# CICERO HEALTH CENTER

Building Medical Homes for the ACHN
Learning Session 4
Health Center Storyboards

# Team Members

- **Lead Physician:  Dr. Anne Jacobson**
- **Pediatric Nurse: Lydia Weber**
- **Social Worker: Matilde Torres**
- **MOA: Michelle De la Torre**
- **Clerk: Maritza Rosado**
- **ACHN Project Facilitator: Donna Scherer**

# PCMH Standard 1: Enhance Access and Continuity

- This year the team developed an informational brochure (English and Spanish versions) to share with families that outlines clinic hours, lab hours, nurse walk-in hours, important phone numbers and the name of their PCP and Care Team contacts.
- Staff also developed a Prescription Refill form and implemented a successful procedure where families submit their refill requests by dropping it in a locked drop box.
  - Staff obtain the refill forms on a daily basis and process the requests.
- 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.

# Standard 2: Identify and Manage Patient Populations

- Staff have created several different patient lists based on diagnosis (CP, DD, Asthma, DM and Medically Complex) but use of these lists to identify CSHCN has been sporadic, at best.
- Developmental Screening efforts have been fully operationalized and staff are successfully screening children at  9, 12 and 30-36 months using the ASQ.
- The referral process lacks feedback from the CFC
- The CCHHS/ACHN is in the process of developing a written policy to facilitate transitioning youth to adult health care.

# Standard 3: Plan and Manage Care

- The MHN *Connect* Portal process for initiating follow-up calls has been successfully transitioned to Medical Assistant staff who log the data into the portal and assign the PCP Team.
- Follow-up for County Care patients is now implemented the same for all IL Health Connect patients using the MHN portal.

# Standard 4: Provide Self-Care Support and Community Resources

- Staff have developed a one-page Resource Page for Providers to share important community services and resources with families.
- They are also working on creating a Resource Bulletin board that can provide information about local resources and services to families.
- The nurse care managements visits have been successful in expanding efforts to educate families and encourage more self-care support.

# Standard 5: Track and Coordinate Care

- Staff are tracking EI referrals and ED/Hospital Discharge follow-up as means to provide more coordinated care.
- Staff have attempted to utilize data to track the number of children who failed the ASQ screen but due to staff shortages this effort has fallen short.

# Standard 6: Measure and Improve Performance

- Practice staff have utilized the Medical Home Index and the Medical Home Family Index as tools to measure their practice improvements and establish new goals for improving the delivery of care.

# Overall Successes

- Staff have established successful procedures for follow-up of Developmental Screening and ED/Hospital discharges.
- They have initiated nursing care management visits which are extremely well received by patients and they have established a successful Prescription Refill process.
- They have recently developed the skills to offer Nebulizer training for parents of children with Asthma and have begun providing the instructional training so that families can better manage their child's asthma at home.

# Overall Challenges/Barriers

- The major challenges have been staffing shortages and the electronic record system limitations.