PCMH User Group Highlights 11/8/17

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

Lisa Nicolaou from NPO presented on the SIM CHIR Clinical Community Linkages (slides):

- CHIR – Community Health Innovation Region is the 10-county region of Northern Michigan. Clinical Community Linkages is part of the State Innovation Model (SIM) that is separate from the PCMH work and looks at Social Determinants of Health, but working toward incorporating the tool into the SIM PCMH practices.
- Social Determinants of Health:
    - 50-60% of health outcomes are attributed to social and environmental factors.
    - Works in conjunction with the move from fee-for-service to fee-for-value.
- Community Clinical Linkages:
    - standardized process by which individuals with needs are screened
    - ability to electronically exchange data related to needs and referrals
    - aggregation of data across different disciplines addressing social determinants of health
- **Community Connections** is the name of the resource developed to take referrals and assist individuals in being able to meet their basic needs
    - Standardized way to assess individuals for unmet health related social needs (questions provided by the state)
    - Information sharing
    - web enabled screening and referral tool – demonstration given
        - benefits of a web-based tool:
            - Standardized process
            - Patient confidentiality
            - Information sharing across the region
            - Decreased administrative burden
            - Tool is built to accommodate growth in information and sharing needs across multidisciplinary team and expansion for the future
    - Navigation teams to assist complex patients
    - Evidence based approach – Pathways community HUB, there are 3 HUBS in the CHIR
        - Community Connections HUB team:
            - Intake worker/call center
            - Community Health Worker
            - Social Worker
            - Registered Nurse
            - HUB Coordinator
    - Practice integration and collaboration
- After explaining the tool, Lisa discussed the progress of the 7 pilot practices
    - 159 screenings have been done since 10/24
    - 87 individuals identified needs
    - 47 individuals referred themselves to the HUB for assistance.
    - Munson Family Practice is the Pilot Practice for the Traverse City Area
- Questions:

- How do you explain to patients either why they are being screened or why they are NOT being screened, as this is a Medicaid project?
  - Right now, the focus is on Medicaid, but the hope is that it grows to all patients.
  - The practices are provided with a script of what to say to patients who are/are not getting screened. (Misty from MFP stated this is working for her practice)
- What happens to the information, does the practice know if a referral has been made to the HUB team?
  - Yes, the practice will receive a notice via secure direct email that the patient was referred.
  - An issue may be that the practice, unless someone is constantly monitoring that email, will not know that the referral has been made while the patient is still at the office.
  - Misty from MFP stated that their email is checked once a day.
  - One of the Pilot Practices is trialing the process of asking the patient when they return the tablet if there is anything they need help with TODAY.
- When will this program be rolled out to the rest of the practices?
  - The pilot program is working to test the software, develop best practices and working to bring the rest of the practices into the program.

Cathy Carter from Kids Creek Children's Clinic presented on how her practice has implemented a Community Resource Risk Assessment Tool – on paper. (slides)

- This works for documentation for PCMH Domain 10.5
- Cathy gave a brief description of the process.
  - In June 2017 they began handing out a paper screening tool at all yearly well-child visits.
  - At the same time, they provide the patient with a paper copy of the "Community Resource Guide" to take home with them for reference.
  - The paper tool is completed by the parent and then reviewed by the provider that is seeing them that day.
  - A Clinical staff member then enters the information into the EMR and the front desk scans the actual paper document into the patient's chart.
- Cathy showed the tool that they are using.
- Cathy then showed screenshots of documentation, what a provider referral looks like and how she pulls the registry reports from her EMR. (see slides)
- The providers have been able to work this into their process, and have made 14 referrals to their Care Manager. Cathy does think this number is low, and that more referrals were made, and are working on better documentation from the Care Manager when someone is referred for resources.

Both Mistie and Cathy think that more people need assistance with social determinants of health and that these life issues can interfere with healthcare.

PLEASE NOTE: If you plan to attend the next meeting either in-person or telephonically, please either email kelliott@npoinc.org or call NPO at 231-421-8505 to RSVP. After we receive your RSVP, we send you an Outlook appointment. Please bring in parking garage tickets for validation.

2018 meetings dates will be set soon…..thank you.