Making Connections: The Critical Role of Family-Centered Care in Addressing Social Determinants of Health for CYSHCN

Webinar 2

A webinar series brought to you by the National Resource Center for Patient/Family-Centered Medical Home, Bright Futures National Center, and the STAR Center

Tuesday, June 23, 2020
10 – 11am Central

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MODERATOR

Marcus Allen, MPH
CYSHCN Program Director,
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ABOUT THE PARTNERS

• National Resource Center for Patient/Family-Centered Medical Home
• Bright Futures National Center
• Screening Technical Assistance & Resource (STAR) Center
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• We do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
LEARNING OBJECTIVES

• Describe data trends related to the impacts of SDOH on CYSHCN.
• Increase understanding of the medical home model in addressing SDOH for CYSHCN at the state, community, and clinical levels.
• Identify strategies being implemented by state MCH Title V / CYSHCN programs, families, and primary care pediatricians to address SDOH for CYSHCN by using components of the medical home model.
SOCIAL DETERMINANTS OF HEALTH RESOURCES

• Identification and Screening of Social Determinants of Health among Children with Special Health Care Needs in Medicaid Factsheet
• Integrating Social Determinants of Health Into Health Supervision Visits Implementation Tip Sheet
• Promoting Lifelong Health for Families and Communities
• Bright Futures Tool & Resource Kit, 2nd Edition
• Social Determinants of Health Information and Resources
  o Conversation Simulations for SDOH Counseling
Jeffrey Brosco, MD, PhD, FAAP
Director, Title V, Children with Special Health Care Needs, FL Department of Health
Professor of Clinical Pediatrics, University of Miami Miller School of Medicine
• CYSHCN are doubly vulnerable to social determinants of health
  o Improve health care of CYSHCN (access and quality)
  o Address environmental and other social determinants

• Florida’s Approach
  o Title V CYSHCN is part of Children’s Medical Services (CMS)

• CMS Title V CYSHCN addresses health equity (SDOH)
  o Partner to operate CMS Health Plan with WellCare
    ▪ Enhanced benefits/care coordination (*Community Connections Health Line*)
  o Quality of Life measures
  o Geo-mapping Patient Centered Medical Homes (PCMH)
**Florida’s Children**

- 4.1 million children – vast majority are healthy
  - Obesity, poverty, neighborhoods, schools

- **800,000 children and youth with special health care needs (CYSHCN)**
  - ADHD, anxiety, asthma, and 13,000 other conditions
  - Title V CYSHCN responsibility

- **80,000 children with medical complexity (CMC)**
  - Serious and chronic medical conditions
  - Multiple specialists/medical technology
  - Require tertiary/quaternary medical system-level care
  - 2% of children, but 33% of spending, 40% of deaths
CYSHCN are Doubly Vulnerable

SDOH affect access to health care (national data)

- 36% of families of CYSHCN were frustrated in their efforts to get services for their child compared to 13% of families of non-CYSHCN
- White children were significantly more likely to receive care within a well-functioning system than Black, Hispanic, or Asian

SDOH have greater impact because of a SHCN (national data)

- Children with asthma more likely to be affected by air pollution
- CYSHCN significantly more likely to live in households that could not always afford to eat good nutritious meals
- 33% of CYSHCN experience two or more adverse childhood events, compared to 15% of children without a special need
Role of Title V / CYSHCN Programs

1. Special role of Title V CYSHCN is to improve access and quality of health care to CMC

2. Use a “health equity” lens to address social determinants of health
Florida Children’s Medical Services (CMS)

Every child with special health care needs has access to high-quality, evidence-based, family-centered medical care, regardless of which health insurance the family has.

“Office” of CMS Managed Care Plan & Specialty Programs

- Managed care organization for children with chronic medical complexity (CMS Health Plan)
- MCH Title V
- Patient-Centered Medical Home
- Behavioral Health
- Specialty Programs/Statewide Networks
- Medical foster care; staffing for CMC

“Division” of CMS

- Early Steps (Part C)
- Newborn Screening
- Child Protection Teams
- Poison Information Centers
- Child Epidemiology
- Telehealth support
The greater the focus on the lower (foundational) levels of the pyramid, the greater impact on **increasing** Population Health Outcomes.

**Direct Services**
- Screening/Treatment
- Referrals to specialist

**Enabling Services**
- Patient-centered medical home
- Transportation
- Care coordination that includes addressing behavioral health conditions along with co-morbid physical conditions

**Population Based Services**
- Expanding access by leveraging population behavioral health expertise and utilizing emerging technologies such as tele-psychiatry

**Infrastructure-Building Services**
- Workforce Development
- Program/System Evaluation
- Resource Development and Dissemination
- Quality Improvement
- Integrated Community Development
- Outreach and Education

**Public Health Approach in Florida**
**Title V MCH Pyramid of Health Services**
**Title V System Transformation Model**

**Figure 1: U.S. Healthcare Delivery System Evolution: Health Delivery System Transformation Critical Path**

**Acute Care System 1.0**
- Episodic healthcare
- Lack of integrated care networks
- Lack of quality & cost performance transparency
- Poorly coordinated chronic care management

**Coordinated Seamless Healthcare System 2.0**
- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- Health information technology-integrated
- Focus on care management and preventive care

**Community Integrated Healthcare System 3.0**
- Healthy population-centered, population health-focused strategies
- Integrated networks linked to community resources capable of addressing psycho-social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

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Florida Title V CYSHCN Major Initiatives

Florida’s CYSHCN have access to high-quality, evidence-based, family-centered medical care, regardless of which health insurance a family has.

1. Partner to operate the CMS Health Plan with WellCare (e.g. Standards for Systems of Care for CYSHCN)

2. Transform pediatric practices into patient-centered medical homes (e.g. geo-mapping to identify areas of greatest need)

3. Build capacity of pediatric primary care providers to treat common behavioral health conditions

4. Address variation in Florida’s diverse regions through Title V Regional Teams (e.g. community-based asthma programs)

5. Improve quality and access through contracts with specialty networks that have condition-specific expertise (e.g. cancer, sickle-cell disease)
**Children’s Medical Services Health Plan**

- **“How do we ensure that CSHCN (especially CMC) have access to high-quality, family-centered, evidence-based health care?”**

- **Stakeholder input 2016-2018**
  - Public meetings, focus groups (families) and surveys
  - Request For Information from vendors
  - CMS statewide leadership (Strategic Planning calls)
  - Children’s hospitals, pediatric department chairs
  - Legislature, federal (MCHB) and state partners
  - Expert opinion (AMCHP, AAP, Title V, Family Network on Disability)
  - Other state models (Texas, Colorado, Washington)
  - *Standards for Systems of Care for CYSHCN*

- **Data** – primarily from Title V needs assessment
CHILDREN’S MEDICAL SERVICES (CMS)
HEALTH PLAN 3.0

- **CMS 1.0 (1970s to 2014)**
  - Direct services through specialty clinics
  - Care coordination to clinically eligible children (CMC) with state health insurance

- **CMS 2.0 (Aug 2014 – Jan 2019)**
  - State Department of Health (DOH)/CMS as a managed care organization
  - 67,000 CSHCN in Florida choose the CMS Health Plan

- **CMS 3.0 (Feb 2019 – today)**
  - Partnership with WellCare to implement an enhanced delivery system
  - Based on national Standards for Systems of Care for CYSHCN
  - CMS/DOH responsible for on-going administration and governance
  - 78,500 CSHCN in Florida choose the CMS Health Plan (as of June 2019)
WellCare offers **Community Connections** statewide

- Services available to health plan members and non-members
- Links those in need with community-based services through **Navigator**, a databank of >12,000 organizations and services
  - Financial assistance, housing services, transportation, food assistance, educational/vocational assistance
- Dedicated **Community Connections help line**
  - Uses a peer-support model, connects those in need with local services
- Community grants provide funding to local organizations based on need – a "safety net" to the safety net
## CMS Health Plan’s Additional Benefits to Address SDOH

<table>
<thead>
<tr>
<th>Health and Health Care</th>
<th>Education</th>
<th>Economic Stability</th>
<th>Neighborhood and Built Environment</th>
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<tbody>
<tr>
<td>• Over-the-counter medications</td>
<td>• Tutoring services</td>
<td>• Meals and healthy foods allowance</td>
<td>• Non-Medical Transportation</td>
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<td>• Swimming lessons</td>
<td>• Reading scholarships</td>
<td>• Housing assistance</td>
<td>• Adaptive devices</td>
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<td>• Nutritional counseling</td>
<td>• GED testing</td>
<td>• Financial counseling</td>
<td>• Transition from Skilled Nursing Facility to private home setting</td>
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<td>• Behavioral health services for caregivers</td>
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<td>• Pest control</td>
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<td>• Healthy-wellness coaching</td>
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<td>• HEPA filter vacuum cleaner</td>
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<td>• Planned respite</td>
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<td>• Carpet cleaning</td>
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<td>• Hypoallergenic bedding</td>
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</table>
TITLE V QUALITY TECHNICAL ADVISORY PANEL

• 2018 series of public meetings to discuss and review quality measures for CYSHCN, including CMC

• Panel membership included
  • Providers, managed care experts, Medicaid, health insurance plans, family member, youth with special health care need, Family Network on Disabilities leadership

• Final Statement
  o Health care plans (e.g. CMS Health Plan) & other Title V CYSHCN programs should include measures of
    ▪ Child quality of life
    ▪ Family quality of life
PATIENT-CENTERED MEDICAL HOME (PCMH)

- CYSHCN require health care services beyond what is typically required
- PCMHs have been shown to improve access to health care services
- Relatively few CYSHCN in Florida have access to a PCMH


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What is a Patient-Centered Medical Home?

- It is not a building or a place, **it’s a primary care practice model.**
- PCMH model focuses on the quality of care:
  - Improved outcomes are achieved by providing **whole-person care.**
- **Resources:**
  - National Resource Center for Patient/Family-Centered Medical Home
1. Project PCMH Provider Surveys (Phase One)

- Use data to develop a heat map,
  Where PCMH are
  Vulnerability index
- Identify locations where CYSHCN face greatest need for PCMH, including data on SDOH.
- Target potential pediatric practices based on heat map.

2. HealthARCH PCMH Assessments (Phase Two)

- Title V specialists complete PCMH readiness assessments on willing practices.
- Assessment data used to identify practices most ready for transformation.
- HealthARCH partner works with practices to become PCMH.
PROJECT PCMH HEALTHARCH

Cohort 1
- 12 practices
- Recruitment/Assessment: October - December 2017
- Transformation: January 2018

Cohort 2
- 13 practices
- Recruitment/Assessment: April - June 2018
- Transformation: July 2018

Cohort 3
- 24 practices
- Recruitment/Assessment: January - April 2019
- Transformation: May 2019

- UCF HealthARCH uses NCQA approach to help individual practices become patient-centered medical homes
- Practices previously chosen based on more limited criteria
HealthARCH - Snapshot

Cohorts 1-3 Program Status

- One Florida ESM is % of counties with patient-centered medical homes
- Focus on counties with highest vulnerability index
CONCLUSION

• CYSHCN are doubly vulnerable
• Role of Title V CYSHCN is to improve access and quality of health care to CYSHCN, especially CMC
• Florida uses a “health equity” lens to address SDOH
  o CMS Health Plan
    ▪ Enhanced benefits/care coordination
  o Quality of life measures
  o Geo-mapping patient-centered medical home to focus on areas of greatest need
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Pediatric Medical Consultant, Children and Youth Branch, NC Title V Agency
Pediatrician, Wake County Human Services
Adjunct Assistant Professor, University of North Carolina Gillings Global School of Public Health, Department of Maternal and Child Health
AAP STAR Center, Technical Assistance Project Advisory Committee
AAP Council on Community Pediatrics, Executive Committee
AAP Prevention and Public Health Special Interest Group, Co-Chair
HEALTH ACROSS THE NC DEPARTMENT OF HEALTH AND HUMAN SERVICES (NC DHHS)

Early Childhood Action Plan

Healthy Opportunities

Opioid Action Plan

Medicaid Transformation
NC DHHS PRIORITIES

• Ensure all North Carolinians get a **healthy start** and develop to their full potential in safe and nurturing families, schools and communities

• Turn the tide on North Carolina’s **opioid crisis**

• To improve the health of North Carolinians through an innovative, **whole-person centered, and well-coordinated system of care** that addresses both the medical and non-medical drivers of health

• **Healthy opportunities**...because the opportunity for health begins where we live, learn, work and play
These web resources provide information for families and/or caregivers of children and youth with special health care needs who have a new diagnosis and/or have concerns or questions about their child’s development.

Children and Youth with Special Health Care Needs (CYSHCN) have or are at risk for chronic physical, developmental, behavioral or emotional conditions and need health-related services beyond those generally required by children.

Resources for Families

- Diagnosis and Healthcare
- Insurance and Financial Support
- Family Support
- Education Resources
- Transition to Adulthood
- Advocacy/Legal
- Calendar of Events

COVID-19 Information and Resources

- NC Department of Health and Human Services
- American Academy of Pediatrics

For additional information, please contact the Children with Special Health Care Needs Help Line.

- 1-800-737-3028
- Email

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WCH: Children and Youth with Special Health Care Needs

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https://publichealth.nc.gov/wch/families/cyshcn.htm
CARE MANAGEMENT FOR AT RISK CHILDREN (CMARC)

- Target population is birth to five years
  - NICU graduates
  - Children who have experience toxic stress
  - Substance affected infants
  - Children in foster care
  - Other children with special health care needs
- Services offered in every county by local health departments
- CMARC has a relationship with Medicaid and the Prepaid Health Plans in managed care
CARE MANAGEMENT FOR AT RISK CHILDREN (CMARC)

• Goal is to improve the care of children by:
  o Assessment, screening and patient centered care planning
  o Linkage to a medical home
  o Coordination of care between health care providers and community services
  o Linkage and referral of children and families to needed community programs and supports
  o Parent/caregiver education related to needs/concerns
This is from the Survey of Well Being of Young Children (SWYC) which is used with all CMARC clients.

This is the section that asks about SDOH.

NORTH CAROLINA’S FOCUS AREAS

- Food Security
- Housing Stability
- Transportation
- Interpersonal Violence
- Employment
- Toxic Stress/Early Brain Development
**Multi-Faceted Approach For Promoting the Opportunity for Health**

- Standardized screening for unmet resource needs
- Hot Spot map for Social Determinants
- Statewide Resource Platform: NCCARE360
- Work Force (e.g. community health workers and care managers)
- Medicaid Managed Care (core program elements and regional pilots)
- Aligning enrollment and connecting existing resources
# Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td><strong>Food</strong></td>
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<tr>
<td>1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?</td>
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<tr>
<td>2. Within the past 12 months, did the food you bought just not last and you didn’t have money to get more?</td>
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<tr>
<td><strong>Housing/Utilities</strong></td>
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<tr>
<td>3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?</td>
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<td>4. Are you worried about losing your housing?</td>
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<td>5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?</td>
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<tr>
<td><strong>Transportation</strong></td>
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<tr>
<td>6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?</td>
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<tr>
<td><strong>Interpersonal Safety</strong></td>
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<tr>
<td>7. Do you feel physically or emotionally unsafe where you currently live?</td>
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<tr>
<td>8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?</td>
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<tr>
<td>9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?</td>
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<tr>
<td><strong>Optional: Immediate Need</strong></td>
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<tr>
<td>10. Are any of your needs urgent? For example, you don’t have food for tonight, you don’t have a place to sleep tonight, you are afraid you will get hurt if you go home today.</td>
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<tr>
<td>11. Would you like help with any of the needs that you have identified?</td>
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Source: [https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions](https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions)
Hot Spot Map for Social Determinants

North Carolina Social Determinants of Health by Regions

Overview

http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b

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Housing and Transportation Determinants of Health

Families with difficulties paying rent and utilities are more likely to report barriers to accessing health care, higher use of the emergency department, and more hospitalizations (1). Transportation includes public systems such as city or regional buses as well as cars, bikes, sidewalks, streets, bike paths, and highways. Increased options for public transit can mean better access to care. Rental housing, crowding, and households living without transportation are key housing and transportation indicators.

- Percent Living in Rental Housing
- Percent Paying Greater Than 30% of Income on Rent
- Percent of Overcrowded Household
- Percent of Households without a Vehicle
- Turn All Layers Off

Rental Housing and Income

http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b
WHAT IS NCCARE360?

NCCARE360 is the first statewide network that unites health care and human services organizations with a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina. NCCARE360 helps providers electronically connect those with identified needs to community resources and allow for feedback and follow up. NCCARE360 will launch in all 100 counties by the end of 2020.

NCCARE360 Partners:
NCCARE360 Has Multiple Components

- A **robust statewide resource directory** powered by NC 2-1-1 that will include a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities.

- A **community repository** powered by Expound to integrate multiple resource directories across the state and allow data sharing.

- A **shared technology platform** powered by Unite Us to send and receive electronic referrals, seamlessly communicate in real-time, securely share client information, and track outcomes.

- A **community engagement team** powered by Unite Us to guide change management, workflows and training, and provide ongoing network partner support.
Network Model: No Wrong Door Approach
Understanding Referral Workflows

Client → Care Coordinator → Additional Needs Identified → Referral → Financial Assistance Provider → Referral → Food Provider

Housing Need Identified along with other needs
By the end of June, NCCARE360 will be in all 100 counties
The Healthy Opportunities Pilots will test the impact of providing selected evidence-based interventions to high risk Medicaid enrollees.

Over the next five years, the pilots will provide up to $650 million in Medicaid funding for capacity building and pilot services in two to four areas of the state that are related to housing, food, transportation and interpersonal safety and directly impact the health outcomes and healthcare costs of enrollees.

Pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of healthcare.
<table>
<thead>
<tr>
<th>Food</th>
<th>Housing</th>
<th>Transportation</th>
<th>Interpersonal Violence /Toxic Stress</th>
<th>Cross-Domain</th>
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<tbody>
<tr>
<td>Food and Nutrition Access Case Management Services</td>
<td>Housing Navigation, Support and Sustaining Services</td>
<td>Reimbursement for Health-Related Public Transportation</td>
<td>IPV Case Management Services</td>
<td>Holistic High Intensity Enhanced Case Management</td>
</tr>
<tr>
<td>Evidence-Based Group Nutrition Class</td>
<td>Inspection for Housing Safety and Quality</td>
<td>Reimbursement for Health-Related Private Transportation</td>
<td>Violence Intervention Services</td>
<td>Medical Respite</td>
</tr>
<tr>
<td>Diabetes Prevention Program</td>
<td>Housing Move-In Support</td>
<td>Transportation PMPM Add-On for Case Management Services</td>
<td>Evidence-Based Parenting Curriculum</td>
<td>Linkages to Health-Related Legal Supports</td>
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<tr>
<td>Fruit and Vegetable Prescription</td>
<td>Essential Utility Set-Up</td>
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<tr>
<td>Healthy Food Box (For Pick-Up)</td>
<td>Home Remediation Services</td>
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<td>Home Visiting Services</td>
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<tr>
<td>Healthy Food Box (Delivered)</td>
<td>Home Accessibility and Safety Modifications</td>
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<tr>
<td>Healthy Meal (For Pick-Up)</td>
<td>Healthy Home Goods</td>
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<td>Healthy Meal (Home Delivered)</td>
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<td>Healthy Meal (Home Delivered)</td>
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<tr>
<td>Medically Tailored Home Delivered Meal</td>
<td>Short-Term Post Hospitalization Housing</td>
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SDOH, CYSHCN AND COVID-19

• CMARC continues to provide care via telephone
• Early Intervention Part C is offering services via telehealth
• NC 211
  o Information about COVID-19 via phone and texting
  o Connection for North Carolinians to SDOH resources
• Governor’s Education and Nutrition Working Group developing policies and processes to ensure children and families are supported
• Ongoing efforts to try to increase broad band access for use with telehealth and education
• Messaging and outreach to all Medicaid recipients about importance of well child visits, immunizations and use of telehealth
RESOURCES

• NRC-PFCMH SDOH Resources
• Bright Futures SDOH Resources
• STAR Center SDOH Resources
• Association of Maternal and Child Health Programs SDOH Learning Network Fact Sheet
• National Survey of Children’s Health
• Centers for Disease Control and Prevention SDOH Resources
• Healthy People 2020 SDOH Resources
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PARTICIPANT QUESTIONS
THANK YOU FOR YOUR PARTICIPATION!