SIM Initiative Newsletter

A quarterly publication of Michigan's State Innovation Model
September 2019

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About the Initiative

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the State of Michigan $70 million over four years to test and implement an innovative model for delivering and paying for healthcare in the state. The state has focused its efforts on developing and strengthening connections among providers of clinical care and community-based organizations that address social determinants of health.

Contact Us

The SIM team can be reached for questions at:

MDHHS-SIM@michigan.gov

Links

SIM Initiative website

Welcome to the tenth edition of the State Innovation Model (SIM) Initiative Newsletter. This newsletter is intended to provide updates on the activities taking place across the initiative. It will also be used to make stakeholders aware of any SIM-related events that may be of interest to a general audience.

Previous editions of the newsletter can be found on the SIM website, Michigan.gov/SIM.

Program News and Updates

CMS SIM Site Visit

In August 2019, the Centers for Medicare and Medicaid Services (CMS) came to Michigan to conduct a site visit with SIM program staff in the Michigan Department of Health and Human Services (MDHHS). During the visit, CMS program officers met with key state personnel, attended a Care Coordination Collaborative event hosted by the SIM Patient-Centered Medical Home Initiative, and toured SIM-funded housing programs in Washtenaw and Jackson Counties. The visit offered CMS the opportunity to learn about the successes and challenges in the Michigan SIM Initiative, as well as provide technical assistance and guidance around sustaining SIM activities following federal funding.

MDHHS Announces New Plan to Improve Health of Infants and Mothers

The MDHHS, in partnership with the Maternal Infant Strategy Group (MISG), announced the release of the 2020-2023 Mother Infant Health and Equity Improvement Plan. This improvement plan, which aligns with the plan for improving population health, includes comprehensive statewide strategies that will align stakeholders around key goals to improve the health of mothers and babies. The overall vision of the improvement plan is "Zero Preventable Deaths. Zero Health Disparities."

Michigan has a higher infant mortality rate than the national rate, with 6.8 deaths per 1,000 live births. There are also significant racial disparities, with black infants 2.8 times more likely to die before their first birthday than white infants. The plan emphasizes addressing both clinical and non-clinical factors, such as housing, racial biases, access to family planning, and safe sleep practices. The Mother Infant Health and Equity Improvement Plan, along with additional information, is available at Michigan.gov/miheip.

Population Health

Community Health Innovation Regions

Muskegon CHIR Hosts 100-day Challenge Event: Livability Lab

Nearly 300 business leaders, educators, neighborhood association members, health and human services organizations, and state and local government representatives gathered at the Folkert Community Hub on Tuesday to kick off the Livability Lab's 100-day Challenge—an initiative of the Muskegon County Community Health Innovation Region (CHIR). This community-led effort was created to address barriers to upward mobility, well-being, and business growth in Muskegon County and included community stories and reports about jobs, education, and health.

Local leaders and residents—in partnership with Michigan State University and the Muskegon County CHIR—designed this daylong process, which challenged participants to team up and target issues that impact upward mobility and community livability.

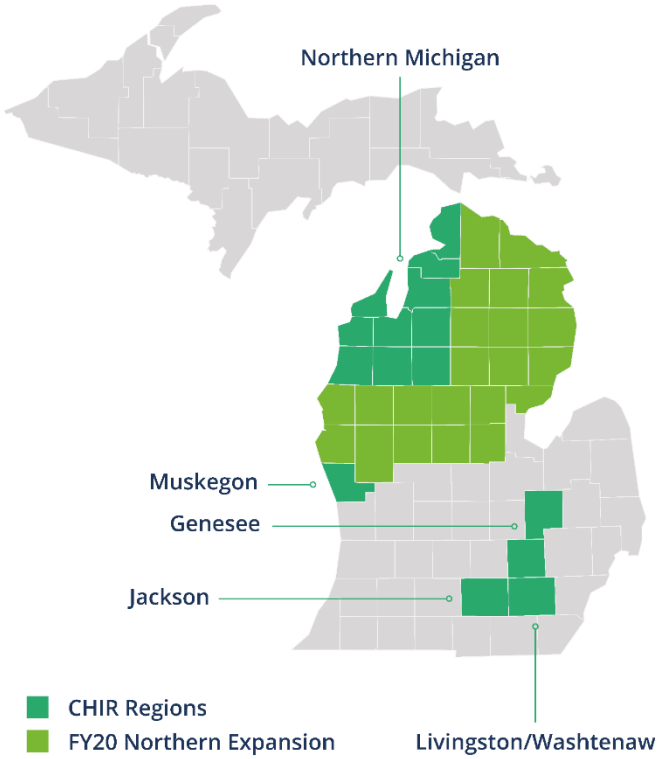
At the event, 19 planning teams formed and will now meet over the next 100 days to pursue rapid, creative solutions to challenges that impede good health and prosperity in Muskegon County. Each team will be staffed by a trained coach who will help manage the work. The teams were created using a framework that prioritizes five livability elements: education, health, social connection and trust, safety and security, and economic opportunity. Some of the projects that emerged include building a neighborhood association council in Muskegon Heights to increase resident voices in local decision-making, creating a mentorship network to increase youth academic and cultural leadership skills, expanding the Youth Book Buddy Program to disadvantaged schools to support literacy, and engaging local businesses in the Wheels to Work program to increase affordable transit options, among many others.

Communities across the nation have successfully used the 100-day approach to encourage creative solutions to complex issues and align objectives and resources.

To learn more about the Livability Lab and follow each team's progress, visit LivabilityLab.com. If other community members are interested in this work, there are opportunities to join the effort.

Northern Michigan CHIR Expanding to Cover 31 Counties

The Northern Michigan CHIR has initiated an expansion of their region to include all 31 counties that are part of the Northern Michigan Public Health Alliance. By the end of the SIM test period in January 2020, the CHIR will have an organizational expansion plan in place and an expanded governance structure that includes leadership from the entire 31-county region. The state CHIR team has been supporting the Northern Michigan CHIR with technical assistance for their expansion and is documenting the expansion process to inform future scalability efforts. The Northern Michigan CHIR staff have conducted extensive analyses of existing county affinity groupings, regional boundaries for other state-supported services (e.g., Medicaid contracting regions, intermediate school districts, services to the aging, etc.), health system markets, health department jurisdictions, and trial court jurisdictions. When the time comes for large-scale expansion, the experience of the Northern Michigan CHIR will be tremendously helpful in those planning efforts.



Health Through Housing Initiative

As part of the Health through Housing initiative's pilot effort to identify and reach out to people who are frequent users of healthcare services experiencing chronic homelessness, permanent supportive housing (PSH) providers are delivering care management services to these vulnerable residents, as well as helping them obtain stable housing. The following example, recently shared with the SIM team, illustrates the importance of this work:

A 38-year-old client was homeless and had been camping outside for six years. The client had not sought services at the county's main shelter, or from other providers, and had refused to use the local warming center because of safety concerns. Because this person had not been using these services, they did not appear on the participating PSH's Community Housing Prioritization list (a list used to determine housing placements for people experiencing homelessness). This person did, however, make frequent visits to the local emergency department. The recent data analytics work conducted by the SIM Technology team to bring homeless management information services (HMIS) data together with Medicaid data led to the identification of this person as someone who needed housing support. The PSH was able to reach out to the person, who moved into housing within one month of being identified as in need of support. The PSH is now helping this person address the health concerns that had led to the frequent emergency department visits to ensure more appropriate use of healthcare services.

Plan for Improving Population Health

MDHHS is required to develop a Plan for Improving Population Health (PIPH) as a condition of its funding from CMS. The purpose of Michigan's PIPH is to describe how Michigan is creating health, equity, and well-being through clinical and community-based prevention strategies that address the social determinants of health. Michigan's plan is grounded in the idea that population health will improve if Michigan works across sectors to address the root causes of health inequity and improve access to the conditions that promote health. The vision statement for the plan is: "Creating fair, just, and equitable conditions so all people in Michigan thrive and achieve optimal health." The mission statement is: "To leverage the collective power of community partnerships to create conditions that foster health, equity, and well-being."

The Public Health Administration (PHA) is coordinating the development of the PIPH in collaboration with partners from across MDHHS. Over the past year, this group of interagency partners drafted the plan's vision and mission, descriptions of the state's health status, and current capacity to address social determinants of health. In August 2019, MDHHS invited external partners to select strategies and develop action plans to address social determinants of health through clinical care, clinical-community linkages, and community change. These groups have identified priority strategies and are developing action plans. Over the next few months, the PHA will gather input on the draft PIPH from SIM partners and deliver the final plan to CMS at the end of January 2020.

Care Delivery

Patient-Centered Medical Home Initiative

Patient Experience Survey shows Positive Impact of SDOH Screening in the PCMH Model

A recent survey of patients and parents of pediatric patients attributed to SIM Patient-Centered Medical Home (PCMH) Initiative practices sought to learn about patient attitudes and experiences related to screening for social needs. The Child Health and Evaluation Research Center at the University of Michigan (a SIM evaluation partner) found that about 40 percent of patients and parents recall participating in a social determinants of health (SDOH) screening at their PCMH and about half of adults and one-third of parents said they had at least one SDOH need identified through the screening. About three-quarters of patients and parents said their PCMH talked with them about how to get help related to needs identified; referrals to other agencies were more common for patients at PCMHs located in a CHIR versus at PCMHs not located in a CHIR. About 80 percent of patients and parents believe healthcare practices should ask about SDOH needs.

SIM PCMH Summit to Focus on Smart Delivery and Cost-effective Care

The SIM PCMH Initiative Summit is scheduled for Tuesday, November 12, 2019 and will focus on sustaining the advances made over the past four years through smart delivery strategies and cost-effective care. Breakout sessions will give participants the opportunity to discuss building strong partnerships; using SDOH screening data to inform patient care plans, community resource discussions, and state-level policy and planning; incorporating coping and resiliency skills in trauma-informed care; and identifying the signs and symptoms of adolescent depression. Summit participants will also get an update on the SIM evaluation being conducted by the Michigan Public Health Institute and the use of alternative payment models to continue best practices implemented in the SIM PCMH Initiative. The full day agenda is available to download from the MDHHS website.

PCMH Clinical Community Linkage Data Partnership

A preliminary report from the SIM state-led evaluation team illuminates some important correlations between social needs and healthcare utilization and costs among people being screened for social needs at participating PCMH practices. In a review of emergency department utilization and per member per month (PMPM) healthcare costs among those screened, the evaluator found children with one or more social needs were 30 to 49 percent more likely to have had an emergency department visit in the past year than children with no social needs identified. Among adults, those with one social need were 86 percent more likely than those with no social needs to be a high utilizer of the emergency department (defined as having five or more emergency visits in the past year). Those with four or more social needs were nearly 300 percent more likely to be high utilizers of the emergency department than those with no social needs.

When looking at healthcare expenditures, PMPM healthcare costs for children with one or more social needs were 21 to 25 percent higher than those for children with no social needs identified. Among adults, those with one social need had 25 percent higher PMPM healthcare costs than those with no social needs. Adults with four or more social needs had PMPM costs that were 63 percent higher than those with no social needs.

These correlations demonstrate the importance of understanding individual social needs when treating a person's physical health. They also highlight the potential for increasing appropriate use of healthcare services, while also decreasing the cost of healthcare, by addressing social needs when they are identified.

Alternative Payment Models

Managed Care Plan Division and Medicaid Health Plans Collaborate on State-preferred PCMH Model

The MDHHS continues to work with Medicaid Health Plans (MHPs) to establish a standard set of PCMH requirements that define the State-preferred PCMH model. The collaborative effort to design these common PCMH requirements is intended to sustain and expand PCMH in the Michigan Medicaid managed care program. The design process began with the SIM PCMH model as its foundation, and MDHHS continues to work with MHPs to clarify requirements and their corresponding compliance and monitoring processes. Since the SIM PCMH Initiative will conclude at the end of 2019, the goal is to ensure sustainability, effectiveness, and consistent best practices beyond grant-funded activities.

The Medical Services Administration Quality Improvement and Program Development (QIPD) section has finalized MHP provider contracting requirements, care management/care coordination utilization benchmarks, and quality measurement and improvement targets for fiscal year 2020 incentive payments. The QIPD team gathered additional data from MHPs about alternative payment model implementation, which included the amount of incentives offered to providers that go "uncollected" (unpaid). This data will be compared with the quality measurement and improvement data to identify trends in incentive structure, as well as improvements in quality of care.

Technology

New Projects Designed to Validate HIE Data

The SIM Technology team has established two projects to validate and catalog the data coming out of the state's health information exchange (HIE). The first, an analysis of the admission, discharge, transfer (ADT) messages, will meaningfully identify opportunities where ADTs are being utilized within MDHHS presently and how they could be used for other business units within MDHHS. The second is an analysis of the Active Care Relationship Services® (ACRS) file, which will be used to determine the accuracy of the attribution between health plans and providers. Both projects have an opportunity to establish the role of the HIE within MDHHS operations.