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About the Initiative

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the State of Michigan $70 million over four years to test and implement an innovative model for delivering and paying for healthcare in the state. The state has focused its efforts on developing and strengthening connections among providers of clinical care and community-based organizations that address social determinants of health.

Links

SIM Initiative website

Welcome to the final edition of the State Innovation Model (SIM) Initiative Newsletter. This newsletter has provided updates on activities taking place across the initiative since June 2017. The SIM website will continue to be available for reference, but it will no longer be updated after the final grant reports are submitted to the Centers for Medicare and Medicaid Services (CMS) in February. **After January 31, 2020, the SIM email account will no longer be monitored.**

Previous newsletters can be found on the SIM website. (http://www.michigan.gov/SIM)

Program News and Updates

Federal SIM Funding Ends

Federal SIM funding from CMS concludes on January 31. Since 2015, Michigan has tested and refined healthcare delivery and financing models that emphasize the importance of connections between clinical care and community-based organizations. Its efforts have been realized primarily through initiatives focused on population health and care delivery.

More than 300 medical practices across the state—representing more than 2,000 primary care providers—participated in the Patient-centered Medical Home (PCMH) Initiative with a commitment to improving care delivery and care coordination. The initiative used SIM funding to incentivize participating providers to administer value-based care and to measure quality and utilization benchmarks associated with increased value-based care. Preliminary outcomes attributed to the PCMH initiative include fewer preventable emergency department (ED) visits, increased cervical cancer screenings, and improved breadth and robustness of social determinant of health (SDOH) screenings among Michigan primary care practices.

Community Health Innovation Regions (CHIRs) in five areas across the state have formed and/or strengthened multisector collaborations with clinical-community linkages (CCLs), which help to identify and achieve shared goals that improve community health—providing a foundation for better meeting residents' needs.

In partnership with Medicaid health plans (MHPs), SIM increased adoption of alternative payment models (APMs) to sustain the focus on value-based care. Additionally, the state's plan for improving population health, to be finalized by the end of January, will provide a roadmap to continue addressing SDOH across the state.

SIM funding was used to provide administrative support for the initiative's operations, technical assistance to practices and providers, resource development, workforce training opportunities to build capacity for care management and coordination, and data aggregation and analysis to support the creation and execution of the performance incentive program.

SIM has funded significant improvements in Michigan's health information exchange that have been critical to improving core use cases like the Active Care Relationship Service®; admission, discharge, and transfer (ADT) messages; and the master person-indexing service, Common Key Service. Further, SIM's technology component has begun advancing the collection of SDOH data throughout the Michigan Department of Health and Human Services (MDHHS). A highlight of this work is the collection of housing data from Michigan's Homeless Management Information System. These data are being combined with Medicaid claims and encounter data to show the connection between homelessness and Medicaid service usage.

Social Determinants of Health Strategy

Although the SIM initiative is ending, the challenges associated with addressing impediments to better health outcomes remain. MDHHS remains committed to its vision of delivering health and opportunity to all Michiganders in reducing intergenerational poverty and health inequity. The department will soon release details related to one of our strategic priorities: addressing social determinants of health, including food/nutrition, housing, and other determinants. Many of the lessons learned from SIM will help inform this strategy. Stakeholders who are subscribed to the SIM listserv will receive notification of a new listserv intended to keep interested parties informed of this important work in 2020 and beyond.

Population Health

Community Health Innovation Regions

As federal funding concludes, CHIRs are continuing their work and planning for the future. The state has budgeted one-time general funds to continue supporting the CHIRs through fiscal year 2020. There is widespread recognition of the need to address social determinants of health, and MDHHS is using lessons learned from the CHIR model as they advance their social determinants of health strategy. While each CHIR is unique, the graphic below demonstrates the core components of a CHIR as envisioned and implemented through SIM funding.

COMMUNITY HEALTH INNOVATION REGIONS

A Systemic Approach to Health and Well-Being

CROSS-SECTOR APPROACH:
CHIRs engage a broad group of stakeholders to identify and address factors that affect residents' health by connecting healthcare and social services.

INFRASTRUCTURE SUPPORT:
CHIRs are supported by staff through a backbone organization, action teams, committees, and State resources.

COMMUNITY SYSTEMS-CHANGE:
CHIRs work to coordinate people, organizations, sectors, and communities to identify gaps in resources, reduce duplication of services, and increase care to residents.

Addressing Social Determinants of Health and Promoting Equity
80% of the factors that influence a person's health are unrelated to access and quality of care. With this as the primary focus, CHIRs have established a systematic process aimed at decreasing inequities throughout their communities.

SCREENING & REFERRING:
Individuals are screened for social needs and referred to a CHIR for assistance navigating services based on the complexity of their needs. CHIRs use aggregated screening and referral data to help inform change.

SHARED VISION & GOALS:
Uniting around a shared vision helps align the region around common goals to achieve a greater impact.

GOVERNANCE:
A multi-sector, diverse governing board provides leadership that makes decisions to proactively support residents by reducing barriers to good health.

These foundational elements are important as they have laid a foundation for future impact. The graphic illustrates how these components combine with a focus on addressing social determinants of health and promoting health equity. These core components will enable multisector collaborations to achieve their desired outcomes. Snapshots of current CHIR activities and accomplishments are described below, including quotes from stakeholders in each community who were interviewed about the initiative.

Genesee CHIR

The Genesee CHIR—with the Greater Flint Health Coalition (GFHC) serving as its backbone organization—continues to focus its efforts on ensuring strong CCLs. All 67 SIM PCMH practices in the region are screening patients for needs related to social determinants of health and submitting the results to the GFHC's central repository, which Great Lakes Health Connect administers. In total, 31,670 screenings were collected through October 31, 2019. As of December 15, 2019, the Genesee CHIR's CCL hub received

9,800 referrals through its community referral platform and other means, and the CHIR's four CCL specialty hubs have served 6,330 unique Medicaid beneficiaries. Many individuals are referred more than once for hub services. A social service stakeholder says,

> The Genesee CHIR has been a very positive project, overall, in bringing the health and community sectors together around social determinants of health and creating pathways for access to critical services. I believe our CHIR has exceeded expectations in the creation of a closed-loop referral system and building bridges between the medical community and community-based service providers.

The CHIR has also established a process for identifying people who misuse or overuse the ED through admission, discharge, and transfer (ADT) notices, MHP claims data, and PCMH providers. Through data submitted to and aggregated by the GFHC, the Genesee CHIR has identified a monthly average of 470 Medicaid beneficiaries with frequent, inappropriate, and/or preventable ED visits for follow-up care coordination services.

Jackson CHIR

The Jackson CHIR has worked with LifeWays Community Mental Health to develop a crisis respite program, called Crisis R&R, based on the community living-room model. The Crisis R&R is housed in a comfortable, homey space where individuals in mental health crisis receive support and mentoring from peers and a needs evaluation by crisis staff. Since opening in May 2018, the program has served 517 individuals through 693 visits. Peer support specialists work alongside guests to help with problem-solving and coping skills and make referrals to community resources that will help with Medicaid enrollment, housing, and food assistance. These specialists have lived experience with mental illness and/or addiction and have received formal training to support others in recovery and resilience, making them especially effective in this setting.

One of the goals of the program is to offer an alternative to the ED for individuals in mental health crisis. While some guests require inpatient care, nearly 90 percent return to their home with a safety plan. The program has been so successful that LifeWays has committed to continuing it as part of their full range of crisis services after SIM funding ends. A social service sector stakeholder says,

> The Jackson SIM project seems solidly able to launch initiatives that will improve the community's access to and use of services. I believe that positive change is and will continue to be present long before it is seen.

Livingston–Washtenaw CHIR

In May 2019, the Livingston–Washtenaw CHIR initiated a 100-day challenge to accelerate transformation of the Washtenaw County substance use disorder (SUD) prevention and treatment system through seven action teams. The teams comprised SUD treatment providers, community mental health organizations, hospitals, law enforcement agencies, public health entities, and others. One team was tasked with identifying and defining shared values for all SUD prevention and treatment organizations. Another focused on the importance of integrating people on the recovery spectrum into the SUD transformation planning and decision-making process. Yet another team created a document that identified the array of organizations providing SUD services for Washtenaw County residents, including contact information for more than 100 organizations, peer groups, meetings, coaches, treatment centers, and more for both adults and youth.

The teams reconvened in September 2019 to highlight accomplishments and outline next steps. The work will continue under the leadership of the Washtenaw Health Initiative's Mental Health and Substance Use Disorders Workgroup. The workgroup will ensure that SUD systems transformation work is tied to other community initiatives and encourages other interested community members and leaders to join efforts to transform the local SUD system. A health-sector stakeholder says,

> The expansion of relationships in our community has helped us not only with delivering services through the SIM initiative, but also more broadly. The real-time data-sharing component has been very helpful in coordinating care.

Brief summaries of the past year's work can be found on the Washtenaw Health Initiative website.

Muskegon CHIR

The Muskegon CHIR is nearing the conclusion of its Livability Lab's 100-day challenge, which kicked off in September 2019. Nearly 300 business leaders, educators, neighborhood association members, health and human services organizations, and state and local government representatives gathered at the start of initiative to address barriers to upward mobility, well-being, and business growth in Muskegon County. A social service sector stakeholder says,

> The Muskegon CHIR has been a blessing to this community. It has been used to create incredible programs, support amazing programs already in place, and help change the way organizations interact with each other. It has brought more accountability, interaction, and connection to the community. More people now know that health is influenced by many different factors, which helps our services become more holistic.

Since the kickoff event, 19 challenge teams have been regularly meeting to pursue rapid, creative solutions to challenges that impede good health and prosperity in the county. Some of the projects include building a neighborhood association council in Muskegon Heights to increase resident voices in local decision-making processes, creating a mentorship network to increase youth academic and cultural leadership skills, expanding the Youth Book Buddy Program to disadvantaged schools to support literacy, and engaging local businesses in the Wheels to Work program to increase affordable transit options, among many others.

To keep up the energy of the initiative, the Muskegon CHIR sent biweekly newsletters to the teams leading up to an event on January 23, where the teams celebrated their accomplishments and identified how to sustain their momentum. More information about the Livability Lab and each team's progress is available on the Livability Lab website.

Northern Michigan CHIR

The Northern Michigan CHIR received multiple accolades in recognition of its contributions toward improving health in the region. In August 2019, Munson Health System presented the CHIR with a Community Health Hero award for its Community Connections Hub in Grand Traverse County for "offering connections to community resources for adults, children, and families, including access to medical care, transportation, food, utilities, education, classes, and more." The Michigan Association for Local Public Health (MALPH) and the Michigan Public Health Association (MPHA) in recognition of its contributions toward improving health in the region. In November 2019, MALPH and the MPHA awarded the CHIR with the Public Health Community Achievement Award.

The Public Health Community Achievement Award notice described the CHIR's "achievements, passion, and commitment of excellence in the field of public health," citing "early evidence that the Northern Michigan CHIR is creating an aligned system and transforming individual lives by launching a paradigm change by promoting a new understanding of the importance of the SDOH and creating a collective innovation space that provides opportunities for health and social services to experiment with new and different ways of working together."

Jane Sundmacher, the CHIR's executive director, remarked on this achievement: "We are honored our work was recognized by leading organizations in the state to address basic needs, like access to healthy food, affordable and safe housing, and transportation options. Barriers to these social determinants of health impact well-being and equity." She also acknowledged the contributions of more than 100 CHIR partners, "including 20 community leaders who serve on our steering committee."

As reported in the September 2019 newsletter, the CHIR has initiated a regional expansion to include all 31 counties that are part of the Northern Michigan Public Health Alliance. The expansion will be complete by the end of January 2020. As a health-sector stakeholder explains,

> We did planning in a silo last year. I ran my own steering committee and prioritized client needs with committee members from my organization. Now, because of the CHIR, the planning process has been transformed into something that's part of a broader community effort. We've given up a lot of control but gained perspective, and having new partners actually makes a difference. It's been a good thing.

Client Experience Survey

In late fall 2019, the University of Michigan Child Health Evaluation and Research (CHEAR) Center interviewed and surveyed clients to find out about their experience with the CHIR model. Overall the findings were quite positive. Between 85 and 92 percent said their CHIR did an excellent or good job of identifying their needs and between 83 and 91 percent said their CHIR helped connect them to services they could not get before. Between 83 and 91 percent indicated that after working with their CHIR, they better understood how to get the services they need, and between 80 and 85 percent said working with the hub has allowed them to take better care of their own health. When speaking about their coordinator, one client said of the service they received,

> She actually came out to the house to help me, which was a great help, and she actually explained things here at my kitchen table. She took as much time as I needed.

The top needs addressed by the participating CHIRs were food insecurity, enrollment in MDHHS assistance programs, housing, employment, and difficulty paying bills.

Health Through Housing Initiative

As part of the Health Through Housing initiative's pilot effort to identify and reach out to those experiencing chronic homelessness and frequently using healthcare services, permanent supportive housing providers are delivering care management services to these vulnerable residents, as well as helping them obtain stable housing. Based on current ED utilization, 22 of 23 housed clients who have been housed for at least six months are expected to have fewer ED visits after one year than they did in the year before they were housed. The SIM Population Health team recently created a video highlighting one participant's story.

Updates on this initiative and other efforts to address chronic homelessness in Michigan are available on the newly created MDHHS Homeless Services webpage.

Care Delivery

Patient-centered Medical Home Initiative

SIM PCMH Initiative Hosts Final Annual Summit

On November 12, 2019, more than 250 SIM PCMH participants gathered in East Lansing to celebrate the initiative's capstone annual summit. Together, participants celebrated various achievements made possible through SIM, including fewer preventable ED visits, increased cervical cancer screenings, and improved breadth and robustness of social determinant of health screenings among Michigan primary care practices.

Dr. Stacey Bartell from Ascension delivered the keynote address and provided valuable lessons and practical tips for enhancing team-based care and organizational effectiveness. She shared useful information regarding population health tools as well as approaches used in her practices to successfully sustain whole-person care.

Dr. Jill Rinehart from the University of Vermont Children's Hospital, an architect of the patient-centered pediatric model in Vermont, was a special speaker at the summit. Her experience in pediatric practice and patient and family engagement inspired audience members.

In addition, morning breakout sessions showcased how community organizations partnered with clinical practices to better serve patients, better connect to patients and caregivers, and move beyond simply measuring social determinant of health needs to more effectively address patient needs. Afternoon breakout sessions provided a look at the SIM evaluation's progress and effect, recognizing and constructively helping patients deal with adverse childhood experiences by building resiliency and working with depression in youth. Presentations focused on ways that the state supports the continuation of best practices throughout SIM and beyond. Representatives from Michigan MHPs shared their ideas for 2020 and the opportunities for practices to build on the SIM PCMH Initiative's work. The SIM Care Delivery Summit webpage has links to the day's agenda, slides, and speaker resources.

A Care Management Success Story from Great Lakes Physicians Organization

After visiting his primary care practice, a patient met with the care manager and told her that he had been experiencing homelessness since January 2019, living in his car and occasionally staying with friends. Though he had been diligent about taking his medications, including insulin, he was only eating one meal per day—from a fast-food restaurant's dollar menu. He was also doing laundry and performing personal care in public restrooms or at a friend's house when he was able to stay there. His relationship with nearby family was strained, so he was unable to seek their assistance.

Together, the care manager and patient identified the core needs to address. The care manager shared information about available resources, including a local soup kitchen, food banks, nearby emergency housing, as well as personal care and clothing banks. The patient agreed to enroll in the local farmers market nutrition program, which provided $10 in market coupons for each class he attended.

The patient now lives with a friend near a local soup kitchen that is open for breakfast and lunch and provides boxed meals for dinner. He has been attending the farmers market program and purchases fresh food weekly. He has also received assistance from local food banks and has been able to access personal care resources, such as shampoo, soap, and bedding for his room. He visited a clothing bank, where he found better-quality clothing, and received a voucher to a local store for a new pair of jeans and three new shirts.

The patient remarked he was glad he told the care manager about his homelessness, even though he feared her reaction. He also said that all of his needs are being met, acknowledged that the care manager "fixed him," and that he could not be happier with his life now. The care manager will reassess his needs during a two-month follow-up appointment.

Alternative Payment Models

Managed Care Plan Division and MHPs Collaborate on State-preferred PCMH Model

The MDHHS continues to work with MHPs to establish a standard set of PCMH requirements that define the State-preferred PCMH model. The collaborative effort has three main objectives: 1) increase the use of APMs, 2) improve quality of care, and 3) reduce provider burden. The design process began with the SIM PCMH model as its foundation, and MDHHS continues to work with MHPs to clarify requirements and corresponding compliance and monitoring processes. Since the SIM PCMH Initiative concluded at the end of 2019, the goal is to ensure sustainability, effectiveness, and consistent best practices beyond grant-funded activities.

The Medical Services Administration Quality Improvement and Program Development (QIPD) section finalized MHP provider contracting requirements, care management/care coordination utilization benchmarks, and quality measurement and improvement targets for fiscal year 2020 incentive payments. The QIPD team believes that quality should be the key driver behind adoption of APMs and has established APM reporting requirements for MHPs to ensure progress toward performance goals and to see how APMs are being used to promote quality in MHP provider networks.

Technology

SIM CHIR Toolkit Will Highlight Individual CHIR Technology Solutions

The SIM CHIR team is creating a toolkit to support expansion of the CHIR model when federal funding ends. The toolkit will include descriptions of technology solutions used by the five CHIRs as examples for other communities seeking to implement a CHIR. The toolkit will also offer general guidance on data that should be collected and technological solutions that can support tracking clinical-community linkages and social determinants of health screening. This toolkit will also include lessons learned in early implementation efforts. The entire toolkit is planned to be completed by early 2020 and will be available as a PDF on the MDHHS website.

For More Information

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