IV. DEFINING PRIORITIES

IN THIS CHAPTER:

- **Define goals around trauma-informed integrated care.**
- **Assess readiness.**
- **Implement change through PDSAs.**

Why Are You Working for Pediatric Integrated Care?

There are many possible rationales for integrating pediatric care – most of which can be applied more specifically to programs targeting trauma/stress and families with young children. Different rationales may appeal to different stakeholders. Being able to articulate your rationales to various audiences will help gain support, keep the team together, and help you decide what to prioritize in your work now and what to address later.

Clear rationales can be especially important when it seems unlikely that programs will pay for themselves or save money. Systems are often willing to make new investments if the product is clear and if the program aligns with the mission and core values of a system.

It is also important to distinguish between rationales and goals, as both are important to consider (though we recognize that terms such as rationale, vision, and goals are often used in confusing and overlapping ways – the exact terms are less important than the concepts):

- **Rationale or motivation**: These are usually more general or are statements of values, mission, or guiding principles – for example, every family has a right to access quality care.

- **Goals:** These are usually more specific and ideally associated with something you can measure – for example, in order to give every family access to quality care, we will develop a business model allowing us to provide preventive care for all families in our community regardless of insurance status.

Table 9. Rationales and Goals for Articulating Impact of Integrated Care

Rationales	Goals
Increase access to behavioral health services /number served	→ Better detection of mental health trauma → Less loss from referral to follow-up → Reduce disparities, equalize opportunities for access to quality care
Increase quality	→ More expert service at point of first access and ongoing → Reduced time to service once in system → Better match of need to referred service
Increased choice/better fit with patient preferences	→ Family satisfaction with point of entry, place of care, locus of coordination → Reduction in "no-show" or treatment drop-out rates
Improved clinical outcomes	→ At the individual level → At the population level
Reduction in costs attributable to:	→ Delays in receipt of any or optimal treatment → Inappropriate or avoidable use of emergency facilities or inpatient stays → Use of expensive medications when there are alternative psychosocial or medication therapies → Disruption to unrelated services → Low rates of provider productivity because of missed appointments or premature termination of treatment → Time lost from work (among patients and staff)
Reduction in future illness, disability, and suffering through prevention and early intervention	→ Better coordination with community services and linking patients to community resources → Greater proportion of children participating in Early Head Start or pre-K programs → Greater proportion of children considered ready for primary school at the appropriate age

Readiness and Where to Start

The families, providers, and systems you work with are likely being asked to consider many other causes or projects at the same time. In the world of health services research this is often referred to as "competing demands" – different causes and priorities compete for attention and resources, and sometimes contribute to what staff members call "initiative fatigue."

Integrating care requires a careful assessment of competing demands. You don't want to implement a program at the expense of another that could be equally important; you don't want your initiative to fail because everyone is too busy with

other things; you don't want to be forgotten when a new concern arises tomorrow; you don't want to add to everyone's burdens; and you don't want this work to become focused on compliance rather than values and system change.

To see if your team is ready to plan, implement, and practice trauma-informed integrated care, we recommend that you examine your existing data sources and complete the Readiness Assessment, based on the Collaborative Change Framework (Appendix B). Completing this Readiness Assessment with your team will allow you think about *if* you are ready to start this work and help you identify *where* to start – by identifying the elements prioritized by your team.

How to Implement Change through PDSA Cycles

Although this work is comprehensive, as described in the next chapter, it is not about making a massive one-time change that will take years to plan. Instead it is about developing effective practices and tools in your clinic that are realistic for you, your staff, and your families.

In order to ensure the practices and tools will be effective and have the results you want, we encourage teams to begin testing changes on a small scale using the Plan-Do-Study-Act / Adjust (PDSA) method. This method uses a series of very small, systematic, and rapid steps that allow you to gain valuable learning and knowledge as you continually improve the practice or process and let it grow and spread in natural ways that will be able to be sustained.

There are many benefits of implementing changes using PDSAs. First, PDSAs rely on an inclusive change process. Those who are closest to the work (including front desk staff, medical assistants, care coordinators, patient navigators, family advocates, providers, etc.) come up with their own ideas of what they'd like to do and then try them out. This is the opposite of organizational change that originates in a meeting room far from where providers interact with actual patients and changes are "rolled out" via email, policy change, or memorandum.

Second, because the tests are done first on a very small scale (with one family or one provider) results of the test are available quickly. There is no need to wait for a month – or even a week – before knowing if the idea is promising.

Third, many ideas can be tested simultaneously, as various team members can try the ideas that resonate with them most. This empowers team members and other staff to do what they know best, take initiative, and apply their own expertise to areas they want to improve.

Fourth, the successes and lessons learned even from these small tests are powerful motivators in bringing others on board. Rather than trying to convince a colleague that an idea has merit in concept, you have experience and some data to share about what it actually might look like in practice. This offers a compelling way of building consensus and accelerating the process of moving forward with new ideas. When several possible paths present themselves, a simple test helps to weigh the pros and cons of each option based on real data, rather than assumptions. For example, instead of spending months around a table debating the merits of various screening tools, or guessing which one might work best, you can simply try out the leading candidates with a few families who are willing to give you their opinions. This feedback can then help move your decision-making to the next stage, which is often to make some adjustments and, again, do a quick test of the revised version.

And fifth, the lessons learned when testing on a small scale first have minimal impact on the rest of the organization in terms of time and cost. The entire program or clinic isn't required to shift to a major new tool, method, or practice all at once before you have a very high level of confidence that it will actually work in your organization.

We have learned that PDSAs work best when you decide ahead of time what questions you are trying to answer. It helps to formulate a hypothesis about what you think might happen. And then you should always circle back to your higher-level data to ensure that these small tests are resulting in the types of improvements you intended. For example, if you are interested in improving the screening of mental and behavioral health problems, a series of PDSAs could help you to select the best screening tool for use in daily practice, based on family and provider feedback. The higher-level data you will want to review might include whether the tool is effective in promoting the assessment of children's behavior during primary care visits (how often it's getting used), how providers are using the information, and whether the tool improves caregiver interest in behavioral and emotional issues. While the "S" (Study) for the first small cycle may be primarily qualitative and anecdotal in nature (e.g., Did the caregiver understand the questions? How long did it take to administer? Was there anything missing from the questions asked?), the data that is collected as part of the study also grows as more cycles are tested. Thus, as a PDSA cycle moves from a small initial test to full implementation, your study phase will become more intensive and evaluative. Before you decide to make something standard practice, you will want to be certain that it is resulting in true improvements based on clear data and outcomes.

When using PDSA cycles, it is essential to realize that they are not intended to be once-and-done tests. Instead, teams use PDSA cycles in which each “A” (Act or Adjust) becomes the “P” (Plan) for the next cycle. In doing this, each subsequent cycle becomes slightly larger, involving more families or more providers. This expansion that occurs as the learning is continually applied helps ensure that the idea has merit across a variety of conditions, audiences, and providers. Moreover, it allows you to work out any “kinks” in the process along the way, further increasing the likelihood of being able to replicate and sustain the work.

Most teams will not start PDSAs on all elements at once. We suggest you consider starting with PDSAs that create “ah-ha” moments, focusing on elements that inspire motivation and support for future changes. For example, you may want to test strategies to develop a trauma-informed office early in the process to foster positive attitudes towards assessment and treatment of trauma-related problems.

Within each element of the Collaborative Change Framework, there are Change Strategies you can test using PDSAs. Below is a PDSA guide to help your team move from a broader Change Strategy to a PDSA that you could “test by next Tuesday.”

Table 10. Steps for Planning and Implementing PDSAs

PLAN
What is the goal for this PDSA cycle? What do you predict will happen? What is the plan for the cycle? What are the steps to execute the cycle, including data collection (who, what, where, when)?
DO
Carry out the cycle. In brief terms, did it work as you expected?
STUDY
Summarize and analyze the observed results. What did you learn from this cycle? Include descriptions of successful interactions, unexpected challenges, and other special circumstances that may or may not have been part of the plan.
ACT / ADJUST
What actions are you going to take as a result of this cycle? (Check one) Adapt the Test Expand the Test Abandon the Test Plan for the next cycle. What changes are needed? If expanding or adapting, what will you do to continue your learning while beginning to spread the successes?

Change through Non-PDSAs

Not all improvement strategies will be in the form of Plan-Do-Study-Act cycles. Sometimes you don't have a question about how to address a challenge (no need to test a hypothesis); or there's only one way to do something; or you have a task or work plan to execute rather than something to *test*. In these cases, you probably have an improvement *task* rather than an improvement *test*. Although they are not PDSAs, these are important parts of your system improvement plan. You'll find several sample PDSAs and a few examples of other improvement strategies as we move step by step through the Collaborative Change Framework elements in chapter five.