Key Driver Diagram TEMPLATE
Care for Children & Adolescent's with a Chronic Condition

Cincinnati Children's
change the outcome

Global Aim

List key clinical and functional outcomes and targets for condition of focus.

Key Drivers

- Effective provider management
- Effective management at home

- New effective/innovative therapies
- Prepared, proactive practice team
- Effective use of protocols and standardized care processes
- Efficient clinical processes for care delivery
- Coordinate care with other providers and school
- Provide effective self management support
- Collaborative interactions with shared decision making
- Patient and Family Access
- Utilization of community resources
- Patient /Family factors:
- Team add other drivers and condition specific interventions

Interventions

-Translational and clinical research integrated into care delivery
-Collaboration between researcher and clinician

-Organize your practice team and meet on a regular basis
-Educate the team on improvement strategy and methods
-Clearly define roles and responsibilities to staff based on their capacity and licensure – delegate work where possible
-Conduct cross training for staff where necessary/appropriate
-Evaluate team effectiveness

-Standardize condition specific care based on current best evidence
-Use planned visits (both individual and group) to support evidence based care
-Conduct visit preparation to ensure labs, screenings, etc are up to date
-Elicit patient and family priorities for visit
-Educate patients about care guidelines and their role in the guideline

-Establish a registry of patients
-Develop processes for the use of the registry
-Use the registry for care planning and feedback to care team and leaders

-Provide training to staff in SMS techniques
-Set patient goals collaboratively
-Determine staff workflow to support SMS
-Obtain patient education materials
-Document and monitor patient progress toward goals
-Link with community resources (schools, service organizations)

-Actively coordinate referrals to community resources for financial, educational, mental health and other support
-Work with community resources to ensure access to services that may not be available from CCHMC

-Segment population into risk levels and provide additional coordination of care for high risk patients

-Assure that patient/family have timely access to care and to own clinical information, treatment, care plan and health education information
-Utilize chronic condition portals for sharing of clinical information and care plan

-Give care that takes into consideration cultural influences, economic resources, literacy, health literacy, intrinsic patient/family factors and family functioning
-Customize care based on family preference