State Innovation Model (SIM)
Progress Report 2

(FY2019 Appropriation Act - Public Act 207 of 2018)

September 1, 2019

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, FY 19 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: Population 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 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. Patient-centered medical homes 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 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 Patient-Centered Medical Home 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. The hubs reached full implementation in February 2018.

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. Four agencies in three CHIR communities (Livingston-Washtenaw, Muskegon, and Northern) are currently working with their target population to secure permanent housing and get connected to other resources.
- **Using data analytics** to identify vulnerable individuals experiencing homeless 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 is currently working on a technology solution that will routinize this data match to access current information.
- **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 intends to submit new waiver language to the Center for Medicare and Medicaid Services by August 2019 articulating the tenant support activities it would like to include in its state Medicaid plan. Once the waiver is approved, MDHHS will be 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. All five CHIRs have completed their gap analysis and have submitted their proposal to make improvements to their Homeless Response System. Four of these proposals have been approved by MDHHS and the implementation work is in progress. The fifth CHIR's proposal is in the process of being revised.

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 made steady progress towards the development of our Plan for Improving Population Health in SIM Year 3. MDHHS selected the Deputy Director of the Population 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 includes partners from Medical Services Administration and Behavioral Health and Developmental Disabilities Administration to guide the development of the Plan and to support alignment across department administrations. In SIM Year 3, the Workgroup began meeting monthly and accomplished several milestones with facilitation support from the Michigan Public Health Institute (MPHI), including reaching consensus on

the vision and purpose of the Plan; developing a broad outline and guiding principles; and creating a strategy for stakeholder engagement.

The purpose of the 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, (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. The first two subcommittees finalized their work together in early 2019.

Over the next three months, subcommittee activity will focus on the third activity. The broader Workgroup brainstormed strategies that address social determinants through (1) clinical encounters, (2) clinical-community linkages, and (3) community conditions. Subcommittees related to each of these topics will meet, select priority strategies, and develop goals and objectives. The subcommittees will each meet twice for 2-hour facilitated sessions to develop the content of the Plan. MPHI will produce a final draft of the Plan for MDHHS review by December 1, 2019 for internal review, and the Plan will be released for Public Comment by January 1, 2020.

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 patient-centered medical home has been viewed, from the outset, as the foundation for a transformed healthcare system in Michigan. The SIM PCMH Initiative is built upon the principles of a patient-centered medical home that generally define the model regardless of the designating organization. Value is 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.

More than 300 primary care practices are participating in the SIM PCMH Initiative. These practices represent approximately 2,000 primary care providers and approximately 325,000 Medicaid beneficiaries. Approximately 15 percent of the total Medicaid beneficiary population in the state is eligible for participation in the SIM PCMH Initiative. While the PCMH Initiative has participating practices statewide, roughly 50 percent of the practices are in a SIM CHIR region.

All participating practices are 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 are 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 must invest in population health management by empaneling their patient population and utilizing feedback reports to drive actionable change through quality improvement.

The state has established a payment model specific to the SIM PCMH Initiative to support practice transformation and care coordination. Each practice participating in the PCMH Initiative will receive payments for its attributed eligible Medicaid beneficiaries. Practices will receive 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 have 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 is working 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 and technology infrastructure. The state’s overarching goal in promoting APMs is to promote service delivery innovation and maximize the opportunities for providers to receive enhanced reimbursement for improving patient health.

The Medical Services Administration 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 has 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 has 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 has also 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 pass-thru 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 (RAMP) in early 2017. Components of the platform continue to function in an integral manner to generating patient lists to participating providers within the SIM PCMH Initiative. For the past year it has provided funding to Medicaid Health Plans for payments to providers belonging to those provider organizations participating in the PCMH Initiative. These same PCMH providers are also exchanging a variety of message types through Michigan's statewide data sharing infrastructure. PCMH participants are actively participating in the Active Care Relationship Service (ACRS); Admission, Discharge and Transfer (ADT) messages; Health Directory; and the Clinical Quality Measure Reporting and Repository use cases. The SIM technology team continues to provide oversight of the RAMP by monitoring the ongoing monthly attribution files for accuracy and timeliness.

The SIM Technology team is supporting the Care Delivery's initiative to collect social determinants of health (SDoH) data. We received a first round of production files from participating providers and are working with them on file validation errors that may have occurred during processing. Based on findings from the first round of submissions we are currently implementing changes to improve the process before the second round of production files are submitted. The SIM evaluation team is reviewing the files that have passed validation.

Regarding the CHIR technology needs, the SIM technology team is supporting the use case for the collection and reporting of social determinants of health data. The SIM technology team is developing the data-sharing and technology platform requirements and recommendations needed to implement clinical-community linkages (CCL). This document will be called the CHIR Technology Tool Kit. The SIM technology team continues to meet with each CHIR to capture the details of the technology they implemented for SIM. This data will be used as content for the CHIR Technology Tool Kit. Technology and lessons learned from the PCMH social needs screening initiative will be used to support the CHIR social determinants of health data requirements.

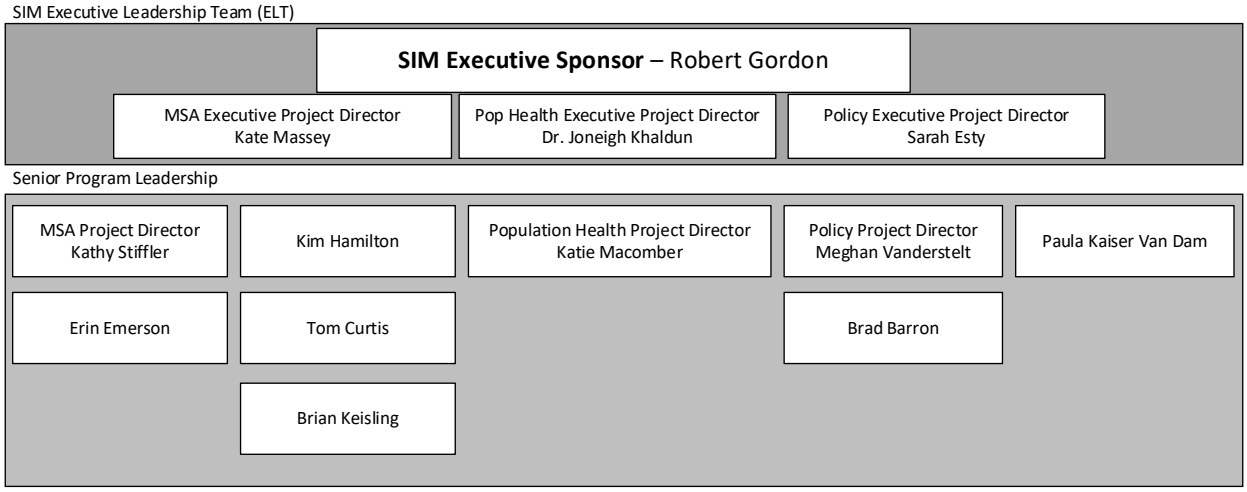
The team continues to work with the CHIRs and the MDHHS Bureau of Community Services to support their initiative of providing housing vouchers to highly vulnerable homeless individuals. Over the past six months, the team pulled additional Homeless Management Information System (HMIS) data needed to support 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 an automated pull of the data. We are in the process of developing the solution and plan to have it production ready by October 2019.

1.4 SIM Program Management

The governor's office continued to be engaged in the State Innovation Model (SIM) Program through regular cabinet updates on SIM progress. Additional engagement is 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. As the state has transitioned to a new administration, the SIM program continues to maintain engagement with Director Robert Gordon and his staff of deputy directors.

1.4.1 Governance Structure

During Award Year 2, an updated SIM organization and governance structure was approved and implemented by MDHHS. Specifically, the expansion of leadership and governance includes an Executive Leadership Team consisting of departmental directors from the Medical Services Administration; Population Health Administration; and the Policy and Planning Administration. Similarly, during Award Year 3, additional representation was added from the MDHHS Bureau of Community Services to reflect the added focus on housing within the CHIR initiative. This newly expanded executive representation and governing body ensures the work initiated by the SIM grant is aligned with broader departmental vision, goals, and related objectives. Regular monthly governance meetings are 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 is 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 SIM 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

The local CHIRs continued to strengthen their Clinical-Community-Linkages (CCLs) and supporting interventions. The CHIRs are now operating under their updated operating plans, which became effective October 1, 2018, and will continue through the remainder of the SIM Model Test period. A statewide SIM CCL consultant works with each CHIR to streamline workflows, manage shared data effectively, and to troubleshoot issues as they arise. An area of focus in this period has been to effectively incorporate the use of screening data into planning processes at the organization, sector, and community levels.

Two convenings of CHIR Backbone Organizations were held on February 27, 2019 and May 15, 2019. At the February meeting, the state CHIR team facilitated discussions regarding communication tools, the development of a CHIR model document, evaluation, and a discussion with Medical Services Administration (MSA) leadership. The May meeting focused around sustainability and a more in-depth conversation between MSA leadership and the CHIRs. As a follow up to the two conversations with MSA leadership, a meeting was facilitated on June 26, 2019 by the state CHIR team for the Medicaid Health Plans to connect with CHIR leaders. Feedback from regional CHIR staff and from Medicaid Health Plan representatives was very positive. Meeting participants felt it was a valuable use of time to discuss how plans and CHIRs can work together to meet the needs of beneficiaries.

In the last quarter of 2018, several CHIRs prepared and submitted proposals describing how they plan to improve the homelessness response system in their communities. Four CHIRs submitted plans that have been approved and are now being implemented. The fifth CHIR is in the process of working with a consultant to conduct a gap analysis of their homeless response system. This homeless response system work represents a very practical opportunity for CHIRs to concentrate on an individual sector in their communities and to use their infrastructure and relationship networks to gather stakeholders to take specific action toward strengthening the local system.

Additionally, many of the CHIRs have completed (or will complete) a comprehensive systems-change training program led by Michigan State University called the ABLe Change Framework. The ABLe Change Framework is a model designed to help communities and states more effectively address the significant social issues affecting children, youth, and families. The model is based upon that premise that communities

can achieve transformative results when they make local system and community conditions the intentional targets of their change initiatives, when they pursue the effective implementation of their efforts, and when they build a community engagement infrastructure that supports real-time learning and action across diverse stakeholders and sectors.

During this time period, evaluation results on collective impact and transformative change were shared with each of the CHIRs. The data for these reports was gathered in the summer/fall of 2018, very shortly after the CHIRs began implementing their interventions. This evaluation will be conducted again in the summer/fall of 2019 to show the growth of the CHIRs.

The MSU Evaluation Team reported that these results were very impressive, given the time period. In addition, these results indicate that CHIRs are creating a cross-sector coordination, alignment and synergy that did not previously exist. This alignment is emerging across individual CHIR members/partners, participating organizations, and the broader service system. CHIRs are strengthening community systems by breaking down silos, strengthening cross-sector partnerships, bridging the gap between health and social sectors, and nurturing collaborative synergies. Below are the evaluation findings and some highlighted quotes for each of the CHIRs:

Genesee:

See Appendix 5.1: Genesee Findings Preview

- 78% of members of the Genesee CHIR report that because of their involvement in the SIM project, their organization is gaining opportunities to have a greater impact than they could achieve on their own.
- 83% of members report they are making changes in their organization because of their involvement with the CHIR to expand efforts to improve community social, health and living conditions.

Clients of the Genesee CHIR have reported[1] that the CHIR has helped them in a positive way:

- 94% agree that they know more about which community services might be available to address a similar problem in the future.
- 91% agree that they understand more about how to get the services or help they need.
- 85% agree they are able do more to support their own health because of the CHIR.

"The SIM is teaching us that different programs can work together regardless of their levels of impact on a person to change their health. We've got… the literacy network; housing, of course; health, diabetes education; …when we put them all together, we can create a more healthy society… not just a healthy society, but a better served society." -Funder, Member

Jackson:

See Appendix 5.2: Jackson Findings Preview

[1] University of Michigan Child Health Evaluation and Research Center invited clients to contact the Greater Flint Health Coalition to give feedback on their interactions with the Genesee CHIR's CCL services in December 2018. Data come from 33 respondents.

- 78% of members report that the SIM project has enabled a level of action and collaboration that could not have happened without it's support
- 76% of members report that the SIM project creates opportunities for significant improvement in the community that could not have happened without its support.
- 71% of leaders representing service-providing organizations report initiating or making changes in policy, procedures, or practices as a result of SIM project involvement

"So what we've learned is that none of these problems exist in a silo. These issues are all tied together, and you can address the symptom, but if you don't figure out what all of the issues are, then we're not going to break the cycle." -Social Sector, Stakeholder

"Working together in this way is an opportunity to achieve things you could never achieve organizationally on your own. There's real power in that, in sharing those resources and sharing the brains that come to the table and really thinking differently about working in a different way." -Funder, Member

Livingston / Washtenaw:

See Appendix 5.3: Livingston/Washtenaw Findings Preview

- 70% of members report the SIM initiative enables a level of action and collaboration that could not have happened without its support.
- 63% of members report the SIM initiative creates opportunities for significant improvement in the community that could not have happened without its support.
- 91% of members of the LW CHIR coordinate their efforts with each other to better leverage resources and outcomes.
- 83% of member organizations are collecting more or different types of data to inform
- 75% of member organizations are increasing efforts to inform individuals about available services/supports.

"…a lot of the folks who keep coming back to the ER have pretty bad physical health issues, but they're really complicated by mental illness, by substance abuse, homelessness, lack of food, [and] lack of transportation So, if we address all of their issues, then their ER utilization is going to go way down, which is going to save healthcare dollars for everybody…" – Social Sector, Partner

Muskegon:

See Appendix 5.4: Muskegon Findings Preview

- 83% of partner organizations report that their involvement in SIM has caused them to expand efforts to improve community social, health, and living conditions.
- 79% of partner organizations report that their involvement in SIM has caused them to increase efforts to inform individuals about available services/supports.
- 75% of partner organizations report that their involvement in SIM has caused them to work to improve the quality of their services.

"Similar to a doctor's office interviewing patients on social determinants of health needs, our district is using CHIR funding [to do this at schools]. We hired our school-based resource navigator. When children have behavioral concerns, she becomes involved from a home-based perspective. This is something new that schools have never done where she goes out to the home and says, "I'm aware of the behavior of your child, and it's disruptive. It's a problem at school. So what's going on?", "How are you doing? Do you have enough food? Is your kid being fed? Does your kid need to see a doctor?" We've only had her for a little over a month, and it is unbelievable the impact that she's had." -Social Sector, Member

"Because of the CHIR, we are learning how to leverage our resources and not duplicate, not compete, but to work as partners and say, you know, "If we can share this information, we just don't have to try to do it all." -Health Sector, Member

Northern:

See Appendix 5.5: Northern Findings Preview

- 83% of partner organizations report increasing efforts to inform individuals about available services/supports.
- 84% of partner organizations report expanding services and programs to address gaps.
- 79% of partner organizations are collecting more or different types of data to inform continuous improvement.

"I think the CHIR is creating the space for people to work together towards a couple of common goals. I'm thinking about the action teams…there's some work related to housing. These are people that work together all the time, know each other. But by connecting with the CHIR, they've had the space available to really focus on a project together and some funding that was made available because of the resources of the CHIR… It's this coordinating, connective effort that makes the space for some cool things to happen." -Social Sector, Member

"I think that the Community Clinical Linkages has really allotted the resources to help patients in all areas of their lives. Having the connections that we've made, it's easier for my community health worker to know who to reach out to when we have a patient that presents with a need that maybe we don't address specifically at the clinic. So that's been really helpful." -Health Sector, Member

Over the past six months the CHIRs have worked to improve the functioning of their CCL and supporting interventions. Some accomplishments this reporting period include:

Genesee:

- Completed analysis of over 1,315 community resident and stakeholder surveys administered regarding socioeconomic, environmental, and quality of life factors; health problems, and risky behaviors that affect the health of the community
- Completed the Community Health Needs Assessment and developed timeline for completing the Community Health Improvement Plan
- Approved focus areas of CHNA: SDoH, substance use, and child health & development, and mental health

- Onboarded additional entities bringing the total to 31 practices participating in clinical-community linkages (CCL) initiative, as well as additional community partners bringing total to 35. Non-SIM practices are expressing an interest in using screening tool.
- Monthly "rounding" calls held on challenging cases are improving care.
- Shared sample intro scrips and engagement conversation statements to standardize processes across CCL hubs
- The Flint Registry is utilizing the CCL community referral platform
- Improved technology by obtaining access to Great Lakes Health Connects Virtual Integrated Patient Record and utilizing admission, discharge, and transfer feeds
- Interventions for substance use and obesity being implemented
- Conducted GAP analysis of local housing support system, submitted and received approval for Homeless Response System Improvement proposal
- 4,657 SDoH screens this quarter bringing total to 21,274.
- 1,094 referrals to the hub
- Specialty hubs served 1,425 Medicaid beneficiaries
- 1,526 unique high emergency department utilizers identified

Jackson:

- Saw a reduction in minor or non-urgent emergency department use by 2% from 2018Q4 to 2019Q1
- Engaged a Behavioral Health Liaison to help create reverse referral pathways at LifeWays and Henry Ford Allegiance Health. The focus is to provide a standard means for a psychiatrist to refer a patient to a primary care provider since currently referrals are not bi-directional.
- 110 visits by 97 unique guests in mental health crisis to the Crisis Respite Center (January-March 2019). 95% were successfully treated without requiring hospitalization.
- Redesigned 24/7 after hours call center into a patient access center to increase access to services for residents.
- E-visit utilization is expanding, and video visits were launched in one of the PCMH practices in April.
- 1,869 visits to the Community Living Room-Reed Manor by 190 unique individuals from January – March 2019. Daily attendance averages 31 guests. A second community living room was launched at the Jackson Interfaith Shelter.
- Jan-March 2019, 791 referrals were made for SDoH.
- Saw an increase in the Top Box Access to Care result from 79.6% in 2018Q4 to 82.8% in 2019Q1
- Working to refine and advance technology to allow interoperability between Epic EMR and the Jackson Care Hub.
- Technology improved so that Jackson Health Network Care Managers receive referrals through the Care Hub rather than through faxed paper referrals.
- SDoH screening notification has been built into the Jackson Health Network's performance management tool as a tracking measure. This allows PCMH practices to identify whether a specific patient has been screened in the last year and the percentage of patient panel that has been screened.
- The Learning Partner teams are working on addressing identified barriers to engagement like, adult literacy, transportation in small remote communities, childcare, and addressing power dynamics in community meetings.

- The workgroup learned more about the "prototyping" aspect of human centered design in preparation for strategy implementation.
- Cross Cultural trainings being held – Area Agency on Aging - 55 people trained. Forty-three primary care physicians and office staff attended introductory Cross-Cultural Conversations. One participant commented, "While it was only two hours, the content definitely has gotten me thinking about how I perceive certain people and my reactions to certain situations."
- A Jackson County Health Department nurse working in the sexually transmitted disease clinic conducted 40 SDoH screenings and made 244 referrals in a six-week period. This was an accomplishment because this clinic's staff were initially hesitant to engage with the CCL.
- 2,821 SDoH screens were completed by the 12 SIM practices in May. An additional 2,580 were completed by nine non-SIM practices for a total of 5,401 screens in primary care practices.
- Six community health workers from the Jackson CHIR completed the Michigan Community Health Worker Alliance training
- Three strategy areas have been approved: Increase youth interaction with caring adults, expand youth programming, improve coordination among youth service providers.
- Collaborative Network has been meeting and discussing a restructuring of their framework. They held a half day meeting and identified how each organization can contribute to the initiative and the importance of sustaining the work by embedding it in partner organizations.

Muskegon:

- Community members living in the "Resilience Zone" participated in a Photovoice, a visual research methodology with the intention to foster social change. Used worldwide, it is a process by which people can identify, represent, and enhance their community through a specific photographic technique. As a practice based in the production of knowledge, photovoice has three main goals: (1) to enable people to record and reflect their community's strengths and concerns, (2) to promote critical dialogue and knowledge about important issues through large and small group discussion of photographs, and (3) to reach policymakers.
- With coaching from the Michigan State University ABLe Change team, Muskegon is planning a 100 Day Challenge event, to facilitate collective impact by uniting the community around a shared vision and championing quick wins to make actionable changes in their community around SDoHs.
- Community-based agency recruitment is underway for the CCL to ensure that SDoH screenings are being conducted outside of the PCMH practices.
- Significant efforts have gone into streamlining data collection and creating a community dashboard to review SDoH data
- Negotiations with health plans to fund community health workers through the CHIR are underway
- Trauma Informed Community trainings
- 15 Individuals enrolled in Muskegon Prescribes Food for Health program

Livingston-Washtenaw:

- Resulting from the ABLe Change training process, they have created 7 work groups for improving their Substance Use Disorder system whose goal is to implement the below listed activities between June – September 2019:

Action Team	Key Activities
Shared Values	Finalize document clarifying what "resident choice" means in the local SUD treatment system. Vet this document with key stakeholder organizations and make changes. Incorporate the agreed-upon values into funding decisions made by the prepaid inpatient health plan.
Public Will and Eradication of Stigma	Work with the Washtenaw Recovery Advocacy Project (WRAP), the local recovery community organization (RCO) to identify all RCOs in Michigan to create a statewide network. Identify preferred anti-stigmatizing language to be shared statewide.
Resident Engagement	Develop and implement a survey for people currently using substances to identify their needs, preferences, and desires around becoming engaged in the SUD system transformation, potentially through an advisory board.
SUD Need Identified	Assess and analyze SUD screening tools in use across the community, both internally to SUD treatment providers and to external providers.
Common, Coordinated Intake	Building on the current practices of the SIM intervention, identify a point person within each organization in the SUD treatment system that liaises with other organizations, and use or modify SIM intervention release of information more broadly across community agencies. Begin identifying aspects of a universal assessment tool.
Integrated Array of Accessible Supports	Building on the service map created during ABLe Change days 5 and 6, document, vet, and share the array of SUD-related services in Washtenaw County.
Aftercare & Reengagement	Working at the nexus of three SIM-related projects that all identified a system gap of discharge from health settings into homelessness, develop and pilot a potential protocol for discharging residents from SUD-related facilities (transitional housing, inpatient, or residential treatment).

- Working to expand clinical-community linkages to include additional organizations into the care coordination meetings beyond just the hublets.
- Continued work to improve the predictive model.

Northern:

- Release of a request for proposals, webinar, and decision of SDoH projects to fund ($50,000 allocated)

- Launch of Local Action Teams aligned with hub service areas to complement SDoH Action Teams
- Annual governance review: officer election, stakeholder analysis, memorandum of understanding/charter edits, etc.
- Presentation of Collective Impact Evaluation results and "sense-making" session
- Presentation of hub client data analysis by gender, year of birth, county of residence, referral source, etc.
- Presentations at community collaborative meetings re: hubs, SDoH work, and MiBridges/211
- Completion of housing assessment, gap analysis, strategy prioritization, and work plan
- Presentation of data analysis of MiThrive regional community health needs assessment
- Presentation of communications products: website and annual report
- Presentation of PCMH provider survey
- Ranking of community health priorities based on MiThrive Community Health Assessment
- Launch of systems changes to the homeless system response
- Submission of proposal to Michigan Health Endowment for access to healthy food/wellness strategy
- Presentation of statistical analysis of social determinants of health screening and hub data
- Beginning to work on expansion of the region

2.1.2 Health Through Housing Initiative

MDHHS, with support from the Michigan State Housing Development Authority 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 social determinants of health.
- **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, four pilot agencies in three Michigan communities will have the opportunity to demonstrate how permanent housing and supportive services directly impact this population's health and well-being. Participants are provided long term rental assistance along with short term case management to stabilize physical and behavioral health conditions. The frequent user pilot is functioning as of October 1, 2018, in three CHIR communities: Northern Michigan, Livingston-Washtenaw (pilot agency is only serving Washtenaw County), and Muskegon.

Each participating pilot agency is continuing to work with their target population. These efforts include; assisting the individual(s) with obtaining housing, providing the support to connect them with needed resources, and helping them make a smooth transition into permanent housing. MDHHS is partnering with Optum to develop analysis reports that provide the Medicaid costs for each Pilot Participant both pre and post housing. These reports give MDHHS the ability to track the effectiveness of the Pilot work in terms of lowering Medicaid costs and emergency department utilization and increasing the overall health and well-being of the participants.

Data Analytics

Bringing together data from the Homeless Management Information System (HMIS) and the statewide Medicaid data warehouse, MDHHS has created an opportunity to identify and evaluate a population of clients experiencing homelessness with high Medicaid costs and/or utilization. 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.

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 MDHHS is currently working to establish a process that will routinize a match between the two data sets. This monthly process is expected to be in place before the end of 2019.

Due to the usefulness of the data by-name lists that were initially provided to the Pilot communities, additional Continuums of Care have reached out and requested a list for their community as well. Currently, we are in the process of providing Kalamazoo with the same type by-name list. We will also be providing Genesee with an aggregate data list that will paint a picture of what the homeless population looks like in their community. Detroit, Jackson and Kent county recently reached out and inquired about this aggregate list and will be receiving one as well.

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 agencies with building these skills, MDHHS is partnering with national technical assistance provider, Corporation for Supportive Housing, to offer targeted training for providers to identify and actively improve their capacity to deliver quality permanent supportive housing. Quality Supportive Housing Training (Permanent Supportive Housing Academy) was provided in May for 35 Permanent Supportive Housing and CHIR staff. In addition, the funding landscape for critical support services is changing -- driving housing programs to seek new sources to fund service delivery. Medicaid is the first step, but other opportunities exist as well. MDHHS is following other states by applying for a waiver through CMS that would allow reimbursement for selected tenant-based support services. This 1915i waiver is expected be approved and in place by October 1, 2019.

Most permanent supportive housing providers, however, are not Medicaid-billable agencies and will need training and support to achieve accreditation. Following the approval of the 1915i waiver, MDHHS will offer training and consultation through the Corporation for Supportive Housing to agencies that are seeking to become eligible to bill Medicaid or subcontract with a Medicaid billable agency for housing-based services.

Another beneficial training that was provided by Corporation for Supportive Housing was the "Supporting Tenants with Opioid Use Disorder" training. Because opioid use and overdose has increased in many communities and homeless individuals entering Permanent Supportive Housing are often dealing with opioid use disorder, this training focused on enhancing skills and understanding of working with individuals with opioid use disorder. Tools were provided to aid housing supportive service and substance use disorder providers in their efforts to deliver effective case management and support for individuals with opioid use disorder. Participants also learned how to apply evidence-based skills and techniques to help support clients with the goal of remaining stably housed. Attendees left the training with an understanding of best practices in overdose prevention, harm reduction, stages of change, assertive engagement, and recovery support.

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 is eligible to receive 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. Each community will receive technical assistance from the Corporation for Supportive Housing, to assist them with 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 CHIRs have completed their gap analysis and have submitted their proposal to make improvements to their Homeless Response System. Four of these proposals have been approved by MDHHS and the implementation work is in progress. The fifth CHIR's proposal is in the process of being revised.

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 social determinants of health 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 social determinants of health 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 operates under a committee charter. The Health Status Committee identified indicators that articulate the health status of Michiganders, with intentional emphasis on the social determinants of health. The Public Health Capacity Committee identified the available public health capacity in Michigan across programs and initiatives focused on social determinants and identifying needs and gaps in capacity impacting population health. These committees completed the work required and have been completed.

Three additional committees are being convened to develop the Plan portion of the Plan for Improving Population Health. MDHHS staff and local health department representatives will develop goals, strategies, activities, and measures for each of the three main sections of the Plan: community conditions, community-clinical linkages, and healthcare access. The Public Health Administration's SIM Workgroup will review committee recommendations to finalize potential strategies for addressing social determinants of health, identify existing levers that can support moving these strategies into action, and will finalize an implementation plan. Recommendations of the committees and the Workgroup will be used to drive the implementation plan.

Finally, a key focus for Year 4 is generating robust stakeholder engagement and ownership for the strategies outlined in the Plan. Michigan Public Health Institute (MPHI) will facilitate four large listening sessions with the following groups of partners: SIM Community Health Innovation Regions, the Michigan Association of Local Public Health, Medicaid Health Plans, and SIM Patient-Centered Medical Home representatives. Feedback and recommendations gathered from these meetings will be incorporated into the final draft. The final draft of the complete Plan will go to public comment for Michiganders by January 1, 2020. The final deliverable of the Plan will be submitted to CMS by January 31, 2020.

2.2 Care Delivery

2.2.1 Patient-Centered Medical Home

The SIM Patient-Centered Medical Home (PCMH) Initiative continues 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 continues to work closely with the Department's Medical Services Administration (Medicaid) managed care team to operationalize actuarially sound Care Management and Coordination payments for Initiative Participants. Additionally, effective January 2019, performance-based incentives have been implemented to further support maintenance and enhancement of embedded care coordination services. This work has 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 continues to support the activities previously described, and continue to bolster participating practices through the expansion and enhancement of the PCMH Initiative Participation Guide. Additional efforts have been focused on improving the patient population identification and payment facilitation process. Finally, significant efforts have been geared towards the development of Initiative Participants' support opportunities. These supports include the formation of the Care Coordination Collaborative, Care Manager training curriculum, and other opportunities to effectively engage participants and support overall success.
Key accomplishments for this reporting period included:

- The PCMH Initiative team in collaboration with key contractual partners hosted two quarterly update virtual meetings (April and July); approximately 130 participants attended each with active engagement, positive evaluation and constructive feedback
- Participant 2018 Self-Assessment and Progress Report 1 of 2 for 2019 were analyzed and key findings presented to stakeholders and reviewed for actionable interventions
- Jan-June Semi-Annual Practice Transformation Report was developed, disseminated, and collected for analysis to occur in August.

- Continued participant compliance and monitoring activities including:
    - Issued and/or tracked three Corrective Action Plans for Quality Measure Information Use Case and 24/7 access, 12 Requests For Information (RFI) for SAPTR and seven RFIs for Care Management Billing
    - Issued eight audits across all participants in the areas of: Care Team Meetings, Practice Consent to Participate, 24/7 Access to a Decision-Maker, Alternative Visits, 30% Open Access, Electronic Health Record Utilization, Dashboard and Patient List Access
- Hosted live virtual office hour sessions on the following topics: Community Health Innovation Region (CHIR) Update, 2019 Initiative Payment Model, Evaluation Update (Care Management and Coordination focus), Michigan Data Collaborative Dashboards, Pediatrics: ADHD and Medication Education, Social Determinants of Health (SDoH) and Patient Engagement, Evaluation: Patient Experience Survey, and Pediatrics: Asthma
- Continued regular monthly newsletters including a recurring segment on current literature and participant best-practice sharing
- With ongoing support of the multi-stakeholder Care Coordination Collaborative (CCC) Planning Committee, MDHHS hosted two in-person CCC events. Each event had over 100 participants from across SIM (CHIR representatives, PCMH participants, and MHP members). The first event on April 9 focused on leveraging the SDoH to coordinate partners and improve outcomes and the care experience. The second event, which was held on July 30, focused on decreasing unnecessary utilization and streamlining care efficiency. Each in-person event highlighted presentations from each attending stakeholder group mentioned above. We were also excited to offer the attendees time to network and complete focused working sessions whereby they worked to collaborate and solve regional barriers focused on clinical-community linkages and using data to improve care coordination.
- MDHHS has also facilitated ongoing committee workgroups with stakeholders in preparation of the single culminating PCMH Initiative Summit, which will be held November 12, 2019. The summit planning committee and MDHHS have developed a robust agenda covering a wide array of topics that will be useful for all SIM stakeholders. Speakers have also been secured for each of the summit sessions including: MHP representatives, CHIR representatives, PCMH participants, and a national speaker from Virginia. Presentation development is ongoing and expected to be finalized early this fall.
- Evaluated participant performance against the approved benchmark for care management/coordination services and implemented the Care Management Improvement Reserve (CMIR) for nine organizations determined to have underperformed for the defined benchmark period.
- Developed the Performance Incentive Program guidelines and presented methodology and operational details to Initiative participants during supplemental technical assistance webinar.
- Disseminated and received executed Amendments to 2019 Agreement reflecting change in Care Management and Coordination training requirements to align with updates made to 2019 Blue Cross Blue Shield requirement.
- 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). New payment file specifications were developed and implemented with health

plans to disseminate payments for 1st quarter of 2019 through the end of the Initiative. Notable changes include termination of Practice Transformation payments and the implementation of CMIR withholds. During this period take-backs were calculated for those 2018 SIM attributed beneficiaries who were found to have been incarcerated, deceased, or receiving care in a skilled nursing facility during the attributed period. These takebacks will be recouped with the 2nd quarter payment of 2019. Note that funding for Care Management and Coordination and Practice Transformation payments does not include SIM federal funds

- Utilizing the Relationship Attribution Management Platform as the foundational process to support attribution, individual monthly patient lists were released February 2019 through July 2019; aggregate patient lists were released to Participants as appropriate
- PCMH Team developed and disseminated 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. Received and analyzed historical data from 8 Physician Organizations
- PCMH Initiative Team worked collaboratively with APM Team to incorporate feedback from Medicaid health plans to enhance a 2020 State-Preferred PCMH Model Interest Application.
- PCMH Initiative Team facilitated State-Preferred PCMH Model Interest Application cycle to solicit and compile responses to application on behalf of Michigan's 11 Medicaid health plans to inform them of provider capability and interest in being considered as paid providers of care management/coordination services for Medicaid managed care beneficiaries after the SIM Initiative concludes. 73 applications encompassing 870 providers and 3,717 providers were evaluated at the practice level for compliance with minimum PCMH eligibility criteria to inform recommendations made to MHPs for consideration for inclusion in their PCMH programs for 2020 contract year. All data received was compiled and submitted to MHPs.
- Held weekly planning sessions with PCMH contractor partners to strategize process improvements, develop 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.

2.2.2 Alternative Payment Models

The state is continuing its work to promote the meaningful use of Alternative Payment Models (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 finalized the fiscal year 2020 capitation withhold program, including Medicaid Health Plan (MHP) provider contracting requirements, care management/care coordination utilization benchmarks, and quality measurement and improvement targets. Additionally, the QIPD team gathered additional data from MHPs about APM implementation which includes 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 will be compared with the quality measurement and improvement data the QIPD will receive 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 the Relationship Attribution Management Platform.

The MDHHS Data Sharing Workgroup established under SIM will continue to pursue ongoing alignment of state initiatives. The workgroup will continue to focus on standard data formats, efficient data flow, timely use of data and transitioning claims-based metrics to quality data. Also, increased efforts will be focused on the effective use of data and data quality, rather than data transfer. SIM Technology work will continue through the MDHHS Data Sharing Workgroup to continue the advancement and appropriate use of health care data exchange use cases including, but not limited to, Admission, Discharge, and Transfer messages and Quality Metrics. In conjunction with MDHHS, the SIM technology team has made great strides leveraging existing standards and processes for improved data governance and usage agreements.

Michigan continues 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. SIM Technology is working with MDHHS and is extracting data and creating reports to define target populations which remains critical to the success of the Health through Housing initiative.

Key accomplishments for this time period included:

Data Stewardship

- The SIM Technology team continued reviewing and facilitating the submission and approval process for the remaining data requests from the CHIR's Internal and external evaluation teams.

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 to produce the federally required quarterly progress report measures.

Care Coordination Enablement

- The SIM technology team implemented a solution for collecting social determinants of health information from SIM PCMHs. Based on lessons learned from receiving the first round of production files from providers we are in the process of implementing changes to improve the process.

- Continued working with the SIM Care Delivery team and our partner, the Michigan Data Collaborative, to develop and test expanded metrics and utilization measures using the Relationship and Attribution Management Platform. Our partner, Michigan Health Information Network, continued technical onboarding of clinical quality data from PCMH participants.

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 Medicaid Health Plans their SIM affiliated members via monthly reports
- The team began work on an approved project to analyze the Active Care Relationship Service (ACRS) files and look for areas of opportunity to optimize how attribution occurs across the state.

Population Health Toolset

- The team utilized the Homeless Management Information System (HMIS) technical solution to receive additional rounds of HMIS data for matching with Medicaid claims and continued analysis. Data matching results continue to be provided to MDHHS to help identify highly vulnerable homeless individuals.
- The team worked with MDHHS and the Michigan Coalition Against Homelessness to capture the requirements related to creating an automatic, monthly data feed of HMIS data to support continued evaluation and reporting. The expected roll-out of the automatic feed is scheduled for the end of September 2019.

Sustainability

The SIM technology team continues to support MDHHS and all SIM components as they define their sustainability plan for SIM by evaluating and supporting any technical solutions needed to make the transition(s).

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.

Throughout the closing months of the project, SIM will use their dollars to continue validation exercises for the data and information coming out of the Michigan Health Information Network. These validation exercises will aid MDHHS in how to integrate health information exchange into departmental activities.

3 Evaluation

3.1 Legislative Update

The state-evaluation continues to be led by Michigan Public Health Institute (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 CM/CC 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 has been the process of securing and subsequent analyses of individual level CCL data from all the CHIRs and the 11 Physician Organizations and practices participating in the PCMH Initiative CCL Data Partnership study. MPHI has also completed the first round of analyses of SIM care management recipients using 2017 Medicaid data, and a second round of analyses using 2018 Medicaid data. Detailed information is as follows:

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.

CHIRs were instructed to provide data on all clients with a CCL activity during the timeframe November 1, 2017 to December 31, 2018. 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. Historical CCL data were received from the CHIRs in February and March 2019. MPHI processed the data and prepared first draft reports on the findings for each CHIR as well as a separate report on all the CHIRs data combined. Each report provides a summary of CCL process metrics, and a separate section that leverages 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. The reports underwent several iterations and refinements to incorporate feedback and recommendations from various stakeholders including from the CHIRs and the MDHHS SIM team.

Initial analysis 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.

Participating Physician Organizations in the PCMH Initiative CCL Data Partnership started submitting test files of patients' Social Determinants of Health (SDoH) screening results and linkage efforts in February and production data in March 2019. Physician Organizations were instructed to provide data on all individuals with a CCL activity during the timeframe 3/1/17 – 12/31/18. The data transfer process has been streamlined for most of the Physician Organizations as bugs have been identified at various stages of the submission process. Out of 11 Physician Organizations, however, only 8 Physician Organizations had data within the timeframe successfully transferred to MPHI. MPHI processed and analyzed the data, including linking the individual level CCL data to Medicaid data, and submitted first draft of the individual 8 reports to SIM leadership for their initial review and feedback. Similar to the CHIR CCL reports, section 1 of the PCMH CCL reports provides a summary of CCL process metrics, while section 2 summarizes individual demographics, chronic conditions and geographic characteristics using the linked Medicaid data, and Section 3 summarizes healthcare utilization and cost before and after having a linkage opened that responds to a social need. Only two Physician Organizations, however, were able to provide linkage information in addition to screening data. The most common needs identified through screening were in the following domains: physical and mental health, employment, education 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 (per member per month) medical cost.

Care Management and Care Coordination Analyses. The main purpose of the CM/CC claims analysis is to better understand whether people receiving CM/CC services experience better outcomes as measured by Medicaid claims data. Medicaid claims data are also analyzed to better understand how CM/CC services are

distributed across managed care beneficiaries, and get a profile including the health and demographic characteristics of CM/CC recipients attributed to SIM PCMHs in contrast to non-SIM attributed CM/CC recipients. MPHI has completed a first round of analyses of Medicaid utilization and cost data for SIM and non-SIM CM/CC recipients using 2017 Medicaid claims data and has submitted initial drafts to the SIM leadership. A final CM/CC report using 2017 data has also been completed and submitted to MDHHS. The final report included refinement of the initial analyses and incorporated recommendations from MDHHS and other stakeholders for inclusion into the report. In addition, 33 individual profile reports of CM/CC recipients for each physician organization participating in SIM have been prepared as well.

A second round of CM/CC analysis using 2018 Medicaid data has been conducted, and a draft report submitted to SIM Care Delivery Leadership at MDHHS at the end May 2019. Similar to the 2017 report, the 2018 profile report is a descriptive comparison of Medicaid beneficiaries with CM/CC services attributed to a SIM PCMH and comparable Medicaid beneficiaries but who were not attributed to a SIM PCMH. Data for the reports were primarily based on Medicaid enrollment and claims data obtained from the State of Michigan's Medicaid Data Warehouse. The PCMH Initiative required all participating practices to track Care Management and Coordination Service provision using a designated set of HCPCS/CPT codes. Starting in 2017, these codes included: G9001, G9002, G9007, 98966, 98967, 98968, 99495, and 99496. In 2018, four HCPCS/CPT codes were added: G9008, 98961, 98962, and S0257.

Results showed a substantial increase in CM/CC services between 2017 and 2018. Over 15,000 SIM PCMH attributed patients have a documented CM/CC claim in 2017; nearly 25,000 SIM PCMH attributed patients have a documented CM/CC claim in 2018. The proportion of SIM attributed patients with a CM/CC service increased from 3.0% of SIM attributed patients in 2017 to 5.1% of SIM attributed patients in 2018. In contrast, less than 1% of non-SIM attributed Medicaid beneficiaries across the state had a CM/CC claim for both 2017 and 2018.

CM/CC claims also were not distributed equally – with variations based on health plans and Physician Organizations, and across the CHIR regions. Muskegon and Genesee have higher rates of beneficiaries with CM/CC services than the other CHIRs and non-CHIR regions. As one might expect, people receiving CM/CC were likely to be older, have more chronic conditions, and be more likely to be exposed to place-based risk factors as indicated by high area deprivation scores.

MPHI will continue to convene key stakeholders from MDHHS, Physician Organizations and practices, and subject matter experts (such as the Care Management Resource Center) and other researchers, and gather their feedback, interpretations of the results and recommendations for further refinement of analysis. MPHI will then refine the analyses based on the recommendations and draft the next iteration of the CM/CC report using 2018 data. Such refinement could include 'controlling' for additional variables or refining the comparison group selection variables.

Clinical Community Linkage Provider Survey 2019. MPHI launched the 2019 Provider Survey in June 2019 independently of MSU. To date, MPHI has received 425 responses and is on track to at least reach the total number of responses for the Provider Survey conducted in 2018. The 2019 Provider Survey went through several updates to incorporate new variables of interest to the evaluation team, but special attention was made not to compromise any comparison of results with 2018 Provider Survey data.

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.

In the past six months, the MSU team has 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 capture by the MSU Collective Impact Evaluation conducted in the summer and fall of 2018. 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 MSU team codesigned and held such sense-making sessions in the CHIRs. 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. The next round of surveys and interviews are currently being planned and scheduled to be launched at the end of August.

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

Client Experience Surveys. A pilot of the CHIR Client Experience Survey was conducted in two CHIRs: Livingston-Washtenaw and Genesee, from October 2018 to January 2019. The goals of the pilot were to identify appropriate populations of CHIR clients for the surveys, the recruitment and data collection options acceptable to CHIRs and clients, and topics likely to yield useful information to CHIRs and MDHHS in efforts to gain support for CHIR model, and test the feasibility and acceptability of data collection process (for clients and for CHIR staff). Results of the pilot were compiled, and a summary of the findings and recommendations for conducting the broader client experience survey submitted to MDHHS. The University of Michigan's Child Health Evaluation and Research (CHEAR) is also working with Northern CHIR on starting the client experience survey implementation process.

Patient Experience Surveys. CHEAR is conducting a multi-component patient experience survey to better understand the impact of SDoH screening in the primary care setting. Part 1 involves a one-page mailed survey (with option to complete online) sent to a sample of Medicaid enrollees (or parents of pediatric patients) seen at a PCMH participating site in the prior quarter. The one-page survey asks: if the patient recalls answering SDoH questions at the PCMH site, if they endorsed an SDoH need; if the PCMH offered information or referral; general views on SDoH screening at the PCMH site; and willingness to be contacted for a follow-up telephone interview. The survey was developed in conjunction with SIM PCMH leadership and with input from PCMH sites. Surveys were mailed beginning in November 2018 and continued to this date. Part 2 involves telephone interviews with survey respondents who reported that they had an SDoH need or who reported negative views on SDoH screening in primary care. The interviews include a combination of

fixed-choice and open-ended questions to allow patients to describe their experiences with screening, getting assistance, and other interactions with the PCMH site. With patient permission, interviews are recorded, and descriptions transcribed, to allow for more comprehensive analysis of data. Interviews began in December 2018 and continued to this date.

3.2 Legislative Metrics and Measures

Section 1144(2) of Michigan Public Act 207 of 2018 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:

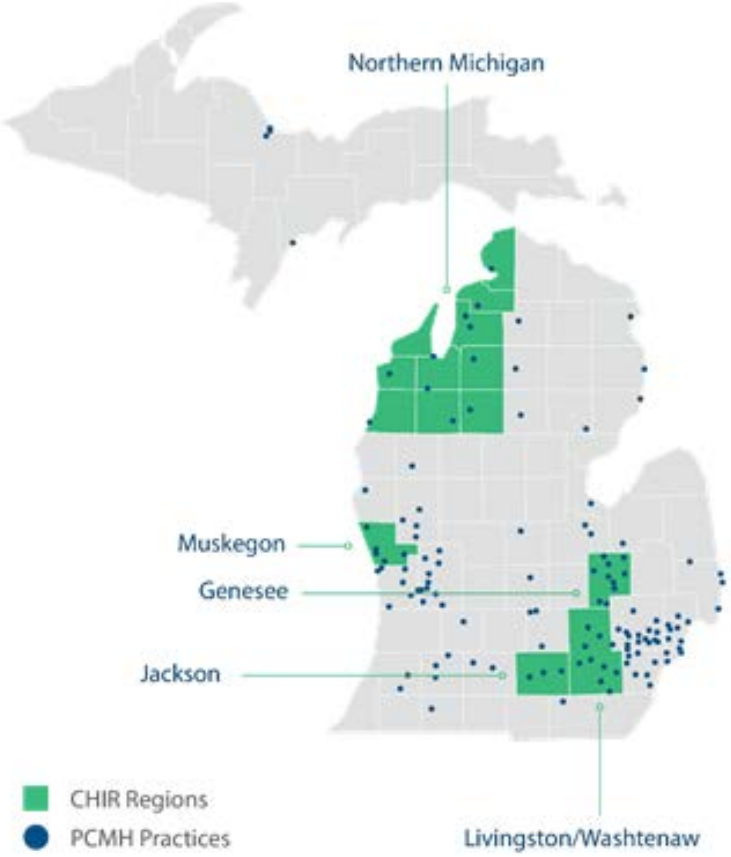
- Increasing number of physician's practices fulfilling PCMH functions
- Reducing inappropriate health utilization, specifically reducing
  - Preventable Emergency Department (ED) visits,
  - the proportion of Hospitalizations for Ambulatory Care Sensitive Conditions, and
  - the state's 30-day Hospital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

For this semi-annual report, the reporting period for the utilization measures is from April 2018 to March 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 (ED) 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.
- 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	11	51	18,078
Livingston/Washtenaw	39	374	35,616
Muskegon	23	140	30,270
Genesee	56	133	40,239
Northern *	18	175	30,458
Total SIM Region	147	873	154,661
TOTAL Non-SIM Region	158	1,206	171,187
TOTAL **	**305**	**2,079**	**325,848**

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

** Beneficiary count based on July 2019 data.

Overall Utilization Measures
(Reporting period: April 2018 to March 2019)

Measure	Numerator	Denominator	Rate (Per 1,000 Attributed Members)
Emergency Department Visits	181,267	256,471	707
Preventable ED Visits	97,050	256,471	378
Acute Hospital Admissions	9,830	256,471	38
Acute All-Cause Readmission	930	7,805	119
Ambulatory Care Sensitive Condition (ACSC) Admissions - Overall Adult Composite	2,369	169,875	14

Rate of Ambulatory ED Visits per 1000 Attributed Members by CHIR Regions
(Reporting period: April 2018 to March 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	20,586	31,977	644
Jackson	Jackson	10,964	14,251	769
Livingston/Washtenaw	2 Counties	16,816	28,797	584
Muskegon	Muskegon	24,751	23,375	1,059
Northern	10 Counties	14,699	23,559	624
Total Non-SIM Regions (Outside CHIRs)		93,451	134,512	695
Overall Total Ambulatory ED Visits		***181,267***	***256,471***	***707***

Rate of Preventable ED Visits per 1000 Attributed Members by CHIR Regions
(Reporting period: April 2018 to March 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	10,409	31,977	326
Jackson	Jackson	5,722	14,251	402
Livingston/Washtenaw	2 Counties	8,822	28,797	306
Muskegon	Muskegon	14,644	23,375	626
Northern	10 Counties	7,302	23,559	310
Total Non-SIM Regions (Outside CHIRs)		50,151	134,512	373

Overall Total Preventable ED Visits		***97,050***	***256,471***	***378***

Rate of Acute Hospital Admissions per 1000 Attributed Members by CHIR Regions (Reporting period: April 2018 to March 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	1,549	31,977	48
Jackson	Jackson	636	14,251	45
Livingston/Washtenaw	2 Counties	1,008	28,797	35
Muskegon	Muskegon	703	23,375	30
Northern	10 Counties	789	23,559	33
Total Non-SIM Regions (Outside CHIRs)		5,145	134,512	38
Overall Total Acute Hospital Admissions		***9,830***	***256,471***	***38***

30-day All-Cause Readmission Rate per 1000 Attributed Members (Reporting period: April 2018 to March 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	152	1,131	134
Jackson	Jackson	52	531	98
Livingston/Washtenaw	2 Counties	110	854	129
Muskegon	Muskegon	34	559	61
Northern	10 Counties	75	605	124
Total Non-SIM Regions (Outside CHIRs)		507	4,125	123
Overall Total All-Cause Readmission		***930***	***7,805***	***119***

Rate of Ambulatory Care Sensitive Conditions (ACSC) Admissions - Overall Adult Composite per 1000 Attributed Members by CHIR Regions (Reporting period: April 2018 to March 2019)

CHIR Region	County	Numerator	Denominator	Rate
Genesee	Genesee	404	21,306	19
Jackson	Jackson	161	10,714	15
Livingston/Washtenaw	2 Counties	218	19,684	11
Muskegon	Muskegon	126	15,441	8

Northern	10 Counties	195	16,172	12
Total Non-SIM Regions (Outside CHIRs)		1,265	86,558	15
Overall Total ACSC Admissions – Adult Composite		***2,369***	***169,875***	***14***

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	$189,125.00	$61,324.01
Fringe Benefits	$103,026.00	$43,831.80
Equipment	$0.00	$0.00
Supplies	$40,000.00	$8,345.87
Travel	$18,627.00	$2,858.89
Other*	$0.00	$15,377.48
Contractual	$24,121,872.00	$7,445,086.41
Total Direct Charges	$24,472,650.00	**$7,576,824.46**
Indirect Cost	$0.00	$0.00
Total	$24,472,650.00	**$7,576,824.46**

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

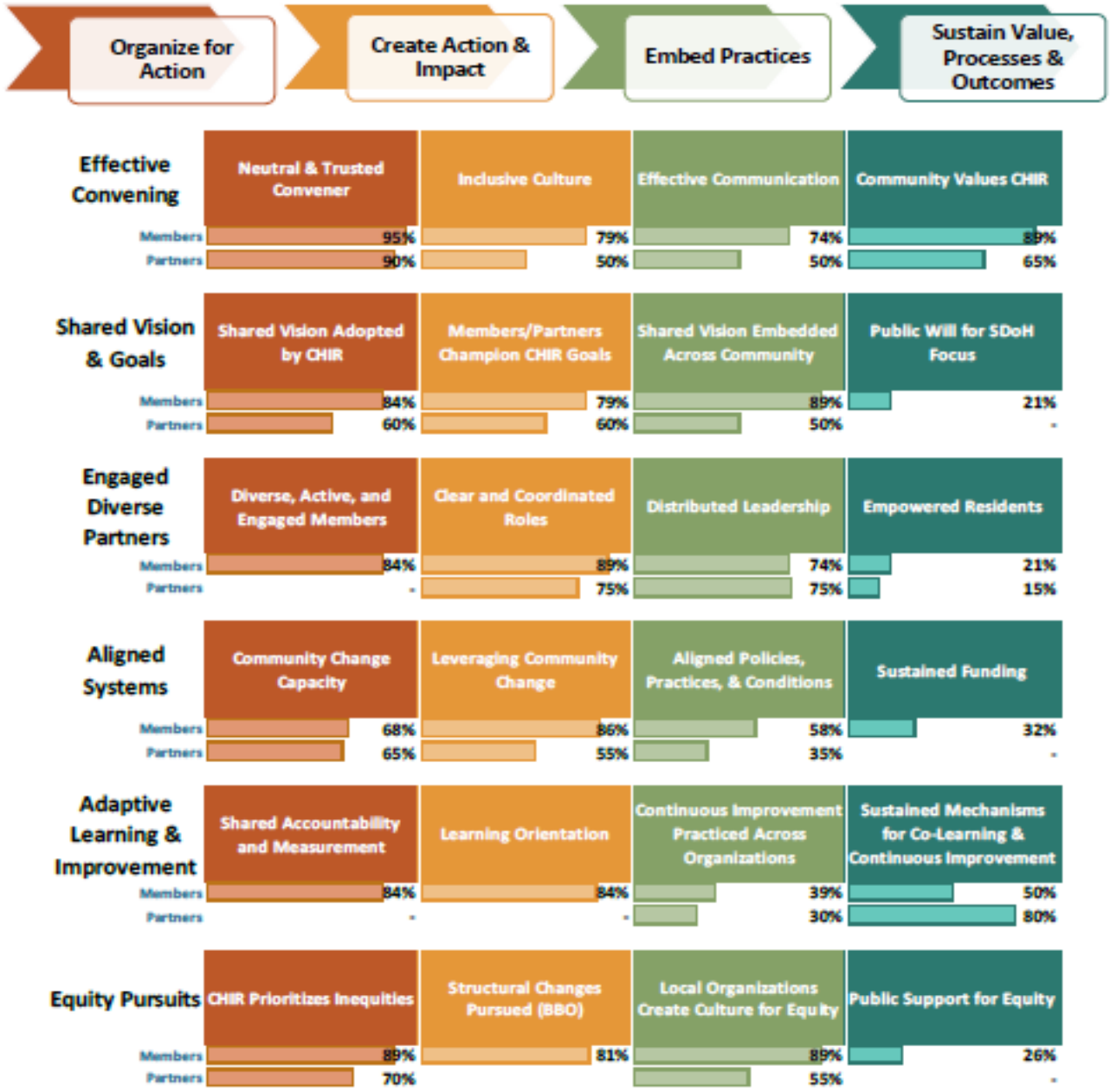
The budget period is 12 months, beginning February 1, 2019 through January 31, 2020. The reporting period spans February 1, 2019 to July 31, 2019. Due to the timing of the posting of expenses into the State's accounting system, not all June and July 2019 expenses are included in the totals above.

5 Appendix:

5.1 Genesee Findings Preview

Genesee SIM Project and the Transformative Change Process

This overview displays how Members and Partners assessed the Genesee SIM Project's work on each critical element at each phase of the transformative change process. In this summary, note that higher percentage scores indicate greater levels of agreement that the SIM Project is actively engaged in the work at that stage. If a cell is marked with "-", that area was not measured in the Member or Partner surveys, respectively.

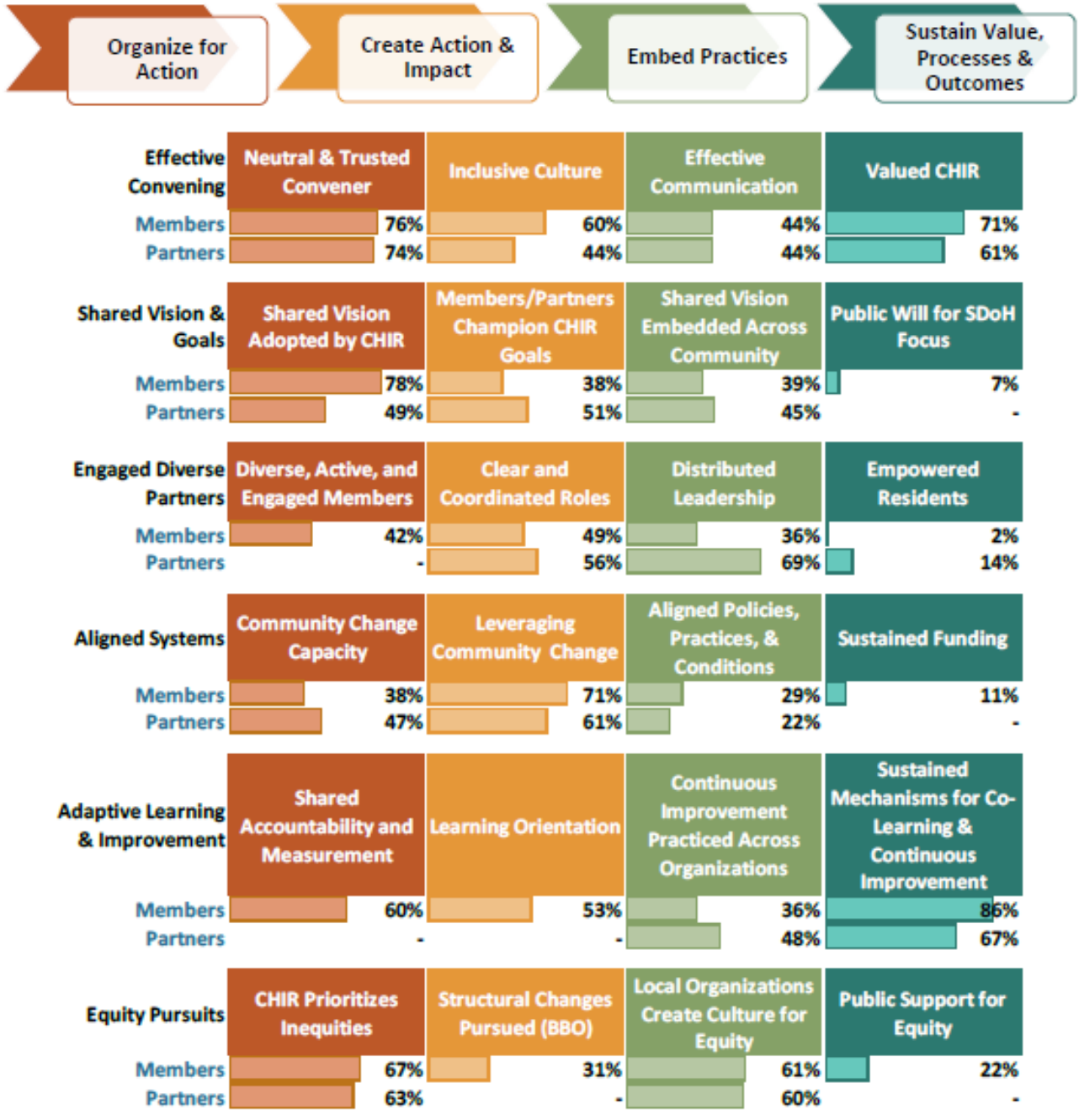


Members: N=19, Partners: N=20

5.2 Jackson Findings Preview

Jackson SIM Project and the Transformative Change Process

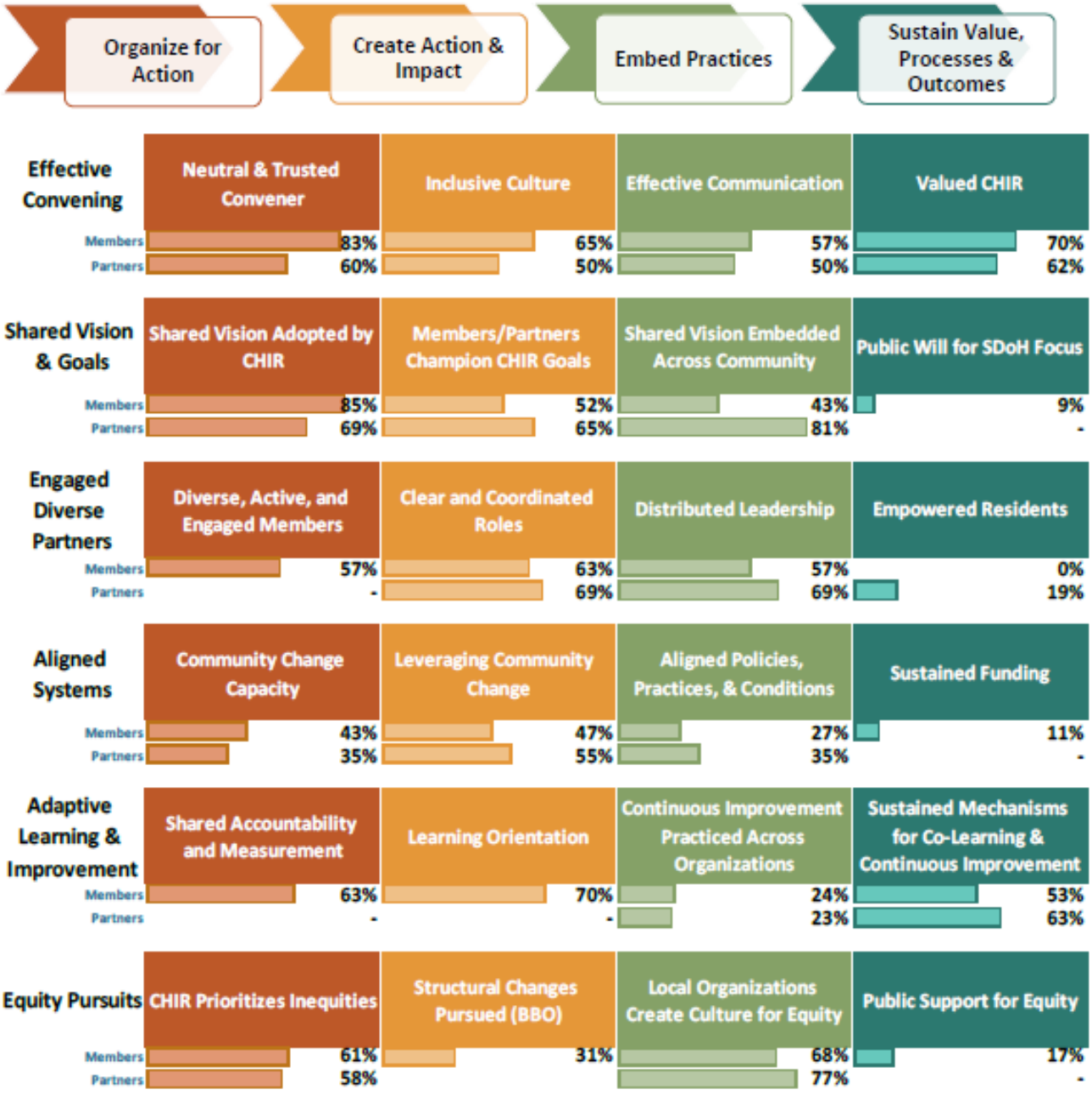
This overview displays how Members and Partners assessed the Jackson SIM Project's work on each critical element at each phase of the transformative change process. In this summary, note that higher percentage scores indicate greater levels of agreement that the SIM Project is actively engaged in the work at that stage. If a cell is marked with "-", that means that area was not measured in the Member or Partner surveys, respectively.



5.3 Livingston/Washtenaw Findings Preview

Livingston-Washtenaw SIM Initiative and the Transformative Change Process

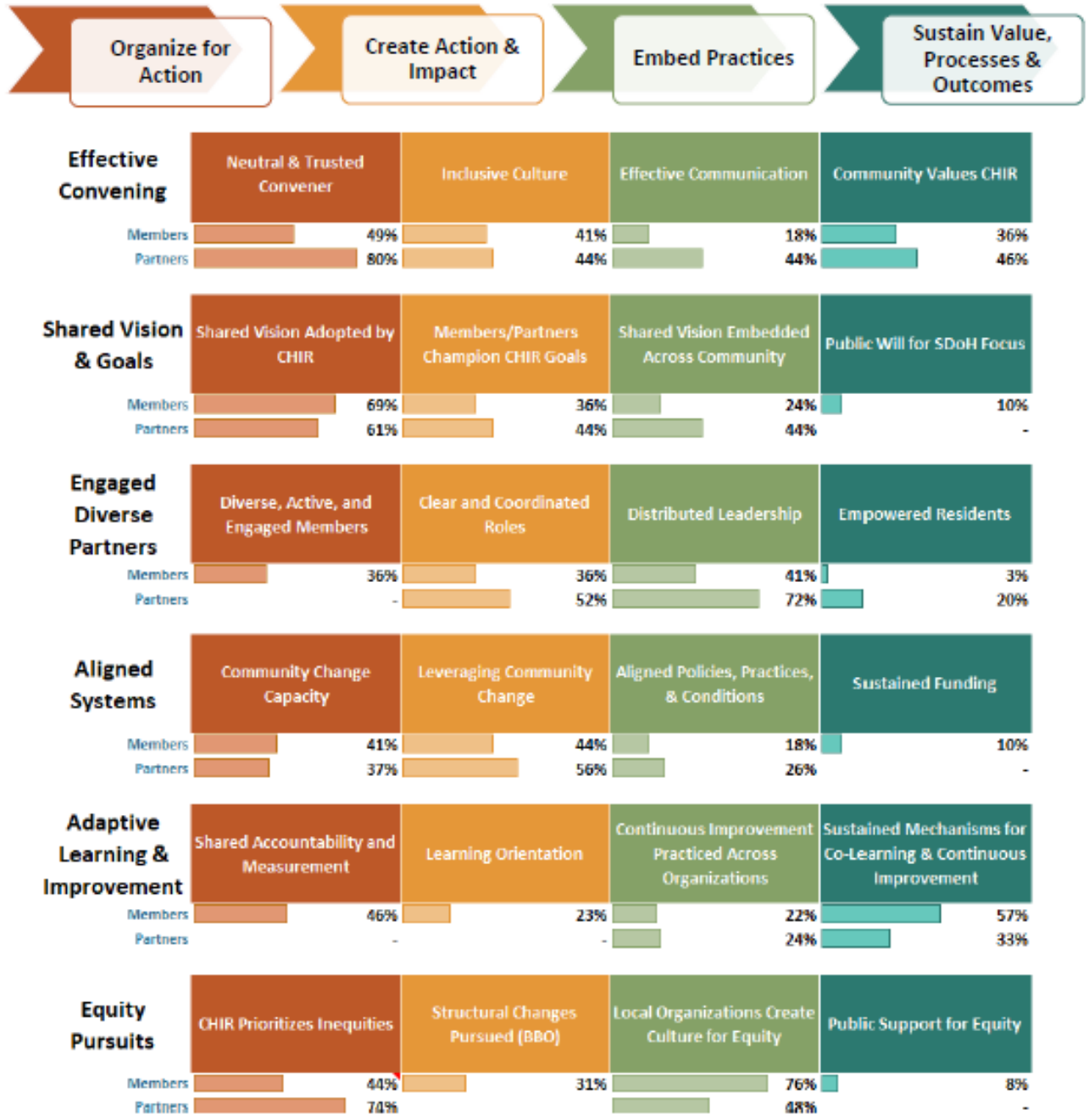
This overview displays how Members and Partners assessed the Livingston-Washtenaw SIM Initiative's work on each critical element at each phase of the transformative change process. In this summary, note that higher percentage scores indicate greater levels of agreement that your community is actively engaged in the work at that stage. If a cell is marked with "-", that means that area was not measured in the Member or Partner surveys, respectively.



5.4 Muskegon Findings Preview

Muskegon CHIR and the Transformative Change Process

This overview displays how Members and Partners assessed the Muskegon CHIR's work on each critical element at each phase of the transformative change process. In this summary, note that higher percentage scores indicate greater levels of agreement that your CHIR is actively engaged in the work at that stage. If a cell is marked with "-", that means that area was not measured in the Member or Partner surveys, respectively.



Members: N=39, Partners: N=54

5.5 Northern Findings Preview

Northern Michigan CHIR and the Transformative Change Process

This overview displays how Members and Partners assessed the Northern Michigan CHIR's work on each critical element at each phase of the transformative change process. In this summary, note that higher percentage scores indicate greater levels of agreement that your CHIR is actively engaged in the work at that stage. If a cell is marked with "-", that area was not measured in the Member or Partner surveys, respectively.

	Organize for Action		Create Action & Impact		Embed Practices		Sustain Value, Processes & Outcomes	
Effective Convening	Neutral & Trusted Convener		Inclusive Culture		Effective Communication		Valued CHIR	
Members		68%		61%		55%		58%
Partners		63%		40%		40%		43%
Shared Vision & Goals	Shared Vision Adopted by CHIR		Members/Partners Champion CHIR Goals		Shared Vision Embedded Across Community		Public Will for SDoH Focus	
Members		68%		48%		35%		10%
Partners		63%		51%		57%		-
Engaged Diverse Partners	Diverse, Active, and Engaged Members		Clear and Coordinated Roles		Distributed Leadership		Empowered Residents	
Members		42%		52%		29%		6%
Partners		-		63%		71%		11%
Aligned Systems	Community Change Capacity		Leveraging Community Change		Aligned Policies, Practices, & Conditions		Sustained Funding	
Members		48%		50%		26%		6%
Partners		49%		52%		24%		-
Adaptive Learning & Improvement	Shared Accountability and Measurement		Learning Orientation		Continuous Improvement Practiced Across Organizations		Sustained Mechanisms for Co-Learning & Continuous Improvement	
Members		58%		58%		13%		75%
Partners		-		-		43%		50%
Equity Pursuits	CHIR Prioritizes Inequities		Structural Changes Pursued (BBO)		Local Organizations Create Culture for Equity		Public Support for Equity	
Members		68%		38%		52%		10%
Partners		54%				68%		-

Members: N=31, Partners: N=63