Program Abstract

Building Medical Homes for the Ambulatory and Community Health Network (ACHN) Cook County, Illinois

Grantee: Illinois Chapter, American Academy of Pediatrics (ICAAP)
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PROBLEM

Many primary care providers and families lack information and training about the medical home model and benefits of providing comprehensive, coordinated, community-based, and family-centered care.

GOALS AND OBJECTIVES

Goal 1: ACHN Centers will receive training on the Illinois Medical Home Model (IMHM) and incorporate principles of the medical home into their ***pediatric*** clinics and improve partnerships with families.

Objectives:

1. Replicate the IMHM by providing quality improvement (QI) team facilitation support to five high volume pediatric ACHN sites (Cicero, Cottage Grove, Fantus, Logan Square, and Vista).
2. Include one to two parent partners on each ACHN medical home QI team.
3. Link participating ACHN sites as a Learning Collaborative and work to ensure pediatric QI systems changes are implemented across the ACHN.

This includes, in the final year of the project, sharing lessons learned and spreading progress from the high-volume pediatric sites with all ACHN sites that serve pediatric patients.

Goal 2: ACHN will provide comprehensive, coordinated health and related services through the medical home.

Objectives:

1. Expand/spread pediatric model care coordination program to ACHN sites that care for children.
2. Link pediatric patients to a provider and care team so both patients/families and team members recognize one another as partners in care.
3. Develop the ability of health care team members to effectively communicate needed information and strengthen relationships between patient/family and medical team.

Goal 3: ACHN will partner with community-based programs, resources, and services to better serve children and families.

Objectives:

1. Build relationships with community partners to link patients with community-based resources.
2. Teach ACHN providers how to make referrals to community-based resources using the Statewide Provider Directory.
3. Implement a routine developmental screening program within ACHN pediatric clinics and better coordinate care with the Illinois Early Intervention (EI) system.

Goal 4: ACHN will receive training on how to provide support to youth and families to facilitate successful transition to adult healthcare.

Objectives:

1. ACHN will develop a written policy to facilitate transitioning youth to adult health care.

2. ACHN will encourage youth to take responsibility for their health and well-being.
3. ACHN pediatric and family physician providers will be invited to participate in ICAAP's CME/QI training that teaches how to successfully transition youth to adult healthcare.
4. ACHN adult-oriented primary care providers will be invited to participate in ICAAP's CME/QI training that teaches how to successfully care for older youth and young adults with special needs within an adult-oriented healthcare system.

Goal 5: Evaluate effectiveness and impact of project.

Objectives:

1. Subcontract with an independent evaluator to implement an evaluation plan to include fielding the Medical Home Index and Medical Home Family Index at baseline and the end of the project.
2. Conduct National Committee for Quality Assurance (NCQA) Medical Home Self Assessment survey with participating ACHN Centers and help assess readiness to apply for Joint Commission accreditation, if they so choose.
3. Measure effectiveness and utilization of IMHM by tracking QI data for key medical home measures.

METHODOLOGY

The program aims to improve access to quality, comprehensive, and coordinated systems of services for children and families who receive healthcare through the ACHN. The initiative is overseen by a Project Management Committee of representatives from ACHN, ICAAP, and Title V Specialized Care for Children. The program teaches the Model for Improvement, including use of the "Plan-Do-Study-Act" cycle of practice improvement. The program establishes systems to support medical home initiatives utilizing resources developed by Center for Medical Home Improvement, National Center for Medical Home Implementation, National Committee for Quality Assurance, American Academy of Pediatrics, Got Transition, ICAAP trainings, to name a few. The program provided three Learning Sessions in years 1-3; a fourth Learning Session will occur November 4, 2014 to spread initiatives and share results with all ACHN sites that see pediatric patients.

The project is helping to provide training on and help develop systems to improve ability to track and coordinate care around developmental screening and referral to the Early Intervention system. It also provides training to assist primary care providers to help youth and families make the transition to adult healthcare. Five large ACHN Centers that see pediatric patients will participate in a Learning Collaborative; be provided with medical home QI facilitators; and participate in three Learning Sessions and receive training, resources and tools. A fourth and final Learning Session will be offered to all ACHN Centers that see pediatric patients in order to assist with spread on preferred models of care across the system.

COORDINATION

The program is administered by ICAAP in collaboration with the ACHN and the IL Title V agency, Specialized Care for Children (SCC). Other partners include an independent evaluator.

EVALUATION

Data will be collected at baseline and 22 months later using Medical Home Index and Medical Home Family Index. NCQA medical home self-assessment results pre- and post- program intervention will be compared. The program will measure medical home improvements, implementing a developmental screening program, use of Health Information Technology and Electronic Medical Record to support care coordination, and improvements with transitioning youth to adult healthcare.

KEY WORDS

Medical home, access to care, community health centers, developmental screening, early intervention, family centered care, transition planning, and quality improvement.

KS – 8/2014