Strategies for Strengthening Relationships with Existing Partners and Identifying and Exploring New Ones

Peer Coaching Call

September 20, 2017

These presenters have nothing to disclose

Peer Coaching Calls (See website)

- ~~Tuesday, September 19, 2017~~
  - Strategies for Getting Buy-in from the Care Team, Patients, and Partners on Clinical-Community Linkages
- **Wednesday, September 20, 2017**
  - **Strategies for Strengthening Relationships with Existing Partners and Identifying and Exploring New Ones**
- Thursday, September 28, 2017
  - Using Data to Inform Improvement of Clinical-Community Linkages
- Friday, September 29, 2017
  - Time reserved for unique Physician Organization Topics


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Practice
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Peer Coaching Call
July 18-21, 2017
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Recording...
Participants (7)
Speaker:
Panelist: 7
TD Tam Duong (me)
Unmute
JN Julia Nagy (Host)
CD coleen dewey
SK Shawn Kintigh
SB Sue Butts-Dion
SG Sue Gullo
TL Teri Lamia
Attendee: 0 (0 displayed)
Chat
from missy davison to all participants:
I am the incentives coordinator and am attending today as a representative. Looking forward to having additional members of our care team attend in another meeting and can share their insights.
from dave stetson to All Panelists:
awesome to have us all as panelists to participate and share collaboratively, nice touch!!
Send to: All Participants
Send
Connected

Peer Coaching Call/Webinar Aims

- Share successes
- Share challenges
- Share learning
- Get support from others
- Hear new ideas
- Share documents, products, or develop together (can facilitate this if know in advance!)
- Time and space dedicated to you!

Welcome

- Your Role
  - Attend with a spirit of transparency, curiosity and willingness to share
  - Feel free to “vote with your feet” if the dialogue that others engage in is not helpful to you—register for another one because the conversations will likely be very different on each!

Review of Tuesday, September 20th

- Strategies for Getting Buy-in from the Care Team, Patients, and Partners on Clinical-Community Linkages

A Team-definition

"A team is a group of people working together ***to achieve a common purpose*** for which they ***hold themselves mutually accountable***."

Teams varied from 1-2 individuals to a full team of PCP, Nurse Manager, MA, CHW, Care Manager and/or Coordinator

Scholtes, P., Joiner, B., & Streibel, B. (2003). *The TEAM Handbook* (3rd ed., pp. 1-2). Madison, WI: Oriel Incorporated

Attributes of Highly-effective Teams

- The purpose and objectives of the team are clear.
- The roles of team members are clear.
- A climate exists that seeks and supports participation of all team members.
- A climate exists that supports problem solving and learning.
- Decision making processes are clear.

Strategies for Getting Buy-in from the ***Care Team***

mixed models- some care manager and or care coordinator/full team integrating all roles for success

how many staff members do you have available to utilise to the top of their license.

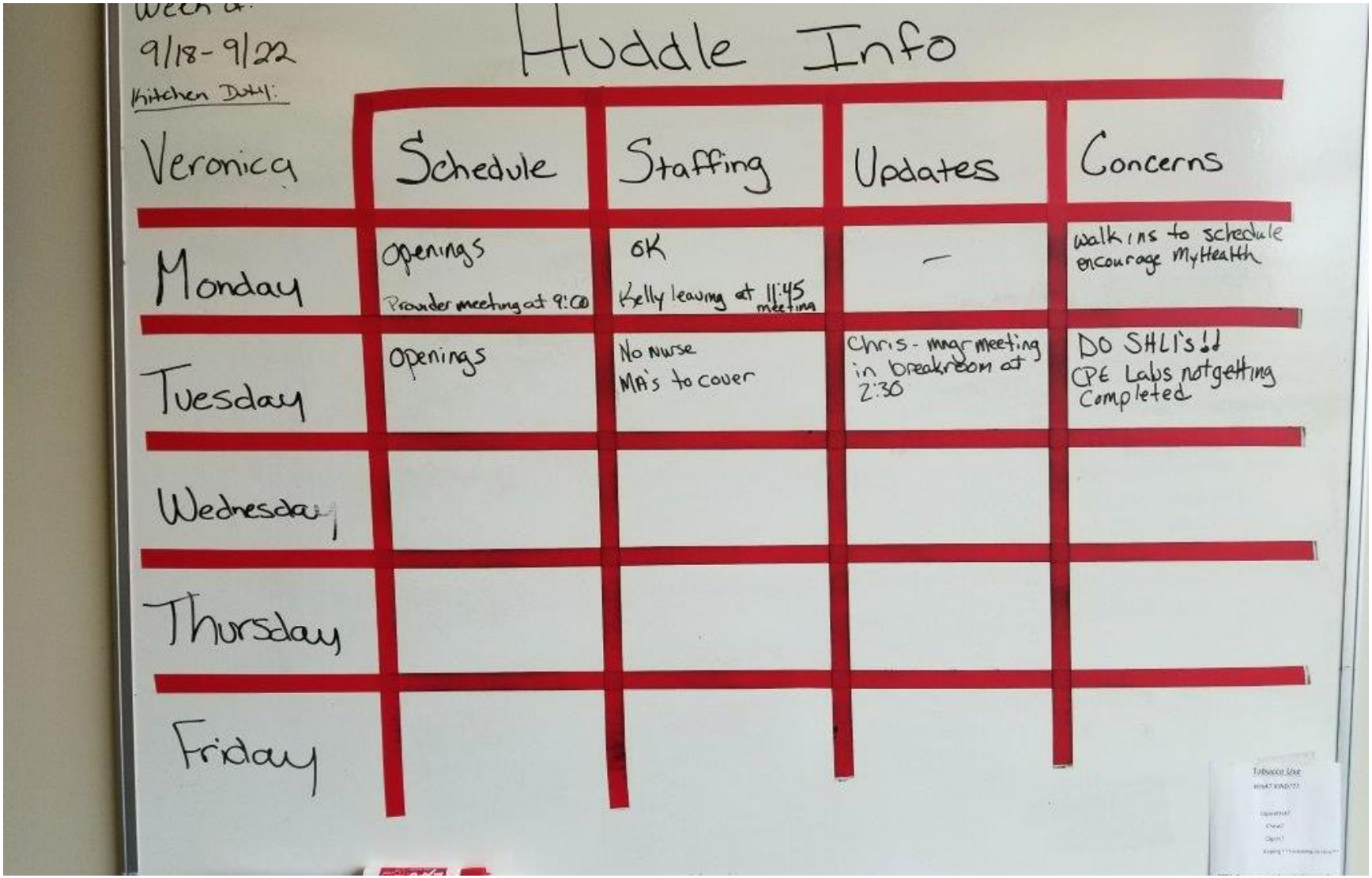
What is the work? How does the team know?

Do you do huddles? Discuss patients for the week?

We go to the back to discuss (where PCP and others are)- post in break room fostering communication amongst all players. Dry erase board in lunch room with sections (Christine will send a picture!)

Huddle- patients needs focused.

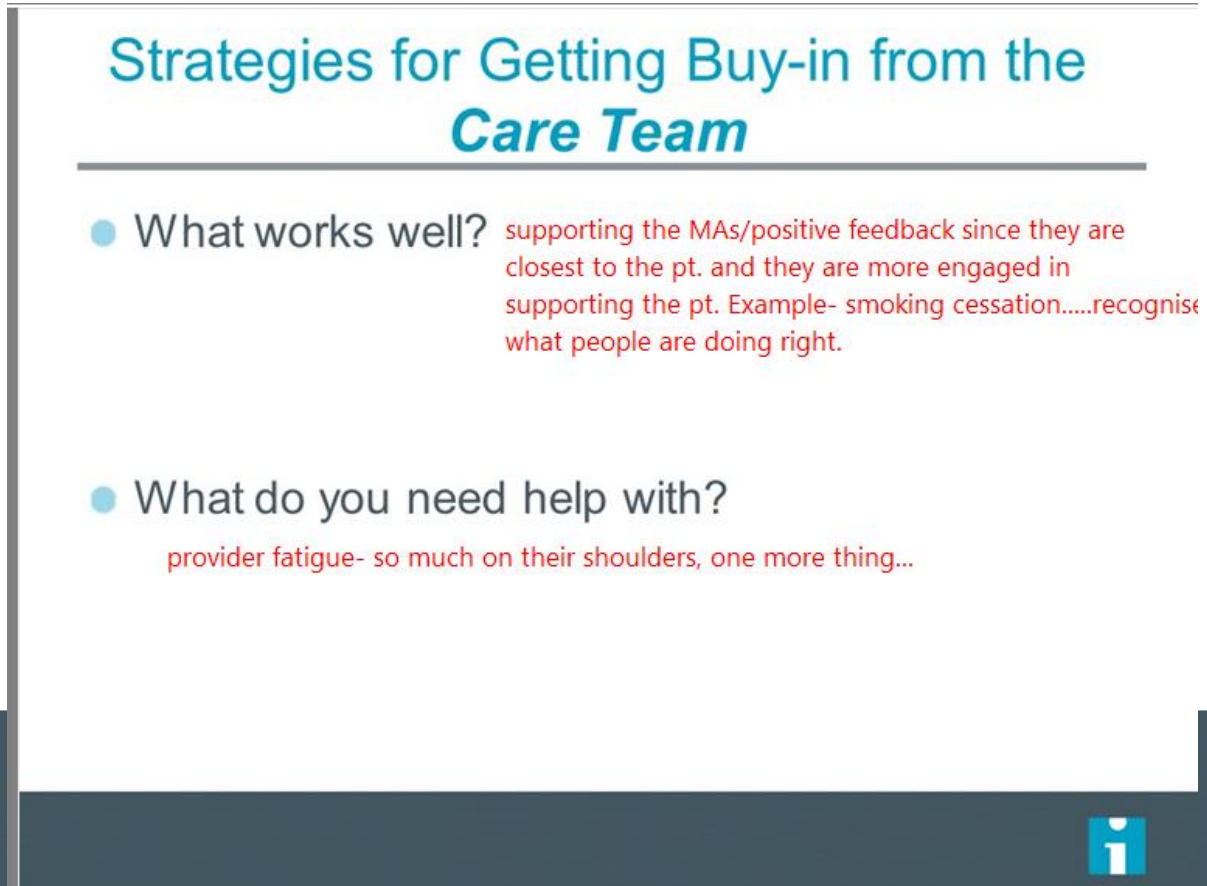
Huddle- interoffice phone system, regular meetings with Care and Case Manager, CHW's.



Christine.Sterenberg@spectrumhealth.org

Strategies for Getting Buy-in from the ***Patient and Family***

- What works well?
- What do you need help with?



From the chat..

- My Health- electronic communications that some love
- We are working on how to close the loop with the CCL's...we are having success with connecting the patient with the needed service but are finding it difficult to get feedback from the resource/linkage.
- Group visits for education on chronic disease. The service is available, but we can’t seem to get patients to sign up.
- Training on PATH = Personal Action Toward Health

Strategies for Getting Buy-in for **CCL**

- What CCLs can be defined as good partners?
  - *Senior Centers*
  - *Community Mental Health*
- What works well?
- What do you need help with? *Struggle with communication*

Wednesday, September 20th

Strategies for Strengthening Relationships with Existing Partners, and Identifying and Exploring New Ones

Clinical Community Linkages

SELF-ASSESSMENT

Choose the point value that best describes the level of care that currently exists in your practice. The levels present key aspects of patient-centered care, showing various stages in development.

- The levels are represented by points that range from 1 to 12. The higher point values within a level indicate that the actions described in that box are more fully implemented.

Linking patients to supportive community-based resources	...is not done systematically.			...is limited to providing patients a list of identified community resources in an accessible format.			...is accomplished through a designated staff person or resource responsible for connecting patients with community resources.			...is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person.	
	1	2	3	4	5	6	7	8	9	10	11	12

Let’s Discuss

- What is working?
- What do you need help with?

Clinical Community Linkages

DEFINITION

"Creating sustainable, effective linkages between the clinical and community settings can improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies."

Types of clinical-community linkages include:

- Coordinating services at one location
- Coordinating services between different locations
- Developing ways to refer patients to resources

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

Clinical Community Linkages

GOALS

The goals of clinical-community linkages include:

- Coordinating health care delivery, public health, and community-based activities to promote healthy behavior
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services
- Promoting patient, family, and community involvement in strategic planning and improvement activities

Collaborations between clinical, community, and public health organizations offer a win-win scenario for participating organizations, clinical teams, and patients.

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

What do Effective Clinical-Community Linkages Offer?

- Patients get more help in changing unhealthy behaviors
- Clinicians get help in offering services to patients that they cannot provide themselves
- Community programs get help in connecting with clients for whom their services were designed

Thank You!

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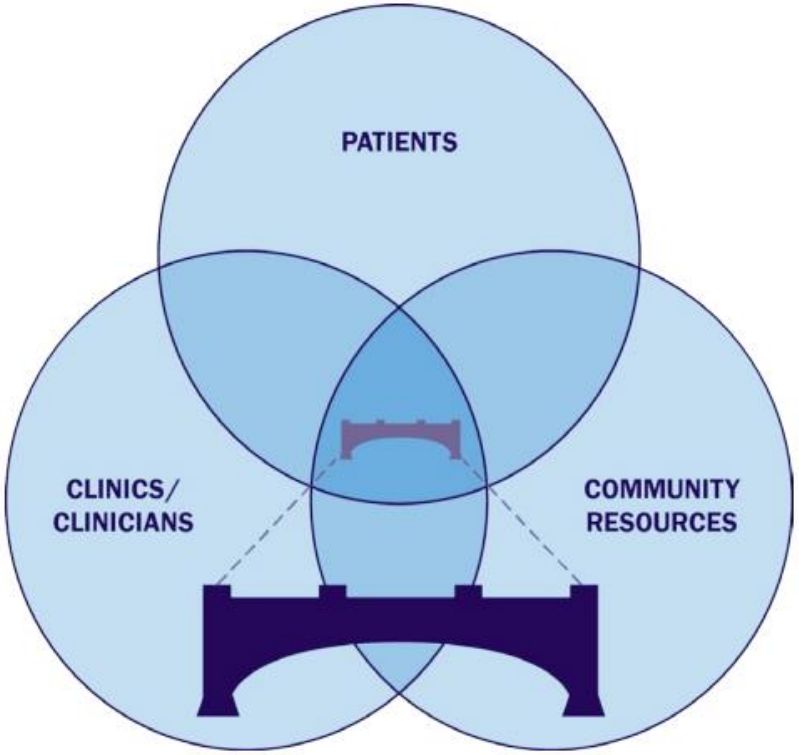
Resources from LS1

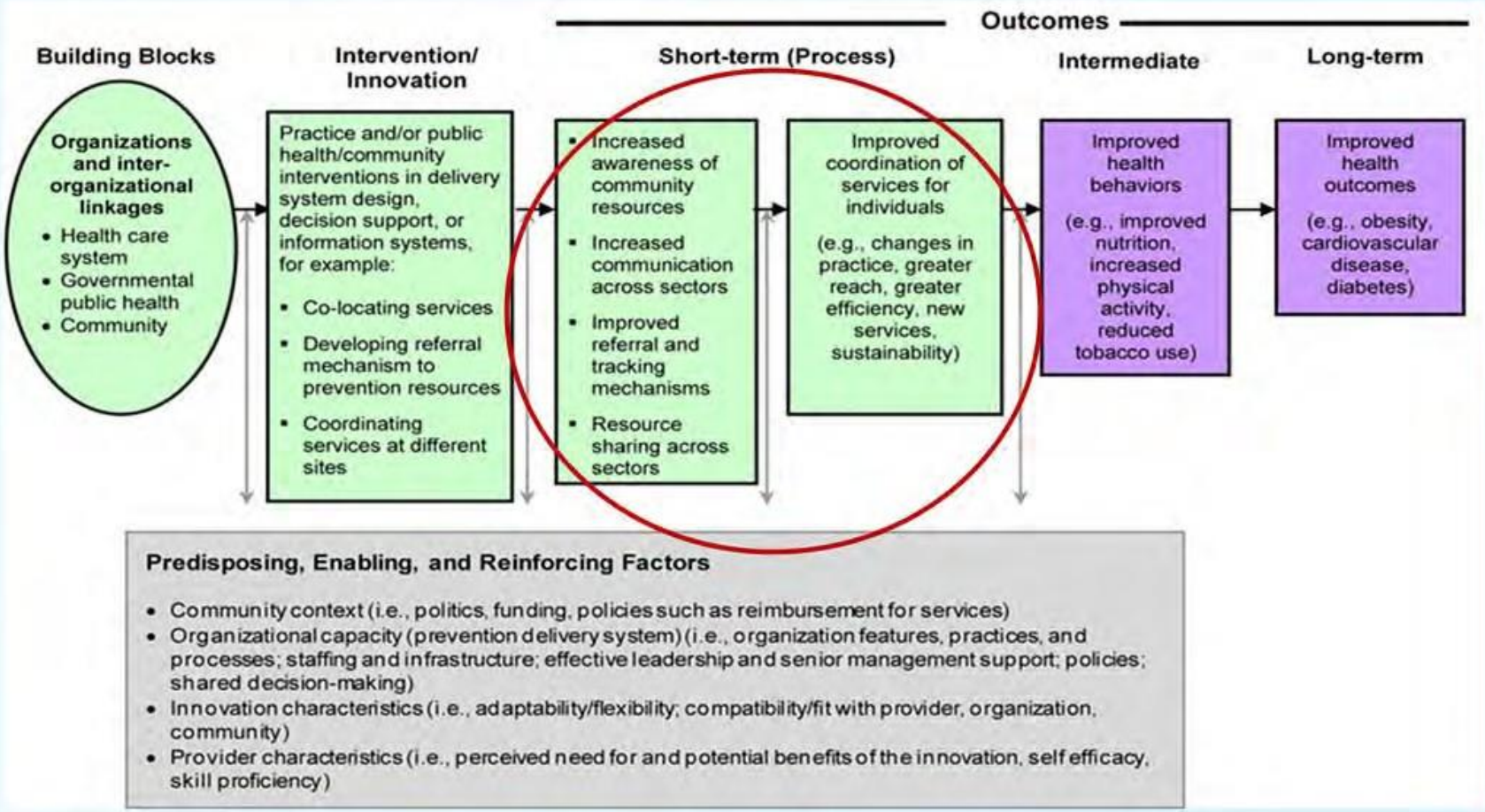
Clinical Community Linkages

Figure A-1. Conceptual framework of linkages between clinics and community resources for delivering clinical preventive services



https://www.ahrq.gov/sites/default/files/publications/files/ccreroadmap.pdf

Example Community-Clinical Linkages Framework



Source: Agency for Healthcare Research and Quality (AHRQ). (Prepared by Porterfield D, Hinnant L, Kane H, et al.). Linkages Between Clinical Practices and Community Organizations for Prevention: Final Report. 2010.

SIM-PCMH Initiative Clinical-Community Linkage Goals

- Coordinated care across not only clinical settings, but also with community organizations and resources

- Community-centered solutions to upstream factors of poor health outcomes

http://www.michigan.gov/documents/mdhhs/SIM_PCMH_Initiative_CCL_3-1-17_553205_7.pdf

SIM- PCMH Initiative Clinical-Community Linkage (CCL) Objectives

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 (SDoH) 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.

http://www.michigan.gov/documents/mdhhs/SIM_PCMH_Initiative_CCL_3-1-17_553205_7.pdf

Care Manager and Care Coordinator Roles In CCL

CCL Job Duties	Care Coordinator	Care Manager
Complete comprehensive assessment of patient's health conditions, treatments, behaviors, risks, supports resources, values, preferences and overall service needs. This can be done in coordination with other members of the care team		X
Develop comprehensive, individualized care plans; coordinate services required to implement the plan; provide continuous patient monitoring to assess the efficacy of the plan; periodically re-evaluate and adapt the plan, as necessary.		X
With the care team, determine the patient's needs for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations and **need for support services**.	X	
Jointly create and manage the individualized plan of care with the patient/family, care team and community based organizations, that outlines the patient's current and longstanding needs and goals for care and addresses coordination needs and gaps in care.	X	
Ensure patients have timely and coordinated access to medically appropriate levels of health and support services and continuity of care.		X
Provide a range of client-centered services that link patients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible; coordination and follow-up of medical treatments; patient-specific advocacy and/or review of utilization of services.		X
Build and maintain community linkages.	X	X
Demonstrate knowledge about community resources by providing information on the availability of and, if necessary, coordinate these services that may help support patients' health and wellness or meet their care goals.	X	
Align resources with patient and population needs.	X	

Four Strategies for CCs and CMs to Develop and Maintain Clinical Community Linkages

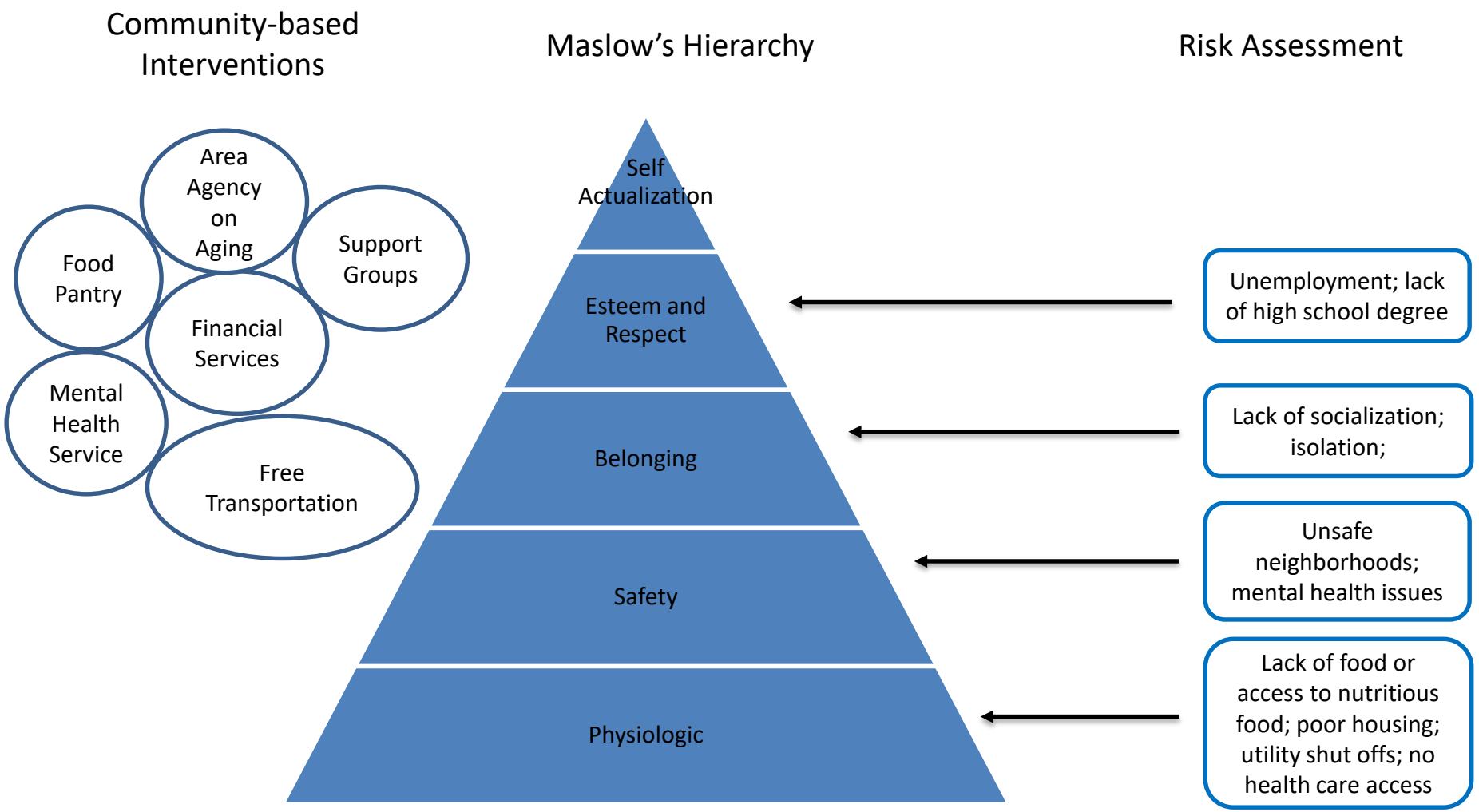
- Patient Assessment of Social Determinants of Health
- Community Assessment
- Establish defined relationships with community partners
- Referral, follow up, and outcome of the referral

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - PATIENT ASSESSMENT

Participate in the design, implementation and interpretation of patient need assessments

- Comprehensive assessment
  - Income
  - Patient-reported depression
  - Education
  - Financial resource strain
  - Intimate partner violence
  - Social connections or isolation
  - Stress
  - Eligibility for public and private benefits
- Data sources
  - Standard screening tools
    - Brief SDOH Screening Tool –*State Innovation Model*
    - ACES – *Adverse Childhood Experiences*
    - Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE) *National Association of Community Health Centers*
    - Self Sufficiency Matrix *Michigan Coalition Against Homelessness*
    - Adult Clinical Social History *Warren County Ohio Combined Health District*

Social Determinants of Health



Adapted from A road map to address the social determinants of health through community collaboration. *Pediatrics* (2015). 136(4).

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - COMMUNITY ASSESSMENT

Participate in the design, implementation and interpretation of community level assessments

- Community Asset Mapping
  - Boundaries
  - Housing
  - Signs of decay and/or pollution.
  - Parks, recreational areas
  - Transportation
  - Health and social service agencies
  - Economics
  - Protective services
  - Religious facilities
  - Schools
  - General
  - Character of the community
  - Subjective feeling
  - Community needs
  - Gaps in service
  - Community Strengths

Community Connections

QUESTIONNAIRE

Community Resource Name: Interview By:

Questions	Responses
What evidence-based programs do you offer for patients with _____?	
Please tell me more about the program.	
Who is the main contact person for the program and how can I get hold of them?	
Do you currently work with other medical groups or practices, or have you in the past?	
Do you have a way to securely send and receive electronic fax information?	
Are there eligibility criteria for your program and if so, how do you assess it?	
Do you have some kind of financial assistance for low-income patients?	
Can you send me program information that I can share with my practice?	

On a scale of 1 to 10...	Poor				Average					Excellent
How patient-centered does this organization seem?	1	2	3	4	5	6	7	8	9	10 Very
How confident would I feel sending my patients to organization—do I think they will receive high-quality and credible assistance?	1	2	3	4	5	6	7	8	9	10
How prepared does this organization seem to be for working closely with a medical practice like ours?	1	2	3	4	5	6	7	8	9	10

Notes:

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/obesity-toolkit/obtoolkit-tool7.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - RELATIONSHIPS

Establish relationships with community partners

- What is the perfect marriage of information the community partner needs to initiate contact and information only a clinician can provide?
- Who will fill out the referral form and at what point during the patient encounter?
- How will the referral form be entered and passed through the system; and how will this referral be documented in the patient's chart?
- What are some of the HIPAA-compliant considerations?

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - REFERRALS

"Patients are often informed that they will be 'referred' but have little or no influence on the process or knowledge about who they will be referred to or how long the expected wait will be."

Murray M. Reducing waits and delays in the referral process. *Fam Pract Manag* 2002;9(3):39-42.

Spell out mutual expectations and responsibilities, such as:

- Which patients are appropriate to refer
- What information is needed before and after a referral
- Roles for both parties after the referral

Don't rely on patients to relay information

- Share important information directly with the other office
- Get information sent directly back to you. Make sure you get a full report prior to patient's next visit

Consider language barriers

- Include information on your patient's language assistance needs when making the referral

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

- Make sure the patient understands the reason for the referral
  - Explain why the patient needs to be seen by someone else, and what might happen if he or she is not seen
  - Ask about and address any concerns or fears

- Offer help with the referral
  - Ask patients if they would like your office to make the initial phone call
  - Ask patients about transportation and other barriers to their completing the referral. Discuss how they could overcome these barriers

- Provide clear instructions
  - Provide easy-to-understand instructions verbally and in writing
  - Explain the referral process fully

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

Follow up – patient completes referral:	Follow up - patient does not complete the referral:
Confirm and document that the patient successfully completed the referral	Reinforce that you feel the patient could benefit from the community linkage/referral
Obtain information on the result of the referral and document in the medical record	Review barriers
Make sure the patient receives the results of any tests or screenings, even normal results	Provide support as needed to facilitate completion of the referral steps
Provide patient with positive feedback for completing the referral steps	

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

- Gather feedback
  - patients experience

- How effective was the linkage in achieving the desired outcome/service?

- Tip: Determine whether the patient needs additional referrals

https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

Effective Referrals and Collaboration

- Prevents fragmentation
- Reduces the likelihood of clients falling through the cracks between disparate and unconnected agencies
- Fosters a more holistic view of the client
- Helps strengthen linkages and communication among various agencies providing different services

https://www.ncbi.nlm.nih.gov/books/NBK64299/

Evaluating Community-Clinical Linkages

Focus on the linkage

- Improving coordination systems
- Improved referral and tracking mechanisms
- Resource-sharing across sectors

https://www.cdc.gov/dhdsp/pubs/docs/cb_march_2014.pdf

Next step…….homework (IHI)

1. Identify one organization that you currently work with and want to improve your collaboration with, or one new organization.
2. During May, can you test the following:
    1. Establish a meeting together
    2. Agenda- review the steps in the referral process from both of your perspectives and map the process steps. Discuss and share what each of your organization's goals and processes are.
    3. Identify a patient who has interacted (or may interact) and ask them to map the process steps from their perspective.
    4. Present what you learned at the June Learning Session answering the questions:
        1. What works well?
        2. What surprised you?
        3. What will you do differently (test)?

Questions?

- General State Innovation Model-PCMH Initiative questions can be sent to: SIMPCMH@mail.mihealth.org
- Visit the SIM website at: www.michigan.gov/sim
- Questions regarding Care Management and Care Coordination can be sent to: micmrc-requests@med.umich.edu
- Visit the Michigan Care Management Resource Center at www.micrmc.org