2019 SIM PCMH Initiative Summit

NOVEMBER 12, 2019 | 8:30 AM - 3:30 PM

KELLOGG HOTEL & CONFERENCE CENTER | EAST LANSING

Welcome and Overview

KATIE COMMEY, MPH

SIM CARE DELIVERY LEAD

Agenda

7:30 - 8:30	Registration, Continental Breakfast and Networking
8:30 - 8:40	Welcome/Context Setting/State Kick-Off
8:40 - 9:40	Plenary: "Sustaining the Gains Through Smart Delivery & Cost-Effective Care"
9:40 - 10:50	Concurrent Morning Breakout Sessions Lessons from a Partner State: Building Strong Partnerships Healthier Communities: What Works to Make Real Change Acting on SDoH Data: Beyond Screening
10:50 - 11:00	Morning Break
11:00 - 12:00	Medicaid Health Plan Panel
12:00 - 1:00	Lunch

Agenda, cont.

1:00 - 2:10	Concurrent Afternoon Breakout Sessions Evaluation Results Adverse Events: From Trauma to Resiliency Adolescent Depression: Presentation, Diagnosis, and Treatment
2:10 - 2:20	Afternoon Break
2:20 - 3:30	Next Steps and Alternative Payment Models
3:20 - 3:30	Wrap-Up and Closing Remarks

Disclosures

There is no conflict of interest for anyone with the ability to control content for this activity.

Continuing Education Nursing and Social Work 5.5 CE Contact Hours

Participants who successfully attend the entire one-day conference and complete the online CE request process including required evaluation with email address will earn 5.5 Nursing CE contact hours.

This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) ONA # 22485

Successful Completion for Nursing and Social Work Contact Hours

- ✓Attendance at the entire program
- ✓Sign in sheet
- ✓Complete the evaluation form: access MDHHS SIM PCMH Initiative Summit registration web page or click here

  - An email will be sent to the email address provided with your certificate
  - Note: to request a non-CE certificate, use the above link
  - QR Code located on your table to complete evaluation of today's SIM PCMH Initiative Summit

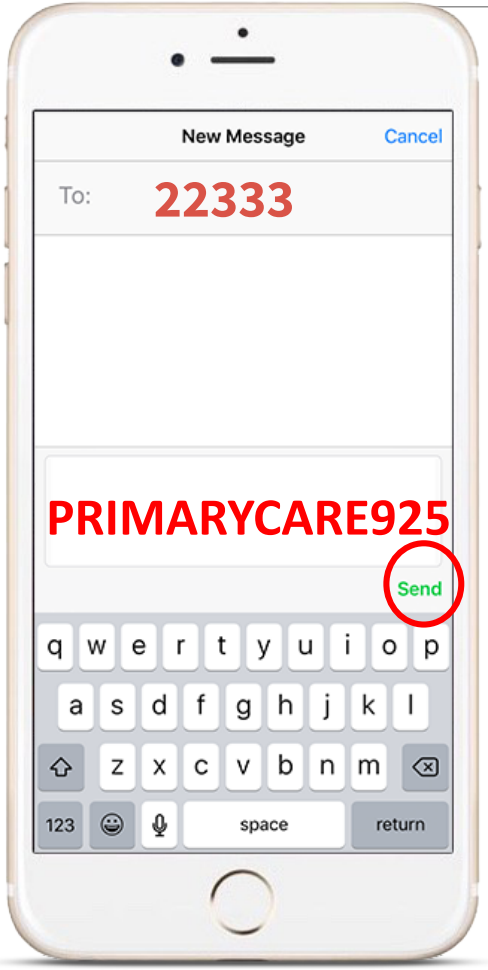
SIM PCMH Initiative Summit Survey

Android Users and IPhone Users (iOS 10 or older): In the Google Play Store/App Store, Search for “qr code reader” and download the app of your choice. We have found that the second app (Lightning QRcode Scanner) has minimal ad and privacy foortprint. Open the app and point it at the QR code. Once the image has been recognized, select “Open Link” on the orange button on the bottom.

IPhone Users (iOS 11+): If you’ve purchased or updated your phone’s operating system since September 19, 2017, you have a QR scanner built into your phone’s camera. Simply point the camera at the code, and once the image is recognized, open the link.

Poll Everywhere

Step 1

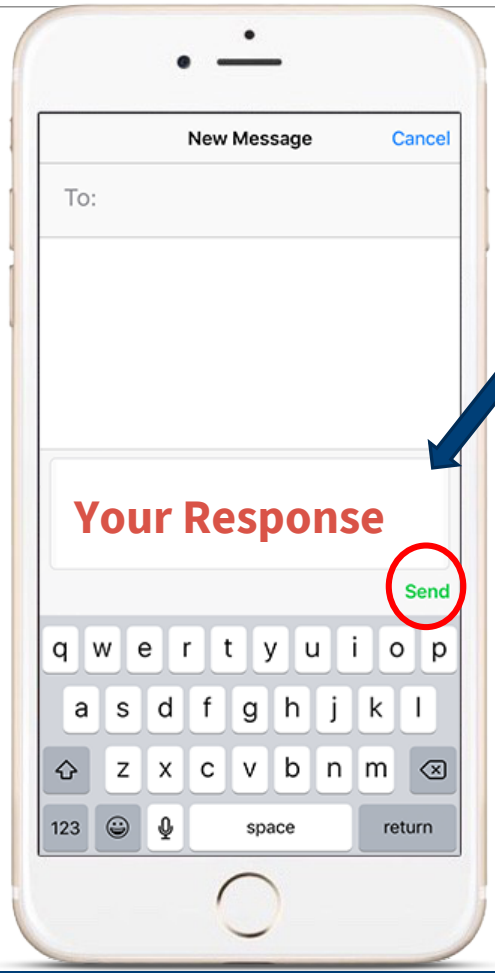


Then you will receive a text message that says…

You've joined PRIMARYCARE925's Session (PRIMARYCARE925)

Note: If you do not receive this message, you are not in Poll Everywhere.

Step 2



Here is where you enter your poll response…

A
B
C
D

Send

SIM MDHHS State Innovation Model

Who do we have in the room ?

A. Clinical care team member
B. Practice or PO Administration team member
C. Payer/health plan representative
D. Community health partner (community organization representative or CHIR backbone organization)
E. State partner or SIM PCMH State support team staff
F. Other stakeholder

Sustaining the Gains Through Smart Delivery and Cost-Effective Care

STACEY BARTELL, MD

ASCENSION PROVIDENCE FAMILY MEDICINE RESIDENCY

Learning Objective

Explain perspectives on the future of primary care and the factors that will position organizations for success.

“Innovation comes from people who take joy in their work.”

- W. Edwards Deming, The New Economics

Telling the Story in Three Parts

1. Sharing and celebrating SIM success
2. Exploring the components of an advanced primary care practice
3. Assessing resources for sustainability

1. Sharing and Celebrating SIM Success

Michigan's History of Multipayer Primary Care Demonstrations*

2012-2016: Multipayer Advanced Primary Care Practice (MAPCP) CMS Demonstration or "Michigan Primary Care Transformation Project (MiPCT)" (with Priority Health, BCBSM, Blue Care Network, Medicaid, Medicare) – 350 practices

2016-2019: State Innovation Model (SIM) PCMH Initiative (with the State of Michigan and its eleven Medicaid Managed Health Plans) – 332 practices

2016-2021: Comprehensive Primary Care Plus (CPC+) (with BCBSM, Priority Health, Medicare) – 450 practices

(*The University of Michigan Multipayer Primary Care Initiative has served at the behest of the State and/or private payers as the convener and backbone infrastructure for all demonstrations)

MiPCT Medicaid Results Overview

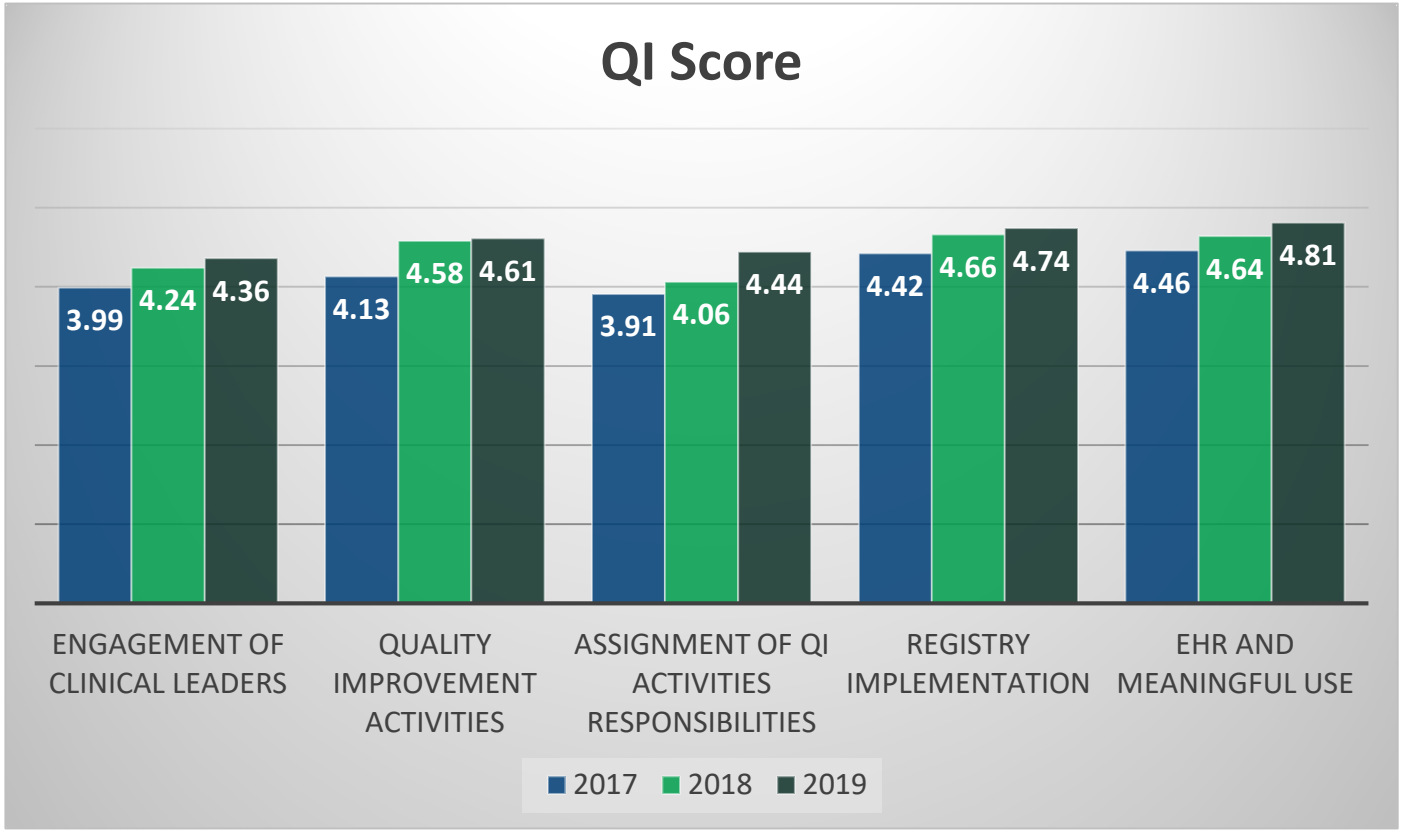
Outcome	Population	2013 Relative Change from 2011		2014 Relative Change from 2011		2015 Relative Change from 2011	
		MiPCT Vs CG1	MiPCT Vs CG2	MiPCT Vs CG1	MiPCT Vs CG2	MiPCT Vs CG1	MiPCT Vs CG2
Standard Cost	Adult	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction
	Adult High Risk	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction
	Pediatric	No Difference	Sig. Reduction	Sig. Increase	No Difference	Sig. Reduction	Sig. Reduction
ED	Adult	Sig. Increase	Sig. Increase	Sig. Increase	Sig. Increase	No Difference	Sig. Reduction
	Adult High Risk	No Difference	No Difference	No Difference	No Difference	Sig. Reduction	Sig. Reduction
	Pediatric	Sig. Increase	Sig. Increase	Sig. Increase	Sig. Increase	Sig. Reduction	Sig. Reduction
Inpatient Hospital Admission	Adult	No Difference	No Difference	No Difference	No Difference	Sig. Reduction	Sig. Reduction
	Adult High Risk	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction	Sig. Reduction
	Pediatric	No Difference	No Difference	No Difference	No Difference	Sig. Reduction	Sig. Reduction
Quality	Diabetes & Preventive	MiPCT had higher rates at every time point, but relative changes were not significant.					

SIM PCMH Initiative Continues the Tradition of Primary Care Innovation in Michigan

- 344K Medicaid Patients Served by the SIM PCMH Initiative
- 2,090 Primary Care Providers
- 305 Practices
- Border to border and coast to coast

SIM Self-Reported Performance

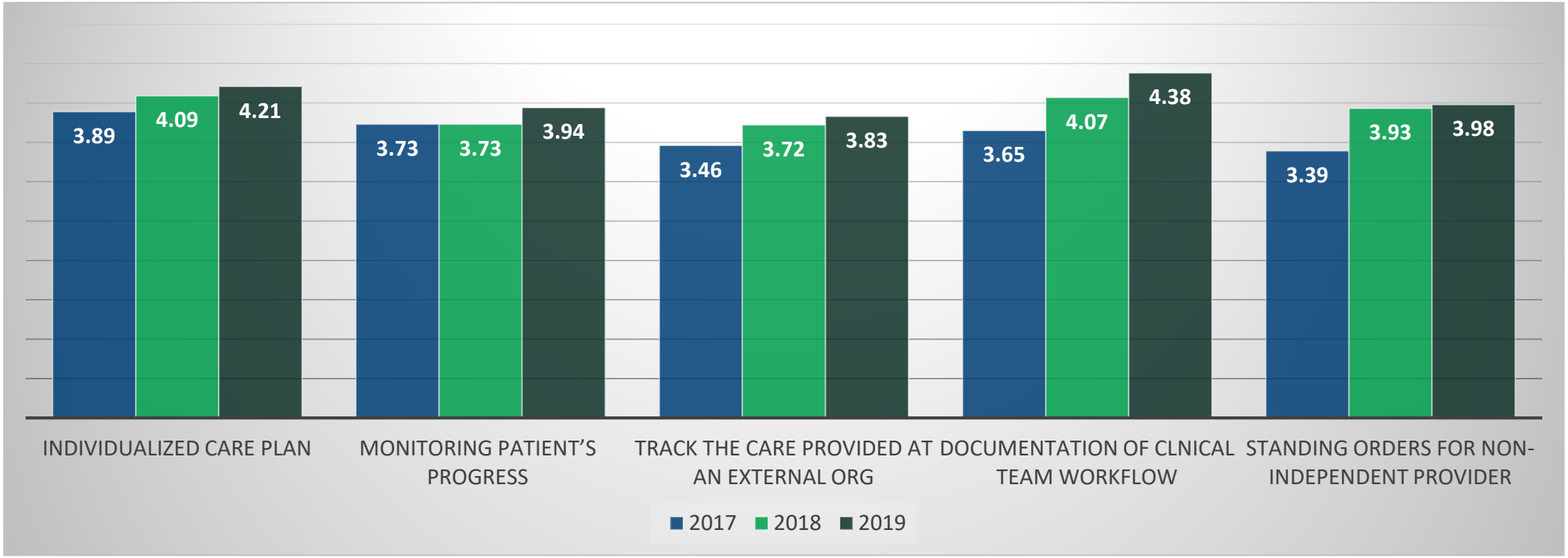
SIM PCMH 2019 Self-Assessment
Quality Improvement



- Scores of all QI engagement and activities have improved continuously from 2017 to 2019

SIM PCMH 2019 Self-Assessment

Team Based Care



- All of the team-based care activity scores have improved from 2018.

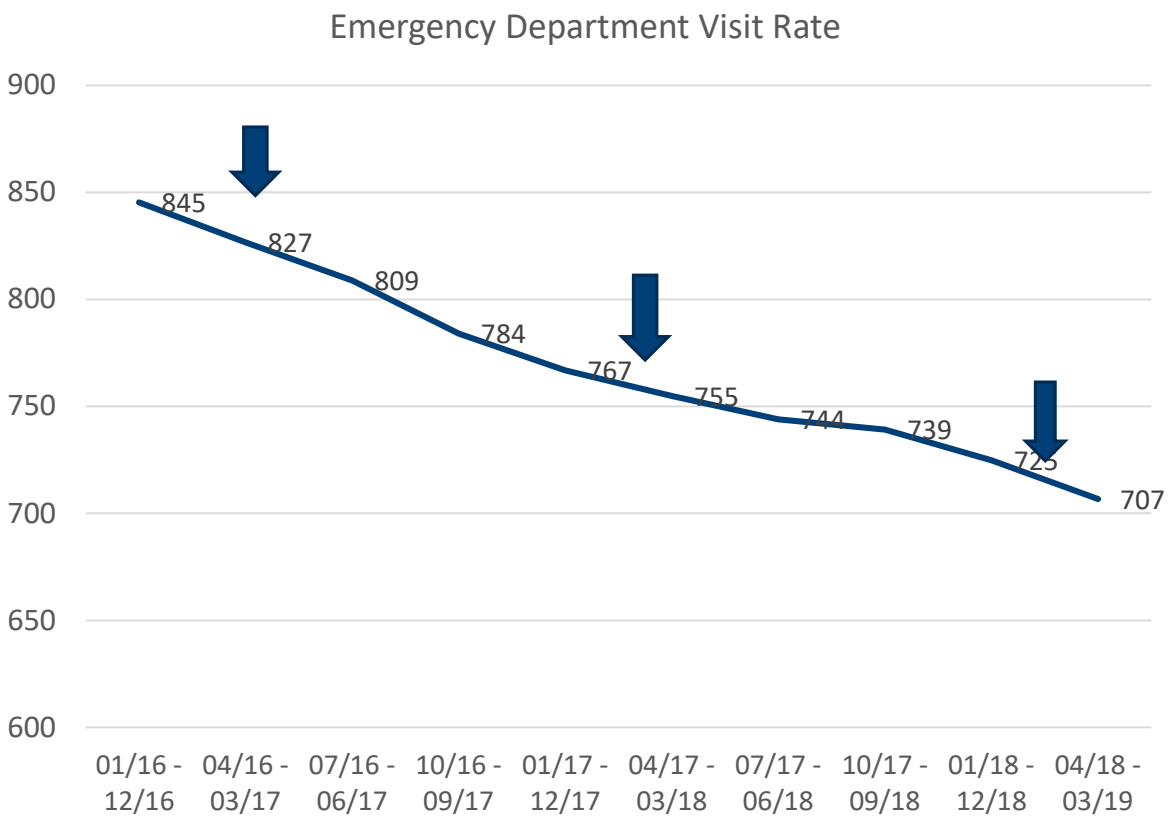
SIM Metric Performance

Performance Measure Highlights

A few measures from the MDC dashboard stood out showing improvement during the SIM PCMH Initiative.

- **Utilization**
  - Emergency Department Visits
  - Preventable ED Visits
- **Quality**
  - Cervical Cancer Screening

Reduced Emergency Department Utilization



Baseline year (1/2016 – 12/2016) the rate was 845

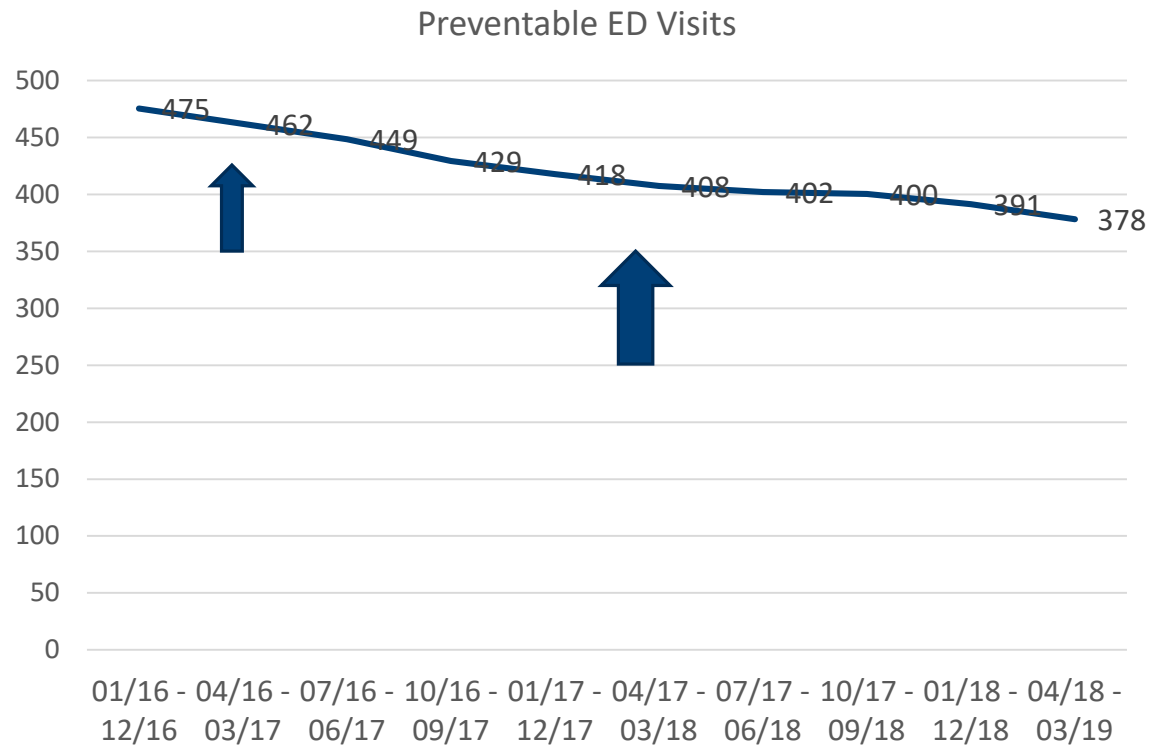
1 year into the SIM PCMH initiative the rate decreased to 767

2 years into the SIM PCMH initiative the rate decreased again to 725

The last reporting period again decreased to 707

Overall the rate decreased by 138 Visits per 1,000 patients since SIM PCMH Initiative began

Reduced Preventable ED Visits



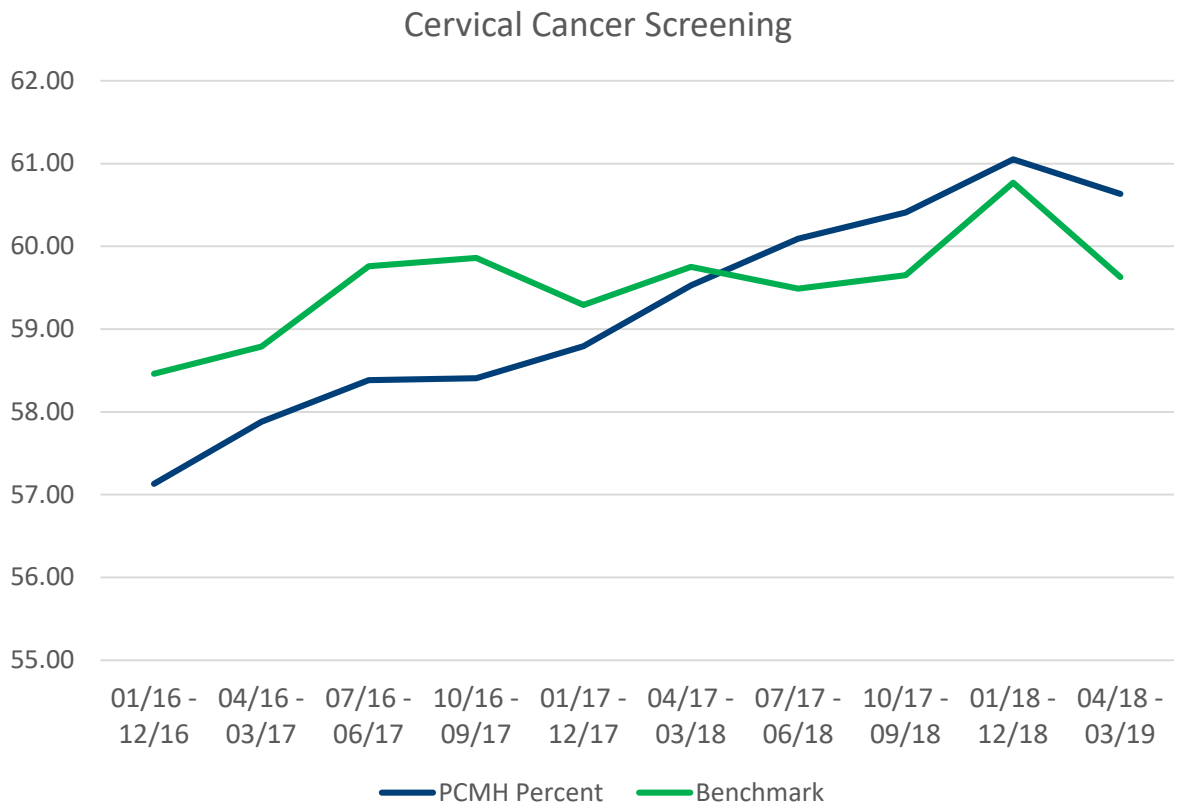
Baseline year (1/2016 – 12/2016) the rate was 475

1 year into the SIM PCMH Initiative, the rate decreased to 418

The last reporting period again decreased to 378

Overall the rate decreased by 97 Visits per 1,000 patients since SIM PCMH Initiative began

Cervical Cancer Screening



Benchmarks are calculated each reporting period using best-in-class methodology which is 5 percentage points below the 75th percentile on a given quality measure.

This methodology creates an achievable benchmark

Participants started below the benchmark and continually improved

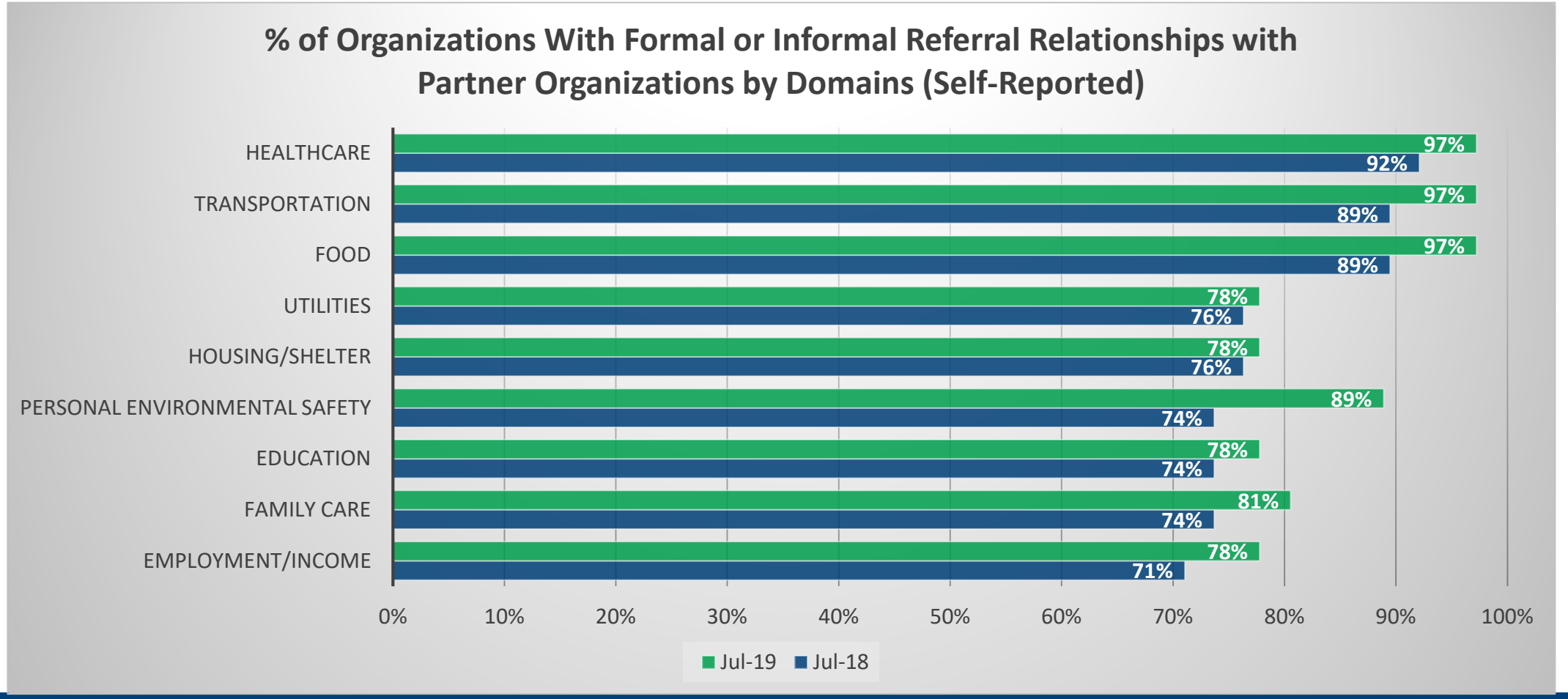
Other Performance Stand Outs

- Similar to the Cervical Cancer Screening measure on the MDC Dashboard, Diabetes HbA1c Testing followed a similar trend demonstrating improvement during the SIM PCMH Initiative

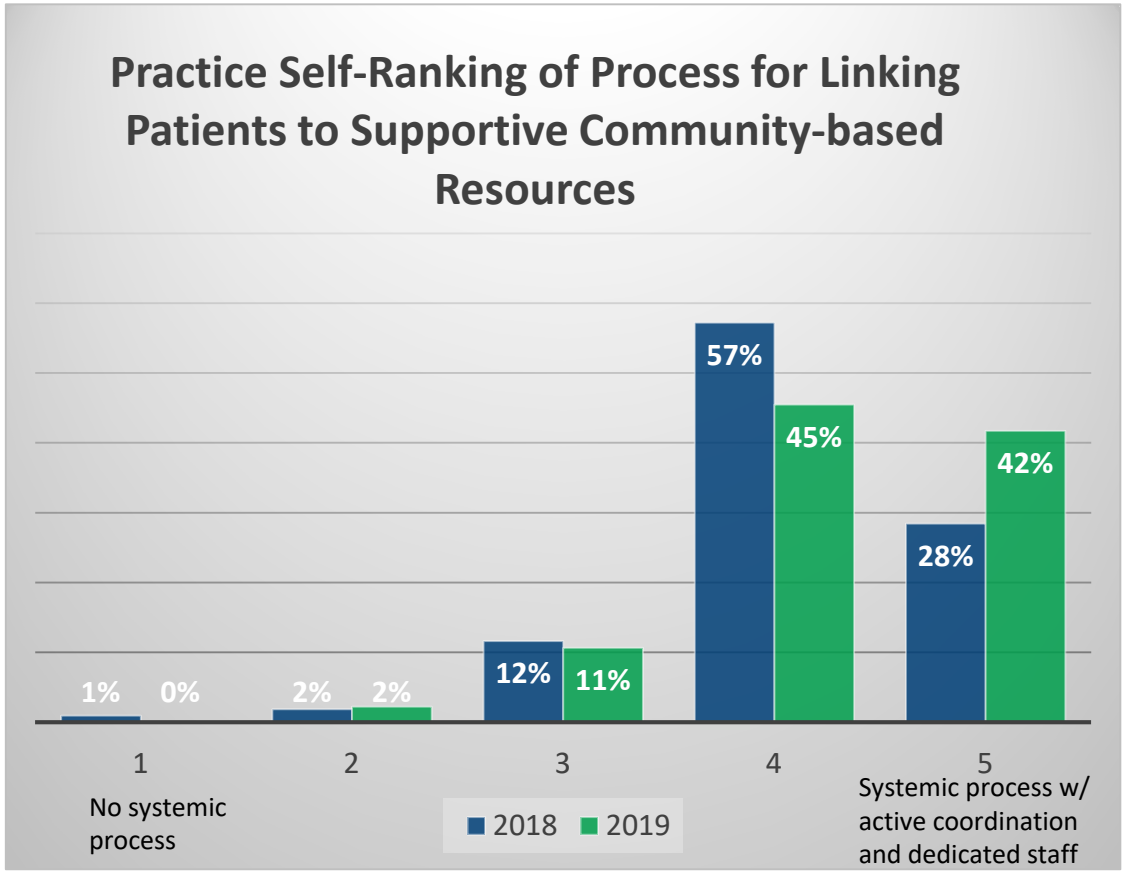
- Additionally, participants consistently performed better than benchmark on the following two measures
  - Acute Hospitalization
  - Diabetes Medical Attention for Nephropathy

SDoH Performance

Improved Referral Relationship with Community Partners in All Domains



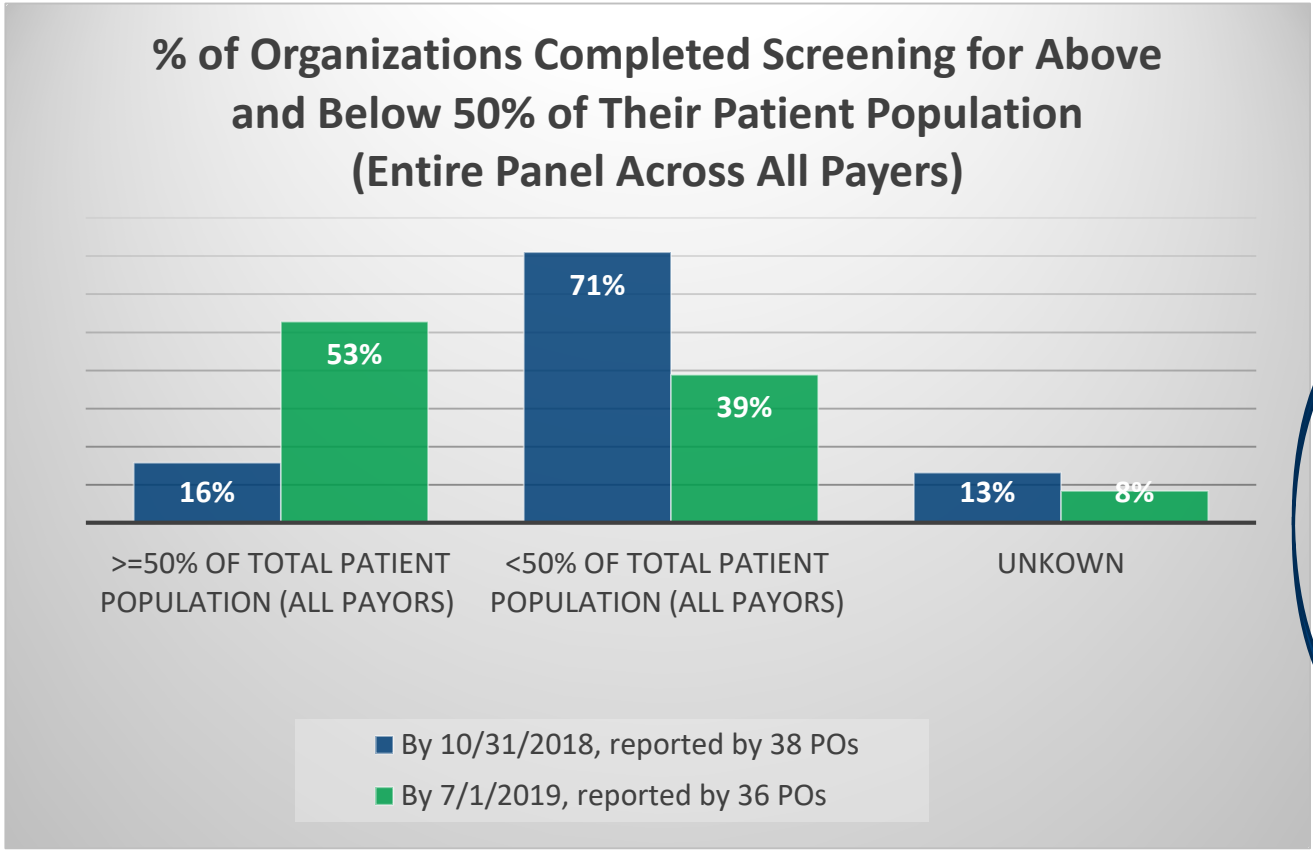
Improved Score for Linking Patients to Community-Based Resources



Score	Description
1	Linking patients to supportive community-based resources is not done systematically
2	Linking patients to supportive community-based resources is limited to providing patients a list of identified community resources; by some teams.
3	Linking patients to supportive community-based resources is limited to providing patients a list of identified community resources; consistently by all teams.
4	Linking patients to supportive community-based is accomplished through a designated staff person or resource responsible for connecting patients with community resources.
5	Linking patients to supportive community-based resources is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person

Average community-based resources linkage score improved from 4.1 in 2018 to 4.27 in 2019.

Improved Efficiency to Screen Patients



Total Number of Screened Patients across All SIM PCMH Organizations	
From 07/01/17 to 10/31/2018 (**16** months)	**576,869**
From 11/1/2018 to 7/1/2019 (**8** months)	**515,370**

Halved the time to screen half a million patients!

From your perspective, do you feel like the SIM PCMH Initiative and its education, learning opportunities and emphasis on working with your community partners, have provided you with useful learning and methods of providing better care to more at risk patients?

A. Yes, very much
B. Yes, somewhat
C. No

2. Exploring the Components of an Advanced Primary Care Practice

My Journey to Advanced Primary Care

- Medical Director of a Family Practice Residency site
- Participated in Society of Teachers of Family Medicine's Conference on Practice Improvement
- Began transformation journey PCMH→MU→PQRS→MIPCT→CPC+ and SIM PCMH
- 4 EMRs later…

Physician Champion
Champion for Team Based Care
Advanced Primary Care Practice Advocate

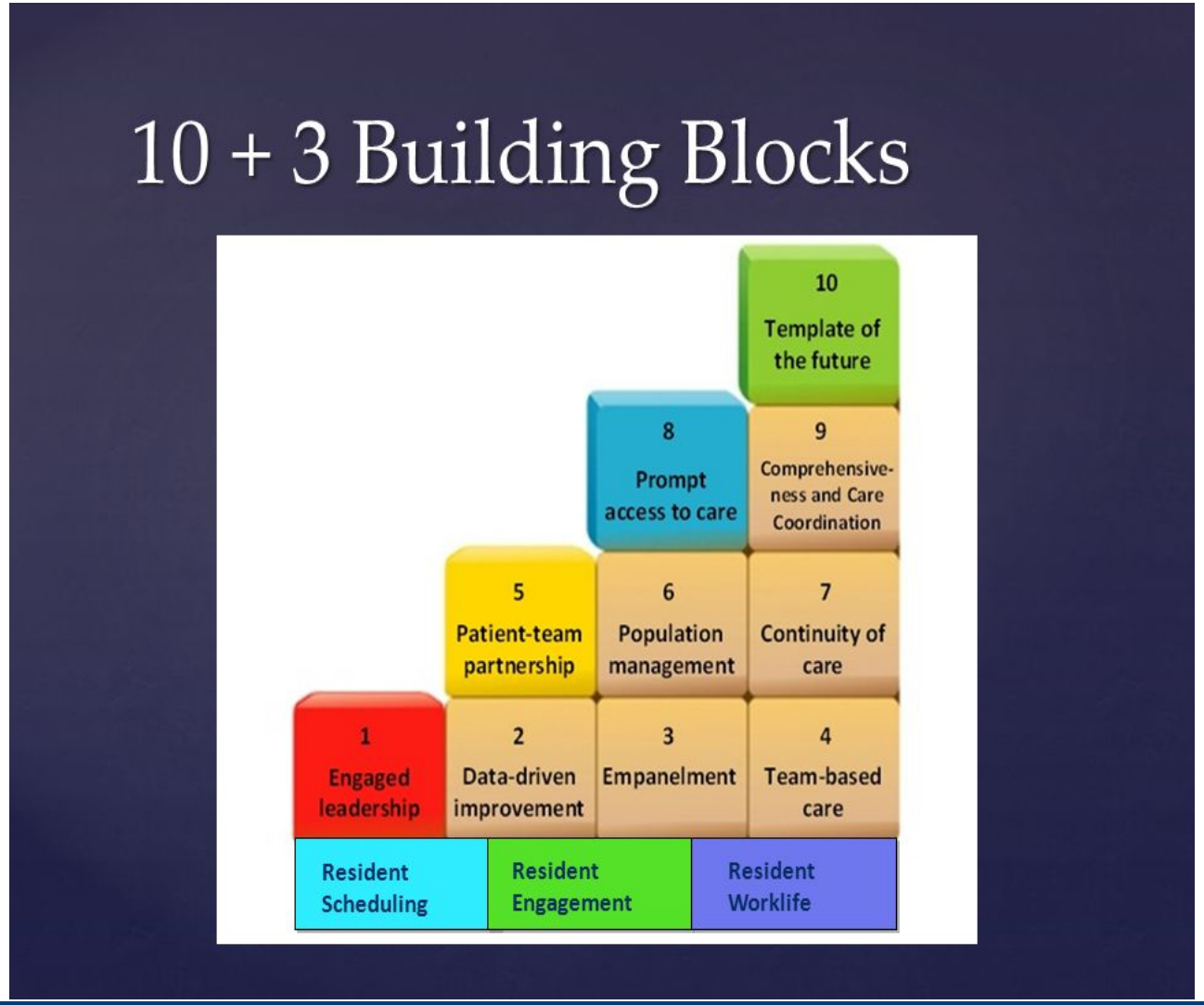
Our Collective Journey …

- All patient screening for SDoH, collaborating with community partners and tracking referrals
- Developing and expanding our health care team and learning roles
- Empowering the team, all levels
- Living in a larger system

From your perspective, do you feel like your practice, organization or group has a plan for sustaining the improvements we have made in the SIM PCMH Initiative?

A. Yes, we have talked about next steps and have a plan to sustain
B. Maybe, I have heard there is a plan in my organization but unsure of my role
C. No, We have not talked about next steps, uncertain how we will maintain these efforts

Ascension Family Medicine Residency Clinic's First Collaborative



Basis: High-Functioning Primary Care Residency Clinic Building Blocks for Providing Excellent Care and Training

Brown, S., Bodenheimer, T., Kong, M. (2016) High-Performing Primary Care Residency Clinics: A Collaboration. The Annals of Family Medicine, Ann Fam Med 2019;17:471-472. https://doi.org/10.1370/afm.2450.

Bodenheimer, T., Ghorob, A., Willard-Grace, R., & Grumbach, K. (2014). The 10 building blocks of high-performing primary care. The Annals of Family Medicine, 12(2), 166-171.

Our Patient's Journey

Time Period	Patient Progress
End of 2017	NP 55 y.o. patient with Type 2 DM with stage 3B CKD and diabetic neuropathy; BMI 47 and A1C 7.6
Jan-18	Referred Patient to Nephrology and Podiatry; Engaged care manger to help with transportation
Sep-18	Patient found to be intermittently taking mediations Bilateral cellulitis with open leg wounds; kidney function stable; **A1C 10.7**
Nov-18	Patient case reviewed in weekly care team conference. Patient moved.
May-19	Patient admitted to hospital with DVT/PE; **A1C 12**
Jun-19	Patient seen in hospital follow-up clinic Introduced patient to Warfarin Clinic (RN manager, CM trained); Regular INR visits every 2-4 weeks Care management engagement (2 office visits since June)
Sep-19	**Improved mediation adherence; BMI still high 40s; A1C 6.9**

Next Steps…

1. Add a social isolation question to our SDoH screen
2. Continue to expand our community collaborations
3. Engaging the patient
4. Leverage our teams
5. Challenge our Leaders
6. Continue to advance our primary care model
7. Teach the next generation

3. Assessing Resources for Sustainability

Innovative Approaches to Address SDoH Needs Among Adolescents and Young Adults

Recurring themes:

- Community coalitions were needed
- Current improvement efforts were siloed; we weren't sharing our lessons learned with each other
- Addressing poverty was a key determinant of health
- Need to provide comprehensive holistic care that was patient centered

Biggest challenge—Lack of stable funding to sustain efforts

Tebb, K. P., Pica, G., Twietmeyer, L., Diaz, A., & Brindis, C. D. (2018). Innovative Approaches to Address Social Determinants of Health Among Adolescents and Young Adults. *Health equity*, *2*(1), 321–328. doi:10.1089/heq.2018.0011

Investing in Interventions that Address Non-Medical Health-Related Social Needs: Proceedings of a Workshop

April 2019 Workshop, National Leaders in this area from Universities, and Health Care Systems

Goals for the Day –Answer 2 questions:

1. Specific recommendations on how to demonstrate effectiveness and investment in SDoH?
2. How do we create a universal business case ?

Housing Interventions, Food Insecurity, Evidence and Policy Gaps, ROI, Oh My!

Employing Community Health Workers (CHWs) to Improve Population Health

The IMPaCT Model @ Penn Center for Community Health Workers

Scalable, Reproducible use of Community Health Workers

- Asked patients what they believed would help them improve their health ?
  - 36.9% Psychosocial Support
  - 35.6% Health Behavior Change
  - 14.5% Resources for Daily Life
  - 10.6% Health System Navigation
  - 2.3 % Medical Care

Kangovi, S., Mitra, N., Grande, D., Huo, H., Smith, R. A., & Long, J. A. (2017). Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial. *American journal of public health*, *107*(10), 1660–1667. doi:10.2105/AJPH.2017.303985

Pathways to Population Health: An Invitation to Health Care Change Agents

Learn - Provides Framework of Population Health Model

Act - Self Assessment "compass" for your organization to use

Improve - "Oasis" Change library to learn from other stories or share your own stories

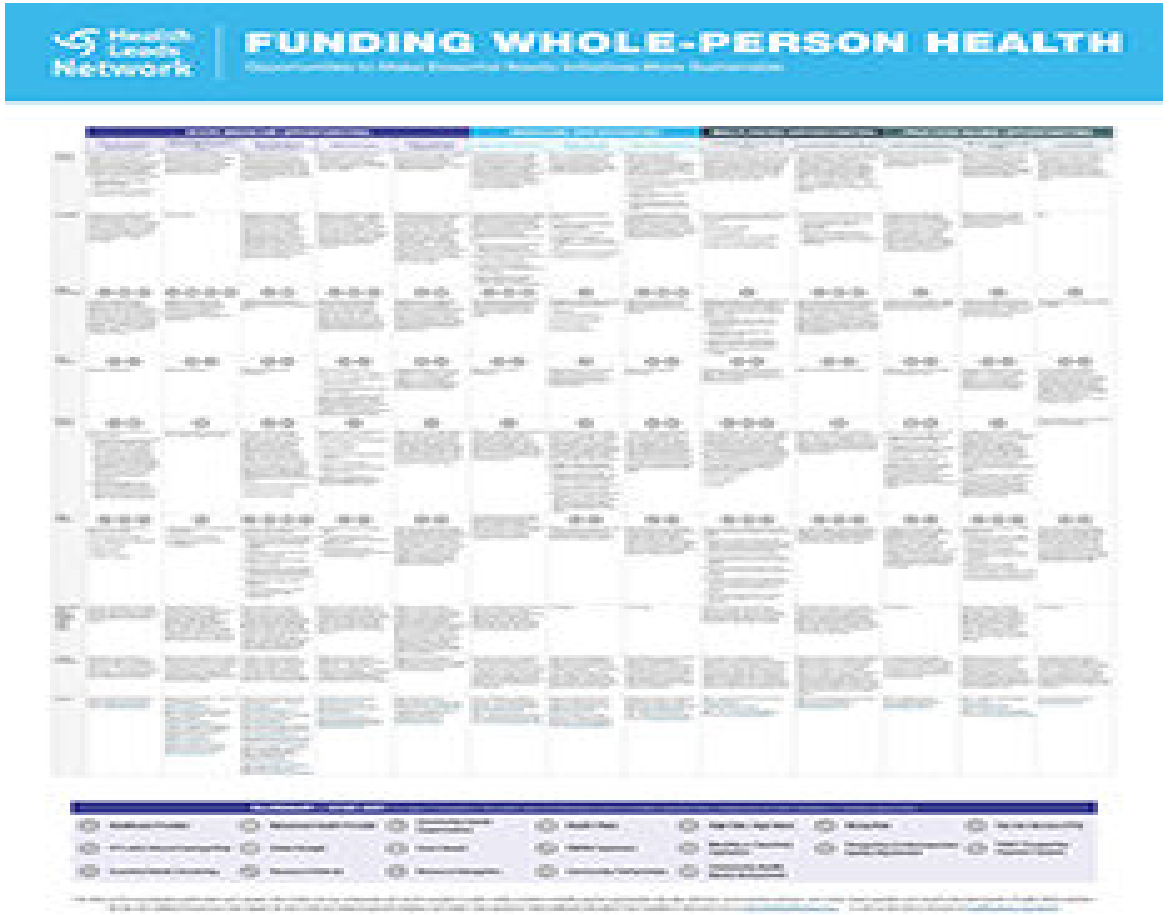
Health Leads

- Community Level Health Initiatives - Partner with Organizations to formulate health goals for a community

- Accelerate Practice - Bring people together who are doing this work, develop community-based innovators, share learnings

- Targeted Advocacy - Reduce systems of inequity that lead to poor health

Funding Whole-Person Health: Opportunities to Make Essential Needs Initiatives More Sustainable



Do you feel in your role that you have been empowered to take what you have learned these past 3 years and continue to make change in your practice, organization or group?

A. Yes, I am excited to continue to participate in or support practice innovation
B. Yes, I have learned a lot, but unsure how to make my voice heard in my practice/organization/group
C. No, I am still struggling with how to incorporate what I have learned and put it into practice

AHRQ Health Care Innovations Exchange: Innovations and Tools to Improve Quality and Reduce Disparities

Disruptive innovators can be upsetting as they challenge the status quo,

Three ways that health care leaders respond to disruptive innovation:

1. Conservative
2. “Second mover“ strategy
3. “First mover” strategy

National Academies of Sciences, Engineering, and Medicine. 2019. *Investing in Interventions That Address Non-Medical, Health-Related Social Needs: Proceedings of a Workshop*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25544.

Our challenge to you…

Be a Disruptive Innovator

Become a Champion of Change

Listen, Learn and Share

“I alone cannot change the world, but I can cast a stone across the waters to cause many ripples.”

- Mother Theresa

Resources and Links

http://www.pathways2pophealth.org/learn.html

https://healthleadsusa.org/ (Tools & Resources)

https://innovations.ahrq.gov/perspectives/harnessing-disruptive-innovation-health-care

National Academies of Science, Engineering, and Medicine 2019. *Investing in Interventions that address non-medical, health related social needs:* Proceedings of a Workshop. Washington D.C. National Academies Press

https://www.carezooming.com/recipes/employing-community-health-workers-chws-to-improve-population-health-via-the-impact-model-penn-center-for-community-health-workers/

Concurrent Morning Breakout Sessions
9:40 - 10:50

Lessons from a Partner State: Building Strong Partnerships

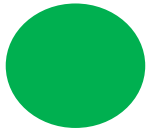
Jill S. Rinehart, MD FAAP

Yellow Dot

Centennial

Healthier Communities: What Works to Make Real Change

Carrie Hribar, MA
Joshua Williams, LLMSW, BSW
Jenifer Murray RN, MPH



Green Dot

Big Ten AB

Acting on SDoH Data: Beyond Screening

Leah Corneail, MPH
Roseanne Paglia, PharmD
Ernest Yoder, MD, PhD, MACP

Blue Dot

Big Ten C

Note: The colored dot on the left side of your name badge indicates the morning breakout session that you will be participating in.

Lessons from a Partner State: Building Strong Partnerships

JILL S. RINEHART MD, FAAP
UNIVERSITY OF VERMONT CHILDREN'S HOSPITAL

Learning Objective

Describe the landscape of primary care in Vermont and approaches to best partner with families, caregivers, patients and others to support population health.

Telling the Story in Three Parts

1. Vermont Overview

2. Describing What We Do and Why We Do It
   How “real” care coordination addresses unmet needs of children and their families

3. Share What We are Learning
   Outline the necessary steps for charting a pathway to family-centered care coordination

1. Vermont Overview

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN
Vermont Chapter

hagan
rinehart
connolly
pediatricians PLLC

Vermont Family Network

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Thank You

The University of Vermont
LARNER COLLEGE OF MEDICINE

VERMONT
DEPARTMENT OF HEALTH

VT LEND
preparing leaders
across health professions

THE
University of Vermont
Children's Hospital

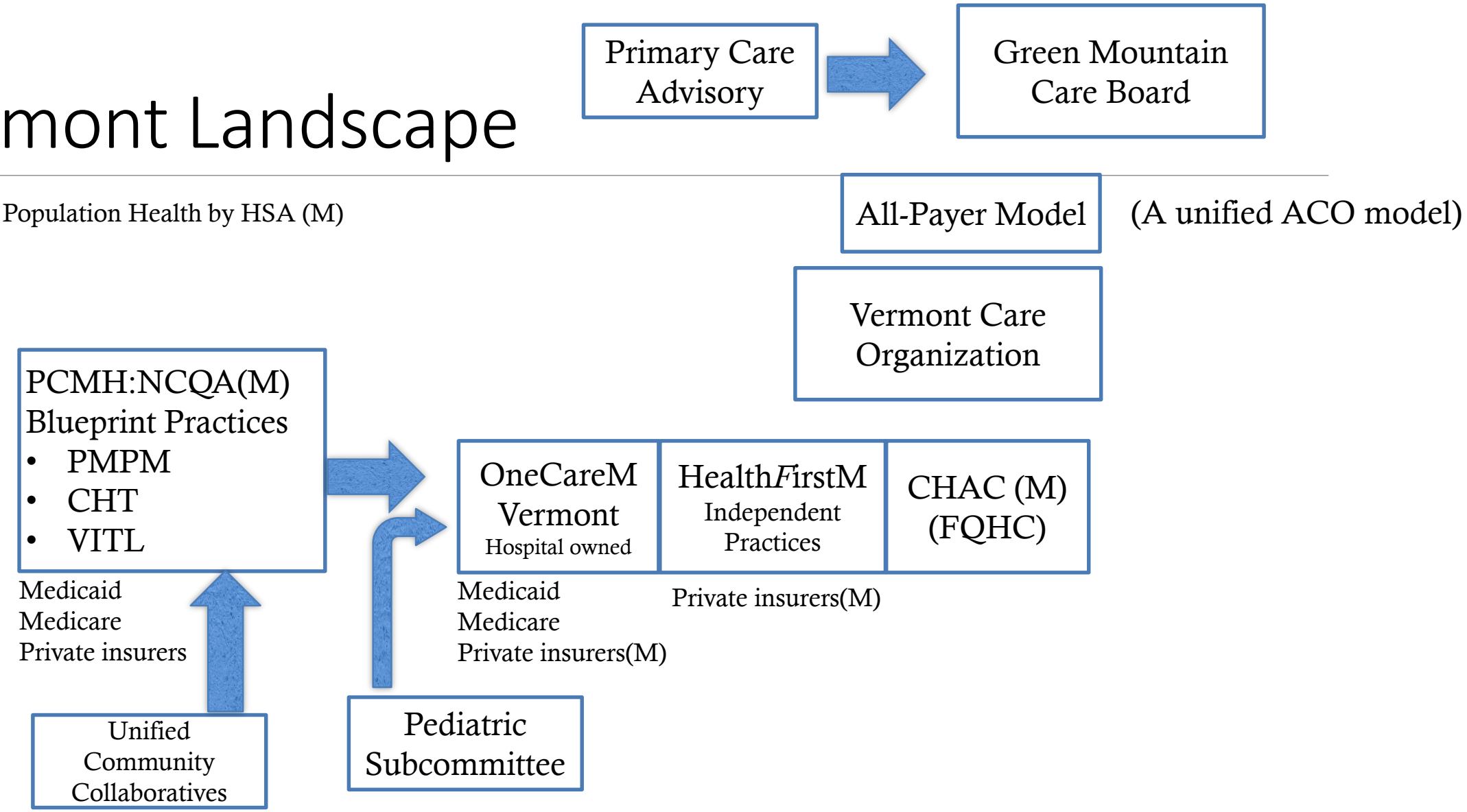
Vermont Child Health Improvement Program(VCHIP)

Creating an electronic Shared Plan of Care (e-SPoC)

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

SIM
MDHHS State
Innovation Model

Vermont Landscape



OneCare Vermont Model

- Team Based Care Coordination Payments ($15PMPM)
- “Patient Activation” Lead Care Coordinator Payments ($150 annually plus $10 PMPM)
- No more than 50 active patients per care coordinator
- Perform lead care coordinator duties (care conferences)
- Record activities in care navigator
- Facilitate shared plans of care with at least one goal with next steps and progress recorded

2. What We Do and Why We Do It

First the “Why"?

Impact on Families

- 13.5% of families spend 11+ hours per week on care and care coordination
- 57% of families experience financial problems
- 54% had a family member stop working to care for their child
- 49% needed additional income for medical expenses

Kuo, D. Z., Cohen, E., Agrawal, R., Berry, J. G., & Casey, P. H. (2011). A national profile of caregiver challenges among more medically complex children with special health care needs. *Archives of pediatrics & adolescent medicine*, *165*(11), 1020–1026. doi:10.1001/archpediatrics.2011.172

“List 3 to 5 qualities, activities or actions you would like to see your child’s doctor do that would demonstrate what is important to you"

- Coordination and communication
- Knowledge: child’s condition; disabilities; seeing the whole child
- Listening to family and child
- Family-centered care: respecting - the family’s expertise
- Access: to doctor – phone, e-mail, clinic visits
- Compassion and empathy





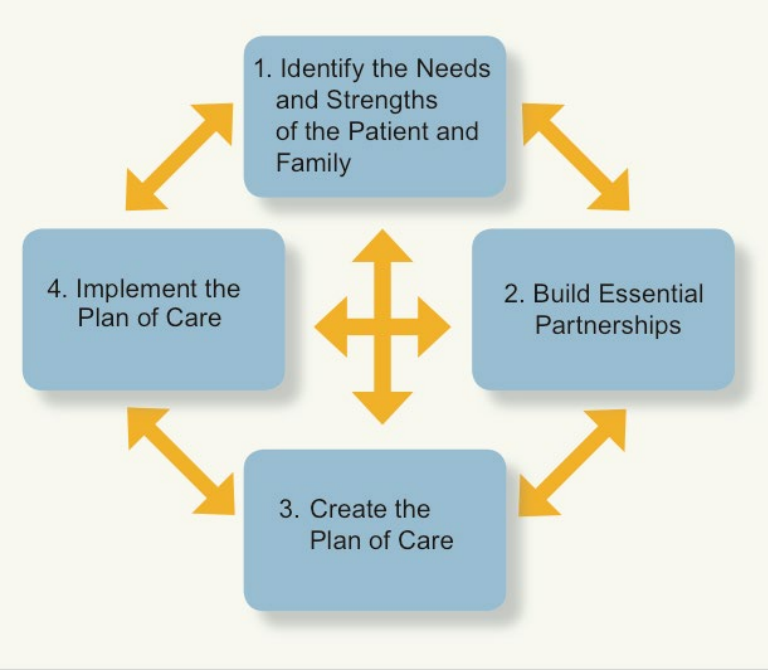
Pediatric Care Coordination Collaborative

Jill S. Rinehart, MD FAAP

August 24, 2017

Recommendations Family-Centered Care Coordination/Shared Plan of Care (SPOC)

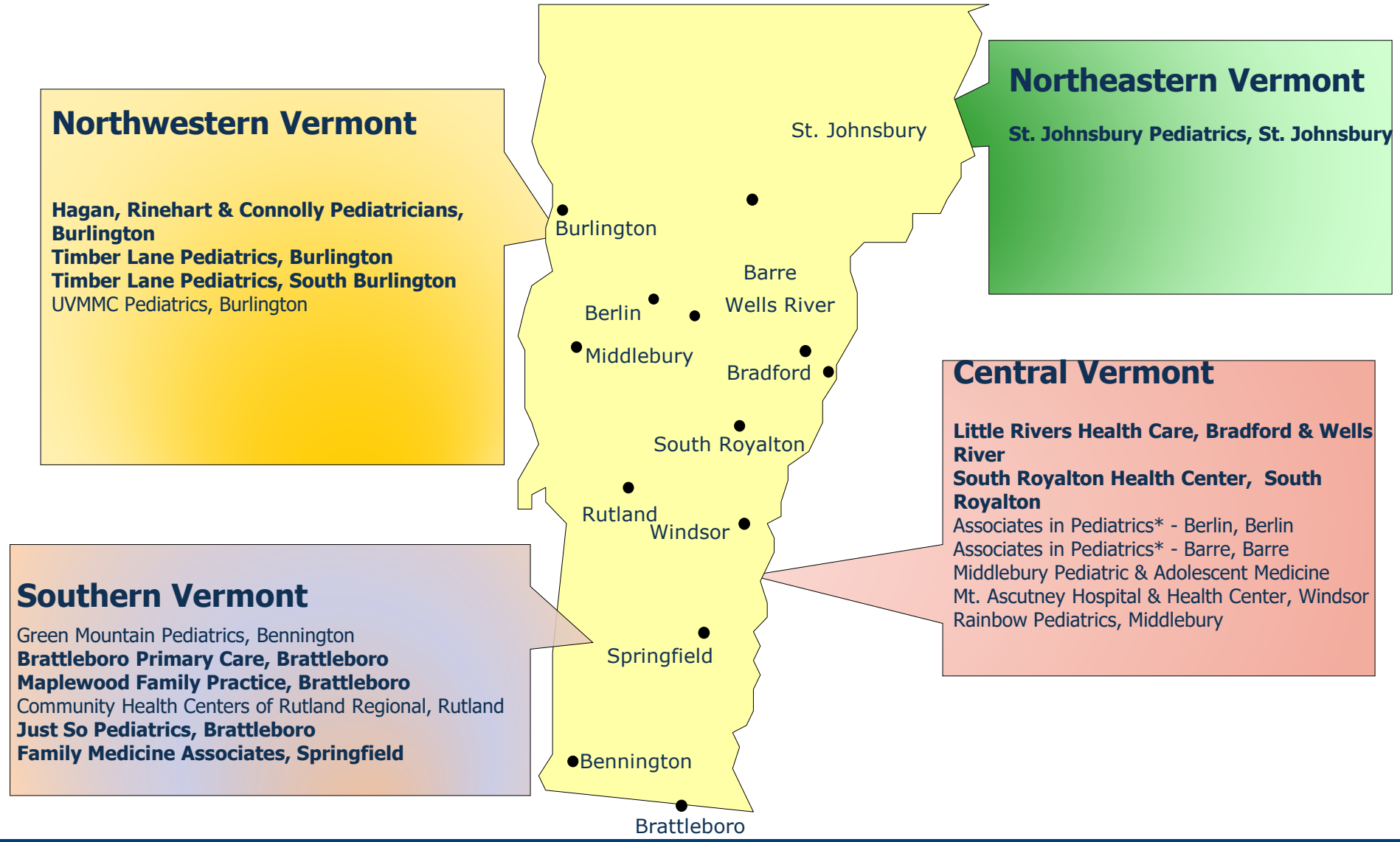
Achieving a SPOC w/CYSHCN & Families



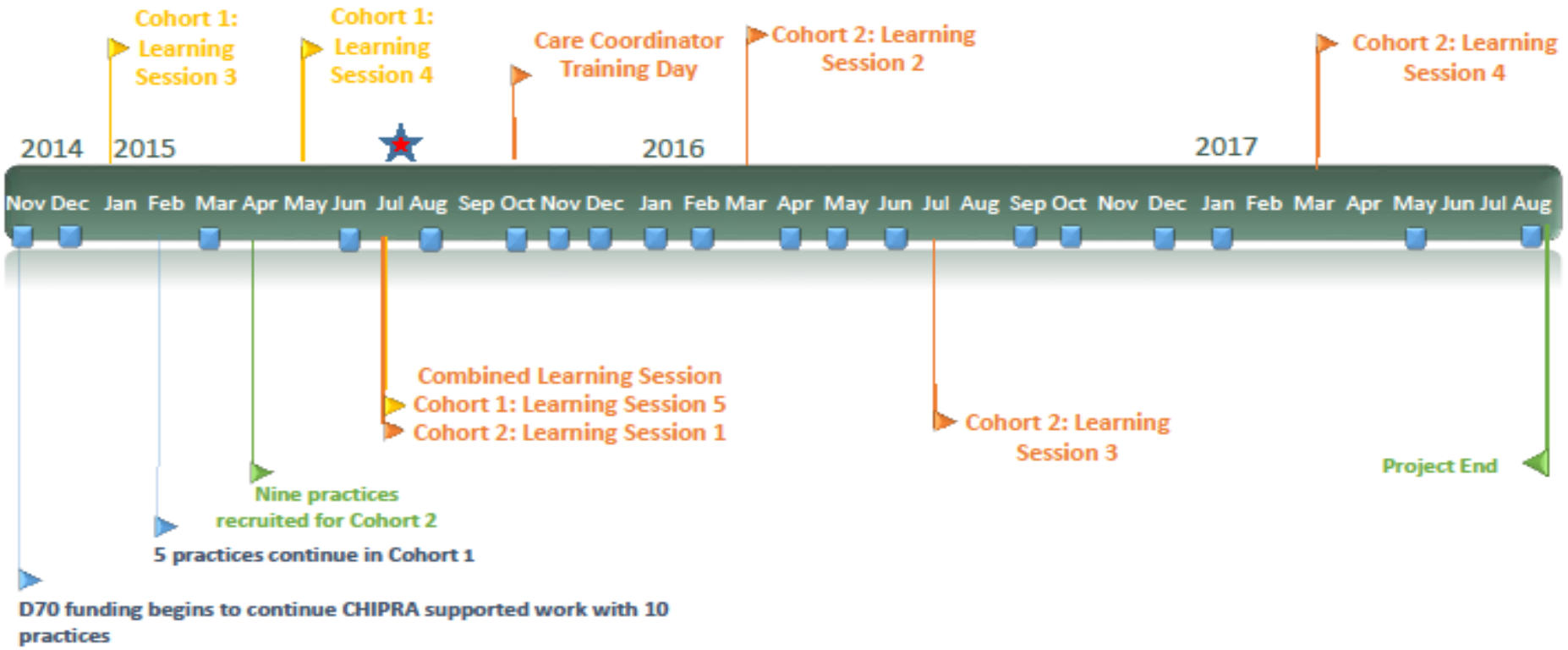
1. Patients & families are central and engaged
2. Teams are enabled/supported to help co-create/use SPOC
3. Health care and community professionals' efforts are integrated
4. Cross system family-centered care coordination is sustained

McAllister J. *Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs:* A White Paper and Implementation Guide. Lucille Packard Foundation for Children's Healthcare;2014

Pediatric Care Coordination Participating Practices



D70 Project Timeline



Care Coordination Tools

Shared Plans of Care

Created with and by family, patient, community

Shared with care team, family, patient, community

Care-Mapping (eco-mapping)

Care Conferencing

Problem Solving Conversations

Community Connections & Medical Home Neighborhood

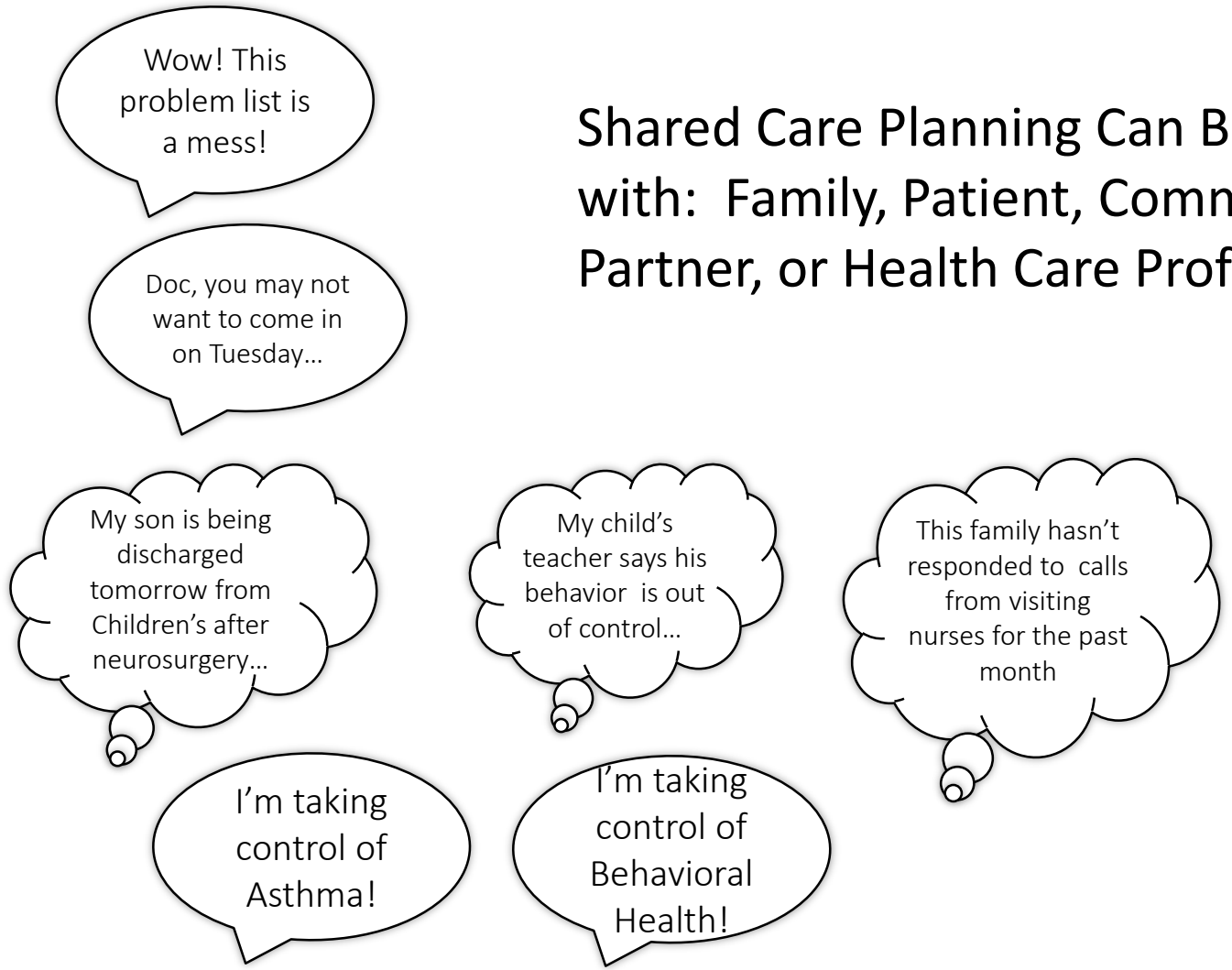
Where to Start?

During a Visit

Previewing the Schedule

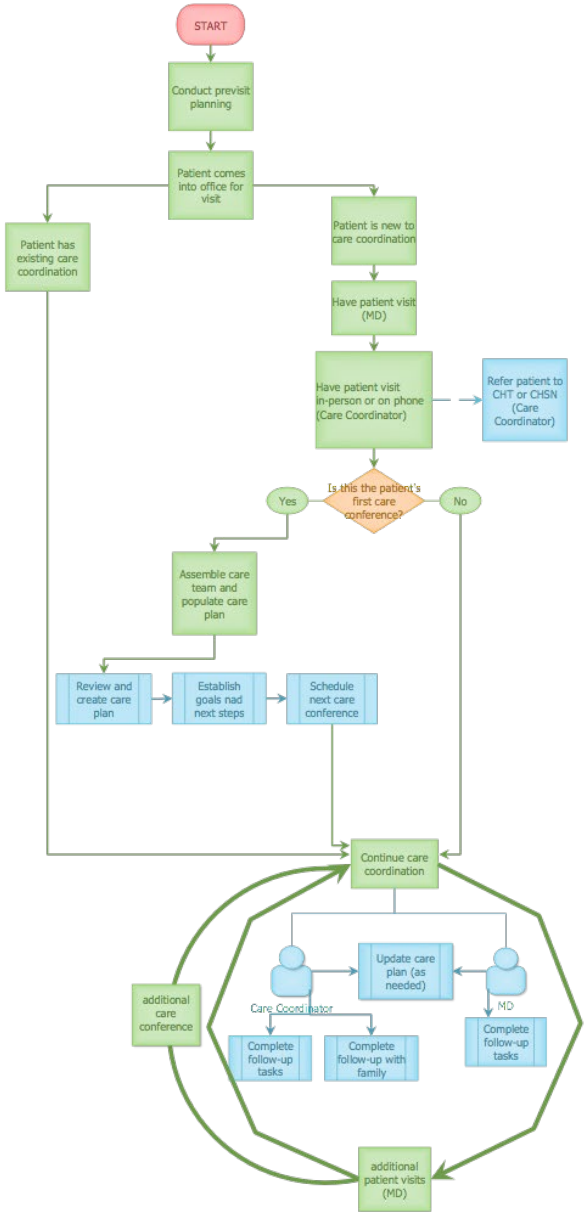
Phone Calls to Medical Home

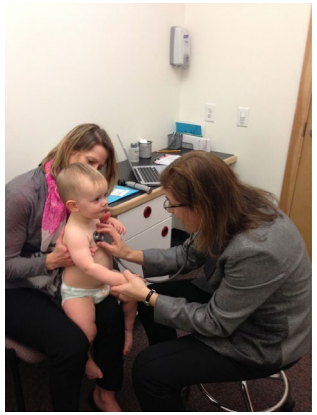
Condition Specific



Shared Care Planning Can Begin with: Family, Patient, Community Partner, or Health Care Professional

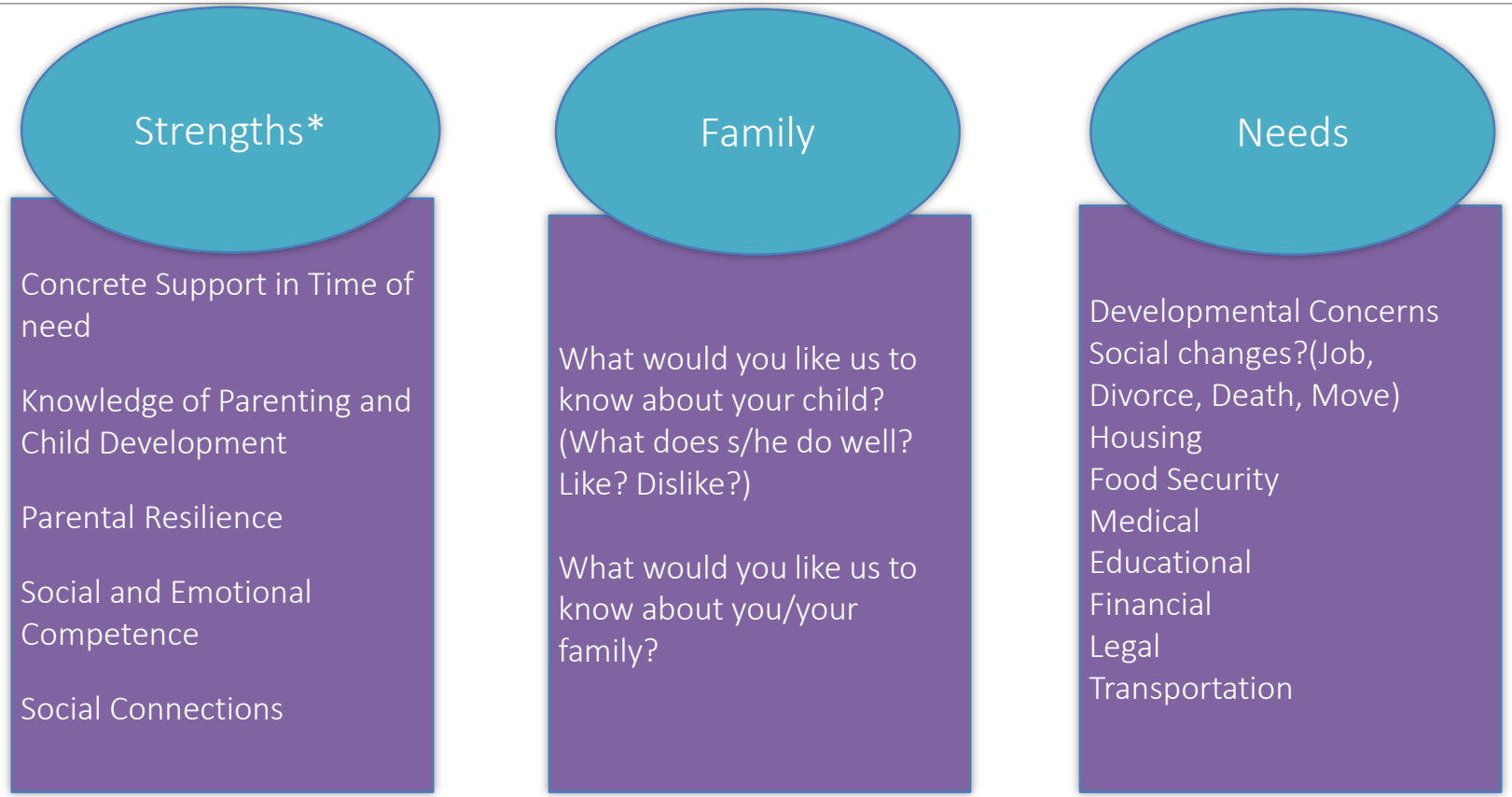
HRC Care Coordination Workflow Draft





hagan rinehart connolly pediatricians PLLC

Comprehensive Understanding



Harper Browne, C. (2014, September). *The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper.* Washington, DC: Center for the Study of Social Policy

Family Centered Care Coordination

"No one has ever asked me these questions before!"

- Parent

Family-Centered Care Coordination

INSERT: Practice Name

1) What would you like us to know about your child/youth?
a. What does he/she do well? Like? Dislike?

2) What would you like us to know about you/your family?

3) Do you have any concerns or worries for your child/youth? *Some examples below.*

- Their growth/development
- Learning
- Sleeping
- Self-care
- Making and keeping friends
- Doing things for themselves
- Falling behind in school
- Behavior
- The future
- Playing with friends
- Other (fill in)

4) Have there been any changes since we saw you last, such as a:

- Brother of sister leaving home?
- Move to a new town?
- Sickness or death of a loved one?
- New job or job change?
- Separation or divorce?
- Other (fill in)

5) Can we help you with any of the following needs?

- **Medical** *For example, help finding or understanding medical information; help finding health care for yourself or your family.*
- **Social** *For example, having someone to talk to when you need to; getting support at home; finding supports for the rest of your family.*
- **Educational** *For example, explaining your child's needs to teachers; help reading or understanding medical information.*
- **Financial** *For example, understanding insurance or finding help paying for needs that insurance does not cover – such as medications, formulas, or equipment.*
- **Legal** *For example, discussing laws and legal rights about your child's health care or their school needs.*
- **General** *Please let us know what else you need help with (if we don't know, we will work with you to find the answer).*

Notes:

Developed by Jeanne McAllister, RN, MS, MHA and the National Center for Medical Home Implementation

NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION

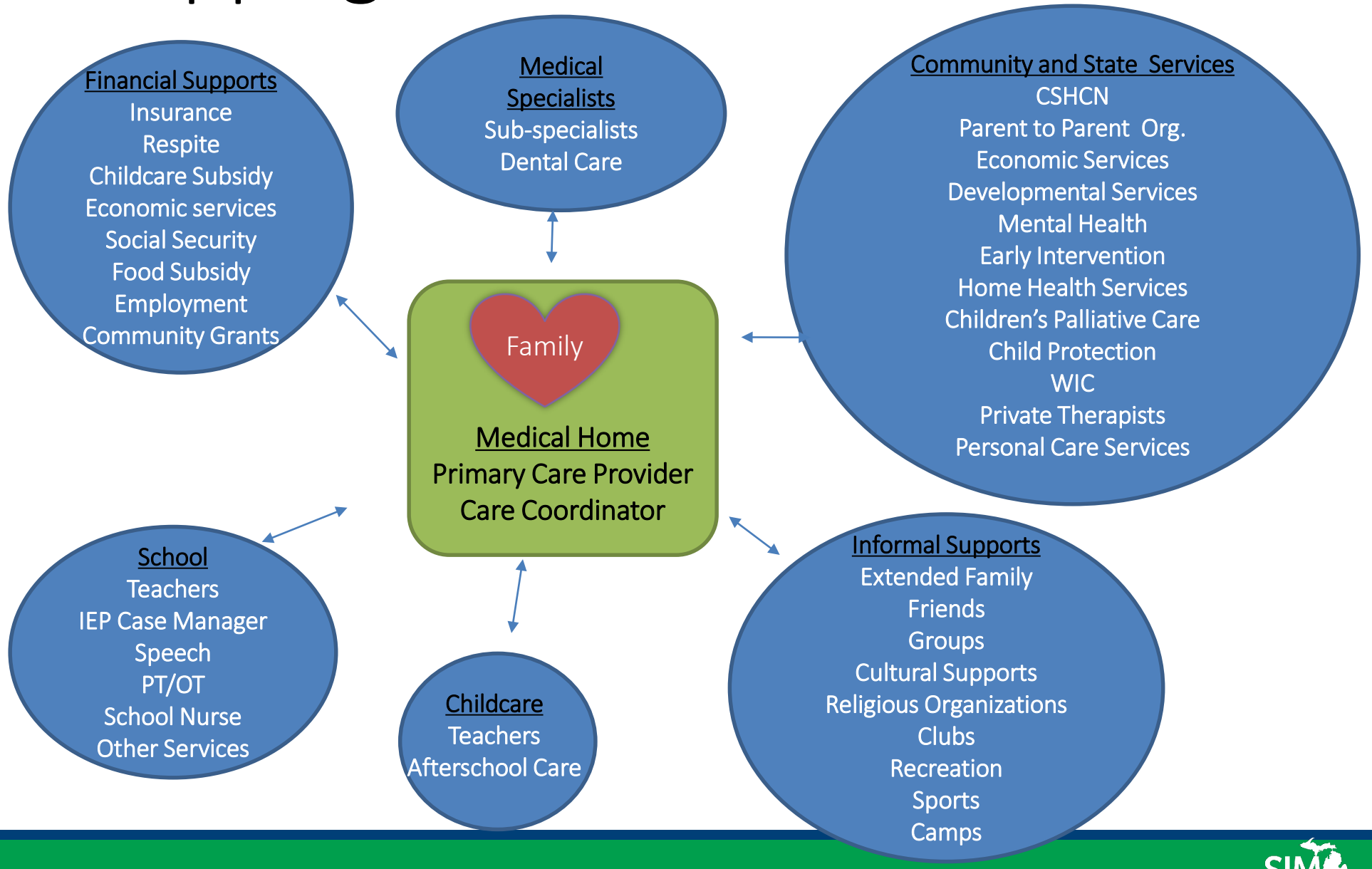
SIM MDHHS State Innovation Model

Pre-Visit Planning

Before you enter the room…

- Share recent, relevant information
- Screening tests (ACT, PHQ9)
- An agenda from the family for today's visit
- Labs, radiology, specialist visit reports
- Follow up from community members

Care Mapping



Informal Supports
Kelsey Murtha
Grammie & Beepah (Seasonal)
Grammy Pammy & Grandpa

Community Supports / Agencies
Make A Wish

Specialists - Research

Children's Hospital Boston

National Institutes of Health
Dr. Ariane Soldatos, Neurology / Lead
Catherine Groden, Nurse Practitioner
Dr. Max Muenk, Genetics Director
Alexander Katz, Genetics Lead
Ellen Macnamara, Genetics Counselor
Dr. William Gahl, Director Undiagnosed Disease Program
Dr. Thurm & Dr. Adamantis, Neuro-psychology & Developmental Pediatrician
Dr. Stratakis and Dr. Raygada, Endocrinology
Dr. Carmen Brewer, Audiology
ENT
Opthalmology
Dr Shamburek, Lipid Metabolism
CSF analyst
Gastroentrerology
Nephrology
Dr. Goldbach-Mansky, Rheumatology
Hepatology
Low Vision OT
Dr. Scott Paul, Physiatry
Nutrition, Danielle Fatemi
SLP, Beth Solomon

Mass General
Dr. Barbara Pober, Genetics
Dr. Frances High, Genetics

Specialists - Clinical

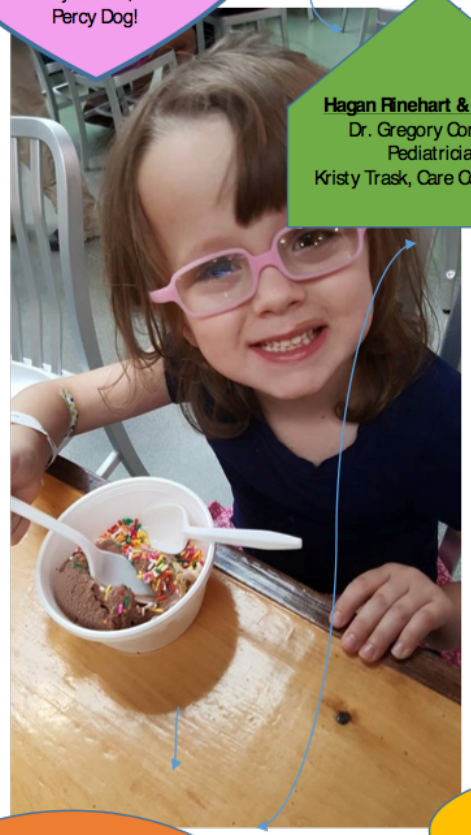
Children's Hosptial Boston
Dr. Mark Gorman, Neurology, Team Lead
Brian Smith, Dr. Gorman Program Coordinator
Michelle Souris, Nurse Practitioner / Spinal Taps
Dr. Ingrid Holm, Endocrinology
Dr. Margaret Kenna, ENT
Dr. Karan Pasad Maski, Sleep Neurology
Dr. Gena Heidary, Neuro-Opthalmology
Dr. Benjamin Warf, Neurosurgery
Karrilee Shea, Dr. Warf Program Coordinator
Dr. MaryBeth Son, Rheumatology
Audiology
CATCR

UVMMC
Julie Stefanski, Audiology
Dr. Niels Geoffrey Giddons, Cardiology
Dr. Michael D'Amico, Gastroentrerology
Dr. Leah Burke, Genetics
Dr. Elizabeth Hunt, Nephrology
Dr. Scott Benjamin, Physiatry
Dr. Thomas Lahiri, Pulminology
Dr. Robert Conover MaCauley, Palliative Care

Other
Dr. Vincent Devita, Emergency Local Eyecare
Dr. Gary Davis, Dental

Pharmacy/ Medical Supply
Hannaford
Wilcox Pharmacy
Briova
Ethan Allen Optical
Keene Medical
The Medical Store
Sarah Thomas, BioMedics

Addison Carroll (Born 4/24/2010)
Savannah Carroll, Sister (11/2/2002)
Isabella Carroll, Sister (1/16/2013)
Ian Carroll, Dad
Tammy Carroll, Mom
Percy Dog!



Hagan Rinehart & Connolly
Dr. Gregory Connolly, Pediatrician
Kristy Trask, Care Coordinator

Essex School District
Kelsey Murtha, Intervener
Jen (?), Case Manager / Special Education
Betsy Synott, Kindergarten Teacher
Stuart Podhaizer, SLP
Meghan Smith, Adaptive PE / PT Consult
Kimberly Bullock, School Nurse
Peter Farrell, Principal
Dylan MacNamara, Director Specail Ed
Megan Favreau, OT consult

Perkins School for the Blind (Boston)
Dr. Nicole Ross – Opthalmologist

Boston Childrens Hospital
Dr. Terrell Clark, Center for the Deaf and Hard of Hearing, Deaf/Blind Neurobehavioral
Katie O'Neil, Augmentative Communication, SLP

Vermont Sensory Access Project
Emma Nelson, Project Director

iTeam
Lisa Woodward, Educational Consultant
Jolene Blanchard, Resource Coordinator

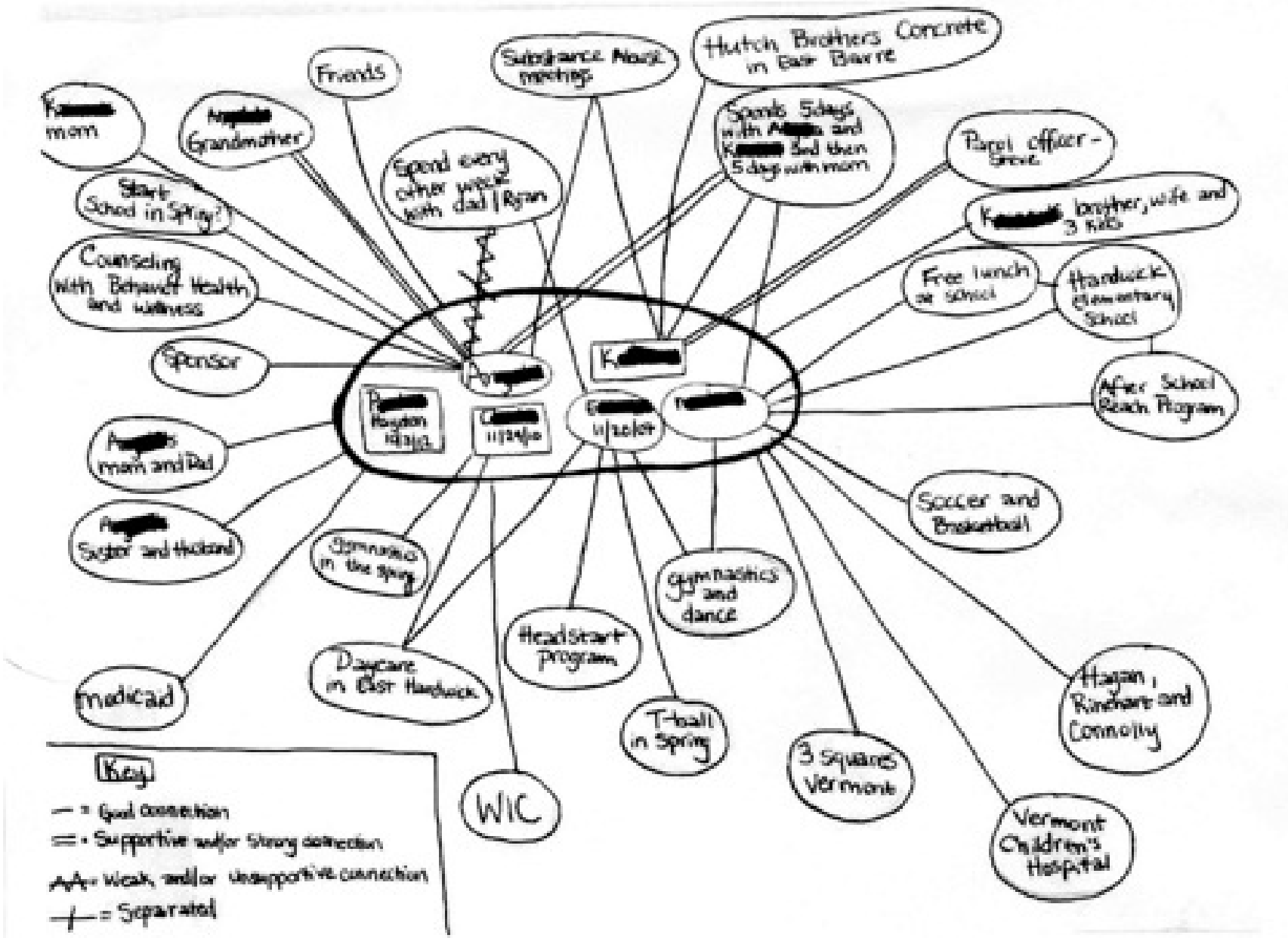
VAVBI
Sheila Thurston, Orientation & Mobility
Sharon Willie-Padnos, Teacher for the Blind

NineEast
Cathy Metz, Teacher for the Deaf

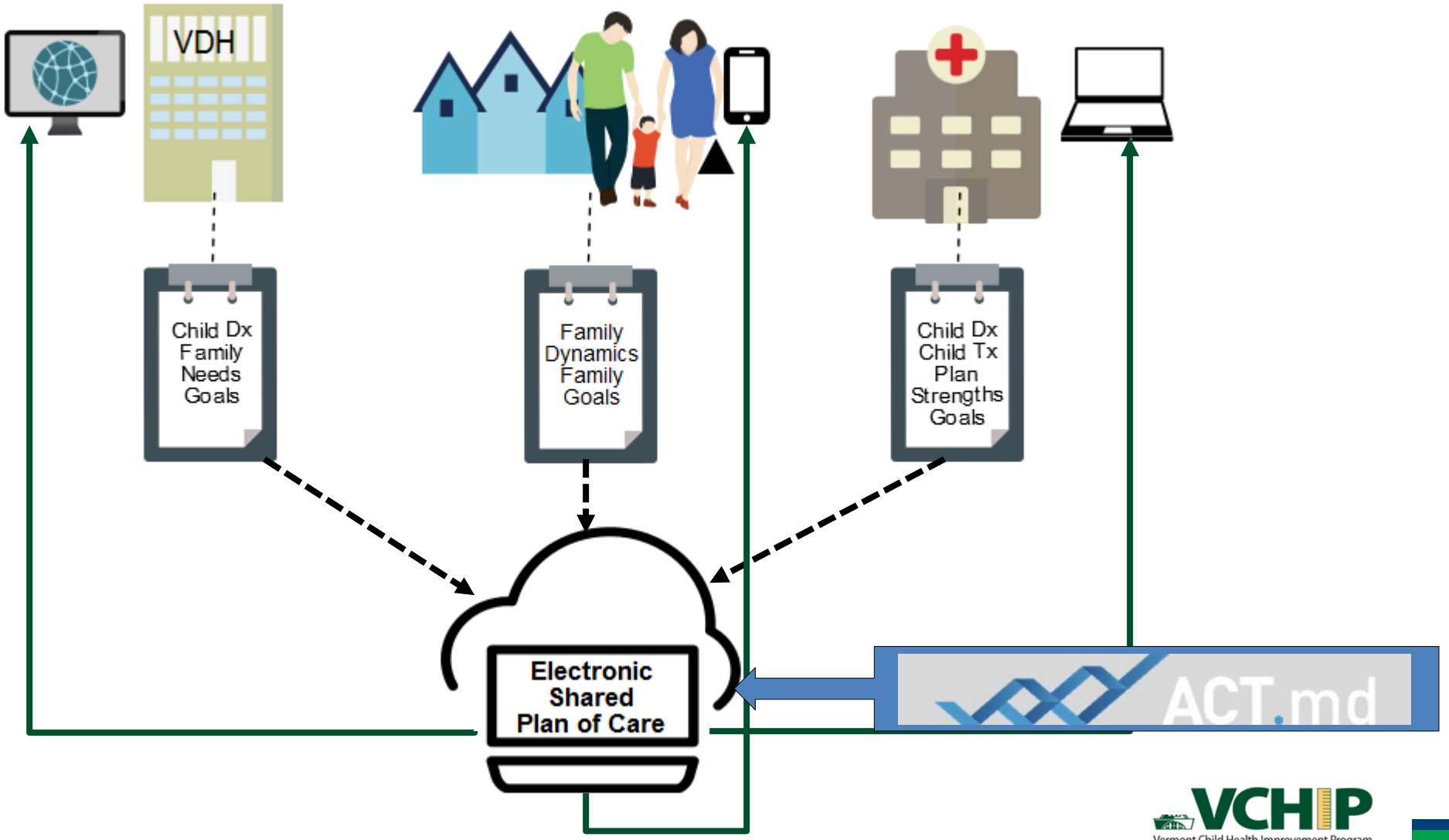
Private Therapy
Melanie Pope, OT, Kids Rehab Gym
TBD, PT, Kids Rehab Gym

Financial Supports
Green Mountain Care Insurance
State of Vermont - Adoption Stipend
Employment - National Bank of Middlebury
Employment - NuHarbor Security
PCA Program
SSTA

Addi's Eco-map, August 2016


Hutch Brothers Concrete in East Barre
Substance Abuse meetings
Friends
[redacted] mom
[redacted] Grandmother
Spends Sdays with [redacted] and [redacted] 2nd then 5 days with mom
Parol officer - [redacted]
Start School in Spring?
Spend every other weekend with Dad / Ryan
[redacted] daughter, wife and 3 kids
Counseling with Behavioral Health and Wellness
Free lunch at school
Hardwick Elementary School
Sponsor
[redacted]
[redacted]
[redacted]
[redacted]
After School Reach Program
[redacted] mom and Dad
[redacted] Sister and Husband
Soccer and Basketball
Gymnastics in the Spring
Gymnastics and dance
Head Start Program
Daycare in East Hardwick
Medicaid
Hazen, Rinehart and Connolly
T-ball in Spring
3 Squares Vermont
WIC
Vermont Children's Hospital
Key
— = Good connection
= = Supportive and/or Strong connection
Weak, and/or Unsupportive connection
+ = Separated

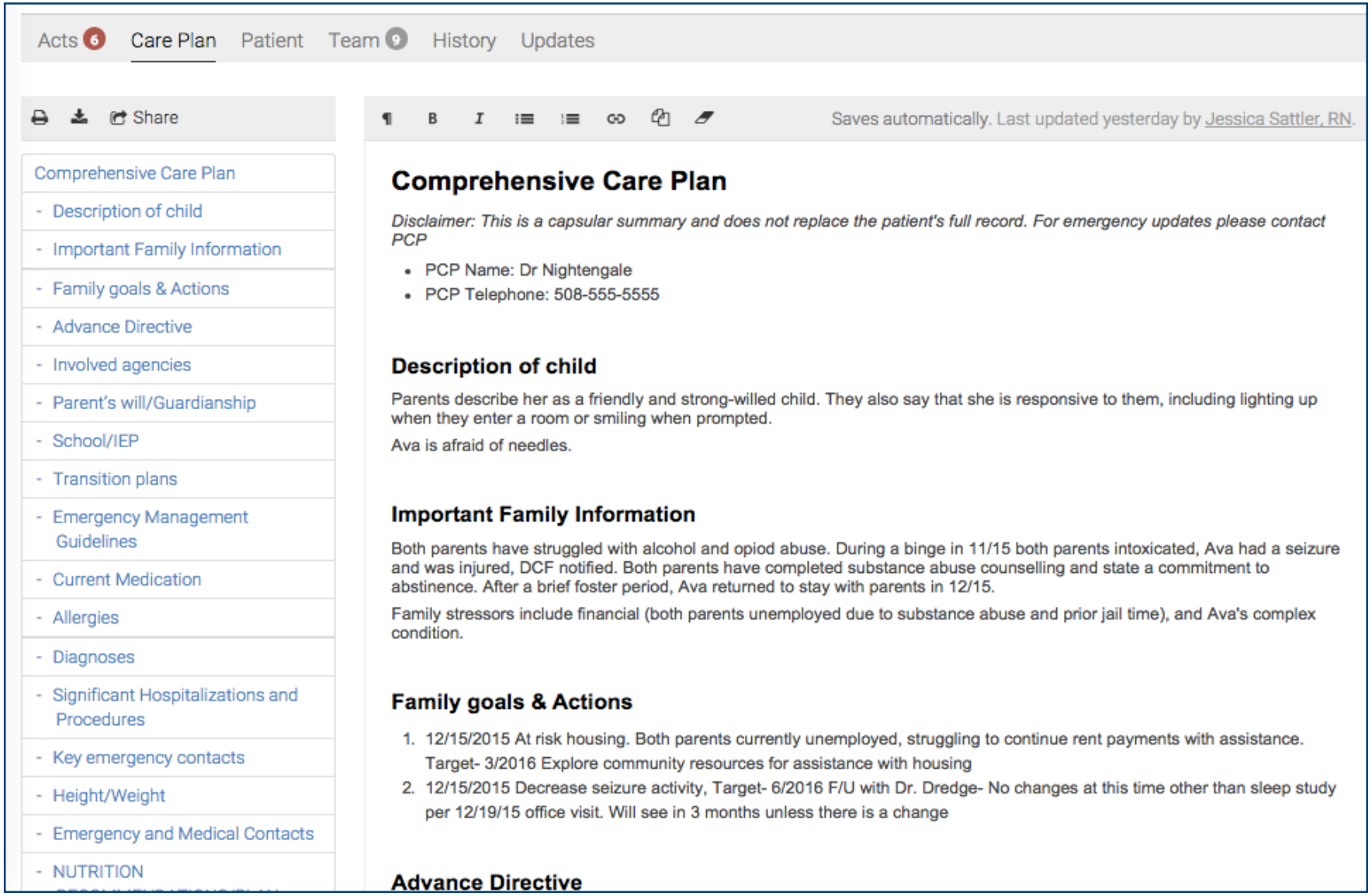
Data Flow Diagram: Electronic Shared Plan of Care



Picture of Patient (in this example, Ava)

Date of Birth, Contact Information, Last Access

ACT.md

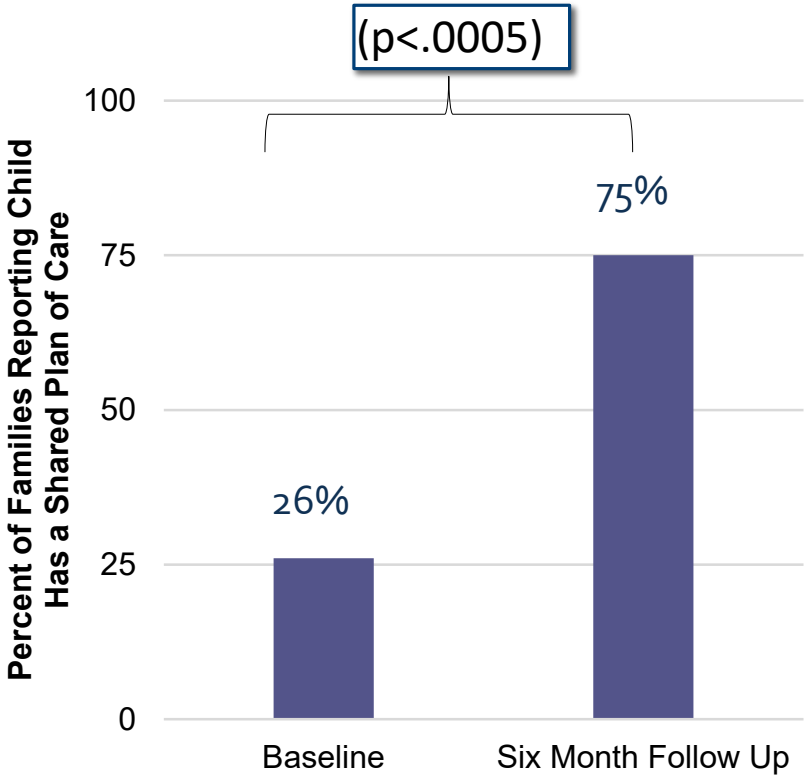


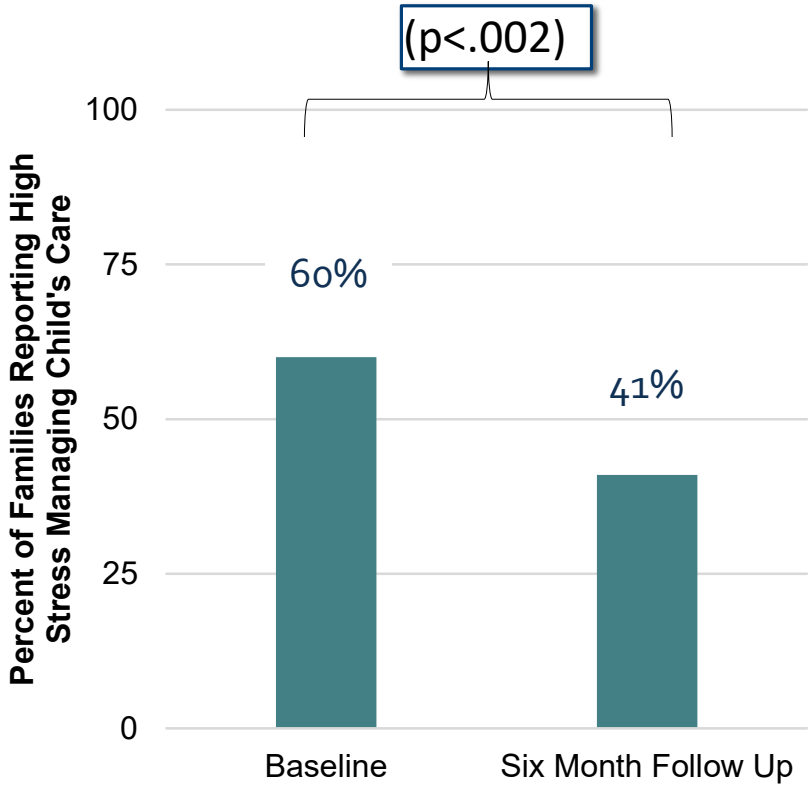
Care Coordination Rounds

- Regular meetings (typically 1 hour) with practice care coordinator, physicians, CHT social worker, (sometimes other community partners as needed)
- Discussion of patients (who needs more intervention and who is doing what part of the work)
- Systems issues
- Prepares provider and community to address family's needs

3. What We Are Learning

Families Experience More Shared Plans of Care and Lower Stress after 6 months of Care Coordination





Key to Family Engagement

Build trusting relationships

Allows for timely, accurate information sharing

And…

…Problem Solving Discussions

Each of us has a piece of the puzzle

Keeping an open mind

Getting from A to B may require going to C and D first

Patience

Kindness

Humility

Parking Lot and follow up

Care Conferences

Introductions/Contacts

Set Agenda

Set Roles: Facilitator

Start with Strengths

Care map

Discussion

Minutes Recorded

Update Plan with Next Steps & Accountability

Next Care Conference Date (if needed)

Care plan is shared at end of meeting

Cultural Humility

"Cultural humility acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own…

Cultural humility requires us to take responsibility for our interactions with others beyond acknowledging or being sensitive to our differences."

Self Awareness

Allows Progression From…

Unconscious Incompetence

↓

Conscious Incompetence

↓

Conscious Competence

↓

Unconscious Competence

Conflict is…

A situation in which the concerns of two or more people/parties *appear* to be incompatible.

Thomas-Kilmann Conflict Modes

Retrieved from: http://www.edbatista.com/2007/01/conflict_modes_.html

LEARN

Listen: to the person's perception

Explain: your perception

Acknowledge: similarities & differences

Recommend: both have ideas on what to do

Negotiate: make a plan WITH (not for) the family

(adapted from Berlin & Fowkes, 1982)

Key Reflections

Practices have strengthened abilities to help families through learning effective skills to facilitate coordination and continuity of care and by identifying a process for prioritizing medically complex patients

Having a practice improvement team that includes family health partners is valuable to developing care coordination procedures

SPoC's are tangible tools to improve communication, coordinate care, and engage families in their care

Lessons Learned

- Engaging key leadership (state level, practice level) is vital to the success of care coordination efficiencies
- Care coordination is a process, not just a person
- Billing and coding for care coordination is still difficult
- Protecting care coordinator's time needs to be a priority
- Engaging family health partners and integrating into practice teams takes a commitment from everyone

From Our Community Clinicians

- Reach out to your peers and community networks for help
- Document what works and what doesn't
- Understand skill sets within your staff…the "care coordinator" doesn't have to do it all
- Learn the expertise of care coordination systems within the community
- Listening to families allows you to understand what the REAL impact is
- Families don't know what they don't know, and practices don't know what they don't know
- Invest in family health partners
- It takes time to develop this collaborative partnership and it's worth it!

Benefits to Clinicians

- Don’t have to have all of the solutions
- Part of a collaborative team
- More time for medical thinking and deeper understanding of situation
- Improved clinical outcomes
- Feel better prepared
- Less time spinning wheels
- Focus on important issues—not “catching up”
- Less Phone Time

Parents' Voices

NO Care Coordination

"There was no continuity. We would call the primary care office with a concern and they would say "Oh, you need to talk to your specialist about that." We would call the specialist and they would say "Oh, you need to talk to your primary care doctor about that." It was just back and forth all the time and the concerns never got addressed."

WITH Care Coordination

"Now there is a sense that I'm being listened to – that his medical needs are being addressed. We have a plan with where we are headed, especially with the school, we know where we are going."

Maier, Parent interview, March 6, 2014

Questions?

Healthier Communities: What Works to Make Real Change

CARRIE HRIBAR, MA
JOSHUA WILLIAMS, LLMSW, BSW
JENIFER MURRAY RN, MPH

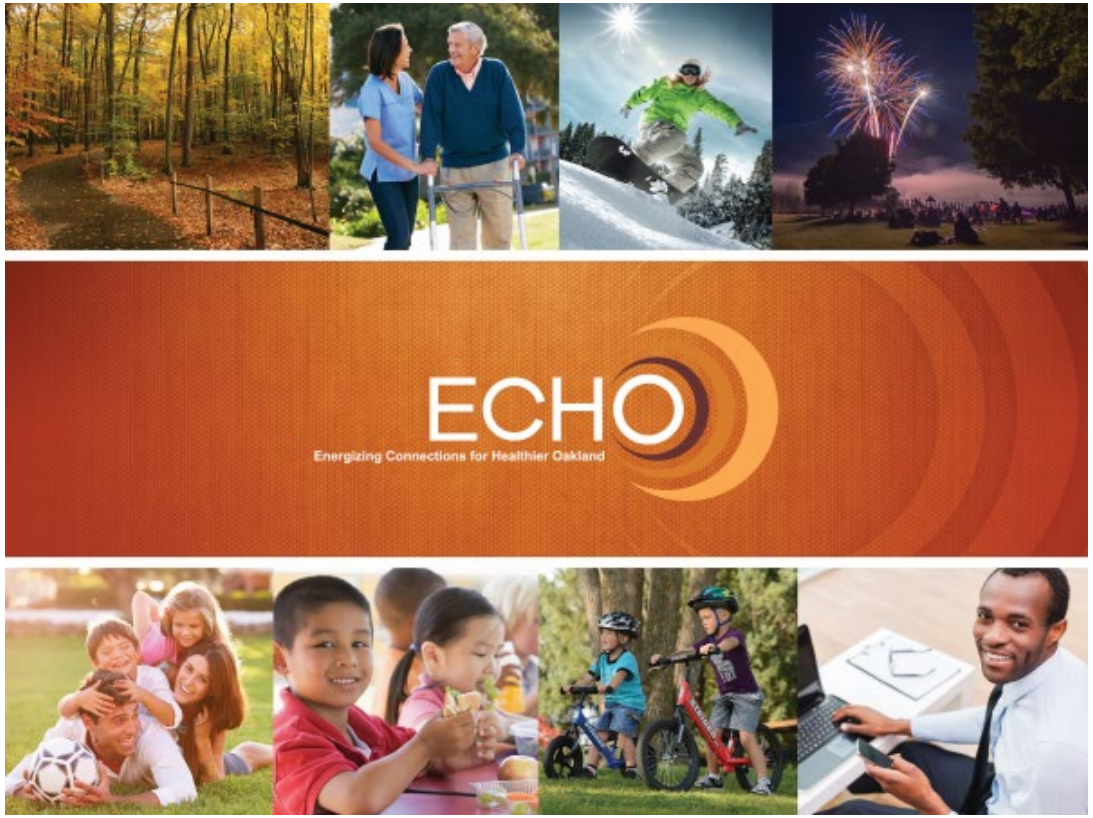
Learning Objective

Relate the approaches of groups that partner with community stakeholders to work together on health innovation and identify the strategies that they use to address population health improvement, including SDoH gap needs.

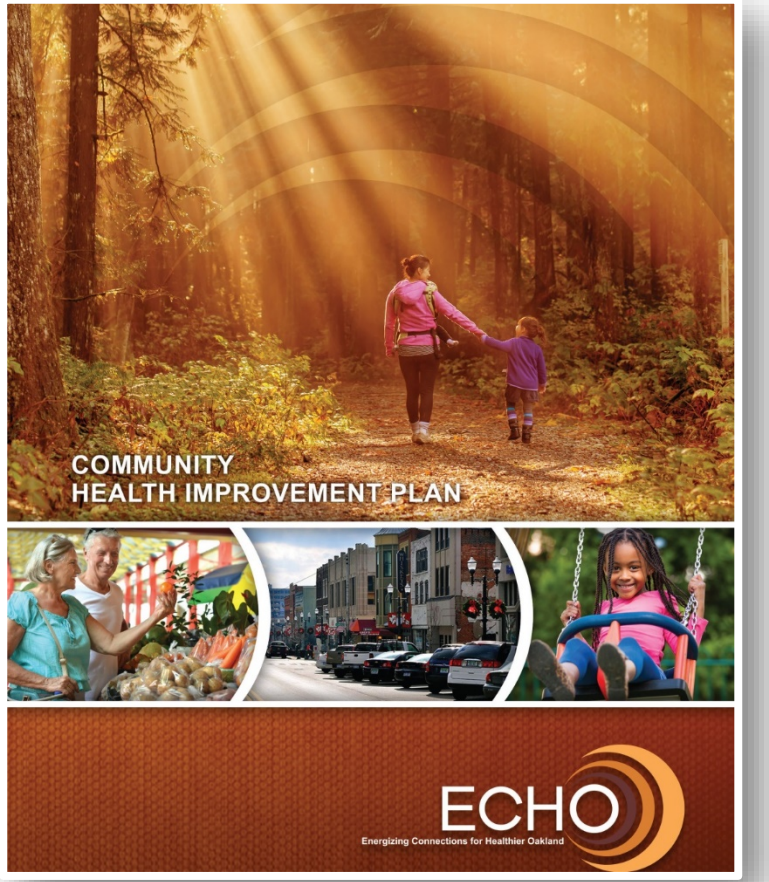
Healthier Communities: Oakland County's Approach

CARRIE HRIBAR, MA
OAKLAND COUNTY HEALTH DIVISION

Energizing Connections for Healthier Oakland (ECHO)



Community Health Improvement Plan (CHIP)



Launched in 2016

Implementing with partners

http://oakgov.com/ECHO

ECHO Strategic Issues

Healthy Eating

Active Living

Built Environment

Access To Care

Data & Informatics

ECHO Action Teams

Access to Care Goals and Objectives

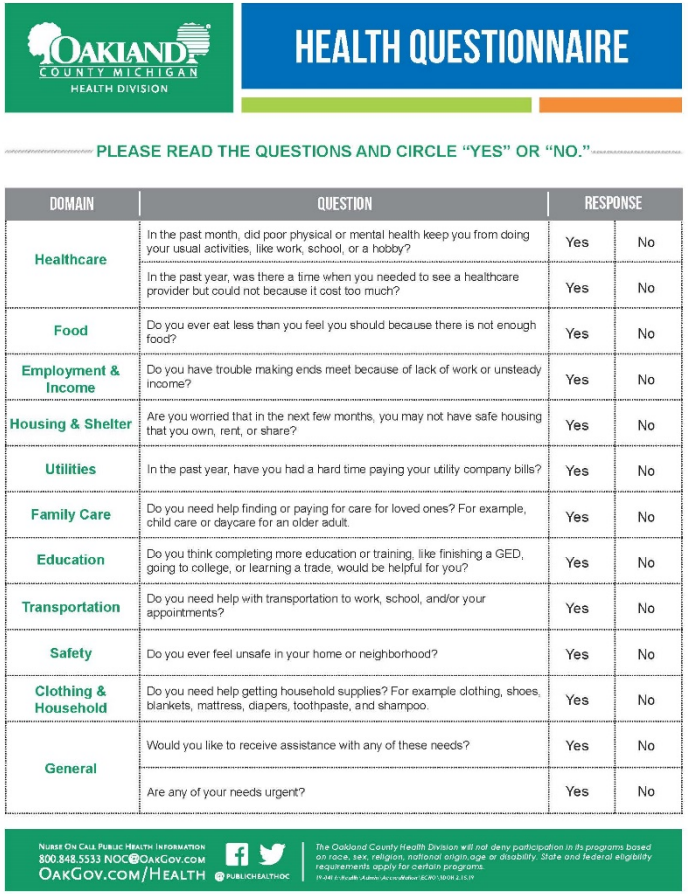
Address identified barriers to and inequities in accessing care

Increase screening and referrals related to Social Determinants of Health

Work with partners to address culture and linguistic barriers to obtaining and understanding health information and services

Promote awareness of and referrals to behavioral health resources

Social Determinants of Health Screening



OAKLAND COUNTY MICHIGAN
HEALTH DIVISION

HEALTH QUESTIONNAIRE

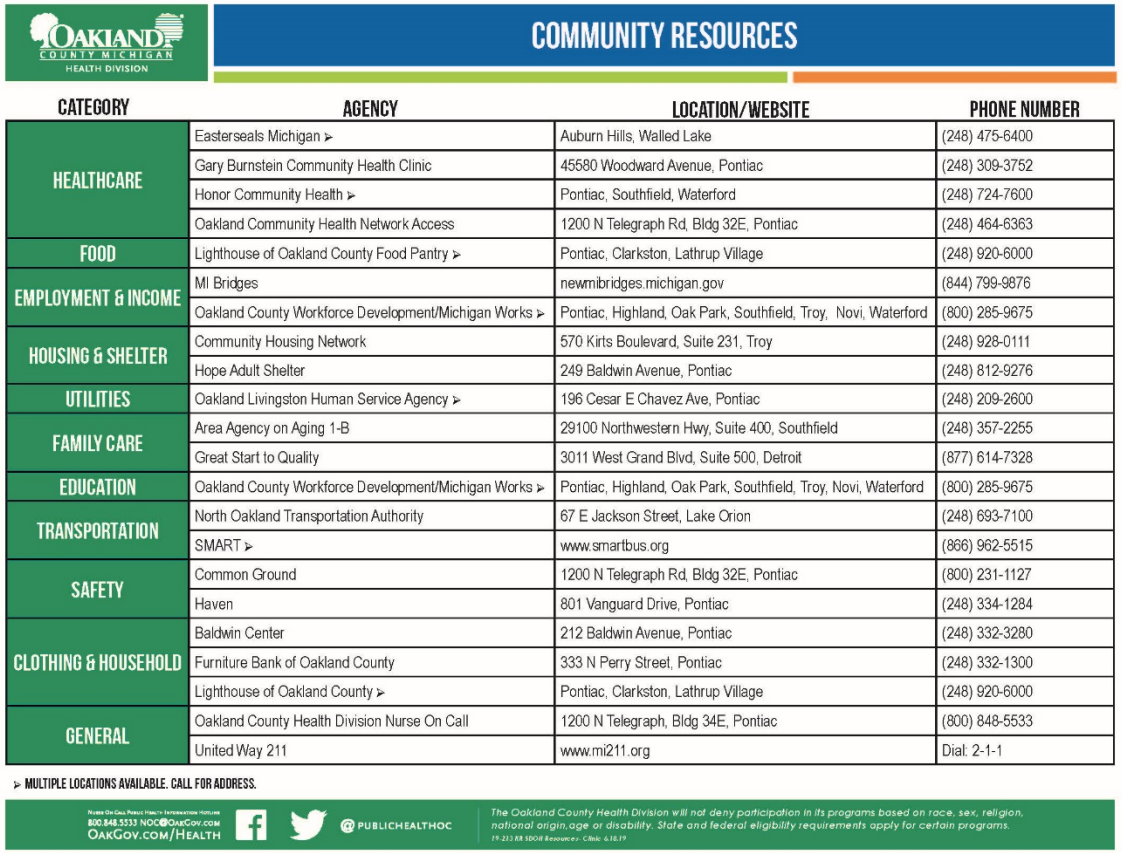
PLEASE READ THE QUESTIONS AND CIRCLE "YES" OR "NO."

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 healthcare provider 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 trouble making ends meet because of lack of work or unsteady 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
Family Care	Do you need help finding or paying for care for loved ones? For example, child care or daycare for an older adult.	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 need help with transportation to work, school, and/or your appointments?	Yes	No
Safety	Do you ever feel unsafe in your home or neighborhood?	Yes	No
Clothing & Household	Do you need help getting household supplies? For example clothing, shoes, blankets, mattress, 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

NURSE ON CALL PUBLIC HEALTH INFORMATION
800.848.5533 NOC@OAKGOV.COM
OAKGOV.COM/HEALTH @PUBLICHEALTHOC

The Oakland County Health Division will not deny participation in its programs based on race, sex, religion, national origin, age or disability. State and federal eligibility requirements apply for certain programs.

Social Determinants of Health Screening, cont.



OAKLAND COUNTY MICHIGAN
HEALTH DIVISION

COMMUNITY RESOURCES

CATEGORY	AGENCY	LOCATION/WEBSITE	PHONE NUMBER
HEALTHCARE	Easterseals Michigan ➢	Auburn Hills, Walled Lake	(248) 475-6400
	Gary Burnstein Community Health Clinic	45580 Woodward Avenue, Pontiac	(248) 309-3752
	Honor Community Health ➢	Pontiac, Southfield, Waterford	(248) 724-7600
	Oakland Community Health Network Access	1200 N Telegraph Rd, Bldg 32E, Pontiac	(248) 464-6363
FOOD	Lighthouse of Oakland County Food Pantry ➢	Pontiac, Clarkston, Lathrup Village	(248) 920-6000
EMPLOYMENT & INCOME	MI Bridges	newmibridges.michigan.gov	(844) 799-9876
	Oakland County Workforce Development/Michigan Works ➢	Pontiac, Highland, Oak Park, Southfield, Troy, Novi, Waterford	(800) 285-9675
HOUSING & SHELTER	Community Housing Network	570 Kirts Boulevard, Suite 231, Troy	(248) 928-0111
	Hope Adult Shelter	249 Baldwin Avenue, Pontiac	(248) 812-9276
UTILITIES	Oakland Livingston Human Service Agency ➢	196 Cesar E Chavez Ave, Pontiac	(248) 209-2600
FAMILY CARE	Area Agency on Aging 1-B	29100 Northwestern Hwy, Suite 400, Southfield	(248) 357-2255
	Great Start to Quality	3011 West Grand Blvd, Suite 500, Detroit	(877) 614-7328
EDUCATION	Oakland County Workforce Development/Michigan Works ➢	Pontiac, Highland, Oak Park, Southfield, Troy, Novi, Waterford	(800) 285-9675
TRANSPORTATION	North Oakland Transportation Authority	67 E Jackson Street, Lake Orion	(248) 693-7100
	SMART ➢	www.smartbus.org	(866) 962-5515
SAFETY	Common Ground	1200 N Telegraph Rd, Bldg 32E, Pontiac	(800) 231-1127
	Haven	801 Vanguard Drive, Pontiac	(248) 334-1284
CLOTHING & HOUSEHOLD	Baldwin Center	212 Baldwin Avenue, Pontiac	(248) 332-3280
	Furniture Bank of Oakland County	333 N Perry Street, Pontiac	(248) 332-1300
	Lighthouse of Oakland County ➢	Pontiac, Clarkston, Lathrup Village	(248) 920-6000
GENERAL	Oakland County Health Division Nurse On Call	1200 N Telegraph, Bldg 34E, Pontiac	(800) 848-5533
	United Way 211	www.mi211.org	Dial: 2-1-1

➢ MULTIPLE LOCATIONS AVAILABLE. CALL FOR ADDRESS.

800.848.5533 NOC@OakGov.com
OakGov.com/Health

@PUBLICHEALTHOC

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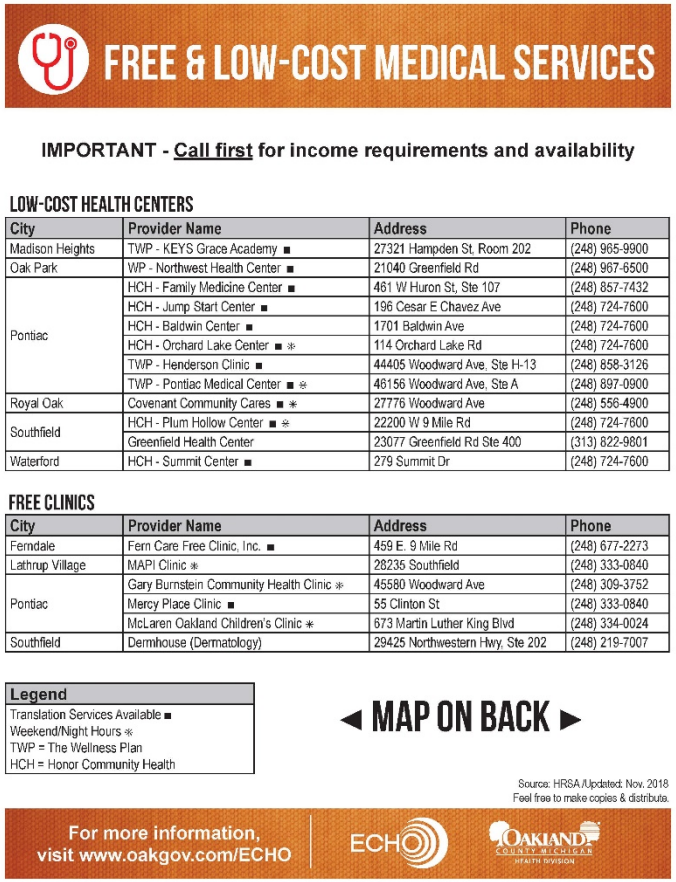
19-233 RR SDOH Resources- Clinic 6.18.19

Access to Care Resource Sheets



FREE & LOW-COST MEDICAL SERVICES

IMPORTANT - Call first for income requirements and availability

LOW-COST HEALTH CENTERS

City	Provider Name	Address	Phone
Madison Heights	TWP - KEYS Grace Academy ■	27321 Hampden St, Room 202	(248) 965-9900
Oak Park	WP - Northwest Health Center ■	21040 Greenfield Rd	(248) 967-6500
Pontiac	HCH - Family Medicine Center ■	461 W Huron St, Ste 107	(248) 857-7432
	HCH - Jump Start Center ■	196 Cesar E Chavez Ave	(248) 724-7600
	HCH - Baldwin Center ■	1701 Baldwin Ave	(248) 724-7600
	HCH - Orchard Lake Center ■ ✳	114 Orchard Lake Rd	(248) 724-7600
	TWP - Henderson Clinic ■	44405 Woodward Ave, Ste H-13	(248) 858-3126
	TWP - Pontiac Medical Center ■ ✳	46156 Woodward Ave, Ste A	(248) 897-0900
Royal Oak	Covenant Community Cares ■ ✳	27776 Woodward Ave	(248) 556-4900
Southfield	HCH - Plum Hollow Center ■ ✳	22200 W 9 Mile Rd	(248) 724-7600
	Greenfield Health Center	23077 Greenfield Rd Ste 400	(313) 822-9801
Waterford	HCH - Summit Center ■	279 Summit Dr	(248) 724-7600

FREE CLINICS

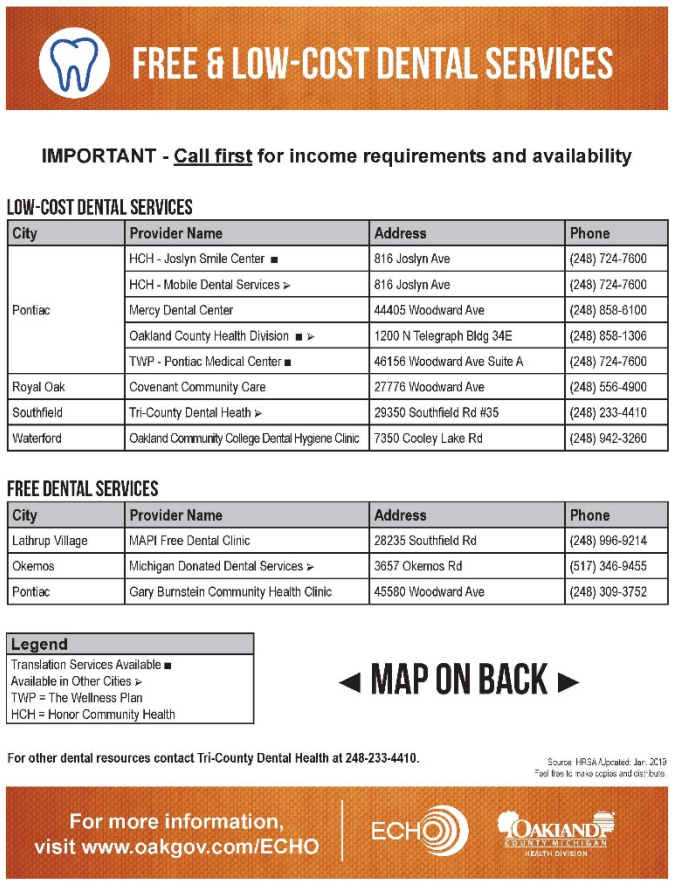
City	Provider Name	Address	Phone
Ferndale	Fern Care Free Clinic, Inc. ■	459 E. 9 Mile Rd	(248) 677-2273
Lathrup Village	MAPI Clinic ✳	28235 Southfield	(248) 333-0840
Pontiac	Gary Burnstein Community Health Clinic ✳	45580 Woodward Ave	(248) 309-3752
	Mercy Place Clinic ■	55 Clinton St	(248) 333-0840
	McLaren Oakland Children's Clinic ✳	673 Martin Luther King Blvd	(248) 334-0024
Southfield	Dermhouse (Dermatology)	29425 Northwestern Hwy, Ste 202	(248) 219-7007

Legend
Translation Services Available ■
Weekend/Night Hours ✳
TWP = The Wellness Plan
HCH = Honor Community Health

◄ MAP ON BACK ►

Source: HRSA /Updated: Nov. 2018
Feel free to make copies & distribute.

For more information, visit www.oakgov.com/ECHO | ECHO | OAKLAND COUNTY MICHIGAN HEALTH DIVISION



FREE & LOW-COST DENTAL SERVICES

IMPORTANT - Call first for income requirements and availability

LOW-COST DENTAL SERVICES

City	Provider Name	Address	Phone
Pontiac	HCH - Joslyn Smile Center ■	816 Joslyn Ave	(248) 724-7600
	HCH - Mobile Dental Services ➢	816 Joslyn Ave	(248) 724-7600
	Mercy Dental Center	44405 Woodward Ave	(248) 858-6100
	Oakland County Health Division ■ ➢	1200 N Telegraph Bldg 34E	(248) 858-1306
	TWP - Pontiac Medical Center ■	46156 Woodward Ave Suite A	(248) 724-7600
Royal Oak	Covenant Community Care	27776 Woodward Ave	(248) 556-4900
Southfield	Tri-County Dental Heath ➢	29350 Southfield Rd #35	(248) 233-4410
Waterford	Oakland Community College Dental Hygiene Clinic	7350 Cooley Lake Rd	(248) 942-3260

FREE DENTAL SERVICES

City	Provider Name	Address	Phone
Lathrup Village	MAPI Free Dental Clinic	28235 Southfield Rd	(248) 996-9214
Okemos	Michigan Donated Dental Services ➢	3657 Okemos Rd	(517) 346-9455
Pontiac	Gary Burnstein Community Health Clinic	45580 Woodward Ave	(248) 309-3752

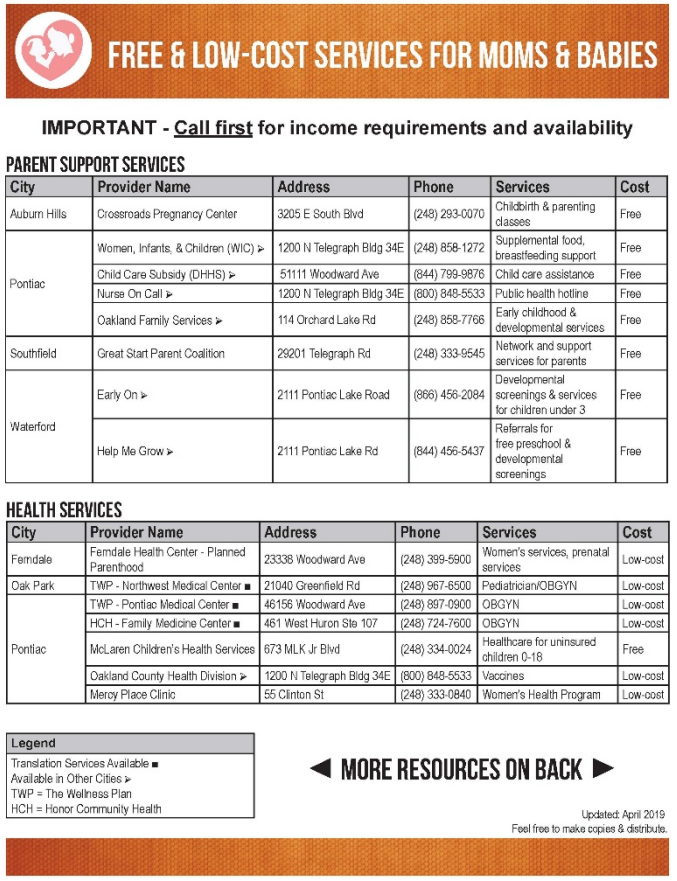
Legend
Translation Services Available ■
Available in Other Cities ➢
TWP = The Wellness Plan
HCH = Honor Community Health

◄ MAP ON BACK ►

For other dental resources contact Tri-County Dental Health at 248-233-4410.

Source: HRSA /Updated: Jan. 2019
Feel free to make copies and distribute.

For more information, visit www.oakgov.com/ECHO | ECHO | OAKLAND COUNTY MICHIGAN HEALTH DIVISION



FREE & LOW-COST SERVICES FOR MOMS & BABIES

IMPORTANT - Call first for income requirements and availability

PARENT SUPPORT SERVICES

City	Provider Name	Address	Phone	Services	Cost
Auburn Hills	Crossroads Pregnancy Center	3205 E South Blvd	(248) 293-0070	Childbirth & parenting classes	Free
Pontiac	Women, Infants, & Children (WIC) ➢	1200 N Telegraph Bldg 34E	(248) 858-1272	Supplemental food, breastfeeding support	Free
	Child Care Subsidy (DHHS) ➢	51111 Woodward Ave	(844) 799-9876	Child care assistance	Free
	Nurse On Call ➢	1200 N Telegraph Bldg 34E	(800) 848-5533	Public health hotline	Free
	Oakland Family Services ➢	114 Orchard Lake Rd	(248) 858-7766	Early childhood & developmental services	Free
Southfield	Great Start Parent Coalition	29201 Telegraph Rd	(248) 333-9545	Network and support services for parents	Free
Waterford	Early On ➢	2111 Pontiac Lake Road	(866) 456-2084	Developmental screenings & services for children under 3	Free
	Help Me Grow ➢	2111 Pontiac Lake Rd	(844) 456-5437	Referrals for free preschool & developmental screenings	Free

HEALTH SERVICES

City	Provider Name	Address	Phone	Services	Cost
Ferndale	Ferndale Health Center - Planned Parenthood	23338 Woodward Ave	(248) 399-5900	Women's services, prenatal services	Low-cost
Oak Park	TWP - Northwest Medical Center ■	21040 Greenfield Rd	(248) 967-6500	Pediatrician/OBGYN	Low-cost
Pontiac	TWP - Pontiac Medical Center ■	46156 Woodward Ave	(248) 897-0900	OBGYN	Low-cost
	HCH - Family Medicine Center ■	461 West Huron Ste 107	(248) 724-7600	OBGYN	Low-cost
	McLaren Children's Health Services	673 MLK Jr Blvd	(248) 334-0024	Healthcare for uninsured children 0-18	Free
	Oakland County Health Division ➢	1200 N Telegraph Bldg 34E	(800) 848-5533	Vaccines	Low-cost
	Mercy Place Clinic	55 Clinton St	(248) 333-0840	Women's Health Program	Low-cost

Legend
Translation Services Available ■
Available in Other Cities ➢
TWP = The Wellness Plan
HCH = Honor Community Health

◄ MORE RESOURCES ON BACK ►

Updated: April 2019
Feel free to make copies & distribute.

SIM MDHHS State Innovation Model

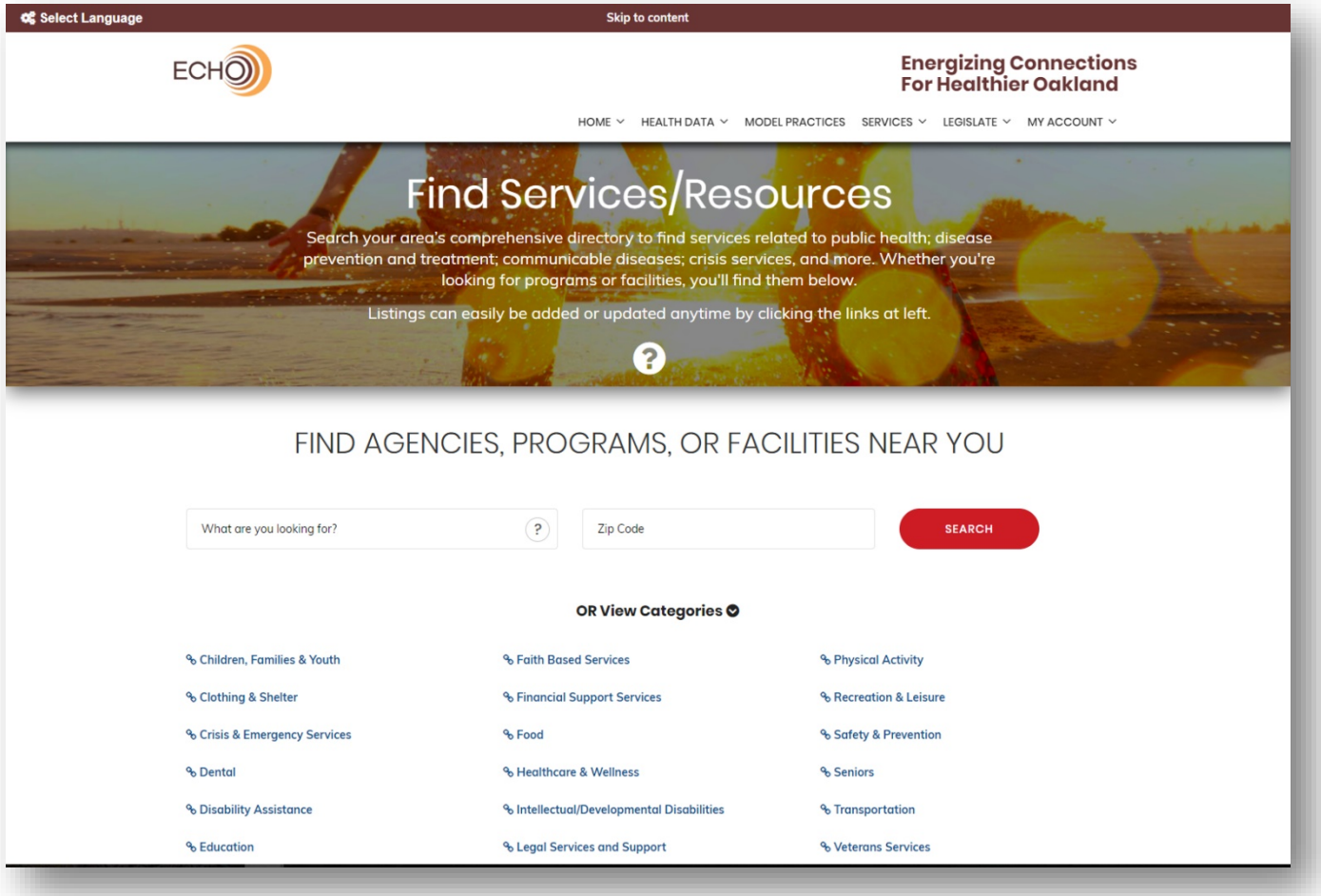
Oakland County Health Division (OCHD) Nurse on Call

Experienced Public Health Nurses provide callers with reliable, up-to-date information

Referrals to services & community resources

1-800-848-5533 or noc@oakgov.com

ECHO Service Directory



Next Steps

- Exploring electronic referral and data system
- Sharing and aggregating data across partners
- Include screening data in next Community Health Assessment
- Identify top needs for Oakland County and upstream approaches to address them

Lessons Learned

- Unfamiliarity with resources is biggest barrier to using screening tool
- Trusted partners are key to expanding SDoH work
- Rely on partners and experts in your community to remain current on what resources are available
- Start small and pilot to work out any kinks

Jackson Community Health Innovation Region (CHIR)

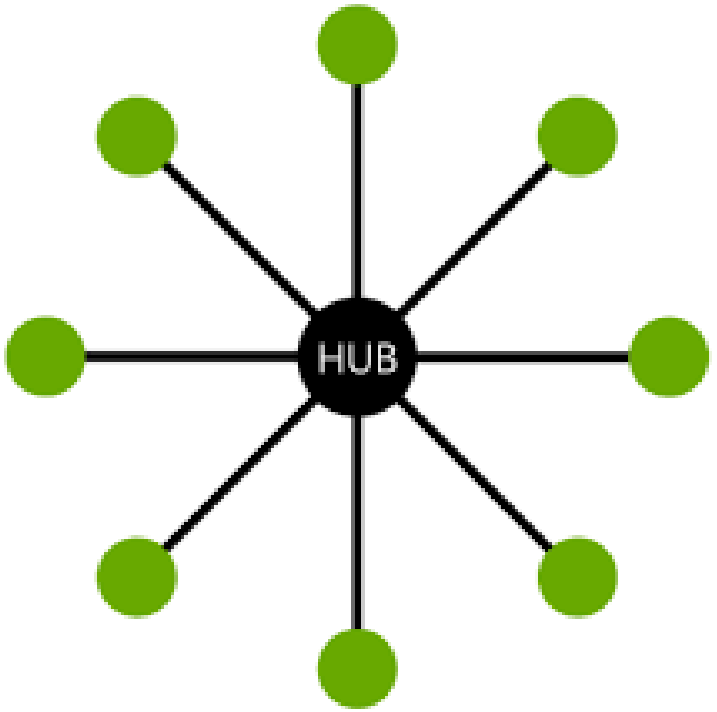
JOSHUA WILLIAMS, LLMSW, BSW
JACKSON COLLABORATIVE NETWORK

Implementing SDoH Screening

- Assessment of community's current state
  - In person interviews
  - Document assessment matrix
- Developing the questionnaire
- Implementing across sectors
- What do we do with the results?
- Creating clinical & community linkages

Designing the Jackson Care HUB

- Online platform accessible to the community partners to conduct screenings
- Community designed
- Integrated with partners EMR (EPIC)
- Assessment of needs identified
- Integrated with data bases of information
  - Resources
  - Client info (MIHIN)
- Electronic referrals & real time feedback



Jackson's Current State- 9.12.19

- Online platform
  - 30+ Community Partners
    - Screenings
    - Referrals
    - Care Team
- Integrated with EPIC
  - Screening
  - My Chart
  - Jackson Care HUB Launch
- 60,000 SDoH Screenings Completed
- 4,000 Community Referrals made

Lessons Learned

- Screening takes time but not impossible
  - Power-through the hesitancy & pilot
- Be flexible with workflow/process
- Community design leads to ownership
- Embedding the work
- Ongoing Technical Assistance

Clinical Community Linkages - NMCHIR

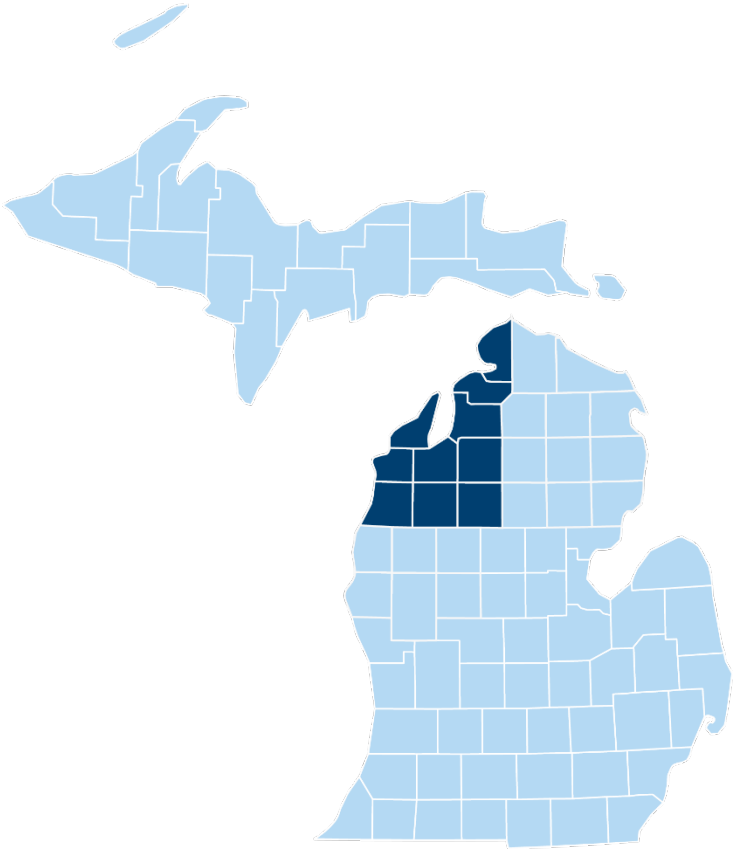
JENIFER MURRAY RN, MPH

NORTHERN MICHIGAN CHIR

Northern Michigan CHIR

SIM funds are dedicated to five pilot sites in Michigan.

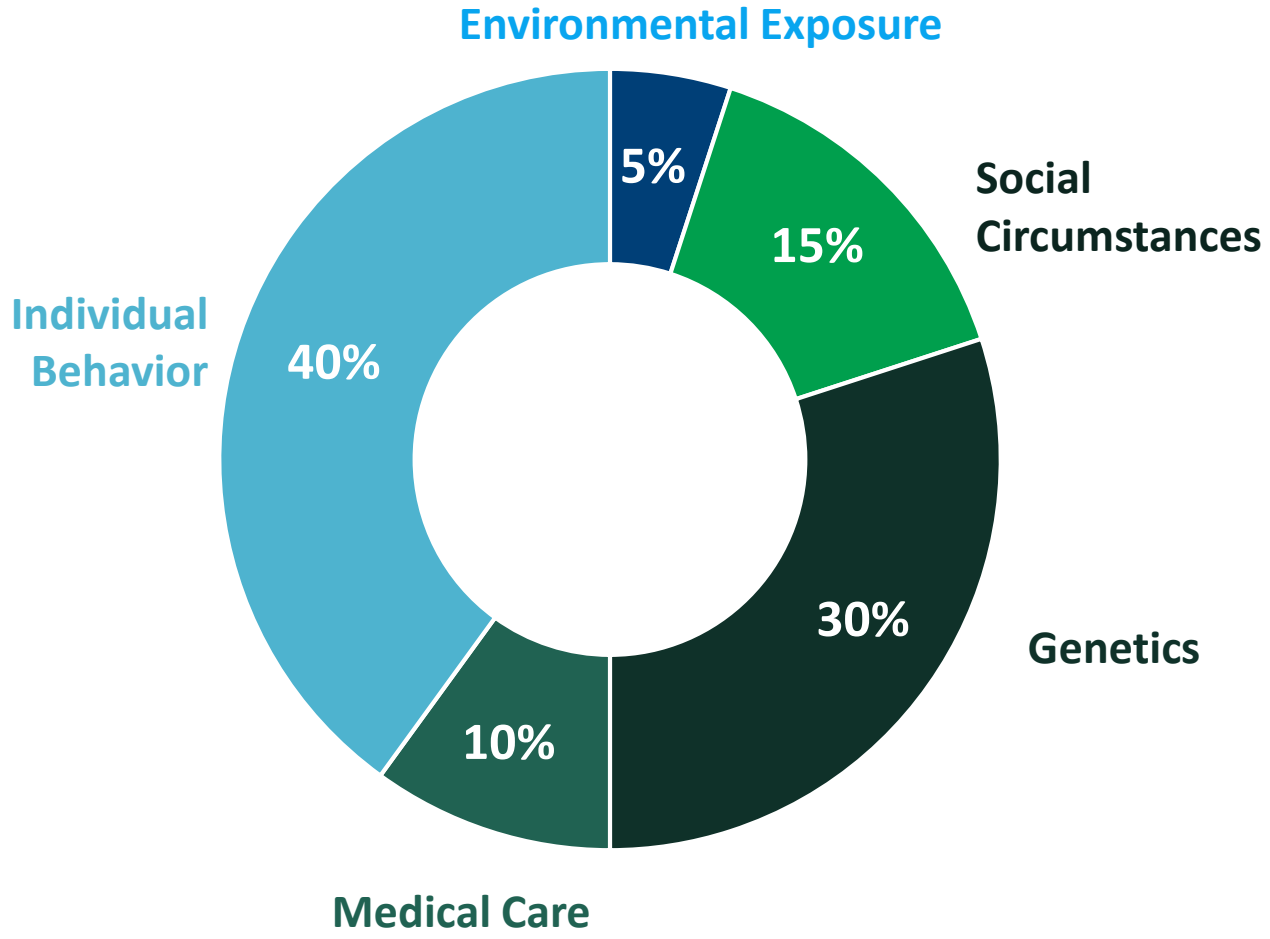
The Northern Michigan Community Health Innovation Region (NMCHIR) is our rural pilot.



WHAT Determines Health

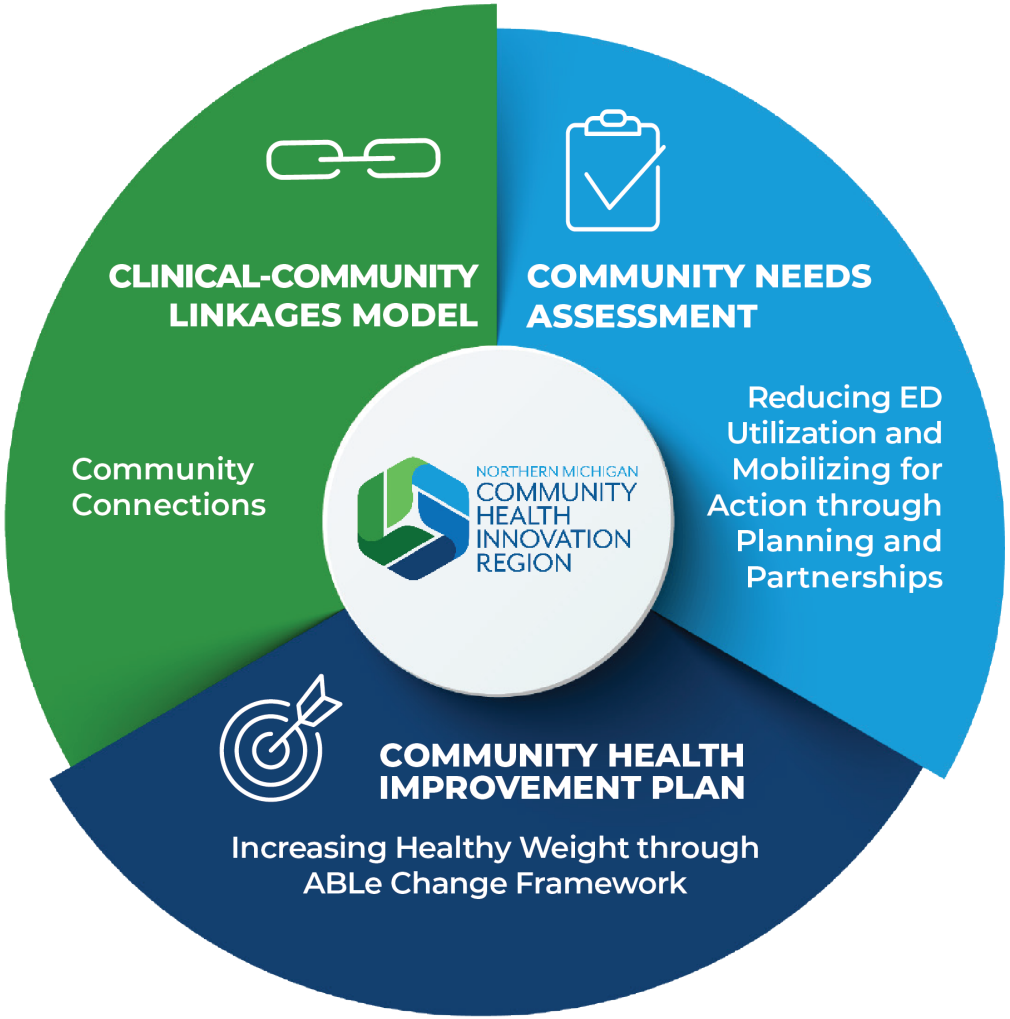
Medical Care is only 10% of what makes a person healthy.

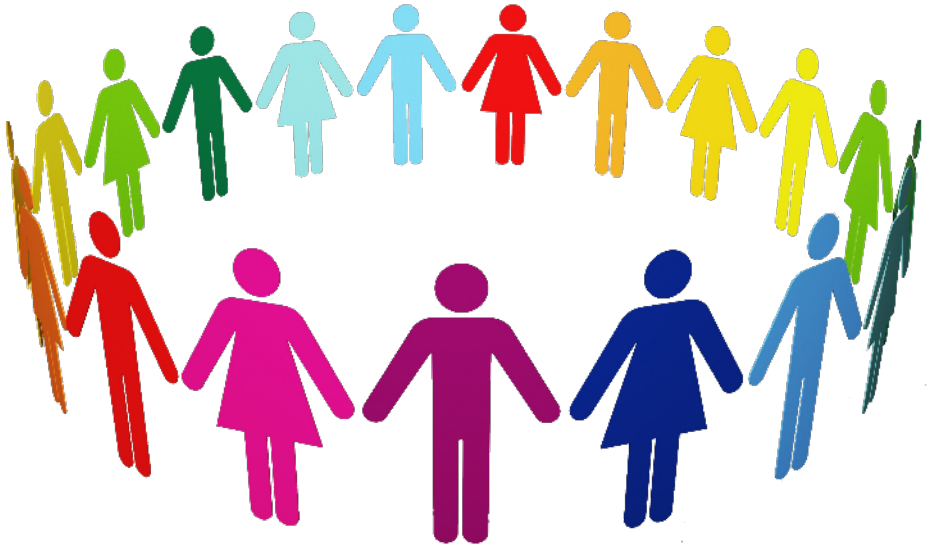
We have less control over Genetics, but we can influence Environmental Exposure, Social Circumstance and Individual behavior.



Schroeder, S. A. (2007). We Can Do Better — Improving the Health of the American People. New England Journal of Medicine, 357(12), 1221–1228. doi: 10.1056/nejmsa073350

Community Health Innovation Region





COMMUNITY connections

In partnership…

NORTHERN MICHIGAN COMMUNITY HEALTH INNOVATION REGION

BENZIE-LEELANAU DISTRICT HEALTH DEPARTMENT

District Health Department #10
Healthy People, Healthy Communities

Grand Traverse County 1851 HEALTH DEPARTMENT

HEALTH DEPARTMENT of Northwest Michigan

What is COMMUNITY connections

A FREE PROGRAM

Connecting adults, children, and families to community resources

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Like food, housing, transportation, physical and mental health

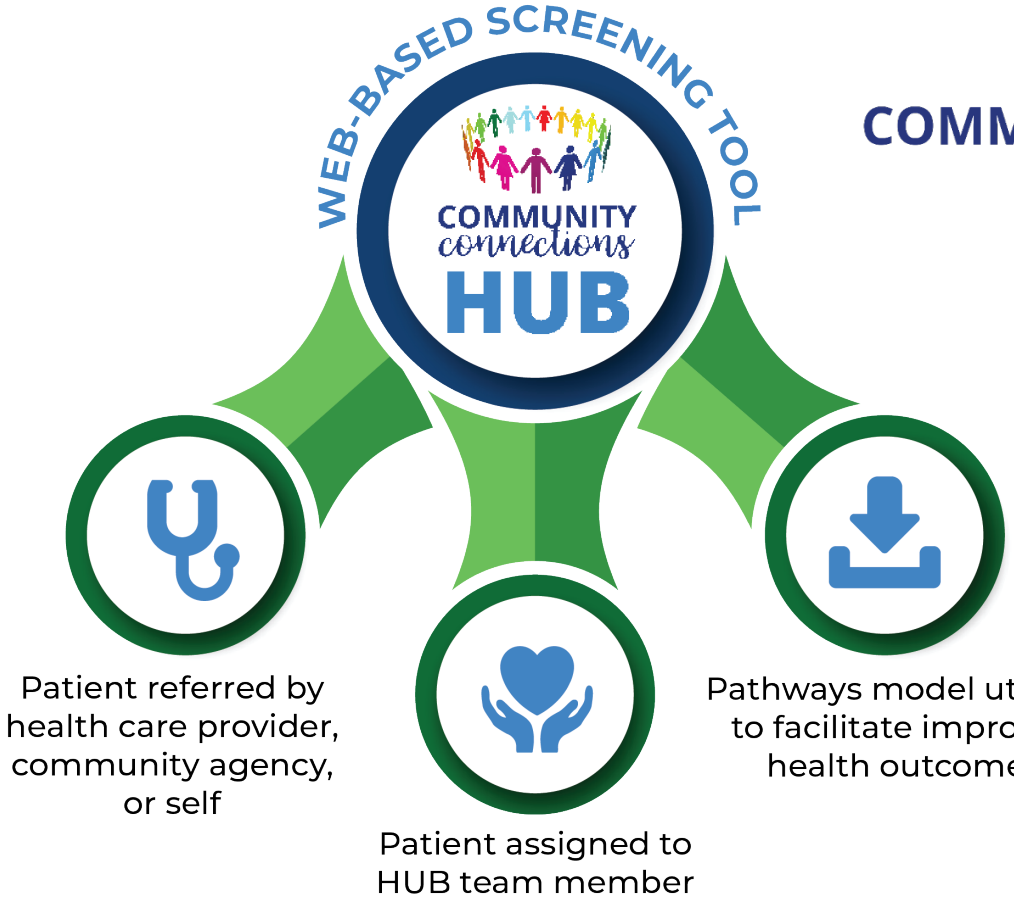
BY PROFESSIONALS

Community Health Worker, Registered Nurse, or Social Worker

THROUGH MULTIPLE CHANNELS

Phone calls, home visits, and office visits

Clinical-Community Linkages Model



COMMUNITY connections

Community Based Access Point

NORTHWEST HUB
Antrim, Charlevoix, Emmet

DHD#10 HUB
Kalkaska, Manistee, Missaukee, Wexford

GRAND TRAVERSE HUB
Benzie, Grand Traverse, Leelanau

Screening Questions

01 POOR PHYSICAL HEALTH?

02 POOR MENTAL HEALTH?

03 COULDN'T SEE A DOCTOR?

04 NOT ENOUGH FOOD?

05 WORK OR INCOME?

Screening Questions, cont.

06 HOUSING?

07 CHILD CARE?

08 MORE EDUCATION?

09 RELIABLE TRANSPORTATION?

10 UTILITY BILLS PAID?

PCMH's Screening in Our Region

Alcona Health Center- Emmet County Site

Little Traverse Primary Care

Bellaire Family Health Center

Central Lake Family Health Center

East Jordan Family Health Center

Bay Area Family Care

Grand Traverse Children's Clinic

Kids Creek Children's Clinic

Munson Family Practice Center

Northern Pines Health Center

Traverse Area Pediatric And Adolescent Clinic PLC

West Front Primary Care PLLC.

Northwest Michigan Health Services Inc

Crystal Lake Health Center

Kalkaska Medical Associates

Munson Healthcare Manistee Hospital - Pediatrics

Munson Healthcare Manistee Hospital - Family Care

Munson Healthcare Manistee Hospital - Primary Care

Cadillac Family Physicians

Cadillac Primary Care and OB Gyn

Great Lakes Family Care - Cadillac

Mackinaw Trail Pediatrics

Gregory P Lambourne, MD

Pathways Community HUB Process

Referral

- Client Referral to HUB
- HUB central intake registers client into the database
- HUB coordinator assigns client to CHW (RN , SW or CHW)

CHW services

- CHW connects with client 1) Collects information and assesses needs, 2) Implements Core Pathways 3) links to community resources 4) confirms successful connection to resources

Outcomes

- Measures and documents results
- Reports feedback on referral to referral source

Documenting Outcomes

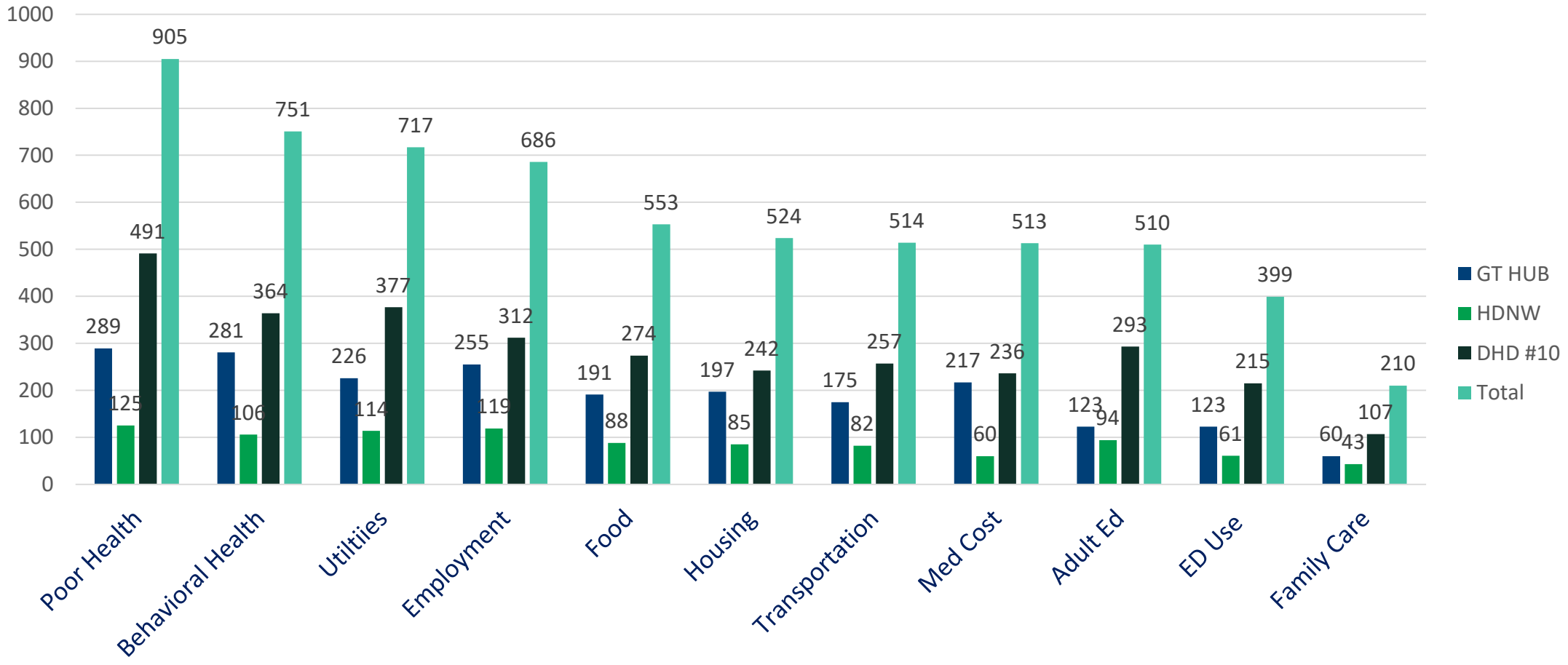
HUB staff documents progress meeting an outcome:

- 20 standardized/nationally recognized evidenced based Pathways (Sarah Redding, MD)
- Mental health appointments kept, housing secured, food assistance received, etc.
- Focus on progress & outcomes/achievement of client's health goals
- In order for a Pathway to be closed as "complete" CHW must document & verify the service was received by the client.
- Working towards a value-based reimbursement: Payment for engagement of high-risk clients & completion of evidenced based Pathways

SDoH Screenings – Ten Counties

	2018	January - June 2019
Web and Paper Screenings	22,485	10,425
Completed Screenings, Identified Needs, Wanted Assistance and provided Consent	2,396	1,202

Screening Needs of Those Referred
(July 2018 – June 2019) 3 Regional HUBS



Insurance of THOSE WHO are Referred
January 2018 –June 2019

	3 Regional Hub total	3 Regional Hub %
Medicaid	**1610**	**52%**
Medicare	**333**	**11%**
Private	**264**	**9%**
Uninsured	**329**	**11%**
Unknown/Other	**537**	**17%**
Total	**3073**	**100%**

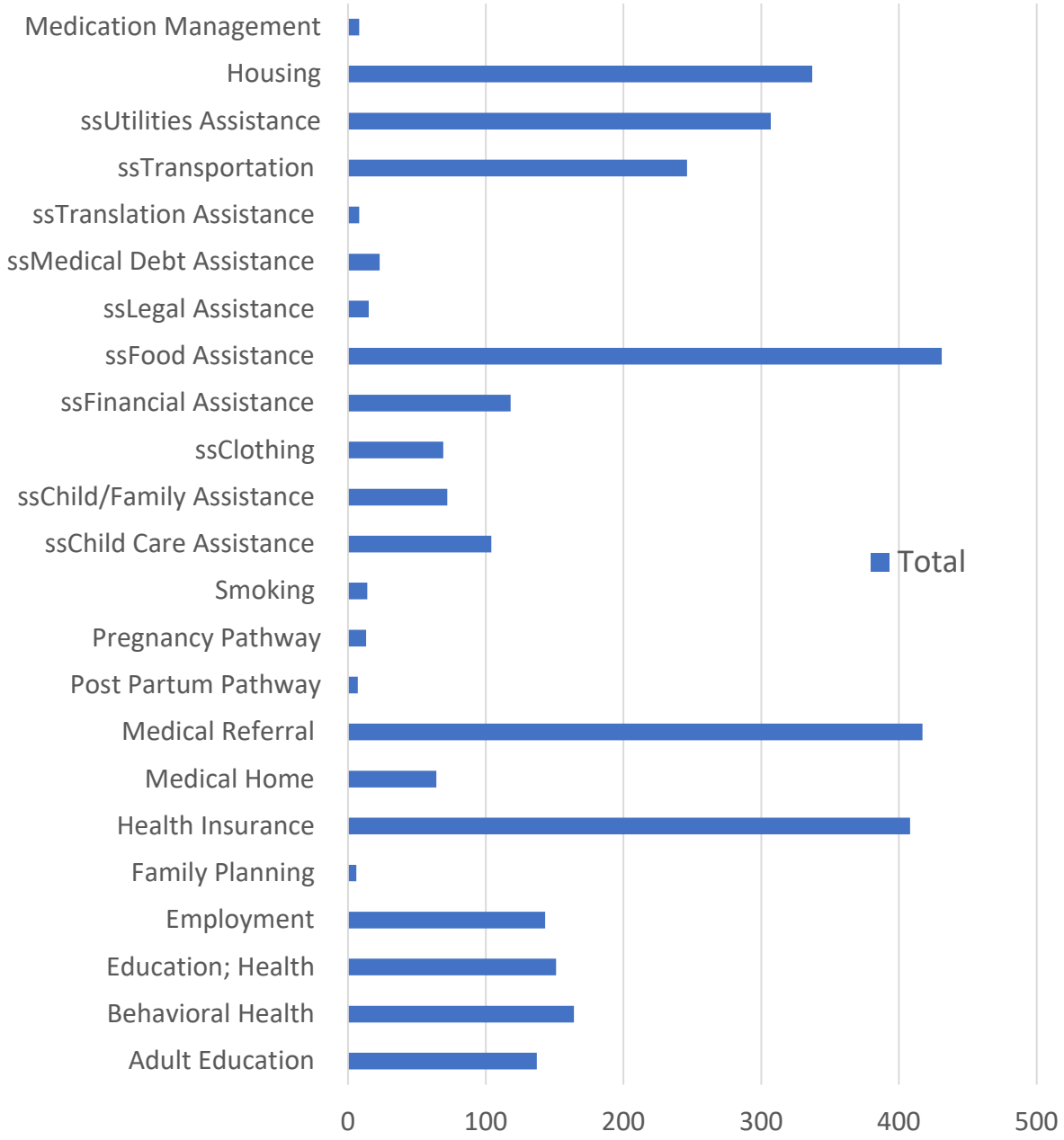
Referral and Acceptance Rates
July 2018 – June 2019

2,102 Total Referrals

904 Contacted

654 Accepted (Of those we contact 72% accept services)

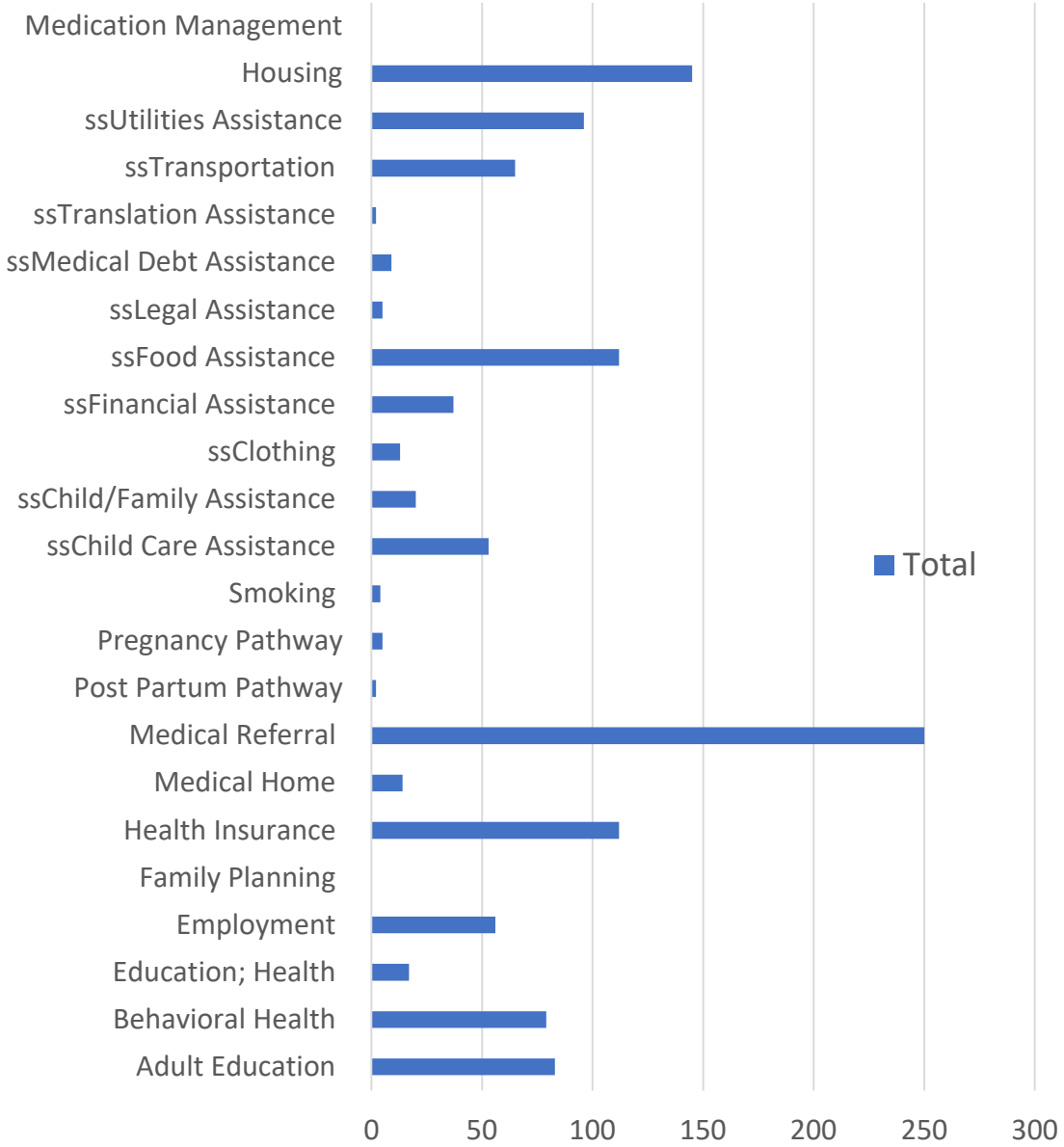
250 Declined (25%)



Pathways OPENED

NMCHIR Region – 3 HUBS

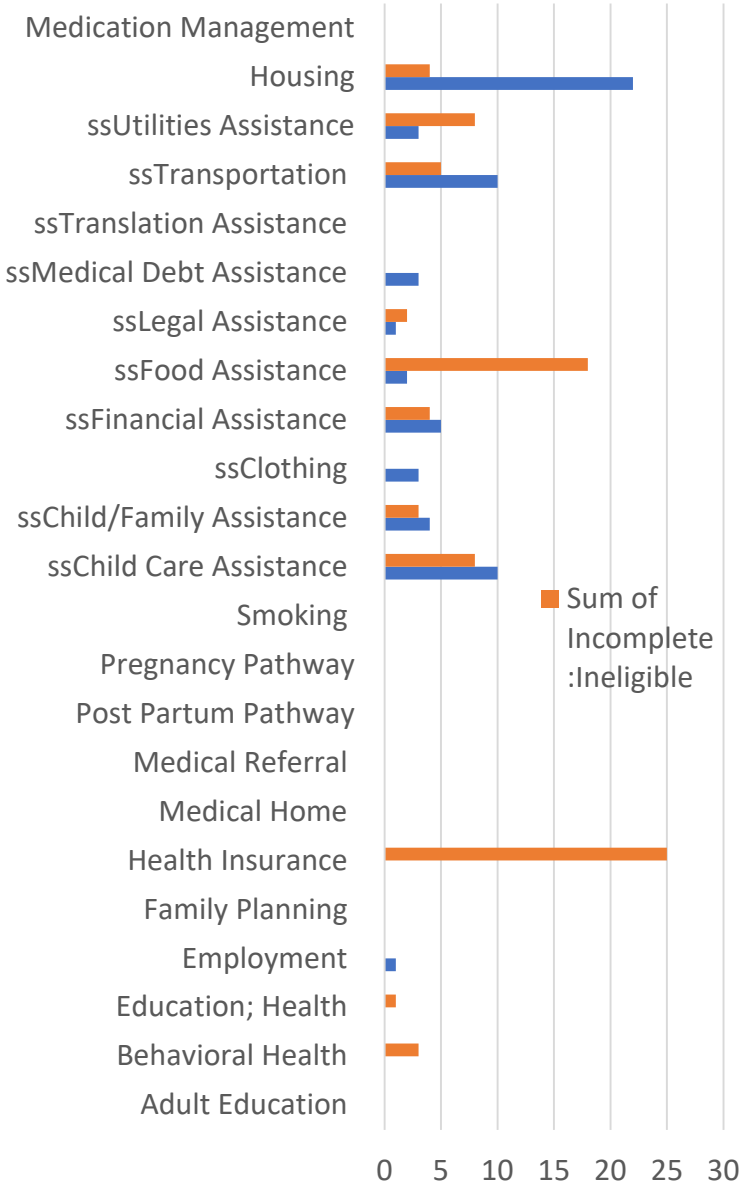
2018- 2019



Pathways INCOMPLETE

NMCHIR Regional – 3 HUBS

2018-2019

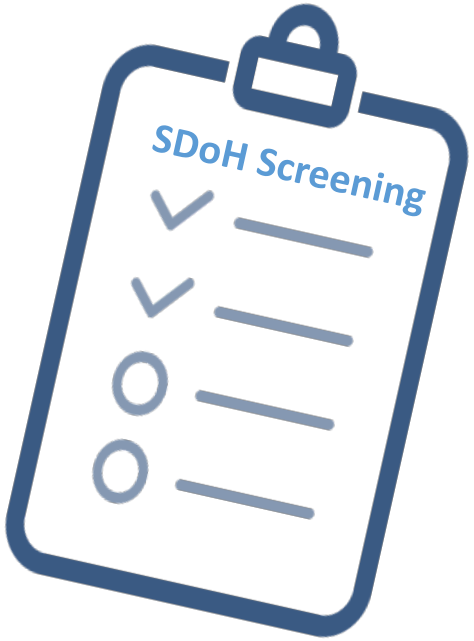


Pathways INCOMPLETE

by Resource Not available and Ineligible

January 2018 – June 2019

Opportunity to Create Feedback Loops



CCL Data Identifies Transportation as a Need

Data Shared with Action Team

Action Team adjusts strategies to respond to client needs

HUB provides detailed client feedback to Action Team

Action Team asks HUB to provide more details

HUB Coordinators

DHD#10 HUB	GRAND TRAVERSE REGIONAL HUB	NORTHWEST MICHIGAN HUB
Sally Mellema	**Debbie Aldridge**	**Yvonne Louiselle**
231-355-7529	231-882-2108	231-547-7603
smellema@dhd10.org	daldridge@bldhd.org	y.louiselle@nwhealth.org

Acting on SDoH Data: Beyond Screening

LEAH CORNEAIL, MPH
ROSEANNE PAGLIA, PHARMD
ERNEST YODER, MD, PHD, MACP

Learning Objective

Relate the strategies for optimizing SDoH use in patient care planning, community resource discussions, and state-level policy and planning.

Aggregating SDoH Data at the Community Level

LEAH CORNEAIL, MPH

MICHIGAN MEDICINE

Collecting and Aggregating SDoH Data

Community Health Innovation Region (CHIR) Participation

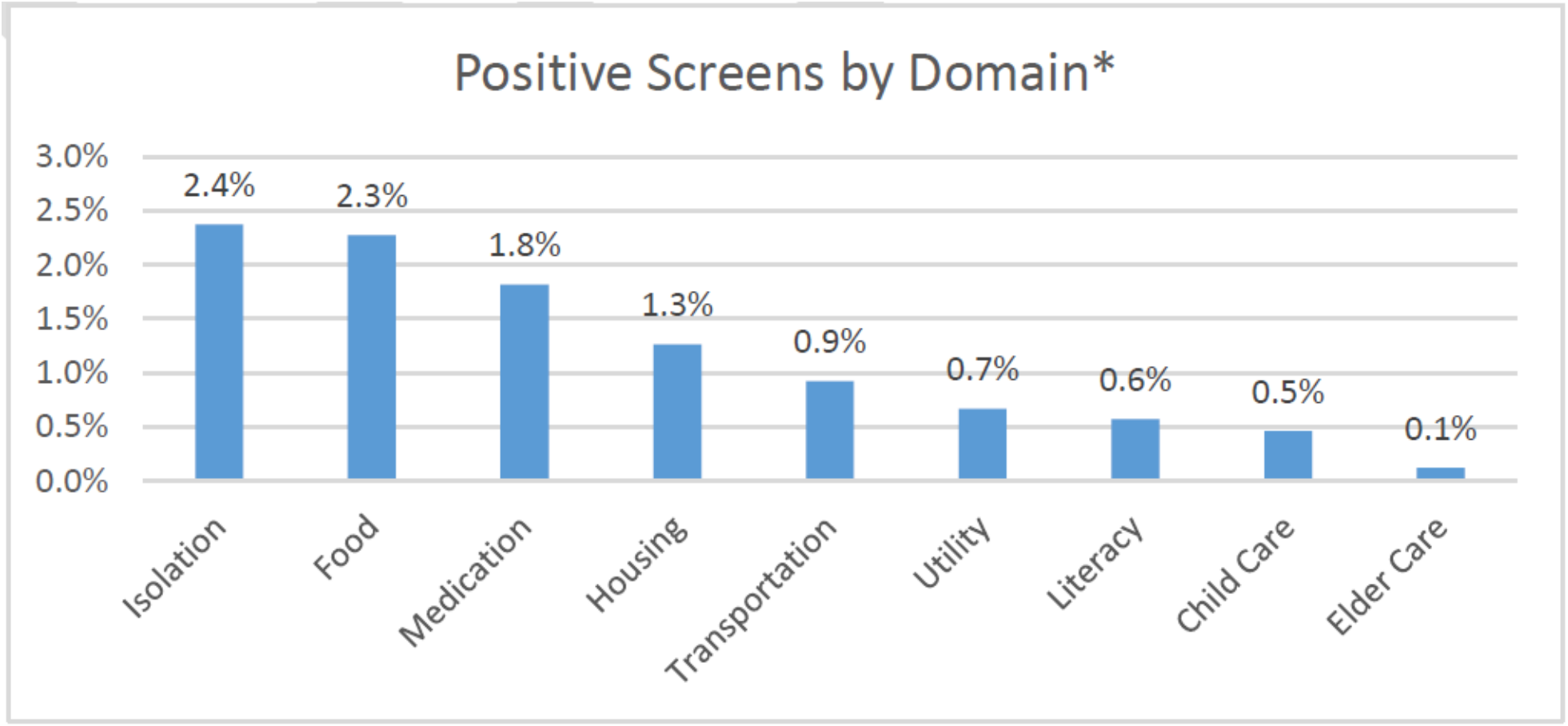
- Michigan Medicine is part of the Washtenaw/Livingston CHIR, along with two other POs: HVPA and IHA
- The CHIR backbone organization, The Center for Health and Research Transformation, convened a workgroup and a number of subcommittees to support SIM implementation
- As part of the PCMH Subcommittee, the three POs in the region coordinated around a set of SDoH questions
- Initially, Michigan Medicine did not screen for social isolation as our Guest Assistance Program (GAP) felt like there weren't enough resources in the community to refer patients who screened positive

Collecting and Aggregating SDoH Data, cont.

Data Aggregation

- Through the PCMH Subcommittee, the POs in the region partnered with the Michigan Health Information Network (MiHIN) and Michigan Data Collaborative (MDC) to aggregate data
- From January 1, 2018-December 31, 2018, 182,941 distinct screenings were completed by the 3 POs and 83,522 in Livingston and Washtenaw Counties

Findings: SDoH Needs Data



*Michigan Medicine (MM) did not ask social isolation, child care, or elder care questions until October 2018. This data does not include MM data for those needs.

Disseminating SDoH Needs Data

- CHRT and the three POs partnered to create a report with aggregated SDoH data
- Shared findings with a number of local community organizations, funding bodies, and government representatives
  - Food Gatherers
  - Jewish Family Services
  - Catholic Social Services
  - Avalon Housing
  - Washtenaw Coordinated Funders
  - County officials
  - State representatives
  - And many more…
- Particular interest from UNITE
  - Partnership between Michigan Medicine and St. Joe's to complete a joint Community Health Needs Assessment
  - Interested in social drivers of prioritized health issues and had done additional research into social isolation

How is Data Being Used? Social Isolation Example

- Social isolation is highest need for HVPA/IHA patients
  - As a result, Michigan Medicine leadership decided to add social isolation question and refer patients to in-clinic MSWs rather than central Guest Assistance Program (BSWs)
- Literature suggests that social isolation and loneliness are adversely associated with different aspects of functional status, mental health, and physical health (cardiovascular disease in particular) in older adults[1,2]
  - Strong body of literature for older adults, but Washtenaw/Livingston data suggest social isolation affects all age groups

[1] Shankar, A., Mcmunn, A., Demakakos, P., Hamer, M., & Steptoe, A. (2017). Social isolation and loneliness: Prospective associations with functional status in older adults. *Health Psychology,36*(2), 179-187.

[2] Courtin, E., Knapp, M. (2015). Social isolation, loneliness and health in old age: a scoping review. Health and Social Care in the Community, 25(3), 799–812.

How is Data Being Used? Social Isolation Example, cont.

- UNITE team partnered with UM School of Public Health to further investigate social isolation
  - Difference between social isolation (objective) and loneliness (subjective)
  - Researched social isolation in a variety of subpopulations
  - Next step: exploring current state of resources in Washtenaw/Livingston Counties
- Michigan Medicine Community Health Services and Physician of Michigan Accountable Health Organization (POM ACO) applied for grant through Michigan Health Endowment Fund to investigate social isolation in older adults

Next Steps

- CHIR aggregated utilization and demographic data from Michigan Medicine and St. Joe's to feed ED predictive model for SIM ED Intervention
  - Plans to use CHIR utilization data to assess whether SDoH and utilization are correlated
- Both IHA and Michigan Medicine plan to implement vendor within Epic to enhance community resource database and potentially track referrals
- Continue to aggregate and share SDoH data across community
- Food Gatherers study
- Internally, Michigan Medicine plans to:
  - Screen patients for SDoH in the ED who are being admitted to the hospital
  - Incorporate SDoH data into risk score in order to appropriately risk stratify patient population

Acting on SDoH Data

ROSEANNE PAGLIA, PHARM.D.

ST. JOHN PROVIDENCE PARTNERS IN CARE

What We Have Learned

- The United States spends more money on health care than any other country.
- At least 70% of health outcomes are attributed to environment and behavior.
- Environmental conditions present in a community have a significant impact on the health of the community.
- Social and economic factors present in a community strongly influence patient behaviors (Ex: Living in impoverished neighborhoods may limit access to nutritious foods and safe environments for children to play).
- Patient behaviors are built upon foundations established early in childhood.

Solomon LS and Kanter MH. Health care steps up to social determinants of health: current context. Perm J 2018;22:18-139. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207436/#b2-18-139

Health Disparities and Health Outcomes

- Patients with low socioeconomic status experience large health disparities.
- In many situations, interventions that focus on improving healthy behaviors for individuals do not adequately consider the needs of a community.
- Suggested interventions my fall short if communities do not support recommended activities (i.e. outdoor physical activity in unsafe neighborhoods).
- Interventions that support the building of community social structures and community resources need to be incorporated in health policy development and future research.
- Our work within SIM PCMH program offers important insight regarding how communities need to evolve.

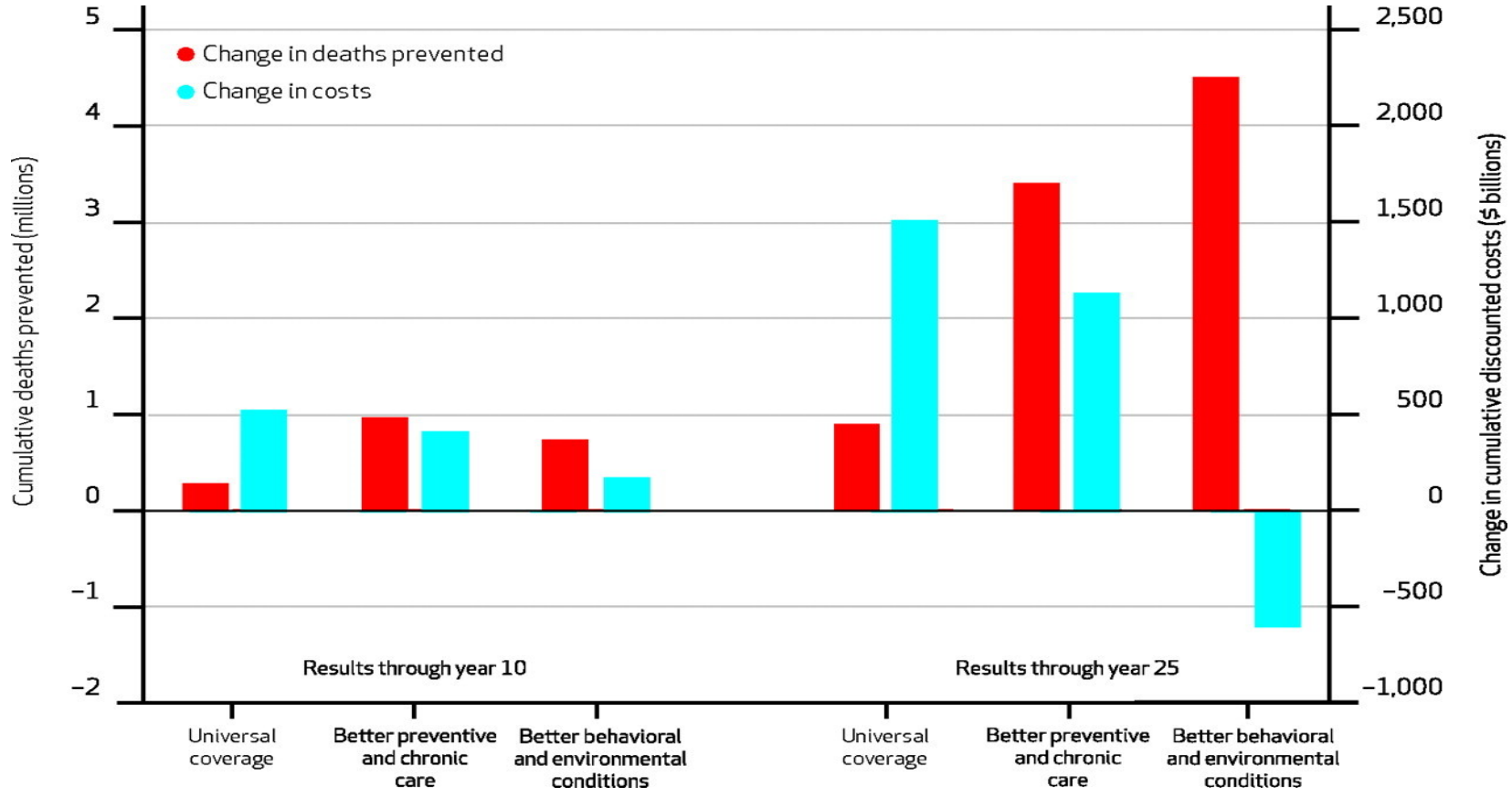
Thornton RL, Glover CM, Cene CW et al. Evaluating strategies for reducing health disparities by addressing the social determinants of health. Health Affairs 35, No. 8 (2016) 1416-1423.

Improving Health Outcomes is Not Only About Providing Health Care….

- Health Care Strategy #1 - Disease Management Approach:
  - Patients with specific disease states are routinely targeted for intervention.
  - Quality data reporting and evaluations include subsets of these patients. Successful interventions and opportunities for improvements are identified from these activities.
- Health Care Strategy #2 - Increasing access to health care services.
- Health Care Strategy #3 - Reduce disparities by addressing social determinants of health.
- What does the data demonstrate if we combine strategies?

Thornton RL, Glover CM, Cene CW et al. Evaluating strategies for reducing health disparities by addressing the social determinants of health. Health Affairs 35, No. 8 (2016) 1416-1423.

Long Term Investments Require Patience



Milstein B, Homer J, Briss P et al. Why Behavioral And Environmental Interventions Are Needed To Improve Health At Lower Cost; Health Affairs. 30, NO. 5 (2011): 823–832.

ICD-10 Coding for Social Determinants of Health

- Understanding data related to social determinants of health is important to guide work and strategies to improve health of a population.
- Z-Codes identified for some (but not all SDoH categories). Some examples:
  - Z55 – Problems related to education and literacy
  - Z56 – Problems related to employment and unemployment
  - Z57 – Occupational exposure to risk factors
  - Z59 – Problems related to housing and economic circumstances
  - Z60 – Problems related to social environment
  - Z62 – Problems related to upbringing
- Proposed revisions include expanded categories and more precise situations.

2018 American Hospital Association. ICD-10CM Coding for Social Determinants of Health. Retrieved from http://www.ahacentraloffice.org/PDFS/2018PDFS/value-initiative-icd-10-code-sdoh-0418.pdf

Where Do We Go From Here?

- Continue and expand SDoH efforts!
- The complexity of factors that lead to health disparities cannot be reversed with short-term investments and strategies.
- Efforts to reduce health care disparities should focus on scaling up interventions for implementation at local, state and national levels.
- Engage patients in your plans.
- Engage community partners in your plans.
- Build upon successes and learn from failures.

References:

1. Thornton RL, Glover CM, Cene CW et al. Evaluating strategies for reducing health disparities by addressing the social determinants of health. Health Affairs 35, No. 8 (2016) 1416-1423.

2. Milstein B, Homer J, Briss P et al. Why Behavioral And Environmental Interventions Are Needed To Improve Health At Lower Cost; Health Affairs. 30, NO. 5 (2011): 823–832.

3. Daniel H, Bornstein S, Kane G. Addressing social determinants of health to improve patient care and promote health equity: an American College of Physicians paper. Ann Intern Med. 2018;168:577-578. doi:10.7326/M17-2441.

4. Billioux A, Verlander K, Anthony S, Alley D. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Washington, DC; 2017.

5. http://www.ahacentraloffice.org/PDFS/2018PDFS/value-initiative-icd-10-code-sdoh-0418.pdf

Acting on SDoH: Data: Beyond Screening Graduate Medical Education

ERNIE YODER, MD, PHD, MACP

DETROIT WAYNE COUNTY HEALTH AUTHORITY

My Personal Hopes for Our Session

That you will leave our discussion with a better understanding of:

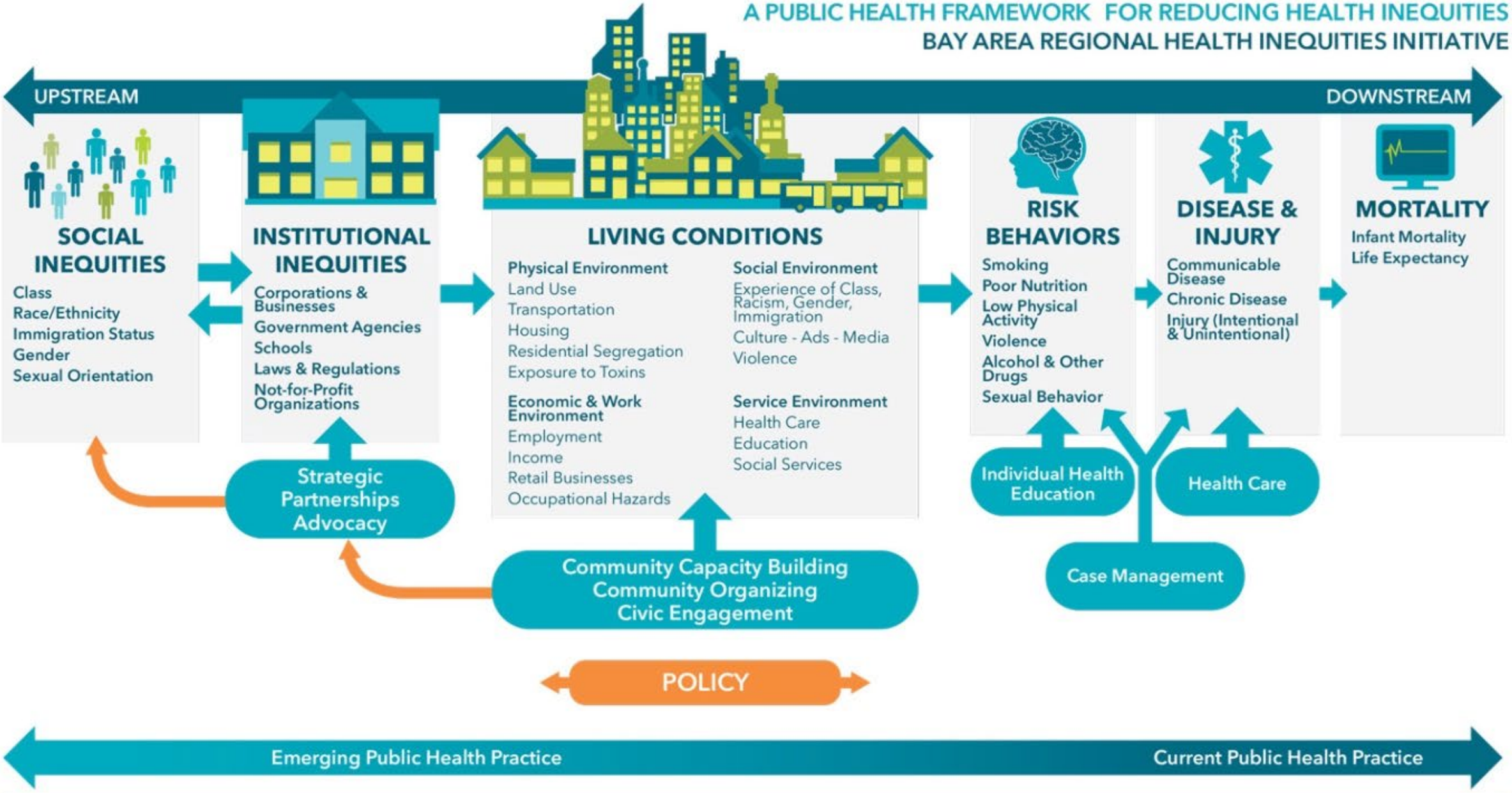
- Practice model(s) designed to prospectively screen for and address SDoH
- Approaches to addressing SDoH in GME practices
- The Teaching Health Center Program (THC)
- Measures relevant to evaluating these kinds of care models

Philosophy (Teaching Health Centers (THC)/American Academy of Family Physicians)

Why treat people and send them back to the conditions that made them sick in the first place?

-Sir Michael Marmot

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE



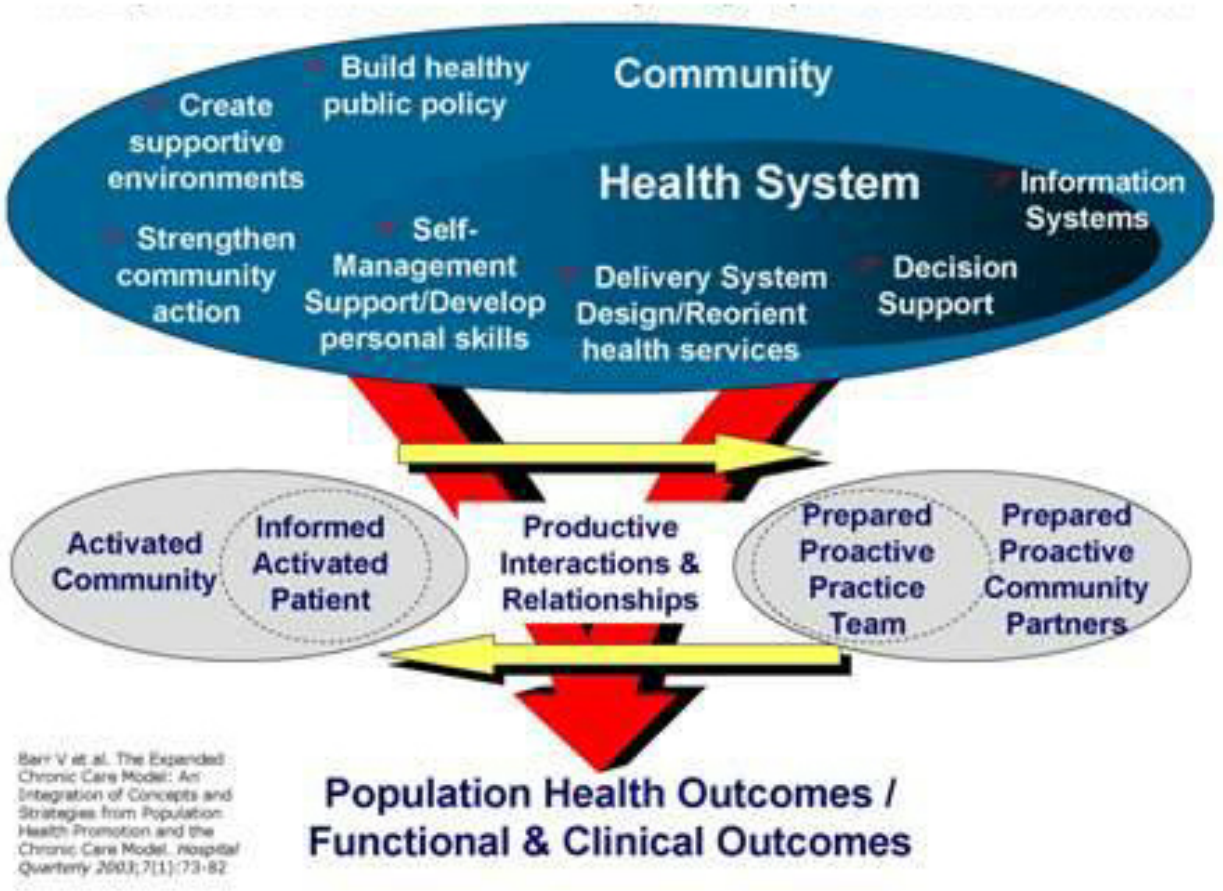
Focus: Health and Wellbeing (Prevention)

Integrated, inter-professional practice in Teaching Health Centers

Application of Wagner's Chronic Care Model

SDoH and social history screening

Chronic Care Model



Teaching Health Centers (THC)

- Training focused in community-based primary care settings (FQHC, RHC, Tribal Health Care), community mental health
- Goal to improve distribution of primary care physicians into economically disadvantaged areas
- Emphasis on underserved communities and populations
- 55% are located in medically underserved communities
- FM, IM, Peds, IM/Peds, Ob/Gyn, Psych, Dentistry, Geriatrics

GME Program/System

- PCMH and Chronic Care Model are implemented
- Interprofessional education (teams of learners, team-based care)
- Continuous Quality Improvement (CQI) to address disparities/SDoH
- Community Medicine rotations (community engagement)
- Population Health Certificate Program
- Faculty development: SDoH, Clinical Learning Environment
- Embedded in learning organization (measuring the educational system/learning environment)

Resident Physician Competencies

- Active listening, recognizes non-verbal cues
- Shows interest in the whole person – expanded social history
- Nonjudgmentally values each person
- Asks about emotions, concerns, distress – and responds
- Assesses for and addresses behavioral variables
- Shares information, promotes patient decision-making
- Practices self-reflection
- Attends to her/his well-being and resilience

SDoH in This Environment

Screening (e.g., Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PREPARE), Accountable Health Communities Tool, American Academy of Family Physicians' EveryOne Project)

- Engaging community resources/agencies to address (established linkages)
- Address upstream conditions: less expensive, more effective
- Extending care to the home environment (individual health goals, health risk assessment, home health education, medication reviews, care management – RN, CHW, etal.)

SDoH in This Environment, cont.

Improved social history exploration and documentation

Neighborhood Centered Health Projects – residents and faculty

IM residency curriculum intervention:

- Screening and addressing SDoH
- Improved resident knowledge, confidence, and practice behavior in addressing SDoH.

Output of THC Program

2011 – 2018, Nationally

- 630 new PCPs in primary care setting, 83% in medically underserved communities or rural settings
- In 2018, 732 residents in 57 programs, across 24 states
- 3.4 times more likely to work in a health center
- 2.7 times more likely to care for medically underserved

DWCHA

- 66% of graduates are serving the medically underserved
- 15% are in FQHCs or RHCs
- 48% are in Michigan

Measurement (Individuals, populations)

Social Determinant Intervention: Home environment, Employment/Income, Social Support, Utilities, Food/Nutrition, Health Literacy

Care Plan/Patient Activation: Engagement, Health behaviors, Adherence to care and follow-up, Care experience, Lifestyle changes (health behaviors),

Implementation of Clinical Guidelines (Care Plans): Risk Factors, HEDIS, UDS, CQI project measures

Outcomes: Access through provider team, Hospital admissions, ED utilization, Health/functional status, Health related quality of life, Treatment target achieved, Disease control/progression/ complications

Health Impact: Mortality, Morbidity (Disease progression, Complications), Cost of care

10:50 - 11:00 AM

MORNING BREAK

SIM
MDHHS State Innovation Model

10:50 - 11:00 AM

MORNING BREAK

5:00

SIM
MDHHS State Innovation Model

Medicaid Health Plan Panel

TOM CURTIS, MANAGER

QUALITY IMPROVEMENT AND PROGRAM DEVELOPMENT

MANAGED CARE PLAN DIVISION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

MHP Panelists

Facilitated by: Tom Curtis

Dena Nagarah, MBA, CHES
Community Outreach Manager
Blue Cross Complete

Nicole M. Felix
Director of Operations
Meridian Health Plan

Shannon Wilson, MPH
Director, Medicaid Outreach & Quality
Priority Health

SIM
MDHHS State Innovation Model

Learning Objective

Discuss approaches and focus areas from the Medicaid Health Plan perspective

Setting the Stage: What Medicaid Did…

Recognized and committed in a broader way to the prevailing evidence of the times: Social factors such as housing, transportation, employment, food accessibility, and educational attainment have a significant impact on member health outcomes.

Re-procured the managed care program in 2015: Significant advancement in identifying and addressing social determinants of health for Medicaid managed care beneficiaries.

Setting the Stage: What Medicaid Did…

Changed contractual requirements and incentives for Medicaid health plans:

- Utilize community health workers (CHWs)
- Screen members for social needs
- Incorporate screening information and CHWs into quality improvement and care management processes
- Develop partnerships to identify and address SDoH

How Medicaid approaches health plans and social determinants of health…

We set the policy goals, and provide program parameters:

- The goals and parameters are designed to ensure the best outcomes for all members, regardless of MHP membership
- We recognize there is variation at the MHP, provider, and community level across the State
- MHPs have some flexibility in how they execute contractual requirements within the context of our goals and parameters
- We monitor implementation to ensure beneficiaries are taken care of, and promising practices can be considered for scaling up

Blue Cross Complete: Member SDoH Screening

Formal SDoH Screening Began August 2017, thus far:

- All Member facing associates have the ability to screen members for SDoH
- 32,800 SDoH surveys conducted
- 15,092 households surveyed
- 61.4% of households screened report to have at least 1 unmet need
- 31.3% of households screened report to have more than 2 unmet needs
- Greatest need is employment (60.3%)
- Greatest crisis need is housing (2.4%)

Blue Cross Complete: SDoH Lessons Learned

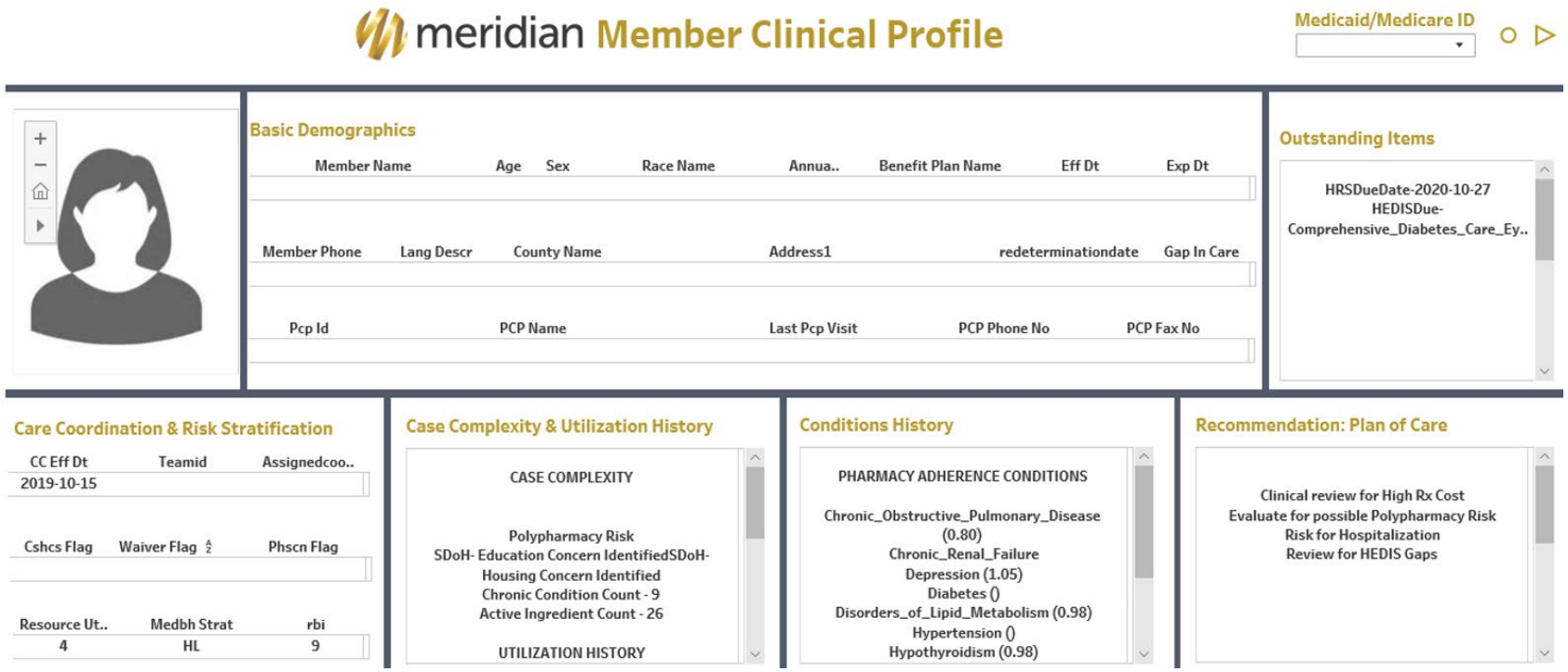
- An internal referral system was built allowing warm transfers to help associates meet member needs in real time.
- CHWs were given tablets to allow for SDoH screening while in the field.
- A community resource database was added to the Blue Cross Complete website as an additional resource for associates and members.
- Often members will not identify needs during the first meeting, but will often reach out to the CHW or other associate later to discuss needs.
- Many members know they have needs, but do not know what resources are available to them.

MeridianHealth: Closing the Gaps

Integration of Social Determinants of Health (SDOH) Data

- Member Stratification through Predictive Modeling
- Meridian 'Member Clinical Profile' Tool
  - Identified SDOH: Case Complexity
- Connection to Resources
- Addressing Barriers

Engagement with Providers and Community Partners



PriorityHealth

Active, Engaged Members

Addressing Social Needs

- SDoH data collection projects
- Housing Initiatives
- Priority Health Connect
- Community Health Worker Strategies

Improving Member Experience

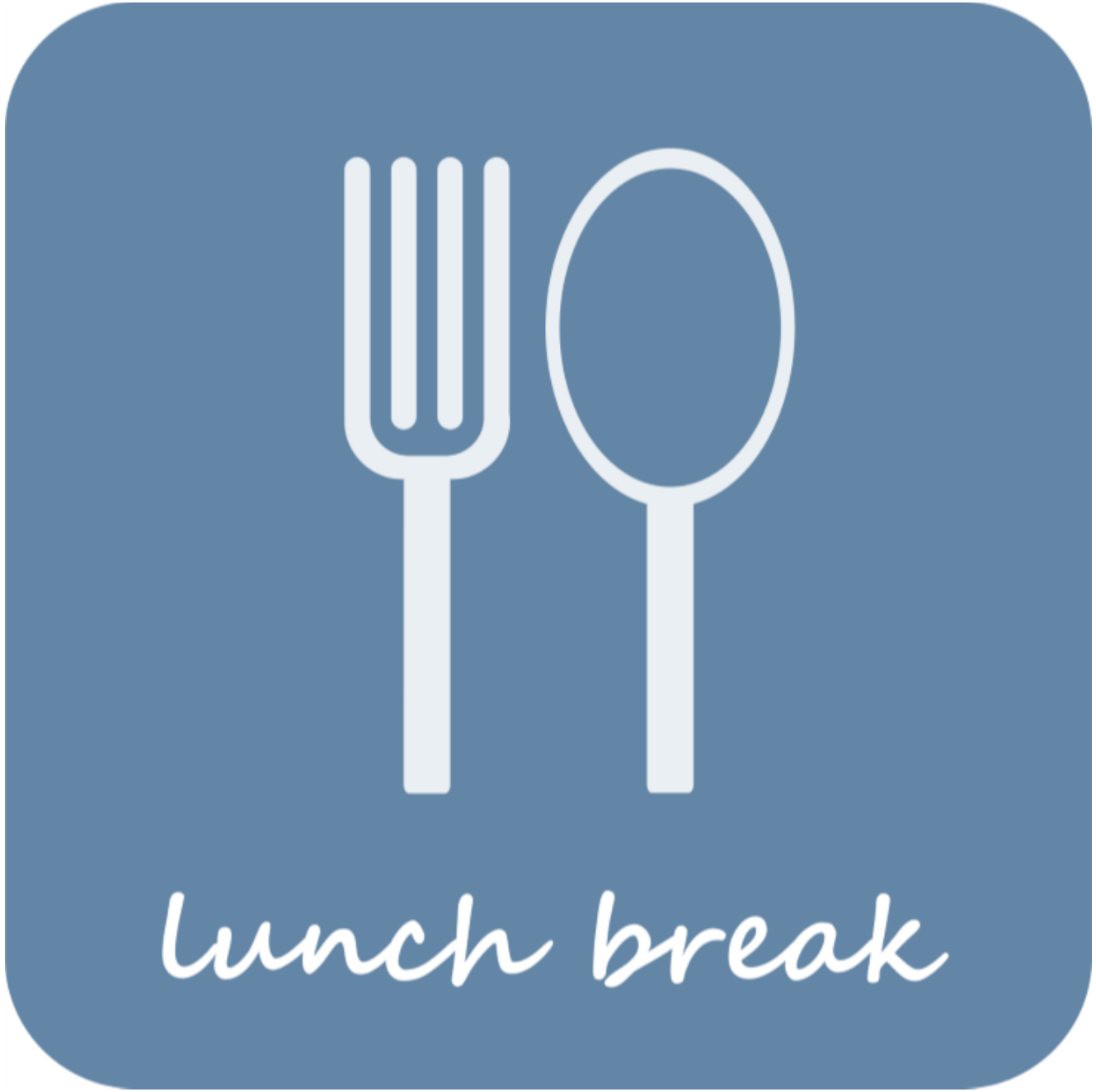
- Priority Health App
- Effective Care Management
- Personalized Communication

Simplifying processes

- Data integration pilots
- Care coordination upgrades

12:00 - 1:00 PM

LUNCH



SIM
MDHHS State
Innovation Model

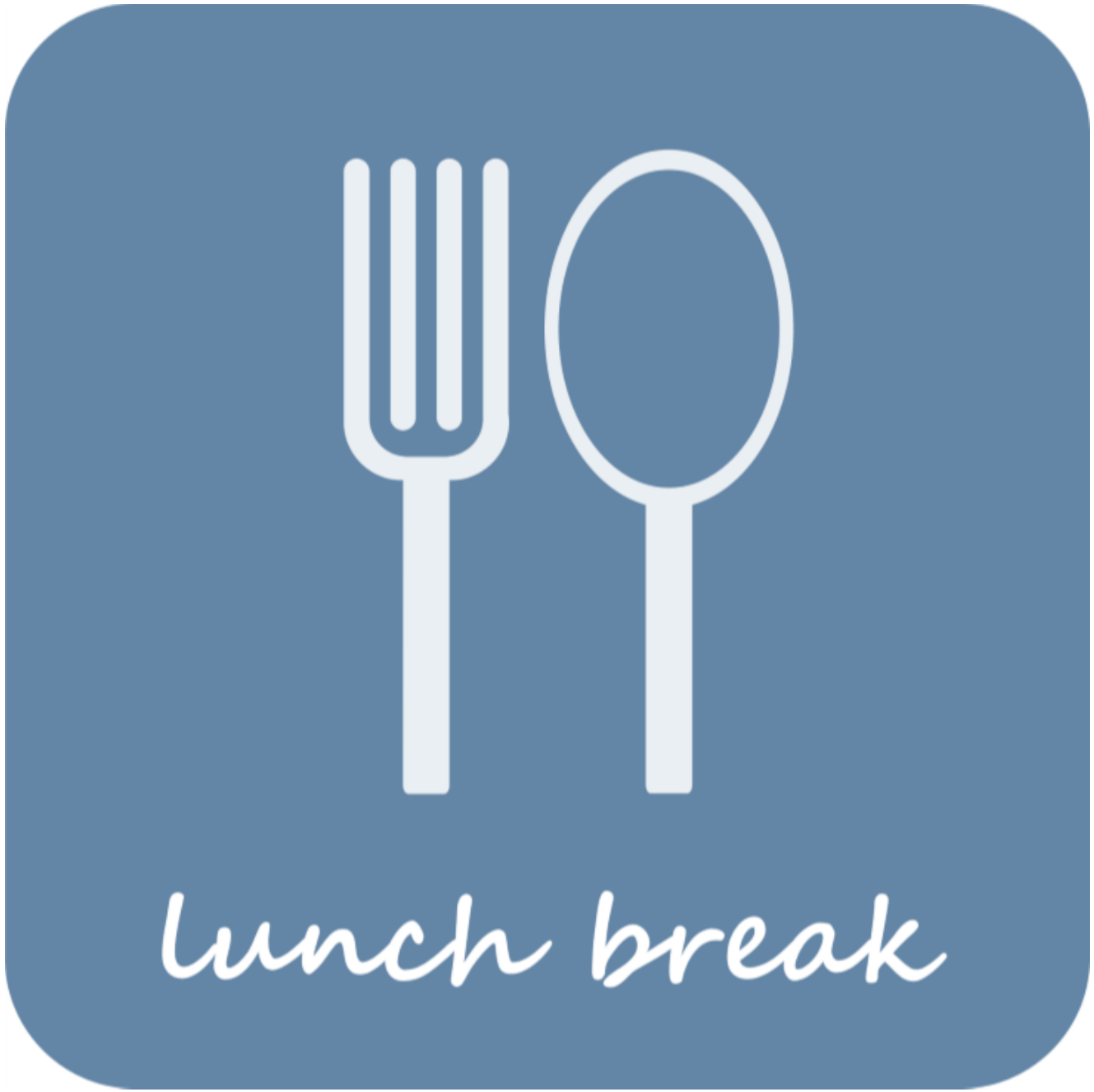
12:00 - 1:00 PM

GO TO YOUR AFTERNOON BREAKOUT ROOM IN

5:00

MINUTES!

SIM
MDHHS State Innovation Model



Concurrent Afternoon Breakout Sessions
1:00 - 2:10

Adverse Events: From Trauma to Resiliency

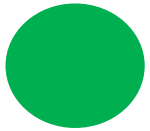
Jill S. Rinehart, MD FAAP

Blue Dot

Big Ten C

Evaluation Results

Clare Tanner, PhD



Green Dot

Big Ten AB

Adolescent Depression: Presentation, Diagnosis, and Treatment

Richard Dopp, MD

Yellow Dot

Centennial

Note: The colored dot on the right side of your name badge indicates the afternoon breakout session that you will be participating in.

Adverse Events: From Trauma to Resiliency

JILL S. RINEHART, MD FAAP
THE UNIVERSITY OF VERMONT CHILDREN'S HOSPITAL

With Thanks to:

- Paula Duncan MD
- Barb Frankowski MD
- Wendy Davis, MD
- Joseph F. Hagan, MD
- Jeanne W. McAllister BSN, MS, MHA
- Bob Sege, MD
- Drs. Brendtro, Van Brokern and Brokenleg
- Scott Johnson and Cheryl Mitchell
- Over 55 Vermont pediatric and Family Medicine practices
- Preventive Services Practices National study
- Drs. Brazelton and Ginsburg

Objective

Identify strategies to address trauma informed care while incorporating coping and resiliency skills resulting in patient empowerment.

Overview

Understand the importance of identifying strengths and needs of families in creating meaningful, family-centered communication.

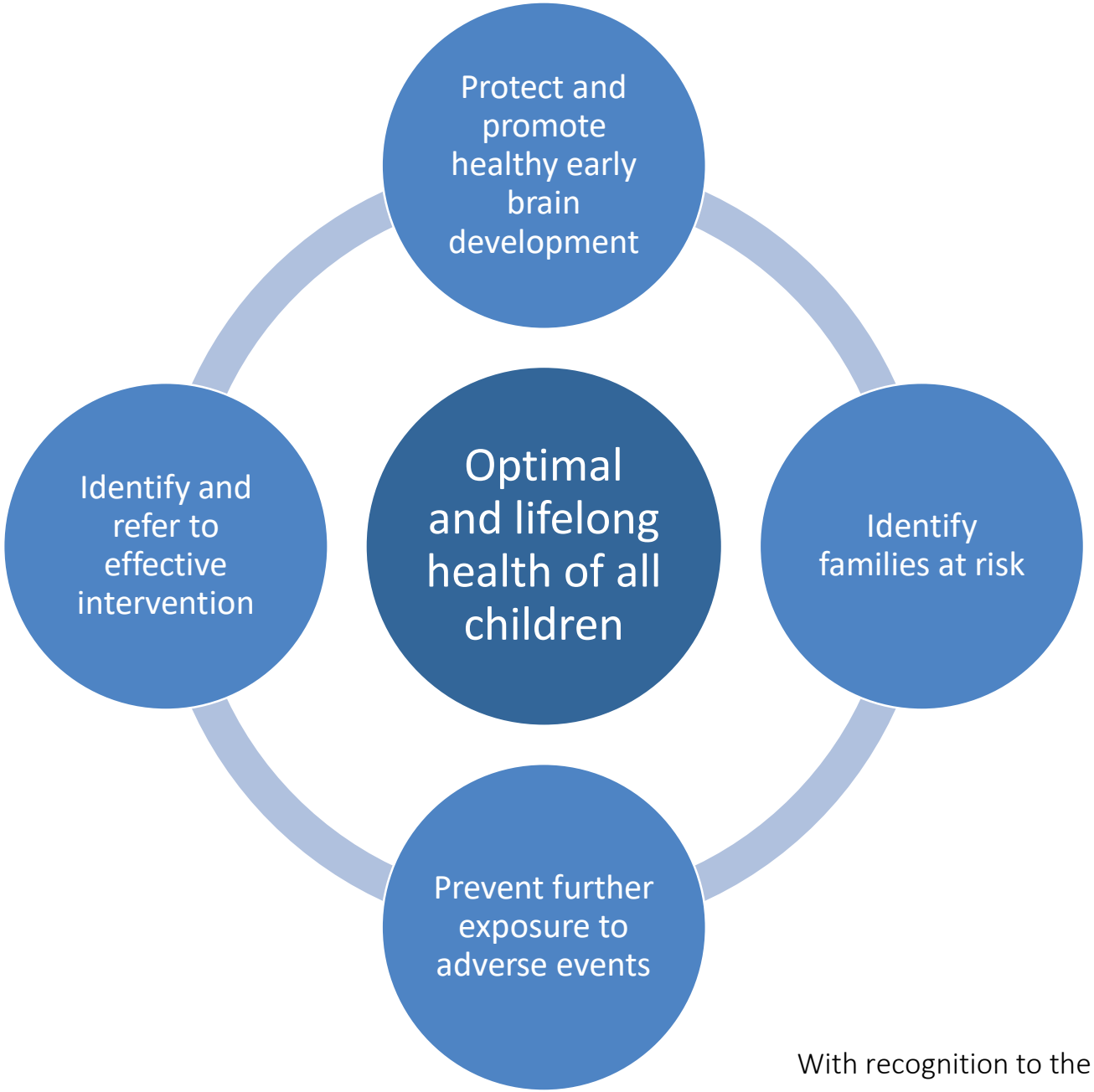
Demonstrate examples of how to structure family-centered conversations that develop goals and improve the quality of life with patients and families with special health care needs.

Understand from a family's perspective the important components of family-centered communication.

Bright Futures Guidelines: Promoting ACEs

- The healthcare setting offers three key advantages in providing parenting support:
  - Reach virtually all families in early years (> 95% of Vermont infants receive routine health care with a child health provider in the first month of life)
  - Lack of social stigma attached to using medical care
  - High level of trust that families extend to their child's healthcare clinician, whose active endorsement encourages engagement in other services
- Pediatric medical homes and *Bright Futures* offer concrete strategies to mitigate toxic stress and prevent ACEs by early identification and addressing the major risk factors in families

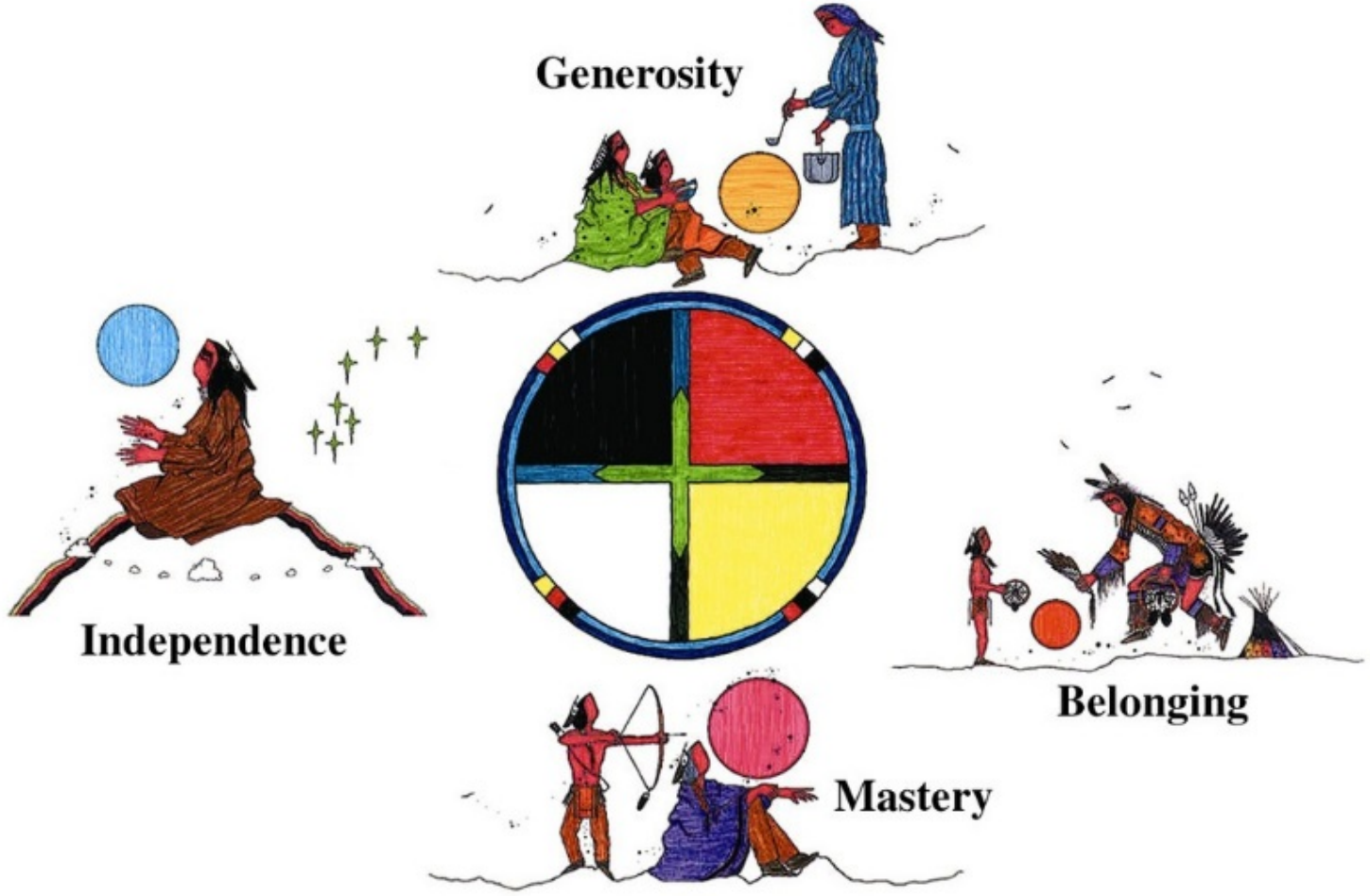
The Goal



With recognition to the American Academy Pediatrics

Bright Futures Guidelines: Health Promotion

- Healthy Development
- Family Support
- Mental Health and Emotional Well-Being
- Nutritional Health
- Physical Activity
- Healthy Weight
- Promoting Lifelong Health for Families and Communities
- Oral Health
- Healthy Sexuality
- Safety and Injury Prevention
- Promoting the Healthy and Safe Use of Social Media
- Children and Youth with Special Health Care Needs



Brendtro, L., & Brokenleg, M. (2009). *Reclaiming youth at risk: Our hope for the future*. Solution Tree Press.

Why Strengths for Families with Young Children?

Partnership with families improves health outcomes for children, youth and families.

Protective factors for all families, especially important for those dealing with difficult situations.

Supports family self care and provides strategies for families to use.

Common effort for all health care, social service, and early care and education professionals and community members.

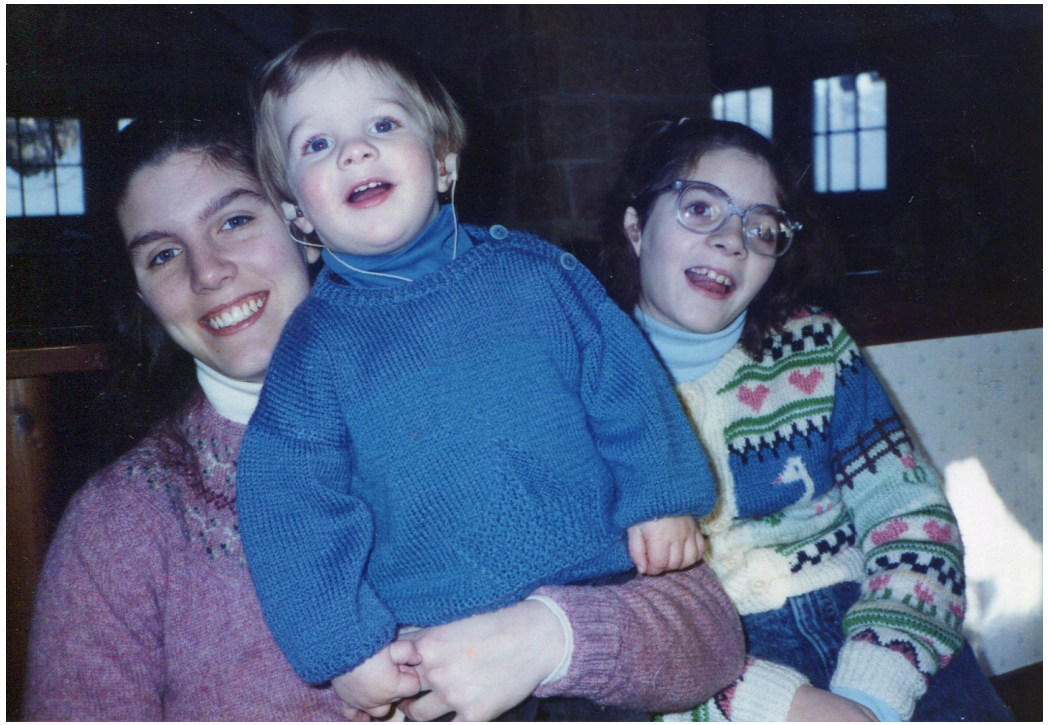
Patient and Family-Centered Care

Family-centered care is about meeting families where they are, and helping them get where they want to go…

Care Partnership Support

A meaningful collaboration between families and the care team to ensure effective and quality care for the patient.

Designed to address family and patient access to quality care and effective communication.

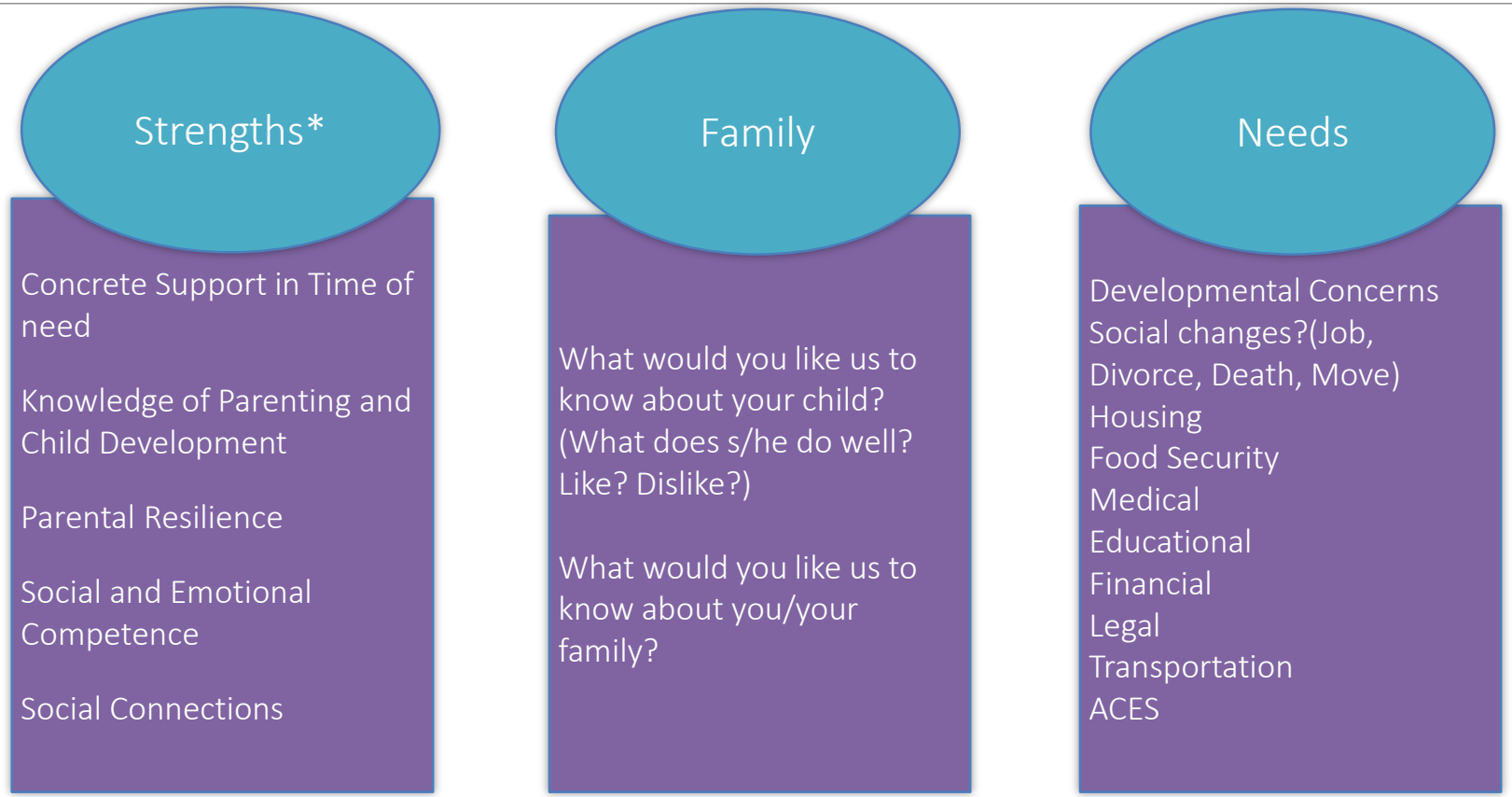


Effective Care Coordination

Care coordination is a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth **while enhancing the care giving capabilities of families**…”

Antonelli, R., & McAllister, J. (2009). *Making Care Coordination A Critical Component of the Pediatric Health System: A Multidisciplinary Framework,*. Retrieved from https://pcmh.ahrq.gov/citation/making-care-coordination-critical-component-pediatric-health-system-multidisciplinary-fr

Comprehensive Understanding

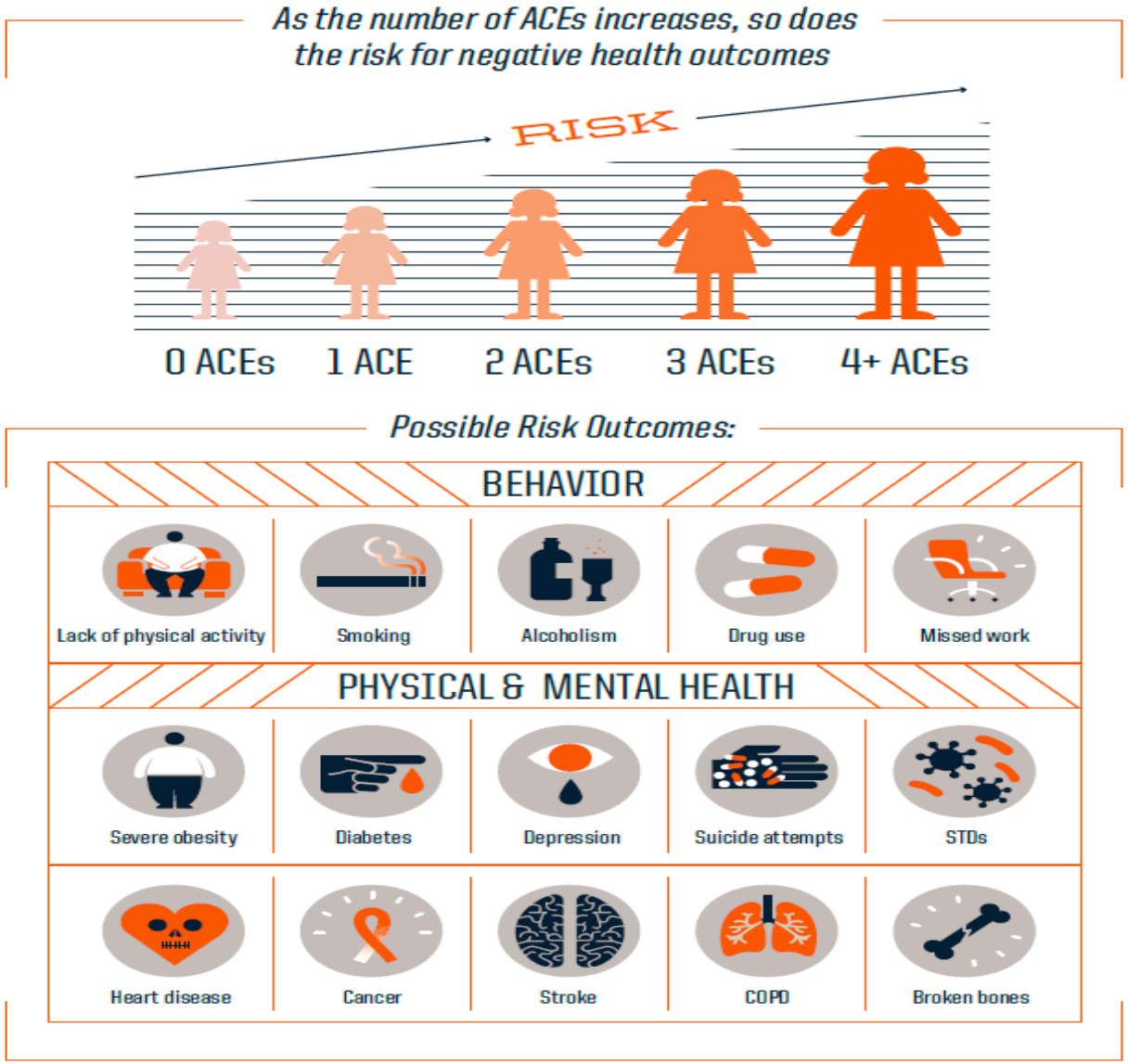


Harper Browne, C. (2014, September). *The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper.* Washington, DC: Center for the Study of Social Policy

Why Do ACEs Matter?

The Adverse Childhood Experiences (ACE) studies show the link between early childhood experiences and physical, mental, and behavioral health outcomes in adulthood.

1 type of experience = 1 ACE or AFE



https://www.rwjf.org/en/library/infographics/the-truth-about-aces.html

Principles of Strength-Based Practice and Early Childhood

Parents are experts on their children and want the best for them.

You are the experts on your professional situation

Know your families and want the best for them.

Brazelton, T. B., & Sparrows, J. (2003). *The Touchpoints Model of Development*. Retrieved from http://www.brazeltontouchpoints.org/wp-content/uploads/2011/09/Touchpoints_Model_of_Development_Aug_2007.pdf

"In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last, and always."

- Urie Bronfenbrenner

National Scientific Council on the Developing Child (2004). Young Children Develop in an Environment of Relationships: Working Paper No. 1. Retrieved from www.developingchild.harvard.edu.

Partnership with Families is a Major Component of Bright Futures - Role for Everyone

- Identify family strengths
- Discuss with families
- Ask about parent concerns and address them
- When a change is needed, use shared decision-making

Workflow for Shared Care Planning

Team or Person/Roles	Pre-Visit→Preparation	Visit→Caring Partnership interactions	After Visits→Accountable follow through
Care Coordinator	Gathers recent information (recent labs, subspecialist notes, community provider updates) Identifies goals	Updates Care Plan, Family/personal goals, medical goals	Negotiate next steps
Youth/Patient/Family	Bring questions Share ideas and referrals	Participates in goal Setting	Negotiate next steps
Health Care Professional	Reviews communications Asks about goals Follows up w/ referrals	Assesses needs Updates Care Plan	Negotiate next steps

McAllister, J. (2014). Achieving a shared plan of care for children and youth with special health care needs: An implementation guide. Retrieved from Lucille Packard Foundation for Children's Healthcare: lpfch-cshcn.org

Strengthening Families Framework

Parental Resilience

Social Connections

Knowledge of Parenting and Child Development

Social and Emotional Competence of Children

Concrete Support in Times of Need

Harper Browne, C. (2014). The strengthening families approach and protective factors framework: Branching out and reaching deeper. *Washington, DC: Center for the Study of Social Policy*, 21-24.

Parental Resilience

"Managing both general life and parenting stress and functioning well when faced with stressors, challenges or adversity. The outcome is positive change and growth."

Managing stressors ….

Parents feel better ….

With more nurturing attention to their child.

Harper Browne, C. (2014). The strengthening families approach and protective factors framework: Branching out and reaching deeper. *Washington, DC: Center for the Study of Social Policy*, 21-24.

Parental Resilience

What helps you keep calm/centered when stressed?

Knowing how to keep calm and regulate your own emotional responses is an important skill in parenting and in life; Increases responsive to child

What do you like best about parenting your child?

Rituals and routines

Grounds them in the part that feels most natural and fulfilling to them

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

Social Connections

Parents have healthy relationships with people, institutions, the community, or a force greater than oneself that promote a sense of trust, belong and that one matters.

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

Social Connections

Who helps you with your child?

Ask them to think about their network and see if there are others they might connect with.

Knowledge of Parenting and Child Development

Nurturing, responsive, reliable trusting relationships

Routines

Interactive language experiences safe environment

Exploration

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

Knowledge of Parenting and Child Development

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Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

Social and Emotional Competence

Relationships

Close, emotional, loving attachment between infant and primary caregiver

Regulate and express emotions

Explore and learn

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

Social and Emotional Competence, cont.

What do you do to build your child's social emotional competence?

How can you help your child explore and learn new things, manage their emotional responses and have a close relationship with you and others in the family?

How can you help your child have normal, everyday interactions that are an easy part of everyday life?

Remember that concern about one's child is a sign of caring

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

Concrete Support

All parents need help sometimes

- Colicky baby, accident
- Job loss, homelessness, food insecurity, substance abuse, domestic violence

May need formal or informal sources of help

Parent reluctance to ask for help

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

Concrete Support

Parents - positive help-seeking behaviors

Availability and accessibility of resources and services

High quality service delivery

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper/

"When their own core capacities and mental health needs are addressed adults are better equipped to promote the development of competence in the children who rely on their care."

Shonkoff, J. P., & Fisher, P. A. (2013). Rethinking evidence-based practice and two-generation programs to create the future of early childhood policy. *Development and Psychopathology*, *25*(4pt2), 1635–1653. https://doi.org/10.1017/S0954579413000813

https://www.snopes.com/fact-check/giant-newfoundland-iceberg/

Tips

Find the language that speaks to the parents and family

Reluctance is the “nut that needs to be cracked”

That means starting where *they* are

Tips

What do you call your problem?

What do you think caused it? Why?

What do you think your sickness does to you?

How severe is it? Short or long course?

What do fear the most?

What are hardest problems this causes you?

What kind of treatment do you feel you need? What are results you hope for?

Kleinman A., Eisenberg L., Good B. Culture, illness, and care: clinical lessons from anthropological and cross-cultural research. Ann Intern Med 1978;88:251–88.

Strength-Based Practice with Parents and Children

Trust

Unique strengths

Knowledge competencies and unrealized resources

Active participants in the change

A chance to help others

Harper Browne, C. (2014). The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper. Retrieved from https://cssp.org/resource/the-strengthening-families-approach-and-protective-factors-framework-branching-out-and-reaching-deeper

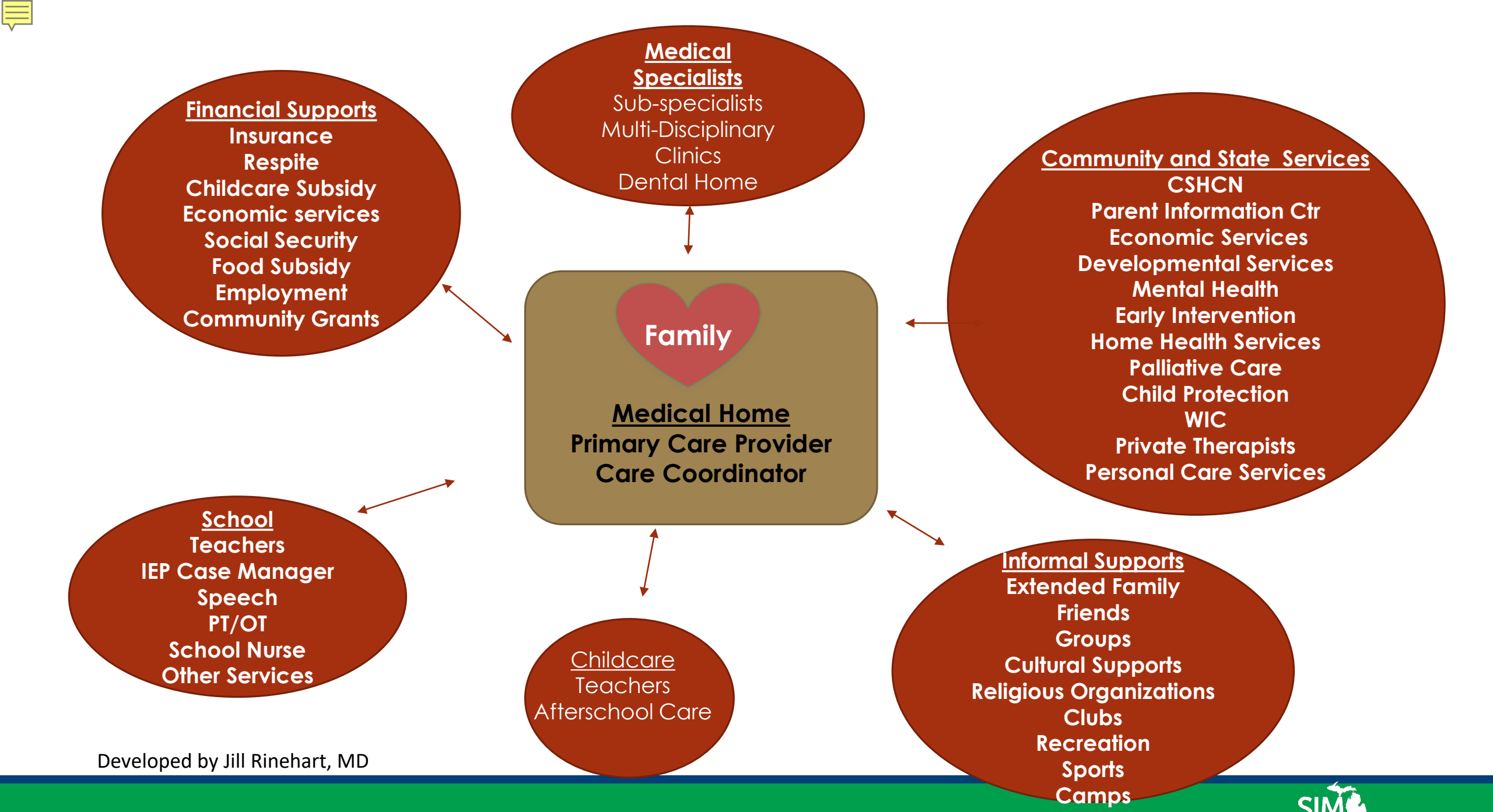
Shared Decision-Making

Options

Consequences

Pick one to start with

Check back



Developed by Jill Rinehart, MD

Eco-Maps

Share copy with the team

Members can identify gaps and update resources

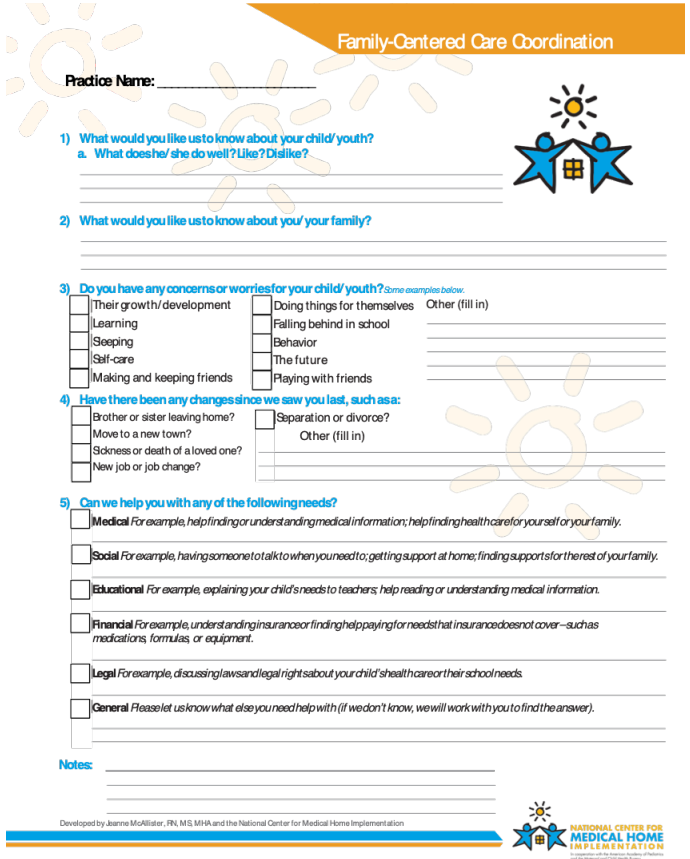
Orients the team to community around the patient

Patient can identify where strong connections are

Who is the “main” care coordinator in some instances

Family Centered Care Coordination

Needs



Family-Centered Care Coordination

Practice Name: _____

1) What would you like us to know about your child/ youth?
a. What does he/ she do well? Like? Dislike?

2) What would you like us to know about you/ your family?

3) Do you have any concerns or worries for your child/ youth? *Some examples below.*

- ☐ Their growth/ development
- ☐ Learning
- ☐ Sleeping
- ☐ Self-care
- ☐ Making and keeping friends
- ☐ Doing things for themselves
- ☐ Falling behind in school
- ☐ Behavior
- ☐ The future
- ☐ Playing with friends

Other (fill in)

4) Have there been any changes since we saw you last, such as a:

- ☐ Brother or sister leaving home?
- ☐ Move to a new town?
- ☐ Sickness or death of a loved one?
- ☐ New job or job change?
- ☐ Separation or divorce?

Other (fill in)

5) Can we help you with any of the following needs?

- ☐ **Medical** *For example, help finding or understanding medical information; help finding health care for yourself or your family.*
- ☐ **Social** *For example, having someone to talk to when you need to; getting support at home; finding supports for the rest of your family.*
- ☐ **Educational** *For example, explaining your child's needs to teachers; help reading or understanding medical information.*
- ☐ **Financial** *For example, understanding insurance or finding help paying for needs that insurance does not cover – such as medications, formulas, or equipment.*
- ☐ **Legal** *For example, discussing laws and legal rights about your child's health care or their school needs.*
- ☐ **General** *Please let us know what else you need help with (if we don't know, we will work with you to find the answer).*

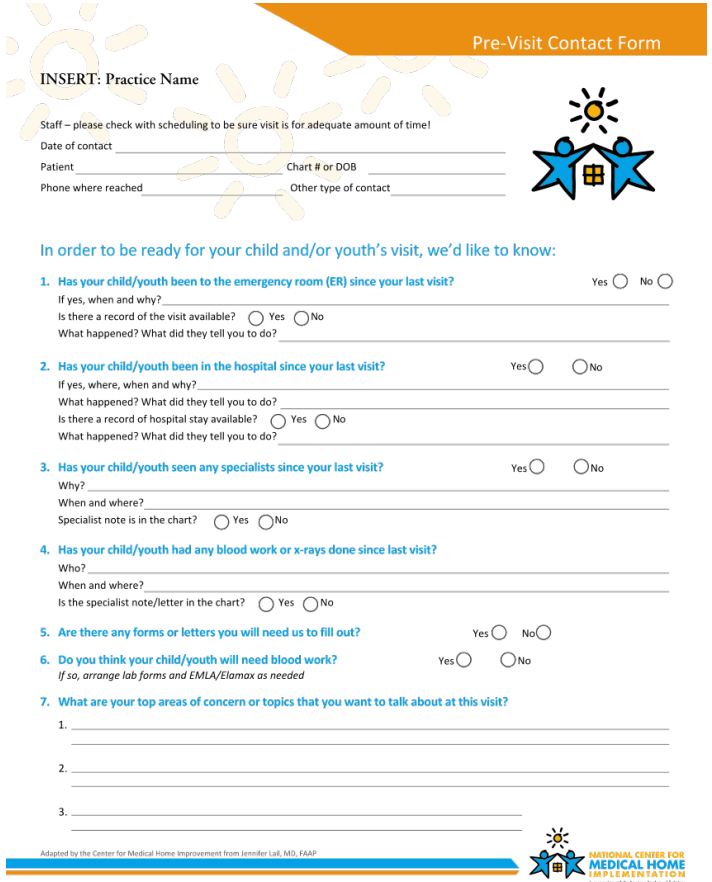
Notes: _____

Developed by Jeanne McAllister, RN, MS, MHA and the National Center for Medical Home Implementation

NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION

https://medicalhomes.aap.org/Documents/FamilyCenteredCareCoordination.pdf

Pre-Visit



Pre-Visit Contact Form

INSERT: Practice Name

Staff – please check with scheduling to be sure visit is for adequate amount of time!

Date of contact _____

Patient _____ Chart # or DOB _____

Phone where reached _____ Other type of contact _____

In order to be ready for your child and/or youth's visit, we'd like to know:

1. Has your child/youth been to the emergency room (ER) since your last visit? Yes ◯ No ◯
   If yes, when and why? _____
   Is there a record of the visit available? ◯ Yes ◯ No
   What happened? What did they tell you to do? _____
2. Has your child/youth been in the hospital since your last visit? Yes ◯ No ◯
   If yes, where, when and why? _____
   What happened? What did they tell you to do? _____
   Is there a record of hospital stay available? ◯ Yes ◯ No
   What happened? What did they tell you to do? _____
3. Has your child/youth seen any specialists since your last visit? Yes ◯ No ◯
   Why? _____
   When and where? _____
   Specialist note is in the chart? ◯ Yes ◯ No
4. Has your child/youth had any blood work or x-rays done since last visit?
   Who? _____
   When and where? _____
   Is the specialist note/letter in the chart? ◯ Yes ◯ No
5. Are there any forms or letters you will need us to fill out? Yes ◯ No ◯
6. Do you think your child/youth will need blood work? Yes ◯ No ◯
   If so, arrange lab forms and EMLA/Elamax as needed
7. What are your top areas of concern or topics that you want to talk about at this visit?
   1. _____
   2. _____
   3. _____

Adapted by the Center for Medical Home Improvement from Jennifer Lall, MD, FAAP

NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION

https://medicalhomes.aap.org/Documents/PrevisitContactForm.pdf

“We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves, we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit.”

- e.e. cummings

Evaluation Results

CLARE TANNER, PHD

MICHIGAN PUBLIC HEALTH INSTITUTE

Acknowledgments

MPHI Team

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UM-CHEAR

Sarah Clark

Session Objective

To provide an update for SIM participants on the results of the evaluation to date

Who is in the audience? Specifically, what is your relationship to a CHIR?

A. Part of Backbone Organization Staff
B. A member or partner of a CHIR
C. None of the above – but located in a CHIR
D. No relationship to a CHIR

Building on MIPCT's Foundation

High-risk adult Medicaid beneficiaries experienced significantly reduced risk of hospitalization

- At the end of MiPCT **500 Care Managers** were **embedded across 346 practices**
- **Physician and staff** reported high levels of CM acceptance
- MiPCT **patients reported significantly better experience** than non-PCMH practices across domains

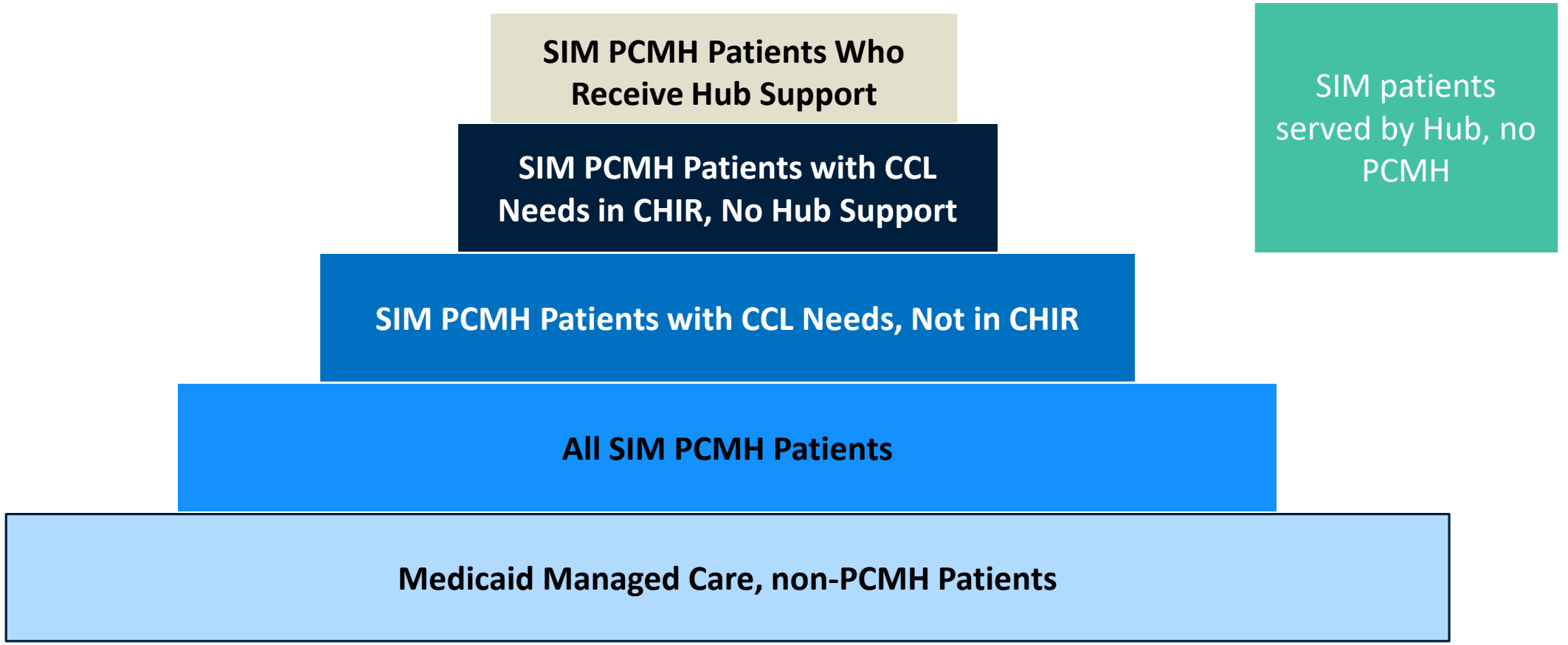
MiPCT Publications

"Multi-payer Primary Care Transformation: Impact for Medicaid Managed Care Beneficiaries" in *American Journal of Managed Care* (in press – November 2019).

"Patient Experience of the Patient Centered Medical Home in Michigan's Statewide Multipayer Demonstration: A Cross-Sectional Study." *Journal of General Internal Medicine* 32(11):1202-9.

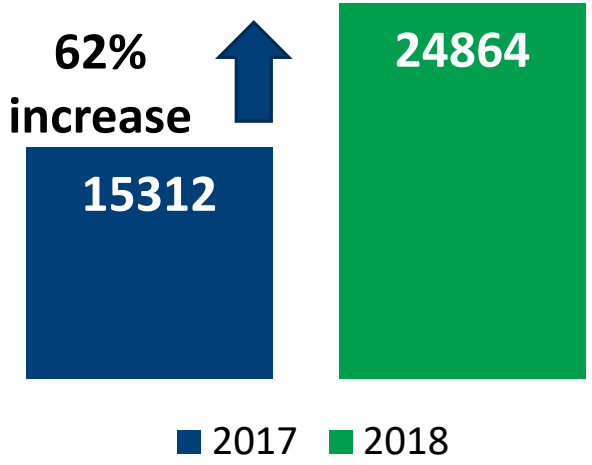
"Physician and Staff Acceptance of Care Managers in Primary Care Offices." *The Journal of the American Board of Family Medicine*, 30:140-149.

Michigan SIM Model



SIM PCMH: Care Management and Care Coordination

of SIM Attributed Beneficiaries With at Least One CM/CC service



- 85% of all patients receiving CM/CC services have one or more chronic conditions
- The **top 4** most common chronic conditions for children are: ADHD, Asthma, Depression, and Anxiety Disorders
- The **top 4** most common chronic conditions for adults are: Depression, Hypertension, Obesity, and Anxiety Disorders
- **16% of all SIM attributed patients** with both MH and SUD diagnoses had at least 1 CM service in 2018 in contrast to only **4% of non-SIM** beneficiaries with both MH and SUD diagnoses receiving CM/CC service.

Clinical-Community Linkages (CCL)

Key Questions from the Field

- How can social services and clinical care be more coordinated?
- How do medical providers feel about the integration of the social and healthcare sectors?
- How do social service providers feel about the integration of the healthcare and social sectors?
- What type of infrastructure/organization is needed to facilitate the integration?

Clinical-Community Linkages (CCL)

CCL Activities Reported by SIM POs/PCMHs:

- Initial screening occurs at
  - Annual or new patient visits
  - Provider recommendation
- **36%** of SIM POs/PCMHs expected to complete initial screening of their entire patient population by 2nd quarter of 2019
- **67%** report screening tools integrated with their EHR or other HIT system
- If screening reveals social needs, over 75% reported that practices:
  - Review the results with the patients
  - Determine the appropriate staff to address the need with the patients

Clinical-Community Linkages (CCL)

CCL activities to date reported by POs/PCMHs (continued):

- > **75% have community partners identified** to address the need in each domain
- Designated* staff person connects patients with community resources or coordinates with community service agencies
    - * Usually care managers, social workers, nurses and/or medical assistants
- Social service linkage considered closed upon confirmation of service receipt or enrollment
- **61%** reported that documentation of closed linkages is entered in EHR/HIT as narrative*
    - * Free text, scanned documents, other non-reportable fashion

SIM CCL Provider Survey

MICHIGAN PUBLIC HEALTH INSTITUTE

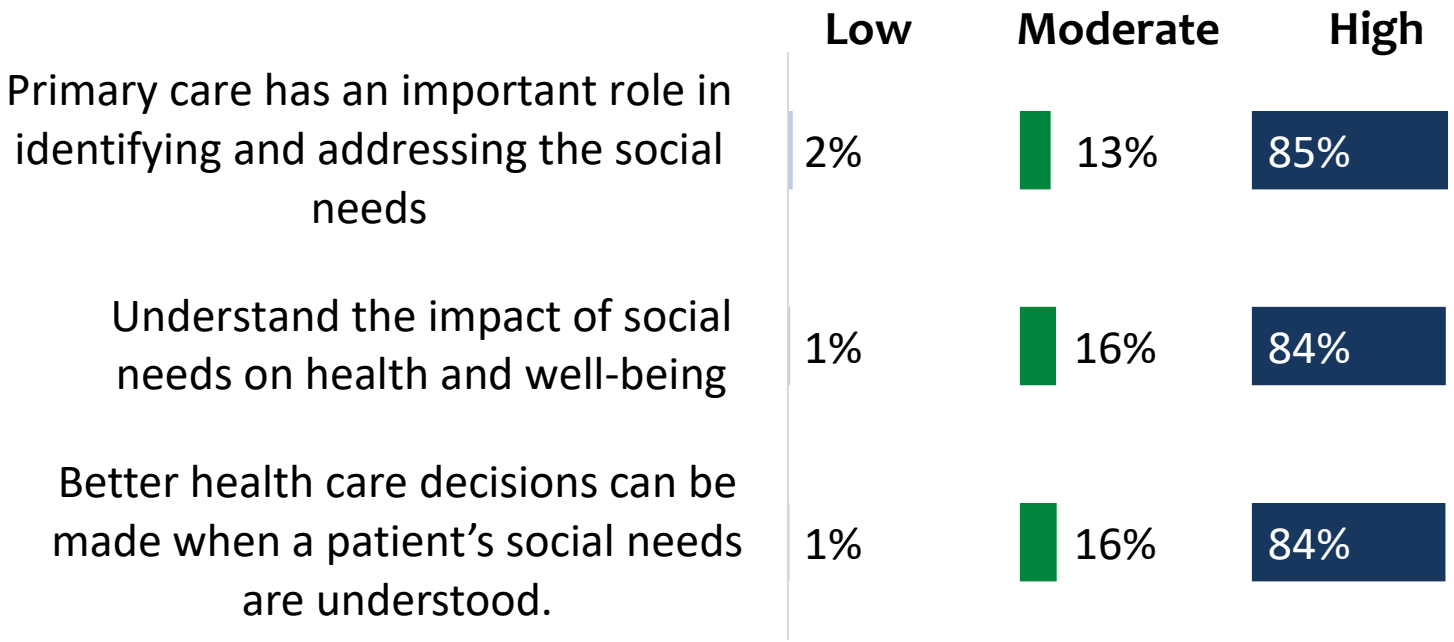
What percent of providers* **strongly endorse screening** for social needs in the PCMH?

*Physicians, NPs, PAs, Care Managers/Care Coordinators, administrators

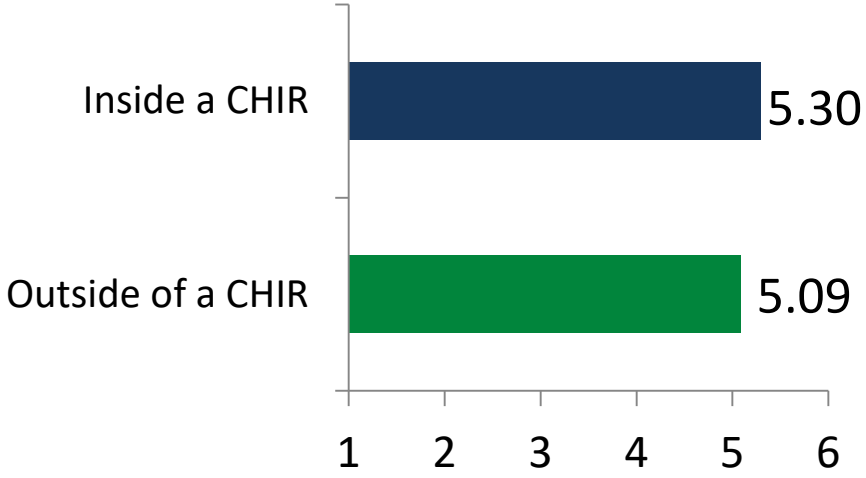
A. ~ 90%
B. ~ 85%
C. ~ 40%
D. ~ 35%

CCL Provider Survey - Motivation

Provider belief in the importance of understanding social needs



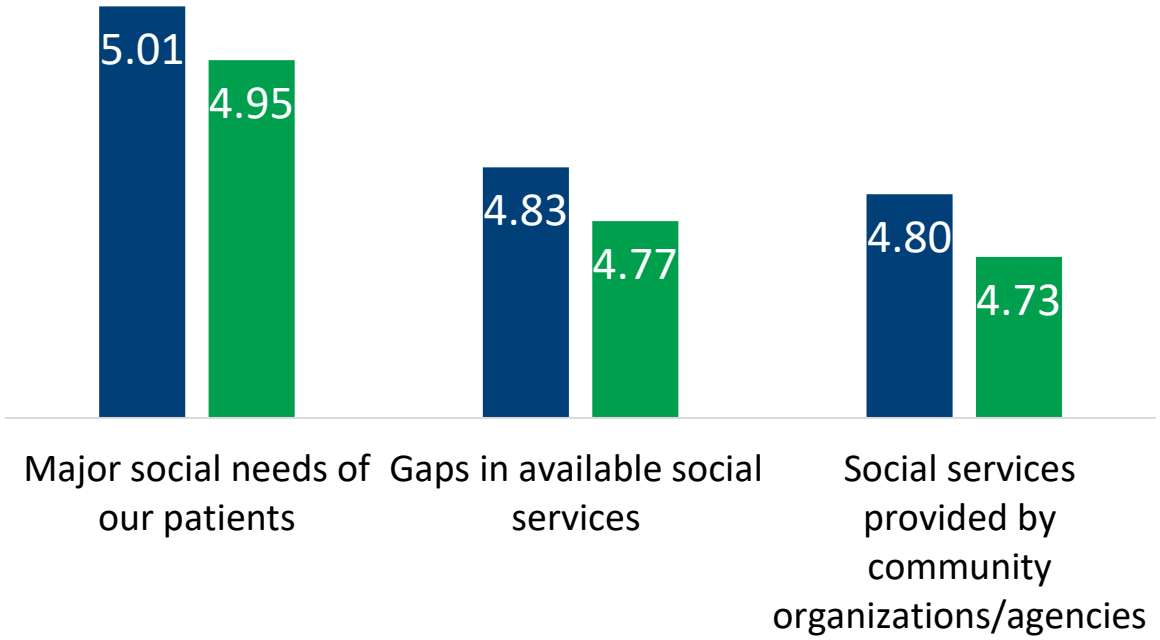
Providers inside and outside a CHIR compared



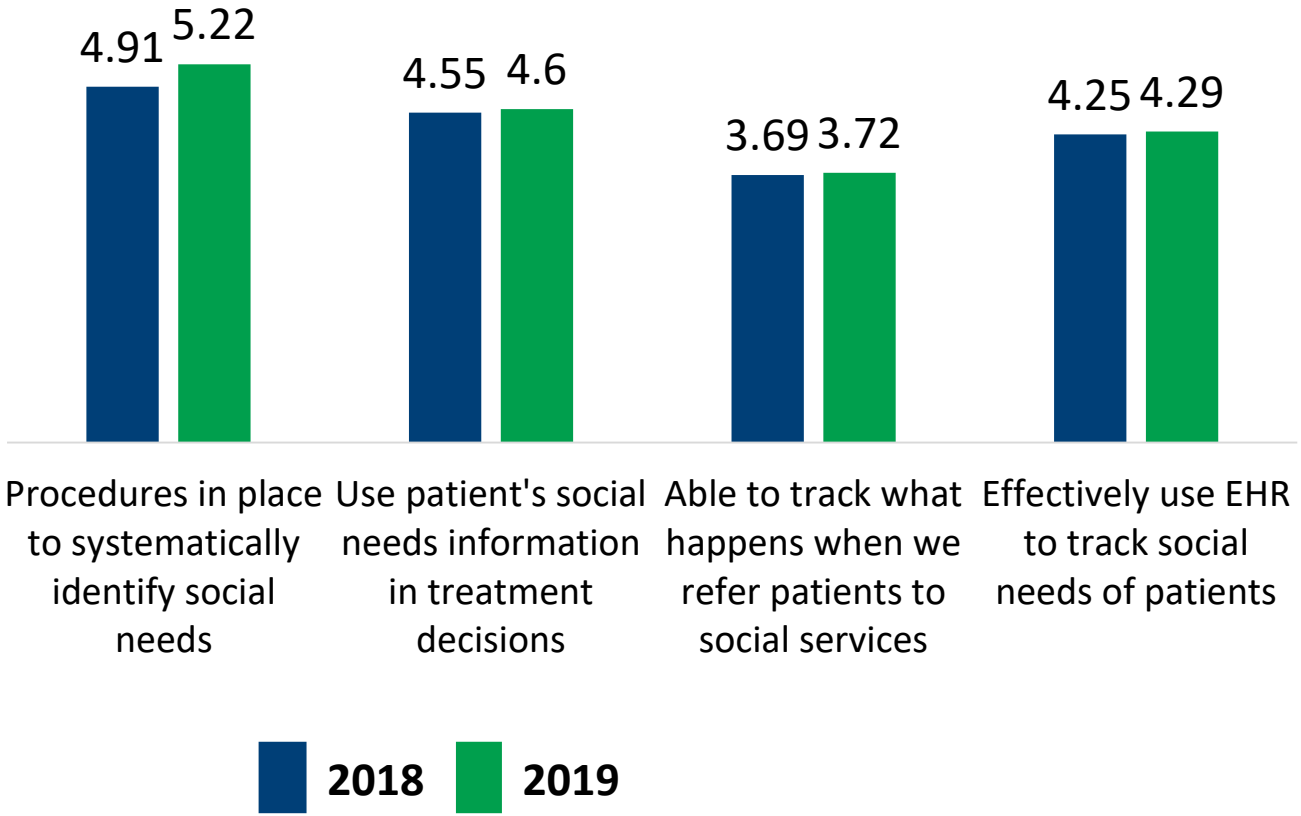
1 (Not at all) to 6 (A great deal).

CCL Provider Survey – Implementation Progress

Awareness of social needs and social service resources in 2018 and 2019



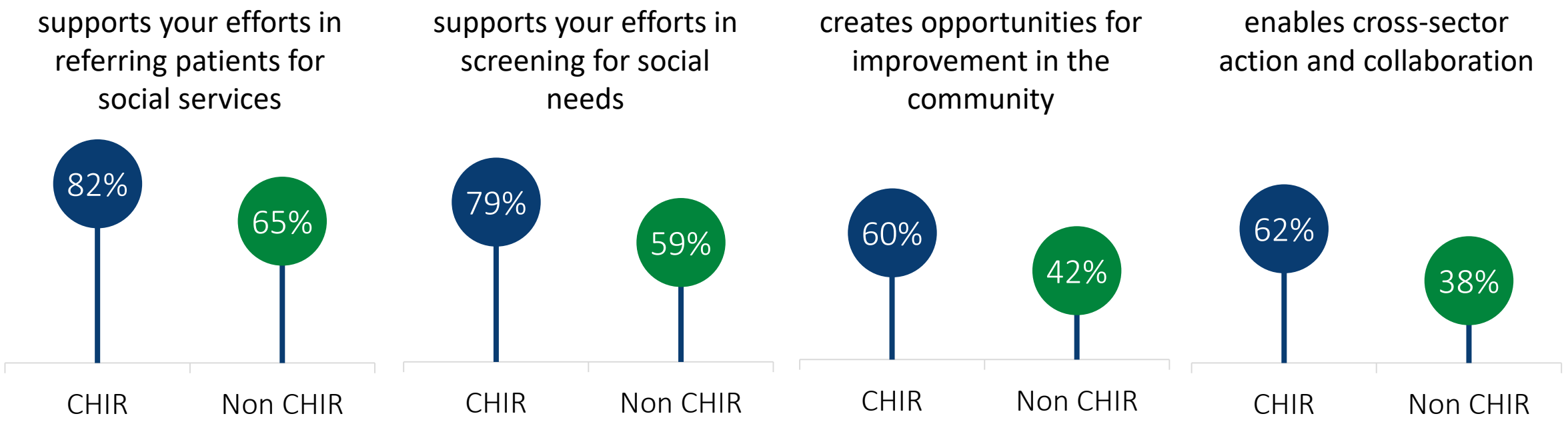
Effectiveness in identifying, tracking, and addressing patient social needs in 2018 and 2019



1 (Not at all) to 6 (A great deal).

CCL Provider Survey - CHIR vs. Non CHIR Respondents

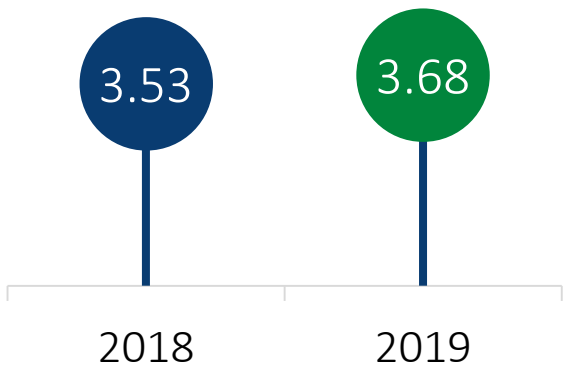
Question prompt: In your community is there an organization/entity that….



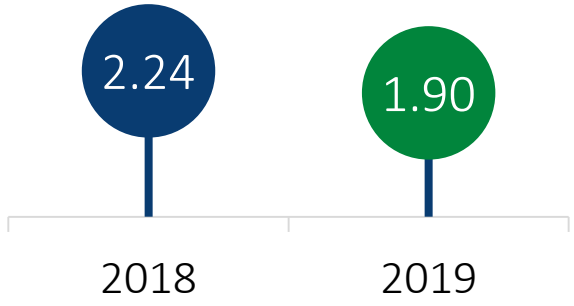
Number of respondents who indicated “yes” to the question

CCL Provider Survey – Comparison of 2018 to 2019

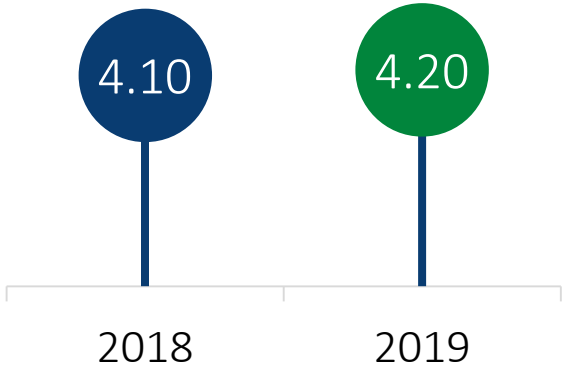
Agreement that their patients are getting healthier



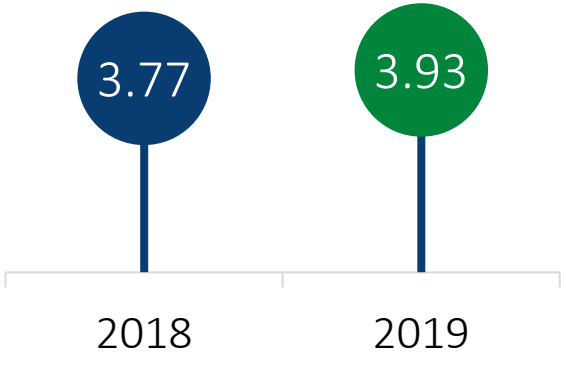
Agreement that staff had a reduced workload as a result of coordination efforts



Agreement that the benefits to their patients outweighed the added work/challenges



Agreement that there is greater trust between providers and vulnerable or disadvantaged individuals



1 (Not at all) to 6 (A great deal).

SIM PCMH SDOH/CCL Patient Experience Survey

SARAH CLARK

UM CHILD HEALTH EVALUATION AND RESEARCH (CHEAR) CENTER

Patient Perspective on SDoH Screening

Best location for SDoH screening to occur

1st response:	Adults	Parents
PCMH	31%	32%
Caseworker	31%	29%
Health plan	13%	14%
Hospital/ER	9%	8%
Other	14%	17%

*32% of adults and 40% of parents thought SDOH screening should occur in multiple sites.

Why should PCMH's not ask about SDoH?

	Adults	Parents
Don't want others to know	8%	16%
Nothing PCMH can do	7%	2%
Not appropriate for doctor's office	20%	38%
People won't answer honestly	27%	15%
Other	6%	9%
Actually, they should ask	*21%*	*22%*

What percent of parents believe the PCMH **should ask*** about concerns related to food, housing, bills, other challenges?

*Respond ‘definitely yes’ or ‘probably yes’

A. >= 80%
B. 60-79%
C. 40-59%
D. < 40%

Patient Perspective on SDoH Screening

	Definitely Yes	*Probably Yes*	*Probably no*	*Definitely no*
Overall, do you think [PCMH site] should ask parents if they have concerns about food, housing, bills or other life challenges?				
Parents, Not CHIR	34.2%	**45.4%**	15.1%	5.3%
Parents, CHIR	**48.3%**	37.1%	11.3%	3.3%

	Definitely Yes	*Probably Yes*	*Probably no*	*Definitely no*
Do you think parents at [PCMH site] would answer honestly if they have concerns about food, housing, bills, or other life challenges?				
Parents, Not CHIR	7.0%	**66.6%**	23.8%	2.6%
Parents, CHIR	15.8%	**67.7%**	15.8%	0.7%

Collective Impact Survey

PENNIE-FOSTER-FISHMAN, PHD

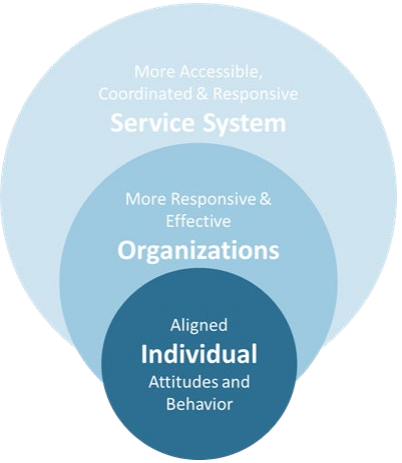
MICHIGAN STATE UNIVERSITY

CHIRS Have Demonstrated Their **Value** in….

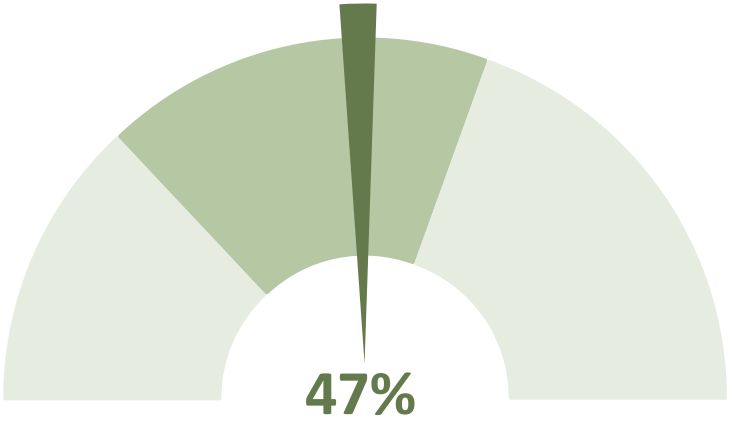
Creating an Aligned System

Transforming Individuals' Lives

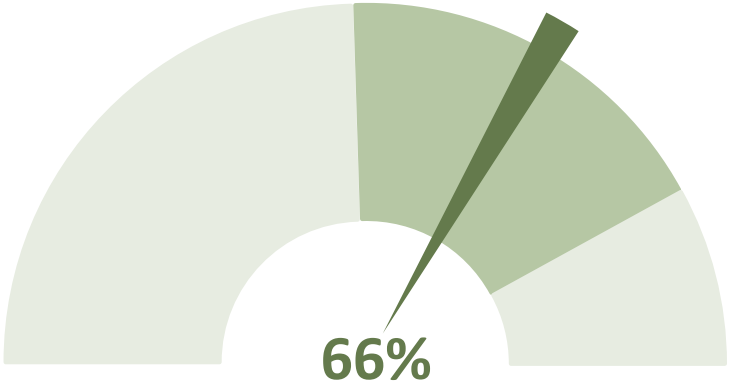
Individual Impacts



Through my involvement in the CHIR, **I am…**

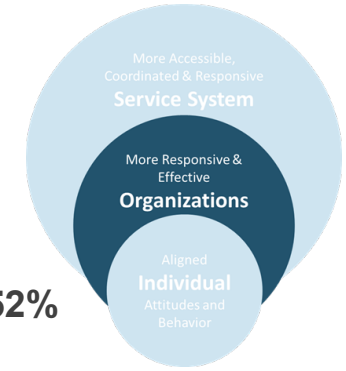


Shifting how I think about health and what is needed to improve health outcomes.

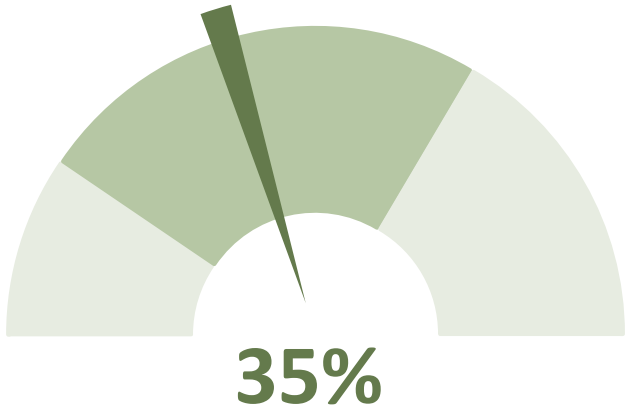


Integrating a stronger focus on social determinants of health in the work I do.

Organization Impacts



Because of our involvement in the CHIR, my organization is more effective:



Transforming Lives: Early Evidence

- **Connecting the Disconnected**
  - People who were **not previously known** to the system are **now getting the services and supports** they need outside of the ED.
- **Saving Lives Outside of the Emergency Department**
  - CHIRs are linking individuals to needed services and supports **before these unmet needs become a health care crisis**.
- **A Lifeline for those in Crisis**
  - Partners report CHIRs have become **a lifeline for those in crisis.**
- **Saving Lives in the Long-Term**
  - Partners believe CHIR efforts have potential to **transform people's lives across their lifespan**, improving quality of life and life expectancy.

*I just heard from a woman we've been working with for about 3 months, and she said **"I don't know where I'd be if it wasn't for the SIM and for the work that you've done. You've literally saved my life."**...*

–Social Sector

***I've watched people suffer and die on the streets**, and **I know how much housing improves peoples' lives and how lack of housing contributes to shortening lifespan**. So the more we keep healthcare and housing as a healthcare issue, the better it is for the people I serve.*

–Social Sector

*We are hearing about **patients that would have never have received that help unless they were given that [SDOH] screening**... that person probably could have had a lot of really bad things happen to them, and **I feel like, yes, we're saving lives one person at a time**, and this is definitely the way to do it.*

–Health Sector

SIM PCMH CCL Report

MICHIGAN PUBLIC HEALTH INSTITUTE

Assistance with employment represents what percent of CHIR services?

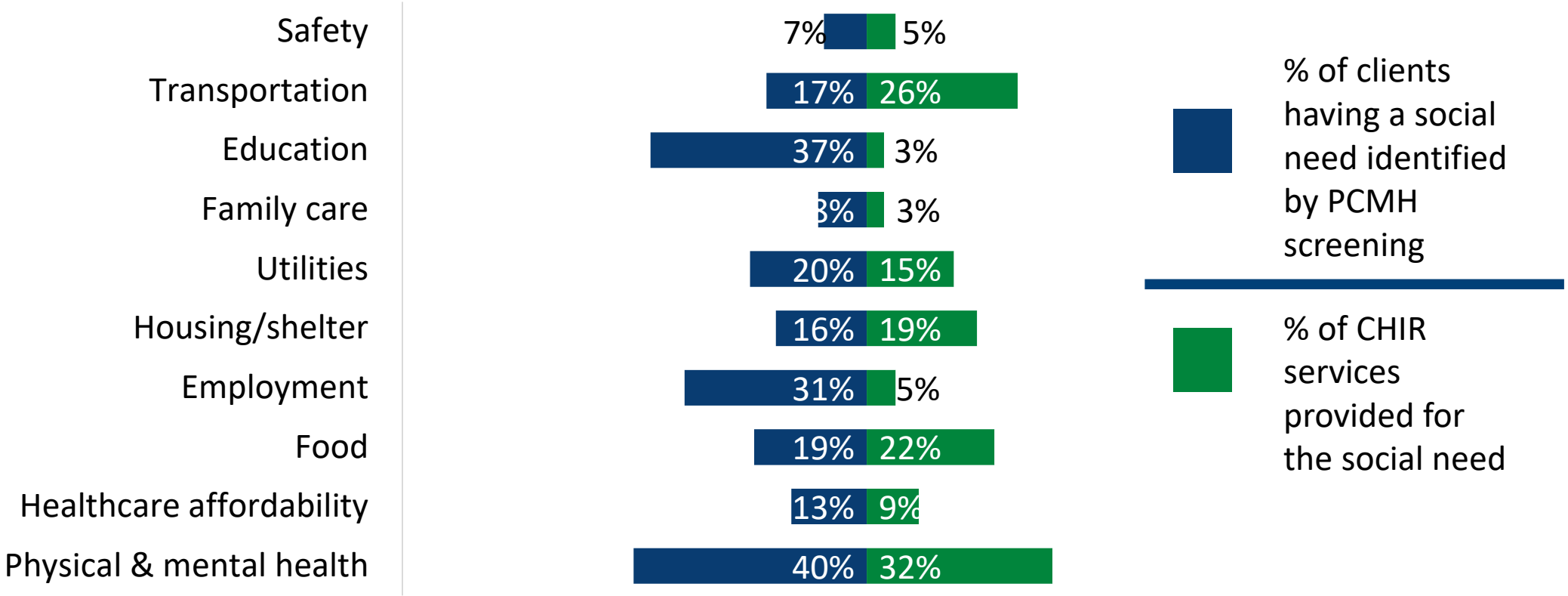
A. ~ 31%

B. ~ 22%

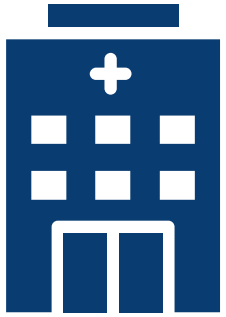
C. ~ 15%

D. ~ 5%

Top Needs of Those Screened By PCMH and Served by CHIRs

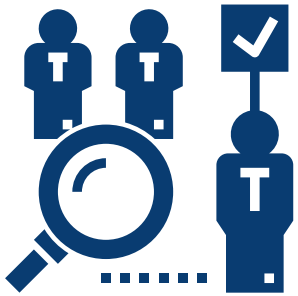


Overview



9
Physician organizations were included in the report

192,146 individuals were attributed to the 9 participating organizations



53,742
individuals were screened between March 2017 and December 2018

22,672 (42%)
individuals were identified as having 1+ social needs

Over half
of individuals with a social need had multiple needs (12,311)

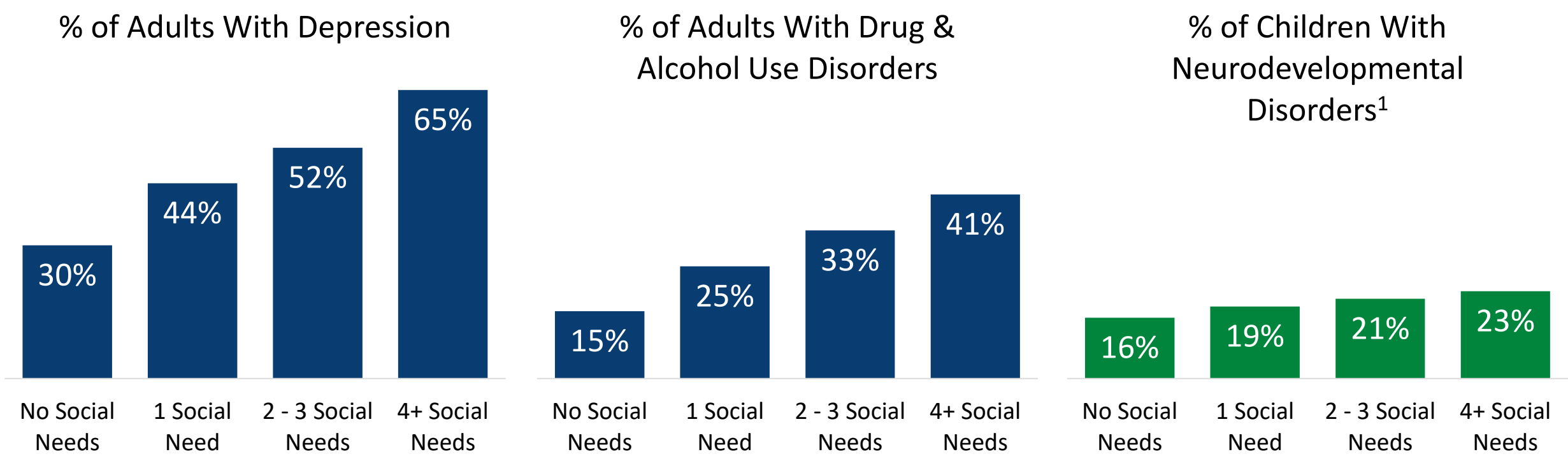
3
organizations were able to report CCL linkage data

What % of people have a diagnosis of depression*, compare people reporting:

→ **NO** social needs
→ **4+** social needs

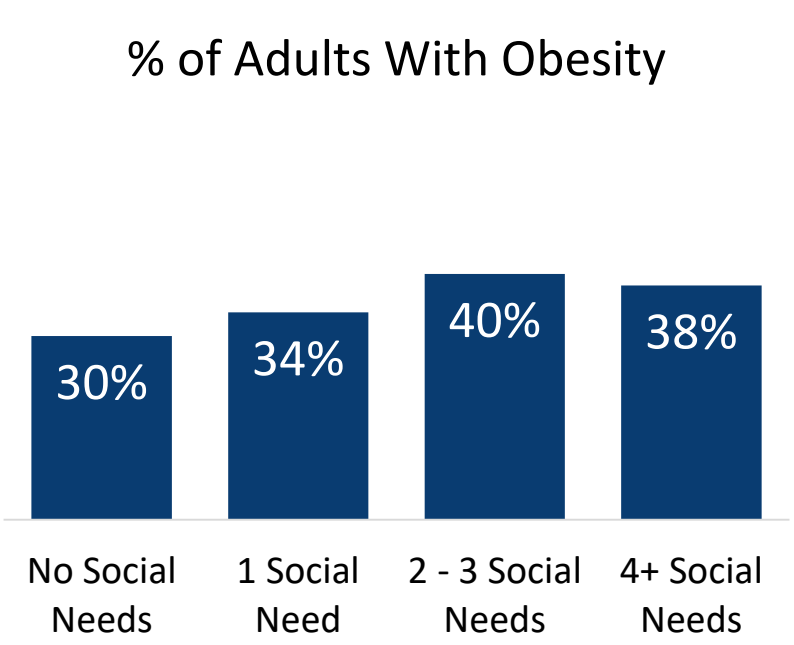
A. 15 % compared to 20% (no social needs vs. 4+ social needs)
B. 15 % compared to 40%
C. 25 % compared to 50%
D. 30 % compared to 65%

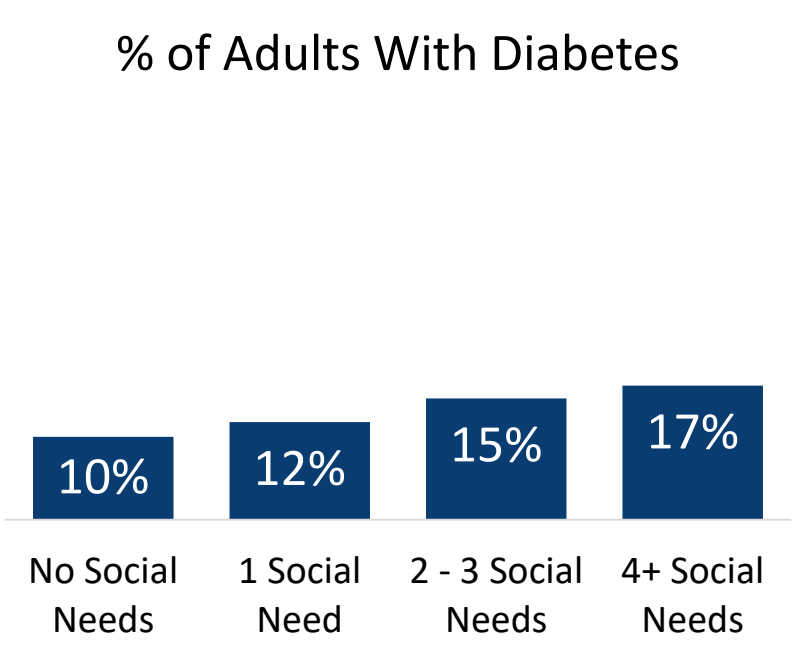
Presence of Social Needs and Behavioral Health/Substance Use Disorder Diagnoses

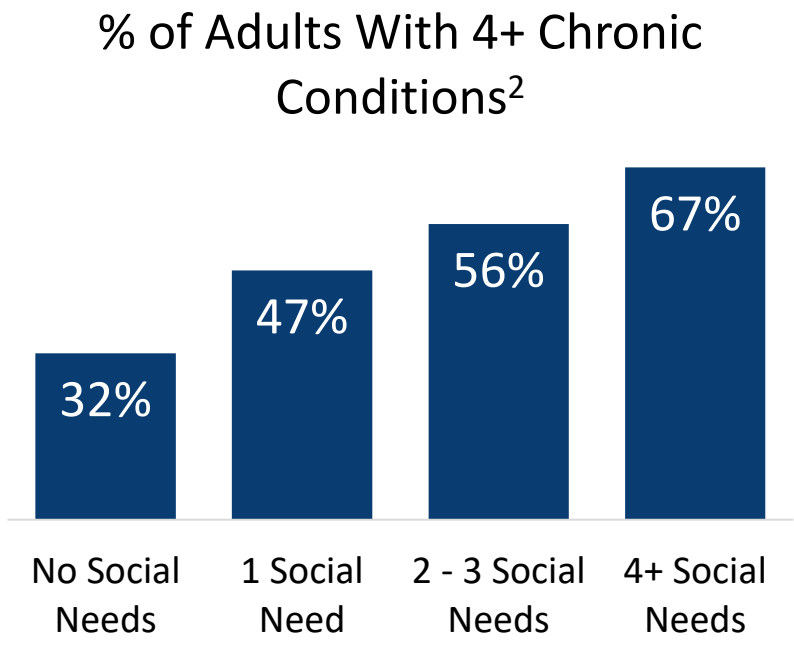


[1]Neurodevelopmental disorders include these conditions: ADHD, autism spectrum disorders, learning disabilities, intellectual disabilities and related conditions, and other developmental delays.

Presence of Social Needs and Physical Health Diagnoses







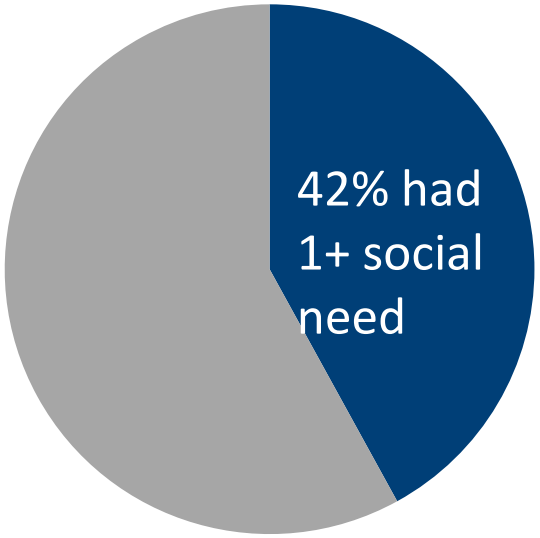
[2]For this report, the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Data Warehouse (CCW) classification categories and algorithms were adapted to identify the chronic conditions of the CCL Medicaid individuals from their Medicaid claims data. The CMS-CCW defines two sets of conditions: (1) a set of 27 common chronic conditions, and (2) a second set of over 40 (to date) other chronic or potentially disabling conditions which includes additional chronic health, mental health, disability-related and substance abuse conditions.

Top Needs Identified

Top 5 Needs Identified for Individuals with at Least One Need

Needs Identified, Linkages Opened, & Needs Met

Of 53,742 individuals screened



22,672

Of 22,672 individuals with 1+ social need

2% had a linkage opened

1,043

Of 1,043 individuals with a linkage opened

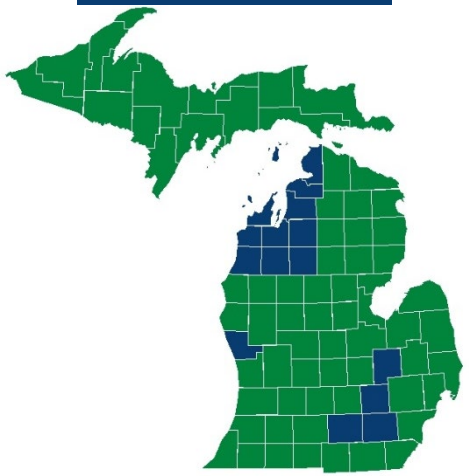
8% had their need met

SIM CHIR Clinical Community Linkages

Michigan Public Health Institute

Overview

5
Community Health Innovation Regions



554
clinical and community partners

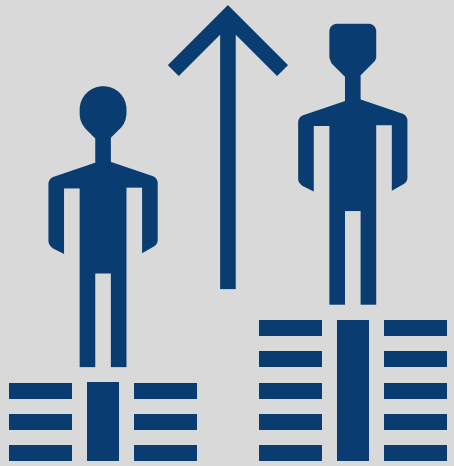
217,954
residents were screened for health and social needs in 2018

7,389
clients were served by the CHIRs in 2018

Who Are the CHIRs Serving?

27%

of CHIR clients live in regions considered the top 10% most disadvantaged in Michigan



Adults served by the CHIR average more than 3X the number of ED visits as those outside the CHIR

84%

of CHIR adult-clients have more than one chronic condition

15%

of CHIR child-clients have more than one chronic condition

Thank you!!

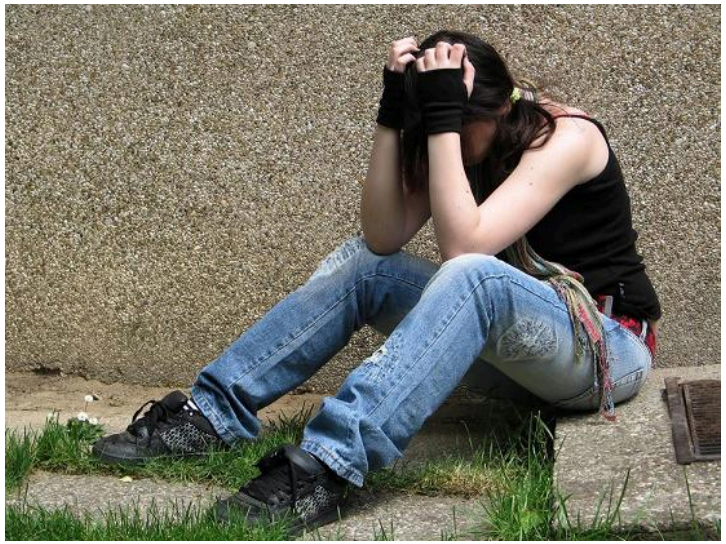
SIM
MDHHS State
Innovation Model

Depression in Youth: Presentation Diagnosis Treatment

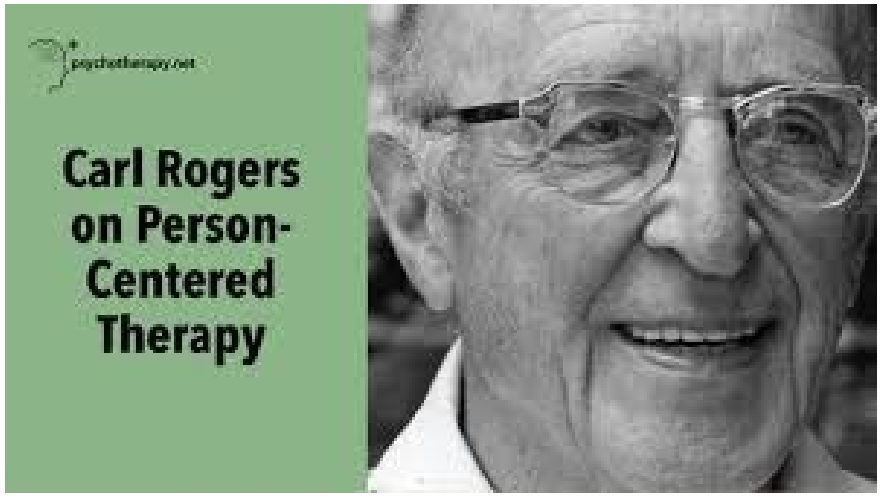
RICHARD DOPP, MD
UNIVERSITY OF MICHIGAN
CHILD & ADOLESCENT PSYCHIATRY

Objective

Identify the signs/symptoms of depression during adolescence and to describe evidence-based treatments for depression including psychotherapy, medication and self-care strategies.



Unconditional Positive Regard



Unconditional positive regard (UPR) is a term credited to humanistic psychologist Carl Rogers and is used in client-centered therapy.

Practicing unconditional positive regard means accepting and respecting others as they are without judgment or evaluation.

Outline

Medical model of psychiatric illness

Engaging patient and family in care

Diagnostic criteria

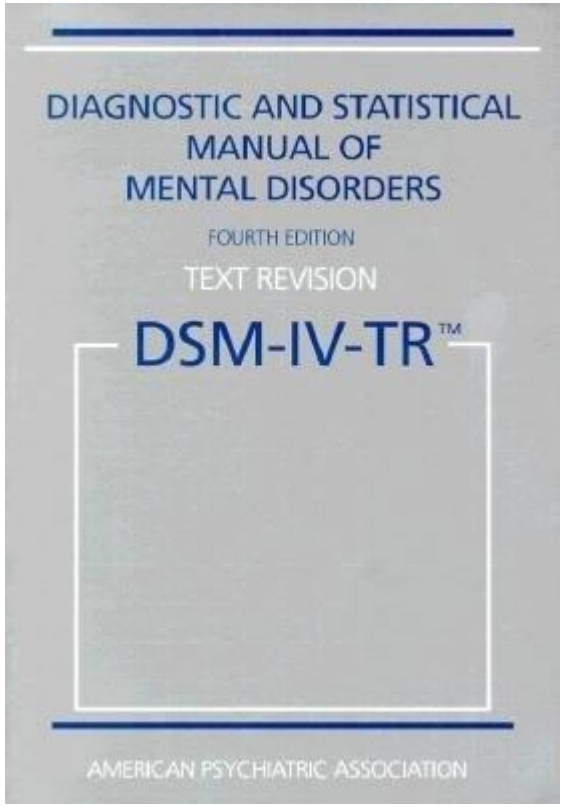
Patterns and prevalence

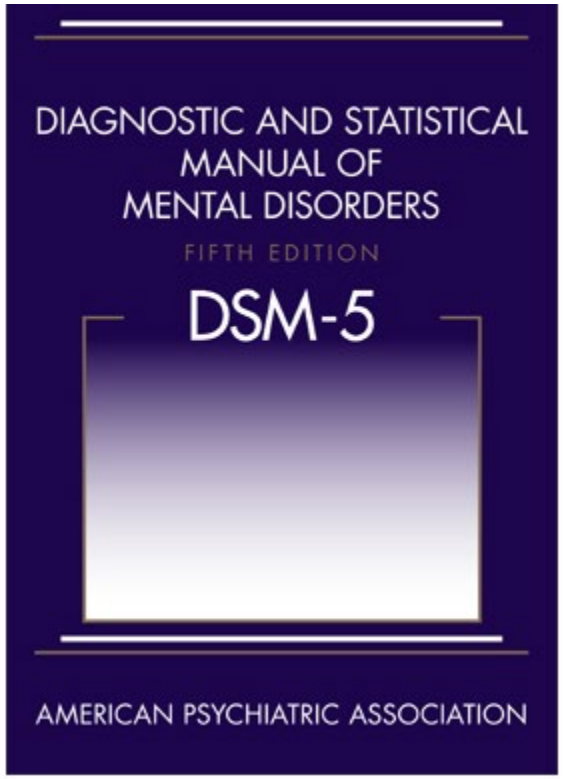
Psychotherapies

Medications

Combination

Diagnostic and Statistical Manuals





Mood Disorders (DSM-IV)

Dysthymia

Major Depressive Disorder

Depressive Disorder NOS

Bipolar Disorder

Mood Disorder NOS

Adjustment Disorders with depressed/anxious features

Depressive Disorders (DSM-5)

Disruptive Mood Dysregulation Disorder

Major Depressive Disorder (MDD)

Persistent Depressive Disorder (Dysthymia)

Premenstrual Dysphoric Disorder

Substance/Medication-Induced Depressive Disorder

Depressive Disorder Due to Another Medical Condition

Other Specified Depressive Disorder

Bipolar and Related Disorders (DSM-5)

Bipolar I Disorder

Bipolar II Disorder

Cyclothymic Disorder

Bipolar and Related Disorder Due to Another Medical Condition

Other Specified Bipolar and Related Disorder

Unspecified Bipolar and Related Disorder

Major Depressive Disorder

Defined by the Major Depressive Episode

Five or more symptoms for two weeks

1. Depressed mood
2. Loss of interest or pleasure
3. Irritable mood

Symptoms of Depression

S - Sleep disturbance

I - Loss of interests

G - Excessive guilt

E - Lack of energy

C - Loss of concentration

A - Change in appetite

P - Psychomotor retardation/agitation

S - Suicidal thoughts

DSM Specifiers

Mild, Moderate, Severe

Chronic

With or Without Psychotic Features

With Catatonic Features

With Melancholic Features

With Atypical Features

With Postpartum Onset

MDD With Seasonal Pattern

MDD With Scholastic Pattern

Depression in Children

0.3% of preschoolers

1-2% of elementary school children

Similar rates for males and females through age 12

Increased rates in children with co-morbid medical issues

Kashani, J., Venzke, R., & Millar, E. (1981). Depression in Children Admitted to Hospital for Orthopaedic Procedures. *British Journal of Psychiatry, 138*(1), 21-25. doi:10.1192/bjp.138.1.21

Anderson JC, Williams S, McGee R, Silva PA. DSM-III Disorders in Preadolescent Children: Prevalence in a Large Sample From the General Population. *Arch Gen Psychiatry.* 1987;44(1):69–76. doi:10.1001/archpsyc.1987.01800130081010

Depression in Young Children

D - defiance, disagreeability, distant

U - undeniable drop in school

M - morbid thoughts or drawings

P - pessimism, low self-esteem

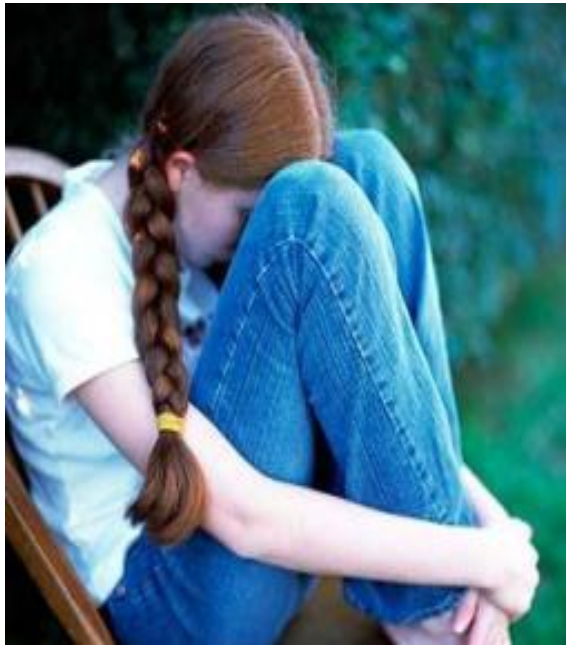
S - somatic (headaches, stomachaches)

Depression in Adolescents

Prevalence up to 8.3% in early adolescence

Rates in females increase at age 13-14; greater than 2:1 when compared with males at late adolescence

1 in 4 adolescents have experienced a depressive episode by age 18



Windstrom, L. (1999). The emergence of gender difference in depressed mood during adolescence: The role of intensified gender socialization. *Developmental Psychology*, *35,*(1).
Kessler RC, Avenevoli S, Costello J, Green JG, Gruber MJ, McLaughlin KA, Petukhova M, Sampson NA, Zaslavsky AM, Merikangas KR. Severity of 12-month DSM-IV disorders in the NCS-R Adolescent Supplement (NCS-A). *Arch Gen Psychiatry*In press

Corrigendum

aps ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

Corrigendum: Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates Among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time

Clinical Psychological Science
2019, Vol. 7(2) 397

DOI: 10.1177/2167702618824060
www.psychologicalscience.org/CPS
SAGE

Corrigendum: Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates Among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time. (2019). *Clinical Psychological Science*, *7*(2), 397–397. https://doi.org/10.1177/2167702618824060

Available online at www.sciencedirect.com

ScienceDirect

Current Opinion in Psychology

ELSEVIER

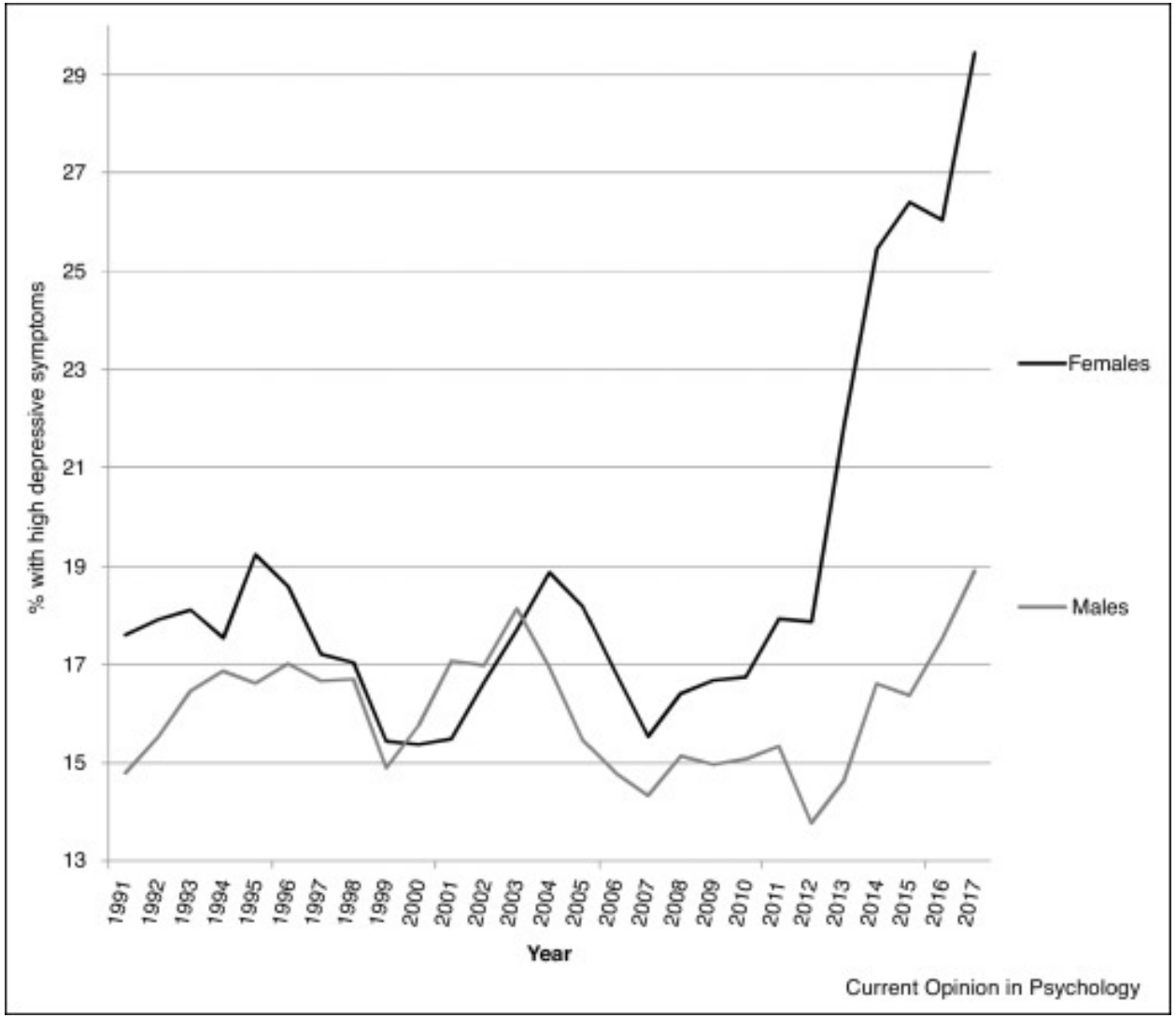
Why increases in adolescent depression may be linked to the technological environment

Jean M Twenge

Twenge, J. M. (2020). Why increases in adolescent depression may be linked to the technological environment. *Current Opinion in Psychology*, *32*, 89–94. https://doi.org/10.1016/j.copsyc.2019.06.0

Increases in Prevalence

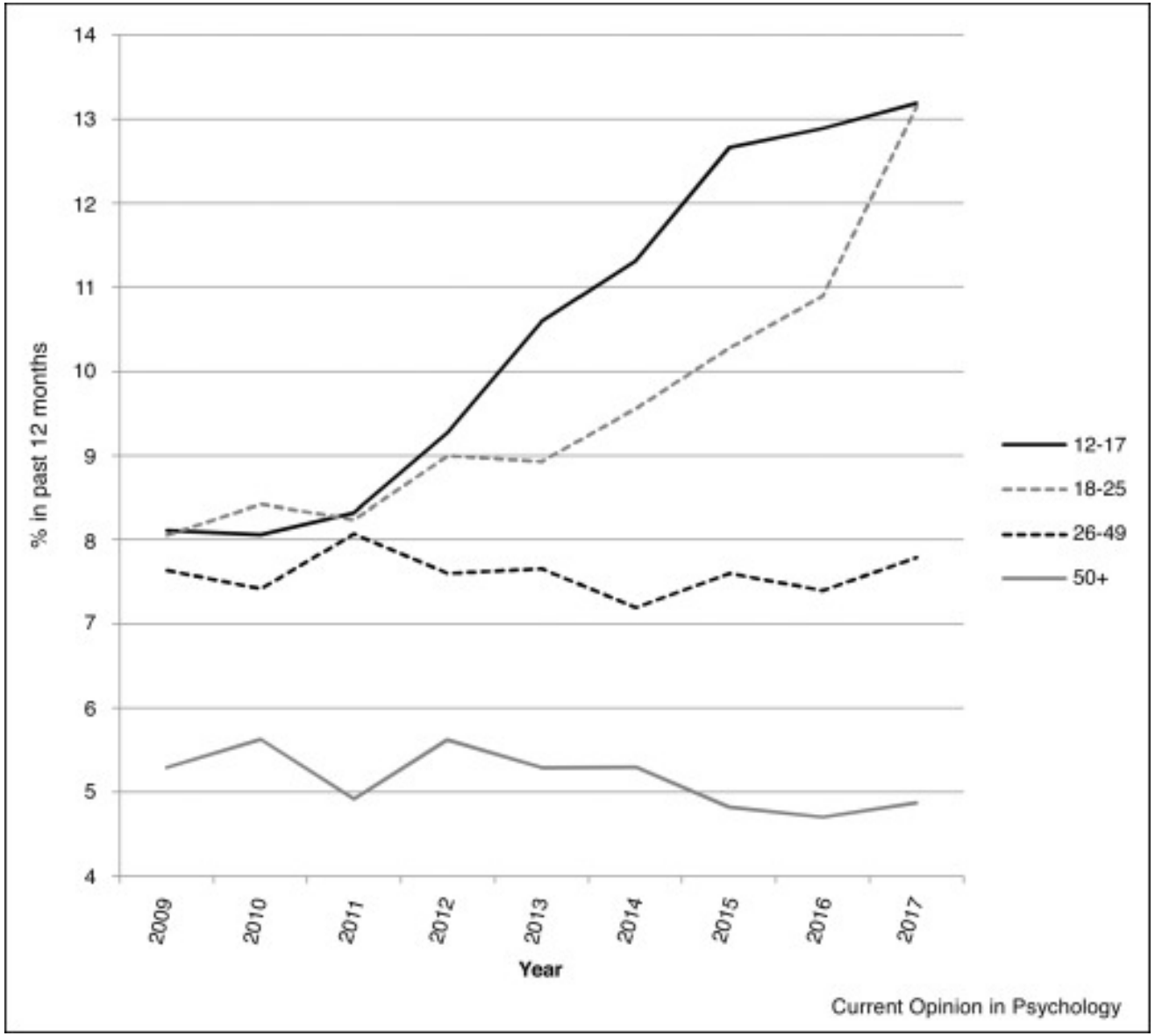
Between 2011 and 2017-2018, rates of reported depression in adolescents has increased approximately 60% with larger increases among adolescent females.



Twenge, J. M. (2020). Why increases in adolescent depression may be linked to the technological environment. *Current Opinion in Psychology*, *32*, 89–94. https://doi.org/10.1016/j.copsyc.2019.06.036

MDD in Adolescents

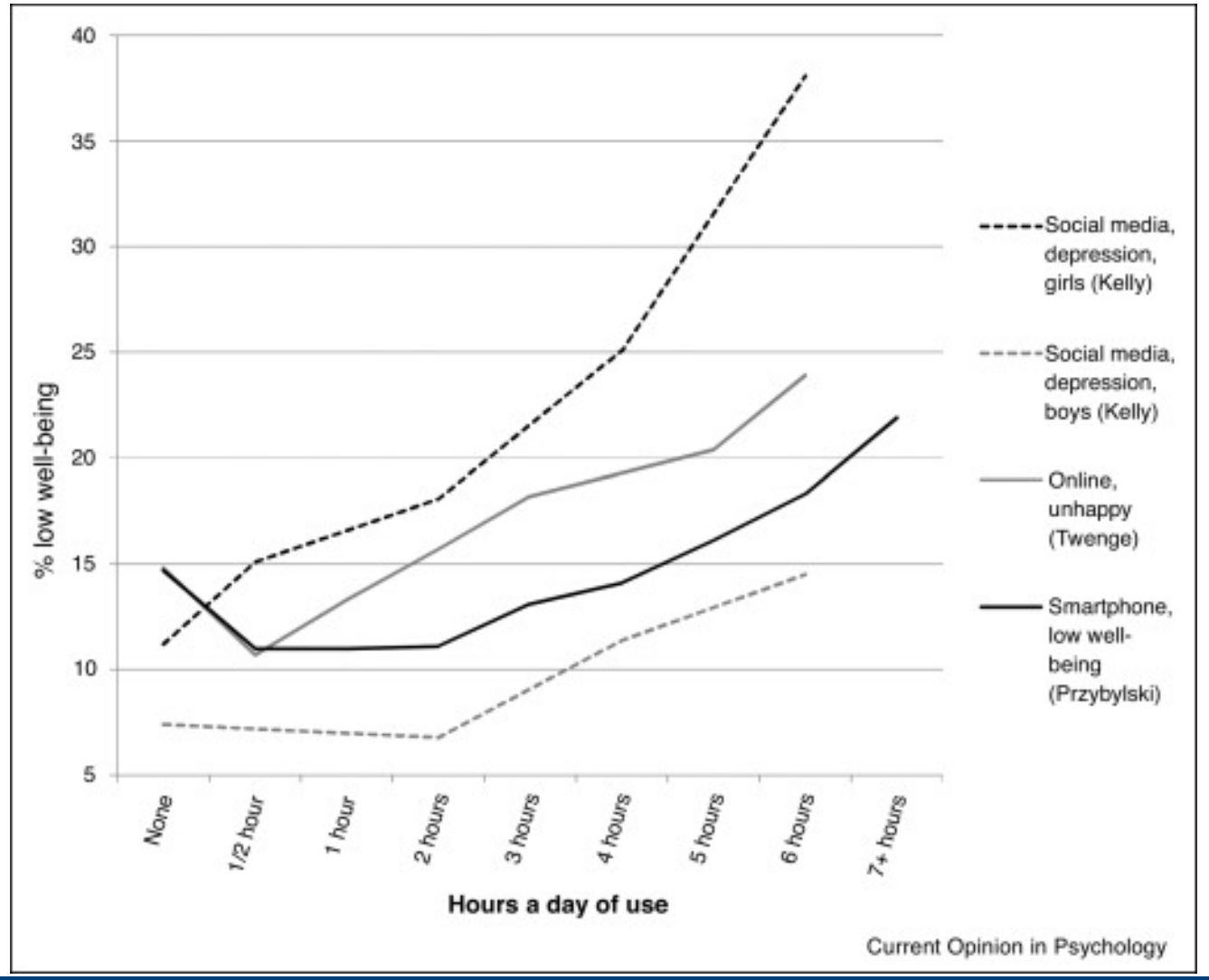
Recent increases in the prevalence of depression seen in youth and young adults.



Twenge, J. M. (2020). Why increases in adolescent depression may be linked to the technological environment. *Current Opinion in Psychology*, *32*, 89–94. https://doi.org/10.1016/j.copsyc.2019.06.036

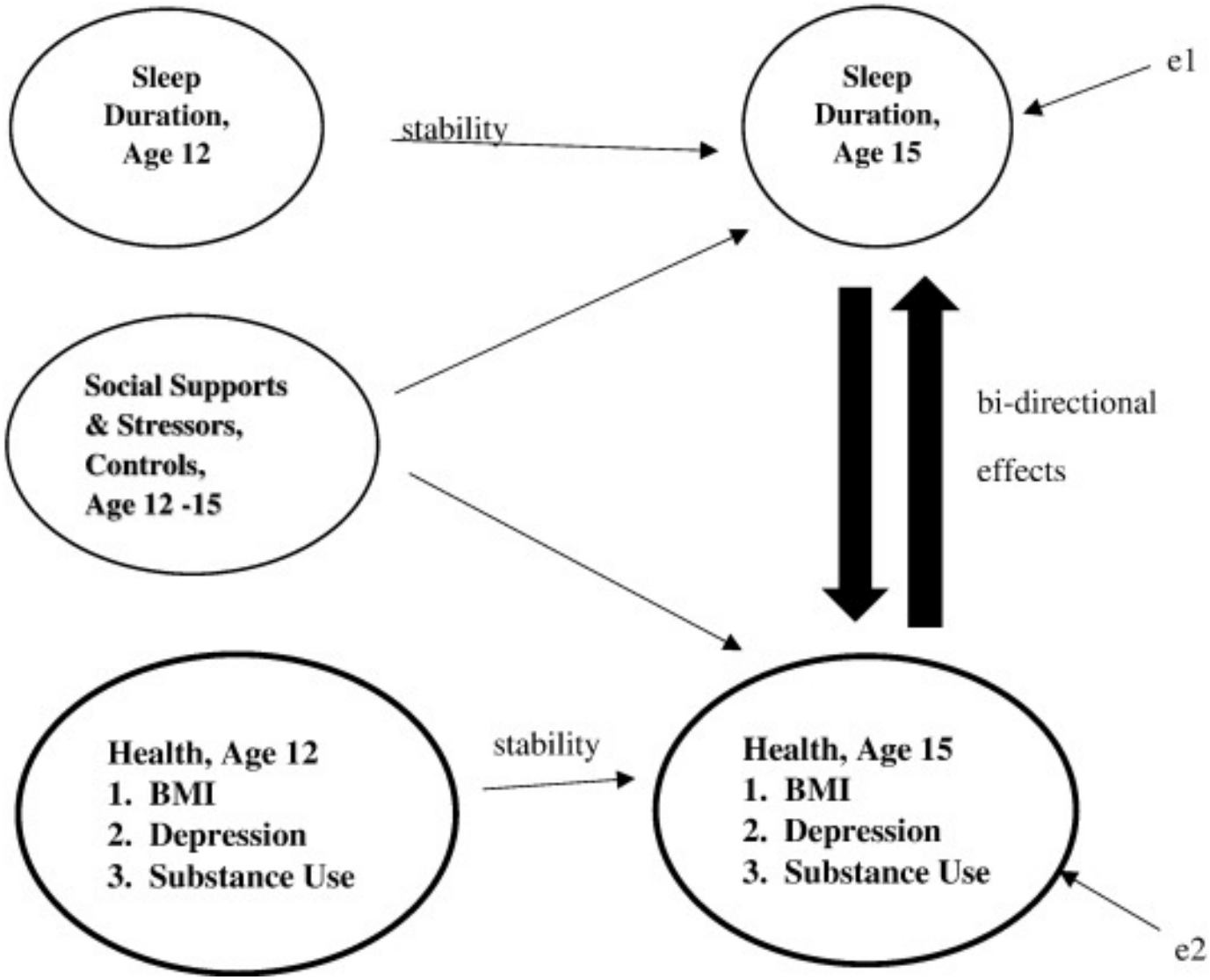
Use of Technology & Well-Being

Time spent engaged in the use of technology is associated with lower reports of well-being.



Twenge, J. M. (2020). Why increases in adolescent depression may be linked to the technological environment. *Current Opinion in Psychology*, *32*, 89–94. https://doi.org/10.1016/j.copsyc.2019.06.036

Sleep, BMI and Depression



Maume, D. J. (2017). Social relationships and the sleep-health nexus in adolescence: evidence from a comprehensive model with bi-directional effects. *Sleep Health*, *3*(4), 284–289. https://doi.org/10.1016/j.sleh.2017.05.006

Co-Morbidity or Multi-Morbidity

ADHD

Anxiety disorders

- Social Phobia
- Obsessive-Compulsive Disorder
- Posttraumatic Stress Disorder

Autism Spectrum Disorders

Substance Use Disorders

Treatment of Depression

- Psychotherapy
- Medication
- Combination
- Augmentation

Psychodynamic Therapy

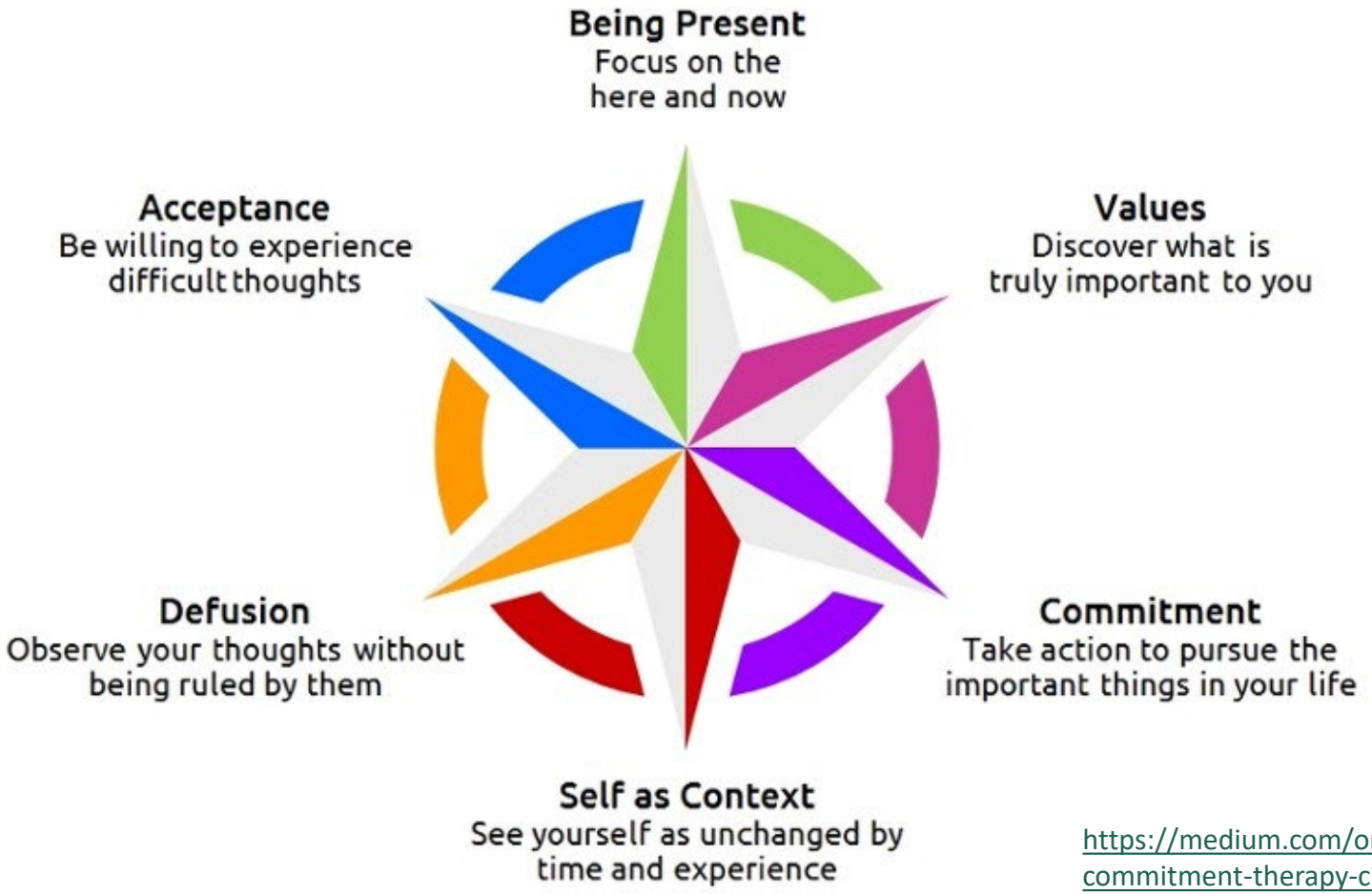
Emphasizes the importance of object loss and self-critical internal representations.

Reduce maladaptive defense mechanisms.

Resolve past psychological trauma.

Accept the realistic limitations of one's family and one's own abilities.

Acceptance & Commitment Therapy (ACT)



https://medium.com/org-hacking/intro-to-acceptance-and-commitment-therapy-c735309f8610

Interpersonal Therapy

Short-term, focused on present social function

Targets interpersonal deficits, role conflicts, grief, and difficult transitions

Additional focus on single-parent families for teens

Klerman GL, Weissman MM, Rounsaville BJ (1984) Interpersonal Psychotherapy of Depression. New York, Basic Books

Mufson L,Moreau D,Weissman MM, Klerman GL (1993) Interpersonal therapy for depressed adolescents. New York, Guilford Press

Dialectical Behavioral Therapy

Confusion about self

Emotional instability

Interpersonal problems

Parent-teen problems

Impulsivity

Cognitive Behavioral Therapy

Seeks to identify and change maladaptive beliefs, attitudes, and behaviors

Negativistic expectancies, cognitive distortions, social skills deficits

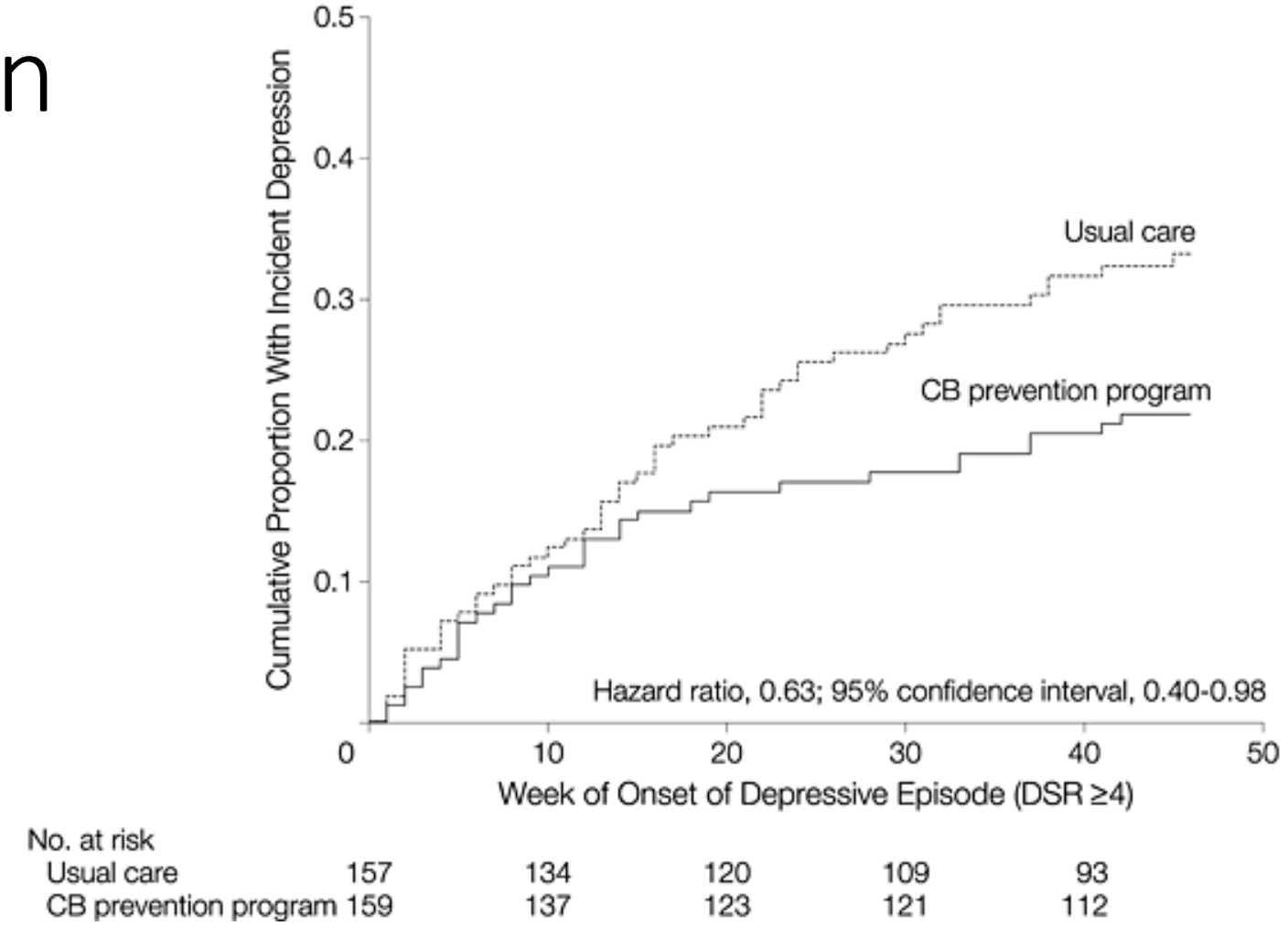
Behavior therapy attempts to improve the quality of one's interaction with the environment (have fun)

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford Press.

Lewinsohn, P. M., Clarke, g. N., Seeley, J. R., & Rohde, . (1994). Major Depression in Community Adolescents: Age at Onset, Episode Duration, and Time to Recurrence. *Journal of the American Academy of Child & Adolescent Psychiatry*, *33*(6), 809–818. https://doi.org/10.1097/00004583-199407000-00006

Cognitive Behavioral Therapy

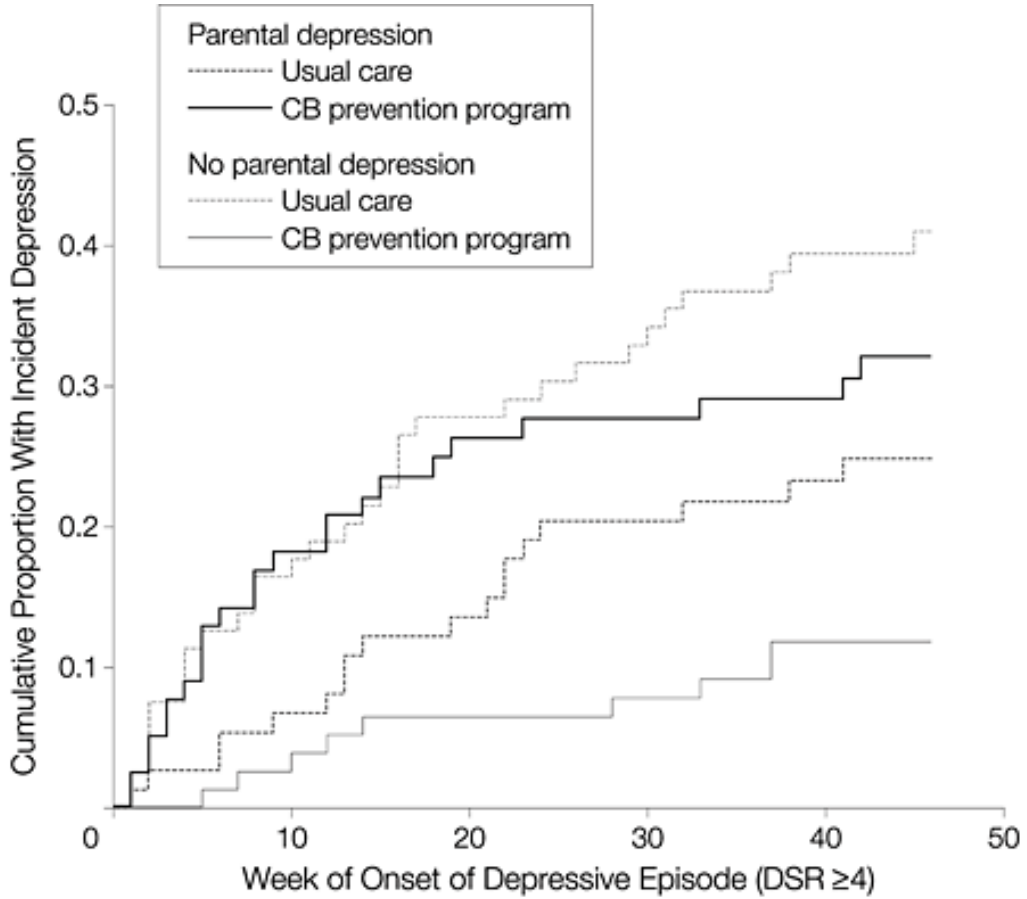
Risk of Incident Depression by Intervention Condition



No. at risk					
Usual care	157	134	120	109	93
CB prevention program	159	137	123	121	112

Garber, J., Clarke, G. N., Weersing, V. R., Beardslee, W. R., Brent, D. A., Gladstone, T. R. G., … Iyengar, S. (2009). Prevention of Depression in At-Risk Adolescents. *JAMA*, *301*(21), 2215. https://doi.org/10.1001/jama.2009.788

Risk of Incident Depression by Intervention Condition and Baseline Parental Depression



No. at risk					
Parental depression					
Usual care	76	68	63	57	51
CB prevention program	81	62	53	52	48
No parental depression					
Usual care	81	66	57	52	42
CB prevention program	78	75	70	69	64

Garber, J., Clarke, G. N., Weersing, V. R., Beardslee, W. R., Brent, D. A., Gladstone, T. R. G., … Iyengar, S. (2009). Prevention of Depression in At-Risk Adolescents. *JAMA*, *301*(21), 2215. https://doi.org/10.1001/jama.2009.788

Outline

Medical model of psychiatric illness

Engaging patient and family in care

Diagnostic criteria

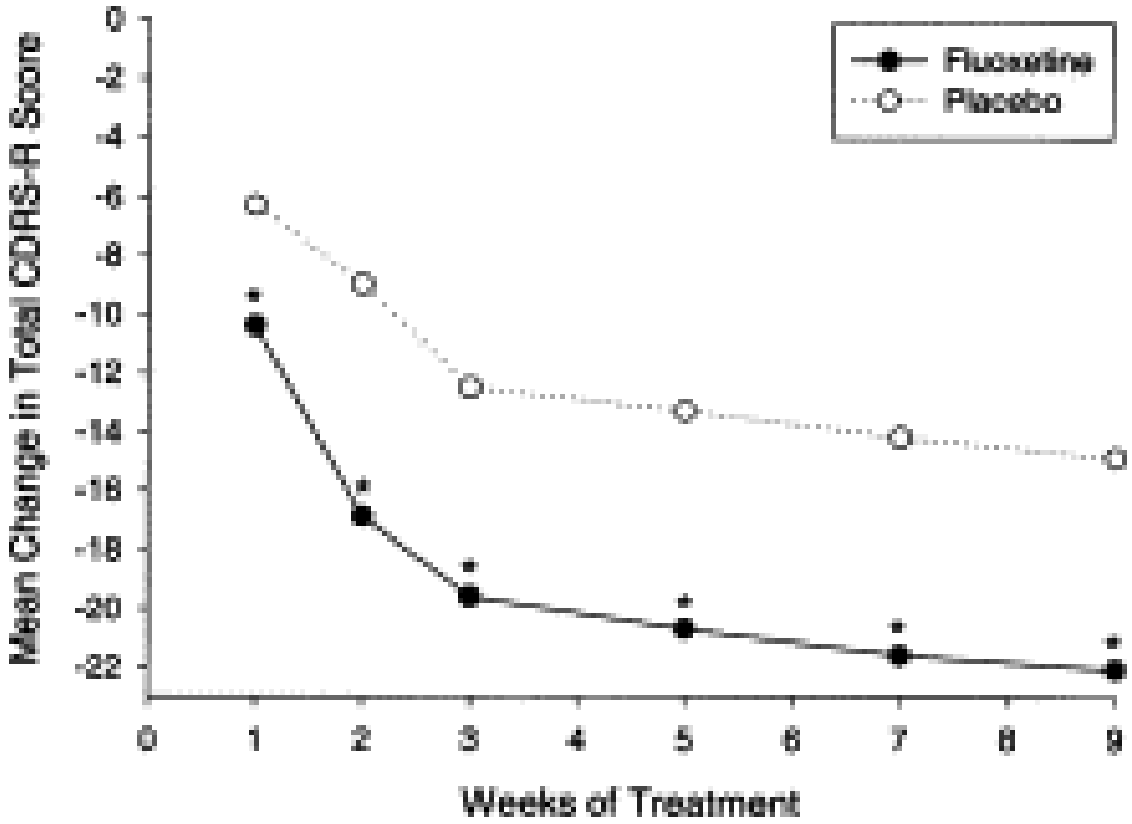
Patterns and prevalence

Psychotherapies

Medications

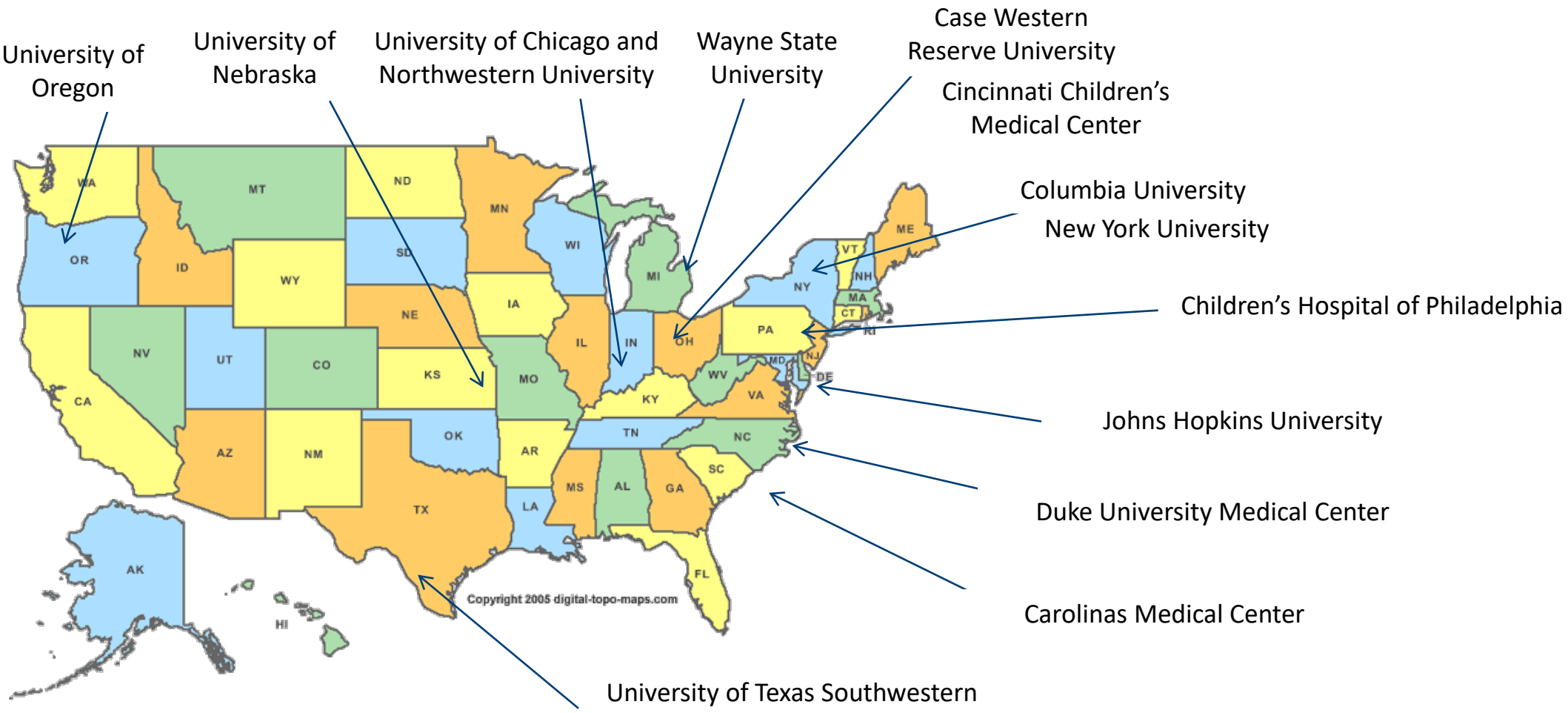
Combination

Fluoxetine



Emslie, G. J., Heligstein, J. H., Wagner, K. D., Hoog, S. L., Ernest, D. E., Brown, E., … Jacobson, J. G. (2002). Fluoxetine for Acute Treatment of Depression in Children and Adolescents: A Placebo-Controlled, Randomized Clinical Trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(10), 1205–1215. https://doi.org/10.1097/00004583-200210000-00010

Treatment of Adolescent Depression Study (TADS)



Marsh, J. (2004). Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression. *JAMA*, *292*(7), 807. https://doi.org/10.1001/jama.292.7.807

TADS

2804 telephone screens

1088 diagnostic interviews

549 baseline assessments

439 randomized adolescents with MDD

Marsh, J. (2004). Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression. *JAMA*, *292*(7), 807. https://doi.org/10.1001/jama.292.7.807

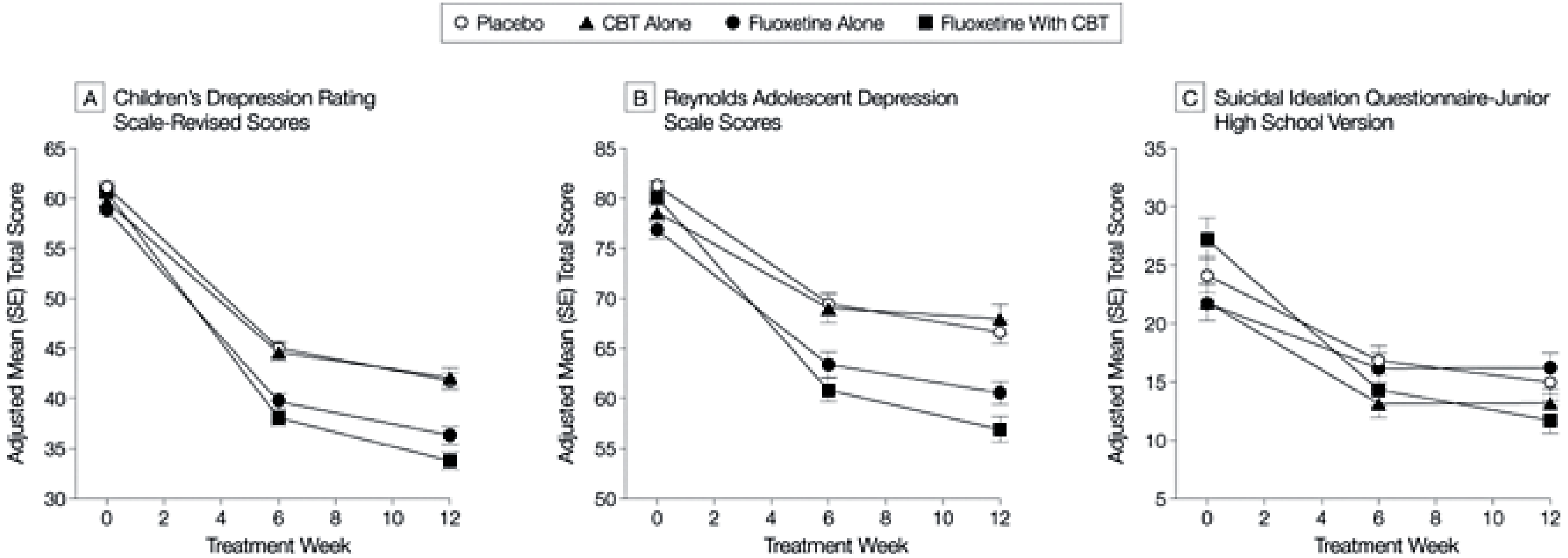
TADS

Randomized controlled trial

1. Placebo
2. Fluoxetine
3. Cognitive Behavioral Therapy (CBT)
4. Fluoxetine + CBT

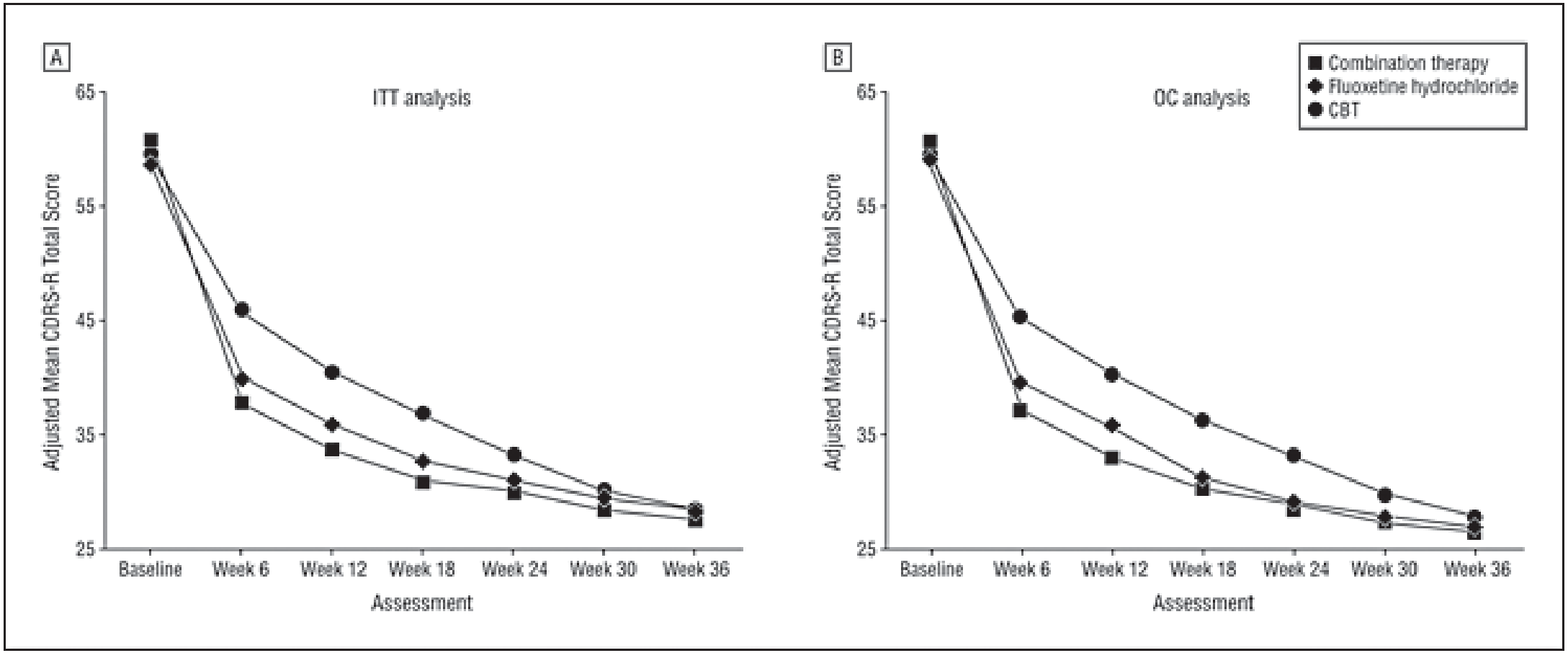
Marsh, J. (2004). Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression. *JAMA*, *292*(7), 807. https://doi.org/10.1001/jama.292.7.807

Adjusted Mean (SE) Scale Scores for Participants in the Treatment for Adolescents With Depression Study



Marsh, J. (2004). Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression. *JAMA*, *292*(7), 807. https://doi.org/10.1001/jama.292.7.807

Adjusted Mean Children's Depression Rating Scale-Revised (CDRS-R) Total Scores



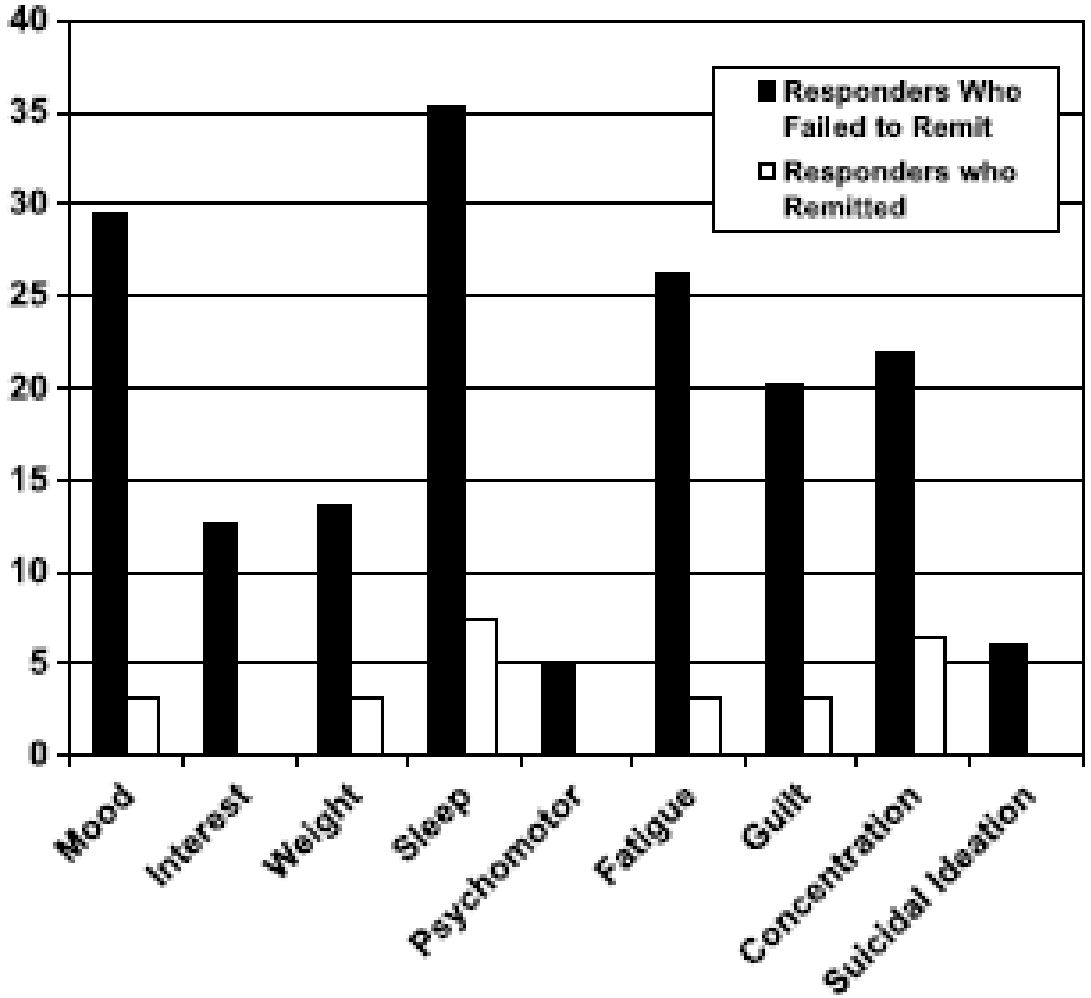
The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term effectiveness and safety outcomes. Arch Gen Psychiatry. 2007;64:1132–1144. doi: 10.1001/archpsyc.64.10.1132

TADS (Overview)

"Findings revealed that 6 to 9 months of combined fluoxetine plus CBT should be the modal treatment from a public health perspective as well as to maximize benefits and minimize harm for individual patients."

March M.D., M.P.H., J. S., & Vitiello, M.D., B. (2009). Clinical Messages from the treatment for adolescents with depression study (TADS). *Am J Psychiatry*, *166*, 1118–1123.

TADS: Remission and Residual Symptoms



Kennard, B., & al, E. (2006). Remission and residual symptoms after short-term treatment in the Treatment of Adolescents with Depression Study (TADS). *J Am Acad Child Adolesc Psychiatry*, *45*(12), 1404–1411.

Treatment of Resistant Depression in Adolescents (TORDIA)

Switching to another SSRI or to Venlafaxine with or without Cognitive Behavioral Therapy for adolescents with SSRI-resistant depression

The TORDIA Randomized Controlled Trial

334 patients with MDD that had not responded to a 2-month initial treatment with an SSRI

Brent, D., Emslie, G., Clarke, G. et al. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the Tordia randomized controlled trial. *JAMA*, 299(8), 901-913

TORDIA: Methods

Randomly assigned to 12 weeks of:

1. Switch to a different SSRI (paroxetine, citalopram, or fluoxetine, 20-40mg)
2. Switch to a different SSRI plus CBT
3. Switch to venlafaxine (150-225mg)
4. Switch to venlafaxine plus CBT

Brent, D., Emslie, G., Clarke, G. et al. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the Tordia randomized controlled trial. *JAMA*, 299(8), 901-913

TORDIA: Results (CBT)

Response at 12 weeks:

CBT (54.8%) > no CBT (40.5%)

"Switching to a combination of CBT and another antidepressant resulted in a higher rate of clinical response than switching to another medication without CBT."

Brent, D., Emslie, G., Clarke, G. et al. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the Tordia randomized controlled trial. *JAMA*, 299(8), 901-913

TORDIA: CBT Effective Components

Participants who had 9 or more CBT sessions were 2.5 times more likely to show response.

CBT participants who received problem-solving and social skills treatment, were 2.3 and 2.6 times, respectively, more likely to have a positive response.

Kennard, B., Clarke, G.N., V.R. Weersing, et al. (2009). Effective components of Tordia cognitive-behavioral therapy for adolescent depression: Preliminary findings. *Journal of Consulting and Clinical Psychology*, 77(6), 1033-1041

TORDIA: Results (Meds)

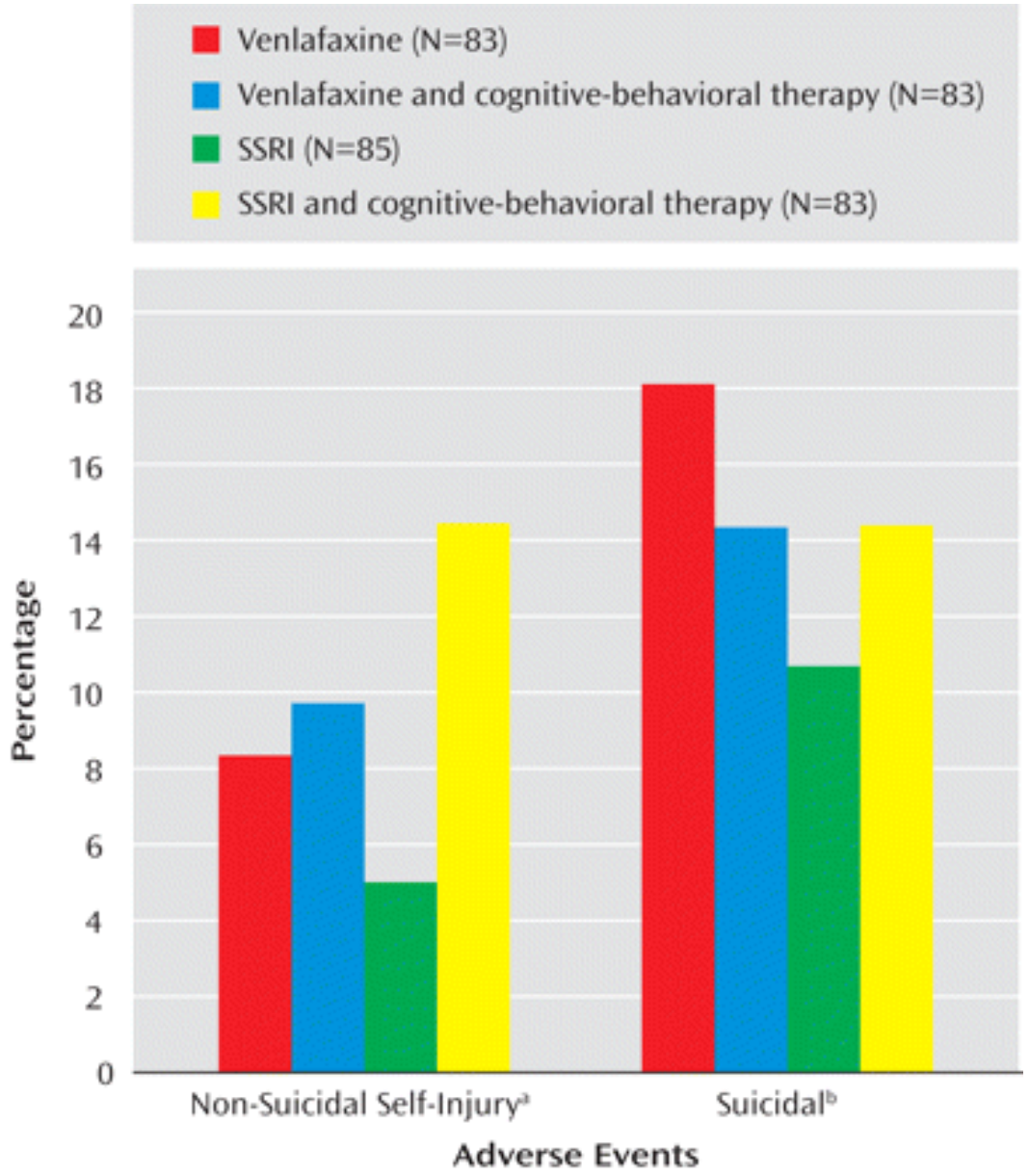
SSRI (47%) = venlafaxine (48.2%)

Among SSRIs:

- Paroxetine - 19/50 (38%)
- Fluoxetine - 41/84 (48.8%)
- Citalopram- 19/34 (55.9%)

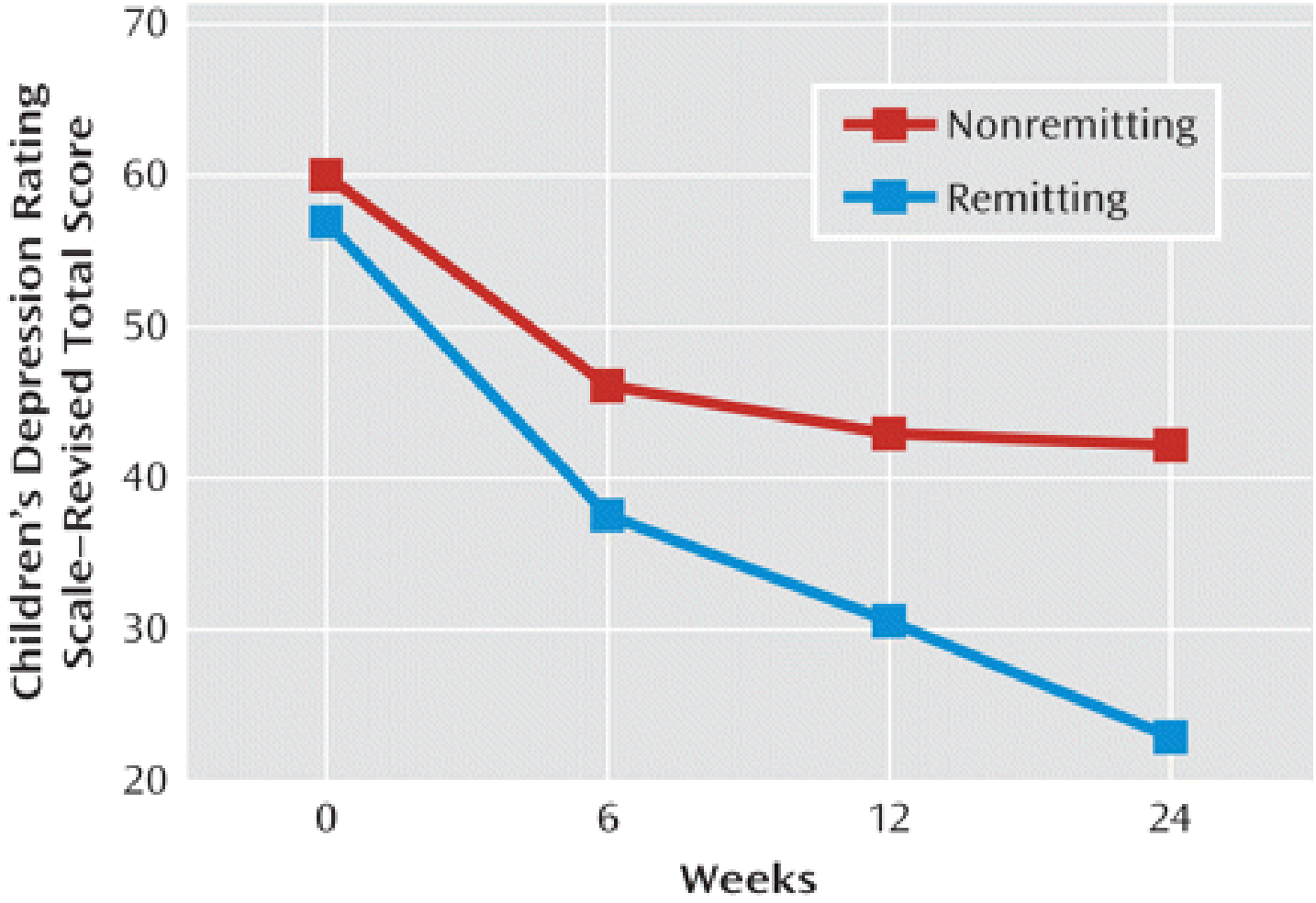
Brent D., Emslie, G., Clarke, G. et al. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the Tordia randomized controlled trail. *JAMA*, 229(8), 901-913

TORDIA: Suicidal Adverse Events



Brent, D.A., Emslie, G.J., Clarke, G.N. et al. (2009). Predictors of spontaneous and systematically assessed suicidal adverse events in the treatment of SSRI-resistant depression in adolescents (TORIDA) study. *Am J Psychiatry*, 166(4), 18-25

TORDIA: Remission



Emslie, G.J., Mayes, T., Porta, G. et al. (2010) Treatment of Resistant Depression in Adolescents (TORDIA): week 24 outcomes. *Am J Psychiatry*, 167(7), 782-791

SSRIs

Fluoxetine 5 - 10mg daily (target 20 - 40mg)

Sertraline 12.5 - 25mg daily (target 100 - 150mg)

Citalopram 5 - 10mg daily (target 20 - 40mg)

Escitalopram 2.5 - 5mg daily (target 20mg)

Sleep, Suicidality, and Depression

Persistent sleep disturbance increases risk of:

- Relapse
- Recurrence
- Future suicidality(in adults and adolescents)

Fawcett et al., 1990; Wingard & Berkman, 1983;Dahl et al., 1990; Emslie et al., 1994

Sleep Treatment

Sleep hygiene

Melatonin 3-5mg at bedtime (safe at 10mg)

Trazodone 25-50mg at bedtime (up to 200mg)

Diphenhydramine 25-50mg at bedtime

Mirtazapine 7.5-15mg at bedtime

Augmentation of Depression

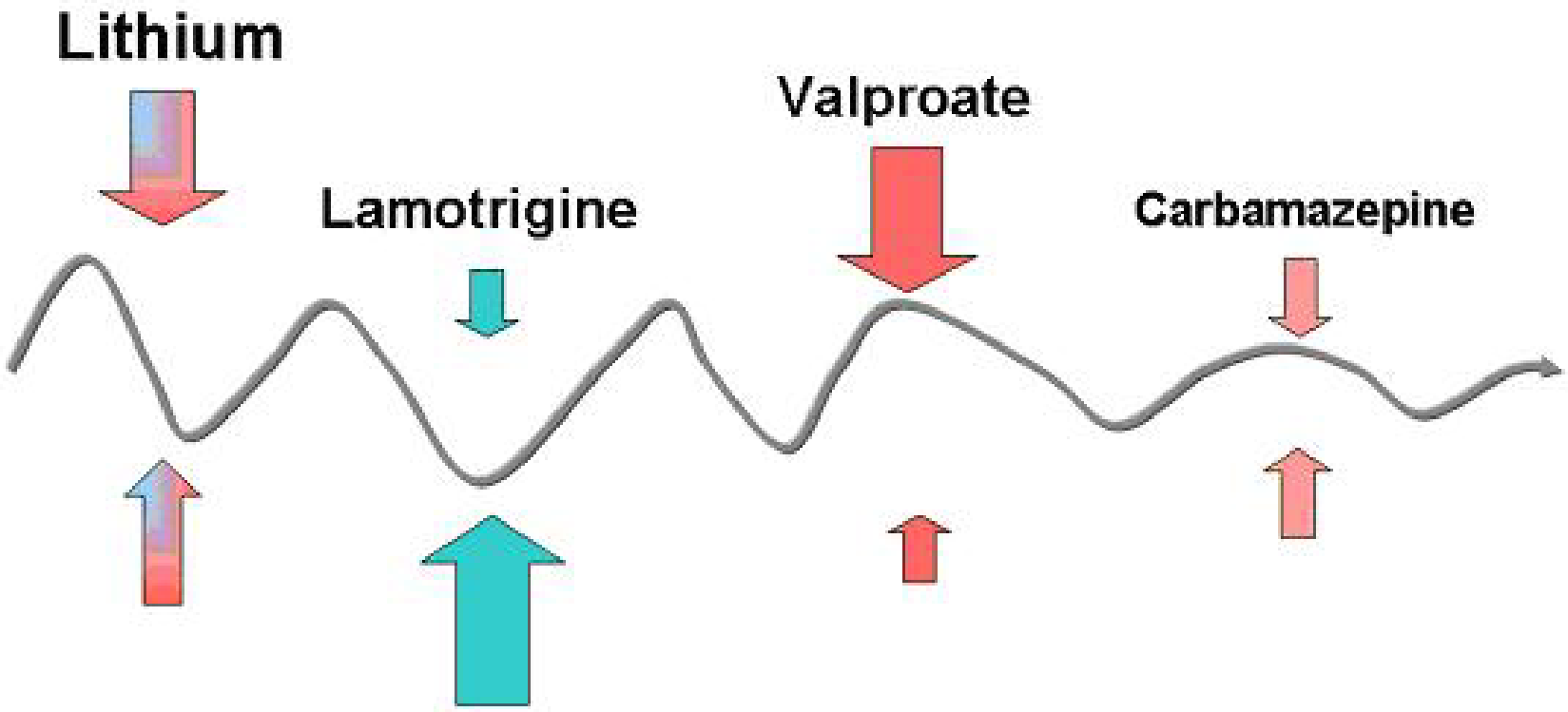
Bupropion (Wellbutrin)

Mirtazapine (Remeron)

Thyroid supplementation (adults)

Lithium (adolescents/adults)

Kinds of stabilizer effect of Mood Stabilizers



The thickness of the arrows indicate the intensity of the effect of each Mood Stabilizer.
Your address whether the therapeutic effects are predominantly exercised by a depressive prevention effect or a manic prevention effect

Retrieved from: https://undepress.net/antidepressants-how-do-they-work-types-choice-list-of-antidepressants/

Atypical Antipsychotics

Risperidone (Risperdal)

Olanzapine (Zyprexa)

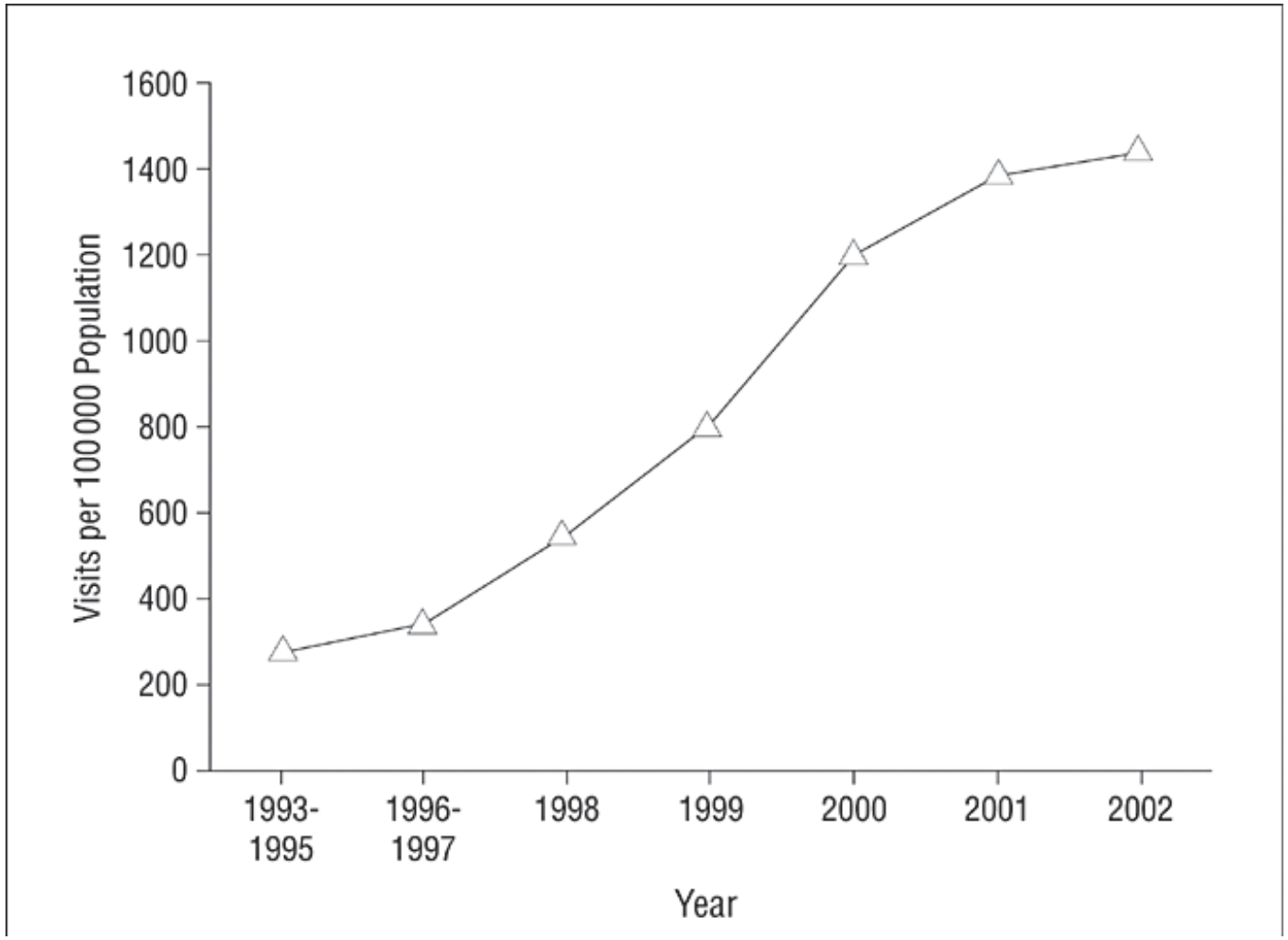
Quetiapine (Seroquel)

Aripiprazole (Abilify)

Ziprasidone (Geodon)

Lurasidone (Latuda)

National Trends in Office-Based Visits by Children and Adolescents that Included Antipsychotic Treatment, 1993-2002



Olfson, M., Bianco, C., Liu, L., & Laje, G. (2006). National trends in the outpatient treatment of children and adolescents with antipsychotic drugs. Arch Gen Psychiatry, 63(6), 679-685

Electroconvulsive Therapy (ECT)

Before an adolescent is considered for ECT, he/she must meet three criteria:

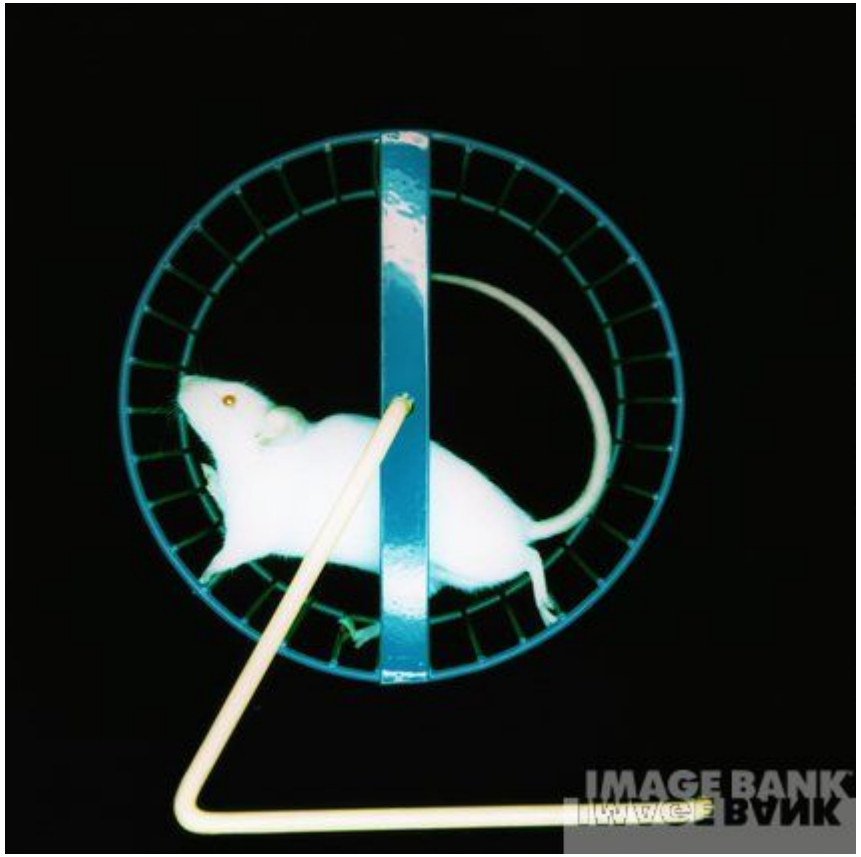
1. Diagnosis
2. Severity
3. Lack of treatment response

Ghaziuddin, N., Kutcher, S. P., & Knapp, P. (2004). Practice Parameter for Use of Electroconvulsive Therapy With Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(12), 1521–1539. https://doi.org/10.1097/01.chi.0000142280.87429.68

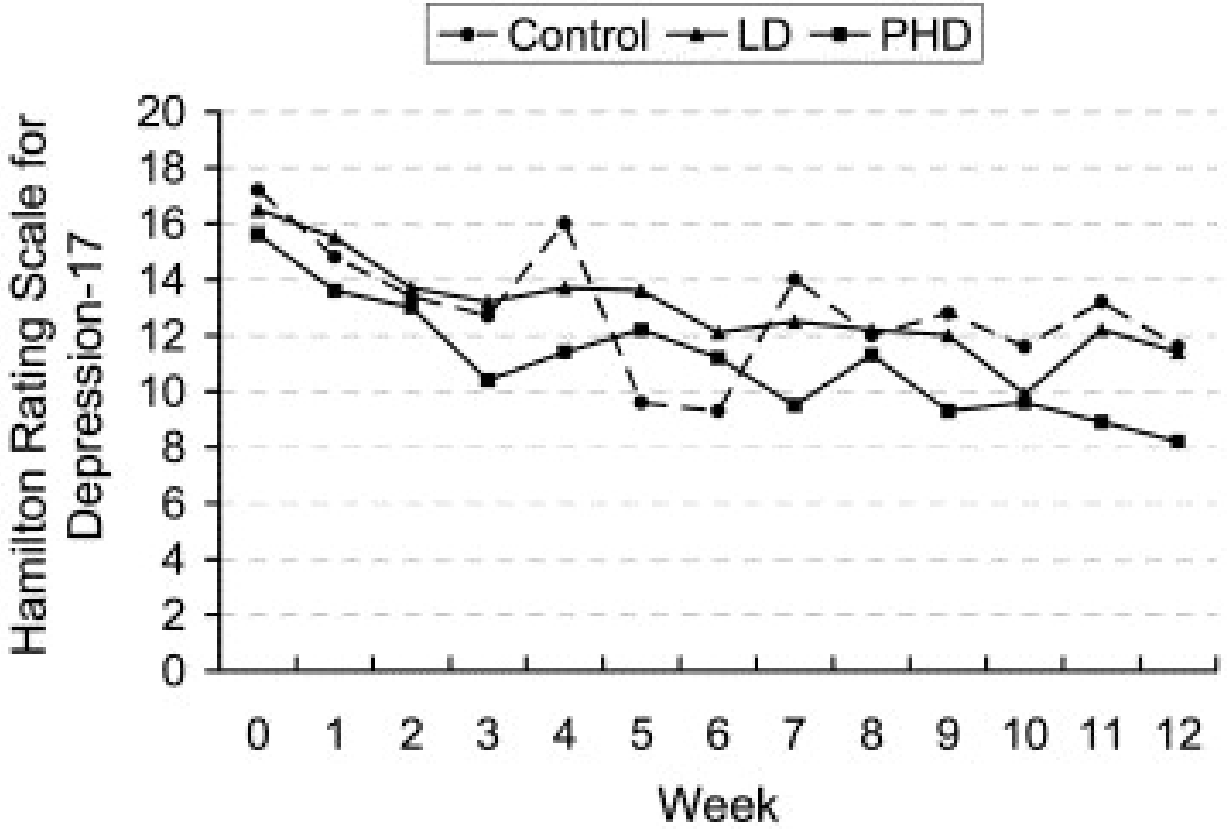
Treatment of Depression

- Psychotherapy
- Medication
- Combination
- Augmentation
- Exercise

Wheel Running

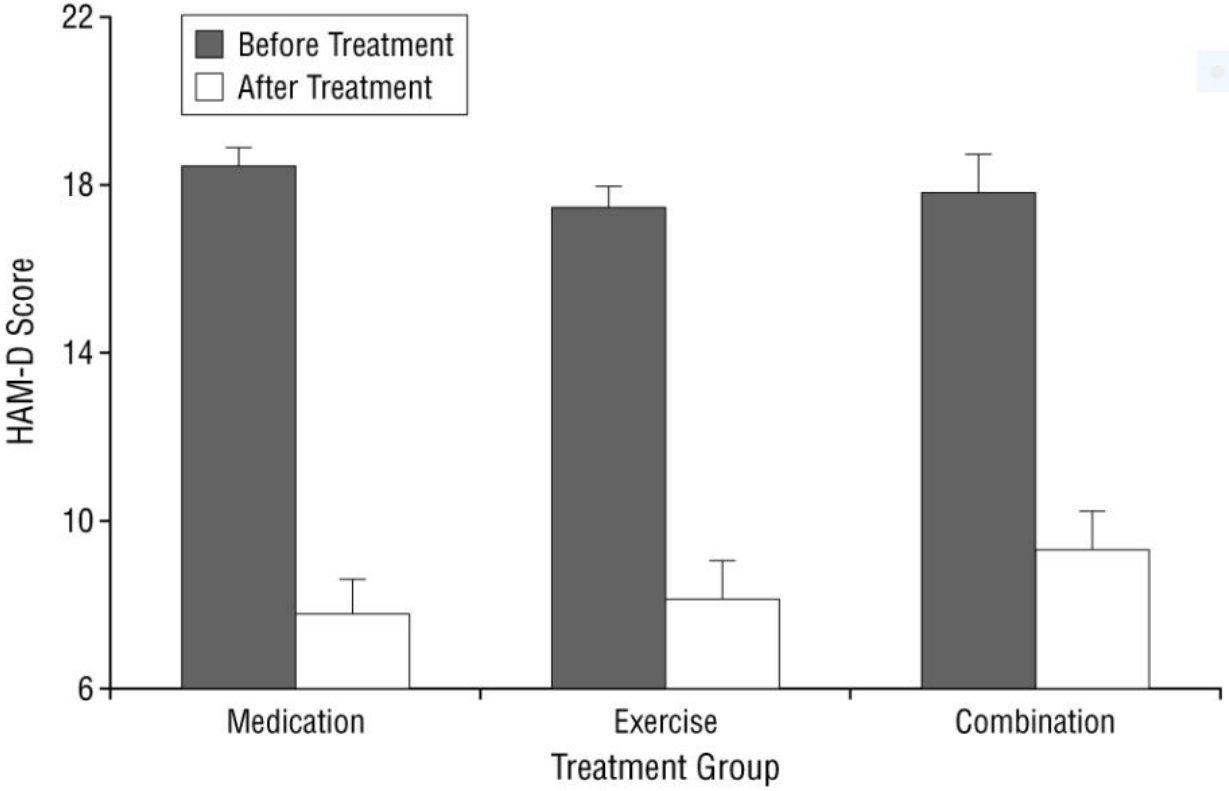


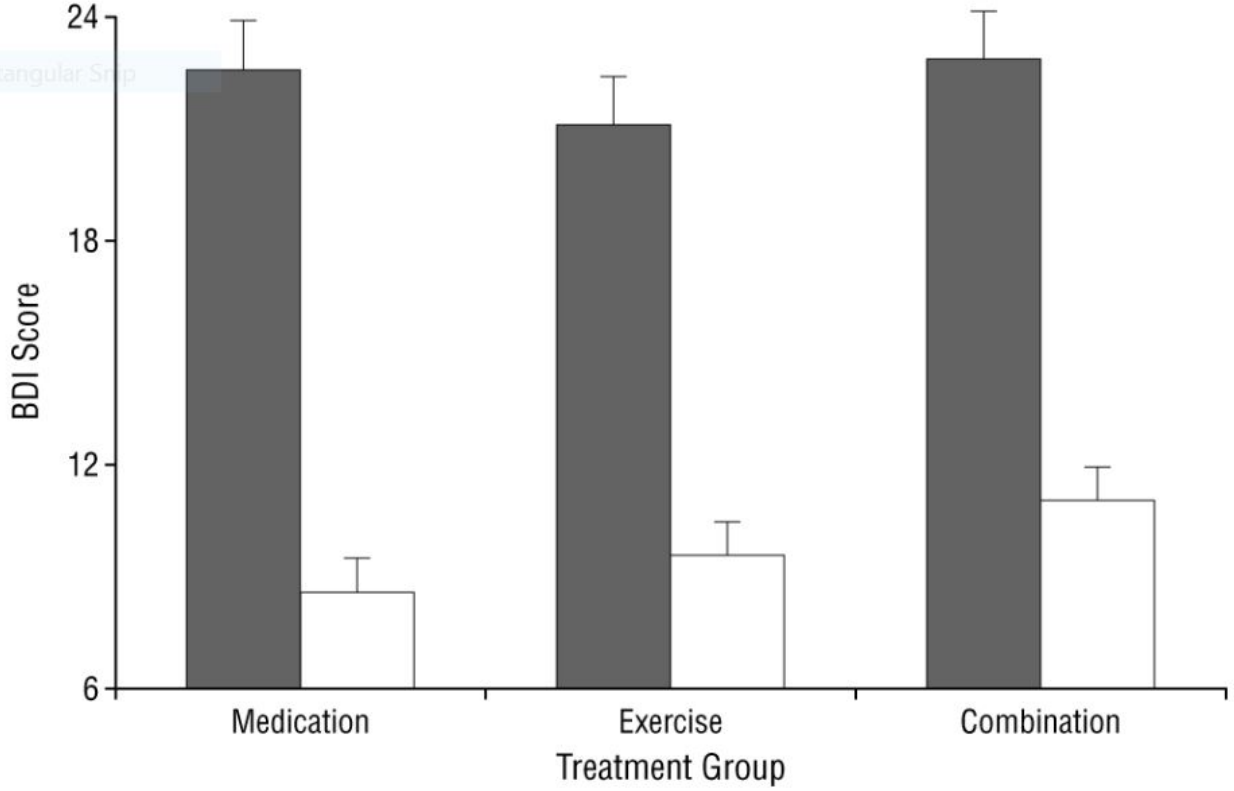
Exercise Treatment for Depression: Efficacy and Dose Response



Dunn, A. L., Trivedi, M. H., Kampert, J. B., Clark, C. G., & Chambliss, H. O. (2005). Exercise treatment for depression. *American Journal of Preventive Medicine*, *28*(1), 1–8. https://doi.org/10.1016/j.amepre.2004.09.003

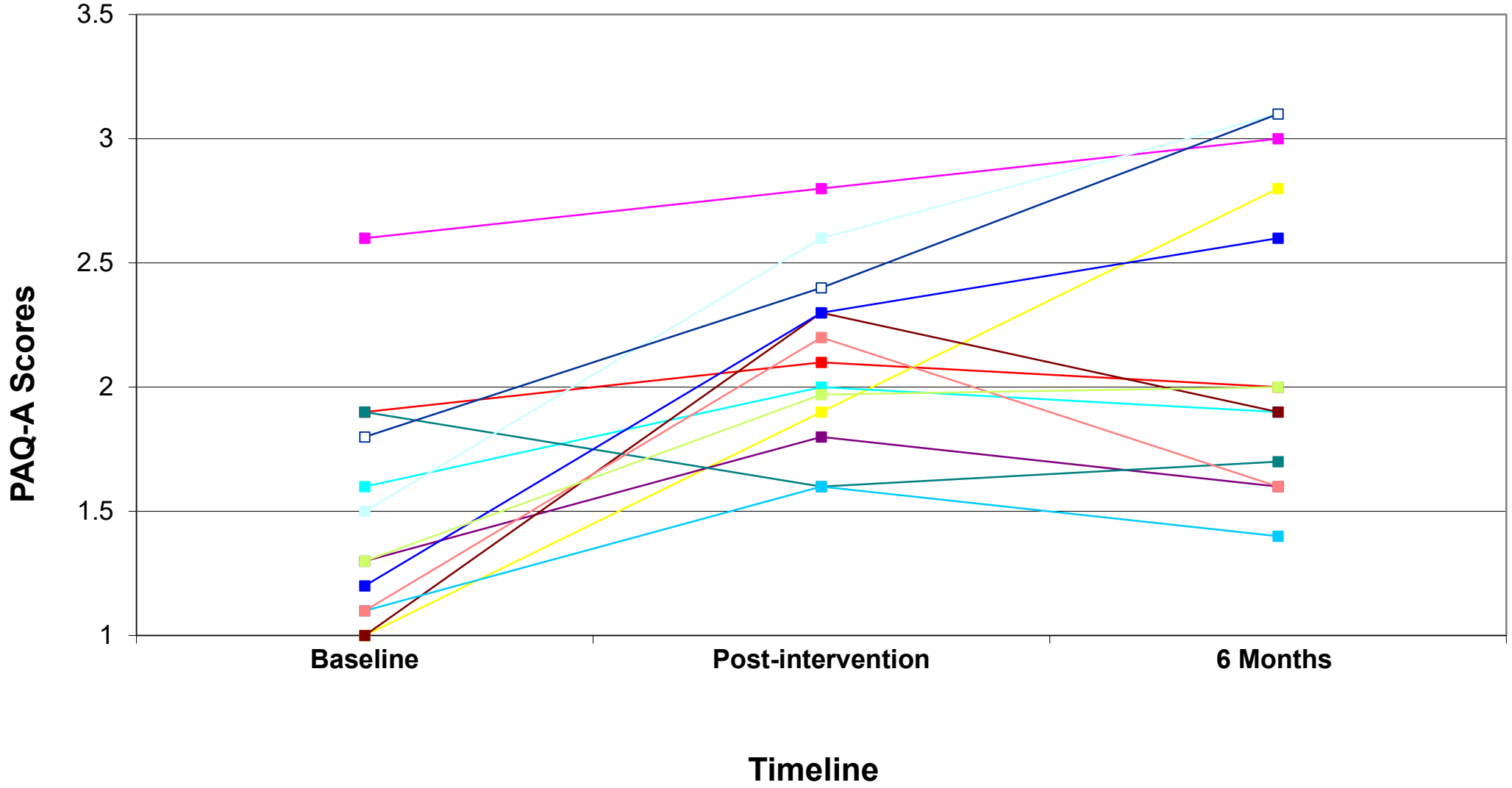
Exercise vs. Meds





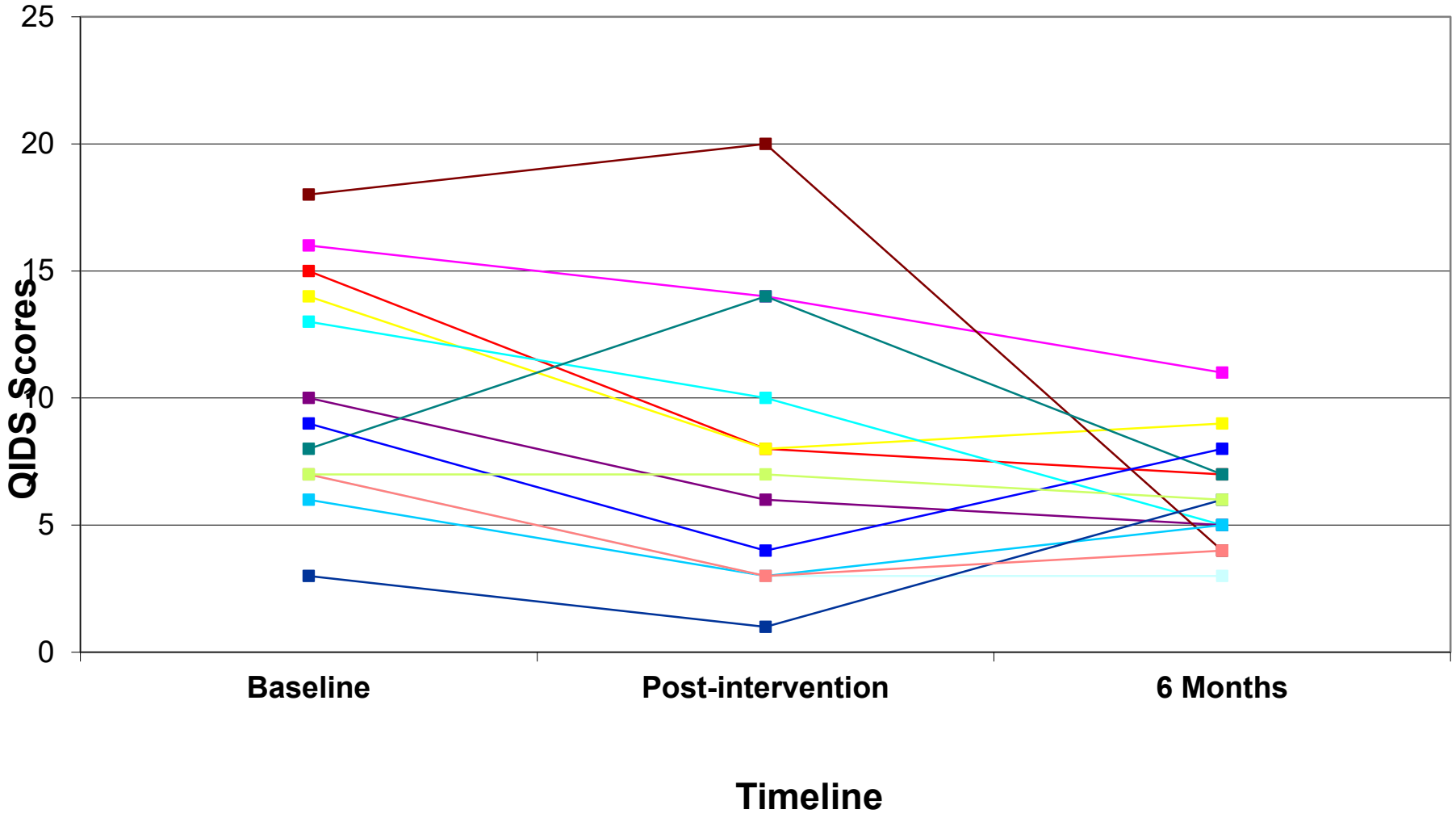
Blumenthal, J. A., Babyak, M. A., Moore, K. A., Craighead, W. E., Herman, S., Khatri, P., … Krishnan, K. R. (1999). Effects of Exercise Training on Older Patients With Major Depression. *Archives of Internal Medicine*, *159*(19). https://doi.org/10.1001/archinte.159.19.2349

Physical Activity Questionnaire



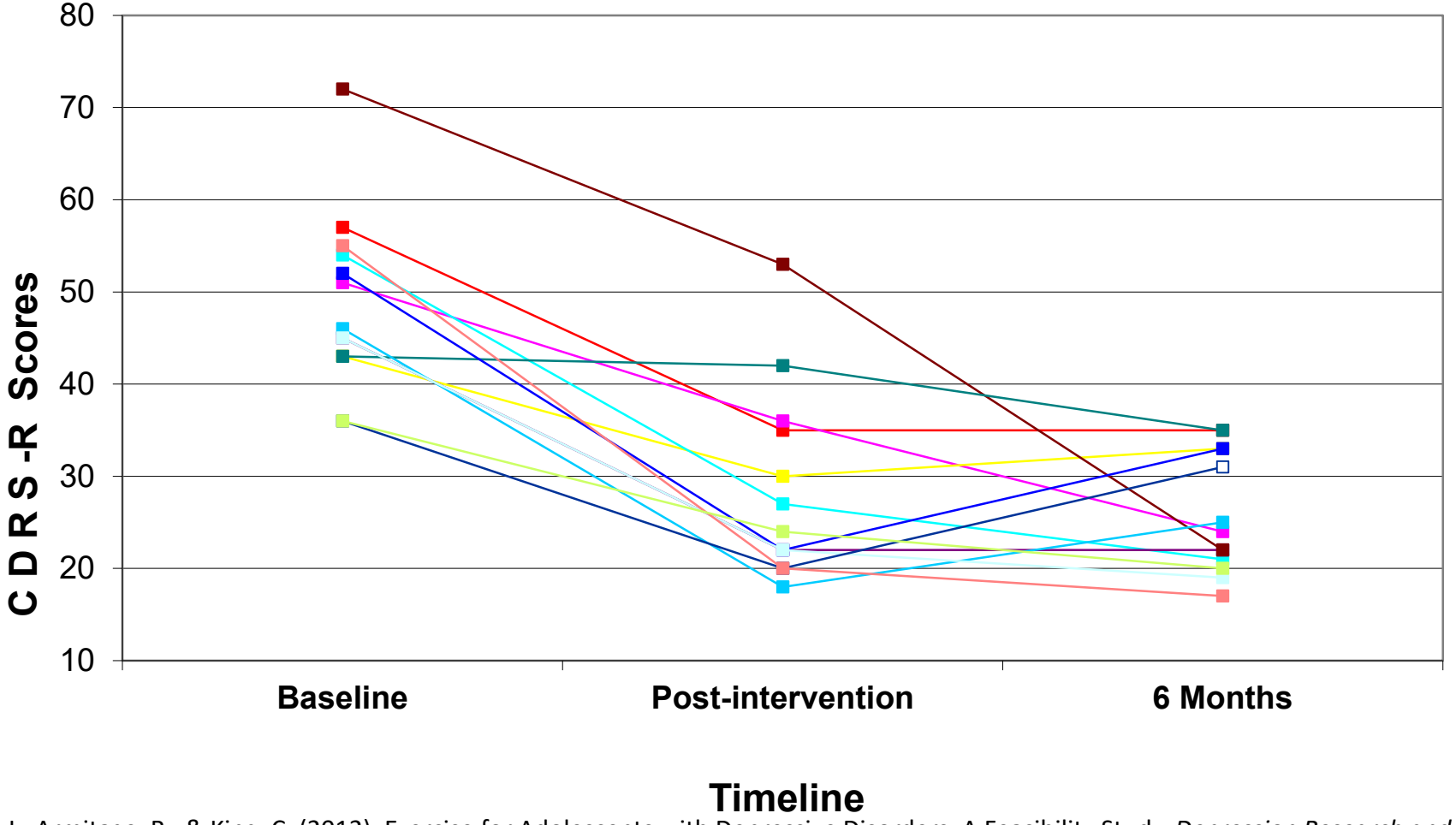
Dopp, R. R., Mooney, A. J., Armitage, R., & King, C. (2012). Exercise for Adolescents with Depressive Disorders: A Feasibility Study. *Depression Research and Treatment*, *2012*, 1–9. https://doi.org/10.1155/2012/257472

Quick Inventory of Depressive Symptomatology



Dopp, R. R., Mooney, A. J., Armitage, R., & King, C. (2012). Exercise for Adolescents with Depressive Disorders: A Feasibility Study. *Depression Research and Treatment*, *2012*, 1–9. https://doi.org/10.1155/2012/257472

Children's Depression Rating Scale-Revised



Dopp, R. R., Mooney, A. J., Armitage, R., & King, C. (2012). Exercise for Adolescents with Depressive Disorders: A Feasibility Study. *Depression Research and Treatment*, *2012*, 1–9. https://doi.org/10.1155/2012/257472

Measurement-Based Exercise

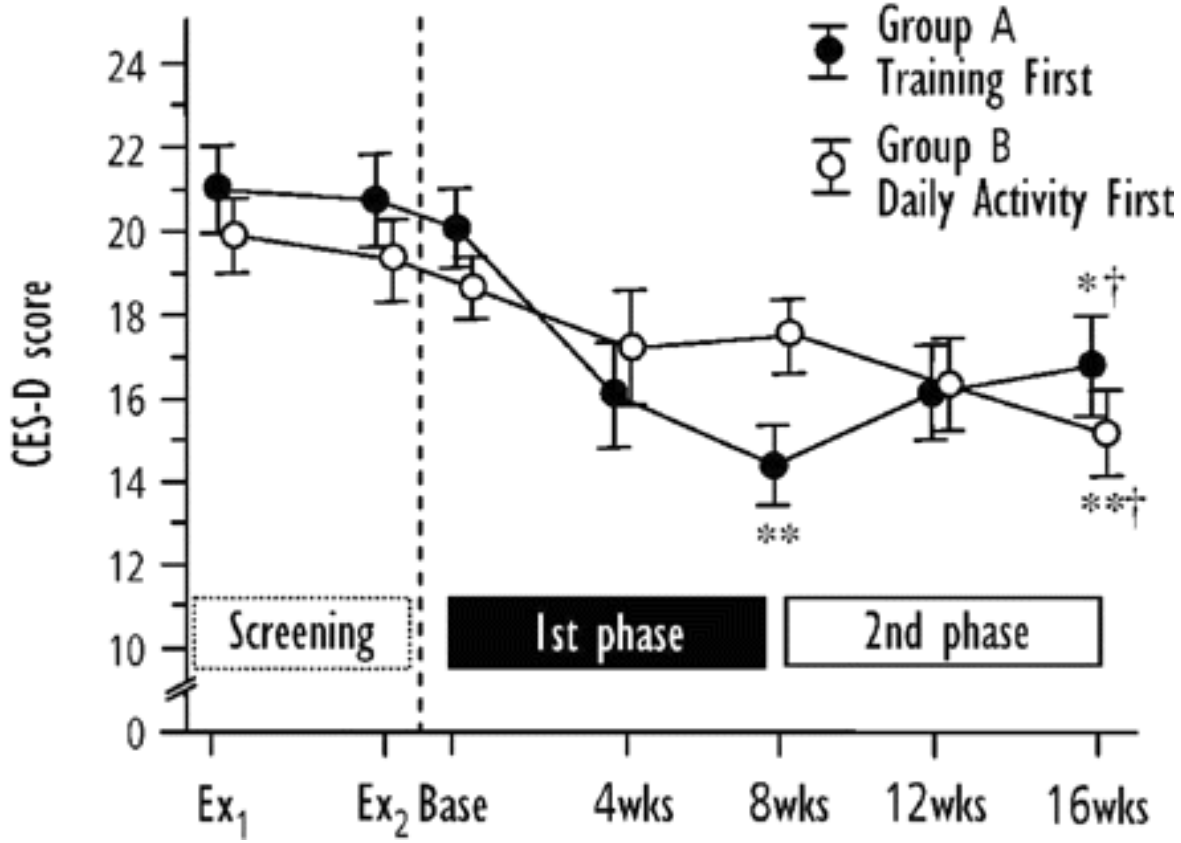
TREAD: Treatment with exercise augmentation for depression: study rationale and design (Trivedi et al., 2006; *Clinical Trials*)

DATE: Depressed Adolescents Treated with Exercise: A pilotrandomized controlled trial to test feasibility and establish preliminary effect sizes (Hughes et al., 2013; *Mental Health and Physical Activity*)

Trivedi, M. H., Rush, A. J., Wisniewski, S. R., Nierenberg, A. A., Warden, D., Ritz, L., … Fava, M. (2006). Evaluation of Outcomes With Citalopram for Depression Using Measurement-Based Care in STAR*D: Implications for Clinical Practice. *American Journal of Psychiatry*, *163*(1), 28–40. https://doi.org/10.1176/appi.ajp.163.1.28

Hughes, C. W., Barnes, S., Barnes, C., DeFina, L. F., Nakonezny, P., & Emslie, G. J. (2013). Depressed Adolescents Treated with Exercise (DATE): A pilot randomized controlled trial to test feasibility and establish preliminary effect sizes. *Mental Health and Physical Activity*, *6*(2), 119–131. https://doi.org/10.1016/j.mhpa.2013.06.006

Running Group in Young Females with Depression



A = 21

B = 28

Nabkasorn, C., Miyai, N., Sootmongkol, A., Junprasert, S., Yamamoto, H., Arita, M., & Miyashita, K. (2005). Effects of physical exercise on depression, neuroendocrine stress hormones and physiological fitness in adolescent females with depressive symptoms. *European Journal of Public Health*, *16*(2), 179–184. https://doi.org/10.1093/eurpub/cki159

Randomized Controlled Trial

18 adolescents with clinically significant depressive symptoms [Children's Depression Rating Scale-Revised (CDRS-R) >40] and low levels of physical activity were randomly assigned to a 12-week exercise intervention or a treatment-as-usual condition.

EX: n=9

TAU: n=9

Dopp, Mooney, Coplai, Miklja, Munier (Manuscript in preparation)

Concurrent Treatments

12 on antidepressant medications (5 EX, 7 TAU)

10 were in therapy (6 EX, 4 TAU)

6 on medication & in therapy (3 EX, 3 TAU)

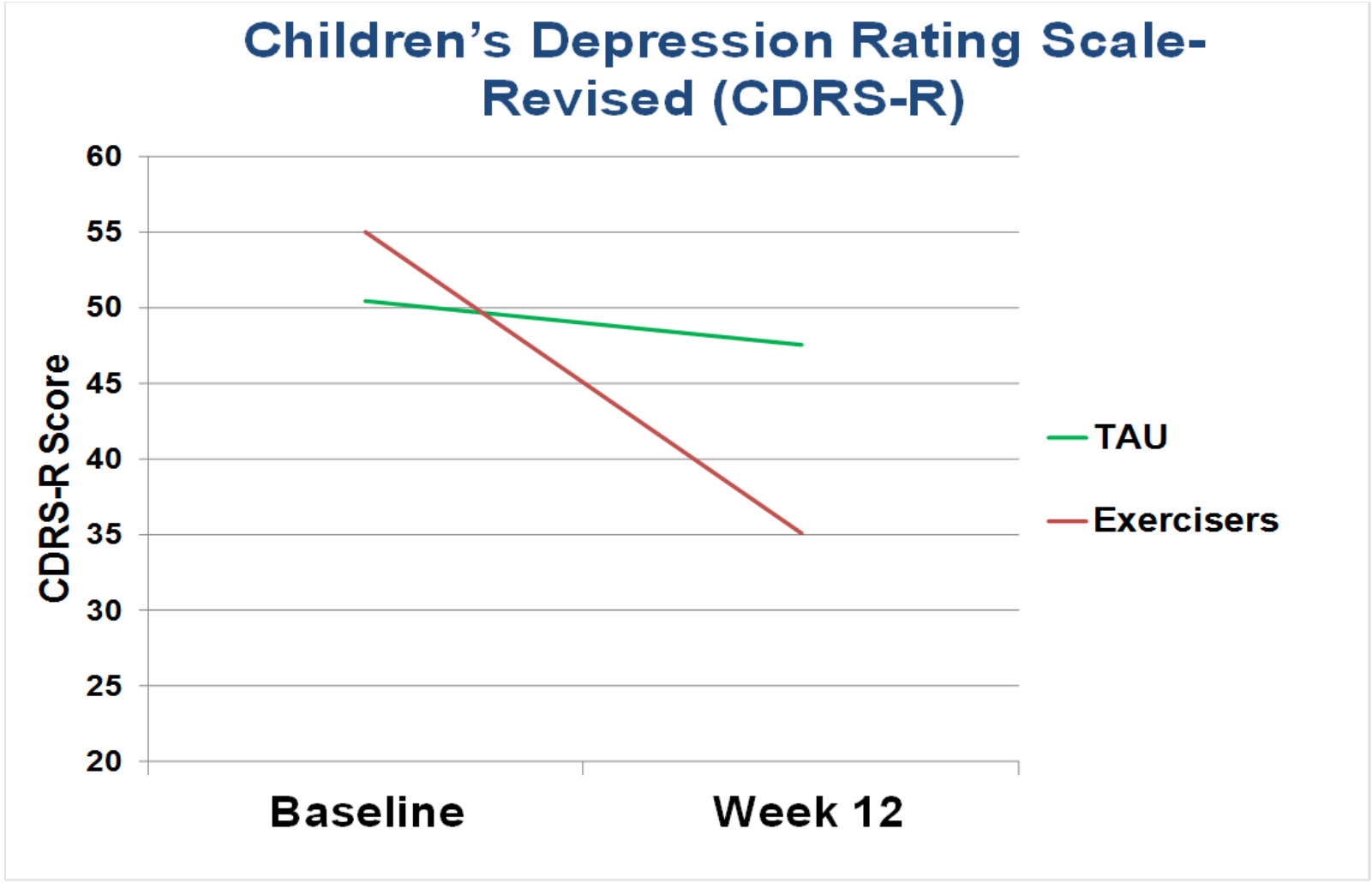
Dopp, Mooney, Coplai, Miklja, Munier (Manuscript in preparation)

Results Table

	Exercisers (*n*=9; Females=6)	TAUs (n=9; Females=4)
CDRS- R baseline	55.0 ± 7.5	50.4 ± 7.7
CDRS-R week 12	35.1 ± 13.0	47.6 ± 13.6
QIDS-SR baseline	14.6 ± 3.5	11.9 ± 3.0
QIDS-SR week 12	6.9 ± 5.8	8.0 ± 4.1
SIQ-JR baseline	31.3 ± 15.0	14.3 ± 7.2
SIQ-JR week 12	17.9 ± 10.9	13.3 ± 10.6

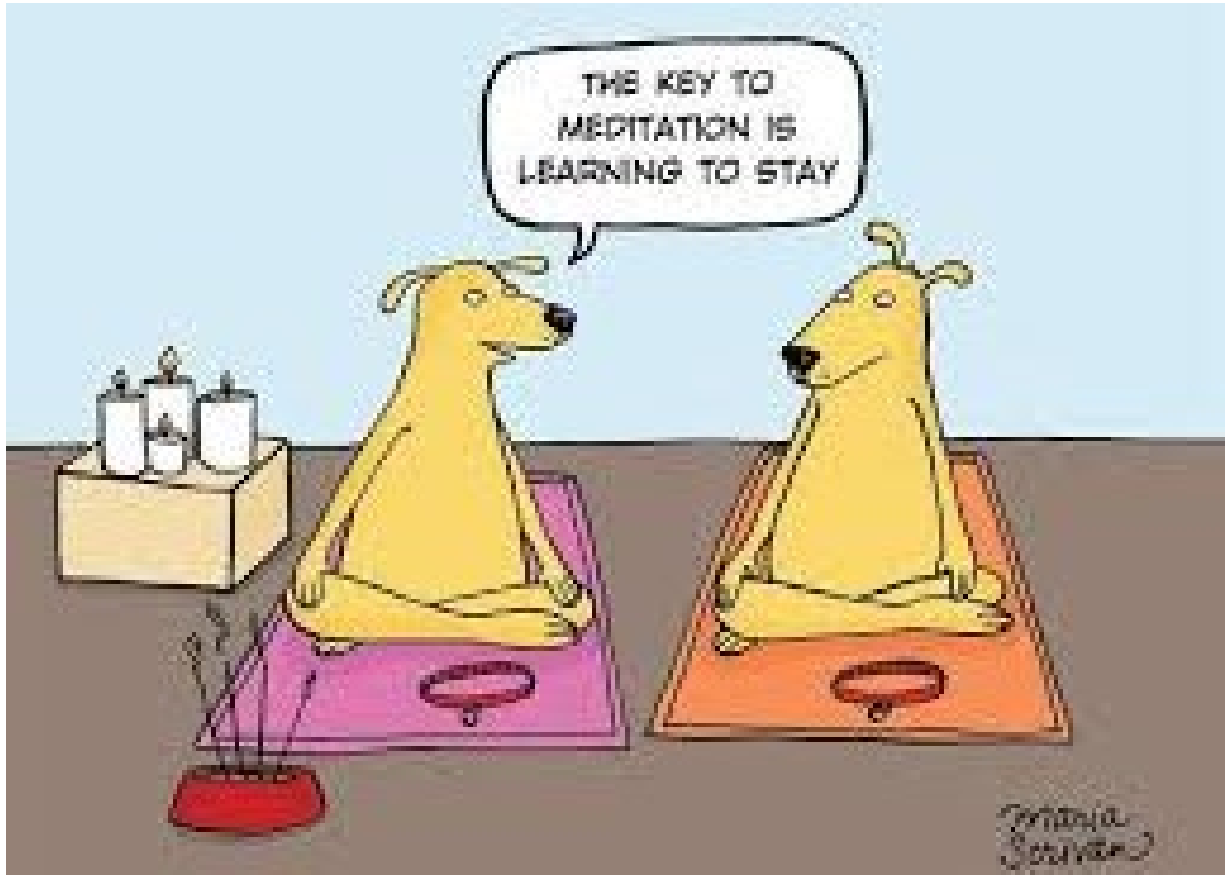
Dopp, Mooney, Coplai, Miklja, Munier (Manuscript in preparation)

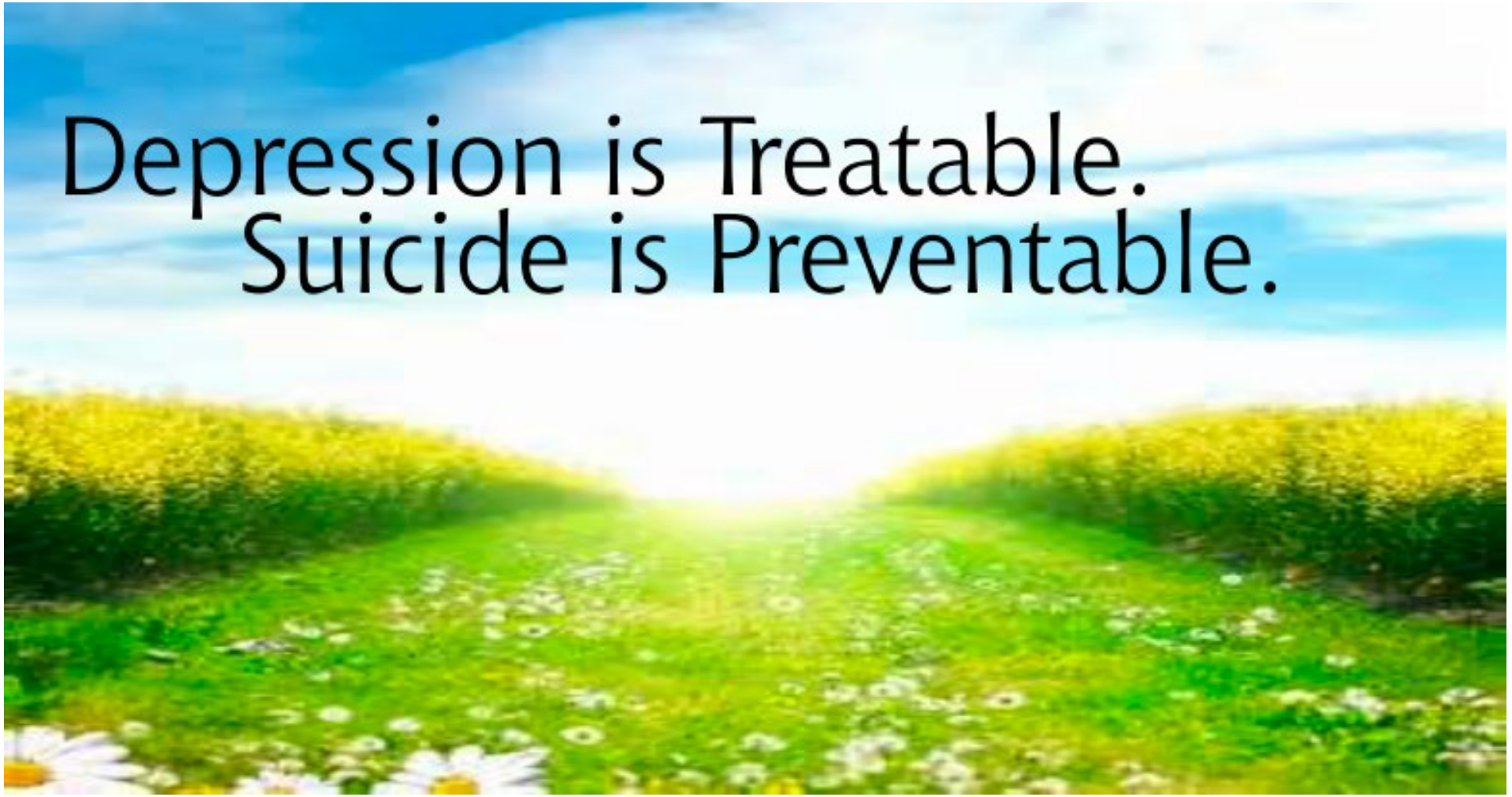
Results



Dopp, Mooney, Coplai, Miklja, Munier (Manuscript in preparation)

Meditation




Depression is Treatable.
Suicide is Preventable.

Journal of Youth and Adolescence
https://doi.org/10.1007/s10964-019-01085-0

EMPIRICAL RESEARCH

Check for updates

A Systematic Review and Meta-Analysis of School-Based Stress, Anxiety, and Depression Prevention Programs for Adolescents

Robyn Feiss[1] · Sarah Beth Dolinger[1] · Monaye Merritt[1] · Elaine Reiche[1] · Karley Martin[1] · Julio A. Yanes[2,3] · Chippewa M. Thomas[4,5] · Melissa Pangelinan[1]

Programs aimed at reducing depression and/or anxiety symptoms in adolescents are generally effective.

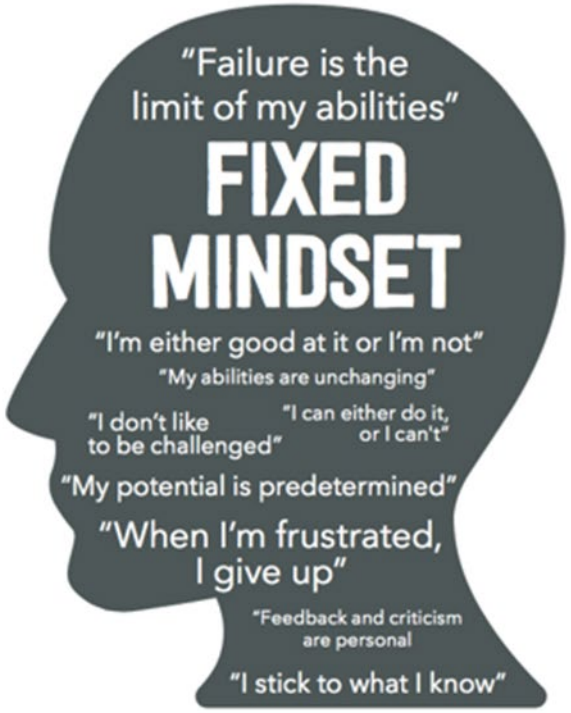
Culturally-sensitive practices may be particularly important for school-based programs that serve minority, low-income, and/or rural populations.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Effective mental health services, accessible in all schools

https://trailstowellness.org/

Develop and Foster a Growth Mindset



Thrive on challenges and see mistakes as opportunities for growth and stretching existing abilities

See their character, intelligence, and creative abilities as static.

Claro, S., Paunesku, D., & Dweck, C. S. (2016). Growth mindset tempers the effects of poverty on academic achievement. *Proceedings of the National Academy of Sciences*, *113*(31), 8664-8668. https://qahs.eq.edu.au/growth-mindset/

Take Home Points!

Depression exists in children and adolescents

Early recognition and treatment are essential

Parental depression increases risk for future depressive episodes in adolescence

The combination of CBT and medication show better outcomes than either modality alone

Complementary strategies should always be considered

University of Michigan Depression Center

Questions!!

References

Fawcett J, Scheftner WA, Fogg L. Time-related predictors of suicide in major affective disorder. Am J Psychiatry. 1990;147:1189–94.

Dahl, R. E., Ryan, N. D., Matty, M. K., Birmaher, B., Al-Shabbout, M., Williamson, D. E., & Kupfer, D. J. (1996). Sleep onset abnormalities in depressed adolescents. *Biological Psychiatry*, *39*(6), 400–410. https://doi.org/10.1016/0006-3223(95)00190-5

Emslie, G. J., Rush, A. J., Weinberg, W. A., Rintelmann, J. W., & Roffwarg, H. P. (1994). Sleep EEG features of adolescents with major depression. *Biological Psychiatry*, *36*(9), 573–581. https://doi.org/10.1016/0006-3223(94)90067-1

Wingard, D. L., and Berkman, L. F. “Mortality Risk Associated with Sleeping Patterns Among 1984,141, 357-362. Adults.” Sleep, 1983, 6, 102-107.

2:10 - 2:20 PM

AFTERNOON BREAK

SIM
MDHHS State Innovation Model

2:10 - 2:20 PM

AFTERNOON BREAK

5:00

SIM
MDHHS State Innovation Model

Next Steps and Alternative Payment Models

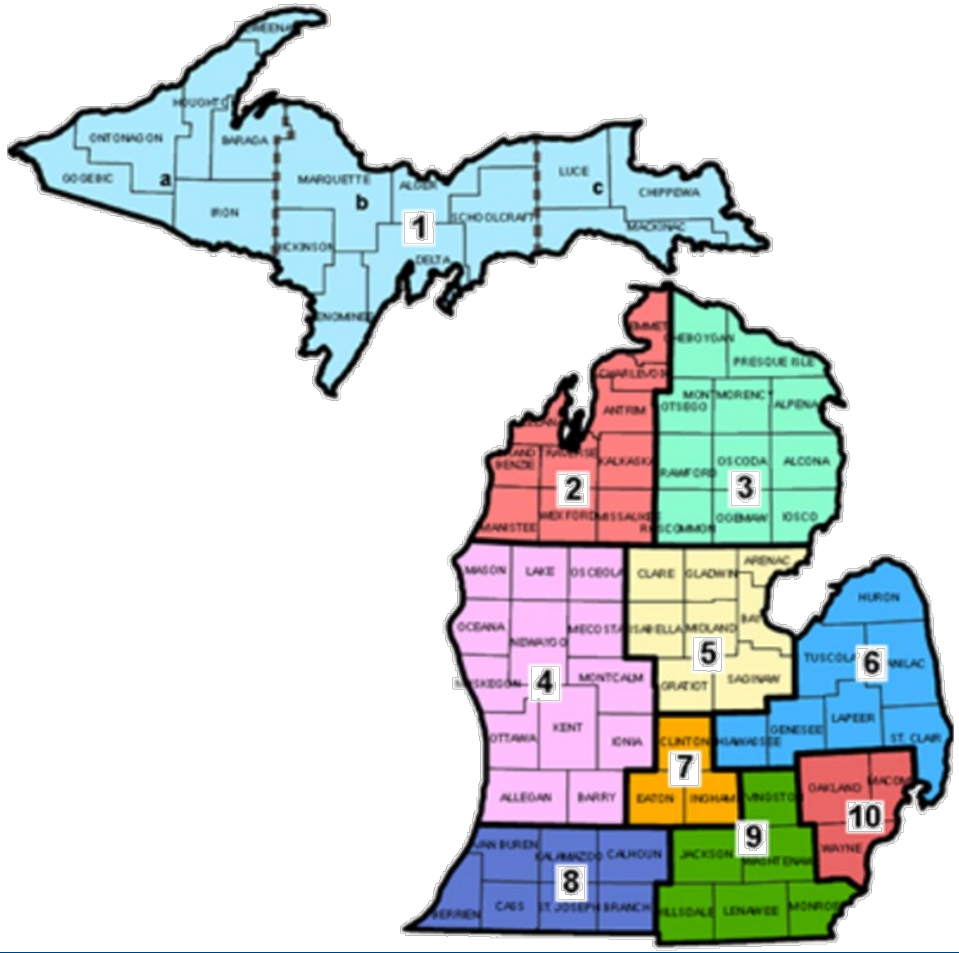
TOM CURTIS, MPA
SANDRA GREYERBIEHL, MSW
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Learning Objective

Recognize how the State is approaching continuing supporting the best practices developed and implemented by participants via the State Innovation Model (SIM).

Michigan's Medicaid Landscape

- Approximately 2 million Medicaid managed care beneficiaries
- About 600,000 are part of the Medicaid expansion population
- 11 Medicaid Health Plans (soon to be 9)
- As high as 500,000 members; as low as 12,000 members

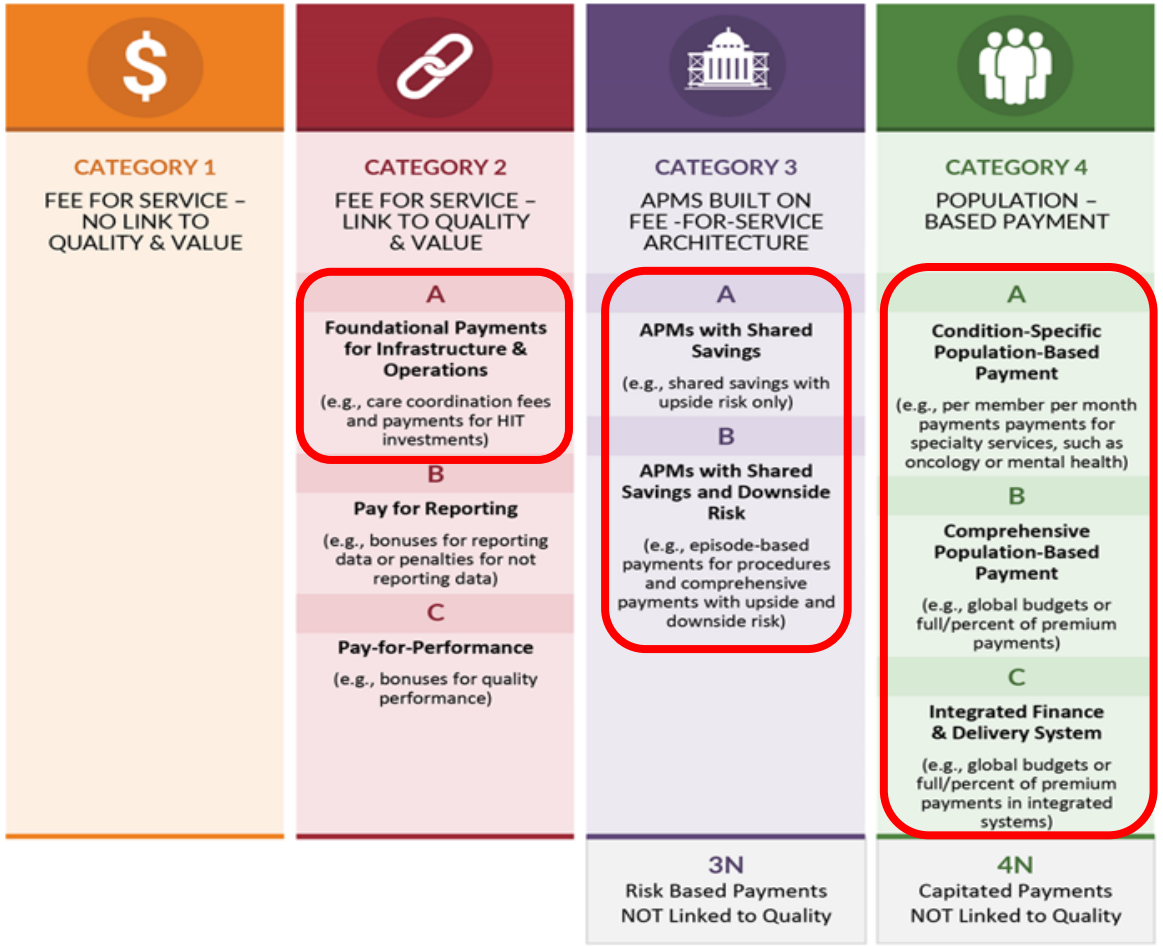


SIM
MDHHS State Innovation Model

Objectives

1. Increase APMs
2. Improve Quality
3. Reduce Provider Burden

Health Care Payment Learning & Action Network Framework



Not reported in APM data

APM Strategy Approach & Oversight

- APM Data Collection Tool
  - Monitor and evaluate APMs
  - Measure Quality impact
- Strategic Plan
  - Strategic goals
  - Implementation Timeline
- Quality Strategy:
  - Regional Measures
  - Plan-Specific
  - Measure reporting

APM Strategy

- Medicaid contract required MCOs to submit an APM strategic plan:
  - Details how MCOs would increase the use of APMs across LAN categories for a 3-year period
  - MCOs set APM goals & utilized (vetted) baseline data to set those
  - Included quality measures required by MDHHS
- MCOs were then required to submit implementation plans for executing their strategies
- MDHHS performs annual site visits to receive updates from MHPs on their APM progress, challenges and to review APM data

APM Data Collection Report Overview

- MDHHS developed a data collection tool to monitor progress of MHPs in implementing alternative payment models (APMs)
- Data collection tool builds off the HCP-LAN Framework
- MCOs reported 2 years worth of data to create a baseline
- MDHHS provided extensive TA to ensure data was valid & reliable

APM Data Collection Report Overview

Measures MHP APM implementation in 6 ways:

1. **Big Numerator -** Follows LAN Framework
   - Measures all provider payments that are part of a contract that includes an APM
2. **Small Numerator-** MDHHS developed
   - Measures only those provider payments within a contract that are actually part of an APM based on performance (e.g., incentive payment)
3. **Total Potential Incentive -** MDHHS developed
   - Measures full amount of the incentive payment a provider is eligible to receive if all reporting, quality and/or cost benchmarks are met in categories 2B and 2C

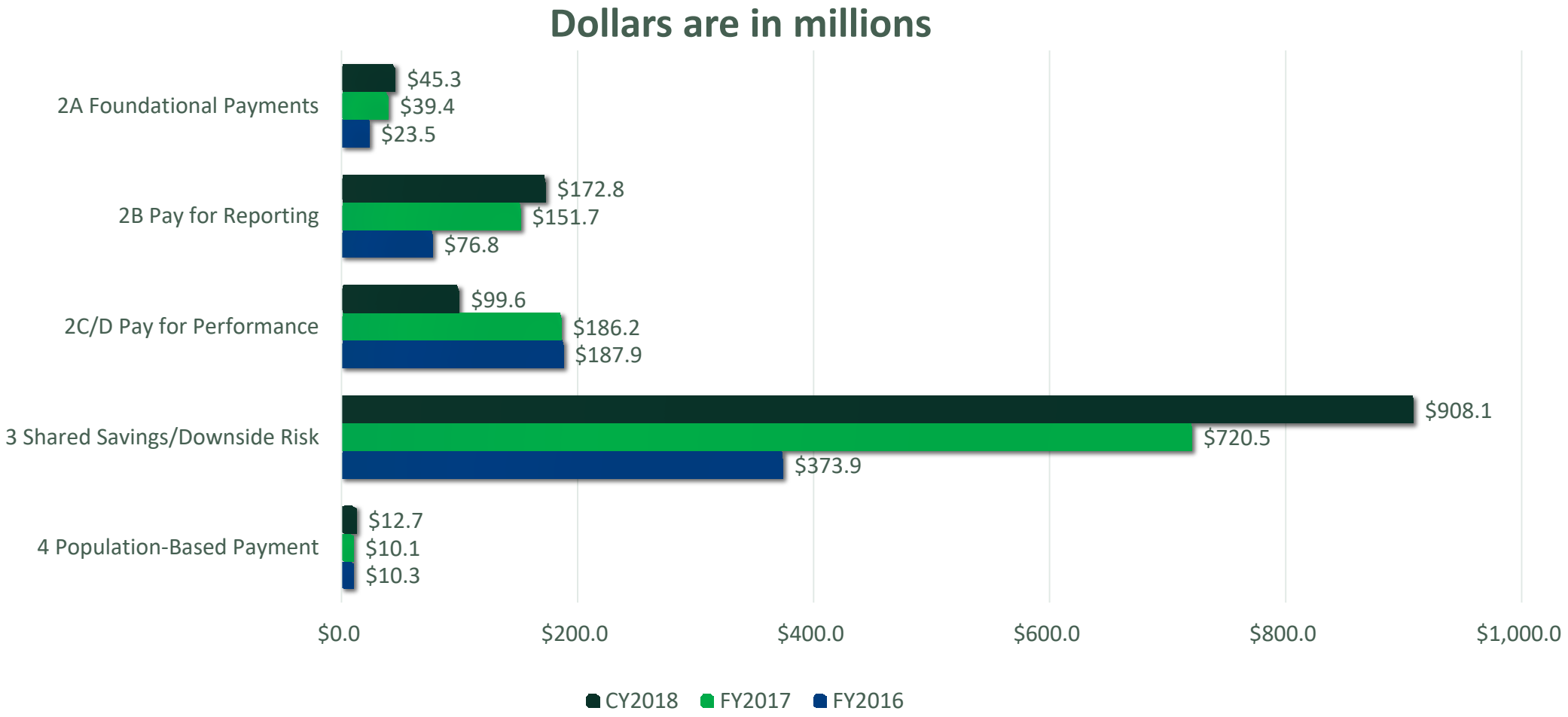
The Importance of Data Validation

Big Numerator APM Targets (LAN APM Category)	**Projected CY2018**	**Actual FY2018**
2A Foundational payments	0.86%	1.59%
2B Pay for Reporting	1.74%	2.96%
2C Pay for Performance	6.28%	7.85%
3 Shared Shavings/Downside-Risk	10.39%	13.25%
4 Population-based Payment	0.59%	0.29%
Total	**19.86%**	**25.93%**

Small Numerator APM Targets (LAN APM Category)	**Projected CY2018**	**Actual FY2018**
2A Foundational payments	0.34%	0.57%
2B Pay for Reporting	0.46%	0.29%
2C Pay for Performance	0.70%	0.49%
3 Shared Shavings/Downside-Risk	0.22%	0.03%
4 Population-based Payment	0.58%	0.32%
Total	**2.30%**	**1.70%**

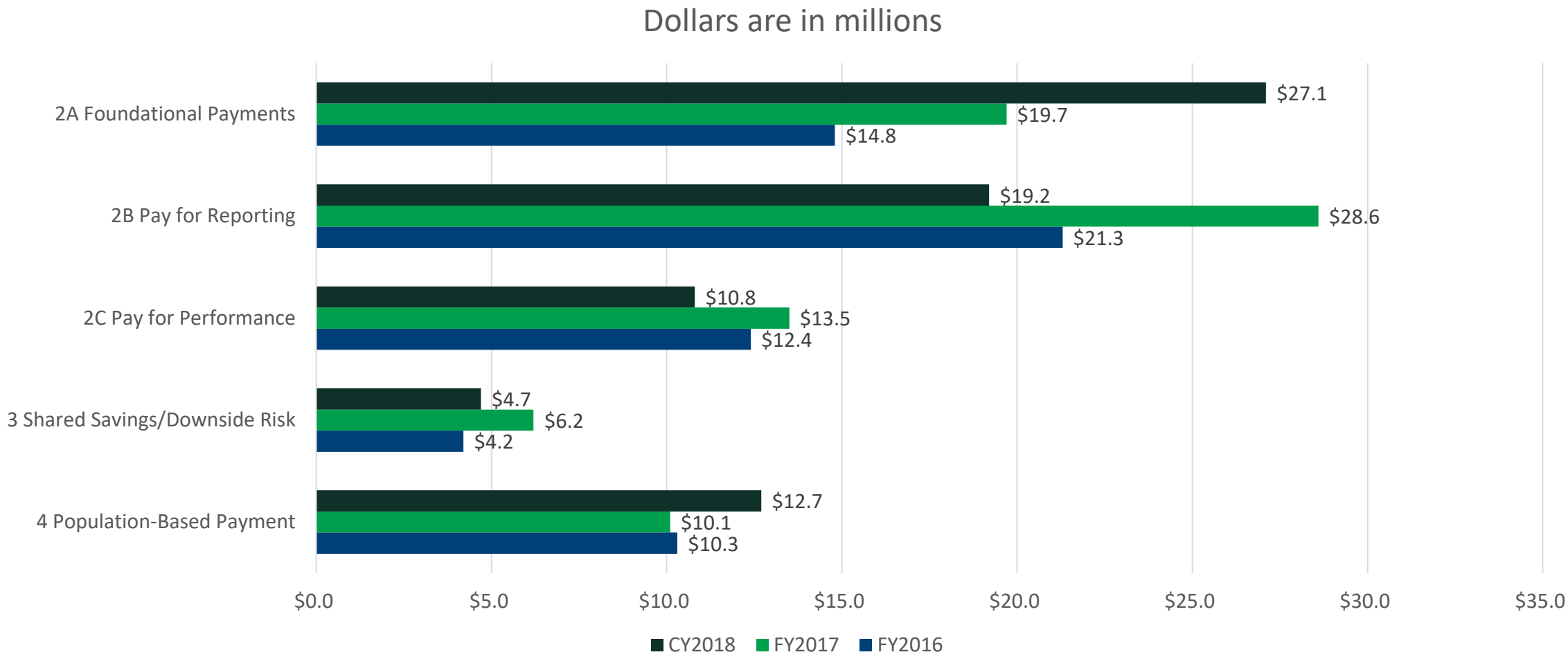
Big Numerator APMs - Change FY2016-CY2018

Based on CY18 Data Submissions June 2019



Small Numerator APMs - Change FY2016-CY2018

Based on CY18 Data Submissions June 2019



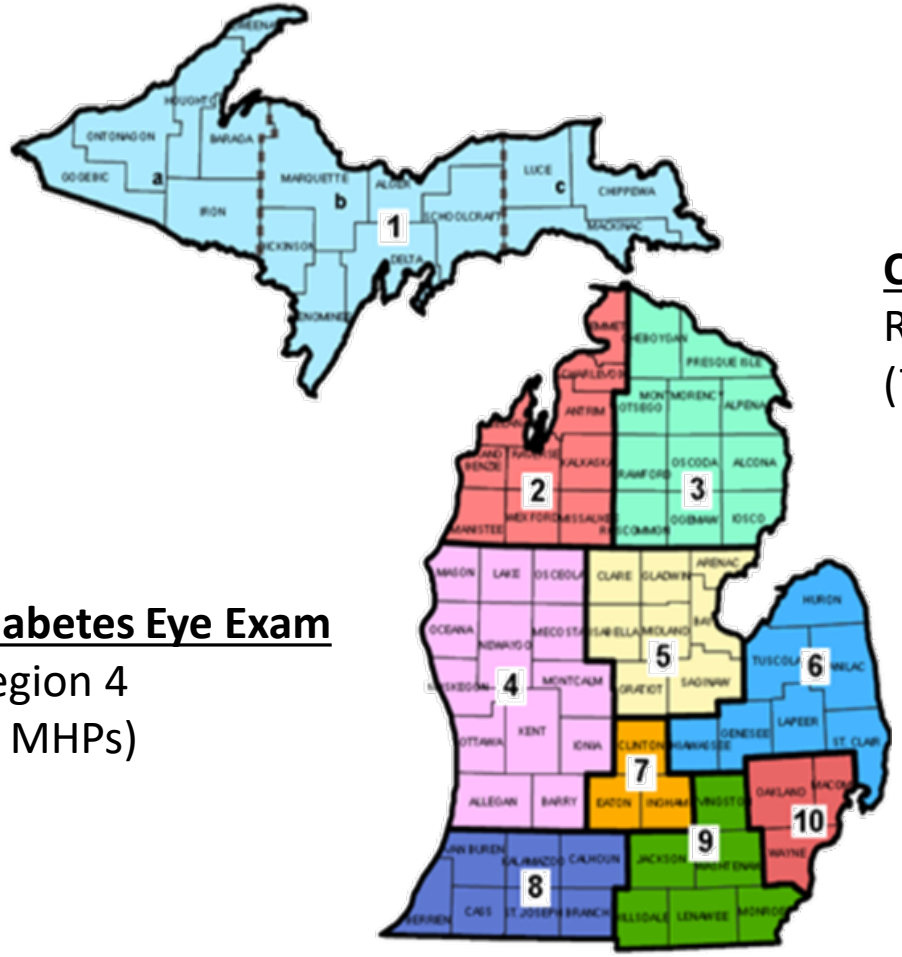
MHP APM Dollars Over Time: Dollar Amounts

Big Numerator APM Targets (LAN APM Category)	**FY2016**	**FY2017**	**CY2018**
2A Foundational Payments	$23.5M	$39.4M	$45.3M
2B Pay for Reporting	$76.8M	$151.7M	$172.8M
2C Pay for Performance	$187.9M	$186.2M	$99.6M
3 Shared Savings/Downside Risk	$374.0M	$720.5M	$908.1M
4 Population-Based Payment	$10.3M	$10.1M	$12.7M
Total	**$672.5M**	**$1,107.9B**	**$1,238.5B**

Small Numerator APM Targets (LAN APM Category)	**FY2016**	**FY2017**	**CY2018**
2A Foundational Payments	$14.8M	$19.7M	$27.1M
2B Pay for Reporting	$21.3M	$28.6M	$19.2M
2C Pay for Performance	$12.4M	$13.5M	$10.8M
3 Shared Savings/Downside Risk	$4.2M	$6.2M	$4.7M
4 Population-Based Payment	$10.3M	$10.1M	$12.7M
Total	**$63.0M**	**$78.0M**	**$74.6M**

MDHHS APM Quality Strategy

Appropriate Testing for Children with Pharyngitis
Region 1 & Region 6
(7 MHPs)



Chlamydia Screening in Women – Total
Region 2, 3, 5, 7 & 8
(7 MHPs)

Diabetes Eye Exam
Region 4
(4 MHPs)

Diabetes A1 Screening
Region 9 & 10
(8 MHPs)

Timely Prenatal Care
Region 10
(8 MHPs)

APM Quality Performance Reporting Requirements

- The purpose of the APM Quality Metrics Report is to ensure that progress is being made toward performance goals identified in the MCOs APM Strategic Plan for each performance area, and understand how plans are operationalizing quality in APMs in their provider networks

- MDHHS wanted to get a general understanding on the process and strategy MCOs used for:
  - Selecting providers
  - Establishing benchmarks
  - Validating Provider Attribution & Performance Reporting
  - Experience with quality measures linked to APM vs those that are not

Putting it all together…

Potential Provider Incentive (PPI) $

MHP Aggregate Data CY2018*					
LAN	**PPI $ Numerator**	(Incentive) **Small Numerator**	**SN as a % of PPI$**	(Contract $) **Big Numerator**	**PPI$ as % of Total Provider Payments**
2A	$27.1 M	$27.1 M	100%	$45.3 M	0.5%
2B	$41.2 M	$19.2 M	47%	$172.8 M	0.8%
2C	$24.7 M	$10.8 M	44%	$99.6 M	0.5%
3	$38.1 M	$4.8 M	13%	$908.1 M	0.7%
4	$12.7M	$12.7 M	100%	$12.7 M	0.5%
Total	**$143.8 M**	**$74.6 M**	**52%**	**$1,238 B**	**2.8%**

Total MCO Program Provider Payments (Denominator):
$5,130,000,000

*Data has been rounded and reflects MHP CY18 submissions to date.

Care Management & Coordination
Evolution

State Innovation Model → **FY2020** → **Future**

- Providers receive CM & CC $ from MHPs for SIM PCMH Initiative participation and requirements as directed by MDHHS
- Requirements:
  - Accreditation
  - Advanced Practice Activities
  - HIE Participation
  - Social Needs Screening & CCL
  - Quality & Utilization Metrics

- MHPs will receive added Capitation $ for CM & CC Services
- MHPs will contract with providers to deliver CM & CC Services
- Providers will meet MHP requirements
- Accreditation and/or Practice Requirements
- Quality/CM & CC Performance
- Panel Size

- Investigate how CM & CC impacts Quality in terms of:
  - Chronic condition
  - Age
  - geography

FY20 CM & CC Utilization Measure

- CM & CC Utilization Measure will be based on previous efforts by MDHHS
- CM & CC Utilization Measure includes ALL managed care populations, not specific to age or diagnosis
- CM & CC Benchmark will be set based on historical data to ensure that the level of utilization for beneficiaries does not fall below that of historical levels

CM & CC Utilization Analysis

MDHHS has Analyzed CM & CC utilization data using SIM CM & CC code set.

- All Managed Care Medicaid (not SIM exclusively)
- FY16, FY17 & FY18 Data
- No continuous enrollment requirement
- Benchmark Proposal
  - By # Codes per Fiscal Year
  - By # of Beneficiaries Served per Fiscal Year

CM & CC Code Set

Code	Description
G9001	Comprehensive Assessment
G9002	In-person CM/CC Encounters
G9007	Care Team Conferences
G9008	Provider Oversight
98966	Telephone CM/CC Services
98967	Telephone CM/CC Services
98968	Telephone CM/CC Services
98961	Education/Training for Patient Self Management
98962	Education/Training for Patient Self Management
99495	Care Transitions
99496	Care Transitions
S0257	End of Life Counseling

of CM & CC Codes by Fiscal Year

Codes	FY 2016	FY 2017	FY 2018
98961	2	26	28
98962	9	9	45
98966	4,392	10,698	21,829
98967	1,821	4,312	9,102
98968	352	1,359	3,408
99495	7,620	9,597	13,258
99496	7,882	11,678	14,192
G9001	815	1,952	3,649
G9002	4,255	13,104	26,521
G9007	1,054	3,702	11,076
G9008	307	729	1,915
S0257	1,248	2,845	3,288
Grand Total	**29,757**	**60,011**	**108,311**

of Unique Beneficiaries with a CM & CC Code

FY 2016	FY 2017	FY 2018
18,523	31,850	51,345

of CC & CM Codes by MHP "Plan Specific Benchmarks"

Health Plan	FY 2018	Jan2018 – Sept 2018
AET	772	619
BCC	11,972	9,575
TRU	47	35
MCL	9,547	7,507
MER	23,648	19,564
HAP	117	79
MOL	18,408	14,771
PRI	22,312	16,675
THC	1,754	1,410
UNI	6,514	5,319
UPP	1,063	765
Total	**96,154**	**76,319**

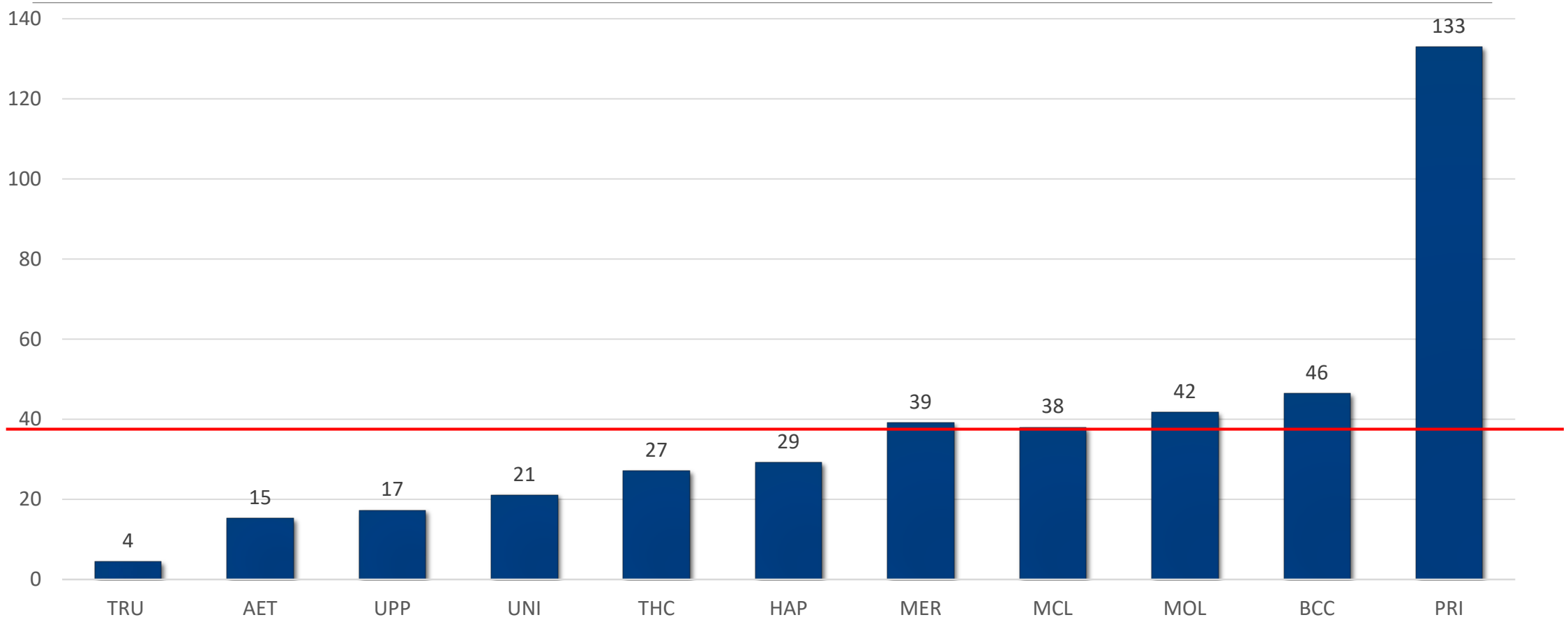
of Beneficiaries with a CM/CC Code by MHP "Plan Specific Benchmarks"

Health Plan	FY 2018	Jan2018 – Sept 2018
AET	400	323
BCC	5,187	4,313
TRU	23	19
MCL	4,352	3,654
MER	11,236	9,600
HAP	54	45
MOL	7,779	6,503
PRI	8,397	6,709
THC	914	746
UNI	3,366	2,805
UPP	540	397
Total	**42,248**	**35,114**

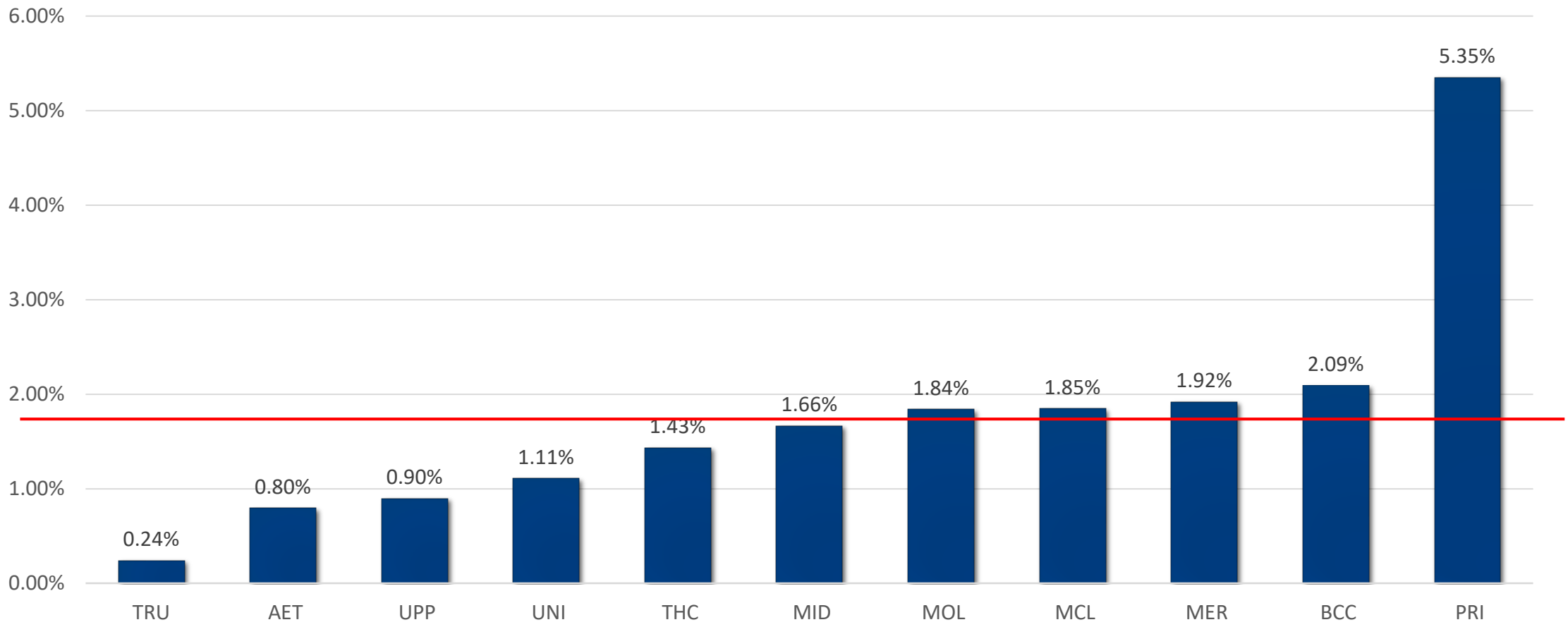
Average Enrollment (MM/12) by MHP

Health Plan	FY 2018
AET	40,561
BCC	206,168
TRU	7,904
MCL	197,674
MER	500,483
HAP	2,703
MOL	353,766
PRI	125,402
THC	52,071
UNI	252,669
UPP	44,317
Total	**1,783,716**

Jan-Sep 18: # of Codes per 1,000 MM



% of Beneficiaries with at Least One CM/CC Service from Jan - Sept 2018



Proposed CM & CC Measure Specification

Contract Year	FY20
Measurement Year	January 1, 2020 – September 30, 2020
Continuous Enrollment	None
Health Plan Attribution	At time of Service
Member Months	Performance Bonus Calculation/12
Exclusions	FFS Claims & Rejected Encounters

Proposed # of CM & CC Codes Benchmark

Measure/ Benchmark
38 Codes Submitted per 1,000 MM
Health Plan Specific: # of Codes submitted per 1,000 MM
1.7 % of Beneficiaries Served
Health Plan Specific: Percentage of Beneficiaries Served

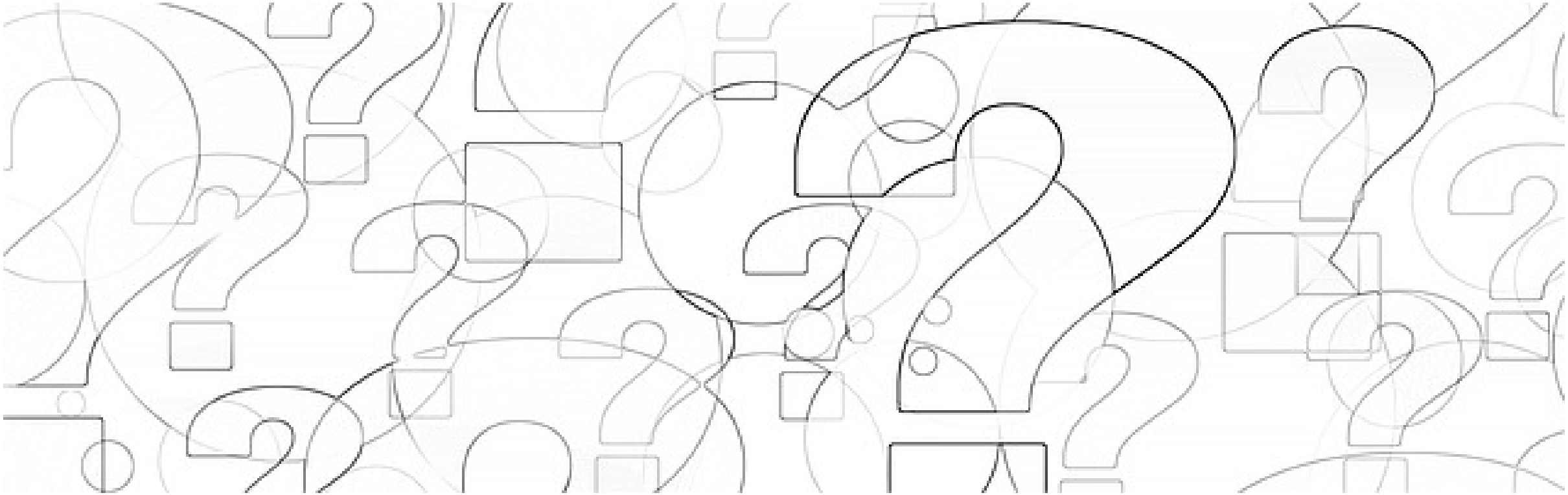
Key Policy Takeaways

- Validity and reliability of data collection process to accurately evaluate and monitor increases in APMs
- Quality improvement should be at the heart of adopting APMs
- Collaborative process and evidence based, rather than prescription and mandated methods to design a standard approach

Key Operational Takeaways

- Attribution is up to date to monitor APM quality metrics & payments
- Work with health plans to establish quality benchmarks and receive performance reports
- Ask health plans for available APM opportunities

Questions



Wrap - Up and Closing Remarks

3:20 PM - 3:30 PM

Successful Completion for Nursing and Social Work Contact Hours

- ✓Attendance at the entire program
- ✓Sign in sheet
- ✓Complete the evaluation form: access MDHHS SIM PCMH Initiative Summit registration web page or click here

  - An email will be sent to the email address provided with your certificate
  - Note: to request a Non-CE certificate, use the above link
  - QR Code located on your table to complete a short survey on today's SIM PCMH Initiative Summit

SIM PCMH Initiative Summit Survey

Android Users and IPhone Users (iOS 10 or older): In the Google Play Store/App Store, Search for “qr code reader” and download the app of your choice. We have found that the second app (Lightning QRcode Scanner) has minimal ad and privacy foortprint. Open the app and point it at the QR code. Once the image has been recognized, select “Open Link” on the orange button on the bottom.

IPhone Users (iOS 11+): If you’ve purchased or updated your phone’s operating system since September 19, 2017, you have a QR scanner built into your phone’s camera. Simply point the camera at the code, and once the image is recognized, open the link.

THANK YOU!

SIM
MDHHS State Innovation Model

Disclosures

There is no conflict of interest for anyone with the ability to control content for this activity.

Continuing Education Nursing and Social Work 5.5 CE Contact Hours

Participants who successfully attend the entire one-day conference, and complete the online CE request process including required evaluation with email address will earn 5.5 Nursing CE contact hours.

This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) ONA # 22485