Children's Health Access Program

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JANUARY 13, 2016

CareHub
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MiCHAP

Introduction of Ingham Health Plan – CareHub Overview

- Pathways to Better Health - Adults with two or more chronic health conditions
- Community Access to Home Visiting - Central location to make referrals to the Ingham County Home Visiting Programs for Pregnant women and children 0-5
- Now CHAP

CHAP Background in Michigan

- Kent County CHAP
  - Children on Medicaid in Michigan and Kent County had poorer health outcomes than children with private insurance
  - Low Medicaid reimbursement made it difficult for practices to accept large numbers of children with public insurance
  - Teaching clinics and FQHCs can be overwhelmed by the numbers of Medicaid patients they are asked to see causing more limits to access
  - Costs due to poor preventive care for Medicaid children are significant in terms of ED use and hospitalization rates
- http://healthnetwm.org/images/pdfs/CHAP-Demonstration-Project-Eval-Report.pdf

MI-CHAP

- Grant from Michigan Health Endowment Fund to expand CHAP in Michigan
- Active Sites:
  - Genesee County
  - Kent County
  - Macomb County
  - Northwest Michigan
  - Wayne County and UP CHAP
- Coming February 2016
  - Ingham County
  - Kalamazoo County
  - Saginaw County

V-CHAP

- Working with 2-1-1 to provide basic CHAP referral resources to counties that do not have an on the ground CHAP

So, what is CHAP?

- Collaborative, community-based medical home improvement program that provides:
  - Technical assistance to improve “medical homeness” of primary care practices
  - Resource coordination of community services
  - Increased office, patient and family education
  - Needed services for children/families
  - Office efficiency assistance
  - Convening of community stakeholders to address systems issues

Desired Outcomes

- Improve health outcomes among children on Medicaid while better utilizing existing resources and decreasing costs
- Decrease inappropriate use of emergency departments and hospitalizations
- Increase appropriate use of medical home
- Increase access to a medical home
- Improve medical home quality
- Provide supportive services and parent education
- Advocate for system-level improvements in the delivery of health care to children

Triple Aim

- Consumer
- Provider
- System

CHAP Triple Aim[7]

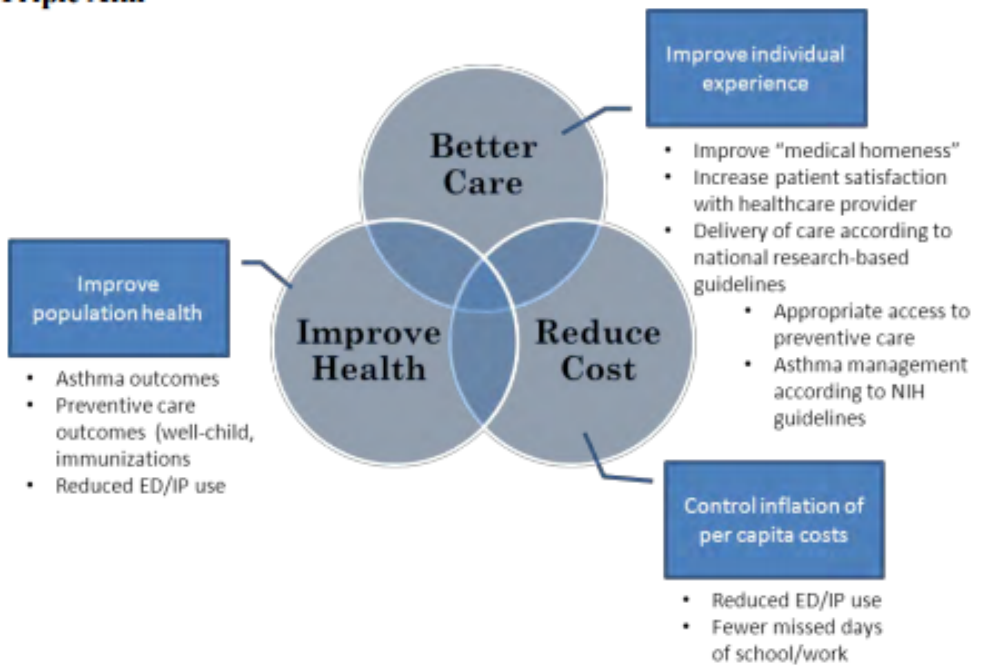

Figure 1

[6] (http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx)

[7] Adapted from http://www.philblock.info/hitkb/_images/the_triple_aim.jpg

I-CHAP Team

- Managed by Hub Manager
- PT I-CHAP Program Manager
- 3 PT Hub Intake Workers
- 1 FT Community Health Worker
- 1 PT MSW
- 1 PT RN (Clinical Case Manager)

I-CHAP Client Eligibility Criteria

- Children age 0-17
- On Medicaid
- Patient of one of the I-CHAP Participating Providers offices

I-CHAP Referral Methods

- Practices may use fax, email, phone, Great Lakes Health Connect, or online intake form
- Patients may self refer
- Stratified lists may be sent from provider for CHAP to identify:
  - High Emergency Room Use
  - Asthma
  - Patients that are overdue for well-child visits or immunizations
  - Community agencies, School Nurses, Public Health Programs, etc.
- https://form.jotform.com/51186082593156

Reasons for Referrals

- Transportation needs (same day or next day to PCP)
- Referral to Community resources
- High no-show
- At-risk for dismissal for practice
- High ED use
- Asthma
- Overdue for well-child check or immunizations
- New Patient to Medical Home
- Coordination and follow through of Behavioral Health System referrals

Questions?

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