Quarterly Report on the Status of Merger

(FY2016 Appropriation Bill - Public Act 84 of 2015)

June 30, 2016

Sec. 233. By the end of each fiscal quarter of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the senate and house policy offices on the status of the merger, executed according to Executive Order No. 2015-4, of the department of community health and the department of human services to create the department of health and human services. The report must indicate changes from the prior report and shall include, but not be limited to, all of the following information:

(a) The impact on client service delivery or access to services, including the restructuring or consolidation of services.

(b) Any cost increases or reductions that resulted from rent or building occupancy changes.

(c) Facilities in use, including any office closures or consolidations, or new office locations, including hoteling stations.

(d) Current status of FTE positions, including the number of FTE positions that were eliminated or added due to duplication of efforts.

(e) Any other efficiencies, costs, or savings associated with the merger.

MDHHS

Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR
NICK LYON, DIRECTOR

Merger Status – Quarterly Report #3

The Michigan Department of Health and Human Services (MDHHS) was created by Executive Order 2015-4 effective April 10, 2015. The reason for the merger of the former departments of Community Health and Human Services was to more effectively and efficiently assure the protection and strengthening of Michigan's families by aligning family and health-related services and administrative functions in state government.

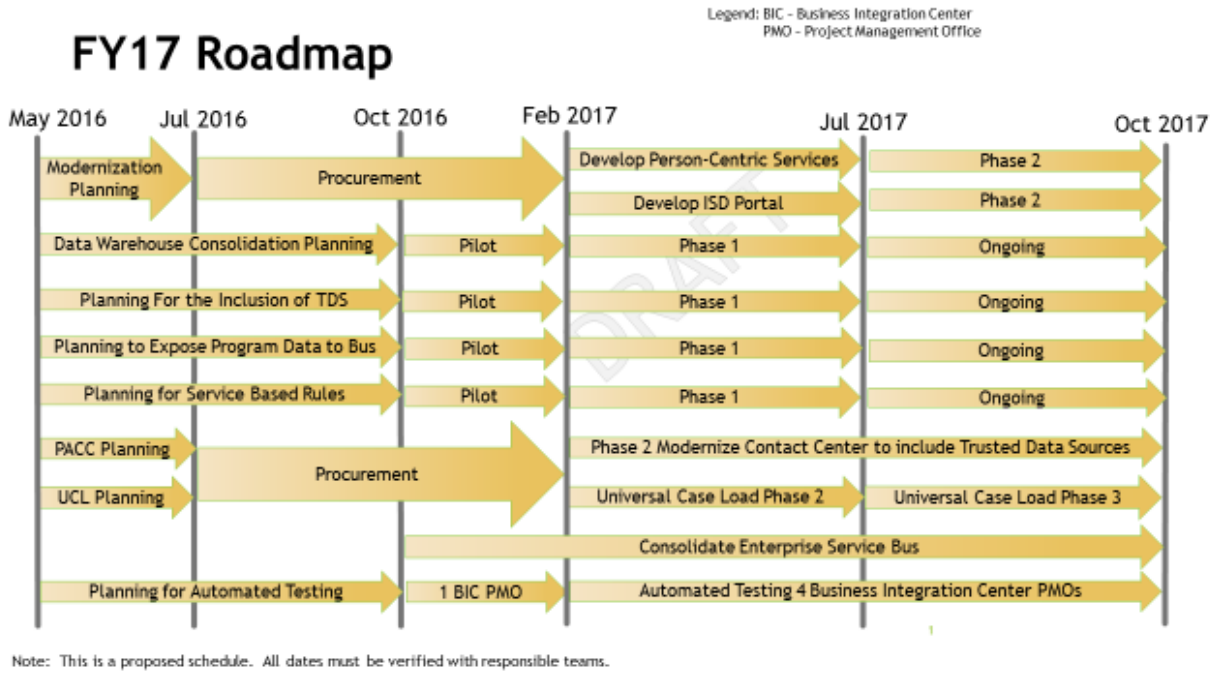
Impact on Client Service Delivery and Access to Services

In the past, the Departments of Community Health and Human Services managed hundreds of unique programs that customers interacted with in a multitude of ways. Through the merger, MDHHS is examining every program to determine how we can deliver services that better achieve positive health and self-sufficiency outcomes for our customers. The combined MDHHS is charged with reforming how we interface with our customers through service delivery and technology innovation which better focuses on customers' needs.

Integrated Service Delivery

In the first two quarterly merger status reports, we discussed the vision of Integrated Service Delivery (ISD), an innovative service delivery method focusing on serving people rather than administering programs which includes workforce innovation, modernization of technology systems, and stronger partnerships with communities.

MDHHS has now secured funding through the Fiscal Year 2017 appropriations process to implement Integrated Service Delivery. We thank the Legislature for supporting this important initiative, and are pleased to provide this update on our implementation plans. A "roadmap" graphic is provided below, followed by some additional detail regarding the proposed schedule and approaches.



Note: This is a proposed schedule. All dates must be verified with responsible teams.

Modernization Planning
The creation of an Integrated Service Delivery Portal and the Person-Centric Services it provides, is new functionality not currently in place in Michigan or any other state. Therefore, this functionality is anticipated to be obtained through the Request for Proposal (RFP) process. Requirements for the RFP are being built from input gathered during the previous year-long Business Process Analysis program and are expected to be complete by July 2016. The RFP is anticipated to be issued in late July, followed by an award in November with the vendor beginning work in January 2017.

Data Warehouse Consolidation
MDHHS currently has two data warehouses. Historically, one supported Human Services functions and one supported Community Health functions. This task consolidates information in the two warehouses by creating a link that can be used to locate information from both warehouses simultaneously. In later years, the link can be used to move the information into a single warehouse. Michigan already owns the infrastructure and software that will be used to virtually consolidate the warehouses.

Person-Centric Services Modules
Inclusion of additional trusted data sources (TDS) and allowing access to person-centric data services will not require an RFP. The data sources already exist within the state. The indexing location will be the existing Master Person Index and the data sources themselves will be made available by the vendors currently maintaining the existing systems.

This module must begin with a planning phase which would last from October 2016 to January 2017, followed by a design phase which would last until April 2017. Implementation and utilization would be complete for five data sources by the end of Fiscal Year 2017.

Universal Caseload Management (UCL)
Michigan recently completed a year-long Business Process Analysis and the output of this exercise, along with the output of the Request for Information (RFI) and business requirements will combine as a reference for a build-by decision. By August 2016, we will complete an evaluation of similar solutions implemented in Ohio, Idaho, New Mexico, Rhode Island, and Florida to determine if an existing solution can be procured to meet Michigan's needs. If an existing state solution cannot be used to satisfy Michigan requirements, an RFP will be issued in September 2016.

Call Center Development
The anticipated two-county pilot has been delayed due to continued privacy concerns by the United States Department of Agriculture, Food and Nutrition Services. Although the Fiscal Year 2017 budget reduces the call center funding by 40% to $11.4 million, DHHS plans to continue to work with the federal government to address their concerns and implement a scaled back version and/or call center pilot sometime during Fiscal Year 2017.

Adherence to Scope/Schedule/Cost
MDHHS has implemented the Business Integration Center (BIC) which administers the Project

Management Offices (PMO). These PMO's will be tasked with oversight of the implementation of the Integrated Service Delivery plan. The BIC process provides timely oversight into scope, schedule, and cost to all levels of stakeholders. The process includes a very refined methodology to identify and address issues that could cause budget overruns, or schedules to slip.

Cross-Agency Collaboration

Collaboration across Health and Human Services has been a major benefit of the major. Some concrete examples of this collaboration in this reporting period include:

- **Strategic Alignment Team**
  - A critical component of the combined MDHHS organization is the establishment of a structure to apply our shared vision consistently to all the work of the department. To this end, Director Lyon formed the MDHSS Strategic Alignment Team.
  - The Strategic Alignment Team focuses on service integration across MDHHS, strengthening internal coordination, managing organizational change, providing consistent accountability and ensuring executive engagement.
  - The Strategic Alignment Team is directed by MDHHS senior leaders (meeting on a quarterly basis), assisted by a core group of supporting leaders who carry out the strategic direction and work initiated by the senior leaders.

- **Increased Access to Home Visitation by Families Involved with Children's Protective Services**
  - In collaboration with the Bureau of Family, Maternal, and Child Health, the Children's Services Agency developed a process to facilitate Children's Protective Services staff to directly refer families to evidence-based home visitation.
  - Although referral data is not yet available, several counties have responded positively to the potential for increased supports for families.

- **Greater Assurance of Informed Consent and Proper Medication Oversight for Children in Foster Care**
  - The department merger has continued to enhance collaboration among staff from Pharmacy Services and the Child Welfare Medical Unit to monitor and provide oversight of psychotropic medication prescribing to foster children.

- **Increased Support to Children with Severe Emotional Disturbance**
  - Beginning in 2016, the MDHHS Waiver for Children with Serious Emotional Disturbance (SEDW) program staff initiated a series of webinars to support its partners in the operational aspects of the SEDW. Webinars include participation by Community Mental Health staff involved in the administration of the SEDW.

- In addition, MDHHS' Behavioral Health and Developmental Disabilities Administration is in the process of submitting an 1115 waiver to the Centers for Medicare and Medicaid Services. This waiver will combine the current 1915b managed care waiver for behavioral health and the 1915c waivers, including the SED waiver. Once approved, the SEDW can expand from 37 counties and 25 Community Health Services Programs to statewide availability.

- **Increased Support to Families with Children with Autistic Spectrum Disorders (ASD)**
  - Together with Legal Affairs and Children's Protective Services (CPS) staff, the Autism Section developed guidelines on information which can be shared with MDHHS/Behavioral Health and Developmental Disabilities Administration (BHDDA) and Community Mental Health program staff serving families with ASD children.
  - Six ASD trainings were provided to Children's Services Agency local and regional staff, along with two ASD safety trainings for local CPS staff.
  - BHDDA and the Children's Services Agency collaborated on case management for ASD children in the juvenile justice system and in foster care and residential settings.

- **Services to Victims of Crimes**
  - In June 2015, Crime Victim Services (CVS) was moved from Legal Services to the Bureau of Community Services within the Population Health Administration, where similar work was also being done by the Michigan Domestic and Sexual Violence Prevention and Treatment Board (MDSVTB). Since the realignment, the MDSVPTB has been able to work more close with CVS in a number of areas. Examples include:
    - Working together to enhance and improve the Safe Response process to better address the costs associated with Sexual Assault Kits;
    - Working collaboratively to begin a planning process for the expansion of Child Advocacy Centers across the state;
    - Sharing information on grant monitoring results of joint grantees and assisting each other with grant review processes.
    -

<u>Office Relocations and Consolidations</u>

Recently, several operational offices within our Financial Operations Administration merged into one location (Grand Tower Building), and the staff from our Capitol View and other locations moved into the South Grand Building.

The department continues to monitor its lease portfolio to maximize efficiencies through consolidation and co-location with community partners.

Current Status of FTE Positions

Pre-Merger FTE Count (pay period ending March 28, 2015)

Department of Community Health:	3,136
Department of Human Services:	10,874
Combined Total:	14,010

MDHHS Post-Merger FTE Count (pay period ending May 21, 2016)

Department of Health and Human Services	13,948.5

Difference from Pre-Merger FTE Count:	-61.5
Difference from Quarter Two Report:	+93.5

Some positions in the department were created and some were eliminated as part of the merged agency to streamline services and support the Integrated Service Delivery initiative. The post-merger FTE count has decreased by 61.5 as of the payroll ending May 21, 2016. The net 61.5 FTE reduction occurred in State Hospitals (-16), Local Offices (-40.5), and Juvenile Justice Facilities (-61), offset by a 56 FTE increase in Central Office. According to the Civil Service Workforce Report, the Central Office FTE count has increased in the third quarter. The Central Office FTE count in this report includes Michigan Rehabilitation Services (MRS) vocational rehabilitation counselors and disability determination examiners which are more properly classified as Field staff given that the work originates from local county offices. Increases in MRS vocational rehabilitation counselor hiring makes up the majority of FTE increase in the 3rd quarter. In Fiscal Year 2016 strict monitoring of all payroll-related line items is taking place and is being shared on a monthly basis with the legislature per the boilerplate report required from section 280 in P.A. 84 of 2015.

MDHHS is integrating and implementing a massive amount of merger-related administrative processes and policies, in addition to planning for and beginning to implement a major change in the department's service delivery model, all with existing staff resources.

Other Efficiencies, Costs, or Savings Associated with the Merger

Efficiencies

In April 2016, the Population Health Administration created a Bureau of Epidemiology and Population Health. This bureau includes the former Bureau of Disease Control, Prevention and Epidemiology and the former Bureau of Family, Maternal and Child Health. The creation of this new bureau has **enhanced coordination of the functions for childhood lead prevention**: surveillance, case management, and environmental investigations.

A significant overlap has been identified in child welfare and Medicaid health reporting. To address this overlap, MDHHS is working to **increase data warehouse reporting capacity for child welfare**. The goal of this project is to develop a Concept of Operation document to

describe how child welfare reporting needs can be met with current available applications such as Connect Care 360.

The joined Office of Inspector General (OIG) administrations **leveraged favorable contract price points** for shared data broker tools for investigators.

The MDHHS Communications Office has been able to leverage the existing advertising agency contract previously held by DCH to **maximize both the time and dollars spent on marketing** for health and human services programs .

Costs and Savings

New short-term costs may include additional work from information technology (IT) contractors to implement the systems that support the Integrated Service Delivery initiative, and from one-time office moving costs.

Examples of potential savings in the long run may include:

- Reduced inpatient hospitalization stays;
- Reduced foster care days of care as the focus on prevention increases;
- Rent or lease cost reductions;
- Information technology and project cost savings resulting from leveraging resources, avoiding duplication of effort, and leveraging of fund sources.

Overall it is too soon to report specific costs or savings associated with the merger. Much of the move towards Integrated Service Delivery and other service delivery-related efficiencies is still in the planning stages.