

# Medical Homes: Spreading Innovative Pediatric Healthcare

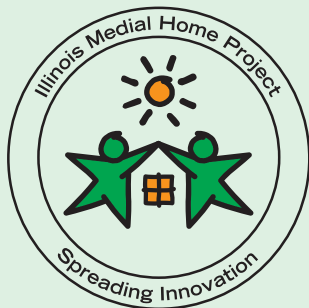
## Illinois Medical Home Project Annual Newsletter

THIRD EDITION

MARCH 2009

ILLINOIS CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

Editor: Kathy Sanabria, MBA, PMP



### *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.*

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### **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  
IMHP-Illinois Medical Home Project  
MCHB-Maternal and Child Health Bureau  
NICHQ-National Initiative for Children's Healthcare Quality  
QI-Quality Improvement

*Photos are courtesy of the Illinois Medical Home Project and the Illinois Chapter of the American Academy of Pediatrics.*

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Kathy Sanabria, MBA, PMP, IMHP Director, Illinois Chapter of the American Academy of Pediatrics

## 1. New National Center for Medical Home Implementation

The American Academy of Pediatrics is pleased to announce that it has been awarded a 5-year cooperative agreement grant from the federal Maternal and Child Health Bureau. The new **National Center for Medical Home Implementation** will support effective implementation of medical home among pediatric health care providers, public health professionals, families, and others who care for children. The new National Center will work to ensure that all children and youth, including those with special health care needs, have the services and support necessary for full community inclusion.

The National Center's Web site <http://www.medicalhomeinfo.org> is the premier resource for improving the lives of children and youth with special health care needs (CYSHCN) and their families through a medical home. The medical home Web site contains resources, information, tools, and practical strategies on how to provide medical homes for CYSHCN that are easy to access and download. The information on this site is intended for all individuals who care for and about CYSHCN.

At <http://www.medicalhomeinfo.org> you can learn what's going on around the country and in your state; learn how to use the Every Child Deserves a Medical Home curriculum, which sets forth practical strategies to educate providers on how to implement medical homes for CYSHCN; and sign up for a free e-Newsletter and Listserv. For more information e-mail [medical\\_home@aap.org](mailto:medical_home@aap.org) or call 1-800-433-9016 ext 7621.

## 2. Web-Based Resources on Medical Home

1. The **Center for Medical Home Improvement** (CMHI) has developed a Parent Partners Guide ([http://www.medicalhomeimprovement.org/assets/pdf/CMHI\\_PP\\_Guide.pdf](http://www.medicalhomeimprovement.org/assets/pdf/CMHI_PP_Guide.pdf)) to help parents and physicians better understand the critical role of parent partners on the Medical Home Quality Improvement Team. To learn more about the many resources and tools developed for primary care providers and families, visit <http://www.medicalhomeimprovement.org>

2. The **Division of Specialized Care for Children** (DSCC), the Illinois Title V agency for CYSHCN, has been working with pediatricians and families since 2002 to advance medical homes in Illinois. DSCC has developed the Medical Home Primer for Community Pediatricians and Family Physicians and the Medical Home Primer for Families to help providers and parents better understand the medical home concept and their respective roles. Visit their Web site at <http://www.uic.edu/hsc/dscc/> to find additional medical home tools.

3. The **Illinois Chapter of the American Academy of Pediatrics** (ICAAP) (<http://www.illinoisAAP.org>) administers the IMHP, which supports development of community-based medical homes for CYSHCN. To learn more about medical homes in Illinois visit <http://www.illinoisAAP.org/medicalhome.htm>

4. The **National Initiative for Children's Healthcare Quality** (NICHQ) is an action-oriented organization dedicated solely to improving the quality of health care provided to children. Founded in 1999, NICHQ's mission is to eliminate the gap between what is and what can be in health care for all children. A national organization with its home office in Cambridge, NICHQ also works with staff and faculty across the country. NICHQ's efforts focus on its four part improvement agenda: prevention of childhood obesity; promoting evidence based, family centered care for children with chronic conditions; purging harm from children's health care; and promoting equity in care and outcomes for all children. To learn more visit <http://www.nichq.org>

### Illinois Medical Home Project Contact Information

Project Title:	Illinois Medical Home Project (IMHP)
Project Funder:	Maternal and Child Health Bureau, Health Resources and Services Administration
Project Number:	1 H02MC02609-03-01 (CFDA #93.110, Priority Three, Integrated Services)
Principal Investigator:	Charles N. Onufer, MD, FAAP
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Project Director:	Kathy Sanabria, MBA, PMP
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Project Period:	4 years from July 1, 2004 to March 31, 2009

### 3. Acknowledgment of Organizations Supporting IMHP

By Kathy Sanabria, MBA, PMP, IMHP Director

The ICAAP thanks the following organizations for supporting the IMHP over these past four-and-a-half years. Your support in helping to spread the medical home model across the state of Illinois is truly appreciated.

American Academy of Pediatrics Department of Community and Specialty Pediatrics  
The Arc of Illinois  
The Autism Project  
CoACH Care Center  
CHOICES for Parents  
Chicago Department of Public Health  
Cook County Department of Public Health  
Family Resource Center on Disabilities  
The Family Support Network  
Family to Family Health Information and Education Center of IL  
Family Voices of Illinois  
Health & Disability Advocates  
Illinois Academy of Family Physicians  
Illinois Council on Developmental Disabilities  
Illinois Department of Healthcare and Family Services  
Illinois Department of Public Health  
Illinois Department of Human Services Office of Family Health  
Illinois Head Start Association  
Illinois Health Connect  
Illinois Maternal & Child Health Coalition  
Illinois Public Health Association  
National Center of Medical Home Initiatives for Children with Special Needs  
Pathways Awareness Foundation  
University of Illinois Division of Specialized Care for Children  
Voice for Illinois Children  
Ounce of Prevention Fund

### 4. ICAAP Receives Grant from The Commonwealth Fund To Strengthen Medical Homes and Early Intervention

By Kathy Sanabria, MBA, PMP, ICAAP Project Director

The Illinois Chapter of American Academy of Pediatrics (ICAAP) and Advocate Health Care's Healthy Steps for Young Children Program are pleased to announce that Illinois has been awarded a grant from The Commonwealth Fund to develop systems to overcome barriers to referral and care coordination for children eligible for Early Intervention (EI) services. The Commonwealth Fund's two-year grant will allow ICAAP and Advocate to identify barriers and obstacles on both sides of the referral process that could potentially contribute to poor care coordination for children with developmental concerns. Drawing from its findings, the project leaders will develop and test an approach for overcoming these obstacles. The approach will include training modules and a variety of educational materials which may be incorporated into statewide and national efforts if effective. The project, *Coordinating Care Between Early Intervention and the Primary Care Medical Home*, is part of the larger Enhancing Developmentally Oriented Primary Care (EDOPC) project. EDOPC is a statewide, comprehensive effort to increase primary care providers' use of validated tools for developmental, social-emotional, and maternal depression screening, with strong partnerships between the primary care medical community, the Illinois Department of Healthcare and Family Services' All Kids program, EI, community service agencies, advocates and local philanthropists.

**451,776 OR 13.9% OF ALL ILLINOIS CHILDREN HAVE SPECIAL HEALTH CARE NEEDS, ACCORDING TO THE 2005/06 STATE LOCAL AREA INTEGRATED TELEPHONE SURVEY**

<http://cshcndata.org/Content/StatePrevalence2005.aspx?geo=Illinois>

**600 ILLINOIS CHILDREN WERE ENROLLED IN A NEW WAIVER FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES (WAIVER YEAR 2008)**

[http://www.hfs.illinois.gov/hcbswaivers/supports\\_cyadd.html](http://www.hfs.illinois.gov/hcbswaivers/supports_cyadd.html)

## 5. Enhancing Developmentally Oriented Primary Care Office Based Training Program Information

By Juanona Brewster, MDIV, MTS, MJ

Early detection and referral is crucial to addressing developmental, social, emotional, and behavioral issues. In addition, surveys indicate that parents want their child's health care provider to address child development and psycho/social issues. Families that receive these types of services have enhanced trust in, and a more successful working relationship with their physician. Additionally, they are more satisfied with the care of their children. New strategies and tools are available to aid health care providers to meet these expectations.

Enhancing Developmentally Oriented Primary Care (EDOPC), a partnership between Advocate Health Care Healthy Steps Program and the Illinois Chapter of the American Academy of Pediatrics (ICAAP), offers developmentally oriented continuing medical education (CME) opportunities to pediatricians and family physicians through office, clinic, and hospital-based training. These free trainings are geared toward the entire staff in order to facilitate a comprehensive team approach to patient care. In addition to CME credits, EDOPC offers resource materials and the opportunity for additional training and technical assistance. Topics currently include:

- Developmental Screening and Referral
- Social/Emotional Screening and Referral
- Early Autism Detection and Referral
- Perinatal Maternal Depression Screening
- Domestic Violence Screening

### 175 CHILDREN PARTICIPATED IN THE CHILDREN'S RESIDENTIAL WAIVER FOR CHILDREN WITH DD (WAIVER YEAR 2008)

<http://www.hfs.illinois.gov/hcbswaivers/cyadd.html>

For more information on EDOPC, please contact Juanona Brewster, MDIV, MTS, MJ, Director, Early Childhood Development Projects for ICAAP at 312/733-1026 ext 203 or [jbrewster@illinoisaaap.com](mailto:jbrewster@illinoisaaap.com).

To schedule any of the above presentations at no charge, please contact Paula Zajac, Project Coordinator, ICAAP at 312/733-1026 ext 212 or [pza-jac@illinoisaaap.com](mailto:pza-jac@illinoisaaap.com).

*Join the movement! A variety of colleagues are participating in EDOPC trainings, technical assistance, and advocacy in Illinois with the support of the Aetna Foundation, Chicago community Trust, Illinois Children's Healthcare Foundation, Illinois Department of Healthcare and Family Services, Michael Reese Health Trust, and the W. Clement and Jessie V. Stone Foundation.*

*"I am excited to be a parent partner for PCC Community Wellness Center's Medical Home Quality Improvement Team. I also work as a medical assistant at the clinic and welcome special needs families into the practice. I especially like helping families who have a child with a developmental delay. The goal is to get them services early and to follow through on their care plan."*

*– Latrena Harthorne, Parent Partner at PCC Community Wellness Center*



## Developmental Screening and Referral

The training offers physicians and their staff the opportunity to:

- appreciate the difference between surveillance and use of screening tools for developmental delays
- learn how to administer and score validated screening tools
- make decisions about tool selection and staff responsibility for administration of validated screening tools
- learn about efficient office procedures related to developmental screening and referral
- successfully use billing and coding information for reimbursement
- learn about community resources for referrals
- use improved parent/caregiver education materials and resources

## Social/Emotional Screening and Referral

This training focuses on:

- the importance of relationships in a child's life
- “red flags” to social and emotional developmental delays
- instruction on how to complete the Ages and Stages Social/Emotional Questionnaire (ASQ/SE)
- successfully use billing and coding information for reimbursement
- learn about community resources for referrals
- use improved parent/caregiver education materials and resources

To learn more about medical homes, visit these helpful Web sites:

American Academy of Pediatrics  
<http://www.aap.org>

Center for Medical Home Improvement  
<http://www.medicalhomeimprovement.org>

Division of Specialized Care for Children  
<http://www.uic.edu/hsc/dscc/>

Illinois Chapter of American Academy of Pediatrics  
<http://www.illinoisAAP.org/medicalhome.htm>

National Center for Medical Home Implementation  
<http://www.medicalhomeinfo.org>

National Committee for Quality Assurance  
<http://www.ncqa.org>

National Initiative for Children's Healthcare Quality  
<http://www.nichq.org>

Patient Centered Primary Care Collaborative  
<http://www.pcpcc.net>

## Early Autism Detection and Referral

This training provides:

- an overview of early warning signs of autism
- explanation of typical and atypical child social development
- information about referral options for children who are showing “red flags” for autism and/or other developmental delays

## Perinatal Maternal Depression Screening

In Illinois, Public Act 95-0469, the Perinatal Mental Health Disorders prevention and Treatment Act was passed to increase awareness of Post Partum Depression (PPD), and to promote early detection and treatment of PPD. PA95-0469 requires the following:

- licensed health care professionals providing prenatal care also provide education to women and if possible and with permission, to their families about perinatal mental health disorders
- all hospitals providing labor and delivery services provide new mothers, prior to discharge following child birth, and if possible, provide fathers and other family members complete information about perinatal mental health disorders
- licensed health care professionals providing prenatal care, postnatal care, and care to the infant invite the women to complete a questionnaire to assess whether they suffer from perinatal mental health disorders

## The Perinatal Maternal Depression Screening

Training focuses on:

- risk factors for PPD
- effects of depression on the mother-child relationship
- differences between “normal” baby blues and true PPD
- administration of the Edinburgh Post Natal Depression Scale (EPDS)
- medication information that could impact both mother and child
- information about referral options for treatment

## Domestic Violence: Effects on Children

This training discusses:

- the risk of domestic violence and its effects on children and families
- use of screening tools
- referral options

**322,534 CHILDREN HAD INDIVIDUALIZED EDUCATIONAL PLANS DURING THE 2005-6 SCHOOL YEAR**

<http://nces.ed.gov/programs/stateprofiles/sresult.asp?mode=full&displaycat=1&s1=17>

## 6. Update/Evaluation Results on Phase II of Illinois Medical Home Project

by Charles Onufer, MD, FAAP, Principal Investigator,  
Kathleen Sanabria, MBA, PMP, Project Director,  
Andrew Cooper, MPH, University of Illinois at Chicago School  
of Public Health, Center for Advancement of Distance Education

### Objectives

Ten primary care practices participated in Phase II of the Illinois Medical Home Project (IMHP), which began July 1, 2006 through October 2008. The IMHP provided medical home quality improvement (QI) teams with either facilitation support or technical assistance, training through a learning collaborative, resource materials, modest funding, and an Institutional Review Board (IRB) approved pre- and post- project evaluation. A control study measured the effect facilitators have in building medical homes.

### Program/Project Description

The IMHP is administered through the Illinois Chapter of the American Academy of Pediatrics (ICAAP) in collaboration with the Division of Specialized Care for Children, Illinois Title V Program and is supported through a \$1,000,000 five-year grant from the Maternal and Child Health Bureau. The IMHP uses the “Plan-Do-Study-Act” cycle of practice improvement. Data were collected from 10 phase II practices at baseline and 22 months later (one team discontinued in year 2) using the Center for Medical Home Improvement Medical Home Index, combined Medical Home Family Index (revised)--Family/Caregiver Survey, ICAAP Medical Home Practice Assessment Checklist, and QI team surveys to measure changes in delivery of care, access to services, utilization of the healthcare system, and satisfaction with care. A control study measured the effect facilitators have in building medical homes. This project received IRB approval from the University of Illinois at Chicago School of Public Health. Overall, results for Phase II of the IMHP indicate that improvements have been made at each of the participating primary care sites. Overall, sites that received facilitation support were more likely to hold monthly QI team meetings and follow through on implementing practice improvements.

### Methods

The Phase II evaluation protocol aimed to: 1) Determine whether or not practices were more likely to provide quality care within the six domains as measured by the Medical Home Index after the IMHP had been implemented for two years; 2) Determine whether practices with facilitators were more likely than those without facilitators to provide better quality of care after the two-year period; 3) Measure the difference in this change between practices with facilitators and those without facilitators; and 4) Determine the relative effectiveness of facilitators for the overall success of the IMHP.

Table 1: Observations Regarding QI Team Accomplishments Facilitated vs. Non-Facilitated

- The number one indicator for QI team success is working with a motivated and passionate QI physician team leader.  
(Two of the Phase II teams that did not have assigned facilitators accomplished significant results due to the strength of the team leader in keeping their staff motivated to make change.)
- Family participation on QI teams is essential for practice improvement; Federally Qualified Health Centers (FQHCs) and university-based systems face unique challenges in recruiting parent partners.
- At the start of the project, all 10 QI teams indicated they wished they had been assigned a facilitator; at the end of the project, participating teams had the same wish.
- QI teams assigned a facilitator held twice as many QI team meetings and accomplished more quality improvement activities.

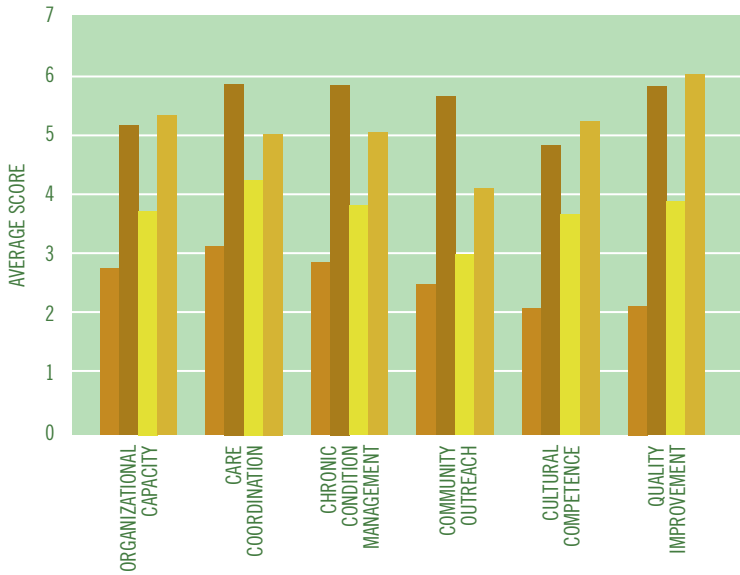
### IMHP Phase II Participating Sites

Lead Physicians	Site Locations
Thomas Danko, MD	Crusader Clinic Rockford IL
Eddie Pont, MD	Elmhurst Pediatric Association Elmhurst IL
Mark Regnier, MD	Fox Valley Women and Children's Health Partners Elburn IL
Leah Mooshil Durst, MD	Friend Family Health Center, Inc. Chicago IL
Peter J. Smith, MD	Friend Family Health Center, Inc. Chicago IL
Kamala (Kay) Ghaey, MD	KidzHealth Chicago IL
Garry Sigman, MD	Loyola University Medical Center, Department of Pediatrics Maywood IL
Chris Briner, MD	PCC Community Wellness Center Oak Park IL
Paul Luning, MD	PCC Community Wellness Center Oak Park IL
Edith Chernoff, MD	Premier Kids Program, La Rabida Children's Hospital Chicago IL
Alejandro Clavier, MD	University of Illinois at Chicago Children and Adolescent Center, Department of Pediatrics Chicago IL
Young Mok, MD	Young Family Health Center Chicago IL

**Figure 1: Medical Home Index Summary Scores Facilitated (5) vs. Non-Facilitated (4) Practices**

Both facilitated and non-facilitated practices demonstrated significant improvement in their Medical Home Index scores from baseline to follow up. One of the non-facilitated teams left the project in year two due to time constraints.

BASE LINE – NON FACILITATED  
 FOLLOW UP – NON FACILITATED  
 BASE LINE – FACILITATED  
 FOLLOW UP – FACILITATED

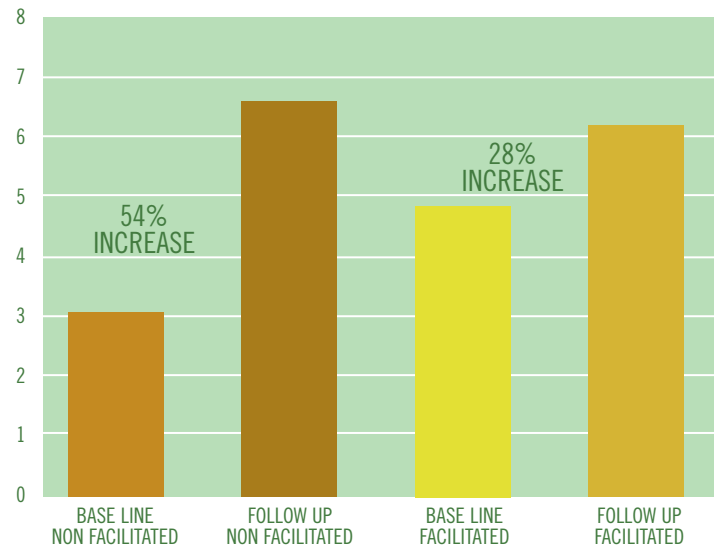


**Figure 2: Medical Home Index Accumulative Summary Facilitated (5) vs. Non-Facilitated (4) Practices**

At the start of the project, the MHI baseline scores for each of the facilitated teams was higher than for the non-facilitated teams. This was not planned or expected, since none of the teams recruited for the project previously had training in the medical home model. Both the facilitated and non-facilitated teams showed improvement in their MHI scores:

Facilitated = 28%  
 Non-facilitated = 54%

Since the facilitated teams' baseline scores were significantly higher at the start of the project, their self-reported gains at follow up were lower when compared to the non-facilitated teams' (technical assistance teams) scores. The significance of the MHI being a self-reported assessment cannot be overlooked. The structure and information provided by the facilitator accounts, in part, for facilitated teams having higher expectations for their level of improvement, when assessing their accomplishments. Accordingly, their overall gains were more modest and realistic.



Center for Medical Home Improvement

### THE MEDICAL HOME INDEX: Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

**ISSUES:**  
 The Medical Home Index for an American family includes:  
 Organizational Capacity, Chronic Condition Management, Care Coordination, Community Outreach, Case Management, and Quality Improvement.

For a domain to be assigned from Level 1 through Level 4, the domain is measured with a progression of score and are reported as a percentage from Level 1 through Level 4. For each domain please do the following:

**First:** Read each domain score description and assign from Level 1 to Level 4. Then:  
**Second:** Select the LEVEL (1, 2, 3 or 4) which best describes how your practice currently provides care for CYSHCN.  
**Third:** When you have selected the level, then indicate whether practice performance is at the level as: "PARTIAL" (some activity within level) or "COMPLETE" (all activity within that level).

For an example below "Domain 1: Organizational Capacity, Theme 1.1 "The Mission..." the score for the practice is "Level 3", "PARTIAL".

THEME:	Level 1	Level 2	Level 3	Level 4
#1.1 The Mission of the Practice	Primary care providers (PCPs) at the practice have individual responsibility for delivery care to children with special health care needs. CHCPs also provide education, experience and attend to the care quality. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Approaches to the care of CYSHCN at the practice are individual rather than family centered. Offer services that do not complementation of care (eg. the process of our paying for care). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The practice uses a family centered approach to care (eg. 2003, 2005) they score 1, 2, 3, 4 and it is not a list of functions or conditions with no measurable feedback, a related data facilities and resources other places (eg. for any change in data). <input checked="" type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3 a parent/ provider/family group/ provider/family centered strategies, practices and policies (eg. enhanced team communication, systematic inquiry to family concerns or problems, evidence based practice, shared self or practice evaluation) or quality care for CYSHCN are demonstrated. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

The Medical Home Index is used by primary care practices to measure the organization and delivery of primary care for CYSHCN.

## Results

Based on the assessment tools – both facilitated and non-facilitated QI teams benefited from the medical home model and participation in Learning Sessions.

The assessment tools did not demonstrate a significant difference between the facilitated and non-facilitated groups.

Modest improvements within most of the six domains of the Medical Home Family Index were demonstrated for participating sites from baseline to follow up.

On average, facilitated QI teams held twice as many QI team meetings than non-facilitated teams; facilitated teams accomplished more improvements not reflected in the scores by the assessment tools.

Overall, results for Phase II of the IMHP indicate that improvements have been made at each of the participating primary care sites. In most cases, sites that received facilitation support were more likely to hold monthly QI team meetings and follow through on implementing practice improvements. Teams with strong leadership accomplished many improvements regardless of which group they were assigned to (facilitated vs. technical assistance).

Figure 3: Family Survey Summary Data Facilitated (5) vs. Non-Facilitated (4)

Modest improvements within most of the six domains of the Medical Home Family Index were demonstrated for participating sites from baseline to follow up.

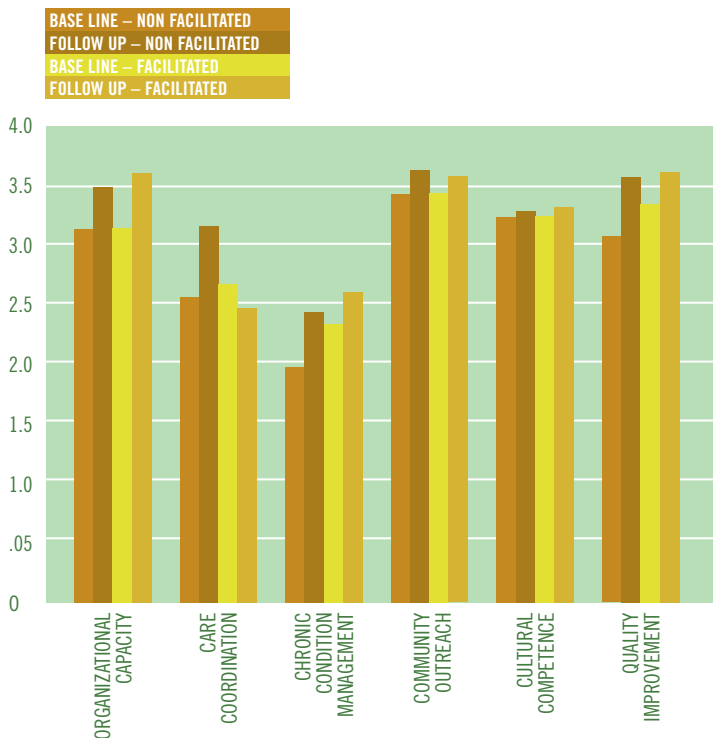


Table 2: General Observations

- Based on the assessment tools – both facilitated and non-facilitated QI teams benefited from the medical home model and participation in Learning Sessions.
- The assessment tools did not demonstrate a significant difference between the facilitated and non-facilitated teams.
- Facilitated practices held twice as many QI team meetings and accomplished significantly more improvements not reflected in the scores by the assessment tools.

Table 3: QI Team Quantitative Results

Overall Percentage of Positive Responses  
Weighted Averages for Facilitated and Non-Facilitated Sites\*

	First Round (Summer 2007)		Second Round (Spring 2008)	
	Strongly Agree/ Agree %	Neutral/Disagree/ Strongly Disagree %	Strongly Agree/ Agree %	Neutral/Disagree/ Strongly Disagree %
Facilitated (n=5)**	91.3	8.7	95.9	4.1
Non-Facilitated (n=4)***	93.2	6.8	94.1	5.9

\* Average for all 15 five-point scale QI team questions. Sample question: Quality Improvement teams are an effective way to implement the medical home concept into a primary care practice.

\*\* 31 respondents at First Round, 30 at Second Round; averages are weighted for number of respondents per site

\*\*\* 25 respondents at First Round, 30 at Second Round; averages are weighted for number of respondents per site

**23,019 CHILDREN  
WERE SERVED BY  
DSCG IN 2008**  
<https://perfdata.hrsa.gov/mchb/mchreports/TVISReports/UL/Snapshot/snapshot.aspx?statecode=IL>

## Conclusions/Key Lessons Learned

The success of improving practice quality improvement in all teams participating in Phase II of the IMHP may have resulted from the multi-faceted approach to building a medical home, which emphasizes provider training, collaborative teams, parent input, and facilitation or technical assistance support. A unique feature of this intervention was the provision of a QI team facilitator external to the practice for five teams matched with five teams that received provider training, collaborative teams, parent input, modest mini-grants, and technical assistance support (facilitators not provided). Practices assigned a facilitator were more likely to hold monthly QI team meetings, implement QI goals and objectives, and follow through on key clinical activities, such as developing written care plans and redesigning office practices to better meet the needs of CYSHCN and families. Additionally, the involvement of families was reported to be an integral component of the intervention, as has been found previously. While the heterogeneity in QI activities across practices prevented us from being able to link outcomes with specific QI activities in this small evaluation, we believe that QI teams experience more success in achieving their goals when encouraged to select QI activities that are most relevant to their practices, rather than having a set of activities prescribed for them.

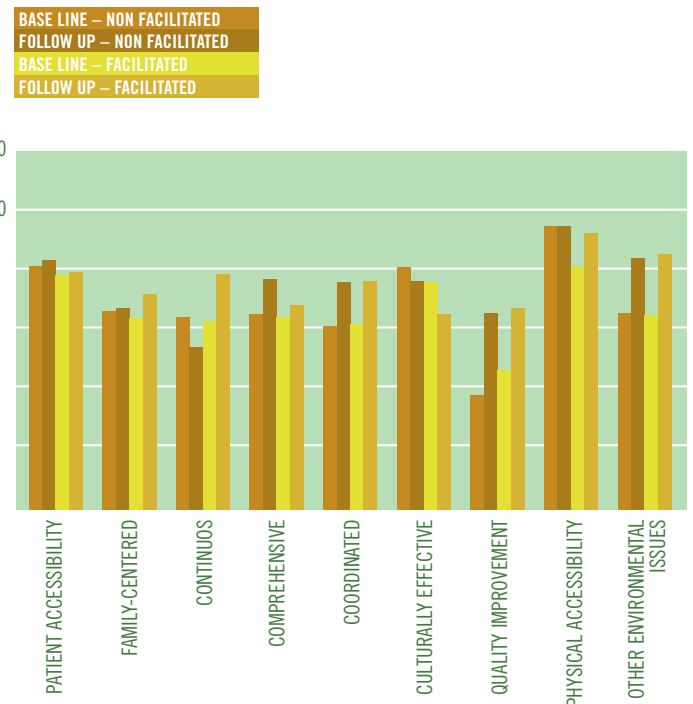
**Table 4: Observations Regarding QI Team Accomplishments Facilitated vs. Non-Facilitated**

- Ability to make systems-level changes vary depending upon practice type:
  - FQHCs: methods to survey families need to be made simple and office-based; medical home QI efforts should be integrated into federally mandated QI requirements for FQHCs.
  - Private Practices: it is easier and quicker to make systems changes in primary care practices than in university-based systems or FQHCs.
  - University-based clinics and FQHCs should invite members from various departments within the clinic to join the QI team to facilitate making system-wide changes.
- It is important to utilize experienced facilitators for QI efforts; communication among QI teams and facilitators is invaluable and helps pass forward successful strategies and lessons learned.
- Medical home QI efforts should be individualized for each site so practices can prioritize their unique needs, goals, and objectives for improvement.

The results of this pilot evaluation demonstrate that using facilitators for QI has a positive impact on practice change. Future research is needed to refine QI interventions at the practice level and to monitor the results of practice changes for periods of time longer than two years to allow families time to appreciate change and for a continuous QI process to take hold. In addition, if practice-level interventions such as the IMHP are to be supported and successful in the future, efforts must be made to address the issues of time constraints in practices, lack of reimbursement for activities performed in a medical home such as care coordination, and a general lack of education about CYSHCN and medical homes among providers. In parallel to the IMHP, ICAAP is currently working with stakeholders at the state and national levels to address reimbursement issues and to disseminate training materials about the medical home. More work is needed to support these efforts in order to ensure that in the future all children have a medical home.

**Figure 4: Practice Assessment Checklist Summary Facilitated (5) vs. Non-Facilitated (4)**

Modest gains within most of the nine domains of the Medical Home Practice Assessment Checklist were demonstrated for participating sites from baseline to follow up. Greatest gains were seen in the areas of environmental issues, quality improvement, and care coordination.



## 7. Parent Perspective on Medical Home Quality Improvement Team

by Sheri Hurdle, Parent Partner La Rabida's Premier Kids Program

When a woman learns that she is expecting, it is likely that she never thinks of what can go wrong. It is likely that her thoughts are all positive, filled with excitement and happiness. My excitement and happiness was shattered at the beginning of my 23rd week of pregnancy with the unexpected birth of my daughter weighing only 14oz. She was given a 10 percent survival rate.

With excellent medical care, I witnessed 6 months of miraculous transformation of a tiny 14oz classified extreme preemie to a 6 lb baby girl who loved to smile. During those early months, my daughter overcame open heart surgery at 1 week old, being extubated and re-intubated three times, 6 eye surgeries to ensure sight, and severe acid reflux. When my daughter was discharged home that's when our issues with adequate health care began. Her outpatient care did not have the same quality as her in-patient care. Therapists and providers were constantly changing and I had to adjust her schedule to ensure medical care. One change was so significant that she went without medical services for almost 8 months which caused her to regress in an area which was very important to her overall well being.

My daughter was referred to La Rabida Children's Hospital for a Diagnostic Evaluation. It was at that moment I was introduced to Premier Kids and one of the evaluators was Mrs. Pamela Northrop, LCSW. The pediatrician and medical staff provided my child with the same hands on medical care as an outpatient that she received as an in-patient. The medical staff ensured that the gaps that were missing in her medical care were all filled with consistent and reliable providers. It was at one of my daughter's well being visits that Mrs. Northrop spoke to me about the Illinois Medical Home Project and asked if I was willing to join their Medical Home Quality Improvement (QI) committee as a Parent Partner. The first step was to attend one of the informational learning sessions provided through this innovative program. Being that it was my first time hearing about Medical Home some of the information in the first half of the session went over my head. At lunch the parents in attendance talked with Mr. Bob Cook, Parent Liaison from the Division of Specialized Care for Children. He explained the purpose of the Medical Home in layman's terms which gave me a whole new perspective.

Due to a medical emergency I was not able to attend La Rabida's Medical Home QI Meetings until the third meeting. I was totally lost at the beginning so I just listened in. Our facilitator, Donna Scherer, and Pam asked the parent partners what we felt was missing from our medical care and what did we expect from our medical providers. As each parent spoke it was amazing that even though our children's medical needs differed, our experiences and what we expected from our providers were the same. Our common complaint was that at every medical appointment our children's complete medical history was being asked, whether it was a referral or not, and even if the child's medical chart was right in front of the provider or nurse. We felt this process took away from valuable time that could be used for examination or explanation of medicine or a current medical challenge. To solve this dilemma it was suggested by the team to draft a care plan for each child in the Premier Kids program. Our first step was to decide what to include in the care plans. The team acknowledged the fact that we want the plans to be thorough but not repetitive and lengthy. We also recognized the fact that children with special needs, depending on their medical challenge, may have vital signs that differ from those of children without special needs or medical challenges. The team used an existing standard form and personalized it to meet the needs of the children of Premier Kids. This process sounds so simple on paper but it was indeed a lengthy process. Once the care plan was complete the challenge was storing the plans. We were fortunate to have a group of nursing students from Purdue University to assist the medical staff with preparing the plans. The team did not want parents to have to deal with excess paperwork when the information on the care plans was updated and we wanted the plans to be easily accessible to the parents as well as all of the providers caring for their child. The solution was to place the plans on a computer flash drive. The flash drive can be easily placed inside a diaper bag, purse, or key chain and it also is convenient if someone other than the parent takes the child to their appointments.

Establishing and implementing Medical Care plans was a major accomplishment for our Medical Home team. Our accomplishment became an honor when our team was invited to present at the MCHB conference titled "Promising Practices" held June 2008 in Washington, DC. I had the pleasure of being one of the presenters. After listening to the various presentations from other medical home teams I discovered that we all had something to learn from each other. The medical home concept is

not only essential to meet the needs of children with special needs but also to meet the needs of the entire population. Quality health care is everyone's right! I was so impressed by the fact that one could not tell who the high ranking medical professional was from the parent representative because everyone's passion was equal. All who were in attendance were so approachable and very interested to hear about one another's personal experience, including Dr. Cal Sia, the father of the medical home concept. I have to admit, at first I was extremely intimidated because I saw myself just as a parent attending a conference to present, but afterwards I saw myself in a different light. I now see myself as an expert, my opinions about medical care are valid and justified because I have experienced both its pros and cons.

At first being a part of the La Rabida's Medical Home team was just something to do in my spare time. But now being a part of the team has opened my eyes to so many different challenges that families of children with special needs face. I am one of the fortunate ones; my child's medical challenges are not such that I can not lead a somewhat normal life. There are families whose child's medical challenges alter their lives in such a way that caring for the child becomes their life. Those families do not have the time to participate on teams such as this. So instead of my participation being a hobby, it is my duty. My duty is to be a voice for those who cannot be heard. Although this is not a duty I asked for, it is a challenge I am willing to accept, conquer and excel at. There was someone whose ideas opened doors for my child and it is my honor to hopefully be able to do the same for someone else's child. That is now my perspective and my purpose for participating with the Premier Kids Medical Home team.

*"My duty is to be a voice for those who cannot be heard. Although this is not a duty I asked for, it is a challenge I am willing to accept, conquer and excel at. There was someone whose ideas opened doors for my child and it is my honor to hopefully be able to do the same for someone else's child. That is now my perspective and my purpose for participating with the Premier Kids Medical Home team."*

*– Sheri Hurdle, Parent Partner at La Rabida's Premier Kids Program*



*Premier Kids representatives speak about their Medical Home Quality Improvement Team at La Rabida Children's Hospital at the Promising Practices Conference held June 2008 in Washington D.C. (left to right: Sheri Hurdle; Cal Sia, MD; Pam Northrop)*



**ACCORDING TO THE 2005/06 NATIONAL SURVEY, FAMILIES OF ONLY 60.3% OF IL CYSHCN PARTNERED IN DECISION MAKING AT ALL LEVELS AND WERE SATISFIED WITH THE SERVICES THEY RECEIVED.**

<http://mchb.hrsa.gov/cshcn05/>

## 8. Dr. Thomas Danko Receives Champions for Children Award

by Donna Scherer, RN, MPH

Dr. Danko, a pediatrician at Crusader Clinic in Rockford, IL and a lead physician for one of the Phase II Illinois Medical Home Project sites was nominated for this award by the Division of Specialized Care for Children (DSCC) Rockford regional office staff in recognition of his compassion and commitment to providing a medical home for children with special health needs. In less than two years the Medical Home Quality Improvement Team at Crusader Clinic, under the leadership of Dr. Danko, has established a care coordinator position and initiated care plans for over 600 children identified with special health needs. These care plans are housed on a shared network drive which is readily available for on call physicians; the providers can then download the care plans to their PDA for easy access. These care plans have been given to families for them to share with other providers and to take to emergency appointments.

The clinic has developed a system to alert staff of children with special needs so longer appointment times can be automatically assigned. Dr. Danko's involvement in the Quality Improvement Team (QIT) has led to the engagement of his peers and the establishment of provider teams at Crusader Clinic in hopes of better serving their clients. Dr. Danko encourages parent involvement not only in their child's care but also within the QIT. As a result of his efforts, three parent partners routinely participate on the QIT. The work of the QIT, led by Dr. Danko, has also spearheaded the development of a Parent Support Group at Crusader Clinic. Dr. Danko is involved with the Rockford Cleft Lip & Palate team providing services to clients in the Rockford community. He works closely with the local DSCC office to provide medical services and care coordination for children with complex health and social issues. He is truly a role model for other health providers and a true asset to the Rockford community, providing a medical home and quality health care to those in need.



Dr. Thomas Danko lead pediatrician for Crusader Clinic's Medical Home QI Team

## 9. Facilitating Medical Home Quality Improvement Teams

by Rita Klemm, MSW and Donna Scherer, RN, MPH

As part of the Illinois Medical Home Project, we have been serving as facilitators for some of the Quality Improvement Teams (QIT) in pediatric practices for the past four years. The Medical Home Model provides the framework for defining quality care provided to children and youth with special healthcare needs (CYSHCN) in a primary health care setting. In Illinois, we have found that a facilitator substantially enhances the quality improvement process by routinely assisting and supporting primary care practices who want to provide a medical home.

The Medical Home Quality Improvement Team is a collaboration of parent-professional partners with a mission to attain practice-based quality improvement. Teams are made up of a lead physician, a nurse or the person who will be serving as the care coordinator, and at least two family members. Other office staff members are included as the needs and work of the team change. The team's goal is to achieve "improvements that blend parent insight, professional knowledge, and care coordination to build primary care medical homes" (Cooley and McAllister, p. 9, [Building a Medical Home Medical Home Improvement Kit](#)).

The basics of facilitation are easily learned and provide a large measure of meeting improvement. The key role of the facilitator is to serve as the meeting organizer, to remain an objective observer of the team dynamics and to ensure that all team members actively participate in the decision making process. The primary function of the medical home facilitator is to help the team as a whole identify and discuss how care is delivered and maintain a momentum for change to improve care for children with special health needs. Guiding the discussion to a plan of action can be accomplished through the use of various tools and approaches; our quality improvement teams use the Plan Do Study Act process to help identify small steps of change that can be implemented, evaluated and built upon.

Facilitators assume a variety of roles including pre-planning and developing agendas, maintaining team meeting minutes, researching quality improvement processes and providing ongoing momentum, and connecting primary care practice staff and the families they serve with essential community-based resources. We have found that having a facilitator that is *not a staff member* of the practice is one of the key factors in the success of this approach to quality improvement. This allows the facilitator to focus on the process of improvement without bias or judgment.

Ned Ruete, a member of the International Association of Facilitators, has written that “facilitation is like playing the piano. You can practice the piano for years, learning new skills, pieces, and exercises and gaining experience and confidence. But when people want to sing "Happy Birthday" at a party, knowing what starting note is comfortable for a majority of people and being able to hit that one note on the piano makes a world of difference to how well the group sings together. By the same token, the basics of facilitation make a world of difference in how well groups work together.”

Working with primary care practices to establish parent-professional partnerships and to discuss and plan for improvement in delivery of care has been very rewarding. The excitement among the staff and parent partners when small changes are made that improve the quality and delivery of care is invigorating and serves as a motivator to pursue other areas of improvement. Small changes such as identifying children with special health needs (creating a registry) make a huge difference in their care experience. When families call, the staff know they have special needs and can offer longer appointment times or make sure they are moved immediately to an exam room.

Many of the practices we are working with have established a Care Coordinator staff position. For most, this is a staff nurse who takes on the role of helping families and children with special health care needs identify and arrange the special needs and services they require. This is a new venture for primary care practices and has been a learning process for the practice and the staff. For many families who have had to coordinate their own child’s needs and care and navigate the service delivery system alone, the Care Coordinator serves as a lifeline and resource to help navigate the complex health care delivery system. One of the practices we provide facilitation support for has a full-time Care Coordinator to help families in planning care and arranging services. Most have a staff nurse who serves as the Care Coordinator on a part-time basis.

As the number of quality improvement teams grows, the benefits to both practices and families are becoming increasingly apparent. Families are seen as equal partners and recognized for their expertise concerning their children. Parents voice appreciation that they are known, listened to, and respected. They feel the practice helps coordinate services and realize these service needs go beyond medicine. Parents feel they are using their experiences in a positive way with the hopes of making a difference in someone else’s life.

Changes implemented through the Medical Home Quality Improvement Teams do not have to be monumental to be significant for children with special health care needs and their families. It is the small steps and strategies that often have the most impact in health care delivery for children and their families.

Rita Klemm, MSW, and Donna Scherer RN, MPH, began serving as Medical Home facilitators for Illinois primary care practices in 2003. Both are employed by the University of Illinois at Chicago-Division of Specialized Care for Children, Illinois’ Title V program for children with special health care needs. Rita and Donna work in collaboration with ICAAP staff members Kathy Sanabria, MBA, and Jana Stringfellow-Estell, to provide facilitation QI Team support.



The ICAAP/DSCC Medical Home Team

## 10. Update from Children's Health Center, Gurnee, IL

by Jon Ashworth, MDiv, MA, LPC, ICAAP Consultant and QI Team Facilitator

Children's Health Center (CHC) was part of the initial phase of the Illinois Medical Home Project. Funding for phase 1 of the project was provided by the Maternal and Child Health Bureau from July 2004 through June 30, 2006.

However, seeing the vital importance of working together to continue to develop the practice as a medical home practice, the CHC Quality Improvement Team (headed by Lead Physician Dr. Sara Parvinian) has continued to meet and make progress, continuing their work from July 2006 up to the present time. The team is continuing to implement the PDSA (Plan-Do-Study-Act) cycle for quality improvement.

Recently, CHC upgraded their care coordination by increasing the number of staff dedicated to care coordination from one to two. Included in this upgrade is the addition of a bilingual care coordinator. Also recently, one of the DSCC Care Coordinators, Shannon Jones (from the Rockford regional office, CHC's region), joined CHC's QI Team, as a partner with the team.

Some of the current efforts that the QI Team is pursuing include:

- Identifying physician referral (transition) resources for children approaching adolescence/adulthood
- Introducing families to medical home/care plan opportunities as early as possible
- Helping families write a care plan for their child
- Partnering with other agencies in the surrounding communities that may be able to support/empower CHC families
- Streamlining and fine tuning interoffice communications regarding serving families and children with a medical home/care plan

In partnership with her fellow physicians at CHC, along with a great support staff and dedicated parent partners, Dr. Parvinian is continuing to pave the way for the continued integration/infusion of the medical home vision into the practice at CHC.

## 11. Building Community-Based Medical Homes for Children

by Jennifer Marks Frantz, MPH, Manager, Medical Home Quality Improvement Programs, Division of Children with Special Needs, American Academy of Pediatrics, and Kathleen Sanabria, MBA, PMP, Project Director, Illinois Chapter of the American Academy of Pediatrics

### Medical Home Model

Medical home, also called patient-centered care, is the model for 21st century primary care, with a goal of addressing and integrating high quality health promotion, acute care, and chronic condition management in a planned, coordinated and family-centered manner. The medical home model has the potential to resolve issues contributing to the primary care crisis and to improve the quality of care for patients facing a fragmented health system. The American Academy of Pediatrics (AAP) describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.<sup>1</sup> This model was developed to promote the implementation of evidenced based practices by the provision of family centered care, care coordination, and continuous quality improvement at the primary care practice. Universal medical home implementation is a key strategy to promote the health and well-being of all children and youth.

### United States Child Health Statistics

The medical home model is designed to improve the quality of health promotion, acute care, and chronic condition management. Currently there is a need for increased access to medical homes for children and youth, particularly those with special needs. According to the 2004 National Survey of Children's Health (NSCH) sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration, only 46% of children/youth (ages 0-17) receive health care that meet the AAP's definition of medical home. In addition, only 58.8% of children/youth (ages 0-17) reported receiving medical and dental preventative care visits over the past 12 months. Parents of children with special health care needs (CSHCN) aged 1-5 are particularly likely to report concerns about their children's development. Of CSHCN in this age group, 43.7 percent are reported to be at moderate or high risk of developmental delay, compared to 21.8 percent of children without special health care needs; only 63.8% of children and youth with special needs were screened early and continuously for physical and developmental delays and other health concerns. Moreover, despite the widespread acknowledgement that care coordination is one of the cornerstones of a medical home, only 57.8%

of respondents receive help from their personal doctor or nurse with follow-up after the child sees a specialist or gets specialized services/equipment, even though 83.3% of these respondents reported having a personal doctor or nurse. Furthermore, only 65.6% of families reported receiving enough time with their personal doctor and nurse and only 66.9% were always explained things in a way that the children and parents could understand.<sup>2</sup>

According to the National Survey of Children with Special Health Care Needs (CSHCN), only 57.4% of CSHCN whose families are partners in decision-making were satisfied with the services that they received, 47% reported receiving coordinated, comprehensive care within a medical home, and only 62% reported receiving family-centered care from health providers (National Survey of Children with Special Health Care Needs 2005/06).<sup>3</sup> Nationally, while children and youth with special health care needs make up 13.9% of the child patient population, they account for 80% of child health care costs.

### Illinois Child Health Statistics

In Illinois, 451,000 or 14% of children ages 0 to 17 years have special health care needs. These children and their families are vulnerable to the complexities of the health care system and the stresses of their child's medical condition. According to the 2005/06 National Survey, families of only 60.3% of Illinois CYSHCN partnered in decision making at all levels and were satisfied with the services they received. In Illinois, only 45.1% of CYSHCN are estimated to have received coordinated, ongoing comprehensive care within a medical home, a 5% decrease from the 2001 Survey. Other Illinois statistics of interest include:

45,096 children under 18 received Social Security Income (SSI) as of 12/06 (<http://www.ssa.gov/policy/docs/stat-comps/supplement/2007/7b.html>)

23,019 children were served by the Division of Specialized Care for Children (DSCC) in 2006 (<https://perfddata.hrsa.gov/mchb/mchreports/TVISReports/UI/Snapshot/snapshot.aspx?statecode=IL>)

17,767 children with Individual Family Service Plans received Early Intervention services the end of October 2007. 59.7% of these children were insured by Medicaid/All Kids. 84.86% of 3 year olds leaving EI were referred to local education agencies Illinois Department of Human Services, Bureau of Early Intervention.

322,534 children had Individualized Educational Plans during the 2005-6 school year (<http://nces.ed.gov/programs/stateprofiles/sresult.asp?mode=full&displaycat=1&s1=17>)

1,349 children participated in child-specific Home and Community-Based 1915(c) Medicaid waivers; 574 were enrolled in the waiver for children who are medically fragile and technology dependent (Waiver year 2006) (<http://www.hfs.illinois.gov/hcbswaivers/tmfc.html>)

600 children were enrolled in a new waiver program for children with developmental disabilities (waiver year 2008) ([http://www.hfs.illinois.gov/hcbswaivers/supports\\_cyadd.html](http://www.hfs.illinois.gov/hcbswaivers/supports_cyadd.html))

175 children participated in the Children's Residential Waiver for children with DD (waiver year 2008) (<http://www.hfs.illinois.gov/hcbswaivers/cyadd.html>)

### Equitable Health Care and Racial and Ethnic Disparities

The medical home model has the potential to promote equitable health care and address racial and ethnic disparities in access to care.<sup>4</sup> According to the Commonwealth Fund 2006 Health Care Quality Survey, patients with medical homes were more likely to receive reminders to obtain preventative care, were more likely to receive preventative screenings, reported better managed chronic conditions and health outcomes, and experienced better coordination between primary and specialty care providers. Furthermore, racial and ethnic differences in receiving health care were reduced or eliminated when adults received care within a medical home.<sup>5</sup>

### Primary Care Provider Shortages

The medical home model may ameliorate some of the driving forces behind the crisis in primary care. Over the past 10 years there has been a downward trend of physicians going into general primary care, of those who do, more are entering specialty tracks. There are fewer physicians staying in primary care practice, and a significant percentage of those are about to retire over the next couple of decades. The two most commonly cited reasons for the decline of primary care physicians are money and lifestyle. Student loans, lower salaries and low or no payment for services are major financial stressors for physicians in primary care practices.<sup>6</sup> Another factor is the limited amount of time the primary care provider has with their patients even though most feel that more time would be an effective strategy to improve the quality of care. Furthermore, over half of these respondents felt that in order to improve quality, their income would be less because of the lack of payment for many services provided outside the visit.<sup>7</sup> Nevertheless, acceptance of the medical home model, which is based on quality, adequate payment, specialization in the comprehensive care of the patient, and

family professional partnerships, by payors and others may be one solution to this ever-growing crisis. Additionally, studies have shown that increased access to primary care compared to specialty care increases both quality and reduces cost of primary care both in the US and abroad.<sup>8</sup>

### Addressing Unmet Needs

The Illinois Chapter of the American Academy of Pediatrics (ICAAP) is committed to advancing the development of medical homes by providing primary care providers with training and support to implement the model in their practices. Through expansion of the pilot Illinois Medical Home Project and implementation of the new **Building Community-Based Medical Homes for Children Program**, ICAAP and DSCC will provide interested practices and clinics with quality improvement team facilitation support to help organize their practices and guide their key clinical activities to build medical homes for all. This initiative will not only support implementation to improve the quality of patient care but also has the potential to increase recognition and payment of services through the National Committee for Quality Assurance's Physicians Practice Connection evaluation program on Patient Centered Medical Home.<sup>9</sup>

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- <sup>7</sup> Audet AJ, Doty MM, Shamasdin J, Schoenbaum SC. Physician's views on quality of care: findings from the Commonwealth Fund national survey of physicians and quality of care. Commonwealth Fund. 2005.
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- <sup>9</sup> National Committee for Quality Assurance. Physician Practice Connections Patient-Centered Medical Homes. National Committee for Quality Assurance website. Retrieved November 19, 2008.

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IN ILLINOIS, ONLY 45.1%  
OF CYSHCN ARE ESTIMATED TO  
HAVE RECEIVED COORDINATED,  
ONGOING COMPREHENSIVE CARE  
WITHIN A MEDICAL HOME,  
A 5% DECREASE FROM THE 2001  
NATIONAL SURVEY.

45,096 ILLINOIS CHILDREN UNDER  
18 RECEIVED SSI AS OF 12/06

<http://www.ssa.gov/policy/docs/statcomps/supplement/2007/7b.html>

Please feel free to copy and share this Newsletter with others. The Newsletter also appears in PDF format and can be downloaded at <http://www.illinoisap.org/medicalhome.htm>

**17,767 CHILDREN WITH INDIVIDUAL FAMILY SERVICE PLANS RECEIVED EARLY INTERVENTION SERVICES THE END OF OCTOBER 2007. 59.7% OF THESE CHILDREN WERE INSURED BY MEDICAID/ALL KIDS. 84.86% OF 3 YEAR OLDS LEAVING EI WERE REFERRED TO LOCAL EDUCATION AGENCIES ILLINOIS DEPARTMENT OF HUMAN SERVICES, BUREAU OF EARLY INTERVENTION.**



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**1,349 CHILDREN PARTICIPATED IN CHILD-SPECIFIC HOME AND COMMUNITY-BASED 1915(c) MEDICAID WAIVERS: 574 WERE ENROLLED IN THE WAIVER FOR CHILDREN WHO ARE MEDICALLY FRAGILE AND TECHNOLOGY DEPENDENT (WAIVER YEAR 2006)**

<http://www.hfs.illinois.gov/hcbswaivers/tdmfc.html>



*“Kindness is the language which the deaf can hear and the blind can see.”*

*– Mark Twain*



*Finding doctors and health care providers for children just got easier with the free Web-based Illinois Provider Directory for Children with Special Health Care Needs. The Provider Directory was created by ICAAP and DSCC to help families and providers utilize the Internet to easily locate specialists serving Illinois children by geography, specialty area, or services needed.*

Follow these links to use the searchable statewide Provider Directory:

[www.illinoisaap.org](http://www.illinoisaap.org)

→ Find a Pediatrician

→ Provider Directory for Children with Disabilities

#### Questions?

Contact ICAAP for more information:

Jana Stringfellow-Estell

312-733-1026, ext 209

[info@illinoisaap.com](mailto:info@illinoisaap.com)

## Membership in the directory is free!

All you need is an e-mail address.

To become a member go to the Provider Directory Web site and click on the “Provider Login” button. The online application is quick and easy to complete. Also you can login to the directory and update your listing anytime.

# Get started on improving your office. Sign up today!

ICAAP offers several office- and hospital-based educational programs focused on universal topics and emerging issues in pediatrics. The majority of these programs provide FREE CME credit to participating physicians and some also provide nursing contact hours. They are presented in your office to your entire practice staff and focus on systems change, staff roles, how to identify local resources, and other practical issues. All programs are presented by trained faculty (physicians and/or nursing professionals) using a peer-to-peer educational model.

Please check all programs that interest you:

- Illinois Medical Home Model Quality Improvement Assistance**
- Get in the Zone Asthma Education**
- Reaching our Goals: Immunization Provider Education**
- The Truth Behind the Ads**
- Early Hearing Detection and Intervention**
- Hepatitis B Vaccine—the Importance of the Birth Dose**
- Bright Smiles from Birth: An Oral Health Education Program**
- Tobacco Use Prevention and Cessation: Strategies for Primary Care Providers**
- Enhancing Developmentally Oriented Primary Care (EDOPC)**
  - Developmental Screening and Referral**
  - Early Autism Detection and Referral**
  - Perinatal/Maternal Depression Screening**
  - Social/Emotional Screening and Referral**
  - Domestic Violence Screening**

Name	
Degree	
ICAAP Member	<input type="checkbox"/> yes <input type="checkbox"/> no
Institution/Practice	
Office Manager/Support Staff Contact	
Address	
Suite/Apt.	
City, State, Zip	
Office Phone Number	Home Phone Number
Fax Number	
E-mail	

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

- Chicago Department of Public Health
- Division of Specialized Care for Children
- GlaxoSmithKline
- Illinois Children's Healthcare Foundation
- Illinois Department of Healthcare and Family Services
- Illinois Department of Public Health
- Michael Reese Health Trust
- The Autism Program
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau
- The Aetna Foundation
- The W. Clement & Jesse V. Stone Foundation
- Chicago Community Trust

For more information on a specific program, please visit <http://www.illinoisaaap.org> or call the chapter at 312-733-1026.

**To register, cut this page off and fax to:  
312-733-1791**

or mail to the ICAAP office at the address on the Table of Contents page. An ICAAP staff member will contact you to enroll your practice into the desired program.