PCMH Initiative Practice Transformation Objective Menu

REQUIRED OBJECTIVE: Clinical – Community Linkage

Develop documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations which provide services and resources that address significant socioeconomic needs of the Practice's population following the process below:

- Assess patients' social determinants of health to better understand socioeconomic barriers using a brief screening tool with all attributed patients
- Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of referrals made
- As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion

SELECT ONE: PCMH Initiative Practice Transformation Objective Menu

Subcategory	Activity
Telehealth Adoption	• Adopt and use of telehealth services to increase patient access to remote specialty care consults or services.
Improvement Plans from Patient Feedback	• Collect patient experience and satisfaction data on access to care. • Develop of an improvement plan, including outlining steps for improving communications with patients to help patients understand access options. • Demonstrate evidence of improvements made as a result of the data collected and improvement plan.
Medication Management	• Manage medications to maximize efficiency, effectiveness and safety by integrating a pharmacist into the care team and conducting periodic, structured medication reviews.
Population Health Management	• Implement regular reviews of targeted patient population needs including access to reports that show unique characteristics of the Practice's patient population. • Identify vulnerable patients and demonstrate how clinical treatment needs are being tailored, if necessary, to address unique needs.
Self-Management Monitoring and Support	• Use tools to assist patients in assessing their self-management skills (e.g. the Patient Activation Measure or How's My Health). • Implement processes that engage patients to strengthen self-management skills and ultimately improve adherence to a patient's treatment plan.
Care Team Review of Patient Reported Outcomes	• Implement a technology solution that enables capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) such as certified EHR technology or patient registry • Ensure patient reported data is identified for easy care team member recognition and action (as applicable)
Integrated Peer Support	• Integrate peer support into the care team to enhance care management activities such as providing motivational supports and/or leading patient support groups.
Group Visit Implementation	• Implement at least one group visit (sometimes called a cooperative healthcare clinic) for chronic conditions (e.g., diabetes) common to the Practice's attributed PCMH Initiative population.
Patient Portal Access	• Provide access to an enhanced patient portal or personal health record (PHR) that provides up to date health information and includes interactive features allowing patients to enter health information and/or enable bidirectional communication.
Cost of Care Analysis	• Build the analytic capability required to manage total cost of care for the Practice population, including training appropriate staff on interpretation of cost and utilization information and using available data regularly to analyze opportunities to reduce cost.

Integrated Clinical Decision Making	• Develop a formal collaborative relationship with one or more behavioral health and/or substance abuse providers.
	• Implement a shared, integrated clinical decision-making approach which includes:
	  ○ A combined/holistic health assessment, including sharing health information
	  ○ Developing a shared treatment plan and goals
	  ○ Ensuring regular communication and coordinated workflows between clinicians
	  ○ Conducting regular case reviews for at-risk or unstable patients