10.0 Linkage to Community Services

Goal: Expand the PCMH-Neighborhood to include community resources. Incorporate use of community resources into patients' care plans and assist patients in accessing community services.

8 total capabilities
All capabilities applicable to: Adult and Peds patients

Applicable to PCPs and specialists.
When patient is co-managed by PCP and specialist, roles must be clearly defined regarding who is responsible for ensuring patients receive needed community services.

10.1

PO has conducted a comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units

PCP and Specialist Guidelines:

a. The review may take place within the context of a multi-PO effort
b. Review should include health care, social, pharmaceutical, mental health, and rare disease support associations
    i. If comprehensive community resource database has already been developed (e.g., by hospital, United Way) then further review by PO is not necessary
    ii. Review may include survey of practice units to assist in identifying local community resources

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Discuss review process with PO representation at the visit. • United Way or other formal databases will count	

10.2 - Required

PO maintains a community resource database based on input from Practice Units that serves as a central repository of information for all Practice Units.

PCP and Specialist Guidelines:

a. The database may include resources such as the United Way's 2-1-1 hotline, and links to online resources.
b. At least one staff person in the PO is responsible for conducting a semiannual update of the database and verifying local resource listings (PO may coordinate with Practice Unit staff to ensure resource reliability)
    i. During the update process, consideration may be given to including new, innovative community resources such as Southeast Michigan Beacon Community's Text4Health program
    ii. It is acceptable for staff to not verify aggregate listings (such as 2-1-1) if they are able to document how often the listings are updated by the resource administrator
c. Resource databases are shared with other POs, particularly in overlapping geographic regions
d. Portion of database includes self-management training programs available in the

community

Required for PCMH Designation: YES	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo examples in the database	

10.3

PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations

PCP and Specialist Guidelines:

a. Practice or PO in collaboration with practice is able to provide a list of organizations providing services relevant to their patient population in which collaborative, ongoing relationships are directly established
    i. PO in conjunction with practice has conducted outreach to organizations and held in-person meetings or face-to-face events, at least annually, that facilitate interaction between practices and agencies where they discuss the needs of their patient population
b. Collaborative relationships must be established with selected agencies with relevance to patients' needs
c. Collaborative relationships need to be established directly with the individual agencies (not via 2-1-1) and involve ongoing substantive dialogue

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Example of relationship • PO in conjunction w/ PU has conducted outreach to organizations	

10.4

All members of practice unit care team involved in establishing care treatment plans have received training on community resources and on how to identify and refer patients appropriately

PCP and Specialist Guidelines:

a. Training may occur in collaboration with community agencies that serve as subject-matter experts on local resources
b. Training occurs at time of hire for new staff, and is repeated at least annually for all staff
c. Practice unit care team is trained to empower and encourage support staff to alert them to patient's possible psychosocial or other needs
d. PO or Practice Unit administrator assesses the competency of Practice Unit staff involved in the resource referral process at least annually. This may occur in conjunction with community agencies.
    i. For example, practice unit staff are able to explain process for identifying and referring (or flagging for the clinical decision-maker) patients to relevant community resources
    ii. Practice Unit is able to demonstrate that training occurs as part of new staff

orientation

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• What training did you receive in developing a process for partnering in community resources for patients? • How did this training improve your process for connecting patients with community resources?	

10.5

Systematic team approach is in place for assessing and educating all patients about availability of community resources and assessing and discussing the need for referral

PCP and Specialist Guidelines:

a. Systematic process is in place for the practice unit team to educate new patients and all patients during annual exam (or other visits, as appropriate) about availability of community resources, and assessing and discussing the need for referral
    i. Assessment and education process must include intake form or screening tool related to social determinants of health, followed up with conversation in which patients are asked whether they or their family members are aware of or in need of community services
    ii. Practice support staff are empowered to alert practice unit staff to possible psychosocial and other needs
    iii. For example, Practice Units may develop an algorithm (or series of algorithms) to guide the assessment and referral process
    iv. Additional information about available community resources should be disseminated via language added to patient-provider partnership documents, PO or Practice Unit website, brochures, waiting room signage, county resource booklets at check-out desk, or other similar mechanisms

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Practice to show tools used for educating patients on community resources • How are a patient's need for resources assessed? What screening tools are utilized?	

10.6

Systematic approach is in place for referring patients to community resources

PCP and Specialist Guidelines:

a. Practice Unit must be able to verbally describe or provide written evidence of systematic process for referring patients to community resources.
    i. For example, systematic process may consist of standardized patient referral materials such as a "prescription form", computer-generated printout that details appropriate sources of community-based care, or other documented process or tools.
    ii. Assessments that identify a patient with need for referral are documented in the medical record to enable providers to follow-up during subsequent visits

iii. Patients should have access to national and local resources that are appropriate for their ethnicity, gender orientation, ability status, age, and religious preference, including resources that are available in other languages such as Spanish, Arabic, and American Sign Language.

iv. For example, if Practice Units within a PO have a great deal of diversity within their patient population, the PO may amass specific information about services for those diverse patient groups. Practice Units may also share information about resources for diverse groups.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• What does the referral process look like and who is involved? • Are appointments made for patients? (Dedicated staff member)	

10.7

Systematic approach is in place for tracking referrals of high-risk patients to community resources made by the care team, and making every effort to ensure that patients complete the referral activity

PCP Guidelines:

a. Practice units have the responsibility to identify those patients who are at high risk of complications/decompensation for whom referral to a particular agency is critical to reaching established health and treatment goals.
b. Referrals to community resources should be tracked for high-risk patients. Practice Units are encouraged to create a hierarchy to ensure that vital services (such as referrals to mental health providers) are being tracked appropriately.
c. The purpose of tracking the referrals is to ensure that these high-risk patients receive the services they need.

Specialist Guidelines:

a. Practice units have the responsibility to identify those patients who are at high risk of complications/decompensation for whom referral to a particular agency is critical to reaching established health and treatment goals.
b. Referrals to community resources should be tracked for high-risk patients. Practice Units are encouraged to create a hierarchy to ensure that vital services (such as referrals to mental health providers) are being tracked appropriately.
c. Specialists must ensure that PCPs are notified about referrals to community resources for high-risk patients.
d. The purpose of tracking the referrals is to ensure that these high-risk patients receive the services they need.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Demo how follow-up occurs with high-risk patients. What are examples of "high-risk" regarding community resources for the practice?	

10.8

Systematic approach is in place for conducting follow-up with high-risk patients regarding any indicated next steps as an outcome of their referral to a community-based program or agency.

PCP and Specialist Guidelines:

a. Patients may be held partially responsible for the tracking process. For example, Practice Units may use technology such as Interactive Voice Response (IVR) for patients to report initial contact and completion, develop a "passport" that patients can have stamped when they complete trainings or attend a support group, or use existing disease registries such as WellCentive to track community-based referral activities.
b. Process includes mechanism to track patients who decline care and obtain information about reasons care was not sought.

Required for PCMH Designation: NO	**Predicate Logic: 10.7**
PCMH Validation Notes for Site Visits	
• Systematic process for follow up w/high risk patients regarding next steps	