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ILLINOIS PEDIATRICIANS RECEIVE THREE-YEAR, FEDERAL GRANT AWARD

Project will apply innovative, evidence-based models to improve services for children with special health care needs in Cook County clinics

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Chicago, IL (October 13, 2011) – The Illinois Chapter of the American Academy of Pediatrics (ICAAP) is pleased to announce that it has been awarded one of 12 new Integrated Community Systems for Children with Special Health Care Needs (CSHCN) grants.

The grant runs September 1, 2011 through August 31, 2014 and is funded by the Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). The award will be implemented in collaboration with the University of Illinois at Chicago (UIC) Division of Specialized Care for Children (DSCC), the Title V program for children with special needs for the State of Illinois. The principal investigator is Kathy Sanabria, MBA, PMP. The lead pediatrician and medical advisor is Judy Neafsey, MD, Director of Ambulatory Pediatrics for the Ambulatory and Community Health Network (ACHN) and Medical Director, Stroger Specialty Care Center, Cook County Health and Hospitals System.

The grant project is titled “**Building Medical Homes for the Ambulatory and Community Health Network (ACHN) of Cook County, Illinois.**” Since 2004, ICAAP and DSCC have worked with dozens of practices and clinics to develop the Illinois Medical Home model, which changes practice systems and improves care for patients, particularly those with special health care needs. Health care providers who implement the Illinois Medical Home model make improvements such as designating a care coordinator to support families; developing written care plans for patients to better manage their conditions; improving coordination with hospitals and specialists; connecting families with other community resources such as mental and behavioral health providers or special recreation programs; and including parents and patients in decision making so that care is truly “patient centered.”

The Illinois Medical Home model will be replicated with five pediatric ACHN sites. The initiative aims to improve access to quality, comprehensive, and coordinated systems of services for children and families who receive healthcare through the ACHN. The project will provide expert facilitation to internal quality improvement teams at each site. These teams will include physicians, nurses, office staff, and “parent partners” – parents of children served by the clinic who share their views on how to improve services. ICAAP uses the “Plan-Do-Study-Act” model of practice improvement. In addition, health care providers from ACHN sites will participate in a Learning Collaborative and receive training, coaching, and other resources.

The American Academy of Pediatrics (AAP) describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Medical home, also called patient-centered care, is the model for 21st century primary care. It addresses and integrates high quality health promotion, acute care, and chronic condition management in a planned, coordinated, and family-centered manner.

ICAAP is a statewide membership organization with nearly 2,000 pediatrician members. ICAAP’s mission is to promote the right of all children to live happy, safe, and healthy lives; to ensure children receive quality medical care from pediatricians; and to assess and serve the needs of our membership.

For more information about ICAAP and its medical home initiatives, visit the ICAAP web site at <http://illinoisAAP.org/projects/medical-home/>.

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Providers and Parents Highlight Benefits of Illinois Medical Home Model

Pediatricians, nurses, care coordinators and parents cite many benefits from undertaking medical home quality improvement with the Illinois Chapter of the American Academy of Pediatrics (ICAAP). The following quotes are from participants in ICAAP’s medical home projects over the last three years.

“I am amazed at what can happen when a group of people with different experiences and insights work together to problem solve. Everyone gives valuable input that we all learn and benefit from. Soliciting recommendations for change from the people actually involved in the process is very effective.”

-- Lead Pediatrician

“I am very excited to be part of a practice that is ‘patient centered.’ Watching staff work alongside patient, family and provider to take the best care of our patients and being able to track the results only

makes us want to work that much harder. Having a focus of better patient care reminds me why I became a nurse in the first place (many years ago!).”

-- Nurse/Care Coordinator

“The Medical Home initiative has been very beneficial to our practice. Having the partnership with providers, outside agencies and most importantly the parents has allowed us to improve the practice to better meet the needs of our patients . . . we have changed our policies on scheduling appointments to allow easier access for all patients. We have also been able to utilize the parents as we develop new or revised policies.”

-- Practice Administrator

“As the facilitator . . . I have seen firsthand the significant and beneficial impact administrative support has on advancing change within the practices. The general consensus is that usually the larger the organization, the slower the progress because of the many layers of administration that must approve changes. However, this has not been the case . . . support of organizational leaders has spurred accelerated improvements in care delivery.”

-- Practice Team Facilitator

“In the first year, we have already demonstrated an improvement in the quality of care to our special needs children. Having a care manager on site is an integral part of the medical home and we are very fortunate to have strong staff and provider participation. [The parents/caregivers] appreciate having a care manager to rely on to help them navigate the sometimes murky waters of the health care system.”

-- Nurse/Practice Manager

“As a mother of two special needs children, it feels good to be a parent partner working [with the practice] towards this goal and giving back the care that has been given to me. Any insight I can give through my experiences that will help other families have an easier journey through this challenging life is worthwhile.”

-- Parent Partner

“Having a care manager has been extremely helpful. During a recent hospitalization the hospital team was well aware of our care manager and communicated with her during my daughter’s stay. Our care manager coordinated our follow-up appointment and helped set up some home medical equipment—she has done a lot for our family and we are grateful.”

-- Parent Partner

“I am most proud of the new policy in place that ensures an easy transition to a new physician. This model will help create a more comfortable and helpful environment for families of children with special needs. Effective communication between parents and medical staff is essential and I feel this model guarantees that communication will be a priority.”

-- Parent Partner

“I am honored to be working [with] this group of physicians and medical professionals. This project has given me a new perspective on the challenges that the medical community faces in trying to transition youth to their next physicians.

-- Parent Partner