRACTICE ACTIVITES

The six core components (outlined in the table below) of the FCSCPA Tool include: reflection of the core values within the tool (see section 1, paragraph 5), scoring the items within the tool, reviewing the scores and identifying core values to better integrate into shared care planning processes. Create quality improvement goals as a team, outline and implement steps to achieve the quality improvement goals, and reassess the team's progress in implementation as needed.

Shared Care Planning teams are typically led by a local public health authority's public health nurse. The public health nurse is responsible for facilitating shared care planning meetings and engaging with CYSHCN and their

families, and other professional partners. The public health nurse drives the implementation of the FCSCPA tool by identifying at least one professional partner to complete the tool with. The team completing the tool reflects on their current shared care planning processes and scores how effectively each core value is being integrated in their processes based on their experiences. Each item scored generates a percentage that correlates with each of the ten core values in the tool. Through discussions facilitated by the public health nurse, teams identify one to two core values that they would like to better integrated in their shared care planning processes. Once decided, the team creates quality improvement goals for the identified core values. Teams reassess their shared care planning processes by repeating the process and completing the FCSCPA tool again (as needed).

Reflection of the core values is critical to the assessment because it allows teams to understand the importance of the core values and how the team is applying them in their practices. Actively scoring the items is completed individually to allow for each participating team member to provide their perspective. By scoring the items within the assessment, teams are beginning to identify ways their shared care planning processes are successful and the areas that could be improved. Team members share their results and perspectives by reviewing their scores together. This discussion among team members allows for an opportunity for the team to collectively identify core values that they agree need better integration and core values that can be celebrated. Teams use these results as well as discussions to identify one to two core values that the team would like to better integrate in their shared care planning processes. A key component of shared care planning is to start small when setting goals to achieve. Based on the quality improvement goals developed, teams discuss and assign next steps to implement and work towards achieving these goals. The team moves forward with implementing the quality improvement strategies to improve operationalizing the core value(s) selected.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Reflection	Team sets time aside to read and reflect on the ten core values within their shared care planning practices	Team understands the ten core values of shared are planning in order to accurately apply these definitions to their own shared care planning processes.
Actively score items on tool	Team uses the assessment tool to score items under each of the ten core values through scoring	The team accurately assesses their shared care planning processes through rating items within each core value; this scoring will help teams identify areas of improvement and success within their practices
Review scores and identify core values to better integrate	Teams will meet together to review the responses to the assessment and compare their responses with other team members' responses; then determine which core values they would like to better integrate	By collectively reviewing and discussing the responses to the assessment, team members can identify the core values that may need improvement and the core values that are being implemented well. It will support consensus and better understanding of family-centered shared care planning

Quality improvement goals	Teams create quality improvement goals for core value(s) of shared care planning and identify next steps for implementation	By discussing and coming to a consensus of what the quality improvement goals are, teams take action on improving integration of 1-2 core values
Implementation	Implement quality improvement strategies to improve operationalizing of the core value the team has selected	Review items within the identified core value that can be better implemented among the team within shared care planning practices; plan how to better integrate these assessment items and who will be implementing the assessment items among the team; Implement quality improvement strategies to improve operationalize of the core value the team has selected
Reassessment (as needed)	Team will reassess their shared care planning processes by completing the assessment tool (often, as needed)	To track improvements over time and ensure successful implementation, teams complete the FCSCPA tool on a regular basis (e.g., 6+ months after implementing improvements)

HEALTH EQUITY

The shared care planning team applies an equity lens to their work. Shared care planning takes an equitable approach to care coordination because it addresses ten core values foundational to the work. Effectively implementing the ten core values, informed by the *Center for Health Care Strategies' Incorporating Racial Equity into Trauma-Informed Care*, in their shared care planning process allows care coordinators to convene teams of professionals and partners to help break down barriers and build strengths so that families can access the services they need. That includes trauma-informed care, family-centeredness, equitable access to support, empowering families, and supporting a strengths-based approach. By effectively implementing shared care planning with the ten core values, teams are improving the equity of the services they are providing. This is in part because shared care planning and its core values consider accessibility, circumstances, and opportunity. The FCSCPA tool asks shared care planning teams to score how well they integrate equity in their processes by reflecting on whether a team honors the family's cultural values, beliefs, and practices. The assessment prioritizes the families' needs by considering their preferred language, comfort with technology, and preferred meeting mode (virtual vs. in-person). Assessing and reflecting on equity in shared care planning breaks down existing barriers that families experience related to receiving basic needs and care. The assessment tool evaluates the shared care planning team's cultural humility towards CYSHCN and their families.

EVIDENCE OF EFFECTIVENESS

As part of the vetting process, two public health home visiting supervisors, skilled in conducting shared care plans, reviewed each section of the tool. They reported that the tool was reflective of the experience of shared care planning and coordinated care. The reviewers shared that the core values aligned with their experiences

implementing shared care planning and found the tool beneficial to reflect on their practices. Overall, the process of reviewing the assessment has gone well and has been well received by those who have seen the assessment tool. One reviewer mentioned reviewing the assessment tool provided motivation to prioritize shared care planning following the impacts of the pandemic. Both public health home visiting supervisors felt that the tool fulfilled a need to reflect on shared care planning work and offer ways to better integrate the established core values. Additionally, the tool itself scores seamlessly with the scored items being calculated instantly to provide results to those completing the assessment. There are two additional public health home visiting supervisors who are currently using the assessment tool with their shared care planning teams. The tool will go out to all LPHAs across the state by Fall 2023 for use. The tool provides tangible strategies for providing family-centered care in alignment with a set of core values.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

To effectively implement shared care planning, OCCYSHN collaborates and partners with local public health authorities for family-centered, cross-sector care coordination. These partnerships allow local public health authorities who have implemented shared care planning to utilize the Family-Centered Shared Care Planning Assessment tool to evaluate their shared care planning processes. OCCYSHN partners with LPHAs specifically given public health home visitors' direct interaction with children and youth with special health care needs. These partnerships have been built over many years through OCCYSHN's implementation of Oregon's home visiting program for CYSHCN, CaCoon. Partnerships are maintained with LPHAs through contracts, continual technical assistance, and training/educational opportunities.

A second key partner was the Oregon Family to Family Health Information Center, which has been housed within OCCYSHN since 2011. The ORF2FHIC has offered OCCYSHN a "window" into the experiences of families, including those who have gone through shared care planning and other multidisciplinary meetings. The representative from the ORF2FHIC contributed to the wording of each value statement and item, reminding the development team about what practices are meaningful to families, and what they really need from the shared care planning process. OCCYSHN's Assessment and Evaluation team was another key stakeholder in developing the FCSCPA tool. The Assessment and Evaluation team supported the development and review of the assessment tool.

Practice Collaborators and Partners			
Partner/ Collaborator	**How are they involved in decision-making throughout practice processes?**	**How are you partnering with this group?**	**Does this stakeholder have lived experience/come from a community impacted by the practice?**
Local Public Health Authorities (nurses/home visitors implementing shared care planning)	To learn from their experiences providing services to CYSHCN and their families	LPHA nurses/home visitors are completing the assessment to evaluate their shared care planning processes	No, however, LPHAs are integral to their communities and families of CYSHCN. They directly interact with the CYSHCN and their families.

ORF2FHIC	To learn from their experiences providing support to CYSHCN families	The ORF2FHIC provided input, expertise, and feedback in the development of the FCSCPA tool	Yes, the ORF2FHIC is made up of professionals with CYSHCN with various levels of experience within Oregon's systems of care
OCCYSHN Assessment and Evaluation	To develop the assessment tool and provide effective evaluation methods	OCCYSHN's Assessment and Evaluation team developed and reviewed the assessment tool	OCCYSHN's Assessment and Evaluation team does not have lived experience. However, their work in understanding the population through engagement, data collection and analysis, needs assessments, and professional background provides key insights and expertise to the development of the assessment tool.

REPLICATION

This practice has not yet been replicated in any other locations.

INTERNAL CAPACITY

This tool was developed by a team of four members of the OCCYSHN staff over the period of eight months:

- Manager, Systems and Workforce unit
- Specialist, Systems and Workforce unit
- Manager, Family Involvement unit
- Manager, Assessment and Evaluation unit

Each member of this team has between 5 and 35 years of experience supporting the CYSHCN workforce, families of CYSHCN, and policy bodies. At least one member of the team has lived experience parenting a child with special health needs. The leadership and knowledge-base of experienced staff members contributed to capacity and long-term applicability of the tool. The FCSCPA Tool will continue to be utilized internally with new staff members in their work to develop the capacity of team-based care coordination associated with OCCYSHN's cross-systems care coordination work throughout the state.

The Systems and Workforce Specialist served as the project manager and took the development process from start to finish, including leading the collaboration with public health teams who piloted the tool.

While there was no need for additional staff to build the tool, we estimate that the Systems and Workforce Specialist spent a couple hours a week to bring the tool to fruition. We recommend, therefore, that other programs seeking to replicate this project consider engaging a project manager who can devote roughly this amount of time. Programs should also select team members who have experience with shared care planning, cross-systems collaboration, assessment and evaluation, and of course, family support.

PRACTICE TIMELINE

This practice can be implemented without a specific timeline. We will integrate implementation into OCCYSHN's cross-systems care coordination work in alignment with NPMs 11 and 12. We will disseminate the tool across systems for use by care coordinators, case managers, and others in similar roles to increase awareness of effective care coordination for families and CYSHCN. Additionally, we will begin to institutionalize the implementation of the tool, leading to sustainability. For more information or examples on how teams have used this tool, please contact OCCYSHN directly at occyshn@ohsu.edu.

PRACTICE COST

There are no significant or direct costs to implementing the Family-Centered Shared Care Planning Assessment tool other than time and effort that goes into utilizing and scoring the tool. For more information, please contact OCCYSHN directly at occyshn@ohsu.edu.

LESSONS LEARNED

Through the development process, OCCYSHN established and reflected on a set of core values of family-centered shared care planning. In creating the FCSCPA tool, OCCYSHN found a way to translate proven care coordination strategies that represent core values and provide a tangible way to apply them to shared care planning. The assessment tool is a tangible tool that OCCYSHN created to support LPHAs implementing shared care planning processes that are family-centered, trauma-informed, and equitable. The FCSCPA tool has the potential to allow shared care planning teams to consider ways to improve their practices as well as reflect on the components they are doing well. One of OCCYSHN's key learnings is that shared care planning is a rewarding process for everyone involved when implemented well. When receiving feedback on the assessment tool, one of the public health nurse supervisors mentioned that reviewing the tool provided motivation for her to prioritize shared care planning. OCCYSHN can collaborate and support shared care planning teams in their work to continue offering families care coordination and family-centered support.

OCCYSHN is in the process of piloting the FCSCPA tool and are still working through the details of how to best implement the tool. Due to the pandemic, the LPHAs are in the process of rebuilding their shared care planning work. The timing for utilizing this tool presents a barrier or challenge as teams are beginning to increase referrals and rebuild relationships/partnerships. OCCYSHN found it challenging to encourage LPHAs to pilot test our assessment tool due to the limited capacity among public health nurses and other partners participating in shared care planning as well as workforce shortages. However, teams that have reviewed the assessment tool have found it beneficial and motivating. We hope to continue to improve the assessment tool and find more ways to encourage teams to use it as a quality improvement tool.

Looking back, after many years supporting shared care planning, we (OCCYSHN) realize that establishing a shared care planning framework and rooting the work in these values may have created a stronger foundation of shared care planning in Oregon. Additionally, if we (OCCYSHN) would've built the logistics of shared care planning using this framework, the continued growth of shared care planning may have helped to prioritize it central to their care coordination work. Having witnessed successful shared care planning processes, we (OCCYSHN) see the value and importance in this work for families and their communities.

NEXT STEPS

OCCYSHN is currently pilot testing the tool with two LPHAs and their public health nurse supervisors who implement shared care planning with families. Following their next shared care plan meeting, the LPHA's public health nurse will complete the assessment with at least one other team member. This other team member will ideally be part of another system supporting a family of a CYSHCN. Once completed, the team will reflect on the results of the assessment, and brainstorm next steps for improving their shared care planning processes. The LPHAs will then meet with OCCYSHN for a brief, reflective meeting to discuss how the implementation went (logistics, accessibility, etc.), any areas of improvement for the assessment, and any areas that went well. OCCYSHN will use their feedback to make any final changes to the tool and strategize next steps of expansion for the assessment tool. The hope is that this tool will be available to all who implement shared care planning as a continuous quality improvement tool. OCCYSHN hopes to continue expanding its work in shared care planning, by implementing the use of this work across other systems to professionals in care coordination and case management roles. The two LPHAs will complete the assessment and meet with OCCYSHN to reflect on their experience and effectiveness of the tool.

OCCYSHN will continue to elicit feedback from local public health authorities and other community-based providers who implement shared care planning and use the assessment tool. OCCYSHN hopes to improve the tool with the feedback of the counties who are piloting the assessment tool with their shared care planning team. One focus for future improvements of the tool is to assess whether people who are using the tool find it valuable in the way we are trying to describe. This insight will allow OCCYSHN to identify the effectiveness of the tool in improving shared care planning processes and aligning with the purpose and importance of this work. Improved shared care planning processes will contribute to improved family outcomes, and as OCCYSHN learns more about the tool's effectiveness, this will be incorporated into our evaluation of shared care planning.

RESOURCES PROVIDED

Included is a link to OCCYSHN's webpage on Shared Care Planning for resources and additional information.

- See Shared Care Planning 101 Video.
- Shared Care Planning template in English, Spanish, Chinese, Vietnamese, and Russian.

APPENDIX

Family-Centered Shared Care Planning Assessment Tool (see attachment on AMCHP Innovations Database page)

References

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