2019 Care Coordination Collaborative (CCC) Event

APRIL 9, 2019 | 9:00 – 12:00

EAST LANSING MARRIOTT

Welcome

KATIE COMMEY, MPH

SIM PCMH INITIATIVE LEAD

With Thanks to the 2019 CCC Planning Group Members

Gail Warner	Affinia Health Network Lakeshore
Samantha Krause	Gensys
Jen Berube	Integrated Health Associates
Cherie Bostwick; Katie Damon	Northern Physician Organization
Debbie Schaefer	Spectrum Health Medical Group
Michelle Barber	MHC
Kerrie Barney	Cherry Health
Stacey Bartell	Ascension
Ruth Crane	Alcona Health
Natalie Harter	Northern Pines
Lori Kunkel	Greater Flint Health Coalition
Anne Levandoski	UPHP
Shannon Lijewski	Everyday Life Consulting LLC & Rural CHW Network
Lori Lynn	Metro Health Integrated Network
Erica Ross	MedNetOne
Shannon Saksewski	Aetna

Agenda

8:30-9:00	*Registration, Continental Breakfast and Networking*
9:00-9:05	*Welcome and Context-Setting*
9:05-10:00	*Panel Discussion - Leveraging Social Determinants of Health Information to Coordinate Partners and Improve the Care Experience and Outcomes*
10:00-10:10	*Break*
10:10-10:20	*Review of Tools for Facilitated Workgroup Intensive Session*
10:20-11:30	*Facilitated Workgroup Intensive Session* *An opportunity to capitalize on the community collaboration present at today's event as well as other partners to identify a goal most useful to them, develop and produce a workplan, and conduct political mapping to assess potential barriers and how they will be overcome.*
11:30-Noon	*Group Report-Outs and Wrap-Up*

Expert Panel Members and Topics

- Shannon Lijewski, MBA, CHCEF, Clinical-Community Linkages Consultant, SIM Community Health Innovation Regions, MDHHS - ***SIM CHIR Insights and Best Practices for Gap Closure***
- Michael Ramsey, Program Implementation Coordinator, Muskegon Community Health Innovation Region Health Project - ***Muskegon CHIR Clinical-Community Linkage Advances and Comprehensive Network Referral Servicing***
- Anne Levandoski, Chief Quality Officer, Upper Peninsula Health Plan – **Health Leads Partnering; CHW Health Desk Screening and Outreach**
- Shannon Saksewski, MSW, MBA, Regional Manager, Population Health, Aetna Medicaid - ***Health Plan Partnering and Innovation***
- Kerrie Barney MA-ORGL, BSN, RN – Director of Nursing, Cherry Health - **The Practice Perspective and Front-Line Partnering with Key Linkages**

SIM CHIR Insights and Best Practices for Gap Closure

SHANNON LIJEWSKI, MBA, CHCEF

CLINICAL-COMMUNITY LINKAGES CONSULTANT, SIM COMMUNITY HEALTH INNOVATION REGIONS, MDHHS

What is a CHIR?

A CHIR is

a model for improving the wellbeing of a region and reducing unnecessary medical costs.

CHIRs engage

a broad group of stakeholders to identify and address factors that affect residents' health.

CHIRs create

a neutral space for partners to unite around a common vision, aligning their objectives and services to meet community needs.

CHIRs result in

communities that are purposeful in their response to residents' needs.

Genesee

- *Greater Flint Health Coalition*

Jackson

- *Health Improvement Organization*

Livingston-Washtenaw

- *Center for Health and Research Transformation*

Muskegon

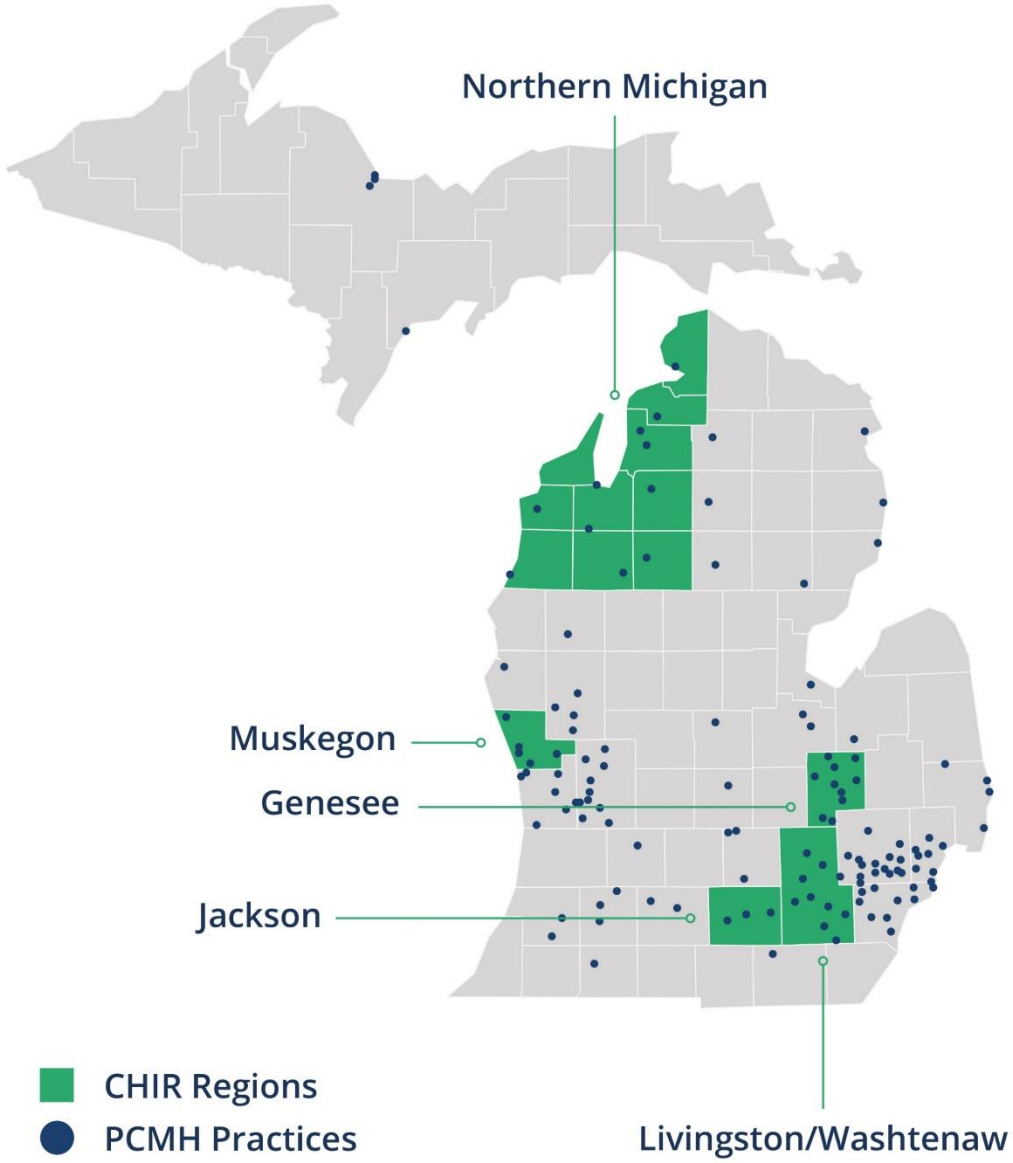
- *Muskegon Health Project*

Northern Michigan

- *Northern Michigan Public Health Alliance*

SIM
MDHHS State Innovation Model

CHIR Communities



What is the CHIR vision?

To build and strengthen connections across our community, creating conditions where all residents can be healthy and productive.

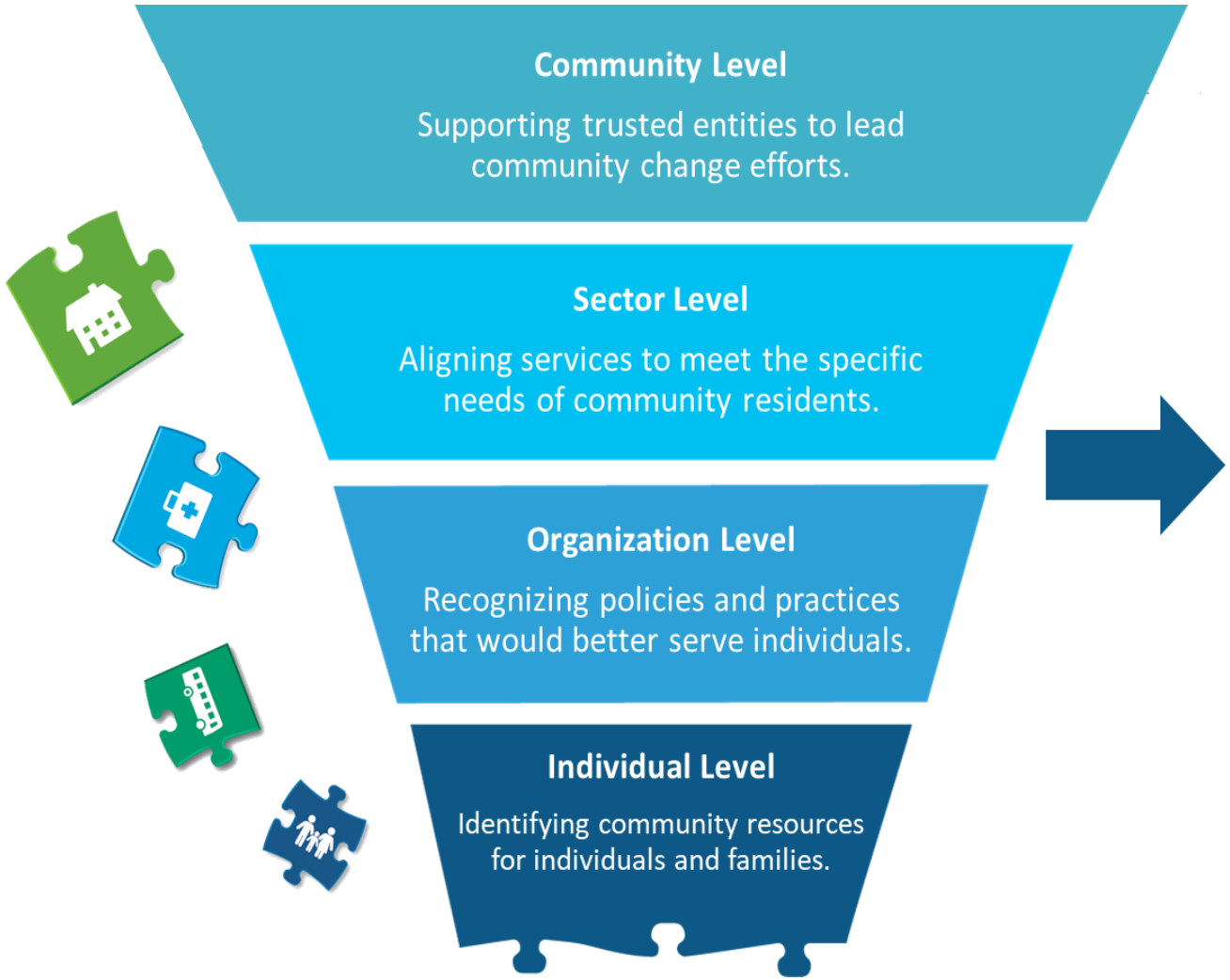
- CHIRs give cross-sector partners the opportunity to **pursue community-centered solutions**.
- CHIRs enhance community collaboration to **address factors that affect residents' health**, such as housing, transportation, food security, and access to high-quality medical care.
- CHIRs support an individual's ability to have **a higher, more productive quality of life**.

How does a CHIR structure work?

- CHIRs are organized by a **neutral backbone organization** that facilitates the development and implementation of key strategies to serve their community.
- CHIRs are driven by steering committees with a **clear leadership structure.**
- CHIRs promote **shared accountability** among partners.
- CHIRs help **align resources** to address priority community health needs.

It takes a comprehensive group of committed partners to meet residents' needs. No one entity can do this alone.

Putting the Pieces Together



The CHIR Model

Creating a community that proactively supports residents by reducing barriers to good health.

SIM MDHHS State Innovation Model

Muskegon CHIR Clinical-Community Linkage Advances and Comprehensive Network Referral Servicing

MICHAEL RAMSEY, PROGRAM IMPLEMENTATION COORDINATOR

MUSKEGON COMMUNITY HEALTH INNOVATION REGION HEALTH PROJECT

Our SDoH Innovation

Who Is Involved: Healthcare system, Community Health and Well-being Organization, CHIR, Community Coordinating Council, and community based organizations

How It Works/Approach: Provide support and build capacity within provider offices through community-wide collaborative efforts while offering network support through Referral Specialists

Start date: November of 2017

Progress/Achievements: Relationships!

Our SDoH Innovation, cont.

Key Tools: Standardized tools and narratives, consistency in facilitation of assessments and delivery of services, creating pathways of support and accountability

What Worked/What Didn't: Creating a system of accountability, assumptions of understanding

Proudest Moment: Improvements in policy and process

Hints for Others: Meeting provider offices where they are, choosing in-office champions, educating offices about frequently recognized domain needs

Health Leads Partnering; CHW Health Desk Screening and Outreach

ANNE LEVANDOSKI, CHIEF QUALITY OFFICER

UPPER PENINSULA HEALTH PLAN

Our SDoH Innovation

Who Is Involved:

- Care Management – Community Health Worker (CHW)
- Customer Service Representatives
- Quality Management Clinical Coordinators

How it Works: Members are screening during routine calls using a brief open ended question, positive screens are warm transferred to a CHW for a more detailed screening and referral assistance. CHW follows up with member to determine if need was met and if additional assistance is needed.

Our SDoH Innovation

Start Date: June 2016

Progress/Achievements:

- Began with incoming calls to customer service and added outgoing calls during care gap outreach and pregnancy focused outreach
- Prepared when MDHHS required Health Plans to report SDoH data
- Individual success stories

Our SDoH Innovation, cont.

Key Tools: Health Leads Connected Communities for Health platform

What Worked/What Didn't:

- Warm transfers became difficult during staffing transitions
- Reaching members for follow-up calls

Proudest moment: That social determinants of health was a UPHP project and priority before it was required by MDHHS

Hints For Others: If you ask, people will identify their needs

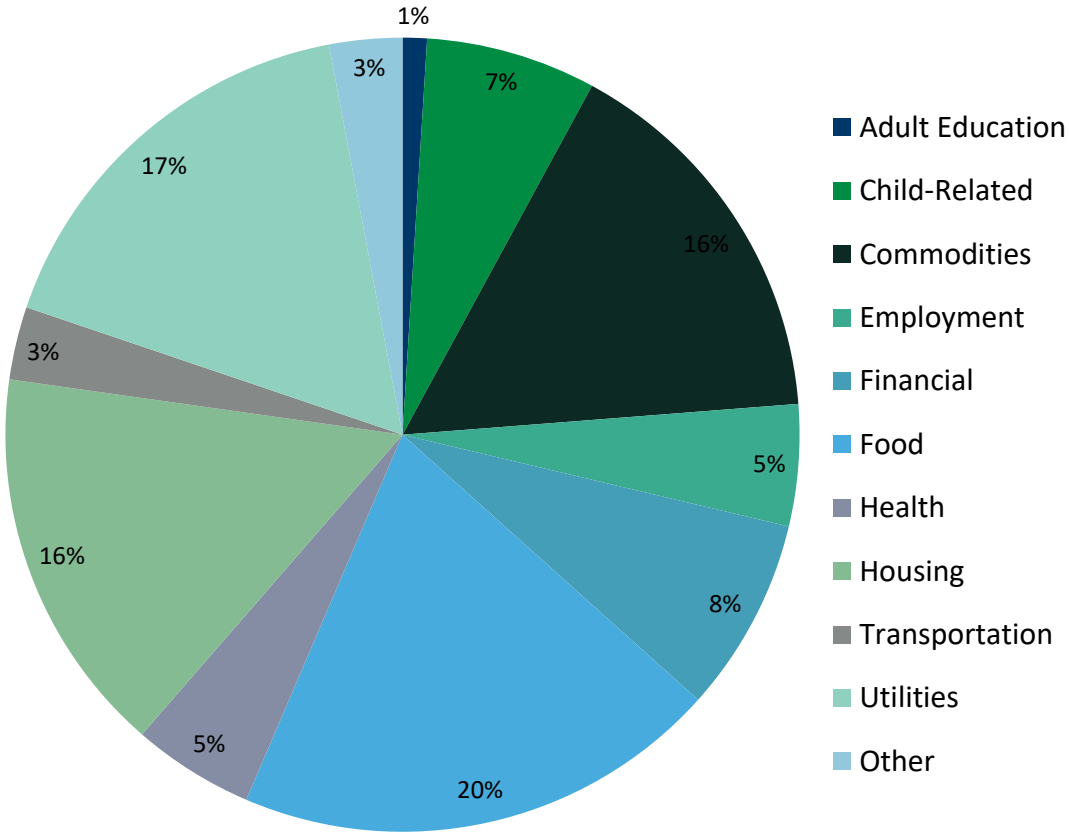
Our SDoH Innovation, cont.

Success Story:

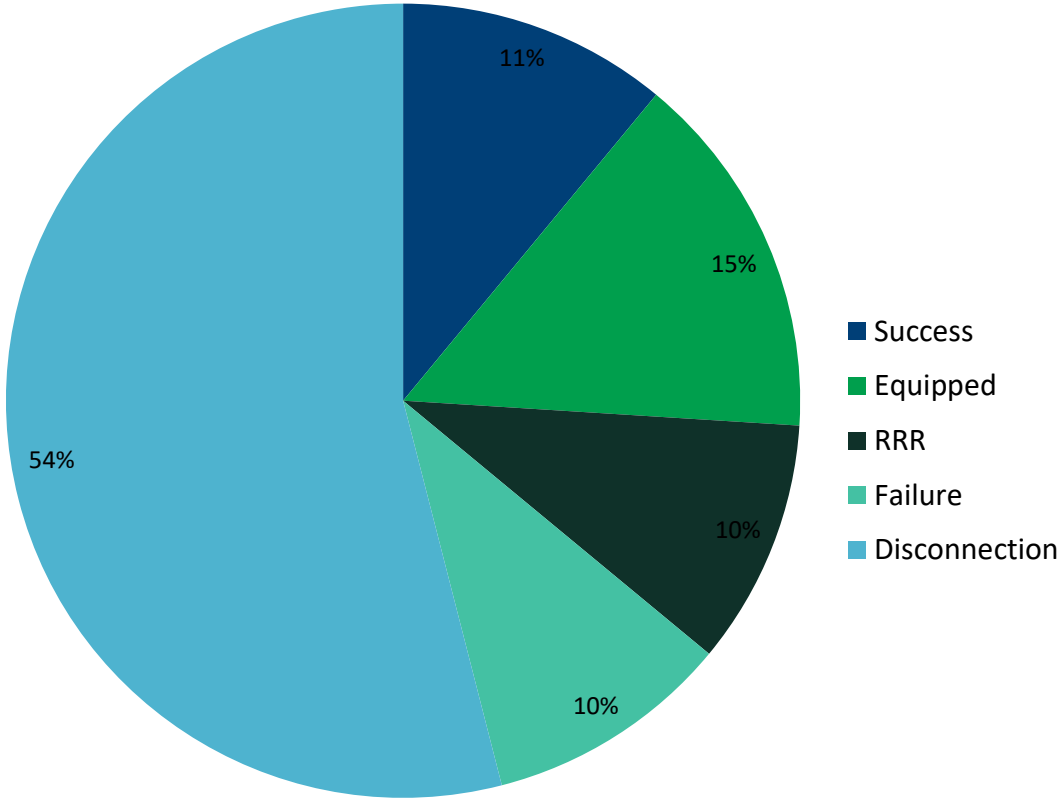
Member was connected to CC4H through an inside referral after completing a health risk assessment. She had just gotten a divorce, had two children and was struggling. Her house didn't have walls, heat, or electricity in a few rooms as her (ex) husband was doing renovations that were not finished before the divorce was final. CC4H staff were able to help her find utility assistance and assistance through Habitat for Humanity to help finish the house. The house in now structurally safe to raise her family in!

Our SDoH Innovation, cont.

June 2017-May 2018 Needs by Service Category



Case Closed Status



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CC4H Referrals by Needs and County

Sub-Need	Alger	Baraga	Chippewa	Delta	Dickinson	Gogebic	Houghton	Iron	Keweenaw	Mackinac	Marquette	Menominee	Ontonagon	Schoolcraft	Total	Need Total
GED/Adult Education	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	Adult Education 1
Childcare/Pre-school Enrollment	0	0	0	1	0	0	0	0	1	0	0	0	0	2	2	Child-Related 5
Childcare Voucher	0	0	0	1	0	0	0	0	0	0	0	2	0	0	3	
Baby Supplies	0	0	2	2	0	0	1	1	1	0	1	0	0	0	8	Commodities 47
Clothing	0	1	3	5	2	1	2	1	0	0	6	3	0	2	26	
Holiday Gifts	0	0	1	0	0	0	1	0	0	0	0	1	0	0	3	
Household Goods/ Furniture	0	0	1	1	1	0	0	1	0	0	1	2	0	1	8	
School Supplies	0	0	1	0	0	0	1	0	0	0	0	0	0	0	2	
Job Placement Services	0	0	0	1	1	0	0	0	0	0	2	2	0	1	7	Employment 9
Job Training	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	
Cash Assistance	1	0	1	0	0	0	0	0	1	0	2	1	0	0	6	Financial 17
Emergency Cash	1	0	2	0	0	0	1	1	0	0	4	2	0	0	11	
Food Stamps/SNAP	0	0	2	1	2	1	1	0	0	0	11	2	0	0	20	Food 74
Pantries & Soup Kitchens	0	1	3	4	4	2	0	0	0	0	15	4	0	2	35	
Seasonal Food	0	1	0	1	1	0	1	0	0	0	5	1	0	1	11	
WIC	0	0	1	0	0	1	0	1	0	0	4	1	0	0	8	
Medical Care	0	0	0	0	0	0	0	0	0	0	1	2	0	0	3	Health 9
Dental Care	0	0	1	0	0	0	1	0	0	1	0	0	0	0	3	
Adult Health Insurance	0	0	0	0	0	0	0	0	0	1	1	1	0	0	3	
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Family Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Emergency Shelter	0	2	0	2	0	0	0	0	0	0	2	2	0	2	10	Housing 44
Rental Assistance	0	0	1	5	0	1	1	1	1	0	6	2	1	3	22	
Subsidized	0	4	0	1	0	1	0	0	0	0	3	2	0	1	12	
Medical Transport	0	0	0	0	0	0	0	0	0	0	1	1	0	0	2	Transportation 7
Public Transport	0	0	1	0	0	0	1	0	0	1	2	0	0	0	5	
Electric/Gas/Oil	0	0	0	4	2	3	3	1	2	0	12	5	2	3	37	Utilities 44
Energy Assistance	0	0	0	0	0		1	0	0	0	4	1	0	0	7	
Total	2 <1%	9 4%	20 8%	29 11%	13 5%	11 4%	15 6%	7 3%	6 2%	3 1%	83 32%	38 15%	3 1%	18 7%	257	
% of Total UPHP population	3%	3%	9%	14%	8%	6%	13%	5%	1%	3%	20%	7%	2%	5%		

SIM MDHHS State Innovation Model

find a resource

BMC Peds Primary Care Clinic

1303 Resources Found

Address

20 West Newton Street, Boston, MA 02118

within 10 miles

Service Categories

No categories selected, showing all

Choose a Service Category:

-- Select a Category --

-- Choose a service type --

Keywords

Languages Spoken

No languages selected, showing all

Spanish

Choose a Language:

-- Select a Language --

Advanced Options

Utility Shut Off Protection (Boston Medical Center)

1 Boston Medical Center Place
Boston, MA 02118

229

0.4 miles from you

Shut off protection- DIMOCK (Timothy Smith Network)

Timothy Smith at Dimock Center
55 Dimock Street
Roxbury, MA 02119
617-442-8800

94

94 successful referrals in the past year

1.8 miles from you

Many low income households are p
utilities being shut-off due to non-pa
even if a client is protected from shu
Advise clients to pay as much as the
protection letter, utility sh...

NStar Discount Rate Program for Gas and Electric (NStar)

800-592-2000

80

Accessible by phone, fax, or online.

Codman Utility Shut-Off Protection (Codman Square Health Center)

637 Washington Street
Dorchester, MA 02124
(617) 825-9660

79

3.5 miles from you

Project Bread Food Source Hotline (Project Bread)

SIM MDHHS State Innovation Model

Health Plan Partnering and Innovation

SHANNON SAKSEWSKI, MSW, MBA

REGIONAL MANAGER, POPULATION HEALTH, AETNA MEDICAID

SDoH and Medicaid Trends

- NCQA has rolled out new Population Health Management standards for all accredited health plans, which include identifying/addressing SDoH

- Plans are using data sets (e.g., ICD-10 Z codes, CM assessments) to identify and address SDoH

- Developing collaborations to address SDoH and its impact on utilization (e.g., ABH-MI's Care Collaboration Model)

Our SDoH Innovation – Care Collaboration

Who Is Involved: Aetna Better Health of Michigan (ABH-MI) and provider CM team members; PIHP representative; ABH-MI utilization management representative & pharmacy director

How it Works

- Current and desired future state processes mapped, necessary changes identified
- Regular, recurring rounds sessions are central to the model; *collaborative conversation is key to identifying and addressing SDoH needs*
- Focus population and goals are chosen before the effort begins; progress is tracked and shared monthly with all stakeholders
- Iteration is expected, problem identification encouraged

Our SDoH Innovation – Care Collaboration

Start Date: Piloted with Lakeland 1/2016, active there since then.

Progress/Achievements:

- Outcomes vary between systems, but include:
  - Readmissions decreases between 20%-80%
  - Admissions decreases between 5%-30%
  - ED utilization decreases between 5%-20%

- Now active with 5 systems in MI (and more to come). Model is being scaled to additional markets, is now active with providers in Ohio and New Jersey and will be active with others soon.

Our SDoH Innovation – Care Collaboration

Key Tools: ADT and claims data, trust-based relationship development with key provider staff, population health technology, rounds sessions as collaboration and accountability opportunities

Challenges: Model can be time intensive, and is outside of the norm; approach is needed population-wide, but currently benefits a subset of people

Proudest Moment: Outcomes presentations, when CMs can see how their collaborative work is impacting members/patients

Hints For Others: Payers are partners in SDoH-related work; CM and CHW resources can help identify and close gaps

SDoH and Medicaid Trends

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- Developing collaborations to address SDoH and its impact on utilization (e.g., ABH-MI's Care Collaboration Model)

The Practice Perspective and Front-Line Partnering with Key Linkages

KERRIE BARNEY MA-ORGL, BSN, RN

DIRECTOR OF NURSING, CHERRY HEALTH

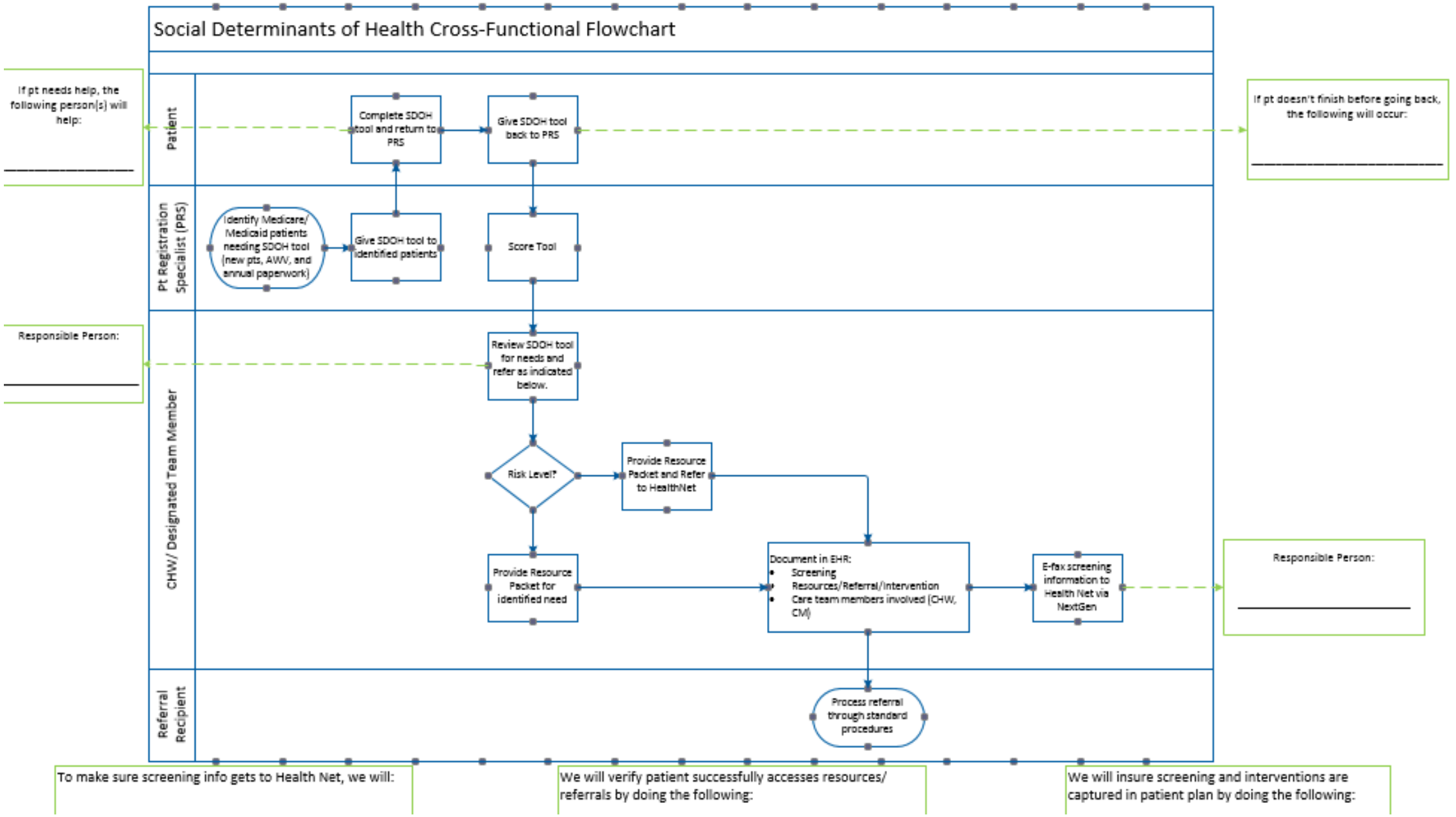
Our SDoH Innovation

Who Is Involved: Grant partnership with HealthNet of West Michigan implemented in 7 Cherry Health Kent County Locations screening health related social needs of Medicare and Medicaid recipients.

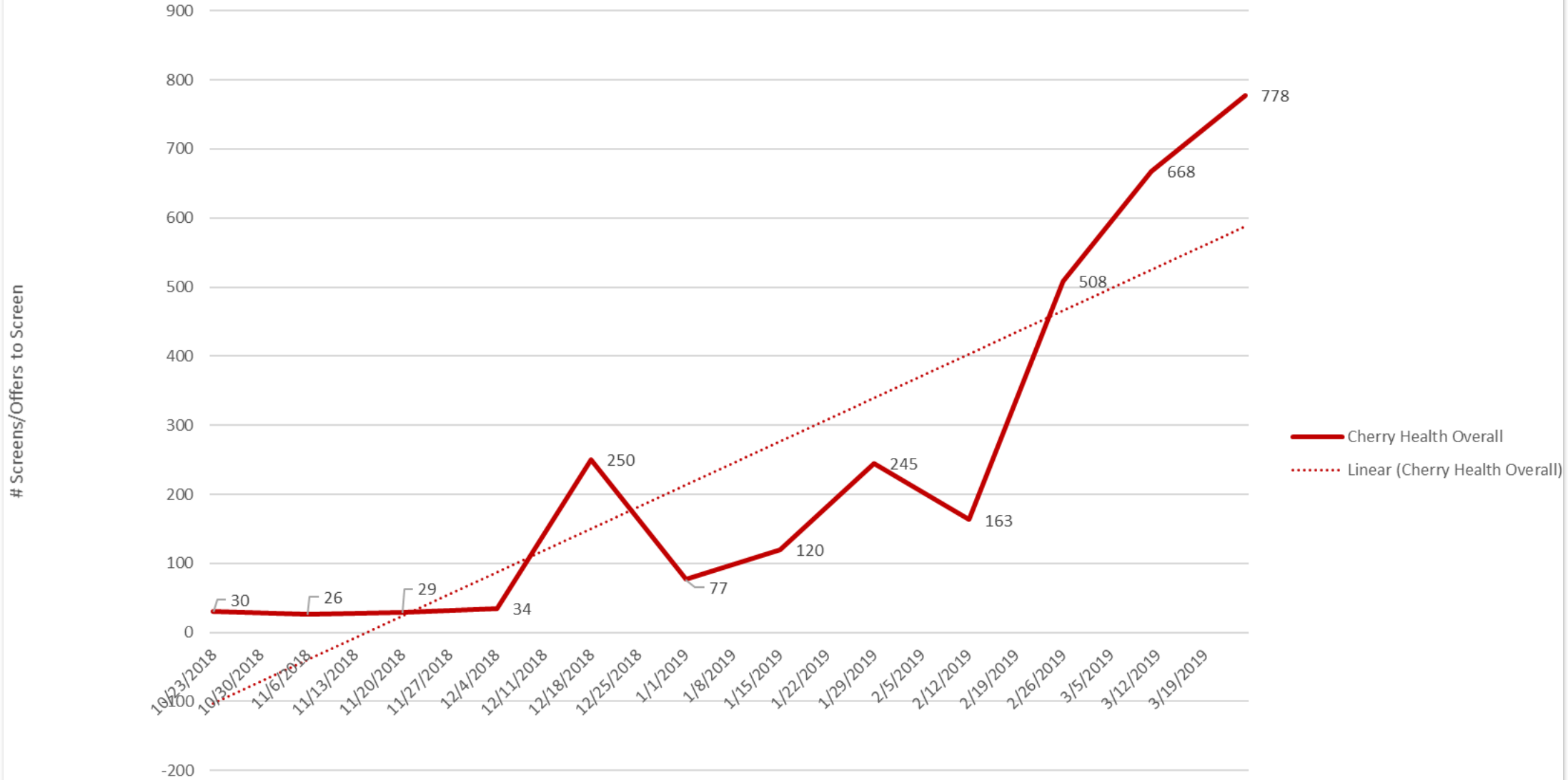
How It Works: Look at our flows to see how we roll!

Start Date: 2 site pilot (10/18), broad go-live 12/18, more to come!

Progress/Achievements: More than 3,000 screens complete


Social Determinants of Health Cross-Functional Flowchart
If pt needs help, the following person(s) will help:
Patient
Complete SDOH tool and return to PRS
Give SDOH tool back to PRS
If pt doesn't finish before going back, the following will occur:
Pt Registration Specialist (PRS)
Identify Medicare/ Medicaid patients needing SDOH tool (new pts, AWV, and annual paperwork)
Give SDOH tool to identified patients
Score Tool
Responsible Person:
CHW/ Designated Team Member
Review SDOH tool for needs and refer as indicated below.
Risk Level?
Provide Resource Packet and Refer to HealthNet
Provide Resource Packet for identified need
Document in EHR:
Screening
Resources/Referral/Intervention
Care team members involved (CHW, CM)
E-fax screening information to Health Net via NextGen
Responsible Person:
Referral Recipient
Process referral through standard procedures
To make sure screening info gets to Health Net, we will:
We will verify patient successfully accesses resources/ referrals by doing the following:
We will insure screening and interventions are captured in patient plan by doing the following:

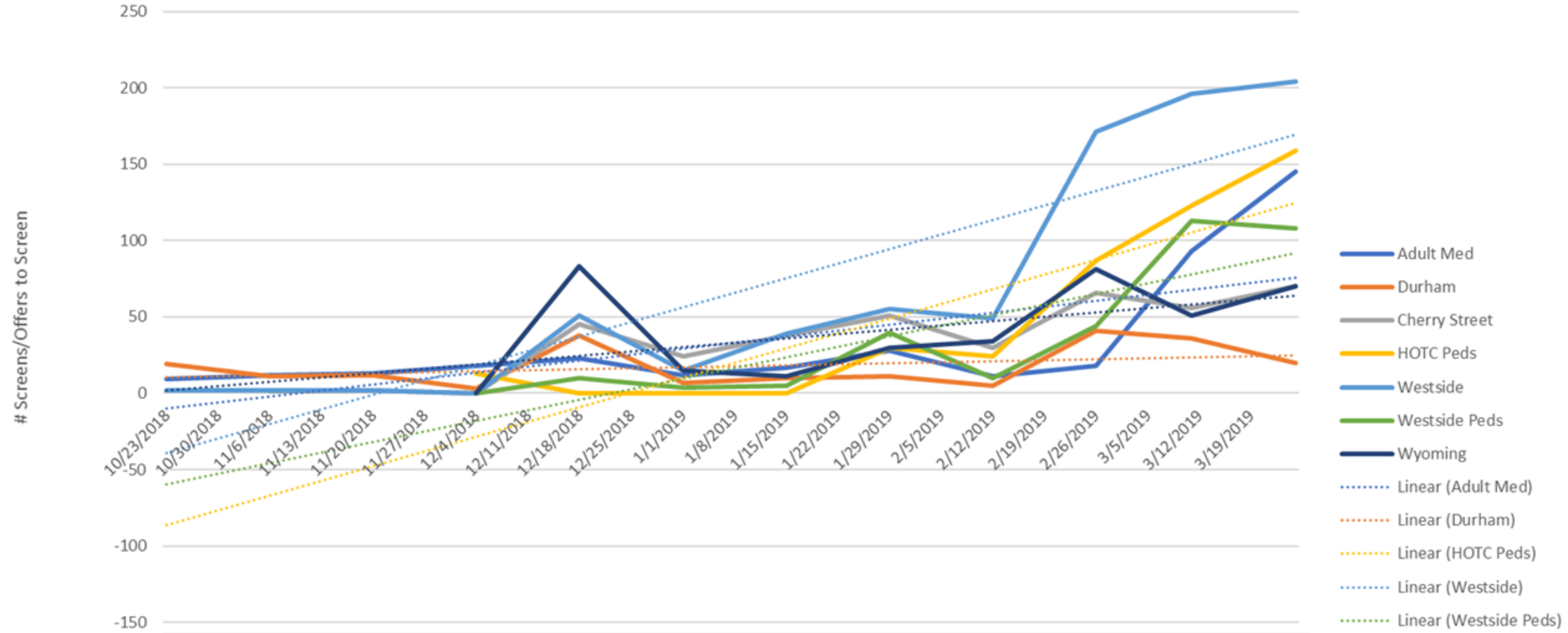
Cherry Health Accountable Health Communities SDOH Screening by Site



	10/23/2018	11/6/2018	11/20/2018	12/4/2018	12/18/2018	1/1/2019	1/15/2019	1/29/2019	2/12/2019	2/26/2019	3/11/2019	3/25/2019
Cherry Health Overall	30	26	29	34	250	77	120	245	163	508	668	778

Report Date (includes data for 2 weeks prior to date)

Cherry Health Accountable Health Communities SDOH Screening by Site



	10/23/2018	11/6/2018	11/20/2018	12/4/2018	12/18/2018	1/1/2019	1/15/2019	1/29/2019	2/12/2019	2/26/2019	3/11/2019	3/25/2019
Adult Med	9	12	13	18	23	12	17	28	11	18	93	145
Durham	19	11	12	3	38	7	10	11	5	41	36	20
Cherry Street		1	2	0	45	24	38	51	30	66	56	70
HOTC Peds				13	0	0	0	30	24	87	123	159
Westside	2	2	2	0	51	15	39	55	49	171	196	204
Westside Peds				0	10	4	5	40	10	44	113	108
Wyoming				0	83	15	11	30	34	81	51	70

Report Date (includes data for 2 weeks prior to date)

Our SDoH Innovation, cont.

Key tools (communications, relationships, data, etc.): See next slide

What worked/what didn't… Hints for Others:

SIM MDHHS State Innovation Model

Key Tools

AHC Grant Tracker	AM Elig	AM Offer	AM Screen	AM % Scr/Off	AM % error free	Durham Elig	Durham Offer	Durham Screen	Durham % Scr/Off	Durham % error free	CSHS Elig	CSHS Offer	CSHS Screen	CSHS % Scr/Off	CSHS % error free	HOTC-P Elig	HOTC-P Offer	HOTC-P Screen
10/23/2018			9					19										
11/6/2018			12					11					1					
11/20/2018			13					12					2					
12/4/2018			18					3					0					13
12/18/2018			23					38					45					0
1/1/2019			12					7					24					0
1/15/2019			17					10					38					0
1/29/2019			28					11					51					30
2/12/2019			11					5					30					24
2/26/2019			18					41					66					87
3/11/2019			93					36					56					123
3/25/2019			145					20					70					
	0	0	399	0	0	0	0	213	0	0	0	0	383	0	0	0	0	
10 Work Day Target			80					20					120					
Daily Target			8					2					12					

Health Net OF WEST MICHIGAN
Navigating Care. Connecting Resources.

Cherry Health

Social Determinants of Health (SDOH) Screening

Familyone Test 01/01/2001

Patient Information
Familyone Test
11111
Wyoming, MI 49509-
Screening Date

DOB: 01/01/2001
Phone: (616)111-1111

11/30/2018 PM

Insurance: Medicaid

Policy #: 123456987

Provider Role

care manager: Amazin
Community Health Wo

1. Who is providing the
☑ Myself ☐ Parent/

2. How many times have

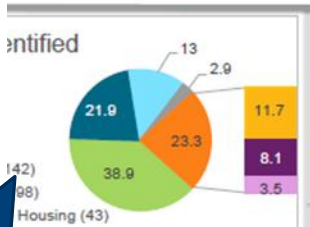
be po
☐ I live

4.

5. Think about the pl ve prob of the following? (Ch k all that apply)
☐ Bug Infestation
☐ Mold
☐ Lead Paint or Pip

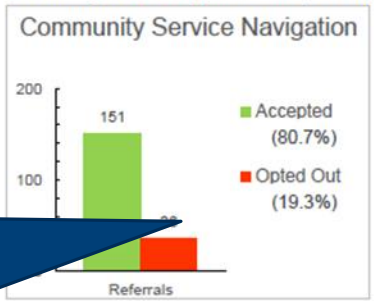
Test, Familyone ID: DO /01/2001

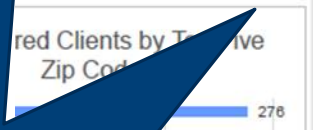
Cherry Health
Screening and Navigation Dashboard
October 1, 2018 – February 28, 2019



Screening Outcomes			
Outcome	Total	% screens	% offers
Negative	513	43.9%	33.2%
Low-risk	433	37.0%	28.0%
High-risk	195	16.7%	12.6%
Ineligible	28	2.4%	1.8%
Total	1169	100%	75.7%

Clients Eligible for Navigation = 187 (12.1%)





Race	
Response	Count
White	276
Black or African American	185
Other or more than one selected	96
Asian	16
American Indian/Alaska Native	15
Native Hawaiian/Other Pacific Islander	2
Total	590

Proudest Moment:
“ Finally! Someone is asking about something that is important to me.”

SIM MDHHS State Innovation Model

Panel Q & A

Break

SEE YOU BACK AT 10:10!

Tools

- Identifying Your Opportunity
- Workgroup Intensive Session Framing Slides
- IHI Process Overview
- Wish, Outcomes, Obstacles, Plan (WOOP) Goal Achievement Model
- Stakeholder Political Mapping

Identifying Your Opportunity
Our SDoH Processes: Current/Better

Current Picture	Future (Better) Picture

Workgroup Intensive Session: Your "Assignment"

GOAL: Everyone walks out of this room with a SDoH-related goal/opportunity that you are energized and care about , as well as a plan for how you will make progress, and an understanding of potential obstacles that might be encountered and how to approach and overcome them

WHAT WE WILL DO IN WORKGROUPS:

1. Introduce ourselves (name, organization, role)
2. Identify an SDoH opportunity and goal that you are interested in working on and championing (individual work first followed by sharing with your table)
3. Discuss potential for table or group goal (if appropriate for your situation)
4. Use the tools reviewed as resources for your customization of an approach that benefits your practice or organization to improve the SDoH integration of biopsychosocial aspects of care

Making a Plan with the WOOP Model

Wish: What is your SDoH wish (challenging, but feasible)? (What SDoH improvement action do you propose for your practice or organization?)

Outcome: What would be the best outcome of fulfilling the wish?

Obstacle: What are the main inner obstacles that could hold you back from fulfilling your wish?

Plan: What can you do to overcome the obstacles (if they are encountered)?

Fill in the blanks below:

- If… , then we will… _____

Overcoming Obstacles: Stakeholder Mapping

Stakeholder Name	**Contact Person** *Phone, Email, Website, Address*	**Impact** *How much does the project impact them? (Low, Medium, High)*	**Influence** *How much influence do they have over the project? (Low, Medium, High)*	**What is important to the stakeholder?**	**How could the stakeholder contribute to the project?**	**How could the stakeholder block the project?**	**Strategy for engaging the stakeholder**

Dealing with Stakeholder Interests

Satisfy

High Influence, Low Interest

These stakeholders are highly influential but they don't have a lot of interest, nor are they actively engaged in your project. Consider their objectives and keep them satisfied to ensure they remain strong advocates. Getting them off side poses a risk.

Examples:

- Regulators (eg. EPA, FDA, Tax)
- Administrators (ie. with discretion over budgets)

Manage

High Influence, High Interest

These are your key stakeholders. They have a lot of influence and a strong interest in the outcomes. Manage these stakeholders well to build strong relationships and ensure you retain their support. Involve them in decisions and engage regularly.

Examples:

- Trade Unions
- Politicians and senior officials
- Investors
- Senior Management
- Project Sponsors

Monitor

Low Influence, Low Interest

These stakeholders sit on the periphery of the project. They are neither interested or have much influence. Monitor their activity from time to time to stay on top of their involvement. Their relevance may change over time. Communicate to keep them informed and encourage their interest.

Examples:

- Support/Complementary Services

Inform

Low Influence, High Interest

These stakeholders have a strong interest in your project but very little power to influence it. Anticipate their needs and keep these stakeholders informed to ensure their continued support. Consult on their area of interest and use their input to improve your chances of success.

Examples:

- End users of a program or product
- Members of the community
- Community Action groups
- Media outlets

Examples: Overcoming Barriers to Adopting a Social Determinants of Health Approach in Clinical Practice

Barrier	Facilitator
Medical model bias and the treatment imperative in health care	Health care provider reminder and recall systems to adopt a more holistic and biopsychosocial approach
Patients who experienced prior stereotyping and discrimination in clinical care	Treating patients with dignity and respect and creating "safe spaces" for disclosure
Physicians feeling overwhelmed, overworked and lacking time	Taking a few extra minutes per consultation to address complex health and social needs
Physicians not knowing what resources exist in the local community	Providing a mapping of benefits and local referral resources for specific social challenges
Physicians unsure of what concrete actions to take to address social determinants	Resources, training and ongoing support of physicians and allied health care workers

Andermann, A., CLEAR Collaboration (2016). Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, *188*(17-18), E474-E483.

Introduction of Facilitators and Room Assignments

Recapping the "Assignment"

GOAL: Everyone walks out of this room with a SDoH-related goal/opportunity that you are energized and care about , as well as a plan for how you will make progress, and an understanding of potential obstacles that might be encountered and how to approach and overcome them

WHAT WE WILL DO IN WORKGROUPS:

1. Introduce ourselves (name, organization, role)
2. Identify an SDoH opportunity and goal that you are interested in working on and championing (individual work first followed by sharing with your table)
3. Discuss potential for table or group goal (if appropriate for your situation)
4. Use the tools reviewed as resources for your customization of an approach that benefits your practice or organization to improve the SDoH integration of biopsychosocial aspects of care

???Does Your Group Want to Work Together to Have Interim Group Calls or Touchbases???

Facilitators and Tools To Help You

- Introducing Our **Wonderful** Facilitators!
- For More Elbow Room, We Will Break Into Two Rooms with Workgroup Table Seating Assigned by Prosperity Region
- Everyone Will Have a Large Copy of the Tools for Easy Reference and a "Leaving In Action "Take-Home" Sheet to Help You Make Your Change Come to Life!
- Each Table Should Assign One Person to "Report Out" to Others In the Room At the Group Sharing Portion of the Agenda
- You Will Take Your Completed "Leaving In Action" Worksheet Home With You, But We Will Scan Them Before You Leave For A Historical Copy,

Time to Get the Real Work Done! (10:20-11:30)

*COMPLETING **YOUR** LEAVING IN ACTION WORKSHEET*

Sharing Results

ROOM ROUND ROBIN REPORT-OUTS

Making Your Change Come to Life! Improving SDoH Gap Closure in Your Practice!

- Don’t forget to get your completed Leaving In Action worksheet scanned before you leave!
- Feel free to agree as a table to hold interim table calls if you wish (share phone numbers and assign someone to get a meeting notice out, if so!)
- Take your worksheet back to your practice, discuss with your team partners, improve it, reach out to other stakeholders as a team, and make the change happen!

And…A Preview of Upcoming Events

The second in-person Care Coordination Collaborative Event will be held on July 30, 2019 (full day event) at the Amway Grand Plaza Hotel in Grand Rapids.

- **Focus:** Partner Sharing and Collaboration to Decrease Avoidable ED and Inpatient Utilization and Streamline Care Efficiency
- **Approach:** Best Practice Sharing, Group Discussion, and Intensive Group Work Session
- **Goal:** Participants Leave With an Identified Goal, Plan and Stepwise Approach to Progress

THANK YOU!