MI PCMH Practice Transformation Collaborative

Notes from Learning Session 1 – World Café Activity

This document is a transcription of the key points recorded by teams during the World Café session at Learning Session 1

1. **Who do you need to be working with to make clinical-community linkages most effective for you and for patients?**
   - Patients
   - Families and friends
   - Providers
     - Own office staff
       - Finance time for the team to spend on linkage development
       - Opportunities to get out in the environment/community
     - PCPs
     - Specialists
     - Community health workers
     - Dental clinic
     - Opthalmology
     - Hospital case workers and discharge planners
     - Private duty nurses, SNFs, HH, DME
     - Substance abuse
     - Behavioral health
     - Hospice
     - Case Managers
     - Rx, physical therapy, rehab
     - EMS
     - Urgent care centers
     - Dieticians
   - Resources
     - Law enforcement
     - Insurance providers (private, Medicare, Medicaid)
     - Legal aid
     - Financial planners
     - Tax preparers
     - Child care resources
     - YMCA
     - Pathways (Hub)
     - Fd banks
     - VA and American Legion
     - AmCa Society
     - Commission on Aging
     - Disease associations (Alzheimer's, Breast cancer, etc.)
     - DHS
     - CMH
     - Common Network Services
     - Translation services
     - Housing/homeless coalitions

- Technology solutions (EHR)
- Group homes
- Social organ (senior center, church, etc.)
- Respite workers for caregivers
- Transportation (van-FQHC)
- Schools. Colleges
- Chore providers
- Volunteer programs
- Senior centers
- Food banks, Meals on Wheels
- Parks and Recreation
- Fitness facilities
- Farmers markets
- WIC
- Maternal and infant health centers
- Michigan Rehab Services
- Convenience stores
- City planning department
- IT/EMR providers

2. **How will the medical home model change the type and scope of the services you are providing?**
   - Build a trust relationship between patients, case managers (less so with practice nurse role)
   - SDoH screening -> narrowing down patient needs
   - Focus on the community -> more patient centered linkages -> more relationship development with community resources
   - Provides info to advocate for increased resources at community level
   - Expansion of BH -> surfaces more issues and factors contributing to SDoH, "non-compliant is not a diagnosis" -> Maslow's Hierarchy of Needs
   - Promising model to improve patient quality of life
   - Start to move away from FFS payment model
   - "Medicating" SDoH will be interesting to implement
   - Reporting specific elements for SIM is a challenge
   - -> outreach to eligible patients may be burdensome
   - Transitioning staff to new roles will be a challenge (e.g. CMs reporting outside practice currently)
   - SDoH assessments are more proactive (previously more informal)
   - Driving care management in general
   - SIM + CPCT -> similar standards for CMs across payers (previously targeted patients with coverage for CM)
   - Major challenge: different payments for CC from different payers
   - Risk assessment algorithms: MCL for all patients or just SIM/BCBSM
   - Codes (w/ CPT)- lack of familiarity/experience w/ billing these codes
   - Working w/ EMR vendor- depression screening, being billed for screenings
   - BCBSM- not all self-insured fund CM services, so some providers hesitant to bill -> hard to know what patient OOP will be

- Pushes practices to build capabilities across domains
- Helps with using all staff to highest level of licensure
- Takes focus off of PCP -> other care team members
- Allows for more personalized, intensive services
- More connection to SDoH (screening, working with CHIR)
- Better, more comprehensive "whole person" approach
- Better education and support systems
- Concern: forces practices to target "SIM eligible" patients over others
- Opens up access/availability for PCP to see more patients, or see them sooner (other care team members can take load off of PCP)
- Staffing will be a challenge – less PCP admin work -> more work for others
- Initial outreach to patients and other practices is difficult- no established relationships
- Other providers may have a sense of patient "ownership". Key to get buy-in from PCP and team (significant roll out effort and give people a "say")
- Expanded hours
- Chronic conditions health fairs (expanded availability of services during event
- Goal of "less clicks"
- Patient assessment, including SDoH, via tablet
- Walk-in services
- Bilingual staff and access to translation
- Engagement with family members
- Guest Wi-Fi
- More standard and safe approaches (policies and procedures)
- Facility renovation, or additional facilities (mobile options?)
- Enhanced access: telehealth, home visits, groups visits, expanded hours
- Move from FFS to VBP
- Evidence based programmatic offerings
- Open notes: patients can read labs, physical notes
- Focus on and IT support for outcomes
- Staff engagement in QI efforts

3. **How could relationships and collaboration between PCPs and specialists be strengthened? Between health care providers and uncommon partners (e.g., YMCA, community supports)**
   - Face to face communication
   - Engaging specialists in care transformation activities
   - Easy access to multi-lingual resources
   - Increased feedback loops from specialists/community orgs
   - Common tech platform for PCP/specialist/community orgs
   - Expanding referral communication abilities
   - Build health advocacy among patients
   - Monthly focus on supports available
   - Engaging state HIE for additional trainings on referral loops
   - Contracts with specialists
   - Increased communication with patients

- Uncommon partners must have a champion
- Educate specialists on the "whole" patient
- Engaging pharmacy in the care team/referral process
- Shared communication tool
- Have a common goal, define co-management

4. **How could your health information systems be more connected?**
   - Connecting POs and hospitals (EMR disconnect)
   - Additional connections with out of network providers
   - Insight into mental health (substance abuse info)
   - Specialist participation
   - Community resource connections
   - Connecting disparate file types (common platform)
   - Action triggered work flows
   - Additional health record directory
   - Social needs data integrated to health records
   - User friendly reporting
   - Attribution issues (patients)
   - Support for orgs with limited technical capabilities (i.e. "mom and pops", churches)
   - "Direct address" HIPAA secure email
   - Standardized formats
   - Push vs pull
   - Statewide records release
   - Usable data vs too much

5. **How could you engage the patient and family in our work and "really" incorporate the voice of the patient in all that we do?**
   - Ask patient what matters
     - Motivational interview
     - Establish patient centered goals
     - Who to include?
   - Advanced care planning (end of life)
   - E-visits
   - Team approach
   - Alignment of plans
   - Proper follow up
   - Health LH/cultural competency/ESL resources
   - Assessment of barriers
   - Stratifying patients to encourage to bring family
   - Engage BH!
   - "Bring a Family Member to Appointment" day
   - Group visits (diabetes, kids, moms)
   - Communicate with patients (portal)
   - Survey
   - Caregiver support (emotional, mental)
   - Patient and family advocacy council

- Increased trust in patient/physician relationship
- Peer support
- Social media
- Focus on improvement feedback (what has helped, what has created barriers)
- Create a comfortable environment (less automated, more individualized)
- "What would you like the clinician to know before your next visit?"- build question onto standard workflow for patient navigation
- Reduce barriers for patient to share feedback, allow anonymity
- Physician/care manager/patient collaborate in the room together, "team huddle"
- Value patient time, make sure they are heard
- Board of Directors with active patient/user of services
- Find opportunities to share, follow-up after linkage

6. **Describe how you are educating the community about this new model.**
   - **Within the office:**
     - Practice open house
     - Educational materials
     - Shared goals
     - Staff bios
     - Invite community resources to market themselves in offices
     - Shared plans of care
     - Posters/flyers in providers offices
     - Mailed brochures (for rural communities)
   - **In the community:**
     - Community events
     - Workgroups and subcommittees
     - Colleges and schools of nursing
     - Human services collaborative board meeting
     - News story
     - Senior/teen centers
     - Monthly or annual community meeting
     - Texting, social media
     - Public Health Department engagement
     - Engage employer groups