

Building Community-Based Medical Homes for Children

Illinois Medical Home Newsletter

SEVENTH EDITION

OCTOBER 2015

ILLINOIS CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

Editor: Kathy Sanabria, MBA, PMP, ICAAP Associate Executive Director



What is a medical home? What does it mean for families?

A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

In a medical home, a pediatric clinician works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family.

The Medical Home. Pediatrics. 2002; 110; 184-186. Reaffirmed 2008.

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Building Community-Based Medical Homes for Children is a publication of the ICAAP. Views expressed by authors are not necessarily those of the ICAAP. Editor: Kathy Sanabria, MBA, PMP, Associate Executive Director, ksanabria@illinoisAAP.com

Acronyms

AAP-American Academy of Pediatrics
CMHI-Center for Medical Home Improvement
CYSHCN-Children and Youth with Special Health Care Needs
ICAAP-Illinois Chapter, American Academy of Pediatrics
IMHM-Illinois Medical Home Model
IMHP-Illinois Medical Home Project
MCHB-Maternal and Child Health Bureau
NCQA-National Committee for Quality Assurance
NICHQ-National Initiative for Children's Healthcare Quality
QI-Quality Improvement

Photos are courtesy of the Illinois Chapter of the American Academy of Pediatrics.
Graphic Design by Kirsten Goede/Statement Design contact@statementdesign.com

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This newsletter is supported by an innovative models grant to the Illinois Chapter of the American Academy of Pediatrics from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, grant number: D70MC23048 and Prince Charitable Trusts. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

1. Letter from the Editor: Medical Home Initiatives Advance in Illinois

By Kathy Sanabria, MBA, PMP
ICAAP Associate Executive Director



It has been three years since we last published an Illinois Medical Home Newsletter. ICAAP has been working on several medical home initiatives during this time. A few have been completed and results are summarized in this edition. Many other activities continue to support pediatricians, providers, and patients and families around the state. In this issue, Sara

Parvinian, MD, FAAP, ICAAP leader, offers a thoughtful commentary on what “medical home” implementation has meant to her personally as a community pediatrician in Gurnee, IL as well as what it has done for her patients.

This edition features two articles on an *Innovative Evidence Based Models for Improving the System of Services for Children and Youth with Special Health Care Needs* (CYSHCN) grant project, funded by the Maternal and Child Health Bureau. The effort was implemented by the Illinois Chapter of the American Academy of Pediatrics (ICAAP), in collaboration with the Division of Specialized Care for Children (DSCC), Illinois’ State Title V Children with Special Health Care Needs (CSHCN) program. The project has helped to spread the Illinois Medical Home Model™ (IMHM™) within a health care system. The model has been previously shown to improve care and services for CYSHCN at the practice level.^{1,2} This grant provided an opportunity to implement the IMHM™ with the Ambulatory and Community Health Network (ACHN), Cook County Health and Hospitals System (CCHHS), in Illinois. Fantus Health Center and Logan Square Community Health Center served as the lead ACHN pediatric sites. The program received support from leaders and a program planning group including: Enrique Martinez, MD, Chief Medical Officer of ACHN (former); lead ACHN pediatricians, Judy Neafsey, MD, Director of Ambulatory Pediatrics for ACHN

ICAAP is a statewide membership organization with nearly 1800 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.

and Medical Director, Stroger Specialty Care Center (retired); and Denise R. Cunill, MD, Associate Medical Director of Ambulatory Pediatrics, CCHHS, Medical Director, Logan Square Community Health Center. Project accomplishments are summarized in the newsletter.

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). Quotes throughout this newsletter are from participants in ICAAP’s medical home projects over the last three years.

—Kathy Sanabria, Editor

Esperanza Community Health Centers participated in a quality improvement Maintenance of Certification (MOC) Part 4-approved activity throughout 2013 and 2014 to transition youth to adult health care. The training was well received and implemented system-wide. Experiences and results are summarized. ICAAP’s *Transitioning Youth to Adult Health Care* training curricula has been well received by pediatricians, adult providers, and patients. We hope your practice takes advantage of the many resources developed for youth and families to facilitate the transition to adult care. Resources can be accessed by visiting the training website or by registering to take the course.

Course resource materials are available for free here: <http://illinoisaaap.org/projects/medical-home/transition/resources-for-physicians/>

Visit the ICAAP e-Learning System to register for the training and to receive Part 4 MOC credit: <http://illinoisaaap.org/e-learning/> or contact ICAAP at 312/733-1026 for more information on the course.

ICAAP’s participation in the Children’s Health Insurance Program Reauthorization Act (CHIPRA) Demonstration Grant ended February 2015. This newsletter provides a summary of practice self-assessments for 23 Illinois CHIPRA project practices that completed the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home 2011 Standards survey.

This newsletter also provides information and updates on Family Medicine’s *Health is Primary* campaign, coordinated efforts to impact the health of obese children, and the I-CARE Illinois immunizations system and registry.

Thank you for your ongoing interest and dedication to the advancement of Patient Centered Medical Homes in Illinois and beyond. We hope the information provided assists you with ongoing transformation. If you or your practice would like more information on medical home transformation, please contact me at ksanabria@illinoisaaap.com

1 Sanabria K.E, Barger J: Building Community-Based Medical Homes for Children Program Evaluation Results. Building Community-Based Medical Homes for Children: Illinois Medical Home Annual Newsletter, Sixth Edition, Fall 2012. 2-6.

2 Rankin K, Cooper A, Sanabria K, Onufer C, Binns H: Illinois Medical Home Project: Pilot Intervention and Evaluation. *American Journal of Medical Quality*. August 2009;24 (4);302-309.

2. Medical Home Perspective

By Sara Parvinian, MD, FAAP
Medical Home Pediatrician Leader



There is no place like home!

In an ideal world, children have a safe, loving, and secure “home” to grow up in, develop, and mature. In an ideal world, children should also have a “medical home” which gives them a secure, loving, and “compassionate” environment to nurture their physical and mental health. To give them “continuous”

and “comprehensive” care that is accepting of their “culture” and beliefs and where family needs are addressed in a “coordinated” and “accessible” manner.

As a pediatric resident at Cook County Children’s Hospital in Chicago (1990-1993), I had the honor of being trained by Dr. Rosita Pildes, the acting chair of Cook County Children’s Hospital and director of the neonatology department. I remember asking her one day at the crib-side of an almost three-month-old infant who was born a premie (29 weeks gestational age) with many problems to a single teenage mother addicted to cocaine, high school drop out living with her mother and four siblings whom I never met due to transportation problems, “Who will take care of the baby when he gets discharged?” That question stayed with me when I became a community general pediatrician who accepted increasing numbers of children with special needs as patients. I began seeing patients who had illnesses and situations that up until very recently would not have allowed them to survive into early childhood let alone adolescence and adulthood. In the 1990s, general pediatricians were not trained to take care of children with special needs. The “medical home” model of care was in its infancy and just beginning to emerge. I became increasingly aware of the struggles faced by families of children with special needs. Having a child at home who is in need of several doctors’ visits a month, plus possibly a few sessions of PT, OT, and speech therapy weekly as well as frequent laboratory and radiologic work ups would mean loss of work hours, with many days/hours requested off by parents or caregivers and would increase the risk of job loss, financial hardship, lack of family and social time, and sleepless nights. One can imagine that this would cause a constant state of anxiety and stress for parents. Additionally, siblings would also be at risk of feeling left out and neglected.

Another challenge many families of children with special needs continue to face is lack of communication between specialists and subspecialists caring for the child, which could result in double procedures and testing being done increasing the cost of care on the family and insurance

providers. Meanwhile, parents can become confused and not have basic knowledge or even understanding of their loved one’s diagnosis, prognosis, and quality of life expectancy since no one took the time to sit down and discuss it with them in an understandable manner. That is why the concept of providing pediatric care as a “medical home” practice was such an important and valuable idea which drew my interest when the learning opportunity to participate in the first medical home pediatric project in Illinois was provided by ICAAP.

So what is a “medical home?” The Patient Centered Medical Home (PCMH) model helps providers and care teams learn how to organize one’s practice to be able to coordinate care for all patients, including complex patients with special needs or chronic illnesses. It provides a model framework to ensure the office is accessible (to make same day appointments, easy phone or electronic access, accessible exam rooms, and easy entrance to buildings and exam rooms). The care must be provided in a compassionate manner, putting patient and family at the center of attention. Care must be centralized and yet cooperate with other health care providers in giving the patient continuous and comprehensive care. The “medical home” becomes the axis that facilitates direct communication with other health care providers and becomes a hub for all upcoming plans of care and management. And at the same time, the care team provides routine preventative care, including vaccinations and school and sport physicals. In addition, the practice provides acute and chronic illness care. The child’s medication list needs to be updated and kept on file to be easily accessible by other care providers when needed. The practice should also be familiar with patients who have chronic conditions and needs. It is hard and stressful for parents to have to explain their child’s special circumstances every time they call to make an appointment. The receptionist, even if she is new to the job, should be aware of the status of that particular child as soon as she looks up the name while talking to the family or the care taker. This can be accomplished by flagging in patient records that the patient has special needs and identifying those up front to enhance communication.

If the child is out of town and in need of medical attention, it would be of immense help to have an updated medical history, diagnosis, medication list, current problems, and contact information of the primary care provider (PCP) handy. With the EMR it should be easy for the PCP or the covering physician to access the patient’s chart and be able to coordinate his/her care management long distance.

Transitioning pediatric patients into adult care is of utmost importance whether for a “healthy” patient or one with “special needs.” But in this case educating parents or family care givers on resources and going through the transition process step-by-step, starting

early by age 12 to 14 years will give the family and patient time and help them to prepare mentally to go through it, to ask questions and have an understanding on changes in their child's status, living requirements, educational options, and so on.

The Illinois Medical Home Project (IMHP) developed and implemented by ICAAP and the Division of Specialized Care for Children (DSCC) provided our practice, The Children's Health Center, in Gurnee, Illinois with enormous amounts of resources including hands-on training seminars, AAP policies, articles, and studies on the Medical Home concept of care. Our practice participated in the project funded by the Maternal and Child Health Bureau from 2004-2009. After the grant project ended our practice continued on with monthly QI team meetings. One of the most beneficial resources provided was the assignment of a practice facilitator for the practice's Medical Home QI team meetings. It gave me and other physicians and care providers a great amount of support, inspiration, and motivation to go forward with the project and sustain the concept in practice. Our "special needs families" became increasingly more confident and comfortable in contacting us about questions or concerns related to their child's care. Our dedicated care coordinator became deeply familiar with each patient and family, knowing the involved therapists, subspecialists, and community resources in each case and was able to solve scheduling difficulties, follow up visits, obtaining lab results, and forwarding them to referral physicians. In many cases by calling and communicating with PCPs or nurses, the previous routine of going to the ED for most acute illnesses or flare ups of the chronic illness was broken and we would either see patients at the office or if it was felt necessary we were able to facilitate an urgent visit to the subspecialist.

I cannot say we've achieved our final goal of becoming a recognized or certified "medical home" clinic yet, but working towards it as a team has been an eye opening experience for a busy community practice serving a multicultural population. The patients we serve are

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

mostly working, low income, and immigrant families. They are the patients that will benefit the most from high quality, coordinated, and managed care.

By realizing our deficiencies, by becoming familiar with and working with community resources and

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). Quotes throughout this newsletter are from participants in ICAAP's medical home projects over the last three years.

—Kathy Sanabria, Editor

to providing the best and highest quality care possible for our deserving patients and families. With improved quality of care and financial savings at the end of the tunnel, the "medical home" model is the "standard of practice" and as such it should be fully compensated. What will it take to make the model routine? It will take trained physicians and nurses dedicated to the practice of medical home to implement team-based care from the beginning. The practice should welcome patients with special needs and share information and knowledge of local community resources, local support service agencies, knowledge of the community's educational school system, districts, and special education rules and requirements. In a nutshell, it will take a well-organized care team who puts the patient/family at the center of care.

So as I suggested, that long ago day to my very dear attending physician, Dr. Rosita Pildes, it would be great if all pediatric residency training programs would routinely teach the "medical home" concept of practice in their training programs. This would help ensure we have physicians in the community who understand their important role in providing family and patient centered care. Medical Home is not a place or location but a concept of care which makes the practice visits an enjoyable, rewarding, and inspirational visit for the child, family, and the PCP and clinic staff. It is a special relationship the family and patients have with their healthcare team and providers. It's HOME.

agencies, by including families in decision making, practice staff realized that we are on the right track. It is not an easy route! There are lots of back falls and hurdles to jump over. It is not financially wise to spend all that extra time trying to coordinate care and resources with no reimbursement by insurance companies. But we are committed

3. Building Medical Homes for the Ambulatory and Community Health Network of Cook County, Illinois

By Denise R. Cunill, MD, FAAP
Kathy Sanabria, MBA, PMP

Project Title:
Building Medical Homes for the Ambulatory and Community Health Network (ACHN) of the Cook County Health and Hospitals System (CCHHS), Cook County, Illinois

Grant Number:
D70MC23048

Lead Pediatricians:
ACHN Lead Pediatricians: Denise R. Cunill, MD, FAAP, Associate Medical Director of Ambulatory Pediatrics, CCHHS and Judy Neafsey, MD, FAAP (retired)

Project Director and Principal Investigator:
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<http://illinoisAAP.org/projects/medical-home/building-medical-homes-for-the-ambulatory-and-community-health-network-of-cook-county/>

Project Period:
September 1, 2011 – February 28, 2015

Total Amount of Grant Awarded:
\$259,500

Background

The Illinois Chapter of the American Academy of Pediatrics (ICAAP), in collaboration with the Division of Specialized Care for Children (DSCC), Illinois' State Title V Children with Special Health Care Needs (CSHCN) program, implemented an *Innovative Evidence Based Models for Improving the System of Services for Children and Youth with Special Health Care Needs (CYSHCN)* grant in the area of access to medical home. One purpose of this grant was to spread the piloted Illinois Medical Home Model™ (IMHM™) within a health care system to improve patient centered care.^{1,2}

This three-and-a-half-year program entitled *Building Medical Homes for the Ambulatory and Community Health Network (ACHN), Cook County, Illinois* (heretofore referred to as Building Medical Homes for the ACHN), was administered by ICAAP and ACHN in collaboration with DSCC. Fantus Health Center and Logan Square Community Health Center served as the lead ACHN pediatric sites.

The program received support from ICAAP and ACHN leaders, a planning group, and ICAAP staff director Kathy Sanabria, MBA, PMP and manager Dru O'Rourke. The ACHN designated its own leaders to oversee the initiative including: Enrique Martinez, MD, Chief Medical Officer of ACHN (former); and lead ACHN pediatricians Denise R. Cunill, MD, Associate Medical Director of Ambulatory Pediatrics, CCHHS, Medical Director, Logan Square Health Center of Cook County, and Judy Neafsey, MD, (retired) Director of Ambulatory Pediatrics for ACHN and Medical Director, Stroger Specialty Care Center, CCHHS; and Irv Pikelny, RHIA.

ICAAP and ACHN also partnered with Illinois Department of Healthcare and Family Services (IDHFS) (Medicaid), Family to Family Health Information and Education Center (F2F), Illinois Academy of Family Physicians (IAFP), community-based groups, and government agencies including Child and Family Connections (CFC), which administers the Illinois Early Intervention (EI) program.

ACHN Engagement

Five high-volume pediatric ACHN clinics and five clinics with lower volume pediatric patients participated in this quality improvement (QI) program. See clinic sites below:

Table 1

Ambulatory and Community Health Network Sites with High-Volume Pediatric Patients:

Site Name	Location	QI Team Facilitator
Cicero Health Center	Cicero, IL	Donna Scherer, RN, MPH
Vista Health Center	Palatine, IL	Jon Ashworth, M.Div, MA, LPC
Cottage Grove Health Center	Ford Heights, IL	Jodie Barger, MSW, LSW Dru O'Rourke
Fantus Pediatrics Health Center (Lead Site)	Chicago, IL	Kathy Sanabria, MBA
Logan Square Health Center (Lead Site)	Chicago, IL	Rita Klemm, MSW Kathy Sanabria, MBA

Table 2

Ambulatory and Community Health Network Sites with Lower-Volume Pediatric Patients:

Site Name	Location	QI Technical Assistant
Fantus General Medicine Clinics	Chicago, IL	Kathy Sanabria, MBA
Woodlawn	Chicago, IL	Jon Ashworth, M.Div, MA, LPC
Englewood	Chicago, IL	Jon Ashworth, M.Div, MA, LPC
Robbins	Robbins, IL	Jodie Barger, MSW, LSW
Austin	Chicago, IL	Jon Ashworth, M.Div, MA, LPC

Goals and Objectives

The program addressed four core Maternal and Child Health Bureau performance measures:

1. families partner in decision making
2. access to comprehensive health and related services through the medical home
3. early and continuous screening, evaluation and diagnosis
4. transition to adult health care

GOAL 1:

ACHN Centers will receive training on the Illinois Medical Home Model (IMHM)[™] and incorporate principles of medical home into their pediatric clinics and improve partnerships with families. (Years 1-3)

OBJECTIVES:

1. Spread the IMHM by providing quality improvement (QI) team facilitation support to five high-volume pediatric ACHN sites.
2. Include parent partners on each ACHN medical home QI team.
3. Link participating sites as a Learning Collaborative and work to implement pediatric QI systems changes across the ACHN.

GOAL 2:

ACHN will provide comprehensive, coordinated health and related services through the medical home. (Years 1-3)

OBJECTIVES:

1. Expand/spread pediatric 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 each other 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. (Years 2-3)

OBJECTIVES:

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

GOAL 4:

ACHN will receive training tools from ICAAP on how to provide support to youth and families to facilitate successful transition to adult health care. (Year 3)

OBJECTIVES:

1. Develop a written ACHN policy for providers and patients to facilitate transitioning youth to adult health care.
2. Develop a system-wide policy related to transitioning youth to adult health care, including how to transition young adults seen in the Emergency Department to an adult-oriented medical home.
3. Adult-oriented ACHN providers will participate in the successful transition of young adults to the adult health care setting.

GOAL 5:

Evaluate effectiveness and impact of project. (Years 1-3)

OBJECTIVES:

1. Subcontract with an independent evaluator to implement an evaluation plan to include fielding the Center for Medical Home Improvement's (CMHI) Medical Home Index (MHI) and Medical Home Family Index (MHFI) at baseline and at end of project.
2. Conduct National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) self-assessment survey with participating ACHN Centers and help assess readiness to apply for NCQA PCMH Recognition or Joint Commission PCMH Certification.
3. Measure effectiveness and utilization of IMHM by tracking process measures and QI data.

Methodology

The program aimed to improve access to quality, comprehensive, and coordinated systems of services for children and families who receive healthcare through the ACHN of Cook County, IL. The initiative was overseen by representatives from ACHN, ICAAP, and DSCC. The program implemented the Illinois Medical Home Model[™] developed by ICAAP and DSCC and taught the Model for Improvement, including use of the "Plan-Do-Study-Act" cycle of practice improvement. The program established systems to support medical home initiatives utilizing resources developed by CMHI, National Center for Medical Home Implementation, Got Transition, and ICAAP, to name a few. The program worked to develop community-based systems to ensure young children are screened for developmental delay and receive coordinated referrals to the Early Intervention program. It also provided support in developing a transitioning youth to adult health care ACHN policy. Five high-volume pediatric ACHN Centers participated in a system-wide Learning Collaborative, attended four full-day training sessions, and received monthly in person QI team facilitation support. By the close of the project, the team-based model of care was spread to all ACHN clinics that serve children.



The ACHN and ICAAP honored Dr Judy Neafsey upon her retirement as Director of Ambulatory Pediatrics for ACHN and Medical Director, Stroger Specialty Care Center, CCHHS, during Medical Home Learning Session 2 held April 10, 2013 at the Illinois Medical District Building.

Experience

The program provided five high-volume pediatric ACHN clinics (and five lower-volume sites that also see children) with PCMH training, in-person QI facilitators, and technical assistance support organized around ACHN provider care teams. Over two years, facilitators met monthly with providers and clinic administrators at the five core sites. A developmental screening and coordinating care with Early Intervention (EI) QI activity was completed (approved for CME and Part 4 Maintenance of Certification credit). The ACHN updated its developmental screening policy. Sites demonstrated significant improvements with routine surveillance, screening, and care coordination for referrals made to EI. Facilitators assisted in developing an ACHN Transitioning Youth to Adult Health Care policy. A fourth and final CME-approved Medical Home Learning Session was held November 2014. Staff from 10 centers participated to spread project results across the ACHN. An independent evaluator prepared a pre- and post-program evaluation report utilizing the MHI and MHFI at baseline and 20–22 months later at follow up that demonstrated improvements in “medical homeness.” This is supported by the fact that the ACHN was successful in its application to receive Joint Commission PCMH certification April 2015. Please read the next article to learn about practice improvements.

1 Sanabria K.E, Barger J: Building Community-Based Medical Homes for Children Program Evaluation Results. Building Community-Based Medical Homes for Children: Illinois Medical Home Annual Newsletter, Sixth Edition, Fall 2012. 2-6.

2 Rankin K, Cooper A, Sanabria K, Onufer C, Binns H: Illinois Medical Home Project: Pilot Intervention and Evaluation. *American Journal of Medical Quality*. August 2009;24 (4);302-309. This grant provided an opportunity to implement the model within the ACHN.

4. Ambulatory and Community Health Network Practice Improvement Summaries

By Denise R. Cunill, MD, FAAP, Lead Pediatrician, Associate Medical Director of Ambulatory Pediatrics, Cook County Health and Hospitals System (CCHHS) and Medical Director for Logan Square Community Health Center

Judy Neafsey, MD, FAAP, (Retired) Director of Ambulatory Pediatrics for ACHN and Medical Director, Stroger Specialty Care Center, CCHHS

Kathy Sanabria, MBA, PMP, Principal Investigator, Grant Director

Denise Roseland, PhD, Change Maker Consulting, LLC, Evaluator

Jon Ashworth, MDiv, MA, LPC, Consulting Partnerships, Practice Facilitator

Background

A medical home is an approach to providing primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In a medical home, the primary care team develops a trusting relationship with the patient and family and works as a partner to assure that all of the child’s needs are met.

Through its medical home initiatives, the ICAAP works with individual physicians, primary care practices, subspecialists, and community and state agencies to support the dissemination and implementation of the Patient Centered Medical Home (PCMH) model, with a focus on improving services for children with special health care needs and their families.

ICAAP partnered with the CCHHS in the *Building Medical Homes for the Ambulatory Community Health Network (ACHN)*, Cook County, Illinois project, beginning in the fall of 2011. This was a 3½ year innovative models grant project funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau with additional modest support from the Prince Charitable Trust. The program helped to spread the Illinois Medical Home Model™ within the ACHN and provided on-site facilitation support to five high-volume pediatric clinics to establish a medical home quality improvement (QI) process and improve care coordination. The ACHN sites with which we worked most intensively were Fantus Health Center, Cicero Community Health Center, Vista Community Health Center, Cottage Grove Community Health Center, and Logan Square Community Health Center. After two years of working with these five sites, eight other ACHN sites that care for children were included in the final year of the project and participated in the fourth and final Medical Home Learning Session held on November 4, 2014 to spread pediatric QI efforts across the ACHN. Additional ACHN sites that participated in the LS included: Austin Community Health Center, Englewood Community Health Center, Jorge Prieto Community Health Center, Morton East School-Based Health Center, Near South Community Health Center,



ACHN pediatric teams participate in the fourth and final ACHN Medical Home Learning Session held Tuesday, November 4, 2014.

Oak Forest Community Health Center, Robbins Community Health Center, and Sengstacke Community Health Center.

The Building Medical Homes Project was administered by ICAAP in collaboration with ACHN leadership and helped clinic staff and practices redesign systems and services to be more proactive and better able to meet the needs of patients and families through implementing the PCMH model. These strategies have also been shown to be effective with adult populations.

Methodology

Each of the five core pediatric clinics had their own Medical Home QI team. Each team was comprised of providers, nurses, medical assistants, clerks, parent partners, and a QI team facilitator. The teams met approximately once per month over a period of just over 2½ years. Each team began by addressing the foundational questions of “What is a Medical Home?” and “Why is a Medical Home so important?” They were introduced to the Model for Improvement QI approach of Plan-Do-Study-Act, or PDSA. Using this technique, each team worked on specifically targeted QI efforts, building a step-by-step process in their pursuit of the desired improvement. Some QI efforts were common to all of the teams e.g., routine utilization of developmental screenings, and some efforts were of specific interest to a particular practice e.g., increasing the use of asthma action plans.

Evaluation and Results: Overview

Each of the sites participated in a two-fold evaluation process. First, an internal practice self-assessment tool (pre and post*), called the Medical Home Index (MHI) was utilized by practice staff. The tool was developed by the Center for Medical Home Improvement (CMHI). Secondly, an external survey tool (also pre and post*) called the Medical Home Family Index (MHFI) was utilized. This survey tool is completed by families from within each specific site who have a child or youth with special health care needs (CYSHCN). This survey is designed to capture family satisfaction and practice proficiency in medical home practices.

Based on the MHI staff self-assessment results, the five sites showed a strong awareness of their own growth as a practice and as a medical home QI team. Within the domains of organizational development, chronic condition management, care coordination, and community outreach, the clinic staff expressed that they could see moderate to significant growth as a practice and team. According to the MHFI results, families across the five sites expressed increased satisfaction with care received. In addition, all of the clinics showed more proficiency in the practice as a medical home.

* = pre tests were completed in spring of 2012; post tests were completed in spring of 2014



Denise R. Cunill, MD, FAAP, Associate Medical Director of Ambulatory Pediatrics, CCHHS and Medical Director for Logan Square Community Health Center, accepts a certificate of appreciation from ICAAP and ACHN for her role as pediatrician leader and PCMH champion presented at Learning Session 4 held November 4, 2014.

The Patient Centered Medical Home (PCMH) model of medicine is one which has been in existence for some time now throughout pediatric practices across the country. However common practice, the transformation takes time, dedication, and multiple systems of support to continue the process through its evolution. The Building Medical Homes for the Ambulatory and Community Health Network (ACHN) of Cook County afforded our core pediatric sites this type of extra support with the ICAAP and site facilitators providing guidance and expert advice. As the sites embarked on their journeys through the quality improvement processes, ICAAP and the site facilitators became an adjunct to the pediatric teams. These core pediatric sites were able to participate and embark on Plan-Do-Study-Act (PDSA) cycles of change maintaining the objective of keeping the family at the center of their PCMH model of medicine. What was learned through this grant continues to be shared with other sites within the ACHN of Cook County. The experiences made possible through this grant will carry on through all of our encounters with future patients and families.

–Denise R. Cunill, MD, FAAP, Associate Medical Director of Ambulatory Pediatrics, CCHHS

Accomplishments from Each of the Five Core Sites

Cicero Community Health Center

HealthTeam Meetings 24 Meetings were held between 3/12/12 and 12/8/14, typically on the 2nd Monday of each month

Team Members

1. Anne Jacobson, MD (Family Physician) (Lead Provider, Former)
2. Lydia Weber, RN (Nurse)
3. Michelle De La Torre (Medical Assistant)
4. Daysi Sanchez (Medical Assistant)
5. Maritza Rosado (Clerk)
6. Matilde Torres (Social Worker)
7. Patty Katsuleas (Parent Partner)
8. Donna Scherer, RN, MPH (QI Team Facilitator)

Examples of Team Quality Improvement Accomplishments

1. Developed a sustainable outreach approach to fall flu vaccination – developed the plan in the summer of 2012 and are still successfully implementing this plan.
2. Established a consistent process of having families complete the Ages and Stages Questionnaire (ASQ-3) developmental screening tool – families have been very responsive to this approach of emphasizing the importance of the screening.
3. Consistent use of the CMap (care management application) alerts for flu vaccine and lead screening.
4. Nurse care management visits have been implemented and have been well received by families served. Families have a 99% show rate for the nurse care management visits.
5. Established a process for routine screenings for asthma, use of the Asthma Action Plan and collaborating with a provider (Neb Medical Services) to have nebulizers on site to provide to patients along with training in use and care.
6. Developed an informational brochure about the Clinic including regular, walk-in, and lab hours, important phone numbers, and care team profiles.
7. Successfully implemented a follow-up process for contacting patients who were seen in the ED/discharged from the hospital as notified by the Medical Home Network (MHN) Connect Portal.



Cicero Community Health Center QI Team: The members from left to right are Alicia Soto (Clerk), Lorenza Vivanco (clerk), Michelle De La Torres (health advocate), Lydia Weber (RN) and Dr. Salman Khan.

Cottage Grove Community Health Center

HealthTeam Meetings 25 Meetings were held between 3/9/12 and 12/12/14, typically on the 3rd Thursday of each month

Team Members

1. Kimberly Walton-Verner, MD, FAAP (Lead Pediatrician)
2. Isabel Argueta (Medical Assistant)
3. Ma. Elizabeth San Juan (Nurse)
4. Marydale Donald (Administrator)
5. Tais Crawford, MD (Medical Director and Family Physician)
6. Dru O'Rourke, Jodie Bargeran, MSW (QI Team Facilitators)

Previous team members included:

1. Virginia Moore, RN (Nurse)
2. Diana Liberti (Social Worker)
3. Alfreda Fason (Clerk)

Examples of Team Quality Improvement Accomplishments

1. Developed an asthma registry that ensures all asthmatic patients receive proper guidance and Asthma Action Plans.
2. Established a routine for families to complete the ASQ-3 developmental screening tool.
3. The team consistently huddles to review the upcoming schedule – this has improved efficiency and workflow.
4. Implemented a process for following up with patients that were discharged from the hospital or ED.
5. Developed a resource bulletin board for patients – the board provides information about health and wellness as well as local resources.

PCMH enhanced our practice making it more patient friendly and improving the patient experience. The QI team has made many improvements since inception of Medical Home. Huddles streamline our work. We are able to anticipate patient needs ahead of time. This improves our efficiency. We use medical records and track if appointments are missed or kept and tie up loose ends. We call patients post ED and follow up, reaching out to patients who need follow up. We also identify community resources to help patients achieve their health and wellness goals.

–Swati Bhohe, MD, FAAP, Lead Pediatrician
at Vista Community Health Center

Fantus Health Center

HealthTeam Meetings

28 Meetings were held between 3/28/12 and 12/1/14, typically on the 2nd Wednesday of each month and later on Mondays

Team Members

1. Jay Mayefsky, MD, MPH, FAAP (Lead Pediatrician, Retired)
2. Mita Patel, MD, FAAP (Attending Pediatrician)
3. Alisa Seo-Lee, MD, FAAP (Attending Meds-Peds Physician)
4. Eugenia Sta. Maria, RN, MSN (Division Nurse Coordinator 2)
5. Dianna Dosie, RN (Nurse)
6. Katina Haymer (Medical Assistant)
7. Ines Murillo (Clerk Administrator)
8. Linda Jackson (Parent Partner)
9. Kathy Sanabria, MBA, PMP, PCMH CCE (QI Team Facilitator)

Previous team members included:

1. Sherry Frausto (Clerk)
2. Marie DiGiacomo, FPNP (Advanced Family Practice Nurse)
3. Judy Neafsey, MD, FAAP (Lead Pediatrician, Retired)
4. Fred Smith (Retired Administrator)
5. Joslyn Jelinek, MSW (Social Worker)

Examples of Team Quality Improvement Accomplishments

1. Implemented several practices to enhance medical home access (e.g., reserving time slots for same day appointments and established practice for after-hours on-call availability).
2. Implemented several practices to aid in identifying and managing patient populations (e.g., electronically searchable patient data and generation of CMapp generated lists for patient preventive care services).
3. Administration of ASQ-3 developmental screening tool.
4. Facilitation of Asthma Action Plans for patients for whom this is needed.
5. Providing educational resources to patients to assist in self-care management.



The Fantus pediatrics care team takes time to meet, eat and talk about ways to enhance patient care during staff and quality improvement meetings.

Logan Square Community Health Center

HealthTeam Meetings

24 Meetings were held between 3/27/12 and 11/25/14, typically on the 4th Tuesday of each month

Team Members

1. Denise R. Cunill, MD, FAAP (Lead Pediatrician)
2. Myrna Gutierrez (Parent Partner)
3. Rosa Rangel (Parent Partner)
4. Candida Flores-Matheu, RN (Nurse Coordinator)
5. Patricia Salgado, RN (Nurse)
6. Joyce Alvarado, LCSW (Social Worker)
7. Matilde Torres (Social Worker)
8. Deyanira Ruiz (Medical Assistant)
9. Maria Pena (Administrator)
10. Cherie Dalbke, UIC-DSCC Care Coordinator
11. Rita Klemm, MSW (QI Team Facilitator)

Examples of Team Quality Improvement Accomplishments

1. Children and families coming to Logan Square have an assigned primary care provider and scheduled appointments are with that provider. Nurse care management visits have also been established with positive responses.
2. Families are given an informational sheet with regular office hours and after-hours access for care. A Depart Summary is given to patients and families at the end of appointments, and the families have been very responsive to this. Also, a list of community resources to which the practice frequently makes referrals was created for staff use.
3. The practice has implemented a standardized developmental screening process to routinely administer the ASQ-3 to patients seen for well child visits at ages 9 months, 18 months, and 24 or 30 months.
4. The Medical Home Network (MHN) Connect portal is used to manage and coordinate patient care following hospitalization or ED visits.
5. Established a positive working relationship with the local Child and Family Connections / Early Intervention office.
6. An initial referral tracking process was initiated. Outside referrals are tracked with use of the EMR reminder system and with electronic "post-its."

Vista Community Health Center

HealthTeam Meetings

25 Meetings were held between 3/9/12 and 12/12/14, typically on the 2nd Friday of each month

Team Members

1. Swati Bhohe, MD, FAAP (Lead Pediatrician)
2. Megan Kane Towle, PA (Physician's Assistant)
3. Victor Medina, RN (Nurse Coordinator and Clinic Administrator)
4. Edith Castro, RN (Nurse Manager)
5. Katy Velasquez, RN (Nurse)
6. Isabel Reyes (Social Worker)
7. Raquel Perez (Medical Assistant)
8. Desiree Dominguez (Medical Assistant)
9. Maribel Reyes (Clerk)
10. Sandra Guerrero Roche (Parent Partner)
11. Stacie Serratos (Parent Partner)
12. Jon Ashworth, MDiv, MA, LPC (QI Team Facilitator)

Examples of Team Quality Improvement Accomplishments

1. Developed a sustainable outreach approach to HPV vaccination series – developed the plan in the summer of 2012 and they are still successfully implementing this approach.
2. Established a consistent approach to having families complete the ASQ-3 developmental screening tool – families have been very responsive to Vista's approach of emphasizing the importance of the screening.
3. Implemented a customer service practice of asking the patient/family at the close of their visit "Were you satisfied with your visit today?" After implementing this simple practice, the satisfaction rate of Vista patients increased from 15% stating that they are always satisfied to 72% stating that they are always satisfied.



Front Row (Left to Right): Megan Kane, PA-C, Dr. Swati Bhohe, MD, Victor Medina, RN
Back Row (Left to Right): Katy Velasquez, RN, Edith Castro, RN, Maribel Reyes, Clerk, Alejandra Carrera, Clerk, and Desiree Dominguez, CMA.



The Logan Square Community Health Center pediatric QI team gathers for a group photo and to celebrate their many accomplishments in implementing the medical home model in practice.

Clockwise from left: Patricia Salgado, RN, Violeta Navas, Clerk V, Myriam Calvache, RN, Joyce Alvarado, LCSW, Deyanira Ruiz, RMA, Denise R. Cunill, MD, FAAP

Patient satisfaction has become a rewarding piece to our work as we have developed care coordination. Defining the medical home has become a tool for the patient but also a means for us to improve the holistic services available for the families.

Evaluation and Results: Insights Gained from the MHI and MHFI

MEDICAL HOME INDEX

Using the MHI, developed by the Center for Medical Home Improvement, 2001, each of the site leadership teams discussed and rated their clinic's current practices related to the organization and delivery of primary care for children with special health care needs (CSHCN) in spring 2012 and spring 2014. The MHI measures levels of care that are important for all children, but are key for CYSHCN. The instrument examines care as delivered in six key domains:

1. organizational capacity
2. chronic condition management
3. care coordination
4. community outreach
5. data management
6. quality improvement

Teams were encouraged to examine practices candidly, as the use of the MHI was designated as a self-assessment tool to guide quality improvement efforts. In addition, the tool was also used in this project for evaluative purposes. The MHI consists of 25 questions divided among six domains. Some domains have as few as two questions, whereas others have as many as seven. Each question is evaluated on a scale from 1 to 8, with these scores falling into four levels of care delivery: basic, reactive, proactive, and comprehensive care.

MEDICAL HOME FAMILY INDEX

The five participating ACHN sites identified a target sample of 25 pediatric clinic patient families each for a total of 125 patient families to be surveyed; 66 responded to the survey at baseline. At follow up, 49 families completed the same survey 20 to 22 months later.

Cicero

Improved 17%

Greatest strengths include: Organizational Capacity, Chronic Condition Management, Care Coordination.

Advocacy, and Community Outreach. New area of strength (2014): Data Management (including Data retrieval capacity).

Greatest improvement (2012 to 2014): Quality Improvement.

1. Increase in families reporting they have seen changes at the clinic because of their suggestions in the past year (10% to 71%).
2. Increase in families reporting that they always have someone at the clinic help them coordinate care for their child (40% to 71%).
3. Increase in families reporting that the staff or Care Coordinator always help them with follow-up activities (10% to 43%).
4. Increase in families reporting that their doctor or nurse is an advocate for the rights and health care for children with special health care needs and their families (30% to 71%).

Cottage Grove

Improved 60%

Greatest strengths include: Chronic Condition Management and Data Management.

New area of strength (2014): Organizational Capacity (including Cultural Competence).

Greatest Improvement (2012 to 2014): Quality Improvement.

1. At follow-up (2014), 100% of families reported they could always access care at the clinic when they needed it.
2. At follow-up, 100% of families reported that staff at the clinic always respected their needs.
3. Increase in families reporting that the clinic has sponsored activities to help their family—e.g., support groups (33% to 50%).
4. Increase in families reporting that their doctor or nurse is an advocate for the rights and health care for children with special health care needs and their families (22% to 50%).

Fantus

Improved 32%

Greatest strength: Data Management.

New areas of strength (2014): Organizational Capacity, Chronic Condition Management, Care Coordination, and Quality Improvement.

Greatest Improvement (2012 to 2014): Quality Improvement.

1. At follow-up (2014), 100% of families reported that staff at the clinic always respected their needs.
2. At follow-up, 100% of families reported that staff at the clinic always knew their child's overall health needs and knew their concerns for their child's health.
3. Increase in families reporting that doctors or nurses always explained things clearly to them (75% to 89%).
4. Increase in families reporting that someone at the clinic always helps coordinate care (50% to 67%).
5. Increase in the number of families reporting that staff always help the family explain their child's needs at school (4% to 44%).
6. Increase in families reporting that their doctor or nurse is an advocate for the rights and health care for children with special health care needs and their families (42% to 89%).

Logan Square

Improved 38%

Greatest strengths include: Organizational Capacity and Chronic Condition Management.

New area of strength (2014): Data Management (including Data retrieval capacity).

Greatest improvement (2012 to 2014): Data Management.

1. At follow-up (2014), 100% of families reported that staff always knew who they were when they (the family) called.
2. At follow-up, 100% of families reported that doctors or nurses always explained things clearly to them.
3. Increase in the number of families that reported that staff always help the family explain their child's needs at school (11% to 67%).
4. Increase in the number of families that report that the clinic staff or Care Coordinator always helps them with follow-up activities (44% to 67%).
5. At follow-up, 100% of families reported that people at this clinic have told them about other services in their community to help their family.

Vista

Improved 93%

Greatest strength: Organizational Capacity. New areas of strength (2014): Chronic Condition Management and Care Coordination.

Greatest Improvement (2012 to 2014): Quality Improvement.

1. Increase in families that reported they always get the health care they need during office hours (50% to 71%).
2. More families reported that doctors or nurses always listen to their concerns (50% to 80%).
3. Increase in the number of families reporting the doctor or nurse always sets goals with them when planning their child's care (23% to 67%).
4. Increase in families reporting that their doctor or nurse is an advocate for the rights and health care for all children with special health care needs and their families (58% to 81%).

Conclusion

During the two-year span between 2012 and 2014, each of the five participating clinics invested a significant amount of time and effort into growing and improving their practices as a medical home. Based on MHI results, the clinics showed a strong awareness of their own growth as a practice and as a medical home QI team. Within the domains of organizational development, chronic condition management, care coordination, and community outreach, the clinics expressed that they could see moderate to significant growth as a practice and team. According to the MHFI, overall, families across the five ACHN sites expressed increased satisfaction with care received. In addition, the clinics showed more proficiency in medical home.

RECOMMENDATIONS

The potential for sustained impact of these efforts is closely tied to the need for clinics to continue to engage in a thoughtful and strategic use of the PDSA cycle, in building professional collaborations with stakeholders, and in aligning practice with the ACHN mission and standards of high quality, patient, and family centered medical home delivery.

The following are targeted suggestions for ways the CCHHS ACHN can sustain QI progress made:

1. Continue to meet monthly with protected time with ACHN QI teams.
2. Continue to empower the designated pediatric PCMH champion at each site.
3. Expand parent/patient involvement with QI Team work and clinic initiatives.
4. Continue to implement PDSA cycles and measure change.
5. Share clinic transformation stories with ACHN leadership, patients and families (public relations, public education, publish articles, newsletter).
6. Implement ACHN policies consistently.
7. Continue to enhance and support patient education/patient self-management skills.

ACKNOWLEDGEMENTS

ICAAP thanks the ACHN for participating in this QI initiative and acknowledges the following individuals for exemplary dedication and support for implementing the PCMH IMHM™ in practice.

ACHN Pediatric Leads: Denise R. Cunill, MD, FAAP, Associate Medical Director of Ambulatory Pediatrics, Cook County Health and Hospitals System (CCHHS), Medical Director, Logan Square Community Health Center

Judy Neafsey, MD, FAAP, Director of Ambulatory Pediatrics for ACHN and Medical Director, Stroger Specialty Care Center, CCHHS (Retired)

ICAAP Staff: Kathy Sanabria, MBA, PMP, PCMH CCE, Principal Investigator and Grant Director, Associate Executive Director, Dru O'Rourke, Manager

Core QI Facilitators: Jon Ashworth, MDiv, MA, LPC, Rita Klemm, MSW, Dru O'Rourke, Kathy Sanabria, MBA, PMP, PCMH CCE, Donna Scherer, RN, MPH

Independent Evaluator: Denise Roseland, PhD, Change Maker Consulting, LLC

Funder: This project was supported by a grant to the Illinois Chapter of the American Academy of Pediatrics, funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), under grant number D70MC23048. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

5. Improving Health and Access for Transition-Aged Youth: A Quality Improvement Project with Esperanza Health Centers

By Dru O'Rourke, Manager, Medical Home Initiatives

In February of 2013, the Illinois Chapter of the American Academy of Pediatrics was awarded a grant from the Chicago Community Trust to partner with Esperanza Health Centers in Chicago on a project to improve access to health care and transition-related services for youth and young adults. The overall goals of the project were to:

- Improve the ability of primary care providers to provide healthcare transition services
- Increase the number of youth who receive transition services
- Transition age patients benefit from a coordinated transfer of care to an adult provider

The *Improving Health and Access for Transition-Aged Youth* project improved health care transition and access to care by providing training, resources, and technical assistance to pediatric and adult-oriented providers using a quality improvement approach to transition care within Esperanza Health Centers' California Avenue and Little Village sites. The Centers serve the predominantly Latino neighborhoods of South Lawndale, Lower Westside, Brighton Park, Archer Heights, Gage Park, and Cicero, where 70% of patients prefer to speak Spanish with their providers. The project provided two web-based training curricula and many public education resource materials in English and Spanish for patients and families. Incentives for providers to participate at the Esperanza clinics included CME-approved training modules, ability to earn Maintenance of Certification (MOC) Part 4 Practice credit sponsored by ICAAP and approved by the primary care medical boards, experienced QI facilitators to work with the sites, and ability to work on transition care as a preventive services measure.

ICAAP staff and Esperanza project leaders began meeting in February 2013 to assess Esperanza’s patient population and providers’ training needs around the area of transitioning youth to adult health care and improved access to care for young adult patients. Project leaders from both sites met regularly throughout the first year of the project to develop a system-wide transition plan for youth and young adults in their practices.

All four of the pediatricians and all four of the family physicians within the two Esperanza Health Centers participated in taking the CME-approved training modules for a total of 100% provider participation.

After completing the education track, providers were asked to select three Key Clinical Activities (KCAs) to implement in practice. The pediatricians selected provide/explain written transition policy; assess health care skills; and discuss need for insurance, benefits, and services information. The family physicians chose maintain a registry for transition care; assess health care skills; and discuss benefits, services, or guardianship. Over the next six months, participating physicians implemented the KCAs in practice and entered data into ICAAP’s Learning Management System every eight weeks to track progress. All physicians improved significantly from baseline to final data cycle. See the tables below:

Pediatric Providers

Provide/Explain Written Transition Policy				
Provider	Baseline	Cycle 1	Cycle 2	Cycle 3
1	0%	30%	100%	100%
2	0%	30%	70%	80%
3	0%	100%	100%	100%
4	0%	20%	100%	100%

Assess Health Care Skills				
Provider	Baseline	Cycle 1	Cycle 2	Cycle 3
1	0%	30%	100%	100%
2	n/a	n/a	n/a	n/a
3	0%	100%	100%	100%
4	0%	20%	100%	100%

Discuss Need for Insurance, Benefits and Services				
Provider	Baseline	Cycle 1	Cycle 2	Cycle 3
1	0%	0%	20%	60%
2	0%	30%	70%	80%
3	0%	100%	100%	100%
4	0%	20%	100%	100%

Family Physicians

Assess Health Care Skills				
Provider	Baseline	Cycle 1	Cycle 2	Cycle 3
1	0%	70%	10%	90%
2	0%	80%	90%	100%
3	0%	70%	80%	90%
4	0%	0%	100%	100%

Maintain a Registry for Transition Care				
Provider	Baseline	Cycle 1	Cycle 2	Cycle 3
1	0%	100%	90%	90%
2	0%	90%	100%	100%
3	0%	100%	100%	100%
4	0%	90%	100%	100%

Discuss Benefits, Services, and Guardianship				
Provider	Baseline	Cycle 1	Cycle 2	Cycle 3
1	0%	70%	10%	90%
2	0%	80%	90%	100%
3	0%	70%	20%	70%
4	0%	0%	0%	40%



This project significantly improved the transition care provided by physicians at Esperanza Health Centers. The center now has its own transition policy that is shared with all transition-age patients and patients are able to transition from a pediatric provider to an adult provider within the Esperanza system or beyond. ICAAP is very grateful to Esperanza project leaders who worked with ICAAP practice facilitators to implement the project, including Alejandro Clavier, MD, MPH; Carmen Vergara, RN, MPH; and David Moreno, MPH.

6. National Committee for Quality Assurance Patient Centered Medical Home 2011 Standards Survey with 23 Illinois CHIPRA Project Practices

By Denise Roseland, PhD, ChangeMaker Consulting, LLC
Kathy Sanabria, MBA

Overview

The National Committee for Quality Assurance's (NCQA) Patient Centered Medical Home (PCMH) model offers a tool for assessing current practice so that plans and actions can be developed for improving primary care. In a set of standards that describe clear and specific criteria, the PCMH gives practices information about organizing care around patients, working in teams, and coordinating and tracking care over time. As part of the Illinois Children's Health Insurance Program Reauthorization Act (CHIPRA) demonstration grant to improve child health, 51 Illinois practices were asked to assess their practices' level of medical "homeness" (in the spring of 2012 and again in the winter of 2014-15) using the NCQA's PCMH 2011 Standards self-assessment tool in order to determine a baseline and post-program measure. The instrument asks a practice to assess its model of care related to patient-centered medical home on six standards:

- access and continuity
- identifying and managing patient populations
- planning and managing care
- providing self-care support and community resources
- tracking and coordinating care
- measuring and improving performance

An analysis of results for twenty-three (23) practices that completed both baseline and post-program follow up was conducted and provided to ICAAP. The practices received varying levels of support and technical assistance from the IL CHIPRA demonstration project. In addition, some of the practices also received assistance from their own health systems and other organizations during the program period.

Overall, participating practices showed considerable growth on the NCQA PCMH self-assessment: at baseline the practices' mean score was 35 and was 78 post-program (of 100 points total).

When looking at the performance by standard, we see that the practices scored the highest on the same three standards at baseline and post-program. For Standard 1 (access and continuity), practices had a mean percent score of 40% at baseline and 83% post-program. Practices also scored well on Standard 2 (identify and manage patient population) with a 50% mean score for baseline and an 88% mean score post-program. On Standard 5 (track and coordinate care), practices had mean scores of 39% at baseline and 88% post-program.

The practices, as a whole, made the greatest increase from baseline to post-program in Standard 3 (plan and manage care) with a 250% increase in mean percent score (from 20% to 71%). This was a targeted area for more intense support via the Illinois CHIPRA project.

Results

As part of the Illinois Children's Health Insurance Program Reauthorization Act (CHIPRA) demonstration grant to improve child health, 51 practices assessed their practices' level of medical "homeness" (in the spring of 2012 and again in the winter of 2014-15) using the Patient Centered Medical Home (PCMH) self-assessment tool in order to determine a baseline and post-program measure. Baseline and post-program results were analyzed using a de-identified data set of the Illinois CHIPRA practices that completed the self-assessment at both time frames. Twenty-three sites (n=23) completed the NCQA PCMH self-assessment at baseline and post-program and provided basic demographic information about the practices through another survey administered by ICAAP.

Participating practices are concentrated to a greater degree in urban inner city and suburban locations. Table 1 shows a summary of practice location and type. Since most sites identified themselves as a pediatric or family practice, those are the only practice types used to examine differences in the self-assessment results.

Table 1

Summary of Practice Location and Type					
Practice Location	Pre	Post	Practice Type (select all that apply)	Pre	Post
Rural	8	5	Pediatric Practice	29	8
Suburban	22	6	Family Practice	20	16
Urban, inner city	13	4	Academic Practice	6	2
Urban, not inner city	8	8	Rural Health Clinic	5	4
Total	51	23		71	23

Practices were asked to indicate whether the practice utilized electronic medical records (EMR). Baseline responses showed that 37 indicated that EMR were used, 13 indicated EMR were not used, and 1 practice did not respond to this question. At follow-up, 20 practices reported the use of EMR (5 of which previously reported not using EMR) and 3 did not provide a response to the question.

Practices were asked to estimate the number of patients with the following types of insurance: ONLY public insurance, public AND private insurance, ONLY private insurance, NO insurance, or other. At the time follow-up

information was collected, there are notable shifts observed in the types of insurance used by patients at the practices as noted in Table 2. In the practices that responded to the follow-up survey, more reported that patients relied on ONLY public insurance than at baseline and that fewer relied on ONLY private or a combination of public and private insurance. These differences are likely attributed to implementation of the Affordable Care Act.

Table 2

Estimated Percentage of Patients Using these Types of Insurance						
Type of Insurance	Baseline Number of Sites Reporting	Baseline Mean	Baseline Median	Follow-up Number of Sites Reporting	Follow-up Mean	Follow-up Median
ONLY Public Insurance	(n=46)	44	41	(n=10)	51	46
Public AND Private Insurance	(n=20)	21	8	(n=4)	12	0
ONLY Private Insurance	(n=42)	37	21	(n=10)	28	30
Uninsured	(n=42)	13	6	(n=10)	16	16
Other	(n=19)	16	5	(n=7)	4	1
No Response	(n=5)			(n=13)		

Practices were asked to report whether they had an internal advocate for quality improvement. At follow-up, 39% reported they sustained an internal advocate throughout the lifetime of the project, 43% reported that they developed an internal advocate during the project, and 21% provided no response at baseline or follow-up. In narrative responses, many practices described one or more quality initiatives that were in operation at the time of the survey. Upon conducting thematic analysis of those responses, several themes emerged related to the kinds of quality initiatives the practices were engaged in:

- Childhood immunization
- Diabetes
- Asthma
- Childhood Obesity
- Bright Futures

The individual who completed the self-assessment on behalf of the practice at each of the sites was asked to rate their own familiarity with medical home. Considerable gains in familiarity with medical home occurred

during the project among the individuals who completed the surveys. At baseline, nearly 70% of these respondents indicated they were somewhat or very familiar with medical home and at follow-up, 100% indicated they were somewhat or very familiar with medical home. The following table highlights the results and shows differences based on location of practices in more detail.

A total of 100 points are possible on the NCQA PCMH self-assessment. Scoring of the PCMH requires that practices must achieve 50% or more of the points associated with ALL 6 Must-Pass Elements AND at least 35 points of 100 to achieve PCMH Recognition at any level. Three levels of Recognition are possible and are shown in Table 3. More details about the Recognition of participating practices will be discussed later in this report.

Table 3

Levels of Recognition		
	Total Points Earned	Must-Pass Elements at 50% Performance Level or Greater
Not Recognized	0-34	Less than 6
Level One	35-59	6 of 6
Level Two	60-84	6 of 6
Level Three	85-100	6 of 6

Table 4 shows the aggregate mean score for the PCMH survey by standard. Overall, the mean score earned by the 23 sites was 35.09 at baseline and 78.78 post-program (100 points total) and scores ranged from 4.50 – 76.50 points for baseline and 39.00 – 98.25 post-program. When we look at the performance by standard, we see that the group of practices scored the highest on the same three standards at baseline and post-program. For Standard 1 (access and continuity), practices had a mean percent score of 40% at baseline and 83% post-program. Practices also scored well on Standard 2 (identify and manage patient population) with a 50% mean score for baseline and an 88% mean score post-program. On Standard 5 (track and coordinate care), practices had mean scores of 39% at baseline and 88% post-program.

The practices, as a whole, made the greatest increase from baseline to post-program in Standard 3 (planned and managed care) with a 250% increase in mean percent score (from 20% to 71%). It is important to note that the median scores overall and for each standard were similar to the means, which tells us that the mean is a reliable indicator of central tendency. For each standard, the scores earned by the practices were evenly distributed across the full range of points possible with some scoring no points on a standard and some scoring all or nearly all points on a standard.

Table 4

By 2011 Standard	Baseline Mean Score Earned	Follow-up Mean Score Earned	Points Possible	Score Range	Baseline Percent Score	Follow-up Percent Score
Standard 1: The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.	8	17	20	0–20	40%	83%
Standard 2: The practice systematically records patient information and uses it for population management to support patient care.	8	14	16	0–16	50%	88%
Standard 3: The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.	3	12	17	0–17	20%	71%
Standard 4: The practice acts to improve patients' ability to manage their health by providing a self-care plan, tools, educational resources and ongoing support.	3	6	9	0–9	29%	71%
Standard 5: The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.	7	16	18	0–18	39%	88%
Standard 6: The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	6	13	20	0–20	32%	67%

A number of sites had substantial knowledge and practice to develop in order to be eligible for Recognition while a number of sites needed to learn and engage in only limited effort to be eligible for Recognition. Standards where the gap between actual scores and scores that qualify a practice for Recognition were the greatest related to planning and managing care (Standard 3) along with measuring and improving performance (Standard 6). By follow-up, scores increased across all standards and a number of practices qualified for NCQA PCMH Recognition.

Must-Pass Elements and Qualifying for PCMH Recognition

Eight of the practices passed all of the must-pass elements associated with the six standards. Of the sites that passed all six (6) must-pass elements, seven qualified for Recognition at level three and one qualified for Recognition at level two. Through other data available, four practices that initially completed the baseline survey but did not respond to the follow-up survey shows that four additional sites passed all six must-pass elements (two at level three, one at level two, and one at level one). At the time the baseline survey results were analyzed, all of the sites that passed the six must-pass elements were suburban and reported very low percentages of public insurance or uninsured patients. At follow-up, there were four urban-inner city practices, two suburban, one urban-not inner city, and one rural practice that qualified for Recognition.

Relying on overall mean scores does not do enough to describe the nature of scores for all practices, however. Table 5 demonstrates that mean scores varied considerably based on the practice location. Suburban practices scored considerably higher than other location type practices at baseline¹ and while rural, urban-inner city and urban-not inner city, made considerable improvements in their overall mean score during the project, their mean scores remained lower than suburban locations.

1 An analysis of variance showed that the effect of location was significant, $F(3, 48)=3.31$, $p = .02$.

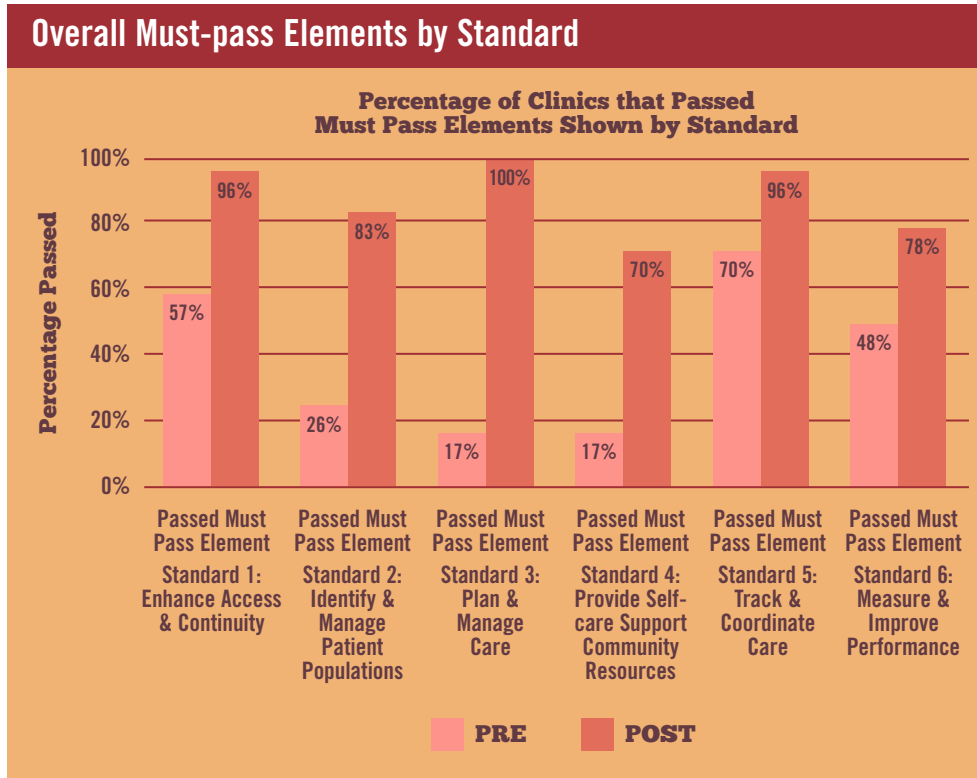
Table 5

	Baseline Mean	Follow-up Mean
Rural	34	73
Suburban	57	89
Urban, inner city	39	74
Urban, not inner city	33	78
Overall mean	45	79

Figure 1 shows the percentage of practices that passed the must-pass elements of the six different standards pre and post-program. This chart shows what gains were made by practices in passing must pass elements. Practices experienced the greatest gains in Standards 2, 3, and 4.

There is little difference in Must-Pass Element results based on practice type. Initially, success on must-pass elements varied considerably based on practice location. Suburban locations were likely to pass 50-100% more must-pass elements than practices in the other three locations. Based on the results at follow-up, results across location type were more consistent among urban-inner city, urban-not inner city, suburban, and rural practices.²

Figure 1



across all sites that participated in the Illinois CHIPRA demonstration project.

When looking at the performance by standard, we see that the practices scored the highest on the same three standards at baseline and post-program. For Standard 1 (access and continuity), practices had a mean percent score of 40% at baseline and 83% post-program. Practices also scored well on Standard 2 (identify and manage patient population) with a 50% mean score for baseline and an 88% mean score post-program. On Standard 5 (track and coordinate care), practices had mean scores of 39% at baseline and 88% post-program.

Using the baseline results reported here, we know that, overall, practices scored the lowest on standard three (planning and managing care) and standard six (measuring and improving performance). Those standards remained the lowest scoring standards at the time of follow-up but aggregate mean scores increased by nearly 40% in both standards. The practices, as a whole, made the greatest increase from baseline to post-program in Standard 3 (plan and manage care) with a 250% increase in mean percent score (from 20% to 71%). This was a targeted area for more intense support via the Illinois CHIPRA project.

Discussion

The initial wide range of scores reported by practices was evidence that basic knowledge and skills related to the implementation of medical home varied considerably across the sites. These practices were exposed to a variety of medical home activities as a way of building foundational skills among the practice leadership and staff during the demonstration period. Learning opportunities focused on providing important skills like working as a team, effective communication skills with patients, enhancing access, managing populations, coordinating care and transitions, use of technology, and engaging patients, staff and other stakeholders more broadly in quality improvement efforts. While not every practice participated in or benefited from the Illinois CHIPRA project's trainings, resources, and support, by the end of the demonstration project, all 23 practices that completed the follow up NCQA PCMH survey reported being somewhat or very familiar with medical home, and scores on all elements of the six standards increased considerably. Some of the enrolled CHIPRA practices were also exposed to supplemental resources provided by other organizations or even their own health systems, which likely assisted them in improving quality of care in these areas.

While practice location and system affiliation had a statistically significant impact on these self-assessment scores at baseline, at follow up that difference was no longer detectable. The reduced response rate made it less likely that statistical significance would be detected but examining scores also highlights broad improvements



² An analysis of variance showed that the effect of location was significant with regards to the number of must-pass elements, $F(3, 47) = 4.14, p = .01$.

Medical Home benefits my work by helping patients and parents feel comfortable around our care team, and feeling like there's somebody at the clinic who they can trust and can always be there for them when needed.

—Alejandra Carrera, Clerk

7. Illinois CHIPRA Project Practices in Study on Nonurgent ED Use



Improving Child Health and Medical Homes for Illinois AllKids

In February 2010, the Centers for Medicare and Medicaid Services (CMS) awarded 10 grants, providing funding to 18 states, to improve health care quality and delivery systems for children enrolled in Medicaid. These Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant programs aim to identify effective, replicable strategies for enhancing the quality of care for children.

In a May-June 2015 *Academic Pediatrics* article¹ national researchers engaged by CMS used practice-reported Patient Centered Medical Home (PCMH) assessments and Medicaid claims from child-serving practices in Illinois, North Carolina, and South Carolina to estimate the linkage between medical homeness and well-child care and nonurgent, preventable, or avoidable emergency department (ED) use.

Medical homeness was not associated with receiving age-appropriate well-child visits in either sample. However, the association between nonurgent, preventable, or avoidable ED visits and medical homeness varied. No association was seen among practices in North or South Carolina that completed their self-assessments. (The Medical Home Index, or MHI, or its Revised Short Form tool were used in those states). However, children served by practices in Illinois with the highest tertile National Committee for Quality Assurance (NCQA) self-assessment scores were less likely to have a nonurgent, preventable, or avoidable ED visit than children served by practices with low scores, and marginally less likely to have such a visit compared with children in practices with medium tertile scores.

While the study was based on self-assessments among a limited number of practices, this suggests that higher levels of medical homeness may be associated with lower nonurgent, preventable, or avoidable ED use by publicly insured children. ICAAP was responsible in the early years of the Illinois CHIPRA project for recruiting the Illinois practices in the sample and for assisting them in conducting their self-assessments.

1 Christensen AL, Zickafoose JS, Natzke B, McMorrow S, Ireys HT. Associations between practice-reported medical homeness and health care utilization among publicly insured children. *Academic Pediatrics* (2015): Vol 15, Issue 3, 267–274.

8. Family Medicine's Health is Primary Campaign

By Ginnie Flynn, Illinois Academy of Family Physicians

Launched at the 2014 American Academy of Family Physicians (AAFP) Annual Scientific Assembly, the *Health Is Primary* campaign is family medicine's message to America – primary care, family medicine and better health. The family of family medicine organizations united under the common collaborative organization Family Medicine for America's Health. You can learn more about them and the member organization at www.fmahealth.org.

The *Health is Primary* campaign is working to increase the collaboration between physicians, systems and patients and to communicate about important health issues. The goal is to transform the family medicine specialty to ensure it can meet the nation's health care needs and, ultimately, improve the health of every American. This means:

- Furthering the evolution of the patient-centered medical home
- Advancing the use of technology in a manner that is helpful to the provider and the patient
- Ensuring a strong primary care workforce
- Shifting the payment system to improve the quality of care and the health of patients
- Improving primary care physician satisfaction

For more information about the campaign, contact Ginnie Flynn at gflynn@iafp.com.

Through medical home I am able to take a teamwork approach to patient care. This enables patients to become an active member of their healthcare, and it allows me to recognize the patients' strengths and areas of need. Most importantly I can provide continuity of care through a holistic approach.

–Katy Velasquez, RN

9. A Coordinated Effort to Positively Impact the Health of Overweight/Obese Pediatric Patients

By Sarah Nau, MSW, Obesity Prevention Initiatives Manager

ICAAP's Obesity Prevention Initiatives is launching a coordinated care pilot project around pediatric overweight/obesity in the fall of 2015. Promoting Health: Improving Patient Outcomes for Childhood Obesity through a Coordinated System of Care ("Promoting Health") is a unique clinical/community integration project designed to increase access to comprehensive care within the medical home, including linkages to community resources for pediatric patients and their families. Promoting Health aims to establish a model for a coordinated system of care for pediatric obesity in a medical home that can be replicated in other communities throughout Illinois. The project will be implemented in two-to-four health centers located in underserved communities in Chicago.

To enhance health care delivery, Promoting Health is facilitating cross-system collaboration and electronic connectivity among community health clinics, specialized care coordination services, and a community partner network through a single point of contact. The Alliance of Chicago, a network of community health centers dedicated to sharing resources and integrating services in order to more efficiently and effectively deliver accessible quality health care, is developing the technological interfaces between the electronic health record (EHR) and care coordination database. This pilot technology will enable real-time data sharing and a feedback loop to the clinic provider about the status of referrals and community program enrollment, completion, and/or disconnection, thereby improving the quality of care for pediatric patients with overweight/obesity and their families.

For the project, ICAAP has also built a community partner network whose members are collaborating for the first time to offer an array of weight management, physical activity, and nutrition programs and resources. The Promoting Health community partner network is



currently comprised of MEND, ProActive Kids, Cooking Matters, ChildServ's Healthy Fit Program, SNAP Education Programs, Women, Infants, and Children (WIC), Greater Chicago Food Depository, and the Chicago Partnership for Health Promotion.

For more information about the Promoting Health project, please contact Mary Elsner, ICAAP Director of Obesity Prevention Initiatives, at 312/733-1026, ext. 220 or melsner@illinoisap.com.

This project is funded by a grant from the Otho S.A. Sprague Memorial Institute.

10. ICAAP Reopens Training on Transitioning Youth to Adult Health Care

By Dru O'Rourke, Manager, Medical Home Initiatives, ICAAP
Kathy Sanabria, MBA, PMP, Course Director

The Transitioning Youth to Adult Health Care for Pediatric Providers course and quality improvement (QI) activity is open again! The course includes a wealth of resources that can be used to improve the care of transitioning patients – including national clinical guidelines, videos, skills building tools for youth, and quality improvement tools.

Visit the ICAAP e-Learning System at <http://illinoisap.org/e-learning/> or contact ICAAP at 312/733-1026 for more information on the course and on other courses on oral health, tobacco prevention and cessation, teen driving safety, obesity management, healthy lifestyles, and more.

The course teaches learners how to use medical home strategies to improve care of transitioning youth, especially those with special health

care needs. The first phase of the curriculum includes 11 educational modules; topics include discussing benefits and services with patients, developing a written transition policy, identifying adult primary care providers, and more. The second phase of the course is the data collection phase for pediatricians who wish to pursue Maintenance of Certification (MOC) Part 4 credit for pediatricians, approved by the American Board of Pediatrics for 20 points. The initiative is administered by ICAAP and is open to primary care and specialty care pediatricians across the country.

From 2012-2014, 35 pediatricians completed the educational course and data collection track. The participants saw significant improvements in their transition care. Based on user feedback, the data collection requirements and timeline were shortened to make the course more feasible for physicians. Participants are now only required to implement and report on three Key Clinical Activities (KCAs) for 10 patients \geq 14 years of age. These include: Provide/Explain Transition Policy, Assess Health Care

Skills, Develop or Review Transition Goals. The data collection cycles were also shortened from eight weeks to six weeks so the MOC track can now be completed in 18 weeks instead of 24 weeks. This phase includes reporting patient record information at baseline and three cycles every six weeks.

ICAAP thanks the US Maternal and Child Health Bureau (MCHB) for support of its medical home projects, which helped lead to development of these modules. For more information about the course, please contact Dru O'Rourke at dorourke@illinoisaaap.com. Visit <http://illinoisaaap.org/e-learning/> to register.

Transitioning Youth to Adult Health Care Course Features

- 11 educational modules
- 20 ABP Part 4 MOC points
- 15 Part I CME Credits
- Reduced timeline and data collection requirements
- Practice tools and resources

CONTINUING MEDICAL EDUCATION CREDIT

- This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint provider-ship of the American Academy of Pediatrics (AAP) and the Illinois Chapter (ICAAP). The American Academy of Pediatrics is accredited by the ACCME to provide continuing medical education for physicians.
- The AAP designates this enduring material for a maximum of 15.00 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- This activity is acceptable for a maximum of 15.0 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.
- The American Academy of Physician Assistants (AAPA) accepts certificates of participation for educational activities certified for AMA PRA Category 1 Credit[™] from organizations accredited by ACCME. Physician assistants may receive a maximum of 15.0 hours of Category 1 credit for completing this program.
- This program is accredited for 15.0 NAPNAP CE contact hours of which 0 contain pharmacology (Rx), (0 related to psychopharmacology) (0 related to controlled substances), content per the National Association of Pediatric Nurse Practitioners (NAPNAP) Continuing Education Guidelines.

11. The Latest News and Updates on I-CARE

By Sandra Han, MA, Director, ICAAP
Matthew Swenny, BS, MA, IDPH
John Welliver, BA, Manager, ICAAP
Anne Wong, BA, Project Coordinator, ICAAP

I-CARE Overview

The Illinois Comprehensive Automated Registry Exchange (I-CARE) system was developed by the Illinois Department of Public Health (IDPH) in 2007; I-CARE is a confidential, computerized information system designed to collect and share immunization records with other authorized I-CARE users throughout the state. Authorized users include hospitals, federally qualified health centers, public health departments, and private providers. The Immunization Information System (IIS) was designed to assess immunization coverage levels for people of all ages in Illinois. There are approximately 9.5 million patients in I-CARE; for nearly eight years, over 1,300+ Illinois and 600+ Chicago Vaccines For Children (VFC) public health providers actively utilize the I-CARE registry. Illinois VFC providers are required to data enter VFC shots administered to children uninsured, underinsured, not insured or insured by Medicaid. The I-CARE registry continues to act as a statewide data collection repository. Over the past few years, IDPH has enhanced reporting features to improve the benefits of the registry and to continue to promote its use. This article provides an overview on useful I-CARE functions, an update on the Chicago Department of Public Health's (CDPH) I-CARE software upgrades, and other helpful tips on how to improve and maintain the quality of patient and inventory vaccine data.

REMINDER FUNCTION AND ITS BENEFITS

Providers are encouraged to maximize the reminder function in I-CARE. The IIS was designed to generate a list of active patients, the last shot they received, and a summary of their immunization records. Providers are encouraged to use the reminder function to pro-actively remind their patients on any upcoming scheduled vaccines, recommended vaccines, or overdue vaccines. It is a best practice prior to mailing reminder letters or postcards to review the accuracy of the patient level data displayed in the reminder report. If you haven't already considered generating reminder letters to patients whose shots are overdue, or soon will be due, your practice may want to consider actively reminding and recruiting patients to return to your office to receive their scheduled vaccines on-time. National medical associations across the country encourage and recommend practices to assess their immunization rates to educate themselves, and to identify where and how improvements can be made. Often, providers are not aware their vaccination rates are low, and assessing vaccination rates at your clinic is starting the vaccination coverage level improve-

ment plan. Reminding school-aged children, adolescents, and their families to minimize missed opportunities to vaccinate is contributing a positive influence on families; they are receiving support from their primary medical provider to stay protected against vaccine-preventable diseases.



CDPH Begins I-CARE Rollout for VFC Providers

This year, the Chicago Department of Public Health (CDPH) plans to offer new I-CARE features to Chicago VFC providers. The new features include online temperature monitoring, reconciling your most recent VFC vaccine inventory and submitting your VFC orders online. CDPH in collaboration with IDPH and ICAAP are working to test the new inventory features in I-CARE with a pilot group of providers. Next year, all providers will be held accountable for properly storing and handling vaccines, reconciling their vaccine inventory, documenting wasted and expired vaccines, and submitting vaccine orders online.

I-CARE Stats:

- **9,493,896** patients have information included within I-CARE
- **4,873 active HL7 providers** with 1600 sending data directly to I-CARE
- **659 Chicago VFC Providers** enrolled in I-CARE

Providers participating in the pilot are held accountable for their VFC vaccine inventory, and are submitting their VFC orders online via I-CARE. The City of Chicago is piloting a plan to test and prepare for an implementation plan for 600+ Chicago VFC providers. On Wednesday, May 6, 2015, CDPH began their pilot with 60 selected and self-selected VFC providers. The pilot group includes small to medium, medium to large providers; the variety of feedback will support CDPH and ICAAP to strengthen their provider education plans for the future go-live groups.

TRAINING VIDEOS AND THE ACTIVATION CHECKLIST

I-CARE has many training documents and videos on its site to educate and guide users on the different features and functions of I-CARE. For providers who are eager to prepare now and learn how to order, they may watch a module titled “VFC Vaccination Checklist” to learn more about this transition.

ACCURATE VACCINE RECONCILIATION FOR HEALTH LEVEL 7 (HL7)

There are five components in I-CARE that require an exact match to achieve accurate vaccine deduction from your vaccine inventory (auto-reconciliation). If these components do not match **perfectly**, then you will have errors in your vaccine inventory, and your electronic communication with I-CARE will leave your practice with hundreds of errors; don't panic, there's a *VFC Inventory Analysis Helper* report to support your practice to clean your bad data, but keep in mind it should be acknowledged to attend to the root cause of your inaccurate data transfers to prevent future duplicative errors. It is strongly recommended that these five components are reviewed with your EHR administrator:

1. Brand names: I-CARE does not recognize generic names, only brand names for vaccines
2. CVX codes: numeric string that identifies the type of vaccine product used
3. MVX codes: alphabetic string that identifies the manufacturer of that vaccine
4. VFC Status of the patient (V02–V07 are the eligible codes)
5. Lot numbers: must be the number either on the packing list or the outside of the box. **DO NOT** use the lot number that is on the vial because it will not deduct from your inventory—the number on the vaccine is different from lot number on your packing list, on the outside of the vaccine box.

Benefits of Utilizing I-CARE

The I-CARE registry is an incredible system for both private and public sectors of the healthcare industry. It compiles vaccination information for the whole state and tracks the health of our children as they grow into healthy adults. I-CARE allows providers to be informed on new protocols, have quick access to immunization records, improves immunization rates through reminders, and reduces paperwork. Today's information is highly mobile, just like most people; with systems like I-CARE we can exchange important, confidential health information quickly, to provide the best care possible.

Thank you to the practices that participated in the Illinois Children's Health Insurance Program Reauthorization Act (CHIPRA) Demonstration Grant Project 2011-2015

ACCESS at Anixter Center—*Chicago*

ACCESS Blue Island Family Health Center—*Blue Island*

ACCESS Grand Boulevard Health and Specialty Center—*Chicago*

ACCESS Madison Family Health Center—*Chicago*

ACCESS Martin T. Russo Family Health Center—*Bloomington*

Adil Pediatrics—*Crest Hill*

Advocate Hope Children's Hospital Outpatient Clinic—*Oak Lawn*

Advocate Medical Group, Yacktman Pediatrics—*Park Ridge*

Austin Health Center of Cook County—*Chicago*

Blessing Physician Services—*Quincy*

Cicero Health Center of Cook County—*Cicero*

Community Nurse Health Association—*La Grange*

Cottage Grove Health Center of Cook County—*Ford Heights*

Crusader Central Clinic Association—*Rockford*

DuPage Medical Group, Elmhurst Pediatrics—*Elmhurst*

DuPage Medical Group, General Pediatrics, Downers Grove—*Downers Grove*

DuPage Medical Group, St. Charles Pediatrics—*St. Charles*

DuPage Medical Group, Lombard Pediatrics—*Lombard*

DuPage Medical Group, Rolling Ridge Pediatrics—*Naperville*

DuPage Medical Group, West Suburban Pediatrics—*Lombard*

DuPage Medical Group, Glen Ellyn Pediatrics—*Glen Ellyn*

DuPage Medical Group, Plainfield Pediatrics—*Plainfield*

East Adams County Rural Health Clinic—*Golden*

Englewood Health Center of Cook County—*Chicago*

Esperanza Health Centers—*Chicago*

Fantus Health Center of Cook County—*Chicago*

Friend Family Health Center—*Chicago*

Hamilton Warsaw Clinic—*Warsaw*

Illini Community Hospital Rural Health Clinic—*Pittsfield*

Logan Square Health Center of Cook County—*Chicago*

Mirshed Medical Center—*Chicago*

Morton East Health Center of Cook County—*Cicero*

North Arlington Pediatrics—*Arlington Heights*

School Health LINK Inc, Rock Island—*Rock Island*

School Health LINK Inc, Silvis—*Silvis*

SIU Pediatrics—*Springfield*

Springfield Clinic—*Springfield*

The Children's Health Center—*Gurnee*

TLC Pediatrics—*Belleville*

Tots 'n Teens Health Associates—*Hoffman Estates*

University of Illinois College of Medicine at Rockford, F.W. Shappert University Primary Care Clinic—*Belvidere*

University of Illinois College of Medicine at Rockford, L.P. Johnson Family Health Center—*Rockford*

University of Illinois College of Medicine at Rockford, Primary Care Clinic at Rockton—*Rockton*

University of Illinois College of Medicine at Rockford, Women's and Children's Health Center—*Rockford*

University Pediatrics—*Peoria*

Vista Health Center of Cook County—*Palatine*

Whiteside County Community Health Clinic—*Rock Falls*

SAVE THE DATE

The 2016 ICAAP Annual Educational Conference will be held on Friday, March 18, 2016 in Lisle, IL.

Join over 150 pediatric providers from across the state for a day of education and networking. For more information, please visit the <http://illinoisaaap.org/annual-conference/>.

Funder Acknowledgments

These medical home programs would not be possible without the support of the following groups:

Chicago Community Trust

Division of Specialized Care for Children

Illinois Department of Healthcare and Family Services

Otho S.A. Sprague Memorial Institute

Prince Charitable Trusts

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau

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Join ICAAP members and partners for the **6th Annual ABC (Autism, Behavior, Complex Medical Needs) Conference:**

A Trauma Informed, Interprofessional Approach to Caring for Children with Special Needs

Friday, November 20, 2015
at Moraine Business and Conference Center (Building M) 9000 W College Pkwy
Palos Hills, IL 60465

REGISTER TODAY:
<http://illinoisaaap.org/projects/abc/>

ICAAP Educational Opportunities

ICAAP offers several web-based educational programs focused on universal and emerging issues in pediatrics. The majority of these programs provide educational credit to participating physicians and allied health professionals and some also qualify for Part 4 Maintenance of Certification points approved by the American Board of Pediatrics and American Board of Family Medicine. The programs are available to your practice staff and focus on quality improvement, systems change, staff roles, how to identify local resources, and other practical issues. Programs are presented by trained faculty using adult-learning educational models.

CURRENT EDUCATIONAL ACTIVITIES

Bright Smiles from Birth: An Oral Health Education and Technical Assistance Program

Childhood Development Initiatives

- Coordinating Care between Early Intervention and the Primary Care Medical Home
- Developmental Screening and Referral
- Domestic Violence Effects on Children
- Identifying Perinatal Maternal Depression during the Well-Child Visit
- Intimate Partner Violence (IPV) and Its Effects on Children
- Social, Emotional, and Autism Concerns
- Trauma-Informed Medical Home: Fostering Strengths & Resilience

Illinois Physicians Advocating for Awareness of Driving Safety

Immunizations

- Talking with Parents about the HPV Vaccine: Understanding and Addressing Parent Concerns
- Immunizations, Power to Protect
- Human Papillomavirus (HPV) Disease and Vaccine
- Business Side of Vaccines: Immunizations Billing and Coding Best Practices
- Meningococcal Vaccination
- What's New with the Flu
- National Influenza Week

Nutrition for Obesity Prevention and Treatment

- Fruits & Vegetables
- Fiber & Fats
- Beverages
- Early Feeding Practices
- What Parents Want to Know
- Addressing Barriers to Change
- Nutrition Resources

Tobacco Cessation for the Primary Care Provider: A Quality Improvement Initiative

Transitioning Youth to Adult Health Care for Pediatric Providers

- Develop and Maintain a Registry for Transition Care
- Develop a Written Transition Policy
- Assess Health Care Skills
- Review Transition Goals
- Discuss Need for Insurance, Benefits, and Services
- Discuss Guardianship and Alternatives
- Develop a Portable Medical Summary
- Identify Adult-Oriented Primary Care Providers
- Review Coding and Reimbursement for Transition Care

For more information about any of these opportunities, please contact info@illinoisAAP.com.

To register for an online course, please visit icaap.knowledgedirectweb.com and create an account. For more information, please contact lms@illinoisAAP.com or appropriate staff. See directory on page 23.

Thank you to the practices that have worked with ICAAP to implement various aspects of the Illinois Medical Home Model™ 2004-2015

Austin Health Center of Cook County–*Chicago*

Chicago Family Health Center–*Chicago*

Children’s Health Center–*Gurnee*

Children’s Healthcare Associates–*Chicago*

Cicero Health Center of Cook County–*Chicago*

Cottage Grove Health Center of Cook County
–*Chicago*

Crusader Clinic–*Rockford*

DuPage Pediatrics–*Darien*

Elmhurst Pediatric Association–*Elmhurst*

Englewood Health Center of Cook County
–*Chicago*

Esperanza Health Centers–*Chicago*

Family and Community Medicine,
Carbondale Clinic–*Carbondale*

Family and Community Medicine,
West Frankfort Community Health Center
–*West Frankfort*

Fantus Health Center of Cook County–*Chicago*

Fantus Pediatric Ambulatory Care Clinic–*Chicago*

Fox Valley Women and Children’s Health
Partners–*Elburn*

Friend Family Health Center–*Chicago*

John H. Sengstacke Health Center of
Cook County–*Chicago*

Jorge Prieto Health Center of Cook County
–*Chicago*

KidzHealth–*Chicago*

Logan Square Health Center of Cook County
–*Chicago*

Loyola University Medical Center,
Department of Pediatrics–*Maywood*

Melrose Park Pediatrics–*Melrose Park*

Near South Health Center of Cook County
–*Chicago*

North Arlington Pediatrics–*Arlington Heights*

Oak Forest Health Center of Cook County
–*Oak Forest*

OSF Medical Group, Knoxville Avenue
Pediatrics–*Peoria*

OSF Medical Group, Washington Pediatrics
–*Washington*

PCG Community Wellness Center–*Oak Park*

Pediatric Center of Chicago, Lincoln Park
Hospital–*Chicago*

Pediatric Center–*Ottawa*

Pediatric Health Associates–*Naperville*

Pediatrics Uptown, Ann & Robert H. Lurie
Children’s Hospital of Chicago–*Chicago*

Premier Kids Program, LaRabida Children’s
Hospital–*Chicago*

Robbins Health Center of Cook County–*Chicago*

Sterling Rock Falls Clinic–*Sterling*

UIC Children and Adolescent Center,
University of Illinois at Chicago–*Chicago*

Vista Health Center of Cook County–*Chicago*

Wheaton Pediatrics–*Wheaton*

Woodlawn Health Center of Cook County
–*Chicago*

Woody Winston Health Center of Cook County
–*Phoenix*

Young Family Health Center–*Chicago*

As of July 2015, there were 109 sites in Illinois certified by The Joint Commission as Primary Care Medical Homes.

As of July 2015, there were an estimated 500 Illinois practices Recognized by the National Committee for Quality Assurance as Patient-Centered Medical Homes. Many of these are clinics within large health systems or networks.

American Academy of Pediatrics



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Illinois Chapter

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ICAAP EDUCATIONAL OPPORTUNITIES

ICAAP offers several web-based educational programs focused on universal and emerging issues in pediatrics. The majority of these programs provide educational credit to participating physicians and allied health professionals and some also qualify for Part 4 Maintenance of Certification points approved by the American Board of Pediatrics and the American Board of Family Medicine. The programs are available to your practice staff and focus on quality improvement, systems change, staff roles, how to identify local resources, and other practical issues. Programs are presented by trained faculty using adult-learning educational models.

CURRENT EDUCATIONAL ACTIVITIES

- Bright Smiles from Birth: An Oral Health Education and Technical Assistance Program
- Childhood Development Initiatives
- Illinois Physicians Advocating for Awareness of Driving Safety
- Immunizations
- Nutrition for Obesity Prevention and Treatment
- Tobacco Cessation for the Primary Care Provider: A Quality Improvement Initiative
- Transitioning Youth to Adult Health Care for Pediatric Providers

For more information about any of these opportunities, please contact info@illinoisAAP.com. To register for an online course, please visit icaap.knowledgedirectweb.com and create an account. For more information, please contact lms@illinoisAAP.com.

SAVE THE DATE

The 2016 ICAAP Annual Educational Conference will be held on Friday, March 18, 2016 in Lisle, IL.

Join over 150 pediatric providers from across the state for a day of education and networking. For more information, please visit the <http://illinoisAAP.org/annual-conference/>.