Building a Medical Home
Quality Improvement Team

La Rabida Children’s Hospital
Premier Kids Program

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Assistant Professor, University of Chicago

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Medical Home Program Manager
Commercial Disclosure

• We have no financial relationships to disclose before presenting

• We do not intend to discuss off-label uses of FDA-approved products
Learning Objectives

• Describe the step by step process involved in LaRabida’s medical home QI implementation

• Utilize information to recruit and sustain parent partners participation

• Discuss initiatives advanced by the QI Team

• Explain helpful hints and lessons learned to colleagues at your site
Premier Kids Program
Quality Improvement Team
Premier Kids Program
Quality Improvement Team

• Physician – Edith J. Chernoff
• Program Coordinator – Pamela Northrop
• Nurse Managers – Lynn Purdy
  – Nancy Richer
• Family Advocate – Leslie Reynolds
• Administrative Assistant – Felicia Oliver
• Volunteer – Joan Lawson
• Parent Participants – Dorothy Owens
  – Felice McDavis
  – Edgar Ponce
  – Vicki Wilson
• DSCC Coordinator – Kim Davis
• Facilitator – Donna Scherer
HISTORY

• 2003 - Premier Preemies was the beginning of Premier Kids

• 2005 - Received grant from Illinois Children’s Healthcare Foundation
PREMIER KIDS PROGRAM

• The aim of this program is to treat and/or prevent health and development problems which affect the physical, motor, cognitive, nutritional, emotional and social growth of young children from birth until 6 years of age.
Goals

• Primary Care Program for children birth to 6 years of age with chronic medical and developmental problems.

• To create an integrated program within the hospital and community.

• To create a centralized, coordinated means of communicating with all disciplines involved in a patient’s care.

• To provide a means for families to navigate the medical and developmental communities more easily, and to provide them with the skills to advocate for their children.
Illinois Medical Home Project

• 2005: Became one of 10 practices in Illinois to participate in IMHP

• 4 year MCH/HRSA funded grant project

• 2 Phases: 10 practices involved in Phase 2
  – 5 with trained facilitators, 5 without

• Each practice required to establish a Medical Home Quality Improvement Team and hold monthly meetings

• Team must include at least 2 Parent Partners

• Baseline assessment using the Medical Home Practice Index and Medical Home Family Index

• Each team decides what parameters to undertake to achieve quality improvement and establish a medical home for families
La Rabida/Premier Kids Program
Quality Improvement Team

- Established Quality Improvement Team November 2006
- Monthly 60 minute meetings over the lunch hour
- 3 Parent Partners regularly attend each monthly meeting
- 8-10 staff regularly attend each monthly meeting
  - Dr., Nurses, Program Director, Family Advocate, Program Volunteer & others
- Title V Care Coordination staff regularly attend monthly meetings.
- Facilitator provided by the IL Medical Home Project helps to keep team members on target and ensure that everyone is actively participating in the decision making process.
Parent Recruits

• Advocate: Skilled in navigating the various community, medical and government systems for their child.

• Outgoing: Open in sharing their concerns, questions, suggestions with the medical practice

• Self Selection - reach out to all families (letter) to see who may be interested in participation
Medical Home Assessment Tools

Medical Home Practice Index & Family Index

• Validated assessment tools developed by the Center for Medical Home Improvement (Dr. Carl Cooley).

• Evaluate the practice on the 6 domains of a medical home:
  • Organizational Capacity
  • Chronic Condition Management
  • Care Coordination
  • Community Outreach
  • Data Management
  • Quality Improvement
Medical Home Assessment Tools

Medical Home Practice Index & Family Index Index

• Used to define baseline status prior to beginning Quality Improvement activities

• QI Team can use the results to help select practice improvement efforts.

• Re-administer after 2 years to determine if the changes have resulted in noticeable improvement in the delivery of care
Medical Home Assessment Tools

• All members of PKP team and 21 families

• MHFI: 59 questions on families’ knowledge, attitudes and beliefs about primary care delivery.

• 25 questions on the MHPI completed by practice staff.
Medical Home Assessment Tools

Results

• Reviewed the results of the initial medical home surveys – the MHPI and the MHFI – in order to decide on an initial QI project.
  – MHPI - lowest in areas of data management and community outreach
  – MHFI - lowest on helping families connect to other families with CSHCN and on collaborating with the families to create written care plans.
QI Team
First Project

Care plans - intrinsic to the AAP and AAFP’s vision of the Medical Home
- exchange of medical information
- to aide in care coordination
- transitions

Family versus Medical Team perceptions

Development of a comprehensive care plan for each patient to include not only the medical information but also nursing, therapy, equipment information

Comprehensive Care Plans = individualized health summary
PDSA cycle – QI technique
PlanDoStudyAct

• **Plan** to improve your operations:
  – Identify the problems faced
  – come up with ideas for solving these problems

• **Do** changes designed to solve the problems on a small scale first.
  – This minimizes disruption to routine activity while testing whether the changes will work or not.

• **Study** whether the changes are achieving the desired result.
  – Continuously study key activities

• **Act** to implement changes on a larger scale if the experiment is successful.
  – Make the changes a routine part of your activity.
  – Involve other persons
QI Process

- Meet: Proposal → discussion → agreement
- Test on small group
- Meet: modify proposal based on small group results
- Roll out change
- Meet -> review and modify
Care Plans

• Create a care plan for our patients
  – Borrowed care plans from other practices
  – -> tested on few patients -> made changes -> tested -> changed-> tested

• The process to develop our own care plans took 6 months

• The end result was 4 - 5 pages long
### Careplan

<table>
<thead>
<tr>
<th>Primary M.D. Specialists</th>
<th>Phone/Fax numbers</th>
<th>Type of Specialty/Hospital Affiliations</th>
<th>Last / Next Apt. Date (Frequency of follow-up)</th>
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<th>Hospitalizations (name of hospital)</th>
<th>Dates (to/from)</th>
<th>Condition Treated/Surgery</th>
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<tr>
<th>EI Case Coordinator</th>
<th>EI Site:</th>
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<td>Therapists (PT/OT/ST/DT)</td>
<td>Phone/Fax numbers</td>
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<td>Therapists (PT/OT/ST/DT)</td>
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<td>Therapists (PT/OT/ST/DT)</td>
<td>Phone/Fax numbers</td>
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School Services: ☐ Special Education ☐ IEP Name of School: ____________________________
School Nurse (name/phone): ____________________________________________________________________________
School Teachers/Therapists: ____________________________________________________________________________
Social worker, Counselor/Dean: ________________________________________________________________________
Other Service Agencies (Early Intervention, DSPC, Home Health Care, Care Coordinators, Respite, etc.): ____________________________________________________________________________
Dentist: ____________________________________________________________________
# Careplan

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<th>Past Procedures/Physical Exam: N/A</th>
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<th>Baseline physical findings: N/A</th>
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<th>Baseline vital signs: N/A</th>
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<th>Baseline neurological status: N/A</th>
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<th>Lab/X-ray Test Results: N/A</th>
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<th>Common Presenting Problems/Findings with Specific Suggested Managements</th>
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<td>Problem:</td>
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<th>Comments on child, family, or other specific medical issues:</th>
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© [Author]/[Date] CarePlan/Findings Specific Suggestion Guide.
## Careplan

### DME: Equipment & Supplies
- [ ] Adaptive Seating
- [ ] Communication Device
- [ ] Hearing Aid
- [ ] Orthotics
- [ ] Walker
- [ ] Other:

### DME Supplier:

### Community Resources (Check ALL that apply and explain on the line below):
- [ ] DSCC: Caseworker: [ ]
- [ ] Early Childhood: Caseworker: [ ]
- [ ] Housing Assistance: Caseworker: [ ]
- [ ] Medical: Caseworker: [ ]
- [ ] DCF: Caseworker: [ ]
- [ ] WIC
- [ ] Work Force Service
- [ ] Food Stamps
- [ ] Child Care

### Permissions
I give my permission to share the information in this care plan with all of my child’s providers and those listed in this plan.

**EXCEPT:***

- [ ] I give permission for the staff of Premier Kids Program to share my information with other community contacts (Parent Groups, Community resources, etc.) to help provide better care for my child/ren.

### Parent/Legal Guardian Signature:

### Date plan sent to providers:

### Primary Care Physician Signature/Date:

### Completed by:

### Extra room if necessary:

<table>
<thead>
<tr>
<th>Surgery type</th>
<th>Dates (to/from)</th>
<th>Hospital</th>
<th>Surgeon</th>
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<th>Medications</th>
<th>Rx (dose, route, frequency)</th>
<th>Ordered by/date</th>
<th>D/C date</th>
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Care Plan
Benefit to Families

“I found it helpful because it limits my repeating myself constantly, especially in an emergency when I want my focus to be on my son.” B.H.

• Another factor for me is that if there is something that I don’t quite understand, I can pull the information up and research it as necessary.” S.H.
Care Plan
Benefit to Families

• “My child receives medical care from a variety of specialists as well as therapists. It is difficult to remember the abundance of information given during those visits. If the provider enters the information into the comment section of the medical history, it will allow the information to be relayed to the other providers accurately, this will ensure that my child’s medical care is less likely be compromised.”
Care Plan
Benefit to Families

• “At times, someone other than the parent will bring the child in for wellness visits. There was an incident where as the grandparent brought the child in for a scheduled visit. The child was ill and was immediately sent to another hospital. The flash drive was extremely helpful due to the fact the Grandparent did not know detailed medical history.”

Nurse Jane
Care Plans

Completing care plan for each patient in PKP
  – Very challenging

1) Began on paper
  – Paper: frays, is hard to carry, cumbersome

2) Time: tried to complete them in clinic
  families found the morning too long to complete the plans in clinic.
The Challenge of Paper

QI team decided to place these care plans on a **flash drive** to enable families to easily carry the information with them and to allow all providers easy access to the care plans.
Flash Drive Care Plan

• Easily and compactly transported
• Information is easily and accurately conveyed
• Password protected
• Big enough to allow outside providers to save their information on the drive
• Improving communication between providers
• Easier to update than paper
The Challenge of Time

- Very time consuming to create plan (>2h per plan)
- Plan often needs input from more than one source
  - Parent
  - Medical Record
  - Therapists
  - Equipment Companies
The Challenge of Time

Solutions

• Volunteer works with families in clinic to understand the importance of the care plan and distributes a paper version of the plan for families to complete at home and mail back (SASE).
  – nurses
  – Administrative assistant
  – DSCC

• Care plan day quarterly

• Have partnered with Purdue Nursing School so nursing students will help complete care plans and will receive credit.

• Working to integrate the care plan into EMR so parts can be automatically generated
Care Plan

Ongoing Struggles/Solution

• How to allow outside providers access without allowing them to change data

  → Have tagged an empty folder on the flash drive into which consultants and other providers may save information.

• How to keep the flash drive up to date.

  → Ask families to bring flash drive with them to each visit in order to update regularly.
Management of the QI Team

• Sustainability:
  – Give a parent stipend to cover expenses such as travel and day care
  – Provide food
  – Allow children to attend
  – Involve parents in decision making when possible

• A symbiotic relationship
  – QI team benefits from parent participation
  – Parents benefit from participation on QI team
Parent Partner
Management of the QI Team

• PKP graduates patients at 6 years to other programs
  – Parents must graduate from the QI team when their children graduate the program

  Replacements must be found
  orientation
  education on philosophy of medical home interaction with other parents
Other Projects

• Creating Parent Advocates
  “You are Your Child’s Voice”
  – Discussion
  – Bookmarks
  – Poster – didn’t work

YOU ARE YOUR CHILD’S VOICE!
Every Child is Different and Has Different Health Needs
When you meet with a doctor, specialist or therapist make sure you find out:
  What is my child’s problem?
  What do we need to do for it?
  Why is it important to do this?

Remember:
You can always ask more questions!
If someone is not being clear, say you need to hear it another way.

Contact the Premier Kids Team about your child at:
Premier Kids Program
La Rabida Children’s Hospital
E. 65th Street at Lake
Michigan
Chicago, IL 60649
Premier Kids Voicemail:
773-256-5774
Email: foliver@larabida.org

YOU ARE YOUR CHILD’S VOICE!
Other Projects

• Results from the initial MHF/PIs indicated that families scored the practice low in helping families connect to other families with CSHCN

• PKP worked to create a family support group that would meet monthly at La Rabida.
  – Not enough participation to sustain the group
Future

• Developing QI Team/teams for Chronic Disease Clinics

• Tracking system to help care coordination
  – Paper versus use of Outlook

• Utilization of new eMR to help support medical home.
Contact Information

• Dr. Edith Chernoff, 773-256-5996 echernoff@larabida.org
• Pam Northrop, 773-256-5957 pnorthrop@larabida.org