SIM Initiative Newsletter

A publication of Michigan's State Innovation Model
March 2018

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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 4 years to test and implement an innovative model for delivering and paying for health care in the state. The state has focused its efforts areas on developing and strengthening connections among providers of clinical care and community-based organizations that address social determinants of health.

Contact Us

Questions can be sent to: MDHHS-SIM@michigan.gov

Links

SIM Initiative website

SIM Population Health webpage

SIM Care Delivery webpage

Welcome to the fourth edition of the SIM Newsletter. This newsletter is intended to provide updates on the activities taking place across the program. It will also be used to make stakeholders aware of any SIM-related events that may be of interest to a general audience.

Previous editions of the newsletter can be found here.

Program News and Updates

2018 Michigan SIM Operational Plan Approved by CMS

On February 1, 2018, Michigan's Year 3 SIM Operational Plan was approved by the Centers for Medicare and Medicaid Services (CMS). The document describes the SIM governance structure and plan for healthcare delivery transformation, along with specific activities to refine and support the Patient Centered Medical Home (PCMH) Initiative, Community Health Innovation Regions (CHIRs), alternative payment models (APMs), and health information technology. It also includes plans for an evaluation of the SIM initiative in Michigan that will look at its impacts on individuals, communities, and systems. The Year 3 SIM Operational Plan is available for review on the SIM website.

Community Health Innovation Regions Gather in East Lansing

On February 28, 2018, the SIM team hosted representatives from each CHIR backbone organization in East Lansing. Each backbone organization serves as a fiduciary and neutral convener for the CHIR's governing body and is also the liaison to the state's SIM program staff. The meeting focused on sharing lessons learned from implementing clinical-community linkages; engagement of Medicaid health plans; establishing workgroups (e.g., data sharing, sustainability, clinical-community linkages); and reviewing the proposed CHIR Participation Guide, which covers expectations for the updated local operational plans. Each region was well represented at the event.

New Materials Available Online

The SIM team recently updated the summary of the Michigan SIM Initiative to reflect changes and new activities from the past year. The previous version, released in April 2017 provided an overview of the various components of the program and a description of their status at that point in time. The updated summary offers information about new activities and those planned for the coming year. A newly created infographic describing the primary components of the SIM Initiative is also available on the SIM website. The infographic describes the purpose of the initiative and demonstrates the connections among its components.

New SIM Email Address

A reminder that the email address for general inquiries about SIM has changed. The SIM team can now be reached at MDHHS-SIM@michigan.gov.

Population Health

Community Health Innovation Regions

CHIR Hubs Support Clinical-Community Linkages

Each CHIR has put a "hub" in place to support clinical-community linkages with the goal of improving health outcomes, increasing health equity, and reducing inappropriate utilization of acute clinical care services. The hubs were piloted through January reached full implementation in February. The hubs have served 712 people to date and are already having an impact on the lives of the people they serve. The **Genesee CHIR** backbone organization, the Greater Flint Health Coalition (GFHC), received a referral for preventable emergency department use from a partner PCMH via its community referral platform. GFHC identified that the person referred needed assistance with food, housing, and utilities and assigned the referral to one of the CHIR's three specialty hubs, the GFHC Community Health Access Program (CHAP). The GFHC CHAP found that the client also needed behavioral health services and helped connect her with Genesee Health System, where she was able to begin receiving medications and crisis stabilization. CHAP was also given permission by the client to speak to her MDHHS worker and successfully advocated on the client's behalf to not have her utilities turned off. CHAP also assisted the client with filling out and submitting a Section 8 housing application. CHAP provided food resources and is continuing to monitor the client's progress. As part of the GFHC's referral feedback process, CHAP informed the referring PCMH of the actions it took to meet the client's needs.

CHIRs to Focus on Housing in 2018

Homelessness (or unstable housing) is a significant social determinant of health and is prevalent in all five CHIRs. People who are homeless are at greater risk of poor health outcomes due to poor living conditions, trauma, and food insecurity. They also tend to have limited resources for self-care. For example, a person with diabetes who is experiencing unstable housing may have difficulty managing their condition without an appropriate place to store insulin or access to nutritious food. People who are homeless also tend to reside in hard-to-reach places (e.g., heavily wooded areas) or be very transient and have little or no transportation options. These issues create challenges in reaching them and establishing the patient-provider relationships necessary for effective healthcare. Given the importance of housing and Michigan's participation in a Medicaid Innovation Accelerator Program housing initiative, MDHHS will develop and implement a new SIM initiative within the CHIR framework to integrate and coordinate housing and health care that fosters housing stability and efficient, effective use of health care and housing resources.

This program will be implemented in the CHIRs to focus on identifying and prioritizing high-need, high-cost patients who are homeless and connecting them to housing solutions. The program will focus on increasing capacity, coordination, and support functions and connecting the beneficiary to proper housing resources rather than financing the housing. MDHHS has appointed a housing lead to direct program activities and leverage SIM resources to support CHIR-related activities.

Northern Michigan Region Implements ABLe Change Framework

As highlighted in previous newsletters, the ABLe Change Framework is designed to help communities more effectively address significant social issues affecting some of the most vulnerable populations, specifically those who are eligible for Medicaid. The model is based upon the premise that communities

can achieve transformative results when they: make local system and community conditions the intentional targets of their change initiatives; pursue the effective implementation of their efforts; and build a community engagement infrastructure that supports real-time learning and action across diverse stakeholders and sectors. CHIRs were encouraged to participate in ABLe Change training and receive coaching supports to help them address social determinants of health and transform health outcomes. Three of the five CHIRs participated in the training and are receiving coaching.

The **Northern Michigan CHIR** completed the training and established strategies that incorporate what they learned and developed through the training. Over the course of six days of training carried out in three two-day sessions between June 2017 and January 2018, community partners from across the region identified barriers to health for the region's residents by reviewing health needs assessments and conducting primary research with community members. During the first two-day training session, the community partners identified five primary barriers: lack of access to healthy food, limited transportation, housing insecurity, limited opportunities to participate in physical activity, and social isolation. To obtain community input, the participating stakeholders surveyed people who seek services at their respective organizations and went to community events like school open houses to gather data from the public. Researchers from the University of Michigan also helped gather community input through a game-like tool called Choosing Health Plans All Together (CHAT), which invites participants to work as a group to make decisions about how to use resources in their community.

Results from the community input were shared at the second two-day training session in October, and the community partners developed teams to identify strategies to address each of the barriers. During the final two-day training session in January, the partners also worked to identify strategies for promoting the issues across the community, so they are considered in the development of policies across all sectors. The strategy design teams have begun to meet regularly and are partnering with coalitions and organizations to move their identified strategies forward, while also exploring potential funding streams to sustain their efforts.

Care Delivery

Patient-Centered Medical Home Initiative

PCMH Initiative Strengthened through Collaboration

The SIM Care Delivery Team is providing platforms for various stakeholders to come together to share ideas and develop strategies for meeting the needs of people in their communities. The Care Coordination Collaborative will bring together CHIRs, Medicaid health plans, and PCMHs to support networking and facilitate exercises to align efforts, reduce potential duplication of services, and identify methods of collaboration for shared beneficiaries. This will ensure stronger relationships and clearer lines of communication among these partners, resulting in better outcomes for patients. A multi-stakeholder planning committee met in March to begin planning for a Care Coordination Collaborative kick-off event in May.

The PCMH Initiative has been working with partners at the Institute for Healthcare Improvement to develop the 2018 Practice Transformation Collaborative. This learning network is a focused opportunity for a cohort of PCMH Initiative participants to engage in concentrated efforts to further refine and implement clinical-community linkages. There will be an opportunity for all PCMH Initiative participants to learn from the 2018 Practice Transformation Collaborative participants through virtual meetings.

SIM PCMH Initiative to Focus on Population Health in 2018

In 2017, PCMH Initiative participants designed and implemented processes to support clinical-community linkages. Practices based within SIM CHIR regions worked with CHIR partners to align strategies for linking patients to appropriate community-based resources. While participants are continuing to carry out and refine clinical-community linkages, practice transformation efforts in 2018 are focused on population health management. All participants are required to assign at least 95 percent of their patient population to a provider or care team within their practice and use quality and utilization reports from the initiative, other payer partners, or internal systems to promote care continuity and quality improvement.

Participation in PCMH Initiative Holds Steady in 2018

As of February 2018, 324 practices representing 2,138 providers are participating in the SIM PCMH Initiative. These practices have a total of 340,707 attributed beneficiaries (based on February 2018 attribution). Nearly half of all practices and more than half of all beneficiaries are in a SIM CHIR region.

REGION	PRACTICES	PROVIDERS	BENEFICIARIES
Genesee	62	152	42,400
Jackson	11	52	17,288
Livingston/Washtenaw	40	378	47,208
Muskegon	24	135	44,907
Northern ***(Antrim, Emmet, Wexford, Kalkaska, Leelanau, Missaukee, Benzie, Charlevoix, Manistee, Grand Traverse)***	22	175	47,566
Total SIM Region	159	892	199,369
TOTAL Non-SIM Region	165	1,246	141,338
TOTAL	324	2,138	340,707

PCMH Dashboard Helps SIM and Participants Monitor Quality and Utilization

The Michigan Data Collaborative calculates quality, utilization, and cost measures, as well as chronic condition prevalence for all participating practices and provider organizations in the PCMH Initiative and presents the data on the SIM PCMH Dashboard. Using the Dashboard, participants can view patient demographics and chronic condition prevalence; view data on care coordination, quality, and utilization; compare their performance against other entities and published benchmarks; and download reports. Data included in the dashboard is based on Medicaid claims. Future dashboard releases will include clinical

quality measures using data transmitted by providers through the Quality Measurement Information Use Case described in previous newsletters.

Alternative Payment Models

MDHHS is collaborating with Medicaid health plans (MHPs) to increase adoption of alternative payment models (APMs). Each MHP has submitted baseline data on their current use of APMs and a strategic plan for increasing APM-based payments. To support the MHPs in developing more detailed goals and plans, MDHHS has developed guidelines on state-preferred APMs. These models represent a shared vision of advancing payment reform initiatives and correspond with areas of provider interest.

MDHHS has also developed a quality strategy, which provides guidance to MHPs on the quality metrics the state would like them to use as a basis for APMs. These include measures specific to the regions in which the health plans operate as well as prevention and quality of care measures that should be used by all MHPs in APM contracts. MHPs are also given the opportunity to identify their own measures for inclusion in APMs based on the types of health outcomes or utilization issues they would like their participating providers to work on.

In March, the APM Workgroup (comprising MDHHS and Medicaid health plan staff) met to engage in conversations about what the State of Michigan is requiring and to share ideas for implementing their strategic plans.

Technology

Housing Analytics Database

The SIM technology team is excited to support the CHIR housing program by identifying healthcare utilization patterns and costs for homeless individuals with chronic disabilities and seeing how those change when people become enrolled in permanent supportive housing. This information should support engagement of housing and healthcare stakeholders in CHIRs and across the state in discussions about strategies to improve healthcare for people experiencing homelessness. These analytics will support the model by identifying return on investment and improving methods for prioritizing the needs of people who are homeless.