Tuesday, 2:30 – 4:00, C7

Pediatric Integrated Care: A Model for Wayne County

Jametta Lilly
313-863-2427 jamettal@gmail.com

Carlynn Nichols
313-833-2500 cnichols1@co.wayne.mi.us

Objective:

1. Identify effective methods for the practical application of concepts related to improving the delivery of services for persons with developmental disabilities
2. Identify lessons learned and systems issues to improve policy and advocacy on behalf of children and youth at risk of developmental delays and/or diagnosed with developmental disabilities

Notes:

Pediatric Integrated Care: A Medical Home Framework

1

A Multi-Disciplinary and Cross-Systems Framework Supporting the Physical and Social-Emotional Development of the Whole Child

Jametta Lilly, MPA-GC, CEO, Wayne Children's Healthcare Access Program, WCHAP Inc.

Carlynn Nichols, LMSW, Director of Children's Initiatives, Detroit Wayne County CMH Agency

Workshop Overview 2:00 – 4:00pm

1. DWCCMHA and WCHAP Who We Are
2. Why DWCCMHA and WCHAP Are Working Together
3. Data – The Case for Pediatric Integrated Healthcare
4. *Your Turn! Audience Exercise*
5. Getting on the Same Page – Key Terms
6. Ok, Now What? WCHAP Framework for Improving Quality, Child Health Outcomes and Building Systems Change
7. Building Awareness and Readiness for Pediatric Integrated Healthcare
8. Programmatic Overview - Building the Infrastructure to Support PIH in WCHAP
9. Advocacy and Policy - The Role of Systems, Health Plans, Community Partners, MI-CHAP, CMH Boards, Associations and Y-O-U
10. *Your Turn! Audience Exercise*

Pediatric Integrated Care: A Medical Home Framework

LEARNING OBJECTIVES

A. Understand Systems Fragmentation and Key Reasons for Integrated Healthcare

B. Key Tenets of Family Centered Medical Home

C. Key Tenets of Pediatric Integrated Healthcare

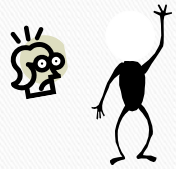
D. Key Challenges and Opportunities for Pediatric Integrated Healthcare at Operational and Strategic Level

2

Why Pediatric Integrated Healthcare?

Lets Connect!

Mind and Body



3

Health Plan Behavioral Health

DHS

Education

Physical Health

Juvenile

CBOs and Systems!

Community Mental Health

Silo Busting!

System Fragmentation!

4

Who is Advocating for Pediatric Integrated Healthcare?

- HRSA
- SAMHSA
- MDCH
- MACMHB
- *Detroit Wayne County Community Mental Health Board*
- NIH
- CDC
- MDCH
- AAP, AAFP
- ***Wayne Children's Healthcare Access Program,*** *WCHAP Inc.*

5

Wayne Children's Healthcare Access Program, WCHAP

A Private-Public Community Health Collaborative Advancing Pediatric Medical Home Implementation

*Increasing Access and Quality
*Improving Child Health and Wellness
*Reducing Costs
*Advancing Partnerships and Systems Change for Medicaid Children and Families

6

Every Child Deserves a Family Centered Medical Home

"…in essence integrated health care is the **systematic coordination of physical and behavioral health care**. **The idea is that physical and behavioral health problems often occur at the same time.**

Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served."

Hogg Foundation for Mental Health *Connecting Body & Mind: A Resource Guide to Integrated Health Care in Texas and the U.S.,* www.hogg.utexas.edu,

OK, So What Is Integrated Healthcare?

Pertaining to every aspect of the child, including health, nutrition, values, attitudes, beliefs and resulting behaviors..

Key Child Developmental Domains

Physical	Language
Social-Emotional	Cognitive

Why, The Whole Child versus Developmental Silos

An Ecological Framework: Helping The Whole Child..
Grow and Bloom!




Working With Children Within the Context of Their Families and Community…Integrating the Building Blocks for Life Success

* Physical Health
* Social-Emotional Development
* Cognitive Skills

WHY Strengthen Connections Between Mental and Physical Health?

Education Connection

Physical and Social-Emotional Issues in infancy and early childhood can hamper school readiness and on-going school performance…with the potential for significant emotional and mental health impact in adolescence and young adulthood

1. 67% of people with a behavioral health disorder do not get behavioral health treatment
2. 84% of the 14 most common physical complaints have no identifiable organic etiology (cause). [8]
3. 80% of people with a behavioral health disorder will visit primary care at least one time in a year.[9]

10

WHY Strengthen Connections Between Mental and Physical Health?

People with common medical disorders have high rates of Behavioral Health issues

E.g., Diabetes, heart disease, & asthma + depression

Worse outcomes and higher costs if both problems aren't addressed

4. 50% of all behavioral health disorders are treated in primary care.[6]
5. 48% of appointments for all psychotropic agents are with a non-psychiatric primary care provider.[10]
6. 30-50% of referrals from primary care to an outpatient behavioral health clinic do not make the first appointment.[11-12]

11

WHY Strengthen Connections Between Mental and Physical Health?

Mild to moderate Behavioral Health issues are common in Primary Care Settings

- Anxiety, depression, substance use in adults
- Anxiety, ADHD, behavioral problems in children

12

Let's Make The Connections so that All Our Children Can Meet Their Potential!

Children with physical, emotional and/or mental health conditions have a harder time with school, are more likely to drop out and encounter the juvenile system.

Key poverty indicators are high school dropout rate, particularly combined with single parenthood.

13

Economic Connection

Behavioral Health disorders account for half as many disability days as all physical conditions.[17]

- **Annual medical expenses--chronic medical & behavioral health conditions combined -- cost 46% more than those with only a chronic medical condition.[18]**
- **Of the top five conditions driving overall health cost (work related productivity + medical + pharmacy cost), depression is number one.[19]**

14

Economic Connection


EVIDENCE-BASED CHILD AND ADOLESCENT PSYCHOSOCIAL INTERVENTIO

American Academy of Pediatrics

Getting on the Same Page Key Concepts

- The Medical Home
- Mental/Social Emotional Health
- Physical Health

What Is a Children's Medical Home?

…it is … "..an approach to providing comprehensive primary care.

A medical home is NOT a…

- Building
- House
- Hospital

A medical home is defined as primary care that is

1. ***accessible,***
2. ***continuous,***
3. ***comprehensive,***
4. ***family centered,***
5. ***coordinated,***
6. ***compassionate,***
7. ***culturally effective***."

17

Child –Family System Challenges

Chaotic and inadequate funding of preventative and holisitic care and *support* for children and families

Poor communication / inadequate coordination between systems and providers

Inadequate professional development to support community based health and wellness geared to the whole child

Fiscal and administrative policies that prohibit or adversely impact health and wellness

Social Determinants of Health

Exacerbated by Poverty, Inequality, Inadequate Education and Disparate Economic Opportunity

18

Why Now?

Now is the Time!

- Gov. Snyder amongst others is calling for Integrated Healthcare and Patient-Family Centered Medical Homes! Improving the Health and Mental Wellness of Children and Teens is a Medical and Community Based Call to Action!
- Pediatric Workgroup has submitted a Concept Paper with specific recommendations to MDCH.

19

Action Steps in Wayne County
Building Awareness

Feb 2011 - Present

- Convened First Meeting of CMH and Physical Health Community Providers
- Integrated CMH concerns into WCHAP meetings with physicians, clinic managers and health plans
- Working towards shared Systems Agenda including policy and fiscal changes to advance PIH

Feb 2011-Sept 2012
Convened Pediatric Integrated Healthcare Workgroup

20

Action Steps in Wayne County
The Pediatric Integrated Healthcare Workgroup, PIHW

GOALS

Develop and Pilot Models of Integrated Healthcare for Children and Youth – Begin 2012

Expand/Advocate Prevention Continuum for All Human Services

Make Recommendations for Improving Physical and Mental Health Care Coordination Between Systems and Agencies and Families

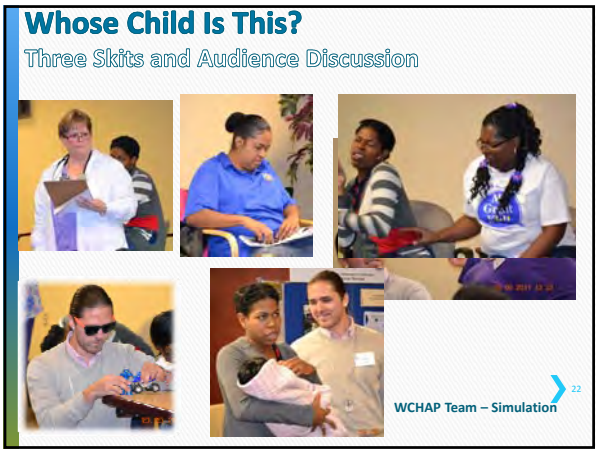
- Policy
- Funding
- Best Practices
- Methods

PIHW How We Do Our Work.
Meet monthly, learn from each other and the field, exchange resources, convene speakers, devise strategies, begin 'piloting', assess progress, align with Integrated Care efforts in adult and other program areas

PIHW Sub-Teams

» Advocacy and Awareness
» Sustainability
» Integrated Models

21


Whose Child Is This?
Three Skits and Audience Discussion
WCHAP Team – Simulation
22


Discussion with multi-sector audience including parents
23


Get Involved!
Every Child Deserves a Medical Home!
DWCCMHA
313 833-2500
WCHAP
313 863-CHAP (2427)
1. Join the Great Start Parent Coalition 734 284 -4001
2. Talk up the Need for Focusing on Prevention and meeting the physical and mental health needs of children
3. Don't let children fall through the cracks! Learn, Advocate, Act!
4. Make sure you speak to your child's physician about social-emotional concerns, communicate and coordinate with all other agencies
5. Participate/learn about Ages and Stages, developmental screening
6. Learn more about child and youth development and how to help them Grow and Thrive through all their stages
7. Check out the Early Learning Hub in your area
8. Call the PIHW for information that can be shared with your agency or group
9. Call DWCCMHA or any of the agencies today for mental health or social-emotional concerns
10. Join WCHAP in the 'Get a Great Start in Health' Campaign! Connect our children to their Medical Home for on-going comprehensive care

Action Steps in Wayne County

Established Programmatic Responses

» WCHAP

» SKIPP Grant

Building the Infrastrucure for PIH

25

Action Steps in Wayne County

Building the Programmatic Infrastructure

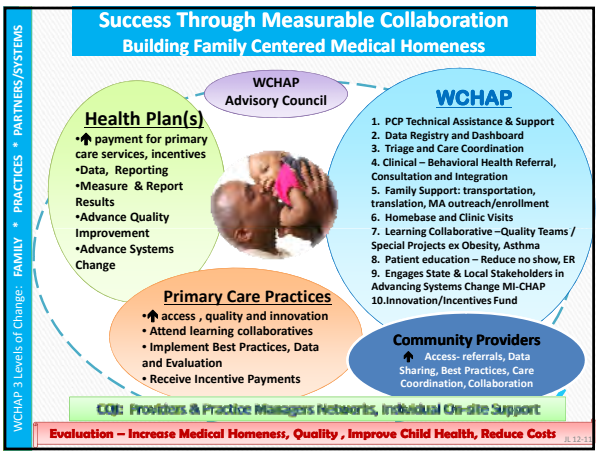
WCHAP

- Coodinating with DWCCMHA and SKIPP Team
- Working directly on PIH with Pilot Practices: Needs Assessment, Planning and Implementation

26

Success Through Measurable Collaboration

Building Family Centered Medical Homeness



What Did We Learn?

Provider Discussions

Need help with

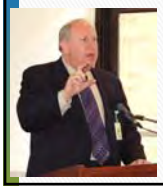
1. Behavioral Health triage, referral and coordination
2. Asthma education
3. High no-show rate
4. Community resources
5. Referral information and coordination w/support programs
6. Improve lead screening rates
7. Obesity management

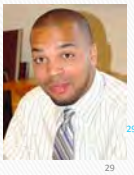
What Did We Learn?

Health Plan Discussions

Need help with

1. Improve HEDIS measures (Well child/adolescent visits, immunizations, lead screening)
2. Reduce ER visits and hospitalizations
3. Increase access for enrolled patients
4. Improve customer satisfaction (families and providers)
5. Improve practice responsiveness to HIT and other innovations





29

What Did We Learn?

Family Discussions

Families Want

1. Education on high frequency common conditions (ear infections, asthma behavior /social-emotional issues (stuff they can do as parents)
2. Consistency of care and information - same doc, staff knowledgeable about their child/family
3. Better hours
4. Respect and compassion
5. Information in a way they can understand

30

What Did We Learn? KentCHAP Partnership

Multiple Site Visits and Collaboration On

- ROI Events
- Learning Opportunities Children's Medical Home Advocacy
- Engaging Health Plans
- Model/Program Improvement

Needs

Champions for Children's Health and Wellness

Statewide Evaluation, Data And IT Infrastructure

Mental Health Coordination

31

WCHAP an Independent, Community Partner Facilitating 'Medical Homeness' and Change At Three Levels

Family

Education/Empowerment
MA Enrollment/Navigation.
Direct Services, Advocacy and Care Coordination

Primary Care Practices

Individual and Pilot Wide Technical Assistance to Primary Care Practices and Community Partners.
Collaborative Learning, Incubating Innovation, Evaluating Ideas, Methods and Models

Partners and Systems

Silo Busting, Multi-Sector and Multi-Disciplinary Planning. Advocacy and Solution Building for Fiscal and Policy Change

FAMILY CENTERED Medical Home

32

WCHAP PILOT Summary

Funding Kresge Foundation Feb 2011 – Jan 2013
W. K. Kellogg Foundation June 2012-May 2015

Impact: **WCHAP Practices service more than 40, 000 children.**
Direct Services: **4,00 children enrolled w/WCHAP Health Plans & Practices**

Health Plan Champions:

*** Meridian * UnitedHealthcare * Coventry**

Primary Care Pilot Champions

1. **Advantage Health Centers**
2. **Detroit Community Health Connections, DCHC -4 clinics**
3. **Covenant Community Care. CCC – 2 clinics**
4. **Detroit Riverview Pediatrics**
5. **Children's Hospital of Michigan**
6. **Western Wayne Family Health Centers – 2 clinics**
7. **School Based Health Centers - Henry Ford Health System.**
8. **Newton Clinic, CCC.**

Specialty Areas

1. ***Asthma***
2. ***Childhood Obesity***
3. ***Behavioral and Physical Health Integration***
4. ***Maternal-Child Health Continuum***
5. ***Oral Health***
6. ***School Based Health Centers***

WCHAP 17567 313 863-CHAP (2427) Fax 313 863-5183

33

WCHAP, Inc. Structure

Board of Directors and Advisory Council
Includes providers, funders, families, health plan(s) strategic partners

- Chief Medical Officer, CMO
- Chief Executive Officer, CEO
- Nurse Coordinator
- Data Specialist
- Admin. Coordinator
- Community Health Workers
- Asthma Educators
- Clinical Social Worker
- Consultants -Evaluator, IT, Program, Promotions

Services Provided

1. *Care coordination via phone, home visits, clinics and community settings*
2. *Behavioral Health*
3. *Practice Manager & Provider network to improve HEDIS and Quality Improvement*
4. *Patient education RE: appropriate ER use, well child visits etc.*
5. *Family support services; transportation, translation*
6. *Asthma case management*
7. *Resource coordination*
8. *Monthly dashboard of quality indicators*

WCHAP Collaborative Plans (Referral)

1. *No Show*
2. *Missed Well Child*
3. *Asthma Diagnosis*
4. *Mental Health*
5. *Frequent ER*
6. *Unnecessary Hospitalization*

Supporting Practices and Community Partnerships

1. Monthly Clinic Managers Network Meetings
2. Provider Network Meetings – every other month
3. Advisory Council Including Parent Representatives
4. Specialty Initiatives
5. Individual PCP TA - Monthly

WCHAP Health Plan Champions

- Meridian
- Coventry Cares of MI
- UnitedHealthcare

MI CHAP FootPrint

Kent Wayne
Kalamazoo Genesee
Saginaw Ingham
Macomb Mid MI
Northwest MI

PIHW and WCHAP Recommendations

Program

- Increase multi-disciplinary professional development, technical assistance and cross-system internships in college and work settings (social work, medical, education, etc)
- Child Family Providers - require collaborative, integrated care, coordination and program development in their programs and by staff

- Increase opportunities for physical and mental health providers to meet, plan and work together – ie. Ex: PIHW meetings and/or special events
- Locally, select 'achievable' cross-sectors projects to implement between service sectors such as Ages and Stages Questionnaire training and implementation.

37

PIHW and WCHAP Recommendations

Systems

- MDCH needs a strategic and operational plan to better integrate physical and mental health at the state level across service sectors
- MDCH, DHS, Education at state should require same at the local level (with involvement from local systems and advocates)

- Administratively Health Plans and Medicaid are needed at the table w/the Wayne County PIHW and WCHAP to plan systems improvements
- Support Providers, WCHAP or other pilots paying for care coordination in mental AND physical health settings – track outcomes, define return on investment

38

Your Turn

- Key Action Steps by
  - Profession
  - Types of Organization
  - Advocacy

MI CHAP Foot Print Near You!

- How can you Connect to an Emerging CHAP in your Community?
- What do you want to learn
- What can you share?

39