State Innovation Model (SIM)
Progress Report 1

(FY2020 Appropriation Act - Public Act 67 of 2019)

March 1, 2020

Sec. 1144. *(1) From the funds appropriated in part 1 for health policy administration, the department shall allocate the federal state innovation model grant funding that supports implementation of the health delivery system innovations detailed in this state's "Reinventing Michigan's Health Care System: Blueprint for Health Innovation" document. This initiative will test new payment methodologies, support improved population health outcomes, and support improved infrastructure for technology and data sharing and reporting. The funds will be used to provide financial support directly to regions participating in the model test and to support statewide stakeholder guidance and technical support.*

(2) Outcomes and performance measures for the initiative under subsection (1) include, but are not limited to, the following:

(a) Increasing the number of physician practices fulfilling patient-centered medical home functions.

(b) Reducing inappropriate health utilization, specifically reducing preventable emergency department visits, reducing the proportion of hospitalizations for ambulatory sensitive conditions, and reducing this state's 30-day hospital readmission rate.

(3) On a semiannual basis, the department shall submit a written report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, and the state budget office on the status of the program and progress made since the prior report.

(4) From the funds appropriated in part 1 for health policy administration, any data aggregator created as part of the allocation of the federal state innovation model grant funds must meet the following standards:

(a) The primary purpose of the data aggregator must be to increase the quality of health care delivered in this state, while reducing costs.

(b) The data aggregator must be governed by a nonprofit entity.

(c) All decisions regarding the establishment, administration, and modification of the database must be made by an advisory board. The membership of the advisory board must include the director of the department or a designee of the director and representatives of health carriers, consumers, and purchasers.

(d) The Michigan Data Collaborative shall be the data aggregator to receive health care claims information from, without limitation, commercial health carriers, nonprofit health care corporations, health maintenance organizations, and third party administrators that process claims under a service contract.

(e) The data aggregator must use existing data sources and technological infrastructure, to the extent possible.

MDHHS
Michigan Department of Health & Human Services

State Innovation Model (SIM)
Section 1144, MDHHS Budget Report

Policy and Planning Administration

State Innovation Model (SIM)

Contents

1 State Innovation Model Executive Summary

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the State of Michigan approximately $70 million over four years to test and implement an innovative model for delivering and paying for health care in the state. The award, made through the CMS State Innovation Model (SIM) initiative, was based on a plan submitted by the state in 2014.

The state, through the Michigan Department of Health and Human Services (MDHHS), has organized the work of implementing its SIM initiative under three main umbrellas: P Health, Care Delivery, and Technology. The Population Health component has at its foundation community health innovation regions, or CHIRs (pronounced "shires"), which are intended to build community capacity to drive improvements in population health. The Care Delivery component encompasses a patient-centered medical home (PCMH) initiative and the promotion of alternative payment models. The Technology component is where the state is leveraging its statewide infrastructure and related health information exchange initiatives to enable and support advances in population health and payment and care delivery strategies.

Recognizing that 20 percent of the factors that influence a person's health outcomes are related to access and quality of care while socioeconomic, environmental, and behavioral factors account for 80 percent; the state has focused efforts in each of these areas on developing and strengthening connections among providers of clinical care (e.g., physician offices, health systems, and behavioral health providers) and community-based organizations that address non-medical factors impacting health. Clinical-community linkages are emphasized heavily in the state's guidance for both CHIRs and PCMHs participating in the SIM initiative. Alternative payment models can provide a way for clinical providers to receive financial support for quality improvements and connecting patients to community resources, and the state's technology solutions support the exchange of health information among partners.

Together, these three components form the foundation for transforming healthcare delivery and payment in Michigan. CHIRs provide a community-based structure for engaging critical partners in identifying and addressing local health challenges with an eye toward preventing the need for intensive use of medical and social services. PCMH and other providers, supported by alternative payment models, will develop stronger connections with community resources and be encouraged to develop innovative approaches to service delivery. Technology that supports connections and information sharing across a diverse array of partners will provide the infrastructure needed to create better, more efficient, and more comprehensive care for Michiganders.

1.1 Population Health Components

1.1.1 Community Health Innovation Regions

CHIRs form the foundation of the Population Health component of the SIM initiative. A CHIR is a place-based model for improving the wellbeing of a region and reducing unnecessary medical costs through collaboration and systems change. CHIRs engage a broad group of stakeholders to identify and address factors that affect residents' health, such as housing, transportation, and food insecurity, as well as access to high-quality medical care. The CHIR model creates a neutral space for partners to unite around a common vision, aligning their objectives and services to meet the needs of the community. The result is a community that is

purposeful in its response to residents' needs, creating conditions that meaningfully support an individual's ability to have a higher, more productive quality of life.

CHIR partners are organized by a neutral backbone organization that facilitates the development and implementation of key strategies, creating the necessary capacity to sustain progress on stated objectives. CHIR steering committees provide a clear leadership structure and promote shared accountability among partners for aligning their resources to address priority community health needs. It takes a comprehensive group of committed organizations to meet the needs of a community because no one entity can do it alone.

The state selected five regions in Michigan in which to test the CHIR model. Each of the five SIM CHIRs are supported by a backbone organization (BBO) that serves as a fiduciary and acts as a neutral convener for the CHIR's governing body.

CHIR Regions and Backbone Organizations

The overarching mission of each CHIR is to align priorities across health and community organizations and support the broad membership of the CHIR in developing and implementing improvement strategies aimed at addressing social/economic conditions to reduce inappropriate emergency department utilization. Specifically, CHIRs will assess community needs, define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between health entities/systems with community-based organizations and social service agencies.

CHIR Region	Backbone Organization
Genesee County	Greater Flint Health Coalition
Jackson County	Jackson Health Improvement Organization (Henry Ford Allegiance Health)
Livingston-Washtenaw Counties	Center for Health and Research Transformation
Muskegon County	Muskegon Community Health Project (Mercy Health)
Northern Region	Northern Michigan Public Health Alliance

Each CHIR backbone organization receives a fixed amount of SIM funding to support administrative functions and a health improvement budget that varies based on the number of Medicaid beneficiaries in the region. Health improvement funding is used to support activities such as designing and implementing clinical-community linkages or other programs, policies, or environmental strategies to improve the health of their communities.

All CHIRs were required to focus initially on reducing emergency department utilization while also assessing community needs and identifying region-specific health improvement goals. Each CHIR has identified a lack of housing supports as a problem in their region impacting emergency department use. In the fourth and final year of SIM, CHIRs have continued to address this need by collaborating with the state to implement portions of the Health through Housing initiative referenced below.

To support clinical-community linkages, each CHIR established a "hub" system to serve people identified as needing assistance with social determinants of health. Referrals are made to the hub from community-based organizations and primary care providers participating in the SIM PCMH Initiative. These community-based organizations and primary care practices screen patients using a common assessment tool and make referrals to the hubs when needs are identified. Each CHIR has developed a data sharing system to electronically track referrals and use of services.

1.1.2 Health Through Housing Initiative

MDHHS has launched the Health through Housing initiative -- a multifaceted approach to partner housing and healthcare information and resources. The initiative consists of four components:

- **Conducting a frequent user pilot** with housing service providers to connect identified homeless and high cost Medicaid clients with housing and other crucial services to directly impact their health and well-being. 3 agencies in three CHIR communities (Livingston-Washtenaw, Muskegon, and Northern) have been working with their target population to secure permanent housing and get those individuals connected to other resources. Once the high priority individuals from their homeless population within their community are housed, the healthcare costs, emergency department utilization, and in-patient stays of those individuals are tracked to witness the impact as a result of being housed over a period of time.
- **Using data analytics** to identify vulnerable individuals experiencing homelessness who show high Medicaid utilization and cost, prioritize them for housing and address other social determinants of health. MDHHS and the Michigan Coalition Against Homelessness has developed the mechanisms necessary for matching data from the Michigan State Homeless Management Information System to Medicaid utilization data. In addition, it has developed the necessary data use agreements and release of information forms to ensure data is shared securely and appropriately. The Department has been

working on a technology solution that will routinize this data match to access current information and generate a new list of the most vulnerable every month.

- **Building capacity** among housing and homeless service providers to enhance their capabilities as providers of permanent supportive housing and strategizing the most appropriate ways of accessing additional funding for tenant-based services. MDHHS submitted new waiver language to the CMS in August 2019 articulating the tenant support activities it would like to include in its state Medicaid plan. Once the waiver was approved, MDHHS began working with a consultant to develop and deliver training academies to permanent supportive housing providers with a priority on the CHIR communities.
- **Improving local homeless response systems** in CHIRs to reduce barriers to housing, build better integrated partnerships between the healthcare and housing communities, and improve overall patient outcomes. After multiple review sessions, all five CHIR's proposals to make improvements to their Homeless Response Systems were approved by MDHHS and the implementation work began. With the implementation work well underway, the CHIRs have now submitted a proposal for continuing their work for improving their homeless response system after the SIM project comes to an end in January.

1.1.3 Plan for Improving Population Health

As part of the State Innovation Model Round 2 funding, each awardee must develop a statewide plan to improve population health as part of the health system transformation efforts over the four-year cooperative agreement. MDHHS selected the Deputy Director of the Public Health Administration as the Business Owner responsible for leading the Plan's development to ensure alignment with future, broader public health assessment and planning activities. MDHHS also formed an internal workgroup, which included partners from Medical Services Administration and Behavioral Health and Developmental Disabilities Administration (BHDDA) to guide the development of the Plan and to support alignment across department administrations.

The purpose of Michigan's Plan for Improving Population Health is to: "Describe how Michigan is creating health, equity, and wellbeing through clinical and community-based prevention strategies that address the social determinants of health." Michigan's Plan is grounded in the idea that population health will improve if we work across sectors to leverage our resources to address the root causes of health inequity and improve access to the conditions that promote health. One key aspect of Michigan's Plan is rather than focusing on a specific health outcome, the Plan will be directed at addressing the social determinants that underlie disparities in multiple health outcomes. The Plan for Improving Population Health will focus on highlighting these disparities by using data-driven, broad population health focused metrics and will highlight evidence-based programs that impact large sectors of Michigan citizens. Following robust discussions on the current state of health in Michigan and the ideal future state, the current vision statement for the Plan is: "Creating fair, just, and equitable conditions so all people in Michigan thrive and achieve optimal health." The mission statement is: "To leverage the collective power of community partnerships to create conditions that foster health, equity, and wellbeing."

In order to develop a Plan for Improving Population Health that fulfills this vision and mission, the Workgroup formed subcommittees to (1) identify data that speak to health equity and social determinants of health (SDOH), (2) identify existing capacity to improve equity and address social determinants, and (3) select strategies, goals, and objectives for improving population health by addressing social determinants. Michigan Pubic Health Institute (MPHI) has produced a final draft of the Plan for MDHHS internal review, and the Plan will be submitted to CMS as part of the final reporting.

1.2 Care Delivery Components

1.2.1 Patient-Centered Medical Home

With the state's focus on person- and family-centered care and strong evidence that the PCMH model delivers better outcomes than traditional primary care, the PCMH has been viewed, from the outset, as the foundation for a transformed healthcare system in Michigan. The SIM PCMH Initiative was built upon the principles of a PCMH that generally define the model regardless of the designating organization. Value was placed on the core functions of a medical home such as enhanced access, whole person care, and expanded care teams that focus on comprehensive coordinated care.

During the final reporting period, primary care practices participating in the SIM PCMH Initiative ranged in number from 298 to 305, encompassing more than 2,000 primary care providers and approximately 320,000 Medicaid beneficiaries. Approximately 15 percent of the total Medicaid beneficiary population in the state was eligible for participation in the SIM PCMH Initiative. While the PCMH Initiative engaged participating practices statewide, roughly 50 percent of the practices were within a SIM CHIR region.

All participating practices were required to invest in clinical practice improvement activities, including the development and continued enhancement of clinical-community linkages. Practices based within a SIM CHIR region were encouraged to work in close collaboration with CHIR partners to develop shared processes and support the alignment of interests and goals across the community, inclusive of clinical systems and community-based organizations. In addition, practices had to demonstrate investment in population health management by empaneling their patient population and utilizing feedback reports to drive actionable change through quality improvement.

The state established a payment model specific to the SIM PCMH Initiative to support practice transformation and care coordination. Each practice participating in the PCMH Initiative received payments for its attributed eligible Medicaid beneficiaries. Practices received payments to support comprehensive holistic care management and coordination services at the practice level as well as advancement of payment methodology over time to progress from foundational to performance based. Michigan's 11 Medicaid Health Plans participated by directing State designated payment amounts to State-approved PCMH practices based on performance metrics.

1.2.2 Alternative Payment Models

In developing its model for health system transformation, the state understands the importance of providing incentives for delivering care based on value rather than on the number of services delivered. Alternative payment models (APMs) provide incentive payments to healthcare practices for providing high-quality and cost-efficient care. The state continues to promote the use of APMs through two primary strategies: (1) setting goals for the use of APMs, starting with payers in the Michigan Medicaid program, and (2) exploring the feasibility of a multi-payer alignment around quality improvement. The state's overarching goal in promoting APMs is to promote improvements in quality of care.

The Medical Services Administration (MSA) managed care team implemented elements of the SIM APM strategy through the Medicaid Health Plan (MHP) contract. MDHHS has adopted the Healthcare Payment Learning and Action Network APM Framework as its method for classifying provider payment types. The Healthcare Payment Learning and Action Network APM Framework is one of the most widely used approaches for organizing and measuring APM progress. The managed care team collected baseline data about the percentage of medical spend for each health plan in each Healthcare Payment Learning and Action

Network category. The managed care team also approved three-year strategic plans for each health plan to increase the use of categories three and four in alignment with the Medical Services Administration's quality improvement goals.

To further the goal of aligning implementation of APMs with quality improvement needs while also streamlining incentivized measures at the provider level, the managed care team additionally implemented regional-based quality measurement requirements. Medicaid health plans implementing APM contracts in each region are required to utilize quality measures identified as disparately low performing relative to other areas of the State. Finally, the managed care team worked with actuary to carve the SIM PCMH payments into the Medicaid health plan capitation rates beginning January 2020. The carve in corresponds with performance bonus criteria the managed care team has developed as part of the fiscal year 2020 capitation withhold pool. The bonus criteria ensure Medicaid health plans are utilizing the additional capitation payment to sustain provider-based care management and care coordination at an acceptable level.

1.3 Technology

1.3.1 SIM Initiative Technology Support

Michigan established the Relationship and Attribution Management Platform in early 2017. Over the past 6 months components of the platform continued to function in an integral manner to generate patient lists to participating providers within the SIM PCMH Initiative. Since its inception it has provided funding to Medicaid health plans for payments to providers belonging to those provider organizations participating in the PCMH Initiative. PCMH participants continued to actively participate in the Active Care Relationship Service; Admission, Discharge and Transfer messages; Health Directory; and the Clinical Quality Measure Reporting and Repository use cases. The SIM technology team continued to provide oversight of the Relationship and Attribution Management Platform by monitoring the ongoing monthly attribution files for accuracy and timeliness.

The SIM Technology team supported the Care Delivery's initiative to collect SDOH data. We received three rounds of production files from participating providers, working with them on file validation errors that may have occurred during processing. The files were stored within the state data warehouse for our SIM evaluator, MPHI, to review and provide evaluation results.

Regarding the CHIR technology needs, the SIM technology team is supporting the use case for the collection and reporting of SDOH. The SIM technology team met with each CHIR to capture the details of the technology and processes they implemented for SIM. This data will be used as content for the CHIR Tool Kit. Technology and lessons learned from the PCMH social needs screening initiative will be used to support the CHIR SDOH data requirements.

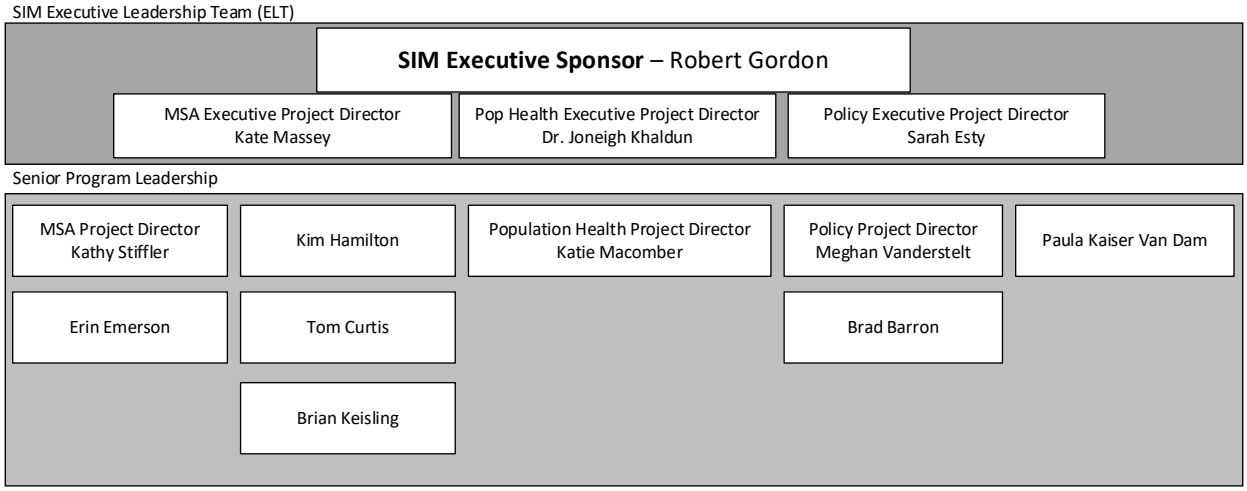
The team continued to work with the CHIRs and the MDHHS Bureau of Community Services to support their initiative of providing housing vouchers to highly vulnerable homeless individuals. Over the past six months, the team pulled additional Homeless Management Information System (HMIS) data needed to support the initiative. In order to streamline the existing manual process of pulling the HMIS data, and to setup a sustainable integration of HMIS data into the MDHHS data warehouse, a project was approved to develop and implement a monthly, recurring pull of the data. The project was completed in December 2019. As we close out the SIM project, the team is working with vendors and partners to ensure sustainability of data and processes needed after SIM.

1.4 SIM Program Management

The Governor's office continued to be engaged in the SIM Program through regular cabinet updates on SIM progress. Additional engagement was accomplished through a Governor's office liaison working closely with Policy and Planning, the administration within MDHHS charged with executing the SIM grant in Michigan. The SIM program also continues to maintain frequent engagement with Director Robert Gordon and his staff of deputy directors.

1.4.1 Governance Structure

The SIM organization and governance structure includes an Executive Leadership Team consisting of departmental directors from the Medical Services Administration; Public Health Administration; and the Policy and Planning Administration. Additional representation was added from the MDHHS Bureau of Community Services to reflect the added focus on housing within the CHIR initiative. This executive representation and governing body ensure the work initiated by the SIM grant is aligned with broader departmental vision, goals, and related objectives. Regular monthly governance meetings were planned, where status, planning, issues, risks, and other program-related topics are discussed; resolutions and mitigations are formulated; and decisions are documented. This input and guidance were essential to the oversight and success of ongoing implementation, operations and sustainability efforts.



1.4.2 Program and Portfolio Management

The Policy and Planning Administration continues to operate a chartered program management office, the State Innovation Model Program Management and Delivery Office, to establish an effective and formal authoritative framework to coordinate, support, track, manage and report on the portfolio of projects, activities and related endeavors that will be required over the lifetime of the State Innovation Model Test initiative in Michigan. The Program Management and Delivery Office is responsible for maturing and evolving the department's SIM program vision, strategy, best practices, standards, and other custom processes. Additional and significant support is being provided to the portfolio of component project management. The Program Management and Delivery Office mandate also includes operating an integrated operative governance model across all SIM components that includes program, project, operational and executive representation required to establish, guide, and provide oversight.

The Program Management and Delivery Office continues to plan, implement and manage the program operational model, ensuring strategy is realized and effective processes followed. Analysis of key component and program performance indicators and other operational data is used to identify potential gaps or other inefficiencies. The Program Management and Delivery Office has streamlined contract and funding request management processes expediting the ability to fund engagements with vendors, partners, participants, etc.

The Program Management and Delivery Office diligently applies proven program and project management processes and other custom organization and initiative controls required to meet the State Innovation Model Test near-, mid- and long-term business requirements and goals.

The Program Management and Delivery Office also continues to supplement the formal governance and operational structure with additional ad hoc and regular participant and other stakeholder engagements. These advisory committees are comprised of subject matter experts from various MDHHS departments and administrations, and other key personnel and Michigan SIM partners. Additional input is also sought and gathered via participant workshops, learning sessions, and other component- and program-wide activities.

2 Legislative Update

2.1 Population Health

2.1.1 Community Health Innovation Regions

Throughout the reporting period, the local CHIRs have continued to operate their Clinical-Community Linkages (CCL) and supporting interventions. A statewide SIM CCL consultant continued to work with each CHIR to catalog and document their CCL processes, and to develop training manuals to enhance and embed workflows, summary level data collection, and to troubleshoot issues as they arise. An area of focus in this period has been to effectively document work from design phase, to implementation phase and plans for sustainability of their CCL. Screening and referral services have continued in every CHIR and individual-level data on these services have been submitted to the MPHI CCL evaluation team. Locally, each CHIR uses the CCL data to inform action around policy and program service issues and to improve their screening and referral practices. In the last quarter of calendar year 2019, CHIRs have been identifying processes necessary for them to onboard to the statewide SDOH use case.

The MDHHS CHIR team held an in-person convening for CHIR BBO staff on October 30, 2019. During this meeting, MDHHS provided a high-level overview of the department's statewide SDOH. Backbone Organization (BBO) staff were introduced to the statewide SDOH use case and were briefed on the onboarding process. The MDHHS CHIR team also engaged BBO staff in a discussion of participation requirements for the post-SIM period.

In the summer and fall of 2019, CHIRs implemented plans to improve the homelessness response system in their communities. Working closely with providers of services to individuals experiencing homelessness, CHIRs identified barriers to coordinating accessible services and worked to mitigate them. This work, which is explained further in a later section of this report, allowed CHIRs to utilize their collaborative and CCL infrastructures and relationships to impact an individual human services sector in their communities, and served as a model for future work in other sectors.

CHIRs also continued work on improving program service delivery across sectors in their own communities. Following is a summary of CHIR-specific activities and accomplishments during this report period:

Genesee

- The CHIR distributed over 200 copies of its 2019 community Health Needs Assessment to member and partners with a focus on non-healthcare organizations.
- Genesee County's three hospital systems, Ascension Genesys Hospital, Hurley Medical Center, and McLaren Flint, as well as the Genesee County Health Department began working with the Greater Flint Health Coalition to identify joint community benefits opportunities as part of a consolidated Community Health Improvement Plan (CHIP).
- Genesee CHIR is now receiving and aggregating Emergency Department (ED) reports from all six Medicaid Health Plans operating in its region for ongoing distribution to PCMH practices.
- The CHIR reviewed high ED reports and identified the top five SIM PCMH practices whose patients account for 70%-80% of the high ED utilization in Genesee County and developed additional practice engagement strategies to increase their referrals to the CCL Hub.
- The CHIR developed a procedure for CCL Specialty Hub care coordinators to assist clients desiring to change primary care providers.
- The Interdisciplinary Care Coordination (ICC) Workgroup discussed next steps to improve the system of care coordination. Workgroup members decided to direct attention to the coordination of Medicaid Health Plan and PCMH practice care management services to improve patient outreach and decrease the duplication of efforts.
- The ICC discussed the potential to utilize Current Procedural Terminology (CPT) and G-codes to identify when health plan beneficiaries are receiving care coordination services from their PCMH to decrease duplication of services and improve coordination among the care coordinators.
- The CHIR convened a meeting of partners to begin efforts to conduct a social isolation feasibility study, given that social isolation is an underlying factor contributing to ED utilization.
- The BBO executed contracts for CHIR's special projects to address SDOH needs, including: expansion of Hurley Food FARMacy, Habitat for Humanity's Financial Opportunity Center, and Genesee Health Plan's Multi-Cultural Systems of Care, as well as support for Genesee Health System's Mobile Behavioral Health unit, development of a medical legal partnership and social isolation feasibility study.
- The CHIR developed and shared a Community Referral Provider Report outlining outbound referrals made by the Specialty Hubs to community service providers from the start of the SIM project through September 30, 2019. The report focused on the closed loop referral process for the 1,536 referrals made via the Community Referral Platform identifying that of these referrals 64.4% were completed, 13.3% declined, 18.5% cancelled and the remaining 3.9% were still open. Highest completion rates were for legal assistance, education/employment, healthcare access/health education, mental health/substance use disorders, and child care. The lowest completion rates were for housing/emergency shelter, utilities/rent assistance, and food insecurity (due to individuals failing to pick up food boxes).

Jackson

- Collective Impact Learning Community members held a convening to work together to help each other figure out ways to address barriers to community engagement. Every team left the convening with solutions to try to address the barriers they are encountering and will share results at subsequent convenings.
- Forty-three primary care physicians and office staff attended introductory Cross-Cultural Conversations.
- Community Health Worker training was held in September and included staff from Community Action Agency, Jackson County Housing Commission, Brown's Advanced Care Pharmacy, Central Michigan 2-1-1, and Region 2 Area Agency on Aging.
- The average number of days from the time a referral is made through the Jackson Care Hub to a connected agency to the time it is completed has decreased from 22 days to 6 between January 2019 and July 2019.
- All Jackson Collaborative Network (CHIR) coordinating councils reviewed network sustainability recommendations and provided feedback for consideration by the Network Sustainability Adhoc Committee.
- The CHIR enabled access for all PCMH practice patients to complete the SDOH screening questionnaire in MyChart, the patient portal, before their visit.
- The Community Living Room Workgroup handed over ongoing oversight for the living rooms to the hosting organizations.
- An upgrade to the Jackson Care Hub allows clinical providers to access the hub directly from the electronic medical record when completing a patient SDOH screen. This allows them to conduct the assessment and make referrals without having to log in separately to the hub.

Livingston/Washtenaw

- The second aggregation of PCMH-based social determinants screening data (for calendar year 2018) was analyzed and data issues were identified. After those issues were resolved, the aggregated data was shared with the PCMH subcommittee and CHIR work group.
- Hublets met regularly for care coordination and quality improvement activities.
- Eleven hublets and two partner entities have trained in using the care coordination platform. This includes a total of 118 hublet staff members.
- Led a cross-sector, community systems change effort in Washtenaw County to identify concrete action steps to improve substance use disorder treatment system issues.
- Created a detailed service map of substance use disorder treatment services in the community, as well as a shared vision document.
- Developed and pilot tested a protocol for discharging residents from Substance Use Disorder (SUD)-related facilities, to avoid discharging individuals from health settings into homelessness.

Muskegon

- The CHIR planned and conducted a Livability Lab kickoff event, held on September 10, 2019. This event drew an audience of nearly 300 individuals from the community and was designed to launch action teams around several community-based initiatives.
- At the event, 19 planning teams formed and began meeting over the next 100 days to pursue rapid, creative solutions to challenges that impede good health and prosperity in Muskegon County. Each

team will be staffed by a trained coach who will help manage the work. The teams were created using a framework that prioritizes five livability elements: education, health, social connection and trust, safety and security and economic opportunity.

- Organizations and funders are committed to embracing the outcomes of this action planning process in their funding priorities and strategic plans.
- A celebration event is scheduled for January 23, 2020, to acknowledge and honor the work that has been accomplished during the 100-day event and to create next steps to sustain these initiatives.
- The CHIR supported the creation of three neighborhood associations in Muskegon Heights, an area that has faced economic challenges to a greater degree than much of the rest of the city.
- These associations have sponsored activities to foster a sense of identity and community in these neighborhoods.
- The CHIR worked with community residents to create a Photovoice project to allow residents to share their stories and voices through photos they took in their neighborhoods. This project was also designed to highlight root causes of problems related to social determinants of health.

Northern

- CHIR supported MIThrive, which was a 31-county shared needs assessment effort to identify common priorities for the Community Health Needs Assessment (CHNA) across the area. Six common priority areas emerged across the 31 counties. Stakeholders across the region have identified shared change goals and metrics relevant to these priority areas.
- The Northern CHIR implemented a universal screening tool to address SDOH at 36 PCMHs and 20 community-based organizations across the 10-county region.
- Based on the number of needs identified, individuals may be referred to the Community Connections Hubs to facilitate access to a variety of community services. The Hubs are staffed by a team consisting of a community health worker, a social worker, and a nurse.
- Hub staff track individuals over time to determine if their needs are met. Data collected through this work also helps identify gaps in community services.
- The CHIR created action teams to address service gaps and monitor outcomes. These action teams are multi-disciplinary and are focused on a specific geographic area.
- The Northern CHIR has initiated an expansion of their region to include all 31 counties that are part of the Northern Michigan Public Health Alliance. By the end of the SIM test period in January 2020, the CHIR will have an organizational expansion plan in place and an expanded governance structure that includes leadership from the entire 31-county region.

2.1.2 Health Through Housing Initiative

MDHHS, with support from the Michigan State Housing Development Authority (MSHDA) and the Michigan Coalition Against Homelessness, has launched the Health through Housing initiative -- a multifaceted approach to partner housing and healthcare information and resources. The initiative consists of four components:

- **Conducting a frequent user pilot** with housing service providers to connect identified homeless and high cost Medicaid clients with housing and other crucial services to directly impact their health and well-being.

- **Using data analytics** to identify vulnerable individuals experiencing homeless who show high Medicaid utilization and cost, prioritize them for housing and address other SDOH.

- **Building capacity** among housing and homeless service providers to enhance their capabilities as providers of permanent supportive housing and strategizing the most appropriate ways of accessing additional funding for tenant-based services.

- **Improving local homeless response systems** in CHIRs to reduce barriers to housing, build better integrated partnerships between the healthcare and housing communities, and improve overall patient outcomes.

Frequent User Pilot

By providing Housing Choice Vouchers and supportive services to a targeted group of homeless Medicaid high utilizers, 3 pilot agencies in the CHIR communities had the opportunity to demonstrate how permanent housing and supportive services directly impact this vulnerable population's health and well-being. Pilot participants are provided long term rental assistance along with short term case management to stabilize physical and behavioral health conditions. The frequent user pilot officially began October 1, 2018, in three CHIR communities: Northern Michigan, Livingston-Washtenaw (pilot agency is only serving Washtenaw County), and Muskegon.

Each participating pilot agency has been continuously working with their target population. These efforts include; assisting the individual(s) with obtaining housing, providing the support to connect them with needed resources, helping them make a smooth transition into permanent housing, and providing ongoing case management to support housing stability. MDHHS partnered with Optum to develop Pilot data reports. These reports give MDHHS the ability to track on a monthly basis the effectiveness of the Pilot work in terms of lowering Medicaid costs, emergency department utilization, in-patient hospital stays, and increasing the overall health and well-being of the participants.

Data Analytics

Bringing together data from the HMIS and the statewide Medicaid data warehouse, MDHHS has created an opportunity to identify and analyze the crossover of the two cohorts. This data can potentially produce key information to prioritize the most vulnerable individuals for housing and health resources. By using these analytics, people could be served more quickly and with a greater impact to their overall well-being.

The technical scaffolding has been put in place to allow for a monthly import of HMIS data into the MA data warehouse. Ongoing data matching will allow for routine monitoring of enrollment information, thereby improving coverage for this vulnerable population while also reducing delays and unnecessary administrative costs. The initial match has been completed and refined and in partnership with Michigan Coalition Against Homelessness (MCAH), Optum and our SIM tech team, MDHHS has established a process that will routinize a match between the two data sets on a recurring monthly basis. MDHHS is currently working to finalize a Data use agreement (DUA) that will allow for the proper data sharing and hand-off process of these high priority lists to kick off this recurring list process throughout the year.

MDHHS brought on Global Data Strategy (GDS) to assess Michigan's HMIS system. The goal of this assessment was for GDS to inform ways to improve housing data quality and overall usability of the system. In order to perform this assessment, GDS presented their initial findings and recommendations including the establishment of a statewide governance structure and creation of a separate data warehouse for reporting.

Capacity Building

Meeting the needs of a homeless population with serious health conditions is a unique challenge. Housing providers must be skilled at delivering the array of services and supports found in quality permanent supportive housing. To assist in the building of these skills, a second Quality Self-Assessment Webinar was held in September for Permanent Supportive Housing (PSH) providers. Providers were encouraged to take the Corporation and Supportive Housing (CSH) quality self-assessment to evaluate their performance, partnerships and agency practices according to the industry standards of Quality Supportive Housing. After completing the self-assessment, their agency received an emailed summary of their score in each of the Dimensions of Quality Supportive Housing. They also received a corresponding resource list of available training and technical assistance to support their agency to further develop best practices in areas where their scores indicated room for improvement.

In addition, since the Quality Supportive Housing training that was provided by CSH to supportive housing and CHIR staff, the funding landscape for critical support services has been changing. One result was the drive for housing programs to seek new sources to fund service delivery. MDHHS followed in the footsteps of other states and applied for a waiver through CMS that would allow reimbursement for selected tenant-based support services. This 1915i waiver was approved and in place by October 1, 2019 and is specifically for individuals eligible for behavioral health services through the carveout.

Because most permanent supportive housing providers are not Medicaid-billable agencies, MDHHS in partnership with CSH, will be providing a Medicaid Academy at the end of January that will train housing agencies on how to become eligible to bill Medicaid or subcontract with a Medicaid billable agency for housing based services. Providers will learn how to secure partnerships with behavioral health partners, comply with regulations, and become licensed, certified and credentialed in Michigan. They will also learn about best practices in supportive housing service delivery.

Improving Local Homeless Response Systems

The goal of the "Improving the Homeless Response System" initiative is to support each CHIR community in their efforts to address current barriers and ensure that individuals and families experiencing homelessness can be housed quickly and permanently. To address these barriers, each participating CHIR received assistance through January 31, 2020, to develop and implement a plan that will have a significant positive impact on the community's ability to serve its homeless population. Communities received technical assistance from the CSH, to assist them in identifying system gaps or barriers as well as structuring their plan proposal. The development and implementation of this plan is a collaborative effort between the CHIR backbone organization and the local homeless Continuums of Care demonstrating the partnership between healthcare and housing systems. All five proposals submitted by the CHIRs for Improving the Homeless Response System were reviewed and approved. These CHIRs have been in the process of working through their early implementation phases within their communities.

As of January, each CHIR has now submitted a proposal for continuing the work they've begun in their communities, post SIM. The hope is that this work will not only become fully sustainable within each community but will create system changes that will improve service delivery long-term.

2.1.3 Plan for Improving Population Health

Michigan's Plan for Improving Population Health focuses on three main components: healthcare delivery, clinical-community linkages, and community conditions. The Plan targets SDOH at each of these layers, focusing on strategies to change systems and pursue equity. The Plan builds on Michigan's SIM design by identifying opportunities to (1) shift practices within the healthcare delivery system to include identifying basic needs and linking clients with community services, (2) create stronger linkages between clinical and community services and settings, and (3) shift community conditions so that the environments in which people live promote health, including the physical, service, social, and economic environment. Through SIM, Michigan focused on coordinating efforts between the care delivery system and organizations in the community. However, the deep health inequities across the state cannot be addressed without changing the conditions in which people live. The Plan for Improving Population Health builds on capacity developed through SIM and across the state to address SDOH through strategies that connect people with services and strategies that change conditions.

Two committees met monthly to inform the development of two main sections of the Plan; the Health Status Committee and the Public Health Capacity Committee. Guiding principles were created to guide the work of each committee, and each operated under a committee charter. The Health Status Committee identified indicators that articulate the health status of Michiganders, with intentional emphasis on the racial disparities and social determinants of health. The Public Health Capacity Committee described the public health infrastructure in Michigan across programs and initiatives focused on social determinants. They also identified needs and gaps in capacity to address social determinants.

Three additional committees were convened to develop the Plan portion of the Plan for Improving Population Health. MDHHS staff, local health department representatives, and CHIR BBO staff developed goals, strategies, activities, and measures for each of the three main sections of the Plan: community conditions, community-clinical linkages, and healthcare delivery. They identified strategies that could be locally driven, and state supported, and they focused on addressing SDOH broadly. MDHHS Public Health Administration staff reviewed committee recommendations and made final updates to the Plan.

MDHHS has been intentional in aligning the Plan for Improving Population Health with other similar state-wide assessments and improvement efforts that overlap with the goals of the Plan. MDHHS has convened meetings with the MDHHS SDOH Strategy team and the Michigan State Health Assessment & Improvement Plan team. Each team has shared the background and goals of each assessment or effort, with the intent of leveraging findings from multiple efforts to improve the health and wellbeing of Michigan residents. This continued focus on strategy and intentionality will allow this Plan to transition to implementation beyond SIM funding.

2.2 Care Delivery

2.2.1 Patient-Centered Medical Home

The SIM PCMH Initiative continued to enable Medicaid funding for patient-centered care and provide opportunities to increase the number of practices invested in primary care transformation. The Care Delivery team worked closely with the Department's Medical Services Administration (Medicaid) managed care team to operationalize actuarially sound Care Management and Coordination payments for Initiative Participants, administered through Michigan's Medicaid health plans. Additionally, performance-based incentives implemented January 2019 to further support maintenance and enhancement of embedded care coordination services, were finalized and included in the final Initiative payment This work provided a foundation for sustainability mechanisms using the Medicaid managed care division's relational, contractual, and incentive levers with Medicaid health plans.

Through technical assistance webinars, meetings and other communications, the team continued to support the activities previously described, and to bolster participating practices through the expansion and enhancement of the PCMH Initiative Participation Guide. Additional efforts focused on improving the patient population identification and payment facilitation process.
Key accomplishments for this reporting period included:

- The PCMH Initiative team in collaboration with key contractual partners hosted one quarterly update and a final project close-out virtual meeting engaging approximately 100 participants with positive evaluation and constructive feedback with respect to post-SIM transition received
- Participant final Progress Report and July-Dec Semi-Annual Practice Transformation Reports were developed, disseminated, and collected for review and inclusion in final evaluation reporting for the Initiative
- Completed participant compliance and monitoring activities including:
    - Issued and reviewed administrative audits on Dashboard and Patient List Utilization; maintained ongoing monitoring of HHIE compliance (Active Care Relationship Service (ACRS), Health Directory (HD), Admit, Discharge, Transfer (ADT), Quality Measure Improvement (QMI)); Issued and tracked to resolution (3) CAPS for Dashboard Utilization to bring participants into compliance
    - 15 audits across all participants in the area of Care Management Training
- Hosted live virtual office hour sessions on the following topics: Servicing the Invisible Patient, Pediatric Depression, Plan for Improving Population Health (PIPH) Update, Trauma Informed Care, and SDOH Technical
- Continued regular monthly newsletters through December including a recurring segment on current literature and participant best-practice sharing
- MDHHS continued facilitation with ongoing committee workgroups with stakeholders in preparation of the single culminating PCMH Initiative Summit, which was held November 12, 2019. The summit planning committee and MDHHS developed a robust agenda covering a wide array of topics useful for all SIM stakeholders. Over 250 SIM participants gathered in Lansing for the capstone event of the Initiative. Achievements made possible through the SIM Initiative were celebrated, including fewer emergency department and preventable ED visits, increased cervical cancer screenings, and substantial improvements in the breadth and robustness of SDOH screening in Michigan primary care practices. Summit sessions included an MHP Panel Discussion, a Michigan clinician, and a national speaker from Virginia,

- Completed final participant performance against the approved benchmark for care management/coordination services and determined final application of the Care Management Improvement Reserve (CP) for those organizations determined to have underperformed for the defined benchmark period.
- Applied the Performance Incentive Program guidelines and presented anticipated Base and Bonus Incentive payment summaries individually to Participants.
- Issued Amendments to 2019 Agreement to managing organizations of (6) practices that lost PCMH designation.
- Both Care Management and Coordination and Practice Transformation payments were coordinated and disseminated to participants through partnering Medicaid Health Plans for 4th quarter (October – December 2018). Payment file was developed and implemented to disseminate payments for remaining 3 quarters 2019. Notable changes included reconciliation of CMIR withholds and disbursement of Performance Incentive Program (PIP) Base and Bonus Incentive payments.
- Utilizing the Relationship Attribution Management Platform as the foundational process to support attribution, individual monthly patient lists were released August 2019 through December 2019; aggregate patient lists were released to Participants as appropriate
- PCMH Team developed and disseminated final supplemental reporting questions for those participants who applied for and received two additional award opportunities to enhance Initiative their organization's advancements in the areas of capacity building for health information exchange and CCL data sharing
- Continued collaborative between multiple vendors and Initiative participants engaged in the CCL Data Partnership initiative to receive social determinants of health screening data files from 11 participants of pilot.
- Held weekly planning sessions with PCMH contractor partners to strategize process improvements, develop or refine 2019 virtual learning and support opportunities, evaluate initiative participant feedback for actionable program enhancements, review participant monitoring reports, and strategize issue mitigation as appropriate.
- Informed and coordinated with Medicaid health plans on Initiative operations through bi-weekly operations meetings.
- Collaborated with colleagues in Managed Care Plan Division to identify mechanisms to sustain key components of the care delivery model leveraged throughout the course of the SIM demonstration.

2.2.2 Alternative Payment Models

The state is continuing its work to promote the meaningful use of APM through health plans in the Michigan Medicaid program. The overarching goal is to increase the opportunities for providers to participate in performance-based payment models, improve quality of care for Medicaid beneficiaries, and create some consistency for providers. Michigan's Medicaid Managed Care Plan Division (MCPD) has developed a broad APM strategy in partnership with the state's Medicaid Health Plans to increase the spread of APMs and make a wider variety of APMs available to support innovative care delivery efforts that are linked to quality improvement.

During the reporting period, the Quality Improvement and Program Development (QIPD) section implemented the fiscal year 2020 capitation withhold program, including MHP provider contracting requirements, care management/care coordination utilization benchmarks, and quality measurement and

improvement targets. Additionally, the QIPD team leveraged data gathered from MHPs about APM implementation which included the amount of incentives offered to providers that go "uncollected" or unpaid. The intent was to document the incentive opportunities MHPs are offering to providers to supplement the existing data collection regarding the amount of incentives actually paid. These data were compared with the quality measurement and improvement data the QIPD will received in August 2019 to identify trends in incentive structure and improvements in quality of care.

2.3 Technology

SIM leveraged existing federal- and state-funded initiatives to define, implement and test a multi-payer statewide data sharing infrastructure and Relationship Attribution Management Platform.

Michigan continued to support population health goals by coordinating with CHIRs to collect information about social determinants of health and to assess each individual CHIR's technical needs. Key accomplishments for this time period included:

Data Stewardship

- In preparation for post-SIM life the SIM Technology team reviewed existing data sharing agreements and worked with appropriate parties to ensure agreements are discontinued or updated as needed.

SIM performance and evaluation tool

- The SIM technical team continued to monitor and manage the monthly attribution process of the Relationship and Attribution Management Platform, correcting data issues as needed.
- The team continued to work the Michigan Data Collaborative (MDC) to produce the federally required quarterly progress report measures.
- As we near the close out of the SIM project, the team met with vendors and partners to review technology timelines for decommissioning functionality and processes no longer needed after SIM.

Care coordination enablement

- The SIM technology team implemented a solution for collecting social determinants of health information from SIM PCMH's. Working with Care Delivery, the team received three rounds of SDOH data from participants and successfully stored the data in the state's data warehouse for the evaluation team to access.

Payment model analytics and reporting

- Continued utilizing the Relationship and Attribution Management platform to determine the SIM population to denote who will receive Practice Transfer Fees payments in the PCMH initiative. Continued reporting to SIM PCMH's and MHPs their SIM affiliated members via monthly reports
- The team continued to analyze ACRS files and look for areas of opportunity to optimize how attribution occurs across the state. All analysis and recommendations will be completed in January 2020.

Population health toolset

- The team worked with Optum, MCAH, and DTMB to implement an automatic, monthly data feed of HMIS data to support continued evaluation and reporting.

- SIM Technology team worked with the CHIR team, Care Delivery, and providers to define requirements for receiving SDOH files from the CHIR's. In the remaining weeks of SIM, CHIR's will be onboarded onto the state SDOH use case for evaluation and reporting after SIM.
- In support of the CHIR team's initiative to create a "CHIR Toolkit", the SIM technology team provided detailed overviews of each CHIR's technology solution implemented during SIM.

Sustainability
For the remaining weeks of SIM, the technology team will continue to support MDHHS and all SIM components as they implement their sustainability plans and decommission any technical solutions no longer needed.

Many SIM Technology investments have been one-time investments intended to enable a piece of technology infrastructure which did not exist or needed improvement. Therefore, they will not require financial investment going forward. Any ongoing technology support needed is a continuation of either the Care Delivery or Population Health components and will be integrated into their sustainability plans.

3 Evaluation

3.1 Legislative Update

The state-evaluation continued to be led by MPHI in collaboration with MDHHS, the team at Michigan State University (MSU) lead by Dr. Pennie Foster-Fishman, and the University of Michigan Child Health Evaluation and Research (CHEAR) Center. The impact evaluation component aims to collect and analyze information on emerging outcomes that will justify continued investment in the model by key stakeholders after the SIM program concludes. The formative evaluation component aims to surface lessons learned along the way that provide real-time information to SIM stakeholders to aid in implementation and inform how the state and other stakeholders should modify, scale, and spread the models during and/or post-SIM.

The evaluation focuses on three interrelated areas that cross both the PCMH and CHIR tracks:

1. Care Management and Coordination (CM/CC)
2. Clinical-Community Linkages (CCLs)
3. Community Change

The evaluation of Care Management and Care Coordination and the CCLs include both process and outcome components. Process analyses are based on PCMH track reporting (Quarterly Reports and Practice Transformation Reports) and focus on implementation progress and barriers. Additional process analyses are based on both CHIR and PCMH submitted individual level data related to screening for social determinants of health, referrals for social services, and linkages opened and closed to address the identified needs. These metrics are tracked over time to measure changes in implementation of CCL activities.

Outcome evaluation of both CM/CC and CCLs includes PCMH provider and staff responses to survey items as well as patient reported outcomes through paper and telephone-based patient/client experience surveys. In addition to the surveys, a key data source for the CCL outcome evaluation are also the individual-level CCLs data submitted by all five of the CHIRs and 11 PCMHs participating in the CCL outcomes study. Outcomes related to CM/CC and to CCL are also being assessed by leveraging the State Medicaid Data Warehouse and

conducting analyses of Medicaid data of patients with CM/CC as well as of CCL clients served by a CHIR hub, and of CCL patients in the 11 PCMHs to determine the extent to which the SIM initiative required activities relate to individual level healthcare utilization and costs over time.

The evaluation of community change focuses on the CHIR structure and leadership for collective impact; on community alignment, including the participation of PCMH, physician organizations, and health systems; and on sustainability and policy changes that are created because of these efforts. Process and outcome analyses are based on qualitative interviews, observations, review of CHIR meeting minutes and other documentation. In addition, Collective Impact surveys are being used to assess the attitudes and experiences of CHIR members, partners, and stakeholders within each participating community.

MPHI-Led Evaluation Activities Six-Month Update

A key focus of MPHI's activities for the second half of 2019 has been the process of securing and analyses of the final set of individual level CCL data from all the CHIRs and the 11 Physician Organizations (POs) and practices participating in the PCMH Initiative CCL Data Partnership study. MPHI also completed the administration of the 2019 Provider survey. MPHI has already completed the first and second round of analyses of SIM care management recipients using 2017 and 2018 Medicaid data in the first half of 2019.

CCL Individual Level Data Analyses

The statewide evaluation has focused on gathering and analyzing individual level CCL data (screening for SDOH needs and social service linkages) on both the population health (CHIR) and care delivery (PCMH) sides. Preliminary work included securing legal and data sharing agreements; promoting alignment and agreed upon standardization of data elements and format of submitted data across contributing organizations; developing and de-bugging data sharing systems and process; and gathering stakeholder feedback on desired analyses and summary tables.

CHIR CCL Data

CHIRs were instructed to provide data on all clients with a CCL activity during specific timeframes. A CCL activity is defined as any of the following: (a) a screening conducted, (b) a social needs linkage opened, or (c) a social needs linkage closed. First round of reporting submitted to the MDHHS SIM leadership and eventually shared with the five CHIRs in May and June of 2019 were based on data received from the CHIRs of CCL activities conducted within the timeframe Nov. 1, 2017 to Dec. 31, 2018. By the end of 2019, varying levels of data submission have been received from the CHIRs of their CCL activities within the requested timeframe of January to June 2019. Only two CHIRs had CCL linkage data that can be properly processed and analyzed for the second round of reporting. The CHIR CCL Report-Round 2 template required more refined analysis and reporting as requested by CHIR and SIM teams and approved by SIM leadership in August 2019. The reports continued to provide a summary of CCL process metrics, and a separate section that leveraged the MDHHS Medicaid encounter and eligibility data to summarize client demographics, geographic characteristics, and healthcare utilization and cost information before and after being served by the CHIR CCL process. In addition, the report included analysis by client subgrouping based on their first linkage opened date and presented findings of two reference groups of non-CCL CHIR Medicaid individuals: those who were SIM PCMH-attributed and those who were not SIM PCMH-attributed. Reports for the two CHIRs (Jackson and Genesee) were submitted to MDHHS SIM leadership in November 2019.

Analyses showed that CHIRs are targeting their resources towards Medicaid clients in their regions with significant health challenges (e.g. over 80% of the adult clients and 15% of the children that CHIRs served have more than one chronic condition), higher medical costs and more complex health and social needs. More than a quarter of the CHIR clients live in regions that are considered among the top 10% most disadvantaged communities in Michigan in terms of income, education, employment, and housing. Most common needs are physical and mental health related, transportation, food and housing; with the most common services provided to meet transportation, food and housing needs. Ascertaining whether needs have been met is, however, difficult for the CHIRs; data on linkage status is frequently missing.

PCMH CCL Data

Participating Physician Organizations and PCMHs in the PCMH Initiative CCL Data Partnership started submitting their data of patients' SDOH screening results and linkage efforts in the first quarter of 2019, and additional data in subsequent two quarters. Out of 11 participating PCMHs/POs, 9 had historical data – i.e. of CCL activities during the timeframe 3/1/17 – 12/31/18 - that were processed and analyzed including linking the individual level CCL data to Medicaid data. All 9 individual PO reports and a separate report of all 9 POs data combined were submitted to the MDHHS SIM leadership by August 2019. The individual reports were also shared with the PCMH/POs. Out of the 9 POs, only 3, however, were able to provide linkage information in addition to screening data.

By November 2019, all 11 POs were able to submit their data of CCL activities up to the end of September 2019. These data were also processed, analyzed and linked to Medicaid data. The second round of reporting included 11 individual PO reports and a report of the aggregate 11 PO data submitted to MDHHS SIM leadership at the end of December 2019. Out of the 11 POs, 5 POs were now able to provide linkage information in additional to screening data.

For both the first and second round of reporting, section 1 of the PCMH CCL reports provides a summary of CCL process metrics, section 2 summarizes individual demographics, chronic conditions and geographic characteristics using the linked Medicaid data by the number of social needs and whether a linkage was opened or not, and section 3 summarizes healthcare utilization and cost.

Key findings from the first round of reporting have been shared in technical assistance presentation to the PCMH, and in a presentation on evaluation results at the PCMH summit in November 2019. In both the first and second round of reports, the most common needs identified through screening were in the following domains: physical and mental health, employment, education, food and utilities. Compared to individuals with zero need, individuals with at least one need were more likely to have received care management/coordination services, have two or more chronic conditions with co-occurring behavioral and physical health conditions, live in the Michigan's top 10% most deprived neighborhoods, and incurred higher baseline year PMPM (per member per month) medical cost.

Clinical Community Linkage 2019 Provider Survey

The Clinical Community Linkages Survey of Healthcare Providers and Associated Stakeholders was first administered in 2018 to assess health care provider beliefs and attitudes around the value of addressing patient social needs within the health care setting, progress in implementing screening for social needs and CCLs in participating PCMHs, and the perceived impact of participating in screening and CCLs on patients, providers, practices and community systems. A second administration of the survey was conducted from June through August of 2019, and had a total number of 608 respondents from the health care sector,

including primary care providers, care managers/care coordinators, practice administrators, and PO staff from participating SIM POs and practices (surpassing the 480 responses received for the 2018 report). A draft report of the survey results has been completed and is undergoing internal review before being sent to the SIM Leadership.

The draft report indicated that healthcare providers participating in SIM continue to report high levels of motivation and progress related to the screening of patients for social determinants of health and referrals for social services. SIM continues to provide needed resources and supports to better align these efforts across participating health systems and communities. Providers are reporting that SIM-supported efforts are leading to positive impacts on their patients' health, their practice's awareness of community resources, coordination efforts with social service providers and overall practice-level policies.

Legislative Dashboard

The MPHI evaluation team worked closely with MDHHS SIM team to pull materials from various sources including reports generated by MPHI and provide key findings to include in the legislative dashboard. The aim of the legislative dashboard/CHIR infographic is to inform the state legislature about the work being done in SIM, and to present data on the CCL progress in Michigan's SIM CHIR initiatives.

Key points in the infographic dashboard pulled from the CHIRs CCL reports include the following:

- CHIRs serve people with significant health challenges:
    - 27% of CHIR clients live in regions considered among the top most disadvantaged in Michigan in terms of: income, education, employment, and housing.
    - 84% of adults and 15% of children have more than one chronic condition (with depression and anxiety as the most prevalent conditions among adults; and asthma and ADHD among children).
- CHIRs are also targeting their resources towards Medicaid clients in their regions with higher medical costs and more complex health and social needs.
- In terms of social needs, the most common services provided were for transportation, food, and housing.

MSU-Led Evaluation Activities Six-Month Update

The MSU evaluation team has the primary focus of the Collective Impact Evaluation. The MSU team has administered and analyzed over 600 responses to surveys to CHIR members, partners, and stakeholders representing 310 organizations. The team also performed a total of over 100 interviews with members, partners, stakeholders and backbone organization staff. Targeted focus groups were also held with community health workers, health plans, and backbone organizations. The findings of these surveys and interviews reveal that the CHIRs have promoted a level of cross-sector coordination, alignment, and synergy that did not previously exist. By making social determinants of health the focus of the work, the CHIRs have launched a paradigm change. Their efforts are transforming people's lives. Due to the CHIR work, people are now getting support before unmet needs become a healthcare crisis. Throughout the evaluation process, the MSU evaluation team has been providing rapid results to the state SIM leadership and to the individual CHIRs through presentations and summary reports of the key findings.

The MSU team has also completed and delivered playbooks integrating quantitative and qualitative findings customized for each CHIR. The purpose of the data playbook is to describe the specific CHIR's successes to

date as captured by the MSU Collective Impact Evaluation data collection activities. The playbook is also the foundation for the CHIR sense-making session – to engage CHIR members, local partners, and key stakeholders in making sense of the evaluation findings. The data and sense-making sessions are being used to develop system level strategies to continue to embed the CHIR work in the community and to address scalability and sustainability moving forward.

Another round of surveys and interviews was launched through the second half of 2019. By the end of 2019, the MSU team worked on drafting the CHIR Bright Spots, an executive summary document of collective impact evaluation, and a roll up report of the 2019 CHIR Collective Impact interviews for submission to the MDHHS SIM leadership in January 2020.

University of Michigan CHEAR-Led Evaluation Activities Six-Month Update

Patient Experience Surveys

SIM evaluation plans included surveys of PCMH staff and community agencies to document the successes and challenges of SDOH screening implementation. SIM leadership also sought to understand the patient perspective, particularly in light of anecdotal reports suggesting that patients did not want to address SDOH needs in the primary care setting. Thus, key questions for the patient experience survey related to whether patients feel that SDOH screening in the primary care setting is acceptable, whether patients identified through screening receive assistance with those needs, and if patients have suggestions for how to improve primary care SDOH screening. SIM leadership asked the UM CHEAR Center to conduct the patient experience surveys.

In consultation with SIM leadership, a two-part data collection method was developed: (1) brief mailed survey of patients who recently received care at SIM PCMH practices, and (2) follow-up phone interviews among a subset of mailed survey respondents who indicated that they had an SDOH need identified through primary care screening, expressed disagreement with SDOH screening in the primary care setting, or had a suggestion of an SDOH need that was not picked up by screening. The surveys were mailed beginning in November 2018 and continued to mid-2019. Interviews began in December 2018 and continued to mid-2019. By the end of 2019, data from the surveys and interviews have been processed, reports of the findings drafted, and presentations conducted to share the findings to some of the CHIRs.

Key findings from the patient experience surveys include the following:

- Most adult patients and parents of pediatric patients have positive interactions with PCMH providers and staff that likely contribute to an environment that encourages disclosure of SDOH needs.
- Overall, 2 out of 5 patients recalled answering questions about SDOH needs at a PCMH visit in the past year.
- Three quarters of patients who reported an SDOH need said the PCMH discussed their concern, and three quarters said they wanted help with their SDOH need.
- Patients/parents reported a wide range of SDOH needs. Health problems of the patient and/or a family member often exacerbated other challenges.
- Among patients who said the PCMH addressed their SDOH needs, most were referred to another agency. Often, patients received some assistance, but it did not completely address their SDOH need.

- Among those who said they did not want help, key reasons were that they felt they could handle it on their own, they thought the PCMH could not do anything, or they felt the situation was not dire enough to require outside assistance.
- The majority of patients had no other SDOH screening. The PCMH was the most preferred location for SDOH screening.
- Patients who expressed reluctance about SDOH screening in the primary care setting commonly felt that the doctor's office should be focused on medical issues, that SDOH needs should be private, and that the PCMH should wait for patients to raise SDOH issues. Patients had few suggestions for how the PCMH could improve the process of SDOH screening.

3.2 Legislative Metrics and Measures

Section 1144 of the legislative boilerplate contained mandates for outcomes and performance measures for the initiative to be collected and included in this report. The list of measures included, but were not limited to, the following:

- Increasing number of physician's practices fulfilling PCMH functions
- Reducing inappropriate health utilization, specifically reducing
    - Preventable Emergency Department (ED) visits,
    - the proportion of Hospitalizations for Ambulatory Care Sensitive Conditions, and
    - the state's 30-day Hospital Readmissions Rate.

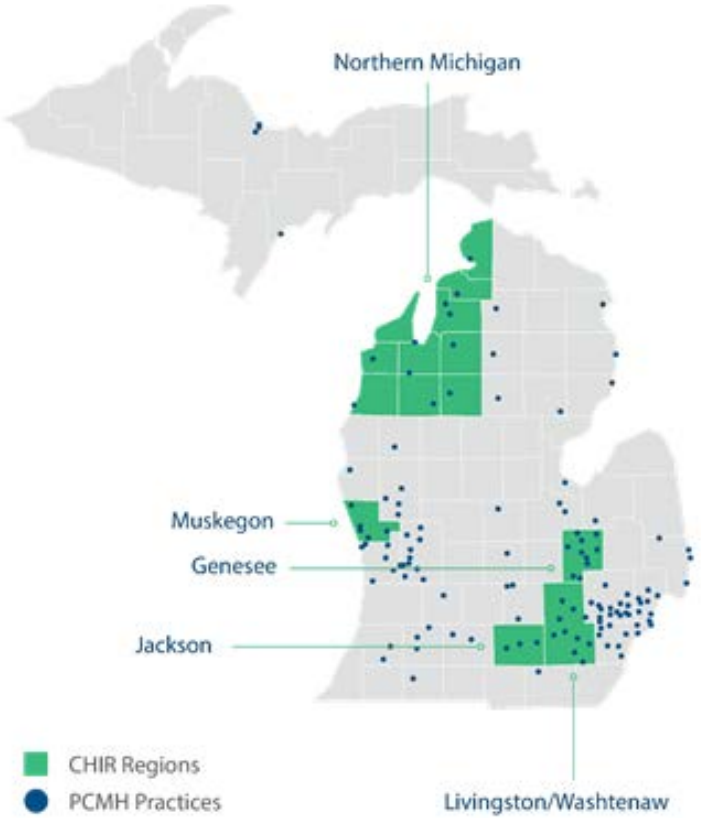
For this semi-annual report, the reporting period for the utilization measures is from July 2018 to June 2019. The measures are of the eligible populations of Medicaid beneficiaries that are attributed to a SIM PCMH whether in a CHIR region or not. Most of the measures are of the full PCMH population including pediatric populations. This current report presents the utilization measures as rates per 1000 attributed members of all ages.

Below is a brief description of the measures:

- Emergency department visits assess ED utilization among PCMH population. Mental health ED visits are included. This measure is the rate of ambulatory ED visits per 1000 attributed members of all ages.
- Preventable emergency department visits measure the rate of preventable ED visits per 1000 attributed members of all ages.
- All cause acute inpatient hospitalization rate is the rate of all cause acute inpatient stays per 1000 attributed members (all ages).
- 30-day all-cause readmission shows the readmission rate for beneficiary population that are attributed to a PCMH, were hospitalized at a short-stay acute-care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. The numerator is the number of acute admissions following acute inpatient hospital stays within 30 days of discharge for patients aged 18 to 64 during the measurement year; the denominator is the total number of eligible acute inpatient stays for patients aged 18 to 64 during the measurement year. The readmission rate is the rate per 1,000 acute care hospital discharges.
- Ambulatory Care Sensitive Conditions (ACSCs) inpatient hospitalization rate is the rate of ACSC inpatient stays per 1000 attributed members. ACSCs are conditions for which good outpatient care

can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. For this report, the Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQIs) measures are used with hospital inpatient claims to identify quality of care for ambulatory care sensitive conditions. The PQIs overall composite per 1,000 attributed members, ages 18 years and older, is used as the ACSC admissions rate.

The performance measures are displayed by the five SIM regions.



PCMH Participation Metrics

REGION	PRACTICES	PROVIDERS	BENEFICIARIES
Jackson	10	47	16,752
Livingston/Washtenaw	39	373	34,180
Muskegon	23	146	29,891
Genesee	56	138	39,963
Northern *	18	179	29,353
Total SIM Regions	146	883	150,139
TOTAL Non-SIM Regions (Outside CHIRs)	152	1,181	168,684
TOTAL **	**298**	**2,064**	**318,823**

* Antrim, Emmet, Wexford, Kalkaska, Leelanau, Missaukee, Benzie, Charlevoix, Manistee, Grand Traverse

** Beneficiary count based on December 2019 data.

Overall Utilization Measures

(Reporting period: July 2018 to June 2019)

Measure	Numerator	Denominator	Rate (Per 1,000 Attributed Members)
Emergency Department Visits	171,714	241,442	711
Preventable ED Visits	92,456	241,442	383
Acute Hospital Admissions	9,060	241,442	38
Ambulatory Care Sensitive Condition (ACSC) Admissions - Overall Adult Composite	2,269	160,897	14
	Numerator	**Denominator**	**Rate (Per 1,000 Discharges)**
30-Day All-Cause Readmission	838	7,260	115

Rate of Ambulatory ED Visits per 1000 Attributed Members (all Ages) by CHIR Regions
(Reporting period: July 2018 to June 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	18,163	29,348	619
Jackson	Jackson	10,231	13,356	766
Livingston/Washtenaw	2 Counties	15,030	25,594	587
Muskegon	Muskegon	23,742	22,315	1,064
Northern	10 Counties	13,493	22,356	604
Total Non-SIM Regions (Outside CHIRs)		91,055	128,473	709
Overall Total Ambulatory ED Visits		***171,714***	***241,442***	***711***

Rate of Preventable ED Visits per 1000 Attributed Members (All Ages) by CHIR Regions
(Reporting period: July 2018 to June 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	9,129	29,348	311
Jackson	Jackson	5,262	13,356	394
Livingston/Washtenaw	2 Counties	7,982	25,594	312
Muskegon	Muskegon	14,246	22,315	638
Northern	10 Counties	6,749	22,356	302
Total Non-SIM Regions (Outside CHIRs)		49,088	128,473	382
Overall Total Preventable ED Visits		***92,456***	***241,442***	***383***

Rate of Acute Hospital Admissions per 1000 Attributed Members (All Ages) by CHIR Regions
(Reporting period: July 2018 to June 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	1,303	29,348	44
Jackson	Jackson	551	13,356	41
Livingston/Washtenaw	2 Counties	928	25,594	36
Muskegon	Muskegon	640	22,315	29
Northern	10 Counties	709	22,356	32
Total Non-SIM Regions (Outside CHIRs)		4,929	128,473	38
Overall Total Acute Hospital Admissions		***9,060***	***241,442***	***38***

Rate of Ambulatory Care Sensitive Condition (ACSC) Admissions - Overall Adult Composite per 1000 Attributed Members (aged 18 and Above) by CHIR Regions
(Reporting period: July 2018 to June 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	333	19,166	17
Jackson	Jackson	154	10,038	15
Livingston/Washtenaw	2 Counties	213	17,570	12
Muskegon	Muskegon	97	15,068	6
Northern	10 Counties	178	15,512	11
Total Non-SIM Regions (Outside CHIRs)		1,294	83,543	15
Overall Total ACSC Admissions – Adult Composite		***2,269***	***160,897***	***14***

30-day All-Cause Readmission Rate per 1000 Discharges
(Reporting period: July 2018 to June 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	107	972	110
Jackson	Jackson	49	464	106
Livingston/Washtenaw	2 Counties	98	786	125
Muskegon	Muskegon	37	521	71
Northern	10 Counties	53	551	96
Total Non-SIM Regions (Outside CHIRs)		494	3,966	125
Overall Total 30-Day All-Cause Readmission		***838***	***7,260***	***115***

4 Budget

The SIM program and its component initiatives highlighted in this report have been funded through a cooperative grant agreement with Centers for Medicare and Medicaid Services innovation center. The SIM program continues to execute component initiatives based on the Centers for Medicare and Medicaid Services approved operational plan and budget. The scale and pace of expenditures throughout award year 3 (February 1, 2018 through January 31, 2019) proceeded at the highest level of any SIM award year. Consequently, these expenditures have made significant contributions to the engagements necessary to progress SIM goals. A portion of award year 3 funds did remain unspent and were carried forward to award year 4. The final budget year utilizes these excess funds to further bolster the ongoing operations, sustainability planning and transition of SIM component initiatives to MDHHS operations.

4.1 Legislative Update

The table below highlights the specific budget and expenditures across standard Centers for Medicare and Medicaid Services grant budget categories. The contractual line includes the funding for numerous program and component planning, implementation and operational teams as well as other specific contractual needs to support the broader SIM goals. The expenditures across the categories below represents only the budgeted and realized in the six months that are encompassed in this report. The spending includes engagements facilitated though both direct State of Michigan master and standard contractual agreements and other contracts and engagements through the designated SIM fiduciary, MPHI.

Categories	12 mos. Budget	6 mos. Expenditures
Personnel	$189,125	$67,244
Fringe Benefits	$103,026	$47,193
Equipment	$0.00	$0.00
Supplies	$40,000	$9,681
Travel	$18,627	$5,118
Other*	$0.00	$22,357
Contractual	$24,121,872	$9,369,035
Total Direct Charges	$24,472,650	**$9,520,631**
Indirect Cost	$0.00	$0.00
Total	$24,472,650	**$9,520,631**

* Other expenses are for cost allocation. $61,400 is budgeted for cost allocation in the fringe category.

The budget period is 12 months, beginning February 1, 2019 through January 31, 2020. The reporting period spans August 1, 2019 to January 31, 2020. **Due to the timing of the posting of expenses into the State's accounting system, not all December 2019 and January 2020 expenses are included in the totals above**.