



North Arlington Pediatrics

North Arlington Pediatrics (NAP) is a large suburban pediatric practice with 8 pediatricians serving **more than 10,000** patients. The practice began the quality improvement process in February of 2005 when they chose to participate on the Illinois team in the second National Medical Home Learning Collaborative sponsored by NICHQ. The practice then received a mini-grant through the Illinois Medical Home Project in January 2006 to augment the improvement efforts already started. The practice's initial Medical Home Index score was 45 out of a possible 200. With the help of 3 parent partners, the facilitator, and guidance provided by the Learning Collaborative and the Illinois Medical Home Project, the quality improvement team assisted the practice in strengthening the quality of their Medical Home, primarily in the areas of Organizational Capacity, Chronic Condition Management, Care Coordination, and Quality Improvement. Within one year the practice had improved their Medical Home Index results to a score of 119 out of 200.

The practice started by improving staff education regarding the medical home. Staff now are more aware of special needs, have better recall of a family's special needs and inquire about those needs. By identifying CYSHCN in the computer system, accommodations can be made when the family is making an appointment and on the day of that appointment. Care continuity has been improved by identifying CYSHCN through the use of a complexity index, the establishment of written care plans, visit summaries and care coordination activities.

The practice has made the most progress in the area of Care coordination. Care coordination did not exist in a formal sense. Care was managed as issues arose, often leading to reactive rather than proactive intervention. Utilizing a laptop computer, staff are better able to put in place written care plans. The parent partners took the lead in developing the template for the care plan, using their experience to put together a form which would be useful to all members of the healthcare team, including sub-specialist, therapists, schools, and of course, families and the primary care physician. The written care plan is re-evaluated at subsequent visits where needs are discussed and an action plan is formulated. Most recently the practice has expanded the services of their part-time nurse/care coordinator to a full-time position. The nurse/care coordinator now spends all of her time assisting and coordinating care for children with special health care needs and their families in their medical home. She works with the providers, families, community organizations and other health care service providers to ensure that referrals are made, services received and needs are met.

The team also developed a "Home Medical Record" to help families organize their child's information. This ring binder contains dividers to help organize information, as well as provide information on community support services and other general information. The Home Medical Record is given out to families with their initial care plan. Families are actively involved in the development of their care plan and establish the level of involvement they wish from the practice.

The practice has also established a Healthy Living program, coordinated by one of the practice nurses. The Healthy Living Clinic was developed in response to the rising rate of childhood obesity. The goal is to identify at-risk children at an early age so that appropriate measures may be taken to avoid obesity and obesity-related disorders. The program is designed to help children and families attain a healthier lifestyle by emphasizing the importance of good eating habits and exercise. Education, individualized care, and close follow-up are essential in helping our families establish and maintain healthy lifestyles.

By embracing the concept of the medical home, the practice has accepted a validated standard of quality in which to improve the delivery of healthcare. With the help of their parent partners, the practice is able to design and implement effective changes in areas of the practice where specific gaps or needs exist. By using the PDSA cycle to implement small tests of change, this approach allows the practice to assess the effectiveness of their changes before implementing them on a wider scale. Quality improvement is an on going process and by making small but steady changes the practice continues to improve the quality of care they provide; not just for children and youth with special health care needs but for all patients and families.

For more information contact Laurie Vlcek, North Arlington Pediatrics Medical Home Care Coordinator at:
North Arlington Pediatrics
1340 N. Arlington Heights Rd.
Arlington Heights, IL.
Email: medhome@ameritech.net
Phone: (847) 253-3600.