

Key questions to guide your planning

1. What is the current primary, overall goal for your network or group?
Broadly, what is your vision of a more coordinated care system in your community?

2. Based on the preliminary results from the Continuity Assessment Tool, in which areas does your network or group most need to focus its efforts first? (*Select no more than two*)
 - Networking and collaboration with a broader group of participating partners
 - Planning for and implementing critical elements of coordinated care
 - Obtaining funding for services in a coordinated care system
 - Increasing access of children and families to coordinated care services
 - Building clinical capacity to deliver care within your community
 - Engaging in outreach activities to raise awareness about coordinated care systems

3. Based on the areas you selected above, what are your goals and preliminary strategies for achieving them?

4. What factors or conditions will enable you reach those goals?
(*See Table 1*)

5. What barriers or challenges do you face in reaching those goals?
(*See Table 2*)

6. How will you measure your success in reaching those goals? What outcomes will you track or measure?

7. What are the first three steps you will take when you return home?

Table 1: Enabling Factors

- New or revised policies in place
- Re-definition of people's jobs/roles
- New departments/structures/processes in place
- Endorsement/involvement by key leadership in clinical, community-based, governmental and/or private payer organizations/institutions/departments (*specify*, e.g., senior administration, medical, nursing, social work, spiritual care, child life, home health, hospice, insurers, school personnel, other)
- Grants or other designated funding for coordination of pediatric palliative care
- Means of paying for range of pediatric palliative care services (medical, non-medical)
- Means of ensuring smooth communication among clinicians/organizations involved in care delivery, eg:
 - a. designated team leader/care coordinator
 - b. routine meetings among all relevant staff
 - c. electronic medical records within/across organizations;
 - d. use of continuity of care record
 - e. common decision-making tools, order sets, and other forms within/across providers and organizations
 - f. other (*specify*)
- Designated coordinating entity available to families 24/7/365
- Means of educating relevant providers in clinical skills/knowledge in pediatric palliative care
- Other necessary enabling conditions (*specify*)

**Table 2: Common
Barriers or Challenge
to Continuity of
Pediatric Palliative
Care**

- Family-centered care planning, decision-making.