LOGAN SQUARE HEALTH CENTER

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

Team Members

- **Name of Facilitator: Rita Klemm**
- **Lead Pediatrician: Denise Cunill, MD**
- **Myrna Gutierrez, Parent Partner**
- **Rosa Rangel, Parent Partner**
- **Maria Pena, Administrator**
- **Candida Flores-Matheu, Nurse Coordinator**
- **Patricia Salgado, RN**
- **Deyanira Ruiz, MA**
- **Joyce Alvarado, LCSW, Social Worker**
- **Matilde Torres, Social Worker**
- **Cherie Dalbke, UIC—DSCC Care Coordinator**

PCMH Standard 1: Enhance Access and Continuity

- Children and families coming to Logan Square have an assigned primary care provider and scheduled appointments are with that provider.
- Families are given an informational sheet with office times and after-hours access for care.
- Patients and families benefit from nurse care management visits.

Standard 2: Identify and Manage Patient Populations

- The practice has implemented a standardized 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.
- Provider education on the importance of listing all chronic condition codes.

Standard 3: Plan and Manage Care

- The Depart Summary is given to the patients and families at the end of appointments.
  - Contains the problem list, medications, labs and appointments pending and referrals within CCHHS.
- The Medical Home Network*Connect* portal process is used to manage patient care following hospitalization or ED visits.
  - Staff assigned check the portal and initiate the follow-up contact.
- In addition to hospitals participating in MHN*Connec*t, we are receiving faxes from Lurie Children's and Presence Hospital System on pediatric post-hospital and ED discharges for Logan Square patients. LS designated staff follows-up using the Presence hospital portal system on inpatient hospitalizations, ED visits, and diagnostics to enhance the coordination of care.

Standard 4: Provide Self-Care Support and Community Resources

- Logan Square created a list of community resources to whom the practice frequently make referrals.
- Logan Square's social worker is expanding this list and her knowledge of community resources to share with families.
  - Attends the Local Interagency Council meetings, meets staff from other agencies and shares information.
  - Visits with local community agencies and participates in resource activities.
- A one page list of Resources was developed to share with families when appropriate; Resource Bulletin Board was created.
- Established relationship with local Child and Family Connections.
- The UIC—Specialized Care for Children care coordinator from Regional Office attends QI meetings and provides services.

Standard 5: Track and Coordinate Care

- Logan Square created a Medical Home Neighborhood list of specialists to whom the practice frequently makes referrals.
- Outside referrals are tracked with use of the EMR reminder system and “Post-its” are added to patient charts.
- Internal referrals to CCHHS are tracked using IRIS and Cerner Message Center.
- Nursing staff routinely ask about ED visits since the last appointment at Logan Square.

Standard 6: Measure and Improve Performance

- Completed the Medical Home Index at baseline and follow-up to evaluate improvements and for use in establishing new goals.
- Families were surveyed with the Medical Home Family Index at baseline and follow-up for their perceptions on the provision of care.
- For year one baseline data on the Medical Home Network Connect portal, Logan Square, at nearly 28%, was very close to meeting the State goal of 30% seen for timely visits.
- The practice consistently screens children at 9 months, 18 months and 24 or 30 months through the developmental screening process.

Overall Successes

- Creation of PCMH team—identifying roles in patient care and working together to improve team communication.
- Established a positive connection and working relationship with local CFC.
- Developed standardized and consistent process for Developmental Screening and referral to EI.
- Created a tracking process for specialty referrals.

Overall Challenges/Barriers

- Coordinating care (obtaining reports) is difficult through the various EMR systems and external documentation systems.
- “Capacity” problems limit the available number of appointments for scheduling follow-up appointments.
- Provider staffing has decreased over the last 3-6 months, thereby greatly affecting accessibility and capacity for patients.