Michigan Department of Health & Human Services

Community-Clinical Linkages

State Innovation Model

Patient Centered Medical Home Initiative

Webinar Recording

Note: will require you to enter registration information to access recording

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Background

- The PCMH Initiative Community-Clinical Linkage (CCL) objective was designed as a focus for providers which reinforces and compliments the efforts of Community Health Innovation Regions (CHIRs)
- The requirement focuses on three important aspects of CCLs in clinical environments which represent the minimum capabilities needed to get started with CCLs
- The CCL efforts of both CHIRs and participating PCMHs support two important goals of the State Innovation Model (SIM):
  - Coordinated care across not only clinical settings, but also with community organizations and resources
  - Community-centered solutions to upstream factors of poor health outcomes
- The Practice Transformation component of the PCMH Initiative payment model provides some financial resources to providers in adapting/developing infrastructure and building capability needed to implement CCL components in a clinical environment
- Implementation timing of the CCL requirement for PCMHs was slated for late 2017 (November) rather than the first half of the year (which would be more consistent with other Initiative requirements) to better line up with CHIR development of CCL programs
  - PCMHs outside SIM regions will follow the same requirements and timeline from a high level perspective, but the depth and breadth of CCL implementation will be different than providers that are partnering with CHIRs

Refresher- PCMH Initiative Participation Agreement

- Practice Requirement, By *November 1, 2017*: "Complete the PCMH Initiative's required Practice Transformation Objective (clinical-community linkage), including submitting practice transformation progress reporting on a semi-annual basis."

- Practice Requirement, *During the Initiative*: "Complete the required Practice Transformation Objective (as defined in the Participation Agreement), demonstrate progress toward completing the Practice Transformation Objective selected from the Initiative's menu of objectives, and report progress in a manner defined by the Initiative on a semi-annual basis."

- PO Requirement (As Applicable): "Submit practice transformation progress reporting on a semi-annual basis for participating Practices which choose to pursue Practice Transformation Objectives in partnership with the PO."

- "Practice Transformation Objective" or "Transformation Objective" refers to the care delivery enhancements and/or quality improvement activities defined by the Initiative that a Practice undertakes as to improve quality, improve health outcomes (including patient experience), improve access to care, and/or reduce health care costs. A list of Transformation Objectives is provided in Appendix F of the Participation Agreement and on the SIM Care Delivery webpage.

Refresher- PCMH Initiative Transformation Payment

- PCMH Initiative Practices will receive practice transformation payment to support needed investment in practice infrastructure and capabilities at a PMPM rate of $1.25 for all Medicaid beneficiaries attributed to the Practice by the Initiative
- To receive the PMPM practice transformation payment, Practices must complete the required Practice Transformation Objective within the timeframe specific in the Participation Agreement, demonstrate progress toward completing the Practice Transformation Objective selected from the Initiative's menu of objectives, and report progress in a manner defined by the Initiative on a semi-annual basis
- Failure to report practice transformation progress, complete the required Practice Transformation Objective, or demonstrate progress toward completion of the selected Transformation Objective will result in corrective action up to and including payment sanction

Refresher- PCMH Initiative CCL Objective

"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:

1. Assess patients' social determinants of health (SDoH) to better understand socioeconomic barriers using a brief screening tool with all attributed patients.
2. 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.
3. 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."

Deep Dive: PCMH Initiative CCL Objective
Assessing Patients' Social Determinants of Health

- The intent of brief social determinants of health screening is to establish a routinized process through which providers identify (in an actionable manner) social barriers their attributed patient population is facing
- Use of the word brief reflects the idea that implementing this screening component of the CCL requirement should result in a concise look at patients' social needs rather than an in-depth assessment
- Accordingly, the brief screening will not take the place of deeper, more comprehensive assessment processes utilized as part of care management or mandated by other programs, but it should inform those processes
    - For Example: A patient whose brief screening reveals one or more social needs should receive follow-up assessment and care coordination support to link the patient to resources (part two of the requirement)
- The PCMH Initiative will provide a template screening tool to participating providers, however this tool can be altered to match local needs (e.g. changing how questions are phrased, varying how questions are categorized in domains, choosing different formats to administer the screening such as an EHR template or incorporating into existing patient questionnaires etc.)
    - PCMHs are discouraged from completely removing one or more of the topics/domains contained in the template, although combining and/or rearranging domains is permitted
    - PCMHs located in SIM/CHIR regions should work with their CHIRs (typically through a PO) to use the brief screening tool the CHIR in your area has/is developing

Deep Dive: PCMH Initiative CCL Objective

Assessing Patients' Social Determinants of Health

Domain	Question	Response	
Healthcare	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby?	Yes	No
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	Yes	No
Food	Do you ever eat less than you feel you should because there is not enough food?	Yes	No
Employment & Income	Do you have a job or other steady source of income?	Yes	No
Housing & Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent, or share?	Yes	No
Utilities	In the past year, have you had a hard time paying your utility company bills?	Yes	No
Childcare	Does getting child care make it hard for you to work, go to school or study?	Yes	No
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	Yes	No
Transportation	Do you have a dependable way to get to work or school and your appointments?	Yes	No
Clothing & Household	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.	Yes	No
General	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No

Deep Dive: PCMH Initiative CCL Objective
Assessing Patients' Social Determinants of Health

- To successfully implement the CCL screening requirement, participating PCMHs should be actively implementing a screening plan and screening procedure on November 1, 2017 which addresses the entire attributed population
  - The Initiative does not expect all patients to be screened by November 1st, that date is the beginning of the screening process (screening a full attributed population for the first time may take up to 18 months)
  - The screening plan should, at a minimum, address:
    - The circumstances/visits during which PCMHs will administer screening
    - Anticipated time it will take to complete the first screening across the attributed population
    - The timing and process for ongoing patient screening
    - The approach to monitoring screening completion and closing screening gaps
  - The screening procedure should, at a minimum, address:
    - How and by whom (if applicable) screening is administered
    - How and by whom results are interpreted
    - How/where results are stored and made available to team members
    - The follow-up steps that are taken when screening reveals a social need
- During semi-annual progress reporting, the Initiative will request a copy of a PCMH's screening plan and screening procedure, the screening tool being administered and a total count of patients screened

Deep Dive: PCMH Initiative CCL Objective
Provide Linkages to Community-Based Organizations

- Based on the outcome of brief social determinants screening, participating PMCHs are expected to provide linkages to resources which can support patients in overcoming social barriers
- The concept of a CCL goes beyond traditional referrals to other healthcare providers, extending the "neighborhood" of organizations collaborating to support a patient's needs to a broader group of community organizations partners
- The expectation of a CCL also goes beyond traditional community referrals in the sense that PCMHs providing linkages are expected to not only initiate the linkage, but support patients in accessing resources and monitor the linkage to determine if resource successfully supported patient needs
- A PCMH's CCL methodology (described on the next slide) may in large part be developed with support from a PO and/or a CHIR (if a PCMH is located within a SIM/CHIR region)
    - Many communities have already invested in creating common processes for CCLs and PCMHs are strongly encouraged to work collaboratively to adopt and leverage these community approaches, especially with CHIRs
    - The Initiative anticipates that PCMHs located in the same community (affiliated with the same CHIR) or PCMHs that are part of the same PO will likely employ similar CCL approaches to leverage shared concepts and expertise across organizations

Deep Dive: PCMH Initiative CCL Objective
Provide Linkages to Community-Based Organizations

- To successfully implement the CCL linkage requirement, participating PCMHs should be actively implementing a community-clinical linkage methodology on November 1, 2017 which, at a minimum, includes the following:
  - CCL roles and responsibilities within the PCMH, with a special focus on team members that are responsible for making and coordinating linkages to supportive resources
  - Communications approach for ensuring all team members, beyond those directly responsible for screening and/or linkages, are informed and engaged in the PCMH's approach to CCLs
  - Training approach (or approaches varying based on role/responsibility) for team members focused on the PCMH linkage methodology and available patient resources within a PCMH's community
  - Partnership approach to ensuring relationships are established and maintained with resource providers and programs that support patient social needs
  - Linkage process (or procedure) which conveys how linkages are initiated (information provided to patients, contact with resource providers/programs, supporting patients in access resources etc.) and how linkage monitoring (patient reminders, follow-up with patients to determine linkage outcome etc.) is conducted
  - Documentation approach for ensuring the process and outcome of the CCL methodology are appropriately stored, ensuring the information is made available to team members and for quality improvement
- During semi-annual progress reporting, the Initiative will request documentation describing the CCL methodology above (PCMHs can choose to include additional detail in their CCL methodology)

Deep Dive: PCMH Initiative CCL Objective
Quality Improvement Activities

- Similar to the aim of quality improvement (QI) activities for all PCMH services, the intent of the quality component of the CCL requirement is to ensure PCMHs have the opportunity to meaningfully measure and improve the effectiveness of their CCL methodology over time
- Information collected and stored through the documentation approach defined in a PCMH's CCL methodology should be leveraged to conduct CCL QI in a data-driven manner
- The Initiative anticipates and encourages PCMHs to pursue QI activities related to CCL as part of their existing quality framework and processes, rather than creating a separate/new QI approach
- The Initiative also anticipates and encourages PCMHs to pursue some aspects of CCL QI in partnership with other organizations (PCMHs, PO, CHIR etc.)

Deep Dive: PCMH Initiative CCL Objective
Quality Improvement Activities

- To successfully implement the CCL quality improvement requirement, participating PCMHs should be actively implementing quality improvement for their screening process and linkage methodology shortly after November 1, 2017 which, at a minimum, include:
  - Review of the SDoH screening process, including monitoring screening completion, revealing screening gaps and circumstances/visits where screening is more and less effective, and ensuring the screening procedure is operationally efficient and being implemented consistently
  - Review of linkages documentation, including the resources referred to and the outcome of those linkages, to determine the effectiveness of partnerships and reveal the need for additional resource partnerships or collaboration with resources providers/programs to improve patient outcomes
- During semi-annual progress reporting, the Initiative will request documentation describing the CCL quality improvement activities above (PCMHs can choose to include/pursue additional CCL QI)

Next Steps

Today's webinar is only the beginning of ongoing CCL conversation and implementation efforts!

- Q&A During Today's Webinar
- Q&A Through Email Following the Webinar
- Additional CCL Discussion During the March Quarterly Update (March 23rd)
- Discussion and CCL Activities April Practice Transformation Learning Collaborative Event (April 3rd-4th)