Michigan Children's Health Access Program

Final Evaluation Report

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PSC

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Table of Contents

Introduction

In February 2015, the Michigan Association of United Ways (MAUW) received a grant from the Michigan Health Endowment Fund (Health Fund) to implement the Michigan Children's Health Access Program (MI-CHAP). The MI-CHAP initiative intended to build on the successes of the CHAP in Kent County, which demonstrated improvements in health outcomes for children on Medicaid, as well as the Michigan 2-1-1 system (also referred to as "2-1-1"), which provides families with quick and easy access to information about health and human services in their community.

MAUW established the following four goals for the project:

1. Improve the health of Medicaid-enrolled children in MI-CHAP
2. Improve the quality of and access to medical homes in MI-CHAP communities
3. Lower the total cost of care by reducing emergency department (ED) visits and inpatient hospital admissions among children on Medicaid
4. Innovate efficiencies and scalability by delivering components of the CHAP model statewide through a new virtual strategy

MAUW used the Health Fund grant to support CHAPs in eight communities across the state and to develop a system within Michigan 2-1-1 for identifying callers who are eligible for CHAP services and connecting them directly to a local CHAP site or with a virtual CHAP (V-CHAP) specialist.

Local CHAP Sites

Local CHAP sites form relationships with primary care providers and work directly with families on Medicaid to help strengthen their connections with primary care and other healthcare providers. CHAPs use a local multidisciplinary team to provide education, care coordination, community resource referral, transportation, and other services to address the social determinants of health (nonmedical factors that influence a person's health and well-being, such as access to transportation, healthy food, and adequate housing) and barriers to medical access for children on Medicaid. This may include connecting their clients to a patient-centered medical home if they do not already have a primary care provider. Additionally, some CHAPs offer their own health programs, such as asthma education, Commit to Fit! nutrition initiatives, or FitKids360, which combines health and nutrition education with physical activity to help participants develop healthy lifestyles.

In the first year of the initiative, MAUW funding supported the expansion of existing CHAPs in two communities, the implementation of new CHAPs in three communities, and planning for implementation in three communities. During the second year, CHAPs in the planning communities began providing services. MI-CHAP sites in the following counties and regions (often referred to as local CHAPs) received MAUW funding:

- Genesee County
- Ingham County
- Kalamazoo County
- Kent County (existing CHAP)
- Macomb County
- Northwest Michigan (Antrim, Emmet, Charlevoix, and Otsego Counties)
- Saginaw County
- Wayne County (existing CHAP)

Virtual CHAP and Michigan 2-1-1

V-CHAP specialists—a new Michigan 2-1-1 component created as part of the MI-CHAP initiative—help connect callers to primary care providers and provide education and referrals to community resources. MAUW trained approximately 85 2-1-1 agents to serve as V-CHAP specialists who could deliver information and education on health plan services, medical transportation options, appropriate use of primary care services, immunizations, and other items. Michigan 2-1-1 agents screened callers for CHAP service eligibility and referred eligible callers to V-CHAP specialists as appropriate. MAUW also provided funding to the Upper Peninsula Commission for Area Progress to implement an enhanced V-CHAP site, called UP-CHAP, that provided a blend of traditional CHAP and V-CHAP services. UP-CHAP services have since been absorbed into the broader V-CHAP system.

Program Evaluation

MAUW contracted with Public Sector Consultants (PSC) to conduct an evaluation of the MI-CHAP initiative. Using a participatory evaluation approach, PSC worked with MI-CHAP's leadership team—composed of representatives from MAUW, Health Net of West Michigan, and Michigan 2-1-1—to develop and finalize an evaluation framework (shown in the appendix) that connects the initiative's goals and objectives with evaluation questions, data sources, and measures.

For the first-year evaluation report, PSC reviewed and analyzed information from documentation provided by the MI-CHAP initiative, interviews with CHAP program directors, and a survey of the MI-CHAP leadership team. PSC's analysis showed that the initiative's early developmental activities were beginning to produce results, including developing partnerships with community organizations, establishing agreements with primary care providers, and increasing the number of clients served. The analysis also identified challenges that surfaced as sites across the state worked individually and collectively to establish a system of services and supports for Medicaid-eligible children and their families. These included delays in hiring staff, difficulty establishing referral agreements with primary care practices, and challenges identifying the appropriate staffing levels for client needs that vary in intensity.

For the second-year evaluation report, PSC conducted interviews, surveys, and focus groups with a variety of program stakeholders to learn how they perceived MI-CHAP's value and utility, as well as to identify successes and challenges in program implementation. PSC's analysis found qualitative evidence of improved health and access to care for children receiving CHAP services, improved use of healthcare services, and development of clinical-community linkages between local CHAPs and primary care providers. In the program's second year, the statewide virtual CHAP 2-1-1 system became fully operational as well. The primary challenge identified in the second year was the lack of a sustainable funding model for local CHAP services, especially because they are not available statewide.

This final evaluation report provides an update on the MI-CHAP initiative, including data on the children served by local CHAPs and the families reached through the V-CHAP model, as well as a cost-benefit analysis of ED visit and inpatient hospitalization reductions.

MI-CHAP Services, Reach, and Impact Through 2017

MI-CHAP services include those delivered by local CHAPs and the 2-1-1 V-CHAP system. An overview of each of these service delivery modalities is provided below, along with data demonstrating their reach and impact.

Local CHAP

Core Services

Local CHAP sites perform two core service delivery functions designed to increase access to needed care and resources and improve health outcomes:

1. They work with families enrolled in Medicaid to establish and strengthen connections with healthcare and community service providers.
2. They work directly with primary care providers to establish referral processes and identify ways to improve the practice's ability to meet patient needs.

Family Services

Once connected with a child's family, MI-CHAP teams work with the family and medical home to coordinate services and improve the consistency and quality of care a child receives. Services include:

- Providing assistance with scheduling medical and other appointments
- Connecting clients to transportation resources, including coordination with Medicaid health plans and third-party providers
- Making referrals to community resources to address needs related to the social determinants of health
- Assisting the child or family with service enrollment
- Navigating the health and social service system (e.g., education and housing systems)
- Providing translation services for children and/or families whose first language is not English or providing interpretive services for children and/or family members who are deaf or hard of hearing
- Educating parents and caregivers on the appropriate use of the ED and the importance of their child attending well-child visits, receiving immunizations, and having a medical home

Provider Services

MI-CHAP sites establish agreements with primary care practices that will refer patients for CHAP services and work with these practices to address barriers to meeting patients' needs. Service coordination and patient engagement strategies are defined and documented in memoranda of understanding and business associate agreements between CHAP sites and medical providers. CHAPs then work to support linkages between clinical and community service providers. All patient service coordination and patient engagement data are logged and shared with the medical provider, so loops are closed following a patient referral.

In addition to engaging primary care practices to refer patients for CHAP services, CHAPs also work to promote the adoption of elements of the patient-centered medical home model among practices with which they form agreements.

Staffing Model and Priority Population

MI-CHAP teams are led by experienced project managers and comprise trained social workers, community health workers, and/or nurses. Each CHAP also has a medical director who assists with the engagement of primary care practices and the development of these practices' quality improvement projects. MAUW funding covered service provision for Medicaid-eligible children and their family members. However, depending on community needs and availability of additional funding, CHAPs may also serve other Medicaid-eligible or uninsured adults, as well as those who are commercially insured.

MI-CHAP Model Fidelity

The MI-CHAP model is characterized by a set of core elements and activities, as delineated in the MI-CHAP Model Fidelity Tool (see appendix). MAUW conducted site visits with each local CHAP in July 2017 and found that all of them were delivering the model with fidelity. The core MI-CHAP elements and activities are:

- Leadership by a strong pediatric provider at the local level (medical director)
- Staffing by a multidisciplinary team that may include social workers, community health workers, or nurses, among others
- Establishment of an advisory committee comprising key community stakeholders, including health plans, health systems, providers, and community agencies
- Robust practice engagement strategies and active participation of pediatric and family practice medical home providers that serve Medicaid-eligible children
- Relationships with health plans operating in the geographic area
- Use of a data system to drive decision making
- Provision of navigation and care coordination services (e.g., parent education, coordination of transportation, translation and interpretation services, community service referral, and assistance with healthcare navigation)
- Commitment to cultural competency and health equity to promote inclusive service delivery
- Development of special projects to address issues identified in community needs assessments

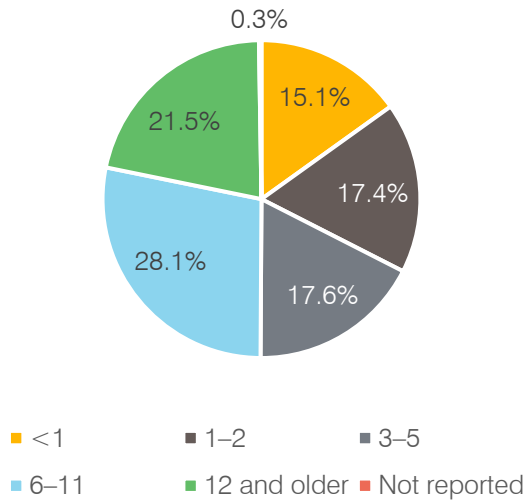
Reach of Local CHAP Services

Delivery of CHAP services funded through the Health Fund grant began in July 2015 at two sites. As they became more fully established, other sites began delivering services in late 2015 and early 2016. Between July 2015 and December 2017, the CHAPs delivered services to at least 7,901 children and their families.[1]

Just over half of the children served were five years old or younger; the remainder were split fairly evenly between ages six to 11 and 12 years and older. Nearly equal percentages were male and female. Race and ethnicity were not reported for a large percentage of the children. Of those for whom race and ethnicity are known, the largest percentage are African American. A demographic breakdown of the children served is provided in Exhibits 1–4 below.

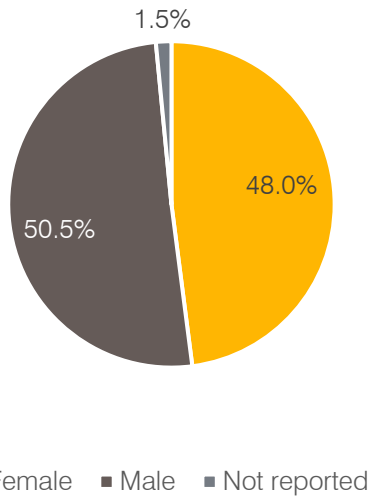
[1] Children with no available Medicaid ID were not included in this analysis.

EXHIBIT 1. Percentage of Children Receiving CHAP Services, by Age



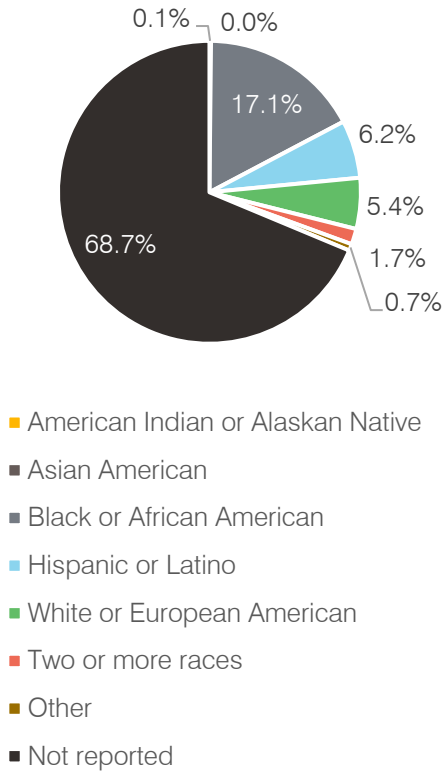
Note: N = 7,901

EXHIBIT 2. Percentage of Children Receiving CHAP Services, by Gender



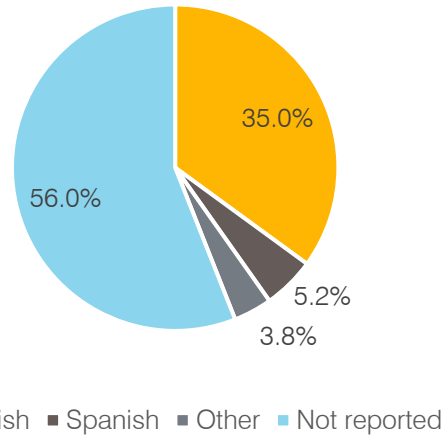
Note: N = 7,901

EXHIBIT 3. Percentage of Children Receiving CHAP Services, by Race and Ethnicity



Note: Total does not equal 100 percent due to rounding.
N = 7,901

EXHIBIT 4. Percentage of Children Receiving CHAP Services, by Primary Language Spoken at Home



Note: N = 7,901

ED Visits and Inpatient Hospitalizations

As part of its goal to reduce healthcare costs, the MI-CHAP initiative focused on helping families understand when it is appropriate to use the ED for care and when a primary care or urgent care provider may be more appropriate. They also worked with families to help them effectively manage their children's chronic conditions, so they would not experience acute symptoms that require emergency care or inpatient hospitalizations.

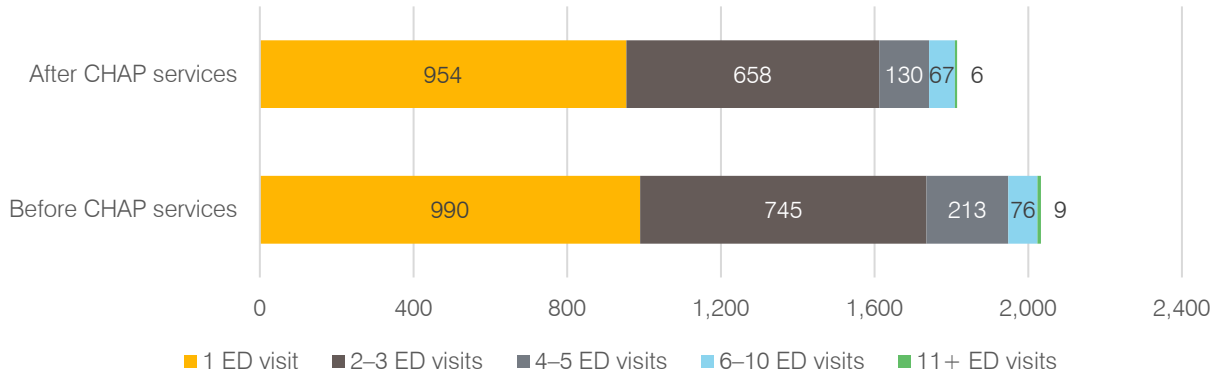
An analysis of Medicaid encounter data—obtained through a data use agreement with the Michigan Department of Health and Human Services—assessed changes in the number of ED visits and inpatient hospitalizations per client as well as in the overall rate of these types of healthcare events. To be included in the analysis, children had to be at least one year old when they received their first tangible CHAP service and have six months of Medicaid program eligibility in the 12 months before and after their first tangible service. The analysis is based on claims for the 3,987 children who met these criteria. The time frame for all of the claims included in the analysis is from April 1, 2014, through December 31, 2017. Two years of claims are included for each child—the year before and after their first tangible CHAP service.

Exhibits 5 and 6 show the decrease in the number ED visits and inpatient hospitalizations per CHAP client aged one to 17 served by all CHAP sites between April 1, 2015, and December 31, 2016.[2] Exhibits 7 and 8 provide rates of ED visits and acute inpatient hospitalizations among these same children.

Reductions in ED Visits and Inpatient Hospitalizations Per CHAP Client

In the year before their first tangible CHAP service, 2,033 children (51 percent) had at least one ED visit, with nearly 300 (8 percent) having four or more. In the year after their first tangible CHAP service, 1,815 children (46 percent) had any ED visits at all—a decrease of 218 children—and only 203 (5 percent) had four or more visits (Exhibit 5).

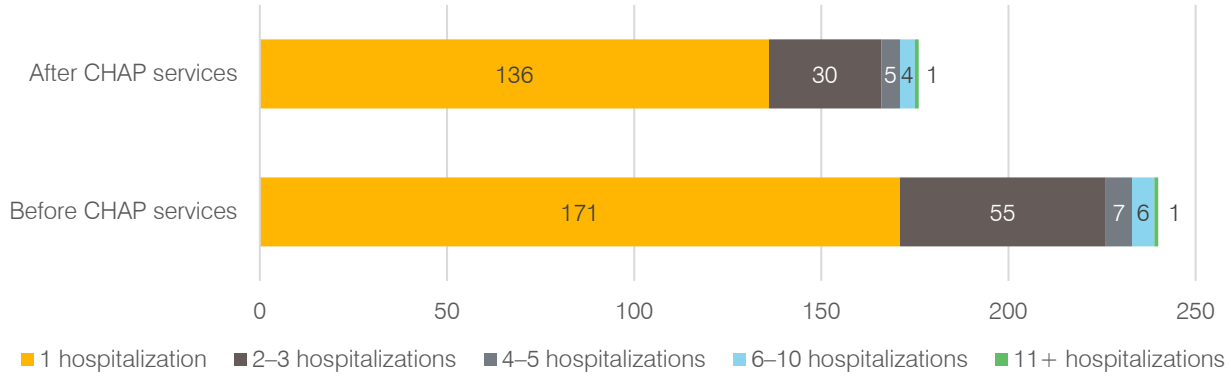
EXHIBIT 5. Number of CHAP Clients Aged One to 17 With One or More ED Visit in the 12 Months Before and After Receiving CHAP Services



[2] Children under one are excluded from the analysis because their births in the year prior to receiving CHAP services skew their pre-CHAP inpatient hospitalization rate.

In the year before their first tangible CHAP service, 240 children (6 percent) had at least one inpatient hospitalization, with nearly 70 having more than one. In the year after their first tangible CHAP service, 176 children (4 percent) had any ED visits at all, and only 40 had more than one (Exhibit 6).

EXHIBIT 6. Number of CHAP Clients Aged One to 17 with One or More Inpatient Hospitalization 12 Months Before and After Receiving CHAP Services



Reductions in ED Visit and Inpatient Hospitalization Rates Among CHAP Clients

The rates in Exhibits 7 and 8 are per 1,000 member months, meaning the number of events (ED visits or inpatient hospitalizations) in a given age group is divided by the total number of months of Medicaid eligibility for children in that age group in the year the events occurred and then multiplied by 1,000.

EXHIBIT 7. Rate of ED Visits 12 Months Before and After Receiving CHAP Services, by Age Group

Age Group (n)	Before CHAP Services *Rate (n)*	After CHAP Services *Rate (n)*	Change *Rate (n)*
1–2 (738)	155.8 (1,325)	110.4 (928)	–45.4 (–397)
3–5 (864)	93.9 (935)	74.9 (750)	–19.0 (–185)
6–11 (1,376)	72.7 (1,168)	63.2 (1,013)	–9.5 (–155)
12 and older (1,009)	75.3 (886)	75.8 (890)	+0.5 (+4)
All children ages 1–17 (3,987)	93.2 (4,314)	77.6 (3,581)	–15.6 (–733)

EXHIBIT 8. Acute Inpatient Hospitalization Rate 12 Months Before and After Receiving CHAP Services, by Age Group

Age Group (n)	Before CHAP Services *Rate (n)*	After CHAP Services *Rate (n)*	Change *Rate (n)*
1–2 (738)	11.9 (101)	6.1 (51)	–5.8 (–50)
3–5 (864)	6.9 (69)	3.9 (39)	–3.0 (–30)
6–11 (1,376)	5.2 (84)	4.0 (64)	–1.2 (–20)
12 and older (1,009)	14.5 (171)	9.5 (111)	–5.0 (–60)
All children ages 1–17 (3,987)	9.2 (425)	5.7 (265)	–3.5 (–160)

Estimated Cost Savings

This analysis uses an estimated range of costs for ED visits and inpatient hospitalizations based on data from the 2016 Medical Expenditure Panel Survey (MEPS) and actual amounts paid for these services by Medicaid for the children included in the analysis. The cost per ED visit is between $393 and $715, and the cost per inpatient hospitalization is between $17,440 and $21,627.[3] Based on the documented reduction in ED visits and inpatient hospitalizations experienced by CHAP clients, a conservative estimate of the program's financial impact can be calculated. The savings estimates for ED visit reductions range from $288,069 to $529,095. Similarly, savings estimates for inpatient hospitalization reductions range from $2.5 to $3.1 million. ED visits occur more frequently than inpatient hospitalizations, but have a substantially lower cost per event. Savings from ED visit reductions account for approximately 10 to 20 percent of the total savings, while reductions in inpatient hospitalizations account for 80 to 90 percent of the savings.

The cost of running a CHAP will vary based on the staffing model and the number of children served, but the operational costs for the Kent and Genesee County CHAPs are very similar and serve as a useful estimate because they are both fairly well-established programs. Kent CHAP estimates its average expenditure per child served to be $372, while the Genesee CHAP estimates this figure to be $367 in 2018. An average expenditure of approximately $370 per child is equivalent to $354 in 2016 dollars. This results in a benefit-cost ratio of 2.2 to 2.8, suggesting the program generates $2.20–$2.80 in cost savings per $1.00 spent delivering services (Exhibit 9).

EXHIBIT 9. Cost-benefit Ratio of Delivering CHAP Services

Event Type	Reduction in Events	Average Cost Per Event	Total Savings	Savings Per Child Served	Medicaid Benefit-cost Ratio
ED visit	733	$393–$715	$288,069–$529,095	$72–$132	2.2–2.8
Inpatient hospitalization	160	$17,440–$21,627	$2.5–$3.1 million	$700–$868	

This benefit-cost ratio is limited to the immediate savings that would accrue primarily to the state's Medicaid program from reductions in ED visits and inpatient hospitalizations. CHAP services represent an early investment in the health and well-being of Michigan's most vulnerable children. Longer-term savings are likely to occur due to improved access to care as well as more effective and regular care. The estimates also do not include the financial savings to families who may have lower out-of-pocket healthcare expenses and fewer missed workdays.

[3] The MEPS estimated the average expenditure per ED visit for children under age 18 to be $715 in 2016. The average amount paid by Medicaid in Michigan for ED visits experienced by the children receiving MI-CHAP services is $393. The MEPS estimated the average expenditure per inpatient stay for children under age 18 to be $17,440 in 2016. The average amount paid by Medicaid in Michigan for inpatient hospitalizations experienced by children receiving MI-CHAP services is $21,627.

Virtual CHAP

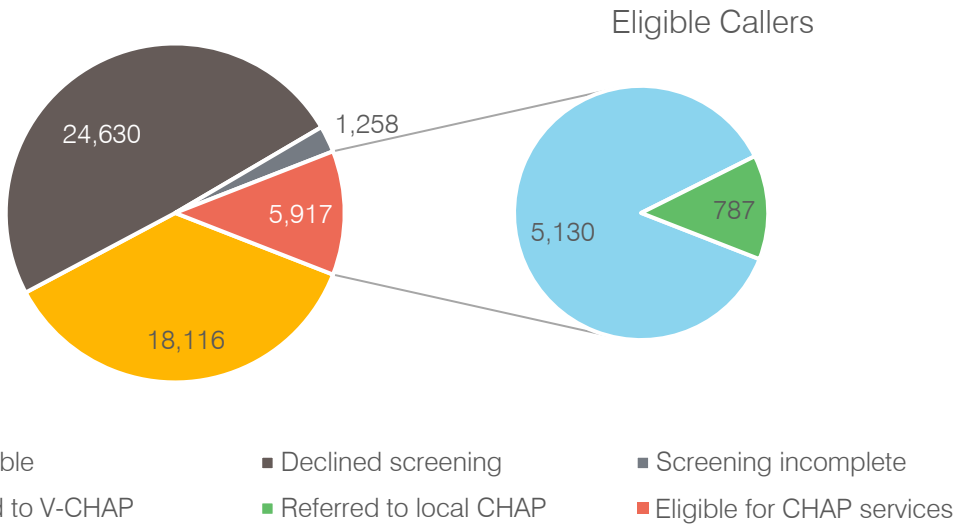
Core Services and Delivery Model

V-CHAP services are delivered over the phone to 2-1-1 callers who are eligible for CHAP services, but do not have access to a local CHAP. When people contact 2-1-1, call center agents offer a CHAP eligibility screening. If callers agree, the agent asks them a series of questions, including whether they have any children under age 18 living in their household, whether they are the legal guardian of those children, the type of healthcare coverage the children have, where they normally go for their children's healthcare, and whether they have seen their child's primary care provider in the past year. Callers are deemed eligible for CHAP services if their child is covered by Medicaid and either has a normal source of care that is not a primary care provider or if they have not seen their child's primary care provider in the past year. When a caller is eligible, the 2-1-1 call center agent asks additional questions to identify the caller's specific needs and transfers them to a trained V-CHAP specialist. The specialist then provides information and education to support the caller in obtaining healthcare for their children.

Reach of V-CHAP Services

V-CHAP services are available statewide. Between August 2016 and December 2017, 24,033 people were successfully screened for eligibility; another 25,888 either declined screening (24,630) or had an incomplete screening (1,258). Of those successfully screened, 5,917 were found eligible and referred to either a V-CHAP specialist (5,130) or to a local CHAP (787) (Exhibit 10).

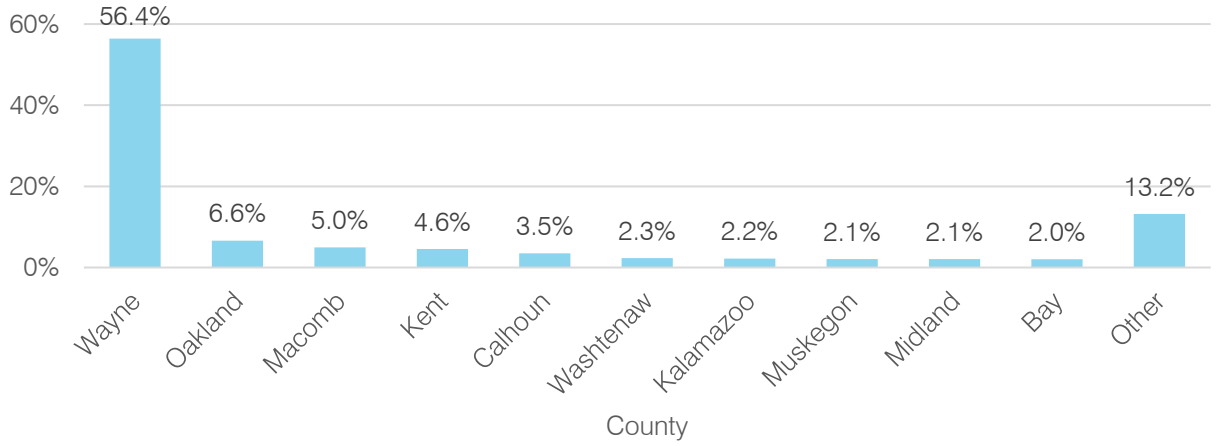
EXHIBIT 10. Status of Callers Offered Screening for CHAP Service Eligibility



Note: N = 49,921 callers for whom a screening for CHAP eligibility was attempted.

Eligible callers live in 70 of the state's 83 counties, with nearly 87 percent from ten counties. The vast majority live in Wayne County (Exhibit 11).[4]

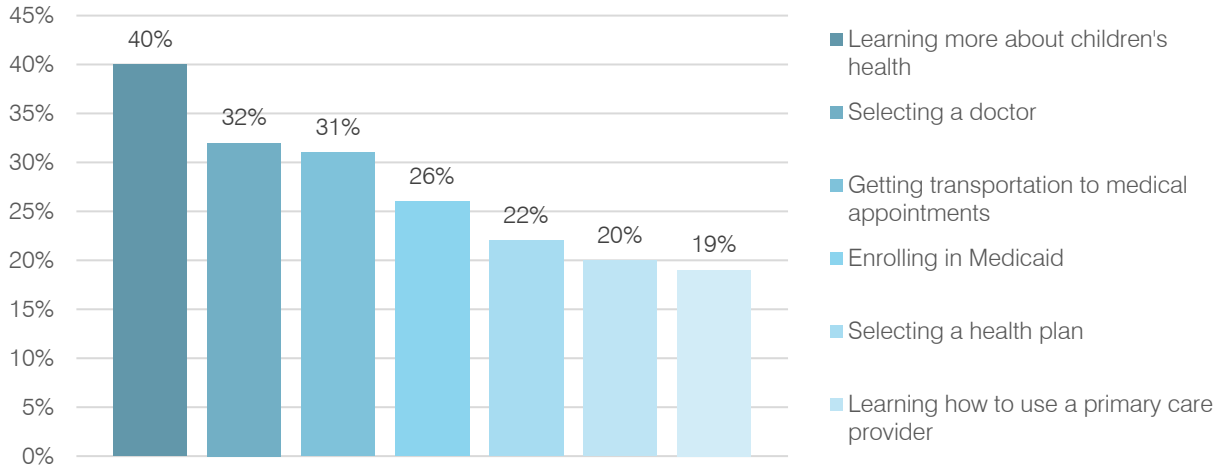
EXHIBIT 11. County of Residence of Callers Eligible for CHAP Services



Note: N = 5,917 callers eligible for CHAP services between August 1, 2016, and December 31, 2017.

The most common reasons for referral to a V-CHAP specialist were assistance with learning more about children's health, getting to medical appointments, and enrolling in or accessing Medicaid services (Exhibit 12). Once callers were connected with a specialist, nearly two-thirds received information on health plan services, with the remainder receiving information and education on a variety of other topics that support access to and appropriate use of healthcare services (Exhibit 13).

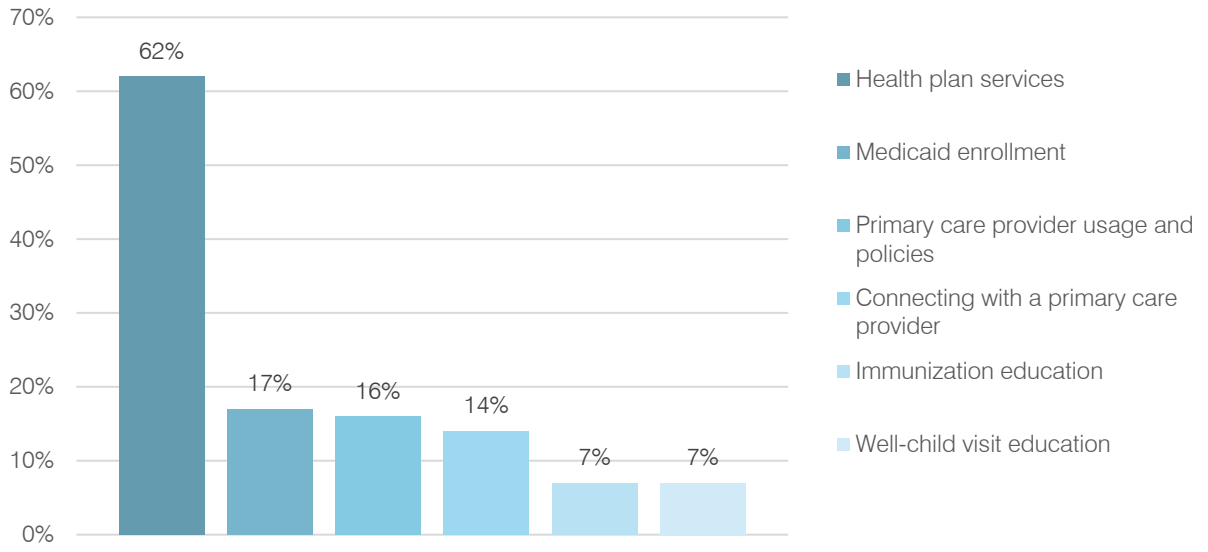
EXHIBIT 12. Reasons for Referral to a V-CHAP Specialist or Local CHAP



Note: N = 5,917 callers eligible for CHAP services between August 1, 2016, and December 31, 2017.

[4] When V-CHAP services first became available, the Wayne CHAP and the United Way for Southeastern Michigan (UWSEM), which staffs the 2-1-1 call center in Wayne County, agreed that UWSEM would triage all referrals for CHAP services and only refer clients to Wayne CHAP whose needs could not be addressed by a V-CHAP specialist.

EXHIBIT 13. Information Provided to Callers by V-CHAP Specialists



Note: N = 1,920 callers who successfully connected with a V-CHAP specialist between August 1, 2016, and December 31, 2017.

Impact and Potential for Cost Savings

V-CHAP's impact is less clear because actual connections to services following calls with V-CHAP specialists cannot be tracked, and healthcare utilization data are not available for the population served. The available data, however, help illustrate the level of need and the healthcare access issues that callers are struggling with most. The data also show the inherent difficulty in providing services by phone to a population with a variety of needs. While 5,917 people were found eligible and referred to a V-CHAP specialist, only 1,920 actually connected with the specialist and received services.

Conclusion

MI-CHAP is a community care coordination model that promotes positive health outcomes for children and their families, prioritizing those who are Medicaid eligible. MI-CHAP sites provide education, care coordination, clinical-community linkages, community resource referral, transportation, and other services to address the social determinants of health and barriers to medical care. By implementing MI-CHAP, MAUW has expanded on the success of the CHAP demonstration program established in Kent County in 2008 to support service delivery in Genesee, Ingham, Kalamazoo, Macomb, and Wayne Counties as well as Northwest Michigan. In addition, MAUW coordinated with the state's 2-1-1 system to bring similar services to families outside of these regions through the V-CHAP model.

Through local CHAP services and the V-CHAP model, families are provided the connections and knowledge they need to use healthcare services appropriately and address needs related to the social determinants of health. Families who participated in focus groups about their experiences with CHAP services described specific health benefits they observed in their children, including better-controlled asthma and healthier lifestyles. Beyond these benefits, MI-CHAP has also improved access to care for

children by expanding an evidence-based model that connects children to a medical home and provides case management to address access issues for families. Parents and caregivers of children who have received CHAP services described fewer missed appointments, increased comfort with healthcare providers, and improved use of healthcare services.

Beyond the direct support they provide to families, local CHAPs serve as partners to healthcare providers, helping to connect their patients to social services and decrease no-show rates (i.e., increasing the likelihood that appointments are made and kept). At the system level, CHAPs promote stronger connections between primary care providers and community-based organizations and also work with healthcare insurers to address member needs.

Because of its statewide scope, the V-CHAP service delivery model is capable of reaching more people than local CHAPs; however, it offers more limited services. The types of information and education provided by V-CHAP specialists and the reach of services demonstrate a widespread need for programs that can help people navigate the healthcare and social services systems. Individuals across the state contact Michigan 2-1-1 for a wide variety of needs. When trained 2-1-1 agents identified people who are eligible for CHAP services and asked about the caller's healthcare needs, they found that a substantial proportion needed assistance with understanding their children's healthcare needs, accessing transportation to medical appointments, and connecting with a primary care provider. V-CHAP specialists offer actionable information to callers that empowers them to access healthcare and use these services appropriately, which has the potential to positively impact healthcare outcomes and costs.

The CHAP model has emerged as a promising practice with demonstrably positive outcomes for children in Michigan. Across nearly 4,000 children ages one through 17 receiving services at seven different CHAP sites, ED visits dropped by 17 percent and inpatient hospitalizations decreased 37 percent in the year following enrollment. A conservative estimate of the model's financial benefits suggests savings of at least $2.80 for every $1.00 spent providing local CHAP services. By using this model to connect children and families to a medical home and address needs related to the social determinants of health, the program appears to have reduced inappropriate healthcare utilization. When longer-term event horizons are considered, the program has the potential to demonstrate lasting financial and social value.

Without a sustainable funding model, however, some of the CHAP sites originally funded by MAUW have had to close their doors.[5] Those that remain (Genesee, Kent, Wayne, and Northern Michigan) had strong foundations in place for delivering and financing the services prior to receiving funding from MAUW and/or have received funding from other sources to support ongoing operations. Identifying a long-term funding solution, including Medicaid reimbursement for CHAP services, will be critical for expanding service reach to increase cost savings for the state and, most importantly, to ensure that children on Medicaid and their families have access to the supports and services they need to be healthy.

[5] The Wayne County CHAP expanded its service delivery region to include Macomb County in April 2019 when the Macomb County CHAP ceased operations. The Saginaw County CHAP ceased operations in June 2018, and the Ingham and Kalamazoo County CHAPs ceased operations in December 2018.

Appendix: MI-CHAP Model Fidelity Tool

MI-CHAP Model Fidelity Tool

Purpose: to ensure fidelity to the key elements of Health Net of West Michigan Children's Health Access Program (CHAP) model is maintained and enhanced in the replication process within MI-CHAP. This tool will be used by the MI-CHAP Program Director to evaluate each local CHAP's adherence to the model. The total scores will be tabulated with the goal of reaching a total of 102. Scores under 70 will have specific action steps associated with them as outlined at the end of the tool. MI-CHAP Program Director will provide a yearly site visit to review the documentation items listed and ensure compliance.

Fidelity Item	Source of Truth	Scale
CHAP CORE ELEMENTS: Elements that must exist in order for a local CHAP to be certified.		
Structure		
1. CHAP requires strong pediatric provider leadership at the local level, with the ability to commit the time necessary as well as the passion to influence key champions within partner health systems with the authority to implement CHAP.	• Medical Director Position Description • Documentation of leadership activities (e.g., copies of correspondence, meeting records)	**10** = Medical director in place demonstrating strong pediatric leadership (e.g., outreach to pediatric practices; presentations to provider groups, health systems, and health plans; participation in community health improvement activities). **5** =Medical director position description exists and recruitment efforts are underway. **0** = Discussions within CHAP about need for medical director have begun.
2. A CHAP team must be led by an experienced project manager with knowledge of program development and	• Local CHAP Staff Resumes/Applications	**10**= **All** staff have received the certification/licensing for their position (CHWs, BSWs, etc.) and Program Director has extensive experience in health care, public health, and/or

the healthcare system. The staffing model should include a multidisciplinary team (e.g. RNs, licensed BSWs/MSWs, CHWs).	• Evidence of training/certification within each position	management and development of health-related programming. **5**= the **majority (greater than 50%)** of staff have received the certification for their position (CHWs, BSWs, etc.); Program Director has extensive experience in health care; and a plan is in place to obtain certification/licensing for remaining staff. **0**= **less than 50%** of staff have received the certification for their position (CHWs, BSWs, etc.) and Program Director has extensive experience in health care.
3. A local CHAP must convene an advisory committee comprising key stakeholders in the community, including multiple health plans, health systems, providers, and community agencies.	• Program documents such as meeting minutes and attendance records	**10** = CHAP actively (at least quarterly) convenes an advisory committee with broad community representation (i.e., including health plans, health systems, providers, and community agencies). **5** =CHAP has convened an advisory committee and recruitment of additional stakeholders is underway to increase the representation of key stakeholders (see above). **0** = CHAP has not convened an advisory committee.
4. CHAP requires the active participation of pediatric medical home providers that accept Medicaid-eligible children.	• Documentation of BAAs and/or MOUs with pediatric medical homes • Documentation of percentage of	**10**= 75% or more of the children served by CHAP are members of CHAP participating pediatric medical homes*. **5** = 50-74% of children served by CHAP are members of CHAP participating pediatric medical homes*. **0** = less than 50% of children served by CHAP are from CHAP participating pediatric medical homes*.

	children associated with CHAP participating pediatric medical homes* for the previous 3 months	(* CHAP participating pediatric medical homes are those practices who have signed a BAA and/or MOU with CHAP.)
5. Local CHAPS must have relationships with health plans operating in their geographic area.	• Documentation of relationship with health plans	**10**= BAAs or contracts are in place with one or more health plans serving the CHAP geographic area, and CHAP demonstrates one or more example of health plans engagement in coordination of services or referrals. **5** = BAAs or contracts are in place with one or more health plans serving the CHAP geographic area. **0** = CHAP does not have a relationship with health plans operating in their geographic area.
6. Local CHAPs must have a data system for use in data-driven decision-making.	• Local CHAP reports/dashboards • Local CHAP meeting minutes (showing discussions of data)	**10**= Within the last 3 months, CHAP demonstrates examples of use of data to support decision-making/sharing (use of reports, meeting discussions, etc.). **5** = CHAP has developed/implemented a data system and is in the process of developing policies/procedures for its use in decision-making/sharing. **0** = CHAP does not have a data system in place to support decision-making.
Family Level		
7. Local CHAP is required to provide navigation and care coordination services delivered by a well-trained,	• Local CHAP documents ○ Referral form	**10**=**All 7 services** listed (a-g) are being provided to clients and evidence was provided OR evidence was provided that services are being offered, but not needed.

multidisciplinary, and culturally competent team. Required services include: a. parent education regarding appropriate ED use b. parent education regarding the importance of well child visits and immunizations c. parent education regarding the need for every child to have a medical home d. coordination/provision of same day transportation e. interpretation for those parents who do not speak English f. referral to community resources g. assistance with navigation of the health care system.	○ Data from CRM (or similar data system) ○ Class schedules ○ Transportation/ interpretation activity reports	**5= 5-6 services** listed (a-g) are being provided or offered to clients, and there is a plan in place to offer the remaining services. **0=less than 5 of the 7 services** are being provided or offered.
Provider Level		
8. Each Local CHAP must have a robust practice engagement strategy as evidenced by: active provider participation in meetings/events/communication with	• Local CHAP documents showing practice engagement strategy	**10** = 4 or more examples demonstrating strong practice engagement strategy (e.g., Practice Engagement Plan, attendance of pediatric providers at 70% or more of meetings (within the last 6 months), examples of CHAP technical assistance to providers for quality improvement

CHAP; willingness to work on quality improvement projects within the practices; and referral of children to CHAP. Also, CHAP must encourage practice participation in the MI-CHAP Evaluation.	• Documentation of practice engagement meetings/events with medical homes	projects (if appropriate), evidence of joint projects to improve services, opportunities to learn and share best practices with other practices, etc.). **5** =2-3 examples of practice engagement (examples above). **0** = no evidence of practice engagement (examples above).
System Level		
9. Local CHAPs must be willing to work toward a population and prevention-based approach to care for their patients, following the elements of a family-centered medical home (that of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective) along with being a catalyst for change within the health care system.	• Program documents such as communications with practices, meeting minutes, program policies, etc.	**10** = 3 or more examples demonstrating strong promotion of the family-centered medical home model (policies that increase access, service provision that is seamless between provider and CHAP, assistance to the medical home with culturally effective policies, etc.) or that displays health system changes (serving as a neutral convener, participating in SIM/CHIR, etc.). **5** =1-2 examples of family-centered medical home promotion (examples above) and/or health system change and plans in place to increase promotion activities. **0** = No examples of family-centered medical home or health system change promotion (examples above).
CHAP SUPPLEMENTAL ELEMENTS: Optional elements that are strongly encouraged, but do not dictate whether a CHAP can be certified.		
1. Local CHAPs commit to active participation in the statewide MI-CHAP Collaborative, including presence at the MI-	• MI-CHAP meeting attendance records	**3**=Program Director, or designee, attends/participates 75% or more of Program Director Meetings, participates in special projects, and actively collaborates with MI-CHAP

CHAP Medical Director and Program Director meetings.		(communication with MI-CHAP Staff, participation on committees/workgroups, etc.). **2**= Program Director, or designee, attends 50-74% of activities listed above. **0**=Program Director, or designee, attends less than 49% of activities listed above.
2. MI- CHAP requires data/information about the patient population that is accurate/robust/valid and drives system changes. Local CHAPs report data to MI-CHAP and commit to shared outcomes as defined through their specific sub-recipient agreements.	• Submittal of data reports to MI-CHAP	**3** = CHAP submits reports in the requested format by the due date. **2** = CHAP submits reports in the requested format with only occasional, minor delays. **0** = CHAP does not submit required reports in the requested format by the due date.
3. Local CHAP staff demonstrate commitment to cultural competency and/or health equity in order to ensure they are delivering inclusive, diverse and appropriate CHAP services to all populations.	• Local CHAP training records	**3**= **All** staff participate in cultural competency/health equity training, activities, or professional development every 6 months. **2**= the **majority (greater than 50%)** of staff participate in cultural competency/health equity training, activities, or professional development at least yearly. **0**= **less than 50%** of staff participate in cultural competency/health equity training, activities, or professional development competency training at least yearly.
4. Each local CHAP may develop "special projects" identified by needs assessment specific to their community, such as the	• Needs Assessment Documentation	**3**=Special Project programming has been implemented according to a local needs assessment and evidence-based programs have been chosen.

provision of home-based asthma education and case management; behavioral health navigation; and childhood obesity programs. Local CHAPs may utilize existing MI-CHAP outcome-based special project models if appropriate, or utilize programming that is specific to their area; if a local CHAP develops a new project, it should be shared within the MI-CHAP collaborative.	(report, meeting minutes, etc.) • Local CHAP Program Curriculum	**2**=Special Project has been implemented, there is no evidence of need, but curriculum is evidence-based. **0**= Special Project has been implemented, there is no evidence of need and no evidence that the curriculum is outcomes driven.

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