Welcome to the Building Community-Based Medical Homes for Children Program Ambulatory and Community Health Network Learning Collaborative Session 4

LEARNING SESSION 4
TUESDAY, NOVEMBER 4, 2014
8:15 AM TO 4:15 PM
COOK COUNTY HEALTH AND HOSPITALS SYSTEM
ILLINOIS MEDICAL DISTRICT COMMISSION BLDG
CHICAGO, IL

NOVEMBER 4, 2014

Commercial Disclosure

- I have no commercial disclosures to make prior to presenting

We Hope You Enjoy the Learning Session

Learning Session Planning Committee

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Building Community-Based Medical Homes for Children Program ACHN

- Program sponsored by ACHN; IL Chapter of the American Academy of Pediatrics (ICAAP); AAP; and University of Illinois at Chicago-Specialized Care for Children (SCC)
- 3-year grant program funded by Maternal and Child Health Bureau (Learning Session 4 is also supported, in part, by Prince Charitable Trusts) 2011 - 2014
- ICAAP and ACHN have worked on medical home transformation since October 2009, when Fantus' Pediatric clinic enrolled into ICAAP's Building Community-Based Medical Homes for Children Program 2009 - 2011

Building Community-Based Medical Homes for Children Program

ICAAP and UIC-SCC will spread the Illinois Medical Home Model ™ by providing QI facilitation support to 5 high-volume pediatric ACHN sites through teaching and application of the Model for Improvement.

At the final Learning Collaborative Session, QI teams will teach key policies and lessons learned to additional ACHN sites to improve outcomes for patients and families across the CCHHS.

Building Community-Based Medical Homes for Children Program ACHN

Innovative Models Funding Category

(Spread positive change across ACHN over 3 years)

Aim: By October 2014, 80% of ACHN pediatric patients will receive comprehensive, coordinated health and related services through the Illinois Medical Home Model™ in which providers partner with families to provide high-quality care, and youth and young adult patients receive services to successfully transition to adult health care.

Participating ACHN Sites

ACHN High Volume Pediatric Clinics (Lead Sites)

- Fantus Pediatrics
- Vista
- Cicero
- Logan Square
- Cottage Grove

ACHN Lower Volume Pediatric Clinics (invited to learn about improvements made and to implement successful strategies in their sites)

- Austin
- Chicago Advocacy Center
- Englewood
- Jorge Prieto
- Morton East
- Near South
- Robbins
- Sengstacke

Building Community-Based Medical Homes for Children Program ACHN

Project Goals 2011-2014:

1) ACHN Centers will receive training on the IL Medical Home Model™ developed by ICAAP and UIC-SCC
2) ACHN will provide comprehensive, coordinated health and related services through the PCMH
3) ACHN will partner with community-based programs to better serve children and families
4) ACHN will develop and implement a policy to support youth who are transitioning to adult health care

The project received exempt IRB approval as a QI project and includes an evaluation. Findings will be used for internal QI purposes.

Learning Session Objectives

- At the end of this learning session attendees will be able to:
- Understand and implement key PCMH CCHHS ACHN Policies including:
  - **Patient-Centered Medical Home (PCMH) Model of Care (Family-Centered Care)**
  - **Team Huddles**
  - **Transition Care for ED and Post-Hospital Discharge Patients**
  - **Developmental Screening Using ASQ-3 and Process for EI Referral**
  - **Immunizations**
  - **Lead Screening**
  - **Transitioning Youth to Adult Health Care (draft policy)**
- Learn from successes and challenges related to PCMH implementation by the high-volume pediatric ACHN sites
- Develop plans to spread and sustain the QI work

Who needs a Medical Home?

Children and youth with special health care needs (CYSHCN) are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

--Maternal and Child Health Bureau, 1995

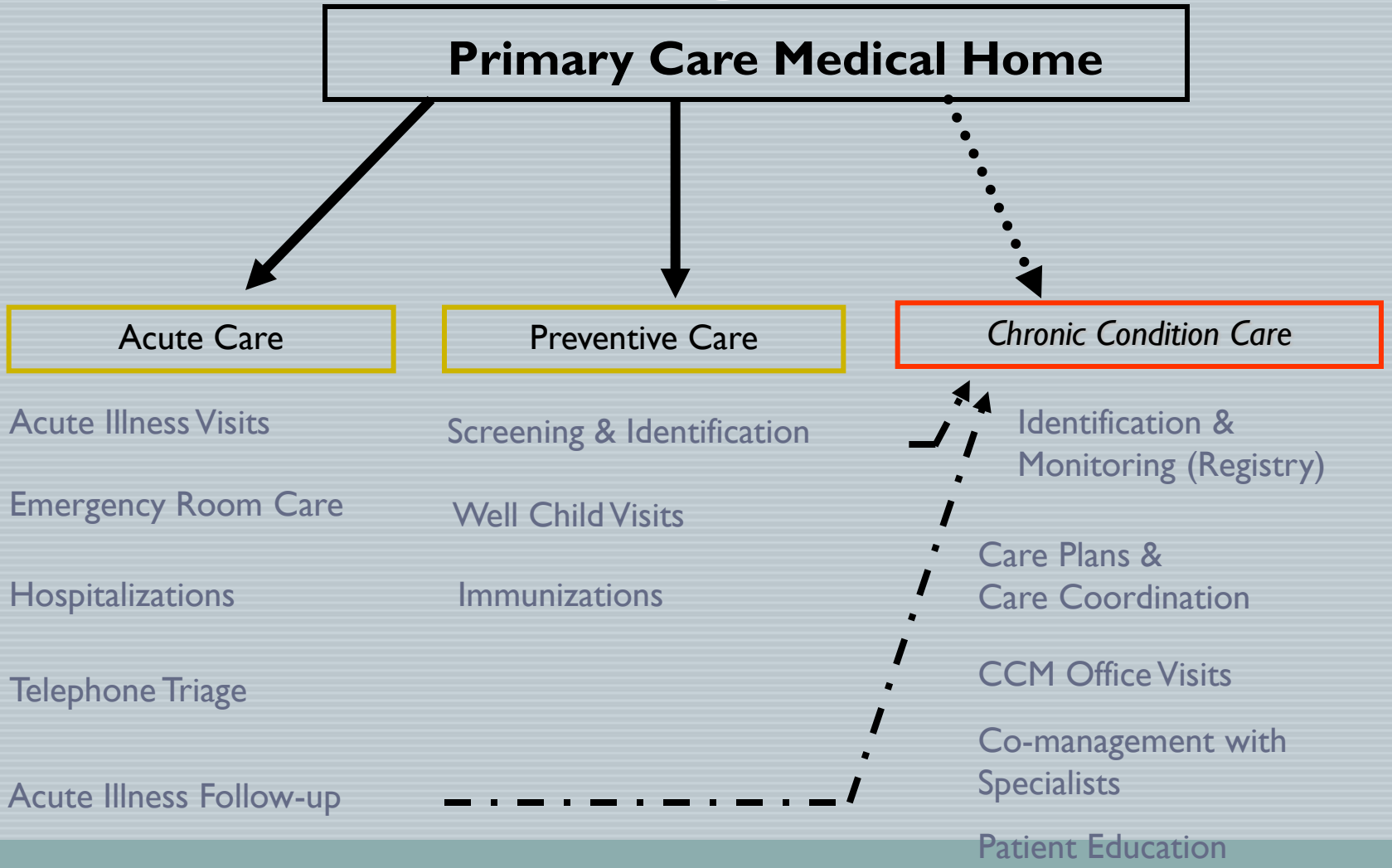
Definition of CYSHCN

Prevalence of CSHCN

Prevalence of CSHCN	2009/2010 Illinois %	2009/2010 National %	2005/2006 Illinois %
Percent of children who have special health care needs	14.3	15.1	13.9
Age 0-5 years	9.2	9.3	9.4
Age 6-11 years	16.3	17.7	16.2
Age 12-17 years	17.4	18.4	16.3
Male	16.2	17.4	16.0
Female	12.3	12.7	11.8

- According to the NSCYSHCN 2009/2010 survey data, the prevalence of CSHCN in Illinois is 14.3%, the national prevalence is 15.1%.
- There was a 3% increase in the number of CSHCN in Illinois since the 05/06 survey.
- Males between the ages of 0-17 years are 32% more likely to have a special health care need than their female counterparts.

The Medical Home Model



Program Offering

- Over the past 3 years, the program has provided 5 ACHN pediatric clinics with outside facilitators (provided by ICAAP & DSCC) and utilizes The Model for Improvement

  [Learn to implement Plan, Do, Study Act (PDSA) cycles]
- QI Team work requires organization provided by lead physicians, nursing staff, MAs, clerks, social work and facilitators
  - Agendas, Minutes, Action Items
  - Baseline and Follow up Assessment Tools
  - Facilitation and Coaching
  - Policies and Workflow
  - Develop and Implement PDSAs
  - Training and Sharing Lessons Learned
- Momentum … slow but sure!

Quality Improvement Process

- Regularly scheduled meetings *(every month) – most sites have met with their QI teams 25-27 times*
- Minimum ACHN QI team members:
  1-2 parents + at least 1 physician + nursing coordinator and other nursing staff + clinic administrator or a clerical representative
- Baseline and follow up measurement (baseline assessments help define QI goals and objectives)
- Develop plans and implement change for quality improvement
- Four Learning Group Sessions Held (April 2012, October 2012, September 2013, and November 2014)
- Developmental screening quality improvement initiative (2013)
- Transitioning youth to adult health care

Medical Home Index

- Organizational Capacity
- Chronic condition management
- Care coordination
- Community outreach
- Data management
- Quality improvement

Levels of Medical Home Health Care Delivery

Level 1: Basic

Level 2: Responsive

Level 3: Proactive

Level 4: Comprehensive Care/Medical Home

(The Hood Center for Children and Families, Lebanon, NH)

The Medical Home Family Index

Let's Ask the Families…

- 25 questions capture the family perspective (survey is being shortened and adapted for ACHN)

- Corresponds with the Practice's Medical Home Index

Examples of Quality Improvement Activities

- Identification of CYSHCN Patient Lists and CMapp
- Team Huddles
- Same Day Scheduling
- Patient Visit Planning
- Resource packets
- Today's Visit Form
- Depart Summaries
- Written Care Plans
- Tracking Referrals
- Care Coordination
- Measuring Change
- Child Health Measures

Visit these web sites for excellent tools and resources

www.illinoisaap.org
www.uic.edu/hsc/dscc/
http://medicalhomeinfo.org/

Highlights of Today's Program

- Parent Partner Perspective
- Medical Home Index and Family Index Results
- Applying QI Principles to PCMH Implementation
- ACHN Clinic Storyboards
- ACHN Policies
- Update on Referral Management Workgroup
- Initiatives of Interest to ACHN
- Next Steps
- Recommendations

Special Thanks to the QI Teams and Facilitators

Vista	Jon Ashworth, Mdiv, MA, LPC
Logan Square	Rita Klemm, MSW
Cottage Grove	Dru O'Rourke
Fantus	Kathy Sanabria, MBA, PCMH CCE
Cicero	Donna Scherer, RN, MPH, Cicero

We hope you enjoy the Learning Session and our time together!