MiCC | **MI Community Care**
WASHTENAW HEALTH INITIATIVE

Impact and vision in the Livingston/Washtenaw region

AUGUST 2022

Table of Contents

MI COMMUNITY CARE

Our mission and vision.

Mission.

1. To provide holistic, coordinated, patient-centered care to people with complex needs, meeting them where they are and helping them achieve their health and personal goals;

2. To support regional health, mental health, and social services providers by improving their capacity and effectiveness; and

3. To enhance the local and state care delivery system.

Vision.

- People empowered to manage their health and overcome disparities through comprehensive, coordinated, patient-centered care.

MI COMMUNITY CARE

How we help people.

The MI Community Care (MiCC) regional collaborative runs a care coordination program **for community members with complex health and social determinants of health needs.**

Individuals with multiple social needs and health challenges are often left to negotiate complex systems to try to get their needs met. In the MiCC collaborative, one community partner organization steps up and is identified as the "lead" for each individual enrolled in the program.

The lead organization works with the individual to identify their health goals, and coordinates the efforts of cross-sector partner organizations working with that individual.

The program provides leads with support from community health workers, care coordinators, and program experts to help reduce barriers to improved health.

Who we serve.

Eligibility criteria. The MiCC care coordination program accepts Livingston and Washtenaw County residents who meet three or more of the following criteria:

- Five or more emergency department visits in the last 12 months
- Homelessness or housing instability
- Three or more chronic medical conditions
- No primary care engagement in the past two years
- A mental health or substance use related need
- And social needs, such as food insecurity, transportation, utility assistance, insurance, etc.

Individuals referred to the program have multiple complex needs and generally require services from agencies across different sectors. Faced with difficult health challenges, these individuals can have a hard time navigating the local system of care and are at high risk for falling through the cracks.

"I have COPD, congestive heart failure, and I use the BIPAP machine (not the CPAP). It's been hard, dealing with my illness. But Becca's been really nice, and Jonita. I love them. And I hope they don't change or leave.

--Program participant
Summer 2022

Referral model. Since the launch of the care coordination program in the fall of 2017, 1,691 individuals have been identified for referral either by a predictive model or by community providers.

Today, any health or social service provider in Livingston or Washtenaw Counties may refer eligible residents using the program's short referral form. Provider referrals have proved to be the most effective approach to ensuring that those referred to the MiCC program enroll in services. Of the individuals referred, only 30 percent (510) signed a consent to participate in the program. Analyzing the data, CHRT found that only 14 percent of the individuals referred by the predictive model consented to enroll in the program, while 61 percent of provider referrals consented to enroll.

Consents by Contact Modality

Predictive Model	~14%
Provider Referrals	~61%
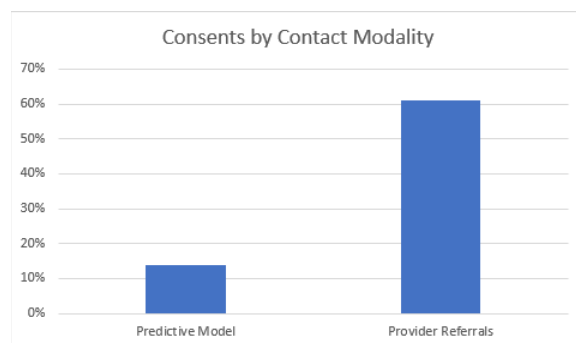
As a result of these analyses, the predictive model was discontinued after 2019.

The predictive model was an innovative and powerful tool, and could be resurrected if combined with a process that pairs the algorithmic identification with a warm handoff from a known provider to help participants feel more connected, more trusting, and more comfortable to engage.

Insurance coverage. A majority of the care coordination program participants qualify for federal and state insurance, with more than three-quarters insured through Medicaid, Medicare, or both.

By comparison, only approximately 40 percent of the population of Michigan as a whole are enrolled in these insurance programs.

"I heard about [MiCC] through my doctor's office. I've had four back surgeries–I have a degenerative back disease–and two heart attacks. I was going to work until at least 65 or 67 and not being able to work has been very detrimental to my health and mental health. I've also been struggling because I was using alcohol to numb some of the physical pain with my back before surgery.

Cheri has been very supportive with my sobriety endeavor; since the first of the year, I've had just one lapse. She's also helped me with Medicaid, with securing a food processor, and with referrals. When she comes over, she's very compassionate, very interested in my success. Just that welcoming sense of belonging, and that people are sincere about working to help you. If I knew someone else that was in my situation, I would highly recommend that they see what the program could entail for them."

--Program participant
Summer 2022

Social needs. In addition to medical needs, participants enter the MiCC care coordination program with multiple social determinants of health (SDOH) needs.

In fact, 57 percent of MI Community Care participants reported four or more SDOH needs at their assessment, and nearly a quarter reported at least six needs. The four greatest SDOH needs reported by participants are resource strain (76 percent), food insecurity (67 percent), transportation problems (64 percent), and housing instability (44 percent).
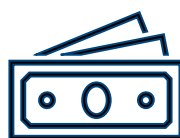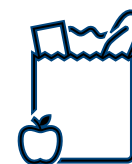
76 percent   **67** percent
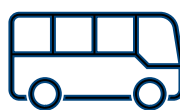
64 percent   **44** percent

The variety and complexity of social needs span the expertise of multiple organizations, highlighting the critical need for cross-sector care coordination. The diversity of missions held by each of the community-based organizations (called "hublets") and partner agencies, and the collaboration that the MiCC facilitates, allow care coordinators to best serve individuals with complicated health needs and work with them to achieve their health goals.

Race and ethnicity. The MiCC care coordination program now systematically collects race and ethnicity data about participants to understand whether individuals are benefiting from the program equitably.

This is part of a broader strategy to intentionally focus on health equity in all activities of the MiCC regional collaborative. In this work, we are working closely with our colleagues in other Michigan CHIRs/regions to align our activities and metrics to support a broader regional initiative. We are retroactively collecting race and ethnicity data from current enrollees in the program to further advance the equity work.

We worked with the vendor of the MiCC technology platform to separate race and ethnicity fields, which had previously been combined in the system. We are also updating the program's referral form to collect race and ethnicity information at the outset. Other health equity-related information we are collecting include: language preference, sexual orientation and gender identity, and zip code (which we were already collecting).

Based on currently available data, more than one-quarter of the individuals who enrolled in the MiCC care coordination program are Black or African American. The same is true for all prospective participants identified for the program since its inception. By comparison, in Washtenaw County as a whole, roughly 12 percent of the population is Black or African American and in Livingston County the Black or African American population is fewer than 1 percent of the total population.
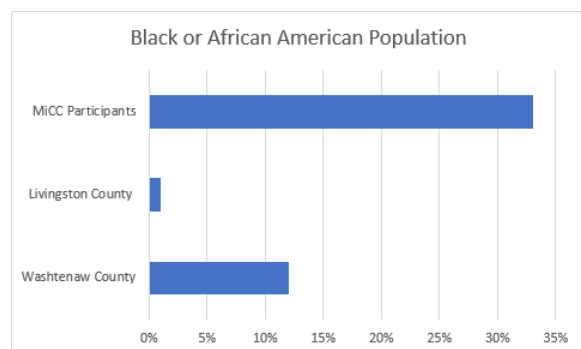
Zip code. A large majority of program referrals and participants live in Washtenaw County.

This is likely partially due to the demographic and population differences between Livingston and Washtenaw Counties, with Livingston having a higher median income, more homogeneity, and a smaller population size than Washtenaw. However, the majority of participating hublets are also located in Washtenaw County, which contributes to the skew in numbers. Growing our network in Livingston by partnering with more health and human services agencies is one of our goals moving forward.

Importantly, roughly 34 percent of all prospective participants and 40 percent of those who ultimately enroll in the program, reside in the 48197 or 48198 zip codes, what we may call a 'hotspot' in our region. These zip codes are located in Ypsilanti, home to many participants with high levels of health needs. The city of Ypsilanti is more than one-quarter Black or African American, compared to Washtenaw County as a whole which is only 12 percent Black or African American. The median household income in Ypsilanti is approximately $40,000 per year, with nearly 30 percent living in poverty, compared to roughly $69,000 in neighboring Ann Arbor.

Duration of care. Due to the complexity of medical and social determinants of health needs, MiCC participants tend to remain enrolled in the care coordination program for multiple months.

The average time for participating in the MiCC program is 322 days (approximately 10.6 months) and the median time is 231 days (approximately 7.6 months).

Black or African American Population

How we serve.

Any health or social service provider may refer eligible Livingston or Washtenaw County residents to the MI Community Care program, with permission of the individuals being referred.

Providers fill out a short MiCC referral form, which includes demographic and health questions as well as health goals. Referrals are sent securely to the program's administrative hub at the Center for Health and Research Transformation (CHRT), where staff create a chart for the referred person in MI Care Connect, a technology platform that is shared across participating organizations.

Assigning a lead. Referrals are carefully reviewed by MiCC care coordinators at participating organizations called hublets. Hublets include local medical organizations, public behavioral health agencies, and social service agencies that take the lead role in coordinating participant cases. Hublets include:

1. **Avalon Housing**, an organization with deep expertise in housing and supportive services.
2. **Jewish Family Services of Washtenaw County**, an organization that works with the elderly and refugees, and that maintains a robust food pantry and transportation services.
3. **Livingston County Community Mental Health**, an agency with deep expertise in mental health and substance use services
4. **University of Michigan Health:** One of the largest nonprofit hospitals in the region with a distinguished academic medical center; our primary contact is the complex care management program.
5. **Packard Health**: A Federally Qualified Health Center that serves many low-income, uninsured, and underinsured adults across the region.
6. **Shelter Association of Washtenaw County**: A community shelter with deep expertise in housing and homelessness.
7. **Trinity Health Michigan**: One of the largest nonprofit hospitals in the region; our primary contact is the complex care management program.

8. **Washtenaw County Community Mental Health**: An agency with deep expertise in mental health and substance use services
9. **Washtenaw Health Plan**: An agency in the county health department with deep expertise in health insurance and benefits.

Each participant is assigned a lead care coordinator from one of the hublets described above. The presence of a pre-existing relationship between a participant and a hublet is the first determinant when it comes to assigning a lead care coordinator, as it enables participants to work most closely with an organization they are familiar with.

Our experience has been that familiarity helps to engage participants, particularly in the early stages of the program. Other considerations in making lead assignments include:

- **Geographic location** — should the participant be assigned a lead in Livingston or Washtenaw County?
- **Participant goals** – What are the known health needs and goals of the participant? How do these match up with expertise at different hublets?
- **Hublet capacity** – Which hublets have capacity for complex MiCC cases at this time?

The ability of the lead care coordinator and participant to build **a long-term, trusting relationship is at the heart of this program for individuals with complex health needs and complex lives.**

Individuals from underserved and disenfranchised communities who are facing a lot of life challenges may find it difficult to engage in programs such as MiCC due to a lack of trust in the health care system or other obstacles. The goal of the lead care coordinator is to provide the participant with a single, stable and trustworthy point of contact.

Setting goals. The lead care coordinator first meets with the participant to describe the care coordination program and completes the consent process for enrollment.

This is followed by a comprehensive needs assessment. For this, the lead care coordinator uses a shared assessment tool that was co-designed by the hublets. The assessment includes health and social determinants of health questions. However, it is not a form that is handed to the participant to fill out. Instead, the lead care coordinator uses the assessment tool to have a detailed conversation with the participant to learn about their health and personal needs. MiCC care coordinators report that this is often an hour-long conversation, where initial rapport is established with the participant.

Based on the identified needs, the care coordinator and participant work together to formulate health goals. The participant's priorities guide this process. At first a few goals are created; over time, as these are achieved, other goals are added as needed. Achieving priority goals and establishing a long-term relationship can lead to new and sometimes more challenging goals the participant was previously not ready to address — such as committing to substance use treatment.

Coordinating services. Once health goals are identified, the lead care coordinator helps the participant achieve those goals by working with MiCC care coordinators at other hublets and partner agencies whose expertise are needed.

For instance, if a participant has chronic medical conditions and is looking for stable housing, access to food, and mental health support, MiCC care coordinators at four different hublets may be involved. An example of such a team would be a lead care coordinator from Trinity Health (for managing chronic medical conditions), with Avalon Housing, Jewish Family Services of Washtenaw County, and Washtenaw County Community Mental Health providing housing, food pantry, and mental health services, respectively. The lead care coordinator is responsible for making connections, consulting and coordinating with the other care coordinators and providers, following up, troubleshooting, and tracking the overall progress towards goals. Those who provide support help to formulate domain area specific goals with the participant and assist in meeting those goals. With the help of the shared IT platform that is accessible to all MiCC care coordinators, the team is able to keep up to date and work from a shared care plan.

Working with peers. The MiCC care coordination program also has Community Health Workers (CHWs).

In fact, the lead care coordinator may either be a care manager from one of the hublets or a CHW. The same lead assignment principles are used in either case; existing relationships with hublets, participant needs and goals, and geographic location.

In Washtenaw, the MiCC CHWs have been based at the Washtenaw Health Plan (WHP). With CDC funding, the CHW program will be further expanding to Livingston County, where the local Community Mental Health agency (LCCMH) will house CHWs.

In addition to being lead on some participant cases, CHWs provide support on others, offering a variety of services and expertise; including deep knowledge of local resources, language support, assistance with provider visits and benefits applications, among many others. Importantly, CHWs are trusted community members who meet people where they are, bringing much-needed services to places people feel most comfortable at.

Working with partners. MiCC has developed partnerships with a number of local organizations that can both refer individuals into the care coordination program and can serve individuals who are already enrolled.

Staff at hublet agencies work with staff at each of partner agencies to meet client needs around person-centered, long-term coordinated care with a single, consistent point of contact that reduces the burden of system navigation.

Partner agencies include:

- **Home of New Vision:** Expertise in substance use treatment
- **Huron Valley Ambulance:** Expertise in emergency medical services and community
- **The Corner Health Center:** Expertise in medical, mental health, supportive services for youth
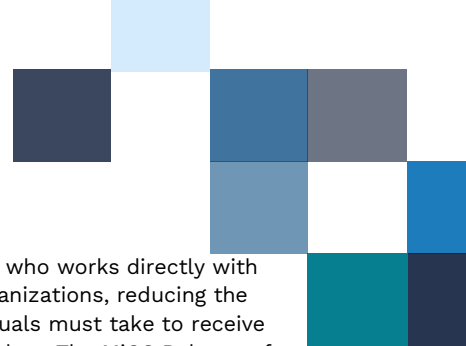
And how we help.

A wide range of services to help meet health goals. The MiCC care coordination program is free for participants, and it is confidential. Participation does not limit or affect the individual's ability to receive other forms of aid.

As part of long-term care coordination, a wide range of services are offered to MiCC participants. The program can assist with goals such as:

- Get health insurance
- Get prescriptions + medical equipment
- Search for safe, affordable housing
- Access food and home-delivered meals
- Fund electricity, heat, and water
- Manage medications
- Schedule appointments with providers
- Support family caregivers
- Access substance use support
- Access mental health support
- Get transportation to appointments
- Find help with medical bills and debt
- Get furniture or home modifications
- Apply for benefits
- Secure substance use treatment
- Get home and community based medical services
- Find help with youth health needs

No wrong door. Participants in MiCC's care coordination program benefit through person-centered, coordinated care across multiple health and human services organizations.

The coordinated, team-based approach makes it easier for participants to access the services they need, without having to bounce back and forth between organizations or struggling to navigate a complicated and often disjointed system of care. This also allows for "no wrong door" access to services; even if a participating organization does not have the expertise to address certain areas of need, they can easily get support from those that do have the expertise.

Because each participant in the program is assigned a lead care coordinator, they have a single, consistent and reliable point of contact who works directly with known contacts at other organizations, reducing the number of steps that individuals must take to receive services from different providers. The MiCC Release of Information forms that list the participating agencies remove the need for the participants to fill out multiple forms at different community-based organizations to get coordinated services.

Home and community visits. The MiCC care coordination program offers home visits, allowing participants to work on some of their goals from their home if feasible and if that is what they prefer.

We believe that home and community visits circumvent some transportation barriers for participants. In addition, seeing the participant's lived environment enables care coordinators and CHWs to better understand their circumstances, identify additional needs, and help them troubleshoot for solutions.

Care coordinators and CHWs can also meet participants out in the community. This allows them to build rapport and trust, and enables services such as accompanying the participant to an appointment to improve communication with their providers.

Reduced medical needs. Among care coordination program participants who completed a six-month reassessment of needs (n = 100), the percentage with self-reported medical issues declined from 58 percent to 35 percent.

Among participants who completed a 12-month reassessment of needs (n = 48), the percentage with self-reported medical issues declined significantly.

69 percent reported medical issues at program start

35 percent reported medical issues 12 months later

Reduced social service needs. Our data show a decline in SDOH needs over time for participants who have a reassessment on file.

Among participants who completed a six-month reassessment (n = 100), 64 percent had four or more SDOH needs at the time of enrollment, while 44 percent had four or more SDOH needs after six months.

64 percent reported four or more SDOH needs at program start

44 percent reported four or more SDOH needs six months later

Among participants who completed a 12-month reassessment (n = 48) — indicating more complex

needs as they remained longer in the program — 65 percent had four or more SDOH needs at the time of enrollment, while 50 percent had four or more SDOH needs approximately one year later.

65 percent reported four or more SDOH needs at program start

50 percent reported four or more SDOH needs 12 months later

The most significant decrease in need from initial to 12-month reassessment was in social isolation as measured by self-report of 'feeling lonely'. At the initial assessment 54 percent reported feeling lonely compared to 25 percent at 12-months.

54 percent reported loneliness at program start

25 percent reported loneliness 12 months later

Improve mental health. Almost half of the MiCC care coordination program participants have screened positive in mental health assessments, underscoring a critical need in the population we are serving.

The MiCC regional collaborative works at the systems level to improve access to mental health services across the community. The backbone organization conducted critical analyses that informed a mental health millage in Washtenaw County. The MiCC collaborative raised concerns about a lack of services for individuals with mild to moderate mental health needs.
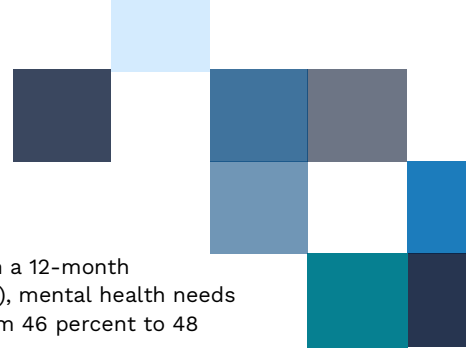
At the individual level, MiCC care coordination program participants have shown improvement in mental health scores after six-months of enrollment, with 53 percent screening positive at initial assessment compared to 43 percent at reassessment (n = 100).

However, for individuals with a 12-month reassessment on file (n = 48), mental health needs showed a slight increase from 46 percent to 48 percent.

In recent years, the program has been using only 12-month reassessments. Hence, we do not know the potential effect of the COVID-19 pandemic on mental health scores.

53 percent screened positive for mental health needs at program start

43 percent screened positive for mental health needs six months later

Mental health needs at program start

Mental health needs 12 months later

MI COMMUNITY CARE

How we improve systems.

To improve the health of vulnerable populations, MI Community Care (MiCC) provides "no wrong door" access to high quality health care and an array of supportive services for the region's most vulnerable populations. But equally important, **MI Community Care takes a preventive approach by investing significant time and effort into improving the Livingston and Washtenaw County region's health, mental health, and social service systems.**

To accomplish this systems change work, the Center for Health and Research Transformation (CHRT) at the University of Michigan, provides administrative, fiduciary, research, and strategic support to the MI Community Care collective. CHRT ensures that MiCC partners receive the full complement of support they need to advance shared values and objectives.

Backbone organizations (BBOs) were originally included in the State Innovation Model (SIM) funding structure to convene community-based organizations (CBOs), communicate with outside organizations including other CHIRs and the MDHHS, administer programmatic requirements, and take on fiduciary responsibilities for the grant funding.

Historically, few funders have supported this essential type of backbone infrastructure in communities. Each CHIR across the state maintains, however, that backbone work was integral to their interventions' success.

- The BBOs functioned as bridges that connected patients with the many other services that impact their health outside of the scope of medical settings.
- The BBOs ensured that each CHIR had a strong foundation for collaboration with all relevant stakeholders, including health plans, the multitude of CBOs participating in the intervention and with outside partners such as MDHHS. Without the BBOs, the cross-

sector work that was vitally important to the CHIRs would have been harder to facilitate.
- The BBOs helped the CHIRs with strategy development, program management, administrative support, capacity building, data collection, and other activities. By using the data that was collected, the backbone could more readily gauge if the systems change was having the CHIRs desired impact.
- The BBOs also helped fuel coordination among stakeholders. In response to the COVID-19 pandemic, CHIRs leveraged the BBOs and the relationships they fostered. For example, CHIRs were able to support rapid rehousing for members of their homeless or housing insecure populations and embed stakeholders in COVID-19 testing sites to screen for SDOH needs and help address those needs.
- The BBOs helped align different stakeholders and created more efficiency in addressing SDOH needs.

CHIRs credit their BBOs as the driving force that kept their interventions on track to meet their goals, as well as the primary reason why the relationships between stakeholders in the region were able to be established, fostered, strengthened, and expanded.

Without fostering those relationships, the greater level of care coordination would have been harder to achieve. Every CHIR agreed that the inclusion of a BBO was invaluable to their intervention and having the existing BBO infrastructure helped CHIRs rapidly respond to the COVID-19 pandemic in their communities.

Improving the substance use response system.

In 2018, dozens of representatives from Washtenaw-area organizations that are deeply involved in the prevention and treatment of substance use disorders (SUD) began to participate in an SUD system transformation process hosted by MI Community Care with support from its backbone organization, the Center for Health and Research Transformation (CHRT). The goal? To improve the county's SUD prevention and treatment system by identifying system barriers and weaknesses and then collectively working to overcome them.

Six full-day convenings were held over a six-month period, and at the final convening, seven cross-agency teams launched a 100-day challenge to kick off the work. Each team developed a series of action steps that members would take to begin to transform the county's SUD prevention and treatment system.

The Resident Engagement Team, for example, explored how community organizations could work alongside residents with lived experience to improve the county's SUD system improvement efforts. The team met with organizations across the county to learn how they engage their clients in programmatic decision-making, whether they surveyed clients about their needs and interests, and what they'd learned from those surveys. The group used this information to collect feedback and advice from residents who are currently using substances, residents who are in substance use treatment, and residents who are in recovery that could inform and improve programs.

The SUD Needs Identification Team cataloged the county's SUD screening tools as a first step toward developing a 'no wrong door' approach for providers across the county. "Sometimes it's confusing for health and human services providers to figure out which SUD services their clients need, and where to refer them for care," said Lisa Gentz, program administrator, Washtenaw County Community Mental Health. "So team members developed a universal screening tool and decision tree to open the door to the right level of care and make sure residents can access the programs and services that best meet their needs."

The Integrated Service Array team mapped the county's SUD prevention, treatment, and support services with the goal of developing a tool that would allow residents and health and human services providers to easily understand their options and quickly access the services they require. And the Eradicating Stigma Team developed a directory of Michigan-based recovery community organizations that could provide input on anti-stigmatizing language for providers.

One of the main recommendations to emerge from this effort was the development of a single point of entry and universal screening tool for Washtenaw County. For the last ten years, residents had been assigned to one of two major SUD service providers based on their date of birth. Today, as a direct result of this systems change process, residents can call a 24/7 MHSUD hotline staffed by licensed mental health and substance use professionals at the county's safety net provider. Staff explain how to access services, give immediate screenings, and also give referrals to community-based providers.

The new intake process allows the county to collect data about substance use treatment needs and outcomes, such as time from assessment to treatment, to inform quality improvement going forward. But already we can say that the switch has significantly sped time to treatment. In the old system, once identifying the correct service provider, individuals seeking SUD treatment needed to speak with someone during regular work hours (M-F, 9-5) to make an appointment one to two weeks out. Until that appointment, individuals couldn't get a referral for treatment. With the new system, the access line is manned 24/7 and individuals can speak with a professional and get a referral immediately.

In addition, having just one number for 24/7 access has had positive ripple effects across the community. The Community Mental Health Partnership of Southeast Michigan—the Prepaid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe, and Washtenaw Counties—has begun to accept referrals directly from the Michigan Department of Corrections for new parolees who require SUD support (historically these individuals had to call to arrange their own services after their release). Having one phone number for each county in the region made that process much simpler to implement. And importantly, all other counties in the region now direct their after hours calls to Washtenaw's 24/7 call line.

Improving the homelessness prevention system.

With funding from MDHHS, staff at the Center for Health and Research Transformation (CHRT) worked with dozens of community partners, on behalf of MI Community Care, **to improve Washtenaw County's homeless system of care by focusing on homelessness diversion.**

The Cleveland Mediation Clinic, leaders in the field, trained frontline workers and support staff at a range of local housing and supportive housing agencies. About 30 to 40 people attended each homelessness diversion training with staff from four pilot agencies getting more intensive "train the trainer" instruction. The pilot launched in January of 2021 and of the 24 families that participated in diversion conversations during the first three months of the program, 54 percent were successfully diverted and none returned to shelter. Of the 61 individuals in diversion conversations, 37 percent were successfully diverted and only five returned to shelter. The average cost per individual was $73. Just one night in an emergency shelter would have cost about $85.

In a lot of cases, diversion workers mediated between the person experiencing homelessness and the people they had previously been staying with or potentially could stay with, to smooth out conflicts, connect them to local community resources, and figure out a plan. Many people were receptive to the idea of hosting individuals and families if their needs were temporary. In other cases, they provided a security deposit, a gas card, bus tickets, or grocery cards.

Diverting from shelter has required much less time than sheltering individuals — an average of four days to divert someone, versus an average of 137 days to get someone housed once they enter the system. It also prevents the kind of stress and trauma associated with episodes of homelessness. And the program is centered around respect for clients, who are often able to find their own solutions with a little extra support.

In addition to this diversion work, the analysis MiCC's backbone organization did—as part of the MiCC initiative— contributed to Washtenaw County's ability to get a housing millage passed. **This millage is now providing significant support for affordable housing across the county, and will continue to do so for many years to come.**

Expanding access to community health workers.

In 2017, MiCC provided funding to the Washtenaw Health Plan to hire three Community Health Workers (CHWs) to serve MiCC participants in Livingston and Washtenaw counties. This was one of the first efforts in the region to coordinate CHW initiatives across health systems and social services organizations.

CHWs are trusted members of the communities they serve, who build connections with their clients in order to help clients achieve their goals. Frontline workers such as duolas, patient navigators, and peer counselors often serve a CHW role. They all build individual and community capacity by providing outreach, education, and other support services. They are resource experts, social emotional supports, and staff members who do whatever it takes to support client needs. A CHW's day might include filling out paperwork with one client for a Section 8 housing application, delivering nutritious food to another client, accompanying a third client to their cardiology appointment to make sure they get there and to help them stay on track with the cardiologist's instructions later on, and helping a fourth client lift a window-unit air conditioner up three flights of stairs.

Though community health workers have worked in Livingston and Washtenaw Counties for years, MiCC employs them in a novel way: as a shared resource and bridge between health, mental health and social service providers. The MiCC CHWs work across MiCC and other organizations to ensure that participants get the full range of supports they need to get and stay healthy. Moreover, CHWs are able to expand the capacity of MiCC partner organizations--they are able to leave the office to conduct home visits, and they are able to do the little things that build trust and help clients follow through on their care goals. For example, one CHW helped a homeless participant during the HUD inspection of her soon-to-be apartment to 1) reassure the client that the process would go well and 2) to ensure that the apartment was in good shape for the client to move into. Making sure someone has a good place to live goes a long way to helping them follow through with their medical care.

When the pandemic hit, while CHWs changed what they were doing (e.g., delivering cleaning supplies in addition to food), their role as trusted helpers did not change. MiCC has seen the importance of the little things that CHWs did and continue to do throughout the pandemic, and it is no surprise that we are now seeing expanded interest in CHWs across our counties.

This past year, MiCC began a pilot with four IHA primary care practices located in the city of Ypsilanti, where patients experience higher rates of social needs, to begin sending referrals to CHWs and to have monthly meetings to discuss client needs. **This pilot has been such a success that the CHWs are fully booked. We are now planning to hire additional CHWs to extend this model to other primary care providers.**

MiCC also hired two CHWs to be based out of Livingston County, recognizing that the more local CHWs are, the more trusted they are in the communities they serve. Packard Health, an MiCC partner agency, has employed two CHWs and the Washtenaw County Health Department is in the process of hiring neighborhood-focused CHWs with American Rescue Plan funding. And finally, the WHP is working on a CHW collaborative across the counties to create a forum through which organizations can learn from one another's best practices and coordinate on training, career development, and CHW reimbursement activities.
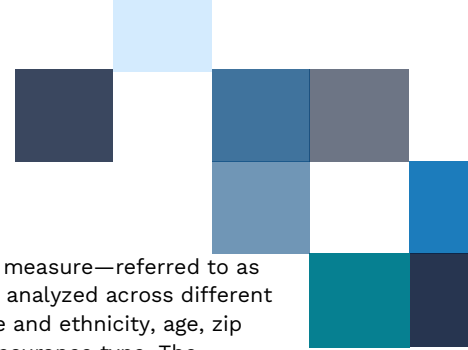
Fostering learning and collaboration.

MI Community Care's (MiCC) backbone organization, the Center for Health and Research Transformation (CHRT), recently sought and received funding to improve upon and scale up the work of the original SIM intervention. One of ways CHRT is doing this is by managing a Health Equity Learning Network for Genesee, Jackson, Kent, Livingston, and Washtenaw County partners. In addition, two new regions are poised to join the Learning Network in 2023.

Each month, Learning Network members come together to share challenges, successes, and lessons learned from their own communities. Additionally, network members look for ways to better align their efforts and to collaborate across regions to achieve a greater impact.

Learning Network members include representatives from MI Community Care, the Center for Health and Research Transformation, the Greater Flint Healthcare Coalition, the Henry Ford Health System, the Jackson Collaborative Network, Health Net West Michigan, the Michigan Social Health Innovations to Eliminate Disparities (M-SHIELD) Collaborative Quality Improvement initiative, and others. To date, they have held sessions focused on:

- Visioning for the work
- Health equity metrics
- Research and evaluation approaches
- Technology platforms and engagement with MiHIN use cases
- Best practices for demographic data collection
- MiHIN's health equity work
- Closed loop referrals
- Engaging individuals with lived experience
- Collaborative quality improvement initiatives
- Care models
- Consent procedures
- Incorporation of community health workers

Learning Network members chose to form an additional working group focused on program metrics and data collection. **Initially, this metrics group focused on defining a single health equity measure that could be analyzed across regions and populations.**

The group chose to create a measure—referred to as "needs met"--that would be analyzed across different demographics, including race and ethnicity, age, zip code, insurance status and insurance type. The metrics workgroup continues to look for ways to align demographic data collection across regions with a focus on specificity and inclusion.

The group is now developing best practices around data collection–particularly for race, ethnicity, language, sexual orientation, and gender identity collection–and bringing in outside trainers to assist.
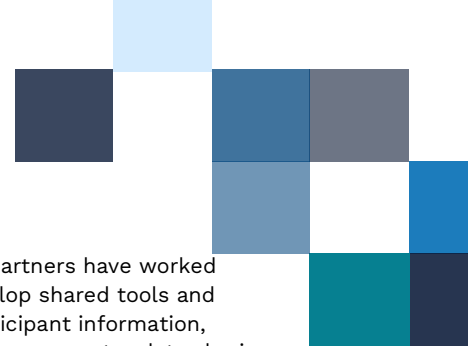
Fueling data and infrastructure development.

In 2006, the State of Michigan brought together stakeholders from across Michigan to identify an approach to promoting the development of technology, process, and legal solutions to allow for the sharing of health information to improve patient care.

The resulting strategic plan outlined the creation of the legislatively mandated Health Information Technology Commission (HIT Commission) and a new not-for-profit organization to serve as the state designated entity for health information exchange – Michigan Health Information Network (MiHIN) Shared Services.

Since its establishment in 2011, MiHIN has worked to build connectivity and enable secure data sharing between healthcare providers throughout the state. In addition to development of the technology infrastructure, MiHIN provides governance, a legal framework, and data standardization to support broad health information exchange. While Michigan continues to be a national leader in terms of the secure sharing of clinical information, the integration of clinical data with social care and social determinants of health data offers significant new challenges.

Community Information Exchange (CIE) often leverages HIE infrastructure to support the integration and use of social determinants of health data, at both an individual and population health level, by a broader set of stakeholders that includes social service providers. In addition to hospitals, primary care providers and specialists, CIE allows for the coordination of care between clinical providers and entities that provide housing, food, substance use services, and other community resources to address a person's overall health. A statewide CIE infrastructure that supports cross-sector information sharing, a shared resource database, and a closed loop referral process to improve access to resources will require stakeholders to address disparate approaches to data access, consent and data use; as well as a lack of funding, standardized and interoperable tools, and technical and human resources especially at the community level.

The COVID-19 pandemic served to expose data gaps that perpetuate health inequity and accelerated efforts to deliver solutions to help clinical providers and social care organizations tackle these challenges.

MiCC and their community partners have worked together to collectively develop shared tools and techniques to exchange participant information, develop the foundations for cross-sector data sharing through shared consent/RoI forms and processes, examine data sources to support improved identification of disparities and increased access to services, build community engagement, and evaluate community resource gaps. Similar efforts are ongoing in other CHIRs across the state.

The MDHHS Social Determinants of Health (SDOH) Strategy (Michigan's Roadmap to Healthy Communities) and the Michigan Health Information Technology Commission's Health IT Roadmap both identify the foundation of CIE as a strategic imperative. A statewide CIE Taskforce has been mobilized to bring together various stakeholders to support efforts to develop and implement a blueprint for CIE. MiCC's nominee for the CIE Taskforce, Kelly Stupple, Program Manager and Child Health Advocate for the Washtenaw Health Plan, was invited to serve on the taskforce.

The work of MiCC and its Learning Network partners promises not only to support MiHIN in the development of a framework for community-based data sharing, but also to help inform the CIE Taskforce, CMS, MDHHS, and other funders and policy makers on critical aspects to designing and addressing social determinants of health policies and programs to meet the needs of individual patients and the broader needs of underserved communities.

Incorporating community paramedicine.

In late 2015, Huron Valley Ambulance (HVA) established a community paramedicine (CP) program based on similar models across the country designed to deliver the most appropriate resources in the right care setting for each patient.

Under approval of the Medical Control Authority's Medical Director, a subset of emergency medical dispatch codes that identify low acuity health needs prompted a CP unit to be dispatched instead of a traditional advanced life support (ALS) unit. To coincide with the launching of this value-based care delivery model, HVA's internal education program developed a 160-hour CP curriculum that is recognized today by MDHHS Bureau of EMS, Trauma and Preparedness as the gold standard for CP education in the state of Michigan. The training also includes 40 hours of hospital training, 36 internship hours on paramedic calls and coursework on the social determinants of health.

Initially the program focused on addressing two specific problems: diverting non-emergent problems from emergency departments (EDs) and providing specialized services to SNFs to prevent their patients from being readmitted to the hospital. CPs are trained at identifying social needs through their experience working in the community, delivering care in patient's homes, and through their established relationships with other local service providers. By delivering care in a patient's home, CPs are given a unique insight into the social needs and health conditions of patients, as they can perform fall risk assessments, or determine whether the person has food in their fridge or is living in a safe environment to manage their health needs.

Integrating HVA CPs into the MiCC network gives CPs a direct connection to a larger health and social service network, and this two-way communication allows the organizations involved to tap into HVA CP's unique vantage point to identify patients that fit MiCC referral criteria for both medical and social needs, as CPs interact with high utilizers frequently in the community.

At times, HVA is the first health care provider to interact with these patients in need. Through these interactions, they can identify early on when a patient enters a period of heightened utilization, such as after they have experienced a major health incident, hospitalization, or a social crisis that has impacted their ability to manage their health needs. By identifying these individuals earlier on, HVA CPs can be a critical partner in getting individuals in Washtenaw County the care they need in the most appropriate setting, and emergency resources can be reserved for urgent needs by keeping low-acuity patients at home. By adding the ability to refer patients to MiCC, HVA can get patients connected to the resources they need to prevent further interactions with the 911 system for non-urgent needs, and MiCC can reach patients who may not currently be interacting with their other partner organizations.

Currently, HVA CPs are undergoing training on the IT platform as well as how to manage referrals. As a seasoned CP program, HVA has also partnered with Livingston County EMS through their relationship with CHRT to help kick off their CP program, so that these services can be provided within their service area as well. Future goals include refocusing on 911 diversion, particularly serving Medicaid populations, and streamlining the process for identifying high utilizers who are under insured and may be good candidates for additional outreach through MiCC.

Once HVA is fully integrated into MiCC, their goal is to share best practices and learnings with other CHIRs, and **to create a blueprint for integrating CP programs and local EMS organizations into other coordinated care networks.**

Building capacity and providing support during COVID-19.

MI Community Care's (MiCC) network of organizations has been on the frontlines of the COVID-19 response in Livingston and Washtenaw County since the beginning of the pandemic. Care managers from our partner organizations, as well as our own community health workers, have provided critical health, behavioral health, and social services, our providers identified worsening resource gaps in rural and urban communities across Livingston and Washtenaw Counties. Housing, food insecurity, personal protective equipment, transportation, and mental health emerged as key areas of need, and continue to be so.

To alleviate these resource gaps, MiCC began distributing federal funds from a Centers for Disease Control and Prevention (CDC) grant to its member organizations with the expertise and infrastructure required to provide these essential services.

Housing. CHRT, the backbone organization and administrative hub for MiCC, is working with its housing providers, Avalon Housing and the Shelter Association of Washtenaw County (SAWC), to expand transitional and temporary housing services in our region.

The financial burden of the pandemic extends to significant increases in housing instability. Avalon is providing rapid rehousing and hotel stays, and supporting storage costs and moves while individuals are waiting for their housing units to become available. SAWC is serving one of the most vulnerable populations during the pandemic--individuals experiencing homelessness--and is housing individuals who need to be isolated due to COVID-19 infection, as well as providing them with food and personal protective equipment.

Investment outcomes.

In May 2022 alone, Avalon Housing provided transitional housing services to 17 individuals in nine households with the CDC funding. Eighty-eight (88) percent of the service recipients were Black and 12 percent were white.

Investment outcomes.

SAWC used CDC funds to offset some of its temporary housing expenses during peak COVID-19 activity in December 2021 and January 2022. Funds provided housing support and COVID-19 supplies for 39 individuals in December and 22 individuals in January, along with 183 meals delivered to these individuals.

- Of those served in December, 54 percent were Black, 3 percent were American Indian, Alaska Native, or Indigenous, and 5 percent were Hispanic.

- Of those served in January, 32 percent were Black and 9 percent were Hispanic.

Food insecurity. CHRT has allocated funds to two MiCC participating agencies—the Corner Health Center and Jewish Family Services of Washtenaw County (JFS)—to support their food pantry and food delivery services for community members facing food insecurity.

These agencies also have special expertise in serving two critical populations: youth and young adults and the elderly. The Corner Health Center provides primary care, specialty care, behavioral health care and supportive services to youth and young adults. Most of their clients live in low-income households, with a majority at or below the poverty level, and often struggle daily with food insecurity, family instability, neglect, abuse, and unsafe housing. JFS's Washtenaw Integrated Senior Experience (WISE) Aging Services Program assists diverse community members aged 60 and over to find and coordinate appropriate resources and alleviate barriers to access.

Mental health. The significant mental health burden of the COVID-19 pandemic has been widely recognized not only in Michigan, but across the nation.

A report published by the CDC[i] states that more than 40 percent of U.S. adults who responded to representative panel surveys on mental health, suicidal ideation, and substance use reported at least

one mental or behavioral health challenge. The report recommended community-level intervention and prevention efforts, including health communication strategies. Livingston County Community Mental Health, an MiCC hublet, will be using CDC funds through CHRT to offer Mental Health First Aid trainings to members of the community, including staff at community agencies, churches, and volunteer groups, to learn about mental health and how to respond to their neighbors. Funds will also cover manuals for 160 trainees.

Transportation. In a survey implemented in June 2021, hublet care coordinators and Community Health Workers (CHWs) identified significant gaps in transportation that are consistent with county data and national findings. Reliability, scheduling, affordability, and location are the top transportation barriers in Livingston and Washtenaw.

Medicaid transportation is often unreliable. Bus routes are limited and difficult to navigate for the elderly, for people with chronic medical and mental health conditions, and for residents in rural areas. Individuals may need door-thru-door services (getting out of their apartment or getting settled at a medical office) and support in making transportation requests. Individuals may know about their appointment needs only a few days before an appointment, but scheduling may not be possible at such short notice. Reliable transportation is necessary to better manage medical and mental health appointments and to address social needs. MiCC is now working with local vendors

-- JFS, People's Express, and soon L.E.T.S. -- to provide transportation services to MiCC participants.

MiCC's community impact during COVID-19 is not limited to the distribution of additional resources to those organizations best positioned to meet rising needs. In fact, that the network exists in the first place has been a great advantage to the community in and of itself. MiCC care coordinators at various organizations have noted that their pre-existing relationships with one another, dating back to the original SIM effort, and continuing today through MiCC, enabled them to get critical services to their clients when no other way was possible. Having personally known each other for years prior to the pandemic, the care coordinators and CHWs were able to remain out of the silos of their individual organizations even when service delivery changed rapidly with remote work, social distancing, and other pandemic precautions. The network was able to adapt quickly to efficiently and effectively serve community members who are formally enrolled in the complex care coordination program and those who are not. MiCC will continue to strengthen existing relationships and create new ones for true community capacity building of this nature.

"During the pandemic, Packard Health was amazing. Just being able to call Packard and arrange in-home vaccinations was pivotal for a lot of folks who didn't have transportation or were scared."

MI COMMUNITY CARE

Meet our partners.

The MiCC regional collaborative currently includes nine organizations, known as *hublets*, and three additional organizations that participate as *partner agencies*.

These partners are key to the program's success, and MiCC works to help these partner agencies build expertise and capacity.

24	Avalon Housing
25	Jewish Family Services
26	Livingston County Community Mental Health (CMH)
27	University of Michigan Health
28	Packard Health
29	Shelter Association of Washtenaw County
30	Trinity Health St. Joseph Mercy Ann Arbor and Livingston
31	Washtenaw County Community Mental Health
32	Washtenaw Health Plan
33	Corner Health
33	Huron Valley Ambulance
34	Home of New Vision

OUR MICC HUBLETS

Avalon Housing

Founded: 1992
Key focus: Supportive housing
Mission: To build healthy, safe and inclusive supportive housing communities as a long-term solution to homelessness
Contact: Aubrey Patiño, Executive Director
1327 Jones Drive Suite 102 Ann Arbor, MI 48105
734-663-5858 / https://www.avalonhousing.org

Avalon Housing is a 501 (c)(3) non-profit services provider, real estate developer and property manager that works to end homelessness by developing affordable housing centered on community, care, and support.

Avalon owns and manages hundreds of rental units in 29 properties across Washtenaw County and provides supportive services to tenants, individuals, and families living in public housing and units owned by private landlords. In total, Avalon serves more than 800 people, including 200 children, in Washtenaw County.

Avalon's approach is known as supportive housing, and is considered the best long term solution to homelessness. Supportive housing prioritizes health and wellbeing by providing resources to help people stay and thrive in their homes. Avalon's supportive housing services include case management, 24/7 access to crisis response, eviction prevention, assistance with basic needs, health care access and advocacy, substance use and mental health support, and links to needed in-home supports.

"Working with MiCC has been a tremendous opportunity to support client goals, and enhance outcomes for clients and the community. We have been able to connect and collectively house many individuals who were homeless, or in uninhabitable housing conditions, in addition to preventing multiple evictions during the global pandemic.

Cross-agency partnerships have enhanced our ability to connect to state resources such as food assistance, emergency relief, access to health insurance, and collective response to APS when needed. In many cases a MiCC care coordinator or Community Health Worker is the only support in a client's life, and certainly the only portal to access complex medical support, assistance with ongoing housing stabilization, SUD support, and access to concrete needs.

MiCC has allowed seamless support across agencies to provide a dynamic and enhanced level of coordination that prevents valued community members from slipping through the cracks."

--Jessica Howell
Hickory Way Support Coordinator
Avalon Housing

Jewish Family Services

Founded: 1978
Key focus: Strengthening family life, fostering individual self-sufficiency and promoting improved social and economic conditions.
Mission: To create solutions, promote dignity, and inspire humanity.
Contact: Anya Abramzon, Executive Director
2245 South State Street Ann Arbor, MI 48104
734-769-0209 / https://jfsannarbor.org/

Jewish Family Services (JFS) of Washtenaw County is dedicated to strengthening family life, fostering individual self-sufficiency, and promoting improved social and economic conditions.

JFS provides affordable, accessible, holistically-oriented and culturally sensitive care to clients, whatever their identification, affiliation, lifestyle, background, race, religious creed, or national origin. Jewish Family Services is also the only agency that provides wraparound services for refugees as well as counseling, nutrition, transportation, employment and interpretation.

Embedded within JFS is the Washtenaw Integrated Senior Experience (WISE) Aging Services Program.

WISE case managers assist diverse community members age 60 and over as they find and coordinate needed resources and alleviate barriers to access – including lack of knowledge, application processes, language skills, etc.

"Being a part of the MICC team has been an invaluable experience not only for the clients we serve, but also for me as a case manager working in the community.

Through MICC, I am able to quickly and efficiently connect with multiple agencies that provide critical services in our community."

--Sarah Russman
WISE Case Manager
Jewish Family Services of
Washtenaw County

OUR MICC HUBLETS

Livingston CMH

Founded: 1989
Key focus: Mental health care
Mission: To create individualized pathways to wellness, resilience, recovery and self-determination economic, social or cultural conditions might otherwise prevent them from accessing health care.
Contact: Connie Conklin, Executive Director
622 East Grand River Howell, MI 48843
517-546-4126 / http://www.cmhliv.org

LCCMH provides emergency services, assessment, health and medication services, client services management, individual and group therapy, assertive community treatment, older adult services, respite, substance abuse services, community supported living, wraparound and psychosocial rehabilitation.

The staff includes trained and licensed social workers; psychologists; psychiatrists; occupational, physical, and speech therapists; nurses; support staff; administrators and others who maintain professional licensure or certification as required by law.

"I think one of the things that [MiCC has] done is improved health care integration.

It started with a project and it became a system of care that's impacted how we look at the larger health care system and what our responsibility is."

--Connie Conklin
Executive Director
Livingston County Community
Mental Health

OUR MICC HUBLETS

University of Michigan Health[1]

Founded: 2005
Key focus: Care management for patients with multiple chronic conditions
Mission: To provide continuous care management in collaboration with Patient Centered Medical Homes for patients with complex medical, mental health, and social support needs.
Contact: Brent Williams, Executive Director
1500 E Medical Center Dr, Ann Arbor, MI 48109
734-936-4000 / www.uofmhealth.org

Michigan Medicine's Complex Care Management Program (CCMP) is comprised of allied health professionals who provide intensive case management for complex patients. CCMP coordinates with community resources to identify and address patients' barriers to managing complex medical conditions. The program is patient-focused and provides support to individuals so they can more successfully navigate the care delivery system. CCMP partners with community agencies including Washtenaw County Community Mental Health, the VA Healthcare System, and others.

"As a hublet in MI Community Care, CCMP has been been able to provide support to hundreds of consumers in Washtenaw and Livingston counties, providing a direct link to the MM health system and assisting [MiCC team members] in navigating its complex system.

This has allowed earlier interventions for consumers."

--Heather Rye
Complex Care Manager and
Program Supervisor
University of Michigan Health

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[1] At University of Michigan Health, we typically work through partners at the Complex Care Management Program.

OUR MICC HUBLETS

Packard Health

Hublet: Packard Health

Founded: 1973
Key focus: Primary care and mental health care for families, food pantry, medication assistance, insurance enrollment.
Mission: To provide the best possible care to our patients and community, including people whose economic, social or cultural conditions might otherwise prevent them from accessing health care.
Contact: Raymond Rion, MD, Executive Director
2650 Carpenter Road, Ann Arbor MI 48108
734-971-1073 / www.packardhealth.org

Packard Health is a Federally Qualified Health Center providing health and social services to the Ann Arbor and Ypsilanti communities since 1972.

In the spirit of *diversity*, *justice*, and *excellence*, Packard seeks to serve all persons including those whose economic, social or cultural conditions might otherwise prevent them from accessing health care.

"Participating in the MI Community Care program has allowed Packard to cement critical partnerships and collaborate in innovative ways with other key social service organizations, helping us to ensure health and social equity for the most high-risk, vulnerable folks in Washtenaw county."

--Becca Fleming, MPH, BSN, RN
Director of Community Health
Packard Health

OUR MICC HUBLETS

Trinity Health Michigan[2]

Founded: 1911
Key focus: Complex care coordination
Mission: To serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.
Contact: Alonzo Lewis, President
5301 McAuley Drive, Ypsilanti, MI 48197
877-586-1174 / https://www.stjoeshealth.org

Trinity Health St. Joseph Mercy Ann Arbor and Livingston has been providing long term case management services for patients with high emergency department utilization since 2015. Our team travels along with the patient across the continuum of care, engaging with patients when they visit our ED, hospitals, specialty care on campus and in the community. Our program specializes in adult patients with complex social and medical problems and assists them by exploring the benefits of changing, reducing or eliminating high-risk behaviors while addressing health inequities.

"MiCC helped establish formal partnerships between hospitals and community-based organizations, which promotes standards of care based on best practice models for our most vulnerable populations in the area. This partnership allows "real-time" access to care for patients, no matter what setting they present in.

The relationships that have been built between hublets does not exist outside of MiCC – these relationships enhance every aspect of the work we are trying to do through our complex care social work program."

--Julia Grover
Complex Care Social Work Program Team Lead Trinity Health Michigan

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[2] Our main contact at St. Joseph Mercy Ann Arbor and Livingston is with the Complex Care Management Program.

OUR MICC HUBLETS

Shelter Association

Founded: 1982
Key focus: residential and nonresidential programs, diversion services, short-term case management, and healthcare to a diverse range of people struggling with homelessness.
Mission: Ending homelessness, one person at a time.
Contact: Daniel Kelly, Executive Director
312 W Huron Street Ann Arbor, MI 48103
734-662-2829 / www.annarborshelter.org

SAWC's served population includes our most vulnerable neighbors of Washtenaw County serving single adults experiencing homelessness in Washtenaw County for over 38 years. Care coordination from the community providers is needed to address unique health challenges and overcome barriers to meeting Maslow's Hierarchy of Needs including housing and health.

"For the Shelter Association of Washtenaw County, most of our client referrals for MI Community Care are experiencing a myriad of challenges including homelessness, unmanaged chronic health conditions, and often untreated health challenges.

Often these clients are unable to prioritize their health goals, medical appointments, or access to medications they have been prescribed.

MI Community Care hublet coordination allows the shelter to connect with the hospitals and complex care social workers to understand the client's advised course of treatment or next steps toward health stability."

--Kate D'Alessio
Program Director
Shelter Association
of Washtenaw County

OUR MICC HUBLETS

Washtenaw CMH

Founded: 2001
Key focus: Mental health care
Mission: To promote hope, recovery, resilience, quality of life, and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.
Contact: Trish Cortes, Executive Director
555 Towner Ypsilanti, MI 48198
734-544-3050 / washtenaw.org/839/community-mental-health

Washtenaw County Community Mental Health (WCCMH) serves over 5,000 individuals annually including adults with serious mental illness, youth with serious emotional disturbance, individuals with co-occurring mental health and substance use disorders, and individuals with intellectual or developmental disabilities across their lifespan.

WCCMH offers treatment from a multi-disciplinary team that can include case management, nursing, therapy, psychiatry, and peer support specialists. In addition to the onsite treatment services, urgent and emergent behavioral health services are available to all community members through the WCCMH mobile crisis team 24 hours per day, 7 days per week.

WCCMH is also a Certified Community Behavioral Health Clinic (CCBHC) which is available to any individual in need of care, including but not limited to, people with serious mental illness, serious emotional disturbance, long term chronic addiction, mild or moderate mental illness and substance use disorders and complex health profiles. These services are provided regardless of ability to pay.

WCCMH also has teams that provide mental health services in the jail, for those that are homeless, and those in specialty mental health courts. Mid-2022 WCCMH also became a MDHHS Behavioral Health Home partner and is providing care coordination services to those that are eligible based on diagnosis and are covered by Medicaid.

"WCCMH has been a hublet with the SIM/MiCC project from the very beginning. MiCC has strengthened the relationship between the social services, health systems, and primary care providers in the Washtenaw/Livingston communities.

The ability to work in real time with other partners to help coordinate care across multiple systems has provided some great outcomes to WCCMH MiCC participants."

--Brandie Hagaman
Program Administrator
Washtenaw County
Community Mental Health

Washtenaw Health Plan

Founded: 2001
Key focus: Access to healthcare for low income individuals.
Mission: Helping low-income and uninsured people access high quality health care and health-promoting services.
Contact: Jeremy Lapedis, Executive Director
555 Towner, Ypsilanti, Michigan 48198
(734) 544-3030 / www.healthcarecounts.org/

The Washtenaw Health Plan is a safety net health care program that serves as an on-ramp to health care and related services for populations that would not otherwise have access to care.

WHP operates a managed care plan for about 2,600 county residents who are ineligible for other health insurance so they can access primary care, specialty care, mental health services, prescription coverage and other services.

WHP also serves approximately 3,500 additional county residents annually by navigating health insurance and public benefits issues, connecting people to dental care and behavioral health services, and resolving access to care barriers such as unpaid bills, transportation, and language or cultural barriers.

WHP staff speak English, Spanish, and Arabic to provide the highest quality care and information to the many low or no proficiency English speakers we assist.

And as the access to care arm of the Washtenaw County Health Department, WHP works closely with their many public health outreach and community programs.

"MI Community Care has allowed the WHP to host three community health workers to support MiCC clients and care managers. The addition of the CHWs to WHP staff has brought a new ability to be able to serve clients in a deep and sustained manner.

Previously, our work focused on high volume and quick processing of client needs, now we can provide assistance to clients who have chronic, ongoing concerns, and develop long-term supportive services. MiCC has brought higher visibility to our work and strengthened our ties with the other hublets."

--Kelly Stupple
Health Advocate
Washtenaw Health Plan

OUR MICC PARTNERS

Corner Health

Founded: 1980
Key focus: Physical and behavioral health care and support services for youth and young adults.
Mission: The mission of the Corner Health Center is to inspire 12- to 25-year-olds (and their children) to achieve and sustain healthy lives by providing judgment-free, affordable health and wellness care and education.
Contact: Ellen Rabinowitz, Interim Executive Director
47 N. Huron Street, Ypsilanti, Michigan 48197
734-484-3600 / https://www.cornerhealth.org

The Corner Health Center, located in Ypsilanti, MI, offers a range of primary and specialty care, behavioral health, and supportive services for youth and young adults ages 12- to 25 (and their children). Their team of board-certified providers is well versed in the unique and specific needs of young people. The team of physicians, nurses, psychiatrists, social workers, nutritionists and health educators provide judgment-free, affordable health and wellness care and education. Services include primary health care, behavioral health, sexual health care, a food pantry, health and wellness classes, as well as a variety of youth leadership development programs designed to help young people transition into adulthood.

Huron Valley Ambulance

Founded: 1981
Key focus: Emergency services, transportation to medical care
Mission: To provide accessible, high-quality pre-hospital health care services to the people and organizations we serve in southeast and south-central Michigan.
Contact: Ron Slagell, President and CEO
1200 State Cir, Ann Arbor, MI
734-971-4420 / http://www.emergenthealth.org/hva/

HVA's Community Paramedic (CP) program has strengthened the health of the Washtenaw County community since 2015 through increasing access to health care and delivering focused interventions. Community Paramedics operate within the EMS system under medical direction from the Washtenaw/Livingston Medical Control Authority to provide traditional 911 care as well as an expanded scope of care through specialized training. This expanded care includes specialized in-home treatments and assessments, aimed at preventing patients with acute or chronic diseases from utilizing the Emergency Department for their non-emergent health care needs, freeing up health system resources for more urgent or complex care. These patient populations are at higher risk for hospital readmission, and their medical needs are often

further exacerbated by social determinants, such as food insecurity, housing instability, or lack of transportation. CPs work with the individuals in our community to connect them to necessary resources to address these social needs, while providing an alternative value-based model of care.

Home of New Vision

Founded: 1996
Key focus: Substance use disorder (SUD) treatment and recovery supports and impacts on people with SUD and their loved ones.
Mission: To provide gender-specific programs and specialized services to empower, protect, encourage, and enrich the lives of men, women, their families, and communities affected by the disease of addiction
Contact: Glynis Anderson, Chief Executive Officer
3115 Professional Drive Ann Arbor, MI 48104
734-975-1602 / http://homeofnewvision.org/

Home of New Vision (HNV) is a 501 (c)(3) non-profit organization that has provided substance use disorder (SUD) treatment and support services since 1996. Offering a wide array of recovery-oriented programs, HNV has locations in Ann Arbor, Ypsilanti and Jackson, Michigan. Home of New Vision provides both outpatient and residential treatment services for substance use and co-occurring conditions using a wraparound approach that incorporates recovery peer coach and case management services. In addition to treatment services, Home of New Vision offers several programs to support individuals from crisis through early and longstanding recovery including a 24-hour crisis intervention center, recovery resources, an opioid overdose response team, four Narcan vending machines throughout Washtenaw County, four recovery houses, and two Medication Assisted Treatment houses.

MI COMMUNITY CARE

How we support partners.

MiCC is a product of community co-design. Since the inception of the Livingston-Washtenaw State Innovation Model CHIR, CHRT has provided facilitation and administrative support for the program. The Washtenaw Health Initiative (WHI) — itself a voluntary collaboration between more than 200 individual and organizational stakeholders — has provided governance and advisory support over the years. However, **key programmatic decisions, such as workflow design for the community care coordination program, are collaboratively made by MiCC partners.**

CHRT facilitates bimonthly Quality Improvement meetings for MiCC partners, and meets with each of the key partners on an annual basis to discuss barriers and opportunities for improving the care coordination program, community needs and gaps, and additional opportunities for partnership and sharing of knowledge and resources across organizations. Any new items identified at individual meetings are brought back to partners for further discussion.

Over the years, partner care coordinators and Community Health Workers (CHWs) have identified ways in which taking part in the MiCC regional health collaborative has impacted their organizations. These include building relationships and infrastructure, helping to develop a vision and means for providing holistic care in a coordinated fashion, and identifying and addressing gaps in the community.

"Having a representative from each agency ma[kes] care coordination so much easier. Anyone from my agency can come to me to reach out to someone at Michigan Medicine, and we can quickly get results and actions that benefit our clients."
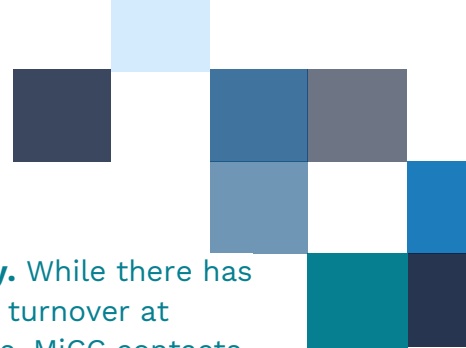
Strengthening relationships.

MiCC was co-developed by participating organizations with facilitation by CHRT. Each organization has at least one MiCC care coordinator representative, as well as a management level contact. Since the beginning of the collaborative in 2016, hublet representatives have been meeting at least once a month. At first, meetings were centered around building the collaborative and its care coordination program. In subsequent years, meetings have focused on quality improvement and care coordination. This relationship building has improved the way local organizations communicate and coordinate with one another. We have witnessed:

Improved efficiency. Care coordinators know, or otherwise can quickly find out through their MiCC contacts, who to talk to at each organization to help clients meet their needs. This results in real-time warm handoffs, wraparound care, and a reduced number of steps to help individuals meet their goals.

While these relationships were initially mostly between MiCC care coordinators at the different organizations, today care coordinators report that the relationships have extended to other staff at their organizations, thereby breaking down silos and building closer connections between agencies. During the COVID-19 pandemic, this improved efficiency helped reduce barriers to care, as organizations had to adapt rapidly to providing services remotely. Because of pre-established relationships, access to services at other agencies and cross-sector care coordination were enhanced instead of being interrupted.

"I think things have become more efficient because we can identify a client need and get it to the agency that can help in the best way. Where it might take us a lot of calls and paperwork and time to solve the problem, we can reach out to someone in the agency that is more familiar and can solve it quicker."

Mutual accountability. While there has been occasional staff turnover at different organizations, MiCC contacts have mostly remained the same over time.

Inter-agency accountability has improved through the building of relationships across care coordinators and program managers over many years. The team approach has helped to nurture feelings of collegial responsibility across organizations, placing clients at the center of care. Collaborative goal setting for clients through this team-based approach helps accomplish goals quickly. The relationships formed across organizations create a social pressure to make sure everyone is completing the tasks assigned to them. This team approach focuses on empowering the client to take little steps which accumulate to the achievement of their goals.

"It's hive mind, right? More brains is better. It's better for resourcing everything."

A network of problem solvers. Established relationships between MiCC organizational representatives have improved each organization's understanding and knowledge of the broader system of care and community resources.

At monthly care coordination meetings and informally outside of these meetings, MiCC care coordinators — including CHWs — rely on each other when they have questions or get stuck on difficult cases. At care coordination meetings, they get advice from others on how best to move forward with overcoming barriers to achieve participant goals. This serves to educate new care coordinators and to support existing care coordinators with resources beyond their own agencies. This was particularly useful during the COVID-19 pandemic, when different agencies were playing different roles in vaccinating people in the community and this forum served as a place to clearly communicate and troubleshoot how to get as many people vaccinated as possible. The relationships also

36

offer a personal support system, countering burnout and allowing team members to cover for each other when they have conflicting commitments or are out of the office.

"It's really kind of amazing to see [colleagues] welcomed by other agencies.... We started out small and then people learned about others at UofM Complex Care or St Joe's Complex Care and started reaching out to those people independently. And it's just sort of blossomed into this sort of normalization of having contact with all these different agencies in a way that we never had before."

mi-communitycare.org

Building infrastructure.

In parallel with building a social infrastructure through enhanced formal relationships, the MiCC collaborative has been building a supporting workflow, process, and technical infrastructure to remove barriers to communication and coordination of care. Hublets have worked together to collectively develop shared tools and techniques to improve exchange of information and provide interdisciplinary and holistic care to community members with the most complex health needs.

Shared consent. Prior to MiCC, a few of the hublets had legal agreements that enabled them to share patient/client information with other hublets, but most did not.

In fact, there was significant variation in consent / Releases of Information (RoI) practices; organizational forms differed in content and expiration timelines. Community members who received services from multiple organizations that needed to exchange information to coordinate their services often had to sign multiple different forms at different times and locations. Completed and signed forms were usually faxed or emailed between organizations, which made it difficult to keep track of new and updated forms.

For MiCC, CHRT facilitated Business Associate Agreements, as well as the development of shared standardized consent/RoI forms that list all participating agencies. Shared forms allow a consistent way of doing documentation for the program and remove the need to complete multiple different forms between agencies, thereby preventing inefficiencies in information exchange. Signed forms are uploaded to the shared IT platform used by MiCC, which is accessible to all program care coordinators and CHWs across hublets and partner agencies. This not only helps with easy tracking of forms, but provides more data security for sensitive information. This legal framework is not only important for the local community; lessons learned over time are also transferable and scalable across regions and could help inform broader cross-sector data sharing initiatives. As the State of Michigan, and indeed the nation, work towards building an infrastructure for health and social determinants of health data exchange, questions concerning an appropriate legal infrastructure will be imperative to address.

Shared needs assessment. Screening practices vary across hublets, especially as they differ in the services they offer.

Screening is only helpful to service recipients if the agency doing the screening is able to offer services or at least make a connection to help meet a need. The MiCC care coordination program provided a reason for participating organizations to complete a needs assessment that includes service areas outside of their expertise, because other hublets are able to address those needs or make the necessary connections. Hence, for MiCC, hublet care coordinators and CHWs collaborated on developing a comprehensive needs assessment tool to identify the health and social determinants of health needs of referred individuals.

This form is not meant to be simply handed to program participants to fill out; instead, it is used as a conversation mediator for developing and prioritizing goals and identifying the required resources needed to support the participant. It is a tool designed to help participants take an active role in their care journey by getting participants to open up and explain their situation and to express and develop personal goals. These goals can be related to medical, behavioral health, substance use and/or social determinants of health needs, such as housing, food, transportation, utilities, and legal assistance. At first, a few goals are identified based on the participant's priorities. As these are met, more — and sometimes harder — goals are set, as the care coordinators and CHWs develop trust and long-term care management relationships with the participants.

Shared IT platform. Prior to MiCC, information between hublets was siloed, often unavailable to one another and at times inaccurately shared. This was particularly true across sectors — medical, behavioral health, and social services.

Care coordinators reported that they typically did not know which agencies were providing services for their clients, what services those agencies were providing, and how their clients were interacting with other agencies. The care coordinators didn't know who to call at other agencies to talk about a shared client, and each time they called they would get a different person, having to start a conversation all over again.

For MiCC, CHRT worked with the hublets in an iterative feedback process to identify six desired features in an information technology platform that would be accessible to all participating organizations:

1. A visible list of all organizations and care coordinators that have an active care relationship with each program participant, including their contact information,
2. Visible notation of the lead organization and care coordinator for each participant,
3. The ability to upload signed consent forms and Releases of Information (RoIs),
4. A secure messaging system for inter-agency communication,
5. A shared care plan for each participant, and
6. The ability to enter progress notes.

Specific document types were also created to capture participant information from an initial screening and a more comprehensive needs assessment.

CHRT then partnered with a workgroup of stakeholders to identify a vendor that could tailor an existing system to meet these needs. The team chose an IT platform by PCE Systems.

Through additional enhancements, MiCC care coordinators also gained access to MiHIN's Longitudinal Health Record and information from Community Mental Health agencies through the PCE platform — such as appointments and medications — to enhance inter-agency coordination for shared participants with appropriate consents in place.

Since its implementation almost five years ago, hublets and partner agencies have consistently identified the shared IT platform as one of the most valuable components of the care coordination program.

The IT platform helps to identify who to coordinate with at other agencies. It keeps everyone aware of the work other agencies are doing with a shared participant, potentially preventing organizations from unwittingly working against each other, having misaligned goals, or duplicating services. The system's secure messaging, case notes, and shared consents have been working seamlessly.

Work still continues in improving other platform and workflow features to reduce administrative burden for care coordinators. Care coordinators have to document the same information in both their institution's IT platform and in the shared MiCC platform. This is one of the biggest challenges with using separate shared systems — a well-recognized problem across the nation, and why MiCC is working with other stakeholders, including the State of Michigan and the state health information network, on tackling interoperability and other data sharing issues.

Our lessons learned from the iterative co-design process with local medical, behavioral health, and social services organizations should be very helpful to these efforts. In the meantime, we have considerable work to do locally to keep improving data fields, data capture and reporting from the shared electronic health record. These efforts are informed by our intention to incorporate a health equity lens and specific outcome measures for the populations we serve.

Finding and addressing gaps.

MiCC hublets get together regularly at monthly Care Coordination and bimonthly Quality Improvement (QI) meetings facilitated by CHRT. Gaps analysis, troubleshooting, and exchange of knowledge and resources are regular activities at these meetings. When concerns about gaps and barriers are raised, the collaborative works together to identify and implement possible solutions.

Identifying and supporting critical partners. In local communities, there are agencies that fulfill a central role in providing critical services to community members. These agencies also often share clients and must communicate and coordinate more closely and frequently.

Building stronger ties and shared infrastructure and resources between these agencies can significantly enhance care coordination locally. For instance, the Shelter Association of Washtenaw County (SAWC) was not among the original hublets of the MiCC collaborative. Based on significant community need for improving housing security, the original hublets identified the housing agency as a critical local partner that was missing from the table and requested CHRT to onboard SAWC as a hublet.

The collaborative also has been responsive to gaps and barriers that are raised by entities that are not formally part of MiCC. For instance, when the Huron Valley Ambulance (HVA) Community Paramedic (CP) Program noted the barriers they were encountering in getting much needed services for their clients, the collaborative supported the onboarding of HVA CP as a formal partner agency to improve community linkages.

"I think another thing is that we've done an excellent job with is recognizing the gaps and then doing something about it. So, we saw that so many of our clients passed through Delonis [Shelter], so we brought SAWC on board. Many of our clients were calling the emergency room, so we got HVA involved. Just like

recognizing those gaps and doing something about it, I think has been huge."

Working toward system-level change. Hublet discussions at care coordination and quality improvement meetings help to identify system-level barriers to care. Hublets bring to these discussions their unique expertise and in-depth knowledge of the populations that they serve.

Historically, hublets have collected data at the individual organization level. When this knowledge is pooled and shared, it becomes a quick and powerful tool for pinpointing broader system-level gaps and barriers, and as a collective they are able to raise these concerns more effectively.

For instance, over the years hublet discussions have sounded the alarm on barriers to accessing mental health and substance use services. MiCC played an important role in facilitating system-level changes that will affect thousands of people across the entire community. Examples of these are provided in the summary on system level impact in this report.

Going forward, MiCC is working on bringing the data together from different agencies to support more powerful insights into disparities and barriers.

"During COVID so many clients have said, I've called this agency, I've called that agency, nobody's answering the phones, nobody's calling me back. Having the connections within this group has been key because we've been able to reach out to [those agencies] and say, 'Hey, we have a client. They're not part of MI Community Care. However, they do need some support. Who in your agency can we reach out to?' So I think that's been huge, at least for us with the

older adults at JFS, because sometimes they don't like to keep repeatedly calling the same numbers when they don't get an answer."

Addressing urgent community needs.
The close ties and regular communication between MiCC agencies—supported by the backbone organization—allow for a community infrastructure that can mobilize quickly in the face of urgent needs.

We clearly observed this during the COVID-19 pandemic. Due to the direct and strong connections established over many years, MiCC care coordinators were able to reach out to one another for support and resources even as isolation and social distancing rendered new connections more difficult for everyone. Care coordinators were able to find resources for clients when they would have had difficulty doing so without known contacts and entry points. For instance, care coordinators at other agencies were able to work with the MiCC primary contact at Packard Health to get in-home vaccinations for their clients. Moreover, because the community at large was practicing isolation and social distancing, it was challenging to hear about the most urgent needs directly from community members. Because MiCC providers have been at the frontlines of COVID-19 response and had direct knowledge of resource gaps in their areas of expertise, we were able to identify significant gaps in the community. This allowed the backbone organization to work with agencies that have the subject matter expertise to direct community capacity building funds towards these needs, including housing, food distribution, personal protective equipment, mental health, and transportation as described elsewhere in this report.

"And I would add for the pandemic, you know, there were large periods of time where case managers couldn't go into an emergency room or a doctor's office alongside the consumers, which is often the way that we're able to share

information and having the SIM contacts made a difference in our capacity to get information to the treaters, as well as get information back in a, a useful way."
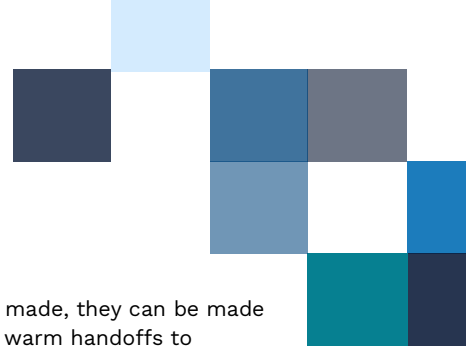
Eliminating barriers.

No wrong door approach. When the Affordable Care Act was signed into law in 2010, it included a "No Wrong Door" provision that would allow residents to fill out one application to learn if they were eligible for a wide range of health and social service programs.

This was not business as usual. Normally, government agencies require residents to enter the right door (even if they don't have transportation), at the right time (even if that time is during work hours), with the right paperwork (even if they don't have a computer), and the right documentation (even if they lost their birth certificate years ago). The idea of developing a safety net system that was easy for residents to access was both wildly simple and complex.

For no wrong door to work, health, mental health, and human service providers need to work together and to communicate securely about client needs. This requires interoperable software systems, shared consent forms, common intake procedures, cooperation across traditional siloes, shared accountability, and more. Unfortunately, the U.S. health, mental health, and human systems weren't built with this ideal in mind. Each system evolved with its own culture, clients, forms, requirements, technologies, and jargon.

Today, many organizations are working to overcome these siloes because they recognize the multiple benefits No Wrong Door provides when it's working the way it should. First, clients don't have to keep making a case for support with every provider they visit. Clients don't have to try this number, then that number, then the other number with their limited phone. In fact, with one visit clients can access the services they need–whether those services are medical, behavioral, or social.

Experience with No Wrong Door systems build trust in the medical and behavioral establishments, and those who work in them, while leading people on the path to health.

MI Community Care is a No Wrong Door program that delivers immediate assistance to the people who need it most–whether that's food, housing, transportation, medical equipment, prescriptions, translators, or connections to a primary care physician.

When referrals do need to be made, they can be made quickly, confidently, and with warm handoffs to partners who are both known and trusted. And if partners don't follow through, or participant needs are complex, MI Community Care staff can resolve concerns at monthly care coordination meetings. MI Community Care is proud of this achievement and excited to continue to build on it in the years ahead.

Support from community health workers. MiCC currently funds three CHWs at the Washtenaw Health Plan (WHP). Although they are based at the WHP, the CHWs provide support to all participating agencies in Washtenaw County.

Now, MiCC is expanding CHW support to Livingston County by funding two CHWs who will be housed at the Livingston County Community Mental Health agency.

CHWs have lived experience and superb knowledge of the communities they serve, the resources available in those communities, and the best way to support community members in the process of accessing those resources. CHWs are often brought in on care coordination cases to expand the reach and services of hublets; for example, they will conduct home visits for hublets that do not do home visits, or they will use their expertise to assist a participant through the process for applying for affordable housing.

Additionally, CHWs bring language and cultural support, and the ability to develop a personal connection with individuals to help them achieve their goals.

CHWs partner with participants, serving them with dignity and compassion that is often lacking from larger systems of care. MiCC CHWs can serve as either the lead or support for care coordination program participants.

MI COMMUNITY CARE

Meet our community health workers.

Ebony Curry

As a kid, Ebony Curry moved around a lot from one family member to another, growing up in Inkster, Detroit, and elsewhere throughout Southeastern Michigan. As such, Curry understands how difficult it can be to open up to a seemingly never-ending series of strangers. One thing Curry appreciates about MI Community Care is that clients don't need to do that. Coming into the program, clients are assigned one care manager who is their contact for all needs—health, mental health, and social. That care manager works

with others in the intervention, and in the surrounding community, to meet client needs outside of her agency and/or areas of expertise.

Curry says she's always been cognizant of the disparities encountered by Black people, Indigenous populations, and People of Color (BIPOC). "We experience all of these situations—from going to a store and being followed, encounters with police, job applications—and a lot of us are unable to access basic human needs and rights because of low socio-economic statuses, systemic and structural racism, and health inequities." Through MI Community Care, Curry can help clients access the services they require, and overcome some of those disparities.

"First, we provide intake and release of information consents; then we do a confidential concrete needs assessment to understand clients' current situation." After that, Curry says she works with clients on the goals they want to work on. It could be as simple as a Medicaid or food stamp application. Or it could be medical equipment, home repairs, emergency food, utility assistance, or care coordination with other agencies. There are hundreds of nonprofit organizations in Washtenaw County, offering thousands of services, and Ebony Curry—who has served as a MI Community Care community health worker for the last five years—knows about many of them.

"MI Community Care is a great program," Curry says. "It is a collection of major agencies in our community—such as hospitals, mental health providers, housing agencies, and others—that collaborate to make sure clients don't fall through the cracks, can live the best lives they are able to live, and don't have to struggle alone."

"Community health workers are case managers, advocates, and resource specialists. And we have the ability to do home visits and meet people where they are."

--Ebony Curry, BA, LLMSW
MiCC Community Health Worker
Washtenaw Health Plan

Stacie Lewis

If you ask Stacie Lewis about her source of inspiration, she'll tell you it's family. Lewis's grandmother was a foster parent in Inkster who took in more than 150 children over the years. Her mother was a caseworker at the Department of Human Services. And her aunt operated a group home in Washtenaw and Wayne Counties. "Helping is what we do," says Lewis.

For the last year, Lewis has helped by serving as a community health worker with MI Community Care. Today's workload, she says, includes helping one client with chronic obstructive pulmonary disease get her electricity turned back on; helping a mother of three avoid eviction; helping a disabled client get food assistance; and more. "Wherever they need help, I guide them in that direction," she says.

Recently, Lewis helped a client move into permanent housing after a long period of homelessnes; worked with care managers to help a gentleman move to a new home before he was evicted; and helped someone else—someone who was frightened to ask for help—navigate his bills. "You can't work on improving yourself or improving your health if your lights are about to be cut off on you," she says. "You can't focus on healing if there's no food in the pantry."

"There are so many people that are under the perception that no one is there, no one is going to help, it's not going to get any better than this, so why even try. But there is help available. If you don't know about it, you don't ask for it. If you don't think it exists, it doesn't—not in your mind. But if more people knew that help was out there, it'd be a much better community with less people running to the ER because they got the help ahead of time."

--Stacie Lewis
MiCC Community Health Worker
Washtenaw Health Plan

Rosie Vazquez

At the age of seven, Rosie Vazquez was hospitalized and diagnosed with a rare form of anemia. Being sick as a child, she says, made her want to help others the way her doctor helped her. "I have this empathy and can feel what others feel," she says. "If someone's crying, I'll probably start crying too. I feel other people's pain. It made me want to learn as much as I can and to help people who have gone through trauma."

As a community health worker for MI Community Care, Vazquez gets the chance to help people on a daily basis. There's transportation to appointments, applying for home chore assistance, translating at medical appointments, talking to insurance companies about unpaid medical bills, requesting home heating credits for insulation, applying for Medicaid, and more. "We try to focus on what the client needs first—whatever they need—and once we've built that relationship, we work with them on their health."

Being a community health worker has opened Vazquez's eyes to pressing needs in the community. She describes MI Community Care as a web, a network, between different establishments such as hospitals and medical providers. And her role is to help clients overcome barriers—language barriers, administrative barriers, and confusion about how to navigate the system—to get the help they need.

"I really enjoy serving the community and being able to make a difference in people's lives. No matter how small I may think it is, it can be very big for them."

***--Rosie Vazquez, BA
MiCC Community Health Worker
Washtenaw Health Plan***

MI COMMUNITY CARE

Evaluations, past & future.

An evaluation of Michigan's Community Health Innovation Regions (CHIR) was administered by the Michigan State University System exChange team from 2018-2019.

A mixed-methods approach was used to collect survey data, key informant interviews, and secondary data. The data was used to identify strengths, opportunities for growth, and priorities moving forward with the CHIR work.

The CHIR Transformative Change Framework was used as an evaluation framework of factors that contribute to CHIR effectiveness. Six elements that need to be in place to ensure transformative change:

1. effective convening,
2. engaged diverse partners,
3. aligned systems,
4. equity pursuits,
5. shared vision and goals,
6. adaptive learning and improvement.

In order to accommodate for the developmental nature of the systems change process, the CHIR evaluation also included four changes which totaled 24 components of the CHIR Framework. This evaluation included the Collective Impact Survey of key cross-sector representatives that were developed to measure each of the 24 components of the CHIR framework.

The CHIR provided rosters of members, partners, and stakeholders to be asked different questions about the transformative change process. Data was collected in two waves in 2018 and 2019. The final results of the evaluation provided strong evidence that CHIRs have significantly strengthened cross-sector partnerships, particularly between the health and social sectors. These sectors reported that they are more likely to focus on social determinants of health in their work.

There is also evidence that CHIRs are creating an emerging community system that is more aligned with moving health upstream. Both CHIR members and partners reported that community systems have become more integrated and efficient, due to the improvement in service coordination and referral processes.

This study found that CHIRs are transforming lives as individuals gain access to needed services and support.

The Collective Impact Survey also examined the individual CHIRs to report the successes and changes emerging.

Data from 152 respondents in 2018 and 114 respondents in 2019 were collected for the cross-sectional sample of the Livingston-Washtenaw CHIR (LWCHIR). Respondents included members, partners, and stakeholders. Also, a longitudinal sample was collected to determine the change over a one year period.

By engaging numerous cross-sector partners within a collective innovation space the LWCHIR has continued to create the conditions for increased health and well-being by creating an aligned system and transforming lives.

The LWCHIR Collective Impact Survey found that 41 percent of health and community service organizational leaders reported initiating or making changes to their own agency's policy, procedures, or practices.

In 2019 members were more likely to say there is improved coordination due to the CHIR's efforts. Healthcare providers and community service staff are becoming more integrated and aligned, offering more coordinated care and treatment plans, and more connected to each other as a result of the CHIR's efforts.

The LWCHIR members reported a significant improvement in the ease of the referral process and staff got better at making referrals which strengthens local infrastructure.

Future evaluation strategy. The next evaluation will be conducted by the Center for Health and Research Transformation's (CHRT's) Research and Evaluation team.

The evaluation will track implementation and outputs, short-, mid-, and long-term outcomes, using a mixed-methods approach. This will include participant surveys and interviews/focus groups with community partners and other stakeholders, as well as utilizing program data, reports, and meeting notes and observations.

The evaluation team will work in close collaboration with project leadership and local sites to finalize the evaluation plan, identify and access necessary data, and validate evaluations findings. Local sites will be included in a cross-site evaluation workgroup to facilitate shared understandings and learnings and to provide a regular forum to discuss and illuminate findings and identify any potential mid-course corrections in implementation. The evaluation will address the following questions:

1. To what extent did the project create systemic changes in assessment of social needs, coordination, and delivery of health care for vulnerable populations? What factors emerged as key in these changes?

2. Did the project overall, and by site, improve health outcomes for vulnerable populations? For which populations and conditions? What factors were involved with success? What barriers or challenges emerged?

3. What is the value proposition for sustaining this project?

To address these questions, the following outcomes will be assessed along with process implementation:

Short-term outcomes	Mid-term outcomes	Long-term outcomes
Strengthened community engagement to support community-driven solutions	Resource gaps reduced or closed for populations made vulnerable to adverse health outcomes	Improved health outcomes for populations made vulnerable to adverse health outcomes
Improved patient activation and engagement	Increased access to health and social services, disaggregated by race and other demographics	Reduced disparities in health outcomes
Improved patient satisfaction and experience	Improved access to and sharing of SDOH data across statewide entities (MiHIN pilot implement)	Project has a path for sustainability
SDOH addressed (closed loop referrals)	Value of project is demonstrated	
Resource gaps identified		
Disparities in access and quality of care identified		
Strengthened relationships between health system and community health partners		
Regions understand and align with MiHIN's goals toward SDOH use case activation		
Perceived value among providers and community based organizations		
Reduced costs of care or demonstrated offsets (cost-neutral) to costs		

MI COMMUNITY CARE

Community needs and barriers.

MiCC monitors the health and social determinants of health needs of Livingston and Washtenaw County communities on an ongoing basis.

Data and feedback from hublets and partner agencies, the needs assessment administered to care coordination program participants, and county and state survey data show the following among the most prevalent needs in these communities:

- Housing Insecurity/Homelessness
- Behavioral Health Conditions
- Food Insecurity
- Chronic Health Conditions

Housing insecurity and homelessness.
Washtenaw County has an affordable housing shortage with an average apartment in Ypsilanti and Ann Arbor costing over $825 and $1,300 per month respectively, while the vulnerable population identified by the Shelter Association of Washtenaw County (SAWC) averages an income of $830 per month.

The American Community Survey shows there are approximately 44,033 households in Washtenaw County who are paying more than 30 percent of their income toward their housing costs, classifying them as cost-burdened.

Avalon Housing reports that, at the end of 2021, approximately 2,600 people were experiencing homelessness in Washtenaw County, and 38 percent were families with young children. SAWC shelters over 800 single homeless people per year, but cannot keep up with demand. Furthermore, Livingston County does not have a year-round homeless shelter, leaving their population uniquely vulnerable (information from LCCMH).

It is important to note that people of color are disproportionately affected by homelessness. While only 12 percent of Washtenaw County's population identify as Black or African American, 61 percent of people accessing assistance for homelessness in the county identify as Black or African American (data from Avalon Housing).

Behavioral health conditions.
Addressing mental health and substance use disorders is among the top priorities identified from both the Livingston and Washtenaw Community Health Needs Assessments (CHNAs) that are conducted by Trinity Health, and the CHNA conducted by Michigan Medicine (Washtenaw County only).

Approximately 20 percent of adults report excessive drinking in both counties. Social isolation, which increased significantly during the COVID-19 pandemic due to quarantines and social distancing, was also a risk factor for individuals with mental health conditions or substance use disorders (Washtenaw and Livingston CHNAs). Nearly 40 percent of clients surveyed by Packard Health, a Federally Qualified Health Center in Washtenaw County, reported feeling lonely with some regularity.

Over 6,000 individuals receive services at Washtenaw County Community Mental Health (WCCMH), 30 percent of whom are Black or African American. In addition, nearly 50 percent of SAWC clients report having a mental health condition and 35 percent report having a substance use disorder. Community partners in Washtenaw highlighted mental health – and particularly access to psychiatric services – and

lack of substance use treatment beds as significant gaps in the county (data from WHP).

Food insecurity. According to the 2021 Washtenaw Community Health Needs Assessment, 31 percent of families could barely afford a monthly budget for basic necessities, and 54 percent of Black families fall below the ALICE threshold (Asset Limited, Income Constrained, Employed).

In addition, 30 percent of 616 patients surveyed at Packard Health reported having concerns about running out of food within the past 12 months.

Food insecurity increased across the county during the COVID-19 pandemic, and hit Ypsilanti, an already high-need area, especially hard. Food insecurity rose by 30 percent and 21 percent respectively in the 48197 and 48198 zip codes that make up the city of Ypsilanti, and 40 percent of the Packard Health patients who reported they were food insecure lived in that region.

Access to food is less of an issue in the wealthier county of Livingston, but concerns remain particularly with the potential that the federal support that expanded during the pandemic will conclude, leaving more individuals vulnerable.

Chronic health conditions. Another critical need in the Livingston and Washtenaw counties is support for individuals with chronic health conditions.

Chronic health conditions require ongoing medical care and include some of the leading causes of death and disability in the United States. These conditions require significant medical attention which can be cost-prohibitive for many. Nearly 40 percent of clients seeking services at SAWC report a chronic health condition or physical disability. In addition, of the 100 highest ED and hospital utilizers with a severe mental health diagnosis, 19 percent also had at least one chronic health condition (data from WCCMH). Furthermore, Chronic Disease and Medication Management is one of the most common SDOH goals that the CHWs in the MiCC program help clients to address, second only to housing instability (data from WHP).

As evidenced above, many of the critical needs facing Washtenaw and Livingston residents are interrelated and require a holistic approach to care. One of the strengths of MiCC is its ability to connect community members to medical, behavioral health, substance use treatment, and social service providers with no-wrong-door access and a coordinated approach to care delivery.

MI COMMUNITY CARE

Vision for the future.

Incorporating lived experience. MI Community Care has always emphasized a holistic approach to participant health, and the program will expand on this approach going forward to offer "no wrong door" access to traditional health care, as well as to less traditional social and behavioral care.

MiCC meets individuals where they are (often in their homes and communities); works with them to develop shared goals around their social, behavioral, and health care needs; provides enhanced supports to historically disadvantaged and marginalized populations by utilizing community health workers from their own communities; and ensures that participant needs are conveyed with dignity and privacy and met efficiently and confidentially through technological solutions and innovations.

Along the way, MiCC has improved the capacity and effectiveness of local service providers through collaboration and magnified impact through systems change initiatives that have facilitated big improvements as well as near real-time responses to COVID-related needs, including vaccination, food, housing and other gaps described in the "Systems Change" section of this proposal.

MiCC has achieved these multi-level successes by working with a balanced mix of organizations to meet participants' housing, transportation, food, mental health, substance use, and medical needs. The original MiCC working group included providers, care managers, leaders from local health systems, provider organizations, independent medical organizations, emergency departments, public health departments, public behavioral health agencies, social service agencies, and health information technology specialists.

To inform all of these individuals, CHRT and the WHI organized focus groups to collect feedback from individuals who were frequent utilizers of emergency department services. What we learned from the focus groups was that frequent emergency department users often contend with lack of connection to primary care providers, lack of sick time, lack of transportation to medical appointments, and more. As a result, frequent ED users found it easier to visit the emergency department, and were very happy with the care they received there. The working group designed our original intervention to take these various perspectives into account.

Today, the foundation that these organizations have built for individual, organizational, and systems-level change is ready for expansion—both locally to better serve rural areas and urban "hot spots"—and regionally as a scalable template and roadmap for other communities across Michigan.

To achieve these objectives, MiCC is in the process of developing a meaningful community engagement plan, with a strategy for implementation, that will engage individuals with lived experience and broader community voices.

Historically, MiCC relied on its community health workers (CHWs) to collect and share participant feedback. This strategy has provided important input for programmatic efforts over many years and we will continue to support and lean on our CHWs to represent those with lived experience and the community writ-large.

However, MiCC leaders believe efforts will be further bolstered by hearing directly from those with lived experience, those served by the program, and other community voices relevant to successful process and outcomes (e.g., including additional community voices from Livingston County as efforts there continue to expand).

We have already recruited and retained a recognized, local patient advisor to help craft a plan for broader

community engagement and to provide input into more immediate issues (e.g., updates to screening/consent forms).

MiCC believes it is important to have meaningful engagement from those with lived experience and other community voices at all levels of the work, including governance, planning, and ongoing operations.

- Engagement at a governance level helps center the work around the client or patient, lessening the inclination to "medicalize" what should be a holistic approach to integrating social care and traditional health delivery.
- Engagement within planning and ongoing operations places pressure and urgency on the work and appropriate accountability to the community in delivering a better connected system.

These types of engagement are not just "nice to have." We believe, based on local experience with patient engagement in other venues, that the approaches offered, and outcomes achieved, through MiCC will be stronger in the short, intermediate and longer-term with more meaningful engagement. In other words, this is a business imperative that is essential to the success of the MiCC initiative.

Based on our collective staff experience and the literature we have reviewed in the engagement space, we understand and recognize this engagement effort will require time, work, and resources, and are already carving out and committing a budget to support engagement–from recruitment, to onboarding and ongoing training, to compensation, to ongoing accommodations for meetings that work for those engaged.

We will lead this work with deep listening, to establish a foundation built on trust and co-ideation and co-development of future MiCC program efforts.

Resources already consulted to outline our engagement program include:

- Engaging people with lived experience toolkit, People with Lived Experience Workgroup, Community Champions from 100 Million Healthier Lives, Institute for Healthcare Improvement.
- The principles of trustworthiness, Association of American Medical Colleges.

- Compensation framework, Patient-Centered Outcomes Research Institute.
- Engaging people with lived experience of inequities: meeting facilitation guide for relationship building, Canedy C., Rumala, B.B., Coleman, S.E., Roary, Y. People with Lived Experience; 2020.
- ACO beneficiary engagement toolkit, Centers for Medicare and Medicaid Services, Learning Systems for Accountable Care Organizations, November 2019.

Technological enhancements. MiCC wishes to access Medicaid claims data so we may pursue parallel evaluation and data analyses on the impact of MiCC on client health care utilization and costs.

For example, MiCC has historically engaged patients who do not have a regular source of primary care. We expect that as clients establish relationships with primary care, part of what MiCC coordinates, and have regular visits for health maintenance, along with MiCC support to close identified social gaps, that there will be a subsequent decline in costly and unnecessary specialty, urgent and/or emergency care.

We believe the same might be true for establishing regular sources of care for behavioral health and substance use disorder. While some utilization of certain primary care, mental health and substance use disorder services might increase, we posit there will be associated decreases in other, more costly services in the intermediate and longer-term.

We did not have time to test this under the SIM, but we would like to examine total cost of care over a particular time period compared with pre-intervention. However, to test these hypotheses and program aims, we need access to Medicaid claims and cost data and a reasonable time horizon to demonstrate impact.

Expansion of community health worker services. Community Health Workers (CHWs) demonstrably improve chronic disease managementby working with clients across medical, social, and environmental health-related social needs.

As national experience in health organization-community collaborations grows, CHWs are recognized as an essential component. Therefore, a foundational element of MiCC moving forward will be expansion and integration of Community Health Workers (CHWs) at MiCC and among our partner health organizations.

We have a strong foundation for building integrated CHW programs in Washtenaw and Livingston County, with:

1. Three CHWs at MiCC administered by the Washtenaw Health Organization,
2. CHWs now employed at multiple local health organizations, and
3. A close working relationship with the Michigan Community Health Workers Association (MCHWA), whose head office is in Ann Arbor.

Our three-year goals for CHW expansion and integration are to:

- Expand the number of CHWs in our community as resources allow,
- More tightly connect CHWs to healthcare-based providers to promote client-specific support for chronic disease management, and
- Provide community-wide facilitation of CHW function across the multiple CHW-supporting agencies by disseminating best practices and coordinating program delivery, and identify scaling opportunities, for example related to training and skills building.

We believe that by building a CHW network with: a) a central facilitating 'hub' at MiCC and b) multiple CHW 'homes' in health care and public health agencies, we can investigate and develop feasible models for community-wide, collaborative CHW programs that could be implemented in throughout Michigan.

Technology and infrastructure development. MiCC has made important foundational progress in technology support for community-wide health initiatives through its PCE-based IT platform, termed MiCareConnect.

MiCareConnect allows care managers from multiple organizations to use a common, confidential health record for its patients that is fully consented and protects each clients' PHI.

While the MiCC technology platform was built, interest in further connecting health information sources to address HRSN has grown significantly across the nation. In our region, conversations are ongoing among and within health organizations around close loop referral systems and community information exchanges to make information on HRSNs more readily available to organizations providing services to individual clients. At the state level, the Michigan Health Information Network (MiHIN) aspires to provide even greater information exchange capabilities to meet patient needs. MiCC leadership has been at the table in all these contexts. While the work is frankly messy, with many unanswered questions about value, data control and ownership, and logistics, it is nonetheless vital and promising. Our three- to five-year goals related to information technology are necessarily poorly specified as this picture unfolds. Our advocacy in the IT space will be to identify specific outcomes and measures, maintain clear and consented boundaries over distribution of PHI, and build metrics to determine success based on patient outcomes where possible.

Given its existing technology infrastructure, connections with multiple large and small health systems and social service and behavioral health organizations, we believe MiCC can play a vital role in developing emergent solutions in information technology related to addressing HRSNs in Michigan.

Expansion of multidisciplinary care coordination services. MiCC is well positioned to expand its work building community-wide collaboration to address health and HRSNs in the next three to five years, resources permitting.

Guided by the Community Health Needs Assessment that identifies obesity, mental health, and perinatal infant and maternity health as key priorities, we envision focusing on geographic 'hot spots' where HRSNs are highly prevalent, and exploring ways to reach rural communities more effectively. Assuming funding support is available, primary methods to achieve these goals in the short term would be to: a) extend the CHW model to additional practices and locations, b) collaborate with neighborhood and other 'grassroots' organizations to fine-tune our service model to best meet local needs, and c) develop MiCC as a referral 'hub' among agencies in our community to provide needs-based, individualized assessment, referral, and follow up care to patients across medical, social, behavioral, and public health organizations.

Move upstream to address key social determinants of health. Given that health-related social needs (HSRNs) are associated with worse health outcomes (Berkowitz 2019; National Academies 2019), health systems and large demonstration projects are investigating ways health systems can more directly address HSRNs, especially housing, transportation, and food security (RTI 2020; Hacke 2017).

In our own community, Michigan Medicine has joined the Health Anchor Network, a national movement for health systems to address local economic conditions.

MiCC has a unique opportunity to lead and amplify programs to address HSRNS in two complementary channels. First, its governance and administrative support are through the Washtenaw Health Initiative (WHI) and the Center for Health Research and Transformation (CHRT), respectively. Through these two umbrella organizations the work of MiCC can complement and amplify the community-facing work of these two large health organizations. For example, MiCC leadership is already at the table of the health systems' programs to screen for and develop closed loop referral systems addressing HSRNs. Second, through its own activities MiCC puts social service and public health organizations alongside health care organizations to identify and address HSRNs throughout Livingston and Washtenaw counties.

MI COMMUNITY CARE

Toward sustainability.

Like many community-based organizations serving marginalized populations, the MiCC program has supported the delivery of services by braiding together funding from disparate sources including grants and contracts from government and private entities. Reliance on grants and contracts often means that there are restrictions on how funds may be used, resulting in a lack of funding to support general operations, technology development, and capacity building. The varying expectations of funders and the pressure to continuously build avenues for funding can lead to mission creep and resources that are stretched so thin that the impact of initiatives is reduced.

The push for accountability has increased the demands on community organizations to report on outcomes and return on investment. Individuals referred to the MiCC care coordination program have multiple complex needs and generally require services from agencies across different sectors. Given the challenges in delivering long-term case management to participants with the most complex needs, measuring return on investment and effectiveness of a program like MiCC within a time-limited grant period can be challenging. The time required to show impact on individual participants, let alone system-level impact, can make it hard to show funders the value of programs addressing social determinants of health needs and build a case for additional funding.

Another well documented limitation of these types of analyses is the "wrong pocket" problem where one sector makes an investment that generates benefits that are realized in another sector. This makes it challenging to measure a return on investment to support the decisions of policymakers and investors on how funding should be allocated.

Moving forward. Having funding from the state established as a line-item in the state budget would bring a new level of stability that would allow us and the other regions in the state doing this work to continue addressing the issues outlined above while we

dedicate time to pursuing additional avenues toward sustainability.

Looking towards the future, we are challenged to continue our effort to demonstrate ROI and use that information to make investment cases to those sectors who are not currently funding MiCC efforts. Potential sources of future funding for MiCC also include community benefit prospective, hard dollar investment from local non-profit hospitals and health systems, public funds through MDHHS, private payers, philanthropic contributions, employers, grants and other potential sources.

With the creation of the Learning Network and partnership in the Promotion of Health Equity project, CHRT has been able to secure substantial funding to four regions across the state, including MiCC, with two new regions potentially being added in 2023. In an atmosphere where nonprofits must often compete to show value for a limited pool of funding, CHRT continues to support efforts that build collaborative solutions to financial sustainability. These high impact partnerships can help deliver more services, help build capacity, and achieve collective impact through collaborative projects that:

- support better alignment with regional and MDHHS strategies and goals,
- support the efforts of local public health departments in their goals for overall health improvement,
- leverage local public health department infrastructure for community development, and
- test new business models that align investments across organizations and communities.

CHRT has a unique combination of expertise in leveraging health analyses to inform policy decisions and experience in performing an operational role as a backbone organization to multiple CHIRs. This combination means that we are well positioned to support the work of MiCC and partners, as well as the state, to expand and refine the research demonstrating the relationship between social

investments and improved health outcomes. CHRT will also work with MiCC to establish a brand that can be marketed to funders and investors. MiCC's new Community Leader will support development of a community engagement strategy that includes development of communications and marketing material that informs stakeholders about MiCC's value story.

MI COMMUNITY CARE

Meet our backbone organization.

Since 2007, the Center for Health and Research Transformation (CHRT) has informed policy decisions that have impacted the health care landscape in Michigan and beyond.

Every day, CHRT works to educate and inform policymakers and decision leaders by expanding the body of health services research and analysis, running demonstration projects that test ways that health and health care can be improved, and helping researchers effectively disseminate research findings.

At any given time, CHRT's two dozen staff members are managing roughly three dozen policy-relevant health projects such as:

- Developing a community integrated health network to address the social needs of seniors in southeast Michigan
- Applying complex systems modeling to understand and strengthen Washtenaw County's community mental health acute crisis care system
- Understanding behavioral health workforce challenges and identifying opportunities
- Integrating public health and primary care: designing a demonstration project to strengthen systems
- Improving health care access, quality, and outcomes among people aging with disability

- Addressing critical issues facing Prepaid Inpatient Health Plans and community mental health service participants
- Understanding the impact, reach, and overall effectiveness of evidence-based family caregiver programs across Michigan
- Supporting national health and human services integration leaders for equitable and thriving communities
- Implementing an alcohol screening and brief intervention in women's health services
- Promoting the integration of primary and behavioral health care in three underserved Michigan communities

Over the past 15 years, CHRT's emphasis on collective impact has grown, and CHRT has expanded its role as a backbone organization.

Rather than working directly with individuals, a backbone organization advances work to assess community needs and the capacity to address those needs. Backbone work can help clarify vision and strategies, as well as align initiatives. Backbone organizations provide infrastructure for mission-based organizations, and can help focus efforts taking place across communities.

As CHRT collects and aggregates partner data to assess community needs and measure impact of partner programs. These data can be analyzed to

pinpoint challenges that specific populations face. CHRT identifies best practices to help community organizations more effectively carry out their work.

The vantage point and capacity of a backbone organization helps local organizations that individually deal with housing, or food insecurity, or complex health care to talk to each other, collaborate, and **work more efficiently for the good of the individual and the community.**

MI COMMUNITY CARE

Background information.

As part of the Affordable Care Act of 2010, the U.S. Centers for Medicare & Medicaid Services (CMS) started a **State Innovation Model** (SIM) grant program. The SIM grants encouraged states to develop and test new ways to improve health and health care delivery in their boundaries. In 2015, Michigan was one of several states to receive a SIM grant as part of this program.

In Michigan, the SIM grant was used to improve the health of Michiganders by creating connections between medical service providers and community-based organizations that meet social needs, such as food insecurity and housing instability, which can both cause and exacerbate health challenges. **The hope:** *That by meeting social needs, in concert with medical and behavioral health needs, Michigan would improve population health more broadly.*

To test this hypothesis, Michigan provided funds to five regions across the state. Each region was encouraged to bring together health, mental health, and social service agencies to address social needs jointly with medical and behavioral health needs. And each region chose a different way to go about the work—a way that best fit the needs of its residents.

In the Livingston and Washtenaw County region, these efforts were led by the Washtenaw Health Initiative (WHI), which launched an intervention to enhance collaboration among core service providers to improve the health of vulnerable populations. Service providers included housing agencies, community mental health providers, complex care management programs, a core substance use treatment center, and faith-based organizations that provided food, transportation, and other services.

The program identified Livingston and Washtenaw County residents with very significant health needs—frequent emergency department users and those with multiple chronic conditions—then coordinated their care through medical, behavioral, and social service staff, including community health workers and care managers, at participating organizations.

A shared information technology platform, called MiCareConnect by PCE Systems, was developed with input from partner agencies to enhance their abilities to work with shared clients. The system was implemented to enhance communication and collaboration across the participating agencies. Monthly quality improvement meetings were held to encourage providers to share best practices, troubleshoot challenges, and learn from one another. And referrals were made both from local providers and from a predictive model designed to identify both frequent emergency department users and those who were likely to need frequent emergency care.

In addition to running the intervention for individuals with complex needs, and supporting community-based providers, the Livingston-Washtenaw region worked to identify and alleviate systemic barriers to accessing services using a collective impact model.

When the original SIM funding ended, the regional collaborative was renamed **MI Community Care.** The predictive model was discontinued mainly because individuals referred through the model were far less likely to consent to participate in the intervention. But MI Community Care introduced new innovations, including efforts to refine the care coordination model, a vision for further improving the local health system for individuals with complex needs, and plans to scale up the work to new populations.

Hundreds of Livingston and Washtenaw County residents have benefited from the intervention, hundreds more are likely to do so, and thousands have benefitted from the system improvements MiCC brought about. But grant funding is not sustained funding for ths important work. The current CMS grant must be approved each year and the current CDC grant expires in 2023.

MI COMMUNITY CARE

Meet our steering committee

Because MI Community Care originated in the Washtenaw Health Initiative (WHI) in 2016, the WHI Steering Committee—as described below—has provided funding and guidance and financial oversight to MiCC to support individual-, organizational-, and systems-level interventions.

MiCC has recruited and retained a recognized, local patient advisor to help create and implement a plan for broader community engagement, including meaningful engagement from individuals with lived experience and other community voices in Washtenaw and Livingston County regarding governance, planning, and ongoing operations.

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Pastor
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Ann Davis
Retired Administrator
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Naomi Norman
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Steering Committee *(continued)*

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MI COMMUNITY CARE

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