Community Health Innovation Regions

BCBSM HEALTHY SAFETY NET 2017
OCTOBER 11, 2017
LANSING MICHIGAN
Presenters

Paula Kaiser Van Dam, MDHHS, Bureau of Community Services

Lori Kunkel, Greater Flint Health Coalition (Genesee County)

Laurie Gustafson, Henry Ford Allegiance Health (Jackson County)

Carrie Rheingans, Center for Healthcare Research and Transformation (Livingston/Washtenaw Counties)

Kelli DeLong, Muskegon Community Health Project (Muskegon County)

Patricia Fralick, Health Department of Northwest Michigan (Northern Michigan Region)

Moderator: Carrie Rheingans
A Vision of Empowerment

A person-centered health system that is coordinating care across medical settings, as well as with community organizations to address social determinants of health, to improve health outcomes; and pursue community-centered solutions to upstream factors of poor health outcomes.

Rationale

• Clinical care accounts for 10%-20% of health outcomes
• Social and environmental factors account for 50%-60% of health outcomes
SIM Components

**Care Delivery**
- Patient-Centered Medical Home (PCMH)
- Advanced Payment Models

**Population Health**
- Community Health Innovation Region (CHIR)

**Focused on:**
Clinical-Community Linkage

**Supported by:**
- Stakeholder Engagement
- Data Sharing and Interoperability
- Consistent Performance Metrics
CHIR Regions
Community Health Innovation Regions (CHIR)

- Foundation of the Population Health component
- Broad partnership of community organizations, local gov’t (LHD, CMH), business entities, health care providers, payers, and community members.
- Build on existing community coalition efforts
- Improve community governance
- Initial focus on reducing ED utilization, assessing community needs, and identifying region-specific health improvement goals
- Establishing/strengthening a clinical-community linkage
Genesee Region

LORI KUNKEL
GREATER FLINT HEALTH COALITION
**Backbone Organization**

**Greater Flint Health Coalition**

- 501(c)3 non-profit established in early 1990’s
- True partnership for collective impact

**Mission:**
- Improve the health status of Genesee County residents
- Improve the quality & cost effectiveness of our healthcare system

**Vision:**
A healthy Genesee County community practicing healthy lifestyles with access to the best and most effective health and medical care

**Focus Areas:**
- Health Improvement
- Access & Environment
- Quality & Innovation
- Cost & Resource Planning
- Sector Workforce Development
- Racial Disparities & Health Equity
Collaborative Approach

GFHC convenes 25 multi-sector coalitions and operates a variety of community-based programs to meet community priority needs.
Clinical-Community Linkage

• **80%** of factors affecting Health Outcomes fall outside traditional healthcare delivery

• Utilize cross-sector partnerships to support the linkage of patients (identified by providers and health plans) to community and social services that address the social determinants of health.

Health Outcomes
- Length of Life (50%)
- Quality of Life (50%)

Health Factors
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit
Clinical-Community Linkage

• **Greater Flint Health Coalition** will serve as a clearinghouse for CCL Hub referrals from PCMH practices, ASCs, and health plans.

• SIM Focus on ED Utilization: High, “Inappropriate” and Preventable

• Genesee CHIR’s community wide Social Determinants of Health (SDOH) screening strategy will inform the CCL initiative’s patient referrals

• Shared processes between care managers (embedded in practices or based at ASCs) and health plans will follow triggers to determine referral protocols to the SIM “Clinical Community Linkage Hub”, which will connect patients to community & social services
Clinical-Community Linkage

- Each referrals will be assigned to community-based nurses, social workers, and community health workers at designated **Specialty Hub Organizations** based upon the patient’s referral needs:
  - Genesee Children’s Healthcare Access Program (CHAP)
  - Genesee CHAP Adult Expansion Model [Community Healthcare Access Program (CHAP)]
  - Genesee Health Plan
  - Genesee Health System [local CMH]

- The SIM Hubs will utilize **Great Lakes Health Connect’s Community Referral Platform**.
  - The referral platform will be used for the GFHC clearinghouse to receive referrals from ASCs, Medicaid Health Plans and medical practices as well as for SIM Hubs to send/track referrals to a collection of community & social service providers.
Clinical-Community Linkage

• GFHC and the United Way of Genesee County have established a network of Community Service Provider Agencies that will utilize the CHIR’s Community Referral Platform to receive referrals on a shared network:

✓ Carriage Town Ministries
✓ Catholic Charities
✓ Child Care Network
✓ Family Service Agency
✓ Food Bank of Eastern Michigan
✓ Genesee County Community Action Resource Department
✓ Mass Transit Authority
✓ My Brother’s Keeper
✓ Sacred Heart Rehabilitation Center
✓ Salvation Army
✓ Shelter of Flint
✓ Valley Area Agency on Aging

• Genesee CHIR’s CCL Initiative working on interventions at the patient/individual, practice, and systems levels.
For More Information

Greater Flint Health Coalition
phone: (810) 232-2228
eMail: sim@flint.org
www.gfhc.org

Thank you.
Jackson Region

LAURIE GUSTAFSON
HENRY FORD ALLEGIANCE HEALTH
Backbone Structure

Network Alignment

Inter-S strand Efficiency

Intra-S strand Excellence

Network Manager

Network Assistant

HIO Strand Coordinator

C2C Strand Coordinator

FSN Strand Coordinator
Jackson Collaborative Network

**Health Improvement Organization** (HIO) operating as collective impact model to address population health in Jackson County since 2005

**Cradle to Career Education Network** created in 2012 using collective impact to address educational attainment

**Financial Stability Network** most recent network addition addressing poverty reduction
Collaborative Approach

- Centralized Infrastructure
- Dedicated staff
- Structured Process
  - Common Agenda
  - Shared Measurement
  - Continuous Communication
  - Mutually Reinforcing Activities
Clinical/Community Linkage

- Clinical Community Linkages (CCL) workgroup:
  - Ensure ownership and accountability by participating agencies in decisions and action plans
  - Ad hoc groups formed to accelerate work
  - Over 70 interviews of clinical and social service leaders and front-line staff
Clinical/Community Linkage

Centralized IT HUB and navigation system to interface with EHR, 2-1-1 and community agencies
Application

Expect to be involved in collaborative efforts in your community.

Adopt a brief screening for social needs.

Consider how you can align your work flow with other sectors.

High intensity cross-sector collaboration requires trust and time.

Take a step back and dream big!
Livingston/Washtenaw Region

CARRIE RHEINGANS

CENTER FOR HEALTHCARE RESEARCH AND TRANSFORMATION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Backbone Organization

Center for Healthcare Research & Transformation

• Health policy center based at the University of Michigan

• CHRT hosts multiple implementation projects:
  • Michigan Primary Care Transformation Demonstration / SIM PCMH Initiative
  • Washtenaw Health Initiative
  • Michigan Community Health Worker Alliance

• ~1.5 FTE for backbone functions

• ~2.2 FTE for transformation functions
Collaborative Approach

Livingston / Washtenaw Community Health Innovation Region (LWCHIR)

**Intervention**

- **Co-Chairs:** Ray Rion, Pam Smith
  - Avalon Housing
  - Blue Cross Blue Shield of Michigan
  - Blue Cross Complete
  - Community Mental Health Partnership of Southeast Michigan
  - Community Mental Health Services of Livingston County
  - Corner Health Center
  - Emergent Health Partners
  - Integrated Health Associates (IHA)
  - Jewish Family Services
  - Livingston County Public Health
  - Michigan Medicine
  - Packard Health
  - SIM PCMH/ Michigan Multi payer Primary Care Transformation
  - St. Joseph Mercy Health Partners Clinically Integrated Network
  - St. Joseph Mercy Ann Arbor and Livingston
  - U-M Gerald R. Ford School of Public Policy
  - U-M Institute of Health Policy and Innovation
  - United Way of Washtenaw County
  - Washtenaw County Community Mental Health
  - Washtenaw County Public Health
  - Washtenaw Health Plan
  - Unified – HIV Health and Beyond

**Data/T**

- **Chair:** Mike Klinkman
  - Blue Cross Blue Shield of Michigan
  - Corner Health Center
  - Great Lakes Health Connect
  - Huron Valley Physicians Association
  - Livingston County Public Health
  - Michigan Data Collaborative
  - Michigan Health Information Network
  - Michigan Medicine
  - St. Joseph Mercy Ann Arbor and Livingston
  - Trinity Health
  - University of Michigan Medical School Department of Learning Health Sciences
  - Washtenaw County Community Mental Health

**Clinical (PCMH/ASC)**

- **Co-Chairs:** Maria Han, Marti Walsh
  - Blue Cross Blue Shield of Michigan
  - Blue Cross Complete
  - Corner Health Center
  - Huron Valley Physicians Association
  - Integrated Health Associates (IHA)
  - Michigan Medicine
  - Packard Health
  - SIM PCMH / Michigan Multi payer Primary Care Transformation
  - St. Joseph Mercy Ann Arbor and Livingston
  - St. Joseph Mercy Health Partners Clinically Integrated Network
Clinical/Community Linkage

Assess, Coordinate, and Deliver Services

Community Hublets

Initial intake:
- Consent participants for intervention and obtain release of information
- Screen participants for existing care/case management relationships
- Determine appropriate lead hublet

Coordination and Service Provision:
- Hublet conducts assessment of concrete social and medical needs
- Hublet coordinates with partner entities and links clinical and social services
- Facilitated by a system that closes loop on appointments and referrals

Quality Improvement Meetings:
- All hublets meet regularly to discuss intervention challenges, complex cases, or cases where appropriate services are not available in the community

Partner Entities

- Work with Community Hublets to provide:
  - Wrap-around services for high risk participants
  - CHW provides linkages between medical and social services
  - Referral to peer support network for particular social/mental health needs
  - Provide linkage to Patient Centered Medical Home

2: CHWs will be housed at the Washtenaw Health Plan, though they will work across hublets and partner entities.
Livingston/Washtenaw Innovations

• Predictive model
• Consent process
• Shared IT platform
• Aggregation of social determinants data
• Intentional process to build relationships
For more information:

Carrie Rheingans
Project Manager, Washtenaw Health Initiative and Community Implementation

crheinga@umich.edu
734-998-7567
Muskegon Region

KELLI DELONG

MUSKEGON COMMUNITY HEALTH PROJECT
Backbone Organization
Engaging Stakeholders:

- Phase 1: Focus Groups & Surveys
- Phase 2: Community Convening
- Phase 3: Collective Impact

Moving the work forward:

- Sharing wins
- Continuous communication
- Advancing diversity across sectors
- Localized data
Clinical/Community Linkage
For more information:

Kelli DeLong
CHIR Project Coordinator
Muskegon Community Health Project
565 W. Western Ave | Muskegon, MI 49440
Phone: 231.672.3201 or 231.672.3388
Fax: 231.672.8404
delongkj@mercyhealth.com
www.mchp.org
Northern Michigan Region

PATRICIA FRALICK, MBA, RN

HEALTH DEPARTMENT OF NORTHWEST MICHIGAN
Northern Michigan Community Health Innovation Region

Goal is to achieve the “Triple Aim”:
better health, at lower cost, with greater patient satisfaction

**Backbone organization** is the Northern Michigan Public Health Alliance with the Northern Health Plan serving as fiduciary

**Steering Committee** is a cross-sector group composed of 20 leaders from health care and other sectors across the 10-county region

**Work Groups** develop required components--
- Clinical Community Linkages Model
- Regional Community Health Assessment
- Comprehensive Community Health Improvement Plan

**Primary target population** is Emergency Department utilizers

**Secondary target population** is chronic disease with focus on obesity
Primary Population: Emergency Department Utilizers

51.4% of Emergency Department visits made by Medicaid beneficiaries in the Northern Michigan Community Health Innovation Region in 2016 were avoidable or preventable

Why?
- Lack of access to healthcare
- Lack of transportation
- Cost
- Lack of knowledge re appropriate use of Emergency Department
ED Assessment Response

**Clinical Community Linkages:**
3 Community Connections HUB Teams in Region
Partner with PCMHs & Community Agencies
Provide Navigation & Resource Linkages

**Emergency Department Utilization Campaign:**
Common messaging from providers—medical & community
Education on appropriate ED use
Community Connections
Clinical Community Linkages Model

Community Screening for Social Determinants of Health

HUB Teams assist clients using Pathways linked to EHR

Unmet client needs addressed by cross-sector NMCHIR
For additional information:
Linda Yaroch, MPH, RN, Executive Director
231-547-7621 or l.yaroch@nwhealth.org