Community Health Innovation Regions

NASHP

AUGUST, 2018

SIM Components

Population Health

- Community Health Innovation Regions
- Plan for Improving Population Health

Care Delivery

- Patient-centered medical homes
- Advanced payment models

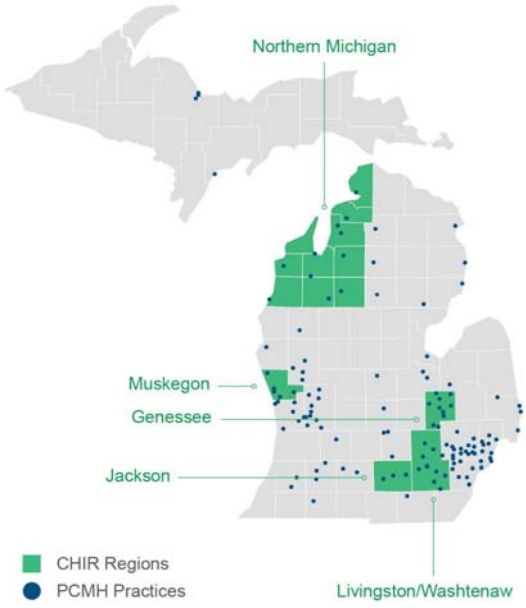
Focused on:
Clinical-Community Linkage

Supported by:

- Stakeholder engagement
- Data sharing and interoperability
- Consistent performance metrics

Community Health Innovation Region Vision

- The State views the role of the community as a vital component in addressing social and economic factors that influence individual/family health and wellbeing.
- The SIM Community Health Innovation Region (CHIR) is a progression in the development of the State's vision regarding linking healthcare and community.
- CHIR governance facilitates effective collaboration of providers, health plans, community based organizations and individuals to pursue community-centered solutions to upstream factors of poor health outcomes and health disparities.
- The State works collaboratively with CHIR participants and stakeholders to continue the development and evolution of the role of community in improving the health and wellbeing of the citizens of Michigan.



MDHHS Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

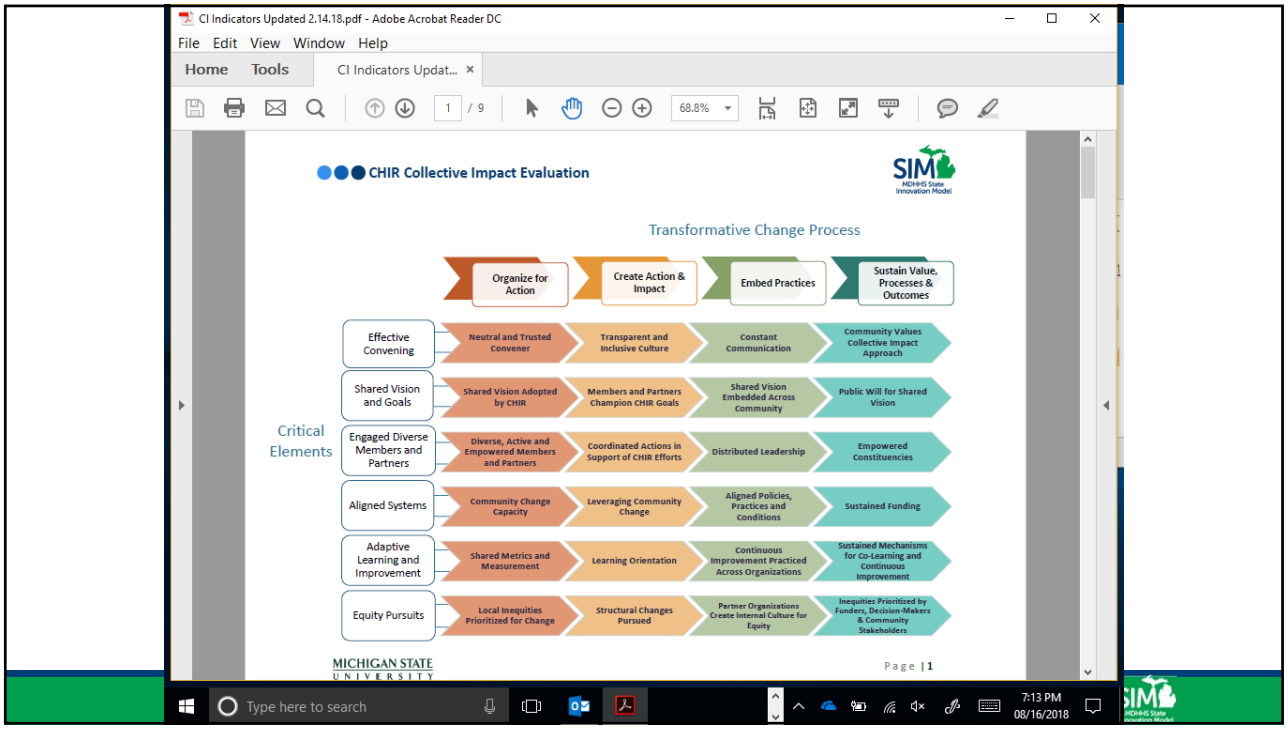
Backbone Organizations

CHIR Region	Backbone Organization
Genesee Region	Greater Flint Health Coalition
Jackson County	Jackson Health Improvement Organization
Muskegon Region	Muskegon Health Project
Northern Region (10 counties total)	Northern Michigan Public Health Alliance
Washtenaw & Livingston Counties	Center for Healthcare Research and Transformation

- Each CHIR backbone organization receives a fixed base level of SIM funding to support administrative functions and a health improvement budget that varies based on the number of Medicaid beneficiaries in their region.
- Health improvement funding is used to support clinical-community linkage activities and other strategies for population health improvement of the SIM target population.

CHIR Alignment

- CHIRs will move regions upstream to address the social determinants of health in partnership with their local payers and providers.
- The CHIR aligns with:
  - Medicaid emergency department utilization efforts required under PA 107,
  - Community Health Needs Assessment/Community Health Improvement Plan requirements of hospitals under the Affordable Care Act & local health departments as mandated by accreditation,
  - Clinical-community linkage efforts previously funded by CMS in MI as part of the Pathways to Better Health Initiative,
  - CMS developed models funded nationwide, such as Accountable Communities of Health
  - MDHHS' Integrated Service Delivery (ISD) initiative.
- Participant Engagement Opportunities
  - Establishment of a collaborative learning network
  - ABLe Change Process for Systems Change



SIM Clinical-Community Linkages (CCLs) Developmental Framework

Clinical-Community Linkages Defined

Screening

Scanning & Improving

Clinical-Community Linkages

The purpose of the CCLs is to enhance the ability of community-based organizations and clinical providers to effectively improve the health of individual and as a result the population, by identifying and proactively addressing social and health needs.

CCLs Developmental Framework

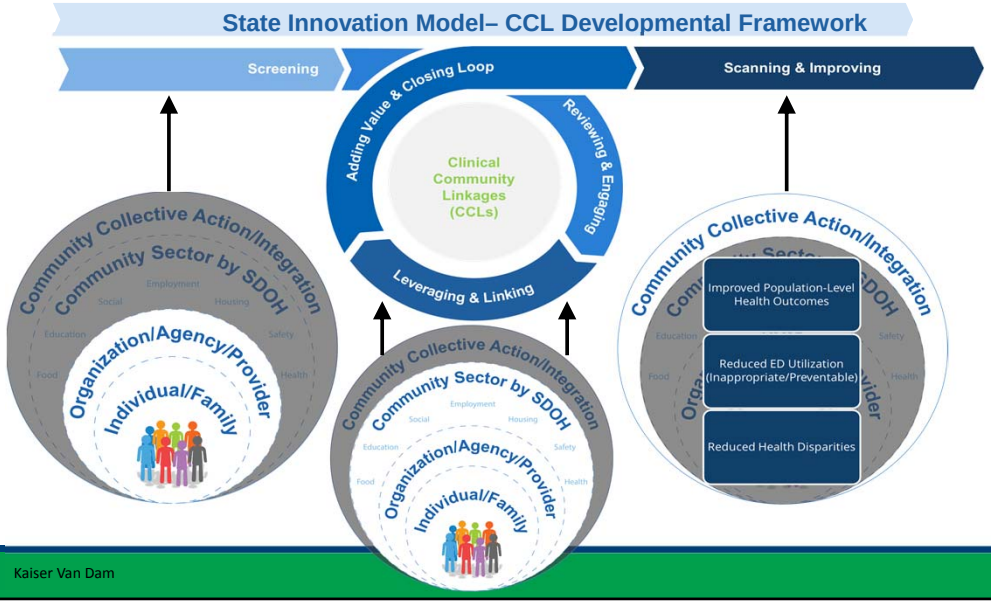
Specifically, the CCLs screen individuals for social and economic factors that may impact their health and link to appropriate community resources. Information from this process helps determine the effectiveness of resources, build community partnerships, and identify opportunities for enhancement and expansion

Clinical-Community Linkage Defined

Interconnected Levels	Screening	Reviewing & Engaging	Leveraging & Linking	Adding Value & Closing Loop	Scanning & Improving
Individual/Family	Individuals are engaged and activated through the social needs screening process.	Individuals work with an organization or provider to discuss and prioritize their needs. *Create a MI Bridges Account at this step	Individuals are provided resources available within the organization completing the screen and also linked to outside organizations based on identified needs. *MI Bridges can be used at this step	Follow up is completed by the individual and/or organization to ensure to complete the linkages or referral (closed the loop). * Note a closed loop does not always indicate a need has been met.	Individuals play a vital role in the improvement process by providing feedback, participating on an advisory group, etc.
Organization/Agency/Provider	Staff outreach to individuals across the population to screen and identify areas of needs.	Staff use motivational interviewing techniques and active listening to further understand needs and to develop a customized action plan in partnership with the individual.	Staff start work with the individual to leverage their own assets to meet their needs and open referrals or links to additional resources where appropriate.	The organizations, agencies and providers completing the screen work with the individual served to close the loop. *Note a closed loop does not always indicate a need has been met.	The organizations, agencies and providers completing the screen will use the information to identify opportunities to improve the process, both on an individual client level and across the population served.
Community Sector by SDoH	Community sectors inform the screening questions and help to identify organizations to screen individuals.	Organizations, agencies and providers within defined sectors by SDoH develop a plan to meet the needs of those they serve and identify gaps in resources.	Organizations, agencies and providers within defined sectors by SDoH coordinate activities to close service gaps in a community. (e.g. coordinated entry)	Organizations, agencies and providers within a defined sector by SDoH adapt and change internal policies and/or procedures to meet the community needs.	Organizations, agencies and providers within a defined sector of SDoH continue to scan and adapt to the changing needs of the community; including policy change.
Community Collective Action/ Integration	Community collective action and policy is used to inform the development and delivery of a shared social need screening tool.	CHIR governing body and/or CCLs workgroup regularly meets to review shared CCLs process, data and experiences (both individual, organizational, and sector levels).	CHIR governing body and/or CCLs workgroup regularly meets to strategize the CCLs development and maturity.	CHIR governing body identifies gaps within the community, CHIR backbone organization (BBO) facilitates identifying resources and strategies to address gaps through advocacy work.	CHIR governing body utilizes feedback from local, regional and state coalitions, resources and data to inform collective action.

*Note that each section of the Clinical Community Linkages (CCLs) defined chart above is interconnected

Moving Michigan's Population Health Upstream



Social Determinants of Health Brief Screening Tool

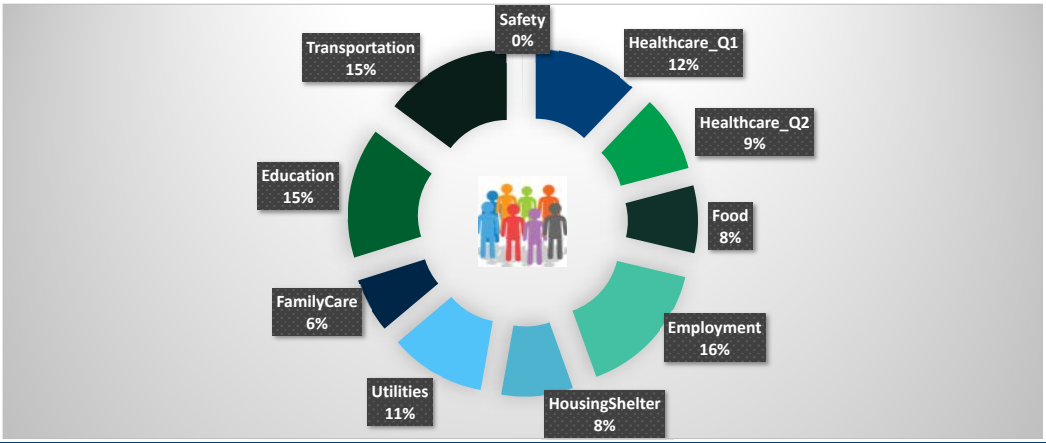
Domain	Question	Yes	No
Healthcare	Does your physical or mental health keep you from doing things you need or want to do? (work, school, take care of yourself)		
	Have you needed to see a provider but could not because of cost?		
Food	Do you struggle to get the food you need?		
Housing	Do you need help with housing?		
Utilities	Do you have a hard time paying your utility bills?		
Family Care	Do you need help finding or paying for care for loved ones? For example, child care or day care for an older adult.		
Transportation	Do you have trouble with transportation?		
Literacy	Do you ever need help reading important papers?		
Employment / Income	Do you need help finding a job, better job or steady source of income?		
Education	Do you think more education could be helpful for you?		
Safety	Are you afraid you might be hurt in your living environment?		
General	Would you like assistance with any of these needs?		
	Are any of your needs urgent?		

Social Determinants of Health Brief Screening Tool

Domain	Intent
Healthcare	Assess patient/client perception of their physical and/or mental health and potential impact on overall wellbeing and independence.
	Assess healthcare access related to cost, or more broadly, economic stability.
Food	Assess food insecurity, access and affordability.
Employment & Income	Assess potential joblessness, and income instability.
Housing & Shelter	Assess potential risk of homelessness, and housing instability.
Utilities	Assess risk, not whether there has been a shut off notice or had services shut off, but as a proxy of economic stability. This question intentionally focuses more broadly than service shut off (i.e. includes notices).
Family Care	Assess whether dependent care may be a barrier to (patient, client, beneficiary) taking care of themselves; assess the potential need for respite care and/or any patient concerns around current family care arrangements.
Education	Assess patient/client education level, ability for economic independence/stability and potential activation.
Transportation	Assess if transportation, or lack of transportation, is a limiting factor in daily life (i.e. goes beyond medical transportation).
Personal and Environmental Safety	Assess potential concerns of personal safety in a broad enough sense to capture potential for subsequent domestic violence screening.
General	Identify if any of the needs the patient, client, beneficiary indicated above are already being addressed or not, and whether the patient, client, beneficiary is open to assistance activation.
	Assess severity of identified needs.

Social Determinants of Health
Screening - Sector Alignment - Policy Change

The social determinants of health (SDoH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.



Housing Vision
Data Integration - Improve Capacity - Pilot

Data Integration

- Data Matching for Prioritization of High Cost Population
- Improve Data Quality

Improve Capacity

- Improve Homeless Response System
  - Gap Analysis
  - Process Improvement Support
- Building Capacity to Enhance PSH Quality
- Building Capacity to Leverage Medicaid Reimbursement

PSH Frequent User Pilot

- Serving 200 Chronically Homeless High Medicaid Utilizers
- 3 Years Starting Fall 2018
- Case Management Funding per Voucher
- Address Other SDOH
- Systems Improvement Participation
- Housing Stability Health Outcomes Tracking and Evaluation

CHIR Next Steps

Clinical-Community Linkages (CCL)

- CHIRs will refine and bring to scale their CCLs to meet the needs of individuals and families.
- PMCH and community organizations will consistently screen for SDoH needs and link to needed services.
- CHIRs will continue to provide a mechanism for health care providers to effectively engage with community organizations who are experienced in meeting the social and economic needs of patients.

Transformative Community Change

- CHIRs will lead community systems change processes to systematically review data, identify root causes, select priorities, and design strategies to address local problems.
- CHIRs will provide a structured framework for coordinated responses to existing problems and gaps in services.
- CHIRs will continue to convene community stakeholders to track collective efforts and build capacity for long-term, sustainable change.

Plan for Improving Population Health (PIPH)

- Lessons learned and emerging best practices from CHIR activities will inform PIPH strategies.

Lessons Learned

SIM MDHHS State Innovation Model

- Be intentional in relationship building
- Recognize and plan for time-intensive work that this will require
- Leverage existing frameworks and partnerships to expand assets and tap into existing capacities
- Be mindful of legal issues crossing different systems and organizations
- Carefully strategize technology needs to ensure it does not become focus of the initiative

Questions and Additional Resources

MDHHS-SIM@michigan.gov

Paula Kaiser Van Dam

Director, Bureau of Community Services

Michigan Department of Health and Human Services
235 S. Grand Avenue, Suite 1106 | Lansing, MI 48913

517-241-0638 (phone)

E-mail: kaiserp@michigan.gov