WASHTENAW HEALTH INITIATIVE

WHI Projects Past and Present

Current WHI Projects

Mental Health & Substance Use Disorder Work Group
Co-chairs: Tim Florence, Washtenaw Community Mental Health and Nancy Siegrist, St. Joseph Mercy-Chelsea
Working group that serves as a forum to share updates about multiple WHI projects in this priority area, as well as updates about other key activities in the community (e.g., Trauma Steering Committee, Public Safety & Mental Health millage).

1. **Peer Network Project** *(in development; lead: Mark Creekmore, NAMI-Washtenaw President Emeritus)*
   This project aims to increase the number of trained peers available in the county for hire to support multiple programs and services. This will include assessing across the community what peer-type roles exist, and how many of each there are. Peers and peer-hosting organizations will be connected as peers are identified.
2. **Youth in Transition Project** *(in development; lead: Kathryne O'Grady, CHRT)*
   The goal of this project is to address behavioral and social needs of youth transitioning out of foster care or out of the juvenile justice system.
3. **WHI Opioid Project** *(co-chairs: Jimena Loveluck, Washtenaw County Health Department and Marci Scalera, Community Mental Health Partnership of Southeast Michigan)*
   The WHI OP is a cross-sector coalition that meets monthly to share updates and best practices around policies, programs, and services related to the opioid epidemic. The group combats stigma, educates the community, monitors data, and implements innovative strategies to reduce opioid overdoses and deaths.
4. **ABLe Change:** Systems Changes around Substance Use Disorders *(leads: Gregory Powers and Carrie Rheingans, CHRT)*
   ABLe Change is a community-level, systems change process facilitated by experts from Michigan State University. Washtenaw County partners work together to identify system gaps and barriers and their root causes, and create cross-sector, powerful strategies to address system issues. The facilitated process will end in May, and the strategies identified and refined through the process will begin implementation.

Community Coordination Projects
(no active, overarching working group)
Projects in this category

1. **Information for Navigating Senior Services** *(co-chairs: Rachel Dewees, Michigan Medicine and Joanne Grosh, St. Joseph Mercy Health System)*
   The group was tasked with addressing the connection gap when seniors and their caregivers seek information to address needs faced by seniors. The group has conducted an extensive root cause analysis and will be piloting methods for information dissemination in select primary care practices and senior centers.

2. **UNITE Hospital Community Health Assessment and Planning** *(co-chairs: Alfreda Rooks, Michigan Medicine and Elisabeth Vanderpool, St. Joseph Mercy – Ann Arbor and Livingston)*
   The three nonprofit hospitals in Washtenaw County have jointly conducted their IRS-mandated community health needs assessment and implementation plan since 2015. This round, the group will jointly identify and implement projects, programs, or policy changes related to social determinants that impact the group's top three health priorities: mental health and substance use disorders, obesity and related diseases, and preconceptual and perinatal health.
3. **Advance Care Planning** (chair: Sheryl Kurze, community member)
   This group aims to increase advance care planning in the community. The group assessed local root causes preventing people from advance care planning, and created a conversation guide for residents and providers to use to begin talking about healthcare preferences.
4. **VA Volunteer Respite Program** *(coordinator: Jenny Smallbone, VA Ann Arbor Healthcare System)*
   This program coordinates volunteers that serve veterans or their caregivers by allowing brief periods of respite for caregivers.
5. **Care Net** *(coordinator: Ruth Kraut, Washtenaw Health Plan)*
   A network of care and case managers across the county regularly shares information and troubleshoots issues related to local programs and services. In addition, orientations to the local service delivery systems and other trainings are regularly offered at low or no cost to local care and case managers.

Medicaid & Marketplace Outreach & Enrollment Work Group
Co-chairs: Kim Hulbert, St. Joseph Mercy-Ann Arbor and Doug Weaver, Michigan Medicine
Working group that serves as a forum to share policy updates and best practices, and to jointly resolve issues across outreach and enrollment agencies.

1. **Community Outreach & Education** *(coordinator: Megan Foster Friedman, CHRT)*
   A team of dozens of graduate student volunteers creates and distributes information about health insurance enrollment each year ahead of and during the open enrollment period for the Health Insurance Marketplace. The students also organize multiple community-wide enrollment events each year.
2. **Outreach & Enrollment Coordination** (co-chairs: *Kim Hulbert, St. Joseph Mercy-Ann Arbor and Doug Weaver, Michigan Medicine*
   Enrollment organizations across the county coordinate and support each other throughout the year, and especially during the open enrollment period for the Health Insurance Marketplace.

State Innovation Model Work Group for the Livingston/Washtenaw Community Health Innovation Region (LWCHIR)
Co-chairs: Doug Strong and Paul Valenstein
Livingston and Washtenaw counties comprise one of five Community Health Innovation Regions (CHIRs) identified by the Michigan Department of Health and Human Services as part of their participation in the federal State Innovation Model initiative. The goal of a CHIR is to ensure that residents can be connected to and access any social services that could improve their health. A CHIR does this in two ways: 1) intervening in a targeted way with people who have multiple

social service needs, and 2) monitoring community-level needs and working with system and sector leaders to allow for easier connections to social services.

1. **LWCHIR Homeless Response System Project** *(in development; lead: Patrick Kelly, CHRT)*

   Working with the Homeless Continuum of Care in each county, experts from the Corporation for Supportive Housing will assess homeless system gaps and work with local leaders to address them.
2. **Clinical/PCMH Committee** *(co-chairs: Leah Corneail, Michigan Medicine and Marti Walsh, Integrated Health Associates)*

   As part of the state-wide State Innovation Model (SIM) Patient-Centered Medical Home (PCMH) Initiative, primary care practices affiliated with Huron Valley Physicians Association, Integrated Health Associates, and Michigan Medicine implemented a common questionnaire screening for social service needs of patients. Primary care sites then connect patients to any services requested by the patients.
3. **Intervention** (Hub, Hublets, Care Coordination Platform, and Predictive Model) *(leads: Jeremy Lapedis and Robyn Rontal, CHRT)*

   This coordinated care coordination intervention serves residents with complex social and medical needs in an effort to reduce unnecessary emergency department use across the region. Potential participants are identified in two ways: provider referrals and through a predictive model. These lists are shared with the intervention hub (CHRT). After the resident consents to participating, they work with a care manager from one of eleven medical and social service agencies (called "hublets") to identify social and medical needs and set goals about how to address their needs. The assessment and care plan are stored in a shared care coordination platform that is accessible and editable by all eleven organizations.
4. **Medicaid Health Plan Coordination** *(co-chairs: Doug Strong and Paul Valenstein)*

   This group establishes protocols and shares best practices for Medicaid health plans and the LWCHIR hublets to share information to better serve mutual participants and beneficiaries.
5. **Livingston Implementation** *(co-chairs: Connie Conklin, Livingston County Community Mental Health and Dianne McCormick, Livingston County Health Department)*

   This group meets quarterly to ensure that the intervention is running smoothly in Livingston County, and to allow for discussion and elevation of community-level issues specific to Livingston.

Past WHI Projects

FUSE & Permanent Supportive Housing Pilot, 2012-2017
Lead: Aubrey Patiño, Avalon Housing
This federally-funded pilot project used a data matching process to identify individuals who were chronically homeless and frequent users of systems in order to engage and house those individuals and address their complex medical issues. More than 100 individuals secured permanent supportive housing through this project, and, overall, participants reported their health improved after being housed.

TaMMS Safety Net Mental Health, 2012-2017
Leads: Gregory Dalack, Michigan Medicine and Marcia Valenstein, Michigan Medicine and VA Ann Arbor Healthcare System
The Tailored Mental Health Management and Support (TaMMS) project implemented the well-established collaborative care model into safety net primary care clinics for the first time. The program screened patients for depression and anxiety and monitors the self-reported symptoms of participants. If symptoms worsened, care managers and psychiatrists increased therapies to the patients' needs, including through in-person and telemedicine interactions. During the pilot period, there was a statistically significant decrease in participant symptoms. The program is now being replicated throughout the IHA and Michigan Medicine systems.

Detox Protocol, 2011-2013
Lead: Marci Scalera, Community Mental Health Partnership of Southeast Michigan
To address the bottleneck of initial referrals for medically-supported detoxification services across Washtenaw County, leaders from the core substance use treatment provider organizations established a community-wide protocol for referring and enrolling residents in care.

2016 Mental Health Assessment
Lead: Nancy Baum, CHRT
A system scan of mental health and substance use treatment providers and services was conducted to identify what system gaps existed. This assessment informed the work of the Community Mental Health Advisory Committee, which established recommendations for use of the mental health-designated funds from the 2017 Public Safety & Mental Health millage in Washtenaw County.

Primary Care Capacity, 2011-2015
Lead: Tom Biggs
After the Affordable Care Act passed in 2010, local safety net clinics were unsure of their capacity to meet the needs of the local population with a much higher insurance rate. The group projected more than 35,000 additional primary care visits would result from the newly insured, and recommended that 7-11 additional primary care providers be hired over time at the six participating safety net clinics. In 2014, four new providers were hired into safety net practices. In 2015, the safety net practices reported that they were meeting the increased demand.

Safety Net Clinic Coordination, 2014-2017
Lead: Brandie Hagaman, Washtenaw County Community Mental Health and Mark Jacoby, Packard Health
After addressing the initial primary care capacity issue, the safety net clinics worked together to identify other top issues they all faced. The group agreed that the top issue was mild and

moderate mental illness, and the group then merged with the WHI Mental Health Working Group.

Blue Cross Complete Pilot, 2013-2014
Lead: Ruth Kraut, Washtenaw Health Plan
This pilot program employed community health advocates (CHAs) to contact newly enrolled BCC members and members with gaps in care, increase the use of preventive services, and increase the number of new BCC enrollees completing their first primary care appointment within 60 days. Of the 1,052 patients eligible for the program, 34% had a primary care appointment within the 60-day window. Participating patients reported strong connections to the CHAs because CHAs were fellow community members. Pilot site staff reported that the CHAs reduced their work load.

Acute Dental Care, 2013-2016
Leads: Ruth Kraut, Washtenaw Health Plan and Bonita Neighbors, Community Dental Center
employed a new referral process from each local emergency department to the Community Dental Center to provide patients with treatment for dental abscesses. During its duration, 232 patients were referred to the CDC, and 167 patients completed treatment for abscesses and other issues. Sixty-two percent of patients' treatment was covered by program funds; 20% by Medicaid, and the remainder by other coverage.

Reduced Fee Dental, 2012-2014
Lead: Ruth Kraut, Washtenaw Health Plan
In this program, over 100 patients without dental coverage directly paid participating dentists a reduced fee that was based on the patients' income.

2015 Dental Assessment
Lead: Ruth Kraut, Washtenaw Health Plan
Key findings from the assessment included that access to dental care for low-income populations improved, particularly because of the expansion of Healthy Kids Dental for children, the Healthy Michigan Plan Medicaid expansion for adults, and the new Washtenaw County Dental Clinic. However, access issues continue to exist for specific populations, particularly for adult populations between 138 - 200 percent of the federal poverty level (FPL), low-income senior citizens, and individuals who don't speak English well.

Co-Located Enrollment, 2012-2015
Lead: Krista Nordberg, Washtenaw Health Plan
Enrollment staff from the Washtenaw office of the Michigan Department of Health and Human Services were co-located in the offices of the Washtenaw Health Plan (WHP), which allowed for quick troubleshooting of enrollment and redetermination activity conducted by WHP staff. The project incurred no additional cost, but allowed hundreds of questions to be answered by MDHHS staff in real time, rather than waiting for MDHHS case workers to call WHP staff back with responses.