Washtenaw Health Initiative

Steering Committee Meeting – June 2, 2014
10:00 a.m. – 11:30 a.m.

CHRT Board Room
2929 Plymouth Rd, Suite 245
Ann Arbor, MI 48105-3206

5 min.	Welcome & Introductions	Marianne Udow-Phillips
55 min.	Future Direction of the WHI *(Attachment A)* • SIM Grant Opportunity and the WHI • Washtenaw County Public Health and the WHI	• Carrie Rheingans • Ellen Rabinowitz
5 min.	Planning Group Preparations *(Attachment B)*	All
10 min.	Reduced Fee Dental Initiative Evaluation Results and Next Steps *(Attachment C)*	Ruth Kraut
10 min.	Blue Cross Complete Pilot Update *(Attachment D)*	Ruth Kraut
5 min.	Funding & Other Meetings	All

Additional Information: Dial – In 605-475-6700, access code: 3749068

Steering Committee Participants:
Rob Casalou
Nancy Graebner
Leo Greenstone
Robert Guenzel
Norman Herbert
Peter Jacobson
Robert Laverty
Eric Kurtz
Robert McDivitt *(unable to attend)*
Ellen Rabinowitz
Pam Smith
Doug Strong
Marianne Udow-Phillips
Brent Williams

Work Group Chairs:
Tom Biggs
Liz Conlin
Gregory Dalack
Deb Jackson
Ruth Kraut
Marcia Valenstein

Guests:
Bob Gillett

CHRT Staff:
Nancy Baum
Theresa Dreyer
Patrice Eller
Ezinne Ndukwe
Claire Peters
Carrie Rheingans
Melissa Riba
Erin Shigekawa
Josh Traylor

**see attached for project status reports (Attachment E)*

Next Steering Committee Meeting: July 10, 2014, 2:00 – 3:30 p.m.

REINVENTING MICHIGAN'S HEALTH CARE SYSTEM
Blueprint for Health Innovation

DESIRED CHARACTERISTICS OF TEST REGION

The State of Michigan proposes a three-year test of the *Blueprint for Health Innovation* and is seeking a Model Test Funding Award from the Center for Medicare and Medicaid Innovation to conduct test pilots in two or three regions in Michigan. A 'test region' can be defined by locally meaningful geographical boundaries characterized by broad stakeholder engagement, a commitment to innovation in health system redesign, and capacity to test the Blueprint for Health Innovation, which includes the following elements: 1) patient centered medical homes, 2) Accountable Systems of Care, 3) new payment models, and 4) Community Health Innovation Regions.

The State will be considering the following in selecting test regions:

Characteristics of the Population and Region

1. Broad stakeholder commitment to improve care delivery and population health outcomes (including purchaser, payers, providers, health system/hospital(s), public health, local government, community partners, and philanthropy)
2. Stakeholders are willing to work with the State to reduce administrative complexity, participate in health information exchange, implement learning systems, and develop a core set of performance measures
3. Demonstrated need for improved population health in the test region

Patient Centered Medical Homes

1. Sufficient number of designated patient centered medical homes with a commitment to ongoing practice transformation (through Michigan Primary Care Transformation program or Michigan Quality Improvement Network)
2. Sufficient access for Medicaid and uninsured to primary care/patient centered medical homes

Accountable Systems of Care

1. Capacity to participate in new payment models (see below)
    a. Defined patient population is large enough to spread financial risk and assess performance outcomes
    b. Mechanisms in place to monitor and address population health, manage utilization, engage and monitor providers and make payments
2. Commitment and capacity to achieve high quality standards through coordinated care and improved care management systems, focused on complex care populations
3. Adequate network of providers to meet health care needs with linkages to behavioral health and community services providers that address social determinants of health
4. Robust health information exchange with ability to share relevant information across systems and collect, analyze, and report performance measures in a timely manner

Payment Models

1. Payers willing to participate in new payment models and contract with Accountable Systems of Care that are able and willing to manage performance risk
    a. Level I: Shared savings, no downside risk
    b. Level II: Partial capitation and/or condition-specific global capitation
2. Self-insured employers willing to participate in the new payment models (if applicable)

Community Health Innovation Regions

1. Broad stakeholder commitment to a collective impact model to improve population health with demonstrated support from local stakeholders, potentially including: health systems, community organizations and service providers, payers, employers, behavioral health, public health
2. Stakeholder consensus on which entity(ies) should serve as a 'backbone organization' providing administration, facilitation, and data/monitoring services
3. Experience with collaborative community projects
4. Innovations in community data sharing

WASHTENAW HEALTH INITIATIVE

WHI Alignment with the State Innovation Model

Michigan's Blueprint for Health Innovation

The Centers for Medicare and Medicaid Services (CMS) funded the Michigan Department of Community Health (MDCH) in February 2013 to create a statewide plan to innovate the health system across the state. This State Innovation Model (SIM) Design initiative resulted in Michigan's Blueprint for Health Innovation, which was submitted to CMS in early 2014.

The SIM has five foundational components:

1. Patient Centered Medical Homes (PCMH) – providing access to high-quality primary care
2. Accountable Systems of Care (ASC) – responsible for improving systems of care to ensure delivery of the right care, by the right provider, at the right time, and in the right place, analogous to Medicare's Accountable Care Organization (ACO) and Blue Cross Blue Shield of Michigan's (BCBSM) Organized System of Care (OSC) models
3. Community Health Innovation Region (CHIR) – building capacity within a community to improve overall population health, supported by a Backbone Organization in each region
4. Payment Reform – payers committed to paying for value rather than paying for volume
5. Infrastructure Support – facilitating system improvements to reduce administrative and delivery system complexity, as well as governing and implementing the Blueprint across the state

Given federal funding restrictions, it is possible that Michigan will not receive federal funding to implement the Blueprint for Health Innovation. In such a case, the MDCH would still like to implement aspects of the foundational components in a limited number of testing locations across the state. Washtenaw County is well-situated to become a testing location, since many of the foundational components are represented in the county already:

1. PCMH – most primary care practices in Washtenaw County have been designated as patient centered medical homes, and many are participating in the Michigan Primary Care Transformation federal demonstration project (MiPCT)
2. ASC – Washtenaw County already has several OSCs (Huron Valley Physician Association (HVPA), Integrated Health Associates (IHA), and the University of Michigan Faculty Group Practice (UM FGP)), and one large ACO (Physicians of Michigan ACO, or POM-ACO)
3. CHIR – the Washtenaw Health Initiative, with the support of the Center for Healthcare Research & Transformation (CHRT) covers many CHIR functions by assessing community health needs and gaps, setting strategic priorities, and developing and implementing action plans
4. Payment Reform – payers participating in the MiPCT in Washtenaw County are committed to paying for value rather than volume

The WHI is well-aligned with the proposed structure of the CHIR, as detailed below. The WHI can also be a foundation to test the CHIR concept, as well as to help other entities in the state to test these concepts. In this regard, WHI staff have developed a tool kit to help other communities in the state launch similar community wide, multi-sector health collaboratives.

Components of Michigan's SIM CHIR that the WHI already has or does

- Cross-sector partnerships
- Engage leadership in the community
- Resources contributed voluntarily
- Backbone Organization – existing neutral entity (WHI, with the support of CHRT)
- Convene stakeholders
- Conduct community health needs assessment
- Address community priorities - WHI worked with local public health department and major health systems to align priorities
- Work towards organized 'entry points' for access to community services
- Demonstrate progress towards specified outcomes
- Sustainable funding
- Alignment with other regional efforts:
    - Hospital Community Health Needs Assessments (CHNA) and implementation plans
    - Washtenaw County Public Health Department Health Improvement Plan (HIP) priorities (depression, access to coverage)
    - Washtenaw Housing Alliance objectives
    - Success by 6 objectives
- Supports relationships between healthcare and community providers
- Provides staffing to coordinate activity and monitor progress and outcomes
- Primary responsibility for quality improvement of community-based services and supports: convenes stakeholders to identify concerns and barriers, develops solutions, assesses impacts, transfers quality improvement process knowledge to community partners
- Provides input into relevant metrics for particular communities based on community priorities
- Monitors progress toward community goals, makes information available transparently

Components that the WHI does NOT currently do

- Robust health information exchange with ability to share relevant information across systems and collect, analyze, and report performance measures in a timely manner

Conclusion

The Washtenaw Health Initiative works across sectors to facilitate innovative strategies for tackling health care challenges as identified by the community partners. Through the collaborative process WHI stakeholders are better able to analyze data to better understand how health care operates at the community level, and to dig for answers to *why* things operate the way they do. With its Steering Committee and community connections, WHI members can make systemic changes that can be far-reaching.

The WHI aligns its work with the community's major health care and health improvement organizations, which allows for everyone's outcomes to be enhanced and community-driven. The WHI's neutrality as a non-patient serving entity and its dedicated staff time—as well as staff's technical support with data and policy analysis—are crucial to the success of the Washtenaw Health Initiative. All these factors combine to demonstrate that the Washtenaw Health Initiative, with the support of CHRT, is well-suited to serve as a Backbone Organization for a regional CHIR under Michigan's State Innovation Model.

FUNCTIONS OF PUBLIC HEALTH

Public health as a discipline exists to prevent disease, promote health and prolong life among the population as a whole. The aim is to provide conditions in which people can be healthy, and the focus is on our entire population, rather than on individual patients or diseases.

Washtenaw County Public Health's Mission, Vision, and Values

Mission

To assure, in partnership with the community, the conditions necessary for people to live healthy lives through prevention and protection programs.

Vision

A healthy community in which every resident enjoys the best possible state of health and well-being.

Values

- We will **emphasize prevention** to keep our community healthy and safe.
- We will lead the development of effective **public health interventions** in partnership with the community.
- We will **promote social justice and reduce inequalities** affecting the health of all in Washtenaw County.
- We will abide by **ethical principles, take responsibility** for our commitments and use our resources wisely.

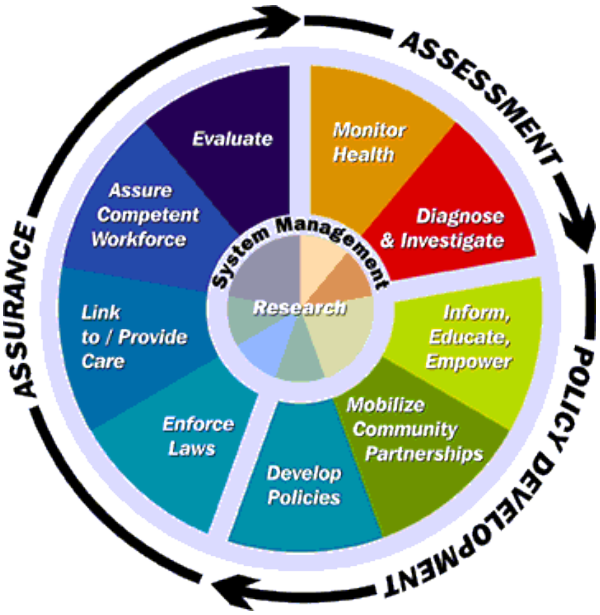
The 3 Core Functions and 10 Essential Public Health Services

The 3 Core Functions and 10 Essential Public Health Services[1] describe the public health activities that healthy communities require.

The unique role of local public health is to perform core functions (assessment, policy development and assurance) and deliver the Essential Public Health Services in partnership with the community.

These functions and services are the foundation of all of Washtenaw County Public Health's (WCPH) work.

Local health departments in Michigan are governmental entities with a legal responsibility to assure the public's health, (Michigan Public Health Code, Public Act 368 of 1978). No other entity assesses threats to the community from communicable and chronic diseases, poor access to health care or health promotion practices or failure to protect the environment.



[1] Core Public Health Functions Steering Committee. *Public Health in America*. Washington, DC: The National Academies Press, 1994.

Assessment and Planning: Health Improvement Plan of Washtenaw County

Community assessment is a core function of local public health and provides a solid foundation for developing a shared countywide Community Health Improvement Plan.

WCPH's local Health Improvement Plan, or HIP, partnership was established in 1995 with the University of Michigan Health System, Chelsea Community Hospital and Saint Joseph Mercy Health System. The HIP partnership assesses health in Washtenaw County and guides partners through a collaborative health improvement planning process. The partnership has three committees with over 300 representatives monitoring progress.

The 3-pillar framework developed – ***"Partnerships, Data, and Evidence-Based Strategies"*** – helps ensure that population health data are collected and analyzed, needs prioritized, and issues addressed in a cost-effective and collaborative manner.

HIP has the following **Strategic Goals**:

Partnerships

- Grow partnerships across sectors and disciplines.

Data

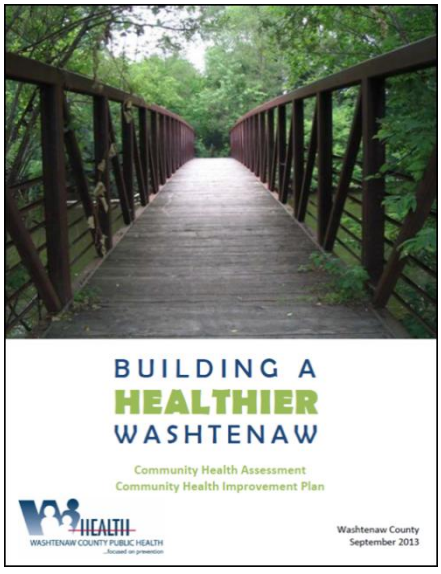
- Collect, analyze, and disseminate data on health factors, outcomes, and disparities in Washtenaw County.
- Establish long term health objectives and monitor progress.

Evidence-Based Strategies

- Increase understanding of evidence-based strategies.
- Increase understanding of policy and environmental approaches.
- Further address social determinants of health, social justice, and health equity.
- Develop, implement, and monitor shared countywide health improvement plan.

In the fall of 2013, HIP published the "**Building a Healthier Washtenaw: Community Health Assessment and Community Improvement Plan.**" "Building a Healthier Washtenaw" tells the story of what our community health looks like; what resources are in place; what issues have been prioritized for action; and which community organizations are involved. Within it, the HIP partnership identifies six priority health issues and associated action plans. Progress on these six priority areas is tracked and reported annually; the entire community health assessment and improvement plan process is completed every five years.

- Access to Care
- Obesity
- Mental Health
- Substance Abuse
- Perinatal Health
- Vaccine Preventable Diseases



Policy Development

Policy development is another core function of public health. WCPH serves as a primary resource for establishing and maintaining public health policies, practices and capacity. WCPH provides information about the public health impacts of proposed and current policies, and actively engages with policy makers in the development and/or modification of policies.

Washtenaw County Public Health and Washtenaw Health Initiative

WHI complements the mission and goals of WCPH. Numerous WHI projects are focused on three of the six priority health issues identified in WCPH's Community Health Improvement Plan – access to care, mental health and substance abuse. These are health problems where clear gaps in services exist. Shared data and a common agenda on these issues increase the effectiveness of interventions in addressing these gaps. While the work of WCPH is focused on the health of the entire population, WHI focus on the low-income uninsured supports the Health Department's goals of eliminating health disparities.

One area where the WHI can continue to complement WCPH work is in the area of community health needs assessments. Through the HIP Coordinating Committee, WCPH has begun work with its hospital partners to align hospital and health department community health needs assessment. Six priority health issues were selected because they were priorities for all of the hospitals and public health. WHI support and facilitation is needed to build upon this work, to further align and ultimately, create one single, shared community health assessment. This would strengthen community focus on identified needs.

In the area of mental health and substance abuse, another common agenda item for the WHI and WCPH's Community Health Improvement Plan, the WHI could facilitate planning work with the county and other partners to support and develop an effective, adequately funded mental health and substance abuse delivery system in the county.

Overview of the WCHO and Related Service Obligations

The Washtenaw Community Health Organization (WCHO) is a multifaceted entity. It is a Community Mental Health Services Program (CMHSP) under the state Mental Health Code, the designated Substance Abuse (SA) Coordinating Agency (CA) under the Public Health Code (until 10-1-14 at which time it becomes the payer/contractor of SA services in Washtenaw County), and a creating partner of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that jointly administers specialty behavioral health services as the Medicaid Prepaid Inpatient Health Plan (PIHP) for Washtenaw, Lenawee, Livingston and Monroe counties.

THE WCHO AS A COMMUNITY MENTAL HEALTH SERVICES PROGRAM

In 2000, the Mental Health Code was amended to allow Washtenaw County and the University of Michigan to form a community mental health ***organization*** that is a public governmental entity separate from the county and the university. The WCHO as a CMHSP, is responsible for a specified array of mental health services within a defined geographic catchment area (Washtenaw County) and it is required to direct its services to individuals who are seriously mentally ill, seriously emotionally disturbed, and/or developmentally disabled. Within those priority groups, preference must be given to persons with the ***most severe forms*** of illness and/or in urgent or emergency situations. The Mental health Code mandated services are included in Attachment A.

THE WCHO AS A PROVIDER AND PARTNER OF THE CMHPSM

Besides its responsibilities as a CMHSP, the WCHO is the sole sourced behavioral health and substance abuse contractor/provider for particular Medicaid benefits included under Michigan's Medicaid specialty services waiver programs. Under these waiver programs and contract with the CMHPSM, the WCHO is responsible for the provision of a particular set of medically necessary Medicaid covered services and supports within Washtenaw County. The CMHPSM-WCHO contract is a ***defined benefit shared risk*** contract for specific individuals (Medicaid beneficiaries) who are entitled/eligible to receive particular services.

These waiver programs are aimed at the same conditions (serious mental illness/serious emotional disturbance, developmental disabilities, and substance abuse disorders) as those targeted under the Mental Health Code priority populations and federal grant requirements. The distinction, however, is that Medicaid beneficiaries with these conditions **are *entitled to particular defined benefits*,** if these benefits are determined to be "medically necessary." Unlike the Mental Health Code required services, the WCHO cannot reduce the level of services to entitled beneficiaries simply because there are unexpected increases in beneficiary demand or in the utilization of covered services; the WCHO is "at-risk" for fulfilling the duties it assumed under the Medicaid CMHPSM contract.

How the WHI Can Help the WCHO Going Forward:

- Bring together more of the Medicaid HMOs and commercial insurers that serve the county to help the WCHO:
    - identify "community" unmet need; and
    - increase clarity about what mental health and substance use benefits will be covered for both the Medicaid and the privately insured populations, and how insurers will meet parity requirements.

. Additional WCHO Information

The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:

- Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.

- Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.

- Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.

- Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.

- Recipient rights services.

- Mental health advocacy.

- Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.

- Any other service approved by the department.

- Services shall promote the best interests of the individual and shall be designed to increase independence, improve quality of life, and support community integration and inclusion. Services for children and families shall promote the best interests of the individual receiving services and shall be designed to strengthen and preserve the family unit if appropriate. The community mental health services program shall deliver services in a manner that demonstrates they are based upon recipient choice and involvement, and shall include wraparound services when appropriate.

FUNCTIONS OF WHP

The WHP strategic priorities listed here are excerpted from the WHP Strategic Plan 2012-2019. The plan, developed in consultation with our hospital partners, provides a blueprint to guide the work of the WHP into the future.

The WHP is a partnership program with strong relationships with Washtenaw County government, Saint Joseph Mercy Health System, the University of Michigan Health System, and other local health care providers. These partnerships inform all of the work of the WHP.

The work of the WHP has changed and grown over the years to accommodate community needs, but the mission of the organization and the commitment to expanding access has remained constant throughout. As it works to expand access, the WHP works with its members to navigate the system, to improve their experience of care, and to, ultimately, improve their health status. The WHP's investments in care management and coordination of care are mechanisms that assist the provider community in controlling costs.

WHP VISION:

A community where *all* County residents have access to the health care they need, when they need it.

WHP MISSION:

The mission of the Washtenaw Health Plan is to expand and assure access to health care and improve the health status of low-income, uninsured County residents. In partnership with local health care organizations, the WHP promotes, organizes, administers and finances programs to increase access to health care for persons unable to pay for such care. The WHP is a public-private partnership with Washtenaw County government, Saint Joseph Mercy Health System, University of Michigan Health System and other local health care providers.

The WHP uses its resources and role in the community to strengthen the local health care safety net by maximizing access to primary care for uninsured and other vulnerable Washtenaw County residents, offering essential coverage to uninsured individuals through WHP "Plan A" and "Plan B". The WHP also reinforces, expands, and works to assure the viability of safety net health care organizations providing primary care for residents facing barriers to health care.

WHP STRATEGIC PRIORITIES:

1. Increase access to health care services by managing a WHP Plan B model for uninsured County residents.

2. Assure access to appropriate services with:

    a. A public benefits outreach and advocacy program to ensure that eligible residents are enrolling in all public programs that they may be eligible for (e.g. Medicaid, Medicare, SSI, SSDI, SNAP, etc.).

    b. A care navigation and care management program for WHP members, and other low-income, uninsured residents, to ensure that they receive the services they need in the most efficient and cost effective setting.

3. Expand capacity of safety net health care partners; provide financial support through WHP safety net grant program.

4. Provide leadership in planning and coordination of safety net service delivery.

WHP and WHI:

The WHP and the WHI share a common agenda – focus on expanding access to care and coordination of care for the low-income uninsured. WHP and WHI engage together in mutually reinforcing activities to address that common agenda. The WHI support of these intiaitves enhances the day-to-day work of the WHP, strengthens community focus, and supports collective impact. Progress on these issues depends on working together toward the same goal.

The WHP serves in a primary role as the implementer of numerous WHI projects, and has also provided funding for various WHI initiatives ($525,000 earmarked).

Moving forward, the WHI could further complement the WHP mission by helping to advocate with the community for a stable, adequately funded program for persons not covered by Medicaid expansion.

WASHTENAW HEALTH INITIATIVE

Mission and Charge

WHI Mission

The mission of the Washtenaw Health Initiative is to help to improve the health of the low-income, uninsured, and Medicaid recipients in Washtenaw County by bringing together organizations to:

- Coordinate and leverage resources;
- Share information on gaps in care, opportunities to fill those gaps and organizational plans;
- Consider opportunities to work together on specific projects and/or functions; and
- Generate innovative ideas, plans and implementation approaches to improve care and access in the County

CHARGE

1. To develop a county wide strategic plan on how to **best organize and provide access to care** with a **focus on the low income population**, specifically:
    - The current Medicaid eligible population, enrolled and not enrolled
    - The current uninsured population (some eligible for Medicaid and some not)
    - The newly eligible Medicaid population, come 2014
    - Those who will remain uninsured post 2014 (principally, undocumented immigrants)
2. The plan must include the following **services scope**:
    - Access to primary care services
    - Access to specialty outpatient and inpatient care
    - Chronic care needs
    - Emergency room diversion
    - Integration of mental health, long term care, dental care, public health with the physical health/medical care system
3. The plan should reflect and describe **future organizational roles** relevant to this charge for:
    - Safety net providers in the county
    - The Washtenaw County Health Plan
    - Any connections between the newly forming ACOs/PCMH efforts in the county and the target population
    - Key public sector entities: public health and mental health
4. **Functional operational issues** should be considered such as:
    - Local roles for enrollment and eligibility
    - Relevant ACA grant opportunities available at the local level with organizational leads identified
    - Funding and structural needs necessary to carry out the county wide plan

WASHTENAW HEALTH INITIATIVE

Annual Report 2012-2013

Who We Are

The Washtenaw Health Initiative (WHI) originated in 2010 when local community leaders convened to prepare health services within the county for the full implementation of the Patient Protection and Affordable Care Act (ACA). A steering committee was formed to clarify the initiative's goals and scope, and to identify organizations and individuals to participate. Since that time, the WHI has grown into a county-wide collaboration of more than 40 provider, payer, safety net, and service organizations that have come together to improve the health of the low-income, uninsured, and Medicaid recipients in Washtenaw County, Michigan. This voluntary, non-governmental collaborative is sustained through the dedicated work of more than 160 members who are focused on identifying community health needs, emphasizing primary care over emergency care, and increasing communication in order to improve access to—and the quality of—care in the county. The goals of the WHI are to:

1. Increase and maintain insurance coverage;
2. Improve access to coordinated, integrated care, and;
3. Become a model and resource for other communities considering how best to serve the needs of their most vulnerable citizens.

The WHI has 11 community-based projects in operation to achieve these goals. The following are accomplishments from October 2012 to November 2013, organized by the goals of the WHI.

Increasing and Maintaining Insurance Coverage

With more than 25,000 uninsured Washtenaw County residents as of 2013, the WHI has prioritized increasing and maintaining health coverage. Through three projects, the WHI and its partners have increased the number of Washtenaw County residents enrolled in health coverage.

- By collaborating with more than 40 organizations and agencies, WHI-initiated projects assisted more than 3,000 Washtenaw County residents in applying for and renewing participation in state assistance programs, such as: Food Assistance, Medicaid, Child Care Assistance, State Emergency Relief and Cash Assistance.
- The WHI assisted 16 agencies to become designated by the federal government to provide hands-on enrollment assistance for consumers newly enrolling in health care coverage. This has yielded approximately 50 to 60 individuals who are trained and designated to do enrollment county-wide.

- The WHI trained more than 60 University of Michigan graduate students and community volunteers to conduct community education, outreach, and referrals among the uninsured in Washtenaw County. In just the first month, the students provided education about enrollment, as well as enrollment support and referrals, to more than 150 community members.

Improving Access to Coordinated, Integrated Care

The WHI is committed to increasing the integration and coordination of health care in the county, particularly within the areas of mental health, substance use disorders, primary care, and dental services. To this end, the WHI has:

- Helped coordinate health care providers who developed the first county-wide substance use disorder detoxification protocol and have trained staff at seven safety net clinics and two emergency departments on implementation of the new protocol.
- Worked to increase primary care capacity in safety net clinics by increasing the number of providers and the level of coordination among clinics.
    - To date, two primary care providers have been hired at Packard Health Clinic and Academic Internal Medicine. Ypsilanti Health Center is currently recruiting one primary care provider.
- Developed a Reduced Fee Dental Initiative that includes nine dentists who have treated over 75 low-income patients.

Building a Model for Community Collaboration and Planning

The accomplishments of the WHI have gained wide recognition across the county and the state of Michigan:

- Since its inception in early 2011, the WHI has more than doubled in size, from 40 members representing 20 organizations to more than 150 members from more than 40 organizations in late 2013.
- More than 70 WHI members regularly attend the quarterly, all-member meetings to share updates, network, and enhance their collaborations. These contacts have enabled the development of multi-partner “spin-off” projects, such as:
    - Implementing a screening, treatment, and referral process for substance use disorders in local safety net clinics.
    - Partnering with schools and immigrant-serving agencies to conduct targeted outreach and enrollment for Medicaid in those settings.
- The University of Michigan Health System and Saint Joseph Mercy Health System incorporated seven of the WHI’s projects into their health improvement implementation plans as models for addressing needs in access to health care

coverage, primary care capacity, and mental health and substance use disorder care.
- WHI staff provided input to the State of Michigan Department of Community Health as they developed a statewide model of integrated care.
- WHI staff met with public health leaders in Macomb and Oakland counties about replicating the WHI within their own communities. This early work has laid the groundwork for potential future partnerships.
- WHI leadership met with faith institutions in the City of Detroit and social service agencies in Ingham County to consult about coordinating Medicaid and other social service enrollment processes across these communities.
- The WHI leadership has now established relationships with each elected state official in Washtenaw County.

In addition to these accomplishments, the WHI has also:
- Coordinated with the Washtenaw County Department of Human Services, the United Way of Washtenaw County, and AmeriCorps to place workers at the Washtenaw Health Plan and Food Gatherers to increase access to state assistance programs.
- Received nearly $180,000 in funding for a program designed to improve mental health management support within the primary care setting.
- Established the CareNet, a group of more than 80 Care Managers, who meet regularly to identify shared patients, improve coordination of care and receive professional training on a variety of topics to better serve these patients.
- Convened eight organizations representing 15 safety net clinics collaborated to identify priority areas to improve operational efficiency.

Concept Paper for Countywide Planning
Health Reform and Access to Care
October 26, 2010

Background:

Washtenaw County and environs has had a longstanding dilemma of providing effective access to primary care for persons with limited financial resources and/or limited insurance. Responses to this have included establishment of various safety-net provider organizations, Washtenaw Health Plan, and other ancillary support services and organizations. However, the two major health systems continue to be providers of last resort, through their emergency rooms, for a significant number of primary care and chronic care patients. The two major heath systems have continuously provided support for the development of alternative high quality delivery programs.

With the passage of health reform, there is an expectation that a greater number of persons with limited resources will be covered by Medicaid, or other variants, increasing their potential access to care. There are other features of the reform legislation that will potentially impact the delivery of services (e.g., incentives for establishing medical homes, FQHC funding and development of accountable health organizations).

Implementation of national health care reform is scheduled for 2014. Without a well-conceived action plan that responds to the impending changes, we are likely to experience the following:

- A significant increase in demand for services by newly covered patients, overwhelming the current delivery system.
- Increased reliance on hospital emergency rooms to be providers of primary and chronic care.
- Persons newly eligible for insurance coverage (Medicaid) failing to apply or frustrated by the application process, taxing our current support systems that assist in applications for benefits.
- Some current safety net provides with focused mission and roles (e.g. The Corner, Hope, WHP) not qualifying for new types of funding.
- Lack of coordination of mental and physical health programs and funding.
- Lack of coordination among providers for developing new forms of provider organizations that can obtain advantageous funding (medical homes, accountable health organizations, FQHC).
- Absence of an established mechanism for responding to possible changes in national health care policy that will impact the development and funding of health care in our community.

Current Situation:

- There is no mechanism in Washtenaw County to develop and implement a coordinated plan for responding to national health care reform that will improve our current system of delivery of primary and chronic health care services.
- We have incredible resources in our community to enable us to develop a model plan: brainpower, community leadership, some very good safety-net providers, two strong healthcare systems, community philanthropic support, quality physician providers, WHP experience with enrollment issues, local governmental support, and a national reputation for innovation and excellence in health care.
- High level of interest among various parties to engage in this effort, subject to the participation and cooperation of the two major health systems.

Objectives:

- Enhance the access to and coordination of primary and chronic care.
- Reduce the reliance on emergency room for provision of primary care.
- Focus on enhanced support for enrollment of newly eligible persons in Medicaid or other variants
- Develop and agree on 5-10 action steps and implementation plans
- Identify funding for action steps.
- Use a focused, short, time-limited process.
- Sponsorship of this process by the two major health systems.
- Establish a mechanism for on-going planning and development as health care reform unfolds.

Agreement Reached Between Leaders of the Two Major Health Systems, Community Co-Chairs and Facilitator:

1. This is worth doing.
2. Process:
    a. Agreement on objectives of process, problem to be solved.
    b. Length of process: Perhaps six months, use steering committee between meetings of the larger group.
    c. Potential participants (see note below).
    d. Facilitator: ask Marianne Udow-Phillips.
    e. A framework for solutions should be pre-identified and this process used to confirm and modify these potential solutions and to develop action plans to implement.
    f. Establish a steering committee/technical workgroup for developing the framework and staffing between meetings of the larger group.
    g. Provide 0pportunity for obtaining community and agency input.
    h. Develop measures to assess successful implementation.
    i. Community leadership co-chairs: Bob Guenzel, Norman Herbert.
3. Personal involvement and attendance at all meetings.
4. Support from UMMC and SJMHS: Brent Williams and Lakshmi Halasyamani.
5. Willingness to do some resource allocation to some actions plans (i.e., shifting of resources to fund some new initiative that will reduce reliance on emergency rooms for primary and chronic care).
6. Next steps:
    a. Meeting with staff and facilitator to begin confirm process.
    b. Identify framework for potential solutions.
    c. Identify and plan the specifics of the process.
    d. Invite participants.
    e. Schedule meetings.

Note on possible participants:

The following is a list of possible participants in this process. The magic is to have sufficient participation to have a successful discussion and actionable plan, and yet not have a group too large to reach conclusions in a timely manner.

Participants who have committed to participate:

Community Co-Chairs: Bob Guenzel and Norman Herbert
Facilitator: Marianne Udow-Phillips - Center for Healthcare Research and Transformation
UMHS: Doug Strong, Brent Williams, M.D.
SJMHS: Rob Casalou, Lakshmi Halasyamani, M.D.

Representation from the following to be invited:

Other Community Leadership
Safety Net Clinic Representatives (Corner, Hope, Packard)
IHA
Washtenaw County Health Department and WCHO
Washtenaw Health Plan
Ann Arbor Area Community Foundation
United Way of Washtenaw County
Ypsilanti Representative
Rural Representative

WASHTENAW HEALTH INITIATIVE

WHI Planning Group
Synthesis of Top Recommendations from Group Members

Topic	Key Points	Recommendation(s) from Small Groups or Specific Individuals	Possible WHI Actions
1. Mental Health	1. General perception that services for mild/moderate population are not adequate – both coverage and availability/access. 2. Many consumers do not know where to receive services 3. Unclear what Medicaid managed care benefit will be and exactly how DCH budget will affect WCHO	1. Determine the provider capacity for mental health services in the community. 2. Ensure providers know what services are available in the community.	1. WHI work group meet more frequently, add member from Blue Cross Complete and other Medicaid health plans 2. Complete capacity analysis that is underway and make recommendations 3. CHRT staff analyze state budget to determine amounts of mental health funding 4. Finalize brief community guide to mental health services for practitioners, including what benefits are covered by Medicaid and WCHO 5. Communicate more with all WHI members about what is being done in WHI mental health group
2. Services for newly insured and remaining uninsured populations	1. The health needs of the newly insured and remaining uninsured are unclear 2. The best ways to help them navigate and connect to the system and receive appropriate care is also unclear (cultural competency and health literacy are part of this issue as are vulnerable populations such as the	1. Define the newly insured and remaining uninsured populations. 2. Determine gaps in services for these two populations to enable recommendations.	1. Create a new work group that includes all Medicaid health plans, health systems, schools (e.g., RAHS), employers, and safety net 2. Refer this to the safety net work group

	homeless)		
3. Dual Eligible Population	1. Aging population in the county presents possible issues such as coordination of care, potential service gaps, caregiver needs, etc. 2. Dual eligibles fit WHI mission most clearly. 3. Unclear what analysis has been done to date, and by whom, to determine gaps.	Need to better understand who is in the aging population and the current services; within that, define the dual-eligible population and continuum of care and service gaps within the county.	1. Determine and supplement analyses done by other organizations. Assess what plans are in place by others, especially for the dual eligible population (e.g., Area Agency on Aging, U-M Complex Care, County's Blueprint on Aging) 2. Determine gaps and next steps after this analysis is complete, including researching best practices to address this population's needs
4. WHI as an Information Source for Policymakers	There is no central, objective entity that analyzes the impacts of proposed policies (county, city, township) on health, to be used by local policymakers to make policy decisions that incorporate a consideration of health services and the social determinants of health.	1. WHI could serve to facilitate sharing of health related data, including social determinants that have an impact on health, and data from multiple sources including health systems, health researchers, policy organizations, etc. for local policymakers 2. Conduct health impact assessments for proposed or new policies in the county *Yousef Rabhi's recommendation*	1. Develop a process to collect and facilitate distribution of key data for policy makers making health-related policy decisions 2. Cultivate relationships with policy makers
5. Community Health Needs Assessment (CHNA)	Hospitals' CHNA would be more effective if planning could be done with the broader community.	WHI could assist the hospitals and health department with community engagement for a county-wide CHNA *Michael Miller's recommendation*	1. Assist all hospitals and health department with community engagement for a county-wide CHNA 2. Convene pertinent stakeholders
6. Obesity with focus on children	Obesity is a cross-cutting issue that is caused by multiple determinants, and it is difficult to know how to influence obesity rates.	With WHI's broad stakeholder input and analysis, determine what can be done to focus on the low-income population, and children in particular *Rob Casalou's recommendation*	1. Create a work group that: a. Assesses obesity among the low-income population in the county b. Develops interventions focused on that population, especially children

Themes and summary of groups attached.

WHI Planning Group Recap

From February 18, 2014 meeting

Top gaps and comments identified among twelve tables
All focus on the low-income

1. **Mental health**
    a. 11 tables noted this as an area of focus
    b. Comments
        i. General feeling that although there is much happening already around mental health (WCHO work, CSTS integrated care, WHI TaMMS project), service gaps still remain, but further current state analysis must be conducted:
            1. Is the service capacity limited for similar reasons to dental, i.e., low reimbursement?
            2. What community services are available?
            3. What do PCPs really know about what community services are available?
            4. How are services coordinated between systems (WCHO and UMHS and SJMHS and other safety net agencies)?
        ii. Need clarification about future funding
    c. Who is already working on this?
        i. WCHO, CSTS, WHI TaMMS project
    d. WHI Role(s)
        i. Data collection, analysis, projections
        ii. Convener
            1. Neutral facilitator
            2. Coordination between entities
            3. Bring in outside expertise
            4. Break down turf issues
        iii. Advocacy
            1. Track and report about policy changes in state mental health services
            2. Make recommendations to WHI member organizations about mental health policy changes
        iv. Best practices research and recommendations
2. **Newly insured and uninsured: navigating the healthcare system/understanding how to effectively connect and communicate with health care system**
    a. 8 tables listed this as an area of focus
    b. Comments
        i. Needs to include both the newly insured and the remaining uninsured
        ii. Not only focusing on how to access services after becoming newly enrolled, but also address:
            1. How patients can follow up on referrals
            2. Providers following up with patients to confirm appointments happened
            3. Educating patients about out-of-pocket expenses
            4. Transportation for appointments
            5. Coordination between providers
            6. Health literacy and cultural competency
    c. Who is already working on this?

i. Each system/organization has its own way or helping patients navigate
ii. WHP

d. WHI Role(s)
i. Convener
1. Coordination between entities
ii. Best practices research and recommendations

3. Aging population

a. 8 tables listed this as an area of focus
b. Comments
i. Further analysis needed to determine what gaps there are and what is already being done to determine appropriate WHI role. May include capacity analysis or, more in line with WHI population focus, analysis of dual eligible population (similar to primary care capacity analysis)
c. Who is already working on this?
i. Area Agency on Aging, Blueprint on Aging, United Way of Washtenaw County
d. WHI Role(s)
i. Data collection, gap analysis, projections
ii. Convener
1. Neutral facilitator
2. Coordination between entities
3. Bring in outside expertise
4. Break down turf issues
iii. Analyze policy impacts of changing state policies
iv. Best practices research and recommendations once gap analysis done

<u>Top gaps identified and described more fully by specific individuals</u>

All focus on the low-income

1. Rob Casalou – childhood obesity and the disparities in different geographic regions of the county, for example, the rates of obesity are higher in Ypsilanti ZIP codes. Addressing this issue requires multi-stakeholder involvement.
2. Martha Darling – early childhood development delivery sites could be a place to reach families for health-related activities
3. Yousef Rabhi – the WHI could serve as a body that can review proposed policies (county, city, township) to identify any health impacts that may result from them. The WHI would be a central source for objective data from multiple sources, including the health systems, which local policymakers can rely on to make policy decisions. WHI could fit that role as provider of key data and analysis of how policies could impact health. An example given was to identify what impacts to health there would be if there were changes to the county's public transit system.
4. Michael Miller – the hospitals and health department are working together to conduct one county-wide community health needs assessment. An implementation plan is also required, and the WHI could assist with facilitating and coordinating county-wide implementation of changes targeting needs that were identified in the assessment.
5. Hazelette Robinson – lack of funding for mental health services for severely mentally ill

<u>Themes</u>

1. The WHI can address disparate, fragmented systems by convening multiple organizations, conducting neutral analysis and facilitating common ground for addressing gaps.
a. Many systems could benefit from better coordination.

2. The WHI can provide organizations data and outcomes that organizations can rely to make decisions or advocate at the state level.
3. WHI as a coalition needs to have better communication with other county-wide coalitions focusing on social determinants of health (Housing Alliance, Success by 6 Great Start Collaborative, Area Agency on Aging, etc.).

Other Topics

Topics discussed, but without specific agreement

1. Health issues that are moving in the wrong direction in the data that was provided (chlamydia infection rate, teen pregnancy, infant mortality)
2. Other health issues (dental)
3. Specific populations (client perspectives, homeless, Latino, limited-English proficiency)
    a. Many of these vulnerable populations are included in the recommendation to focus on the newly insured and the remaining uninsured
4. Social needs (transportation, housing)
    a. Some tables discussed the social determinants of health, and these issues are incorporated into some of the top recommendations from the meeting

WASHTENAW HEALTH INITIATIVE

Planning Group Agenda

Wednesday, June 4
12:30 pm – 1:00 pm: Informal Networking
1:00 pm – 3:00 pm (meeting will start promptly at 1:00)
Kensington Court, 610 Hilton Blvd. Ann Arbor

1) **Welcome** – Norman Herbert 5 minutes

2) **Brief Report Back from February 18 Planning Group** – Norman Herbert 10 minutes

3) **Mental Health Care Delivery System and Capacity** 30 minutes
   – Brent Williams and Eric Kurtz

4) **WHI Mental Health & Substance Use Disorder Work Group Updates** 30 minutes
   a) **Capacity assessments** – Nancy Baum
   b) **Tailored Mental Health Management Support for Primary Care** (TaMMS) – Karla Metzger
   c) **Frequent Users Systems Engagement** (FUSE) – Laurie Ingram
   d) **Opioid Project** – Adreanne Waller

5) **Washtenaw Health Plan** – Ellen Rabinowitz 30 minutes
   a) Project Updates
      i) Reduced Fee Dental Initiative
      ii) Blue Cross Complete Pilot

6) **Washtenaw County Public Health Department** – Ellen Rabinowitz 10 minutes

7) **Wrap up, Next Steps** – Marianne Udow-Phillips 5 minutes

Next Planning Group meeting: September 2, 2014, 1:00 p.m. – 3:00 p.m.

Reduced Fee Dental Initiative Evaluation Report

Ruth Kraut, WHP Program Administrator

May 27, 2014

Beginning in 2012, the WHP agreed to take on the development of a Reduced Fee Dental Initiative. This initiative was a direct result of discussions that took place as part of the WHI Planning sub-groups. The Oral Health group had identified adult dental care as a critical need, and the fact that because of Delta Dental contracts, many dentists could not lower fees for low-income adults as an impediment. Dr. Steve Stefanac of the UM Dental School spoke to Delta Dental about the idea of a pilot program in Washtenaw County where low-income adults would be charged less for dental care, and they agreed.

Recruitment of dentists and agreement on what the reduced fees should be took several months, and the first patient was enrolled in July 2012. The fees were set in two tiers, based on income levels, at 60% and 90% of the 2012 Delta Dental reimbursal rates for dentists. By 2014, there were six practices with nine dentists participating. All of them were general dentists.

Volume

As of May 2014, 90 people have been enrolled in the program directly by WHP staff. For every person who was enrolled in the program, approximately two people were turned away. Many people were referred to Barrier Busters' Emergency Dental program (another program the WHP Board has supported financially) because they had an emergent need. Others were turned away because they didn't have any income and could not afford even reduced payments. In addition, Dr. Bonita Neighbors at Community Dental Clinic has separately enrolled approximately another 20 people as direct enrollments. A couple of the other dentists have referred clients for us to enroll.

Evaluation

Approximately half of the people who were enrolled in 2012 or 2013 were reached by telephone.

Good News: For those who used the program, most of them had 2-3 visits. Generally, they felt quite positive about the care that the dentists gave them. Many of these respondents said that they would no longer be using the program because they expected to be eligible for the Medicaid expansion. The biggest complaint from the people who used the program was that they were unable to get specialty care (oral surgery and root canals) and that, even though the prices were reduced, it wasn't feasible to pay for more than cleanings or the occasional filling.

Disappointing News: Of those reached, half of them never used the program. Reasons given for not using the program were: income too low (in some cases, now eligible for Medicaid); moved out of town; got a job that offered dental coverage.

Summary

This is very much a niche program for people who have some money but not very much money. The "sweet spot" for income-eligible people is fairly small (toward the top of the Tier 1 range). It was fairly difficult to recruit dentists but the dentists that we have had in the program have been excellent and engaged.

The adoption of Medicaid expansion and the development of the Washtenaw County Dental Clinic may make this program obsolete, and it has not had the hoped-for reach—but it has been useful and appreciated by those who used it.

Recommendation

Phase out this project when the Washtenaw County Public Health Dental Clinic opens. The county-owned dental clinic will serve all individuals who are uninsured or have Medicaid, up to 200% of the poverty level. They will offer reduced fees to those uninsured that should approximately match the reduced fee rates. In addition, the Healthy Michigan Plan offers an enhanced dental reimbursement to private dentists who choose to accept Medicaid.

The first "scan" that the WHI Oral Health Working Group did was foundational to the work of the Reduced Fee Dental Initiative and the development of the Acute Dental project. Given the changes in the oral health landscape in the last three years, it would be work repeating this scan and identifying remaining gaps in care.

May 27, 2014

Update on the Blue Cross Complete Pilot Project: Community Health Advocates-Enhancing Use of Primary Care and Addressing Social Determinants of Health

Ruth Kraut, WHP Program Administrator

The WHP has been the Project Manager for the Blue Cross Complete Pilot Program intervention, *Community Health Advocates—Enhancing Use of Primary Care and Addressing Social Determinants of Health*, which arose from a series of discussions at the primary care outreach/care management WHI subcommittee, and has been funded with $33,000 from Blue Cross Complete. As of May 2014, the pilot is operating at the Packard Health Clinic with three community health advocates, and is expected to run through the end of 2014.

The program has been coordinated by a Leadership Team, which has included:

Ruth Kraut and Ellen Rabinowitz from the WHP
Charles Wilson and Sharon Sheldon from the Washtenaw County Public Health Department
Juliette Marvin from Blue Care Network
Huda Fadel from Blue Cross Blue Shield Social Mission
Melissa Riba and Ezinne Ndukwe from CHRT
Julie Wood (and formerly, Ann Schafenacker), from Packard Health (2nd year of project)
Tricia Campbell from Ypsilanti Health Center (1st year of project)

The program was initially conceived as a way to address an identified need—that new Medicaid enrollees frequently do not establish timely care with a PCP—using the support of Community Health Advocates (Workers) who would be able to offer support and services that would make accessing primary care easier, including access to social services and transportation, and assistance with the scheduling of appointments. The initial impetus for the project was also the knowledge that many individuals who have not established care with a PCP will turn to the Emergency Department for general health care. The initial location was the Ypsilanti Health Center. Challenges arose due to the fact that many individuals who were believed to have never accessed primary care in fact had a prior history of care in the UM health system.

However, the work of the CHAs was well-received and so the focus turned to restructuring the project, ultimately at Packard Health. Currently, the focus of the pilot is two-fold: scheduling new BCC members who have not established care at Packard Health, and scheduling patients who have gaps in care. The CHAs are trained to offer assistance for transportation or other necessary social services that may prevent access to care.

History:

1. The initial location chosen was the Ypsilanti Health Center, which has a high volume of new Medicaid enrollees. Blue Cross Complete offered funding; the WHP offered project management; the Public Health Department offered community health advocates; the Ypsilanti Health Center offered space; and CHRT offered evaluation services.

2. Implementation began in 2012. CHAs were chosen and trained extensively on resources, social services, and telephone protocols. They also shadowed YHC staff to understand YHC's systems. Shortly after the project began we identified unexpected challenges:
   a. The records on which the assumption was made, that the majority of new BCC members had never been to that PCP site (or at least not for two years)—was faulty. BCC data did not allow us to see utilization of other systems. So, for example, if the patient was new to BCC but had previously been a WHP patient assigned to Ypsilanti Health Center, BCC identified that patient as "new, never seen" but YHC identified that patient as "established."
   b. Many phone numbers were missing from the Medicaid records, and in addition many of the phone numbers identified families—so 20 new members might actually mean 7 phone calls. The volume did not give the CHAs enough work, although YHC staff thought highly of the CHAs' work.
   c. Other issues included the fact that YHC had other staff who were working on similar lists for other projects; the transition to a new EHR and phone system added complications; and YHC ran out of space for the project due to the addition of new YHC staff.
   d. In early 2013 we "paused" the project, and updated the WHI Steering Committee in March of 2013.

3. We began looking for another space, and also worked with Blue Cross Complete to identify what would be meaningful work for the CHAs. We worked with BCC to revamp the project.
   a. We approached Packard Health in the late summer of 2013, and they were receptive to placing CHAs there.
   b. We identified that there were not enough new members at Packard Health to make outreach to new members the only focus of the project.
   c. The scope of work was then expanded. We identified BCC's "gaps in care" list as a meaningful one for the CHAs to tackle. They have also been able to look up visit histories and see notes that may identify social service needs, as well as directly schedule patients.
   d. The evaluation has been completely revamped to look at differences in scheduling and results for gaps in care, and de-emphasizing social service needs. The original focus is very different from the current focus. Both may have value.

4. Other notes:
   a. The project was originally scheduled to take a year, with a completion date of December 2013. It was run at YHC for approximately 3 months, and will be run at Packard Health for approximately a year, but there was a gap of more than six months between the two

locations while we tried to figure out how to revamp the project. The current completion date is now December 2014.

b. The work of the CHAs has been fairly smooth, in large part due to the (uncompensated) on-site supervision of administrative support staff at both YHC and Packard Health.

SUMMARY:

Between November 2013 and April 2014, the CHAs reviewed over 700 individuals who were on the "new members" list, the "gaps in care" list, or both. The vast majority of individuals had either had recent appointments at Packard Health or were scheduled for upcoming appointments.

CHAs called anybody who had not had a recent appointment, which turned out to be about 10% of the population. They have been able to schedule nearly all of these individuals for appointments.

Two things account for the fact that most people had already had appointments either recently, or scheduled in the near future:

1. The CHAs receive a list of newly-enrolled members, and members with gaps in care, from Blue Cross Complete. In most cases there is a lag of a few months before new Medicaid enrollees are assigned to BCC. Before that, they are fee for service Medicaid clients and may have used Packard as their provider—and even before that, many of them were WHP members or had private insurance and used Packard Health. BCC is unable to see any of that prior data but when the CHAs look in the Packard records they can identify them as having already been seen.

2. The vast number of people who already had a relationship with Packard can be explained by the fact that many of the new members have been either people with chronic health conditions who were enrolled in the WHP, or young children (ages 0-5) who established care at Packard while they had fee-for-service Medicaid.

As the Healthy Michigan Plan implementation continues, we expect to see a reduction in the number of patients who already have a relationship with Packard, and we believe that we will gain new understandings about the new enrollees in the Healthy Michigan Plan, which will be worth sharing with both BCC and the State of Michigan. The extension of the project through 2014 will allow us to understand the changes better.

WASHTENAW HEALTH INITIATIVE

Project Status Reports – June 2014

Project	Status – June 2014
Primary Care Work Group	
1. **Primary Care Capacity**	• Each clinic has trained staff that assist patients with navigating the new application processes for the Medicaid Healthy Michigan Plan and some on the Health Insurance Marketplace. • Group members continue to monitor patient numbers in relation to new enrollments in each of their safety net clinics. Anecdotally, there is nothing yet to report. The formal evaluation will be conducted in 3Q14, to allow time to hire additional PCPs as identified.
2. **Safety Net Clinic Coordination**	• Patient advocate sustainability is becoming a bigger issue with Packard's loss of grant funding. • Sharing best practices for revenue cycle management within safety net clinics. • Lots of interest in strategies to sustain integrated care model at safety net sites, exploring funding strategies.
Mental Health and Substance Use Disorder Work Group	
3. **Detox Protocol**	No change since previous status report as the project's lead, Marci Scalera, is out on long-term medical leave. Thus, the evaluation of the protocol's use and effectiveness will begin in late spring or early summer.
4. **Opioid Project**	• The group released a press release on Friday, May 23 to inform the public about local usage rates and overdoses, evidence based interventions recommended and the collaboration of the WHI Opioid Project. Local media coverage: WEMU, AA Journal, AA News • The group is reaching out to community members and organizations to invite broader participation to further unify and strengthen leadership and approach. • Opioid project continues to collect data on opiate-related mortality, emergency department and treatment admissions, local prescribing patterns, arrests, adult and middle and high school youth abuse.
5. **TaMMS** (Tailored Mental Health Management Support for Primary Care)	• Research Assistant/Patient Enrollment Specialist has been hired for the overall TaMMS project. • Packard Clinic updates: First Care Manager hired and is cross-training. Clinical programming to begin end of June. Pre-implementation baseline evaluation has begun; implementation to begin in late June. • St. Joe AIM clinic updates: Patient participant identification underway.

6. **FUSE**	• 56 people are housed, and a total of 65 are in active case management • Recently awarded just over $50,000 in Coordinated Funding
7. **Mild/Mod Assessment**	Data collection is underway at community primary care safety net clinics in Washtenaw County to measure mental health/substance use clinic visits and provider capacity for individuals with mild/moderate mental illness.
8. **CMH Patients Current State**	Brent Williams is working with new CHRT Fellow, Andrew Jessmore as of May 28 (Andrew's starting date with CHRT).
Medicaid & Insurance Exchange Outreach & Enrollment Work Group	
9. **Enrollment Outreach & Education Coordination**	• Ruth Kraut and Krista Nordberg have done a total of 3 county-wide trainings on the new Healthy Michigan Plan (expanded Medicaid) with a total of approximately 180 attendees representing organizations that do enrollment in the community, such as health systems, community safety net clinics, and social service agencies. • Community Resource Navigators, Michael and Will, continue outreach efforts in Saline, Manchester, Chelsea, Dexter, Washtenaw Community College, Eastern Michigan University, Parkridge Community Center, and Hope Medical Clinic.
10. **Coordination and Support of Enrollment**	• The group focused on problem solving strategies at their May meeting, as there have been difficulties with some people obtaining the coverage for which they are eligible. • Community Resource Navigators, Michael and Will, continue outreach/enrollment efforts and have another training scheduled for June 3, 2014 for those who conduct enrollment in the community.
11. **DHS Co-Location**	While no DHS workers are co-located elsewhere, 1 DHS worker has been assigned to troubleshoot problems for Medicaid/Healthy Michigan Plan applicants with emergency needs and is stationed at DHS.
Community Outreach & Dental Services Work Group	
12. **Blue Cross Complete**	Given the changes in the program being described to Steering Committee during June 2 meeting), the group is in the process of reconstructing the evaluation and the CHAs are collaborating to merge two lists that reflect new members and members with gaps in care, to contact those individuals who have yet to be contacted for either purpose.
13. **Care Net**	Two trainings offered in May: 1) "Everything You Wanted to Know About Medicaid Expansion But Were Afraid To Ask" on May 7th with over 30 people attending; and 2) new case manager training on May 6th with over 40 people attending.
14. **Acute Dental Pilot**	• 186 referrals to date (43 new referrals since the May update) from area emergency departments to the Community Dental Center. • 64 patients (21 since May) have completed treatment since the referral program began October 1, 2013, which

	often includes multiple appointments.
15. **Reduced Fee Dental Initiative**	110 total patients were enrolled in the pilot period covering July 2012 – May 2014 (90 enrolled through WHP, 20 through the Community Dental Center). Ruth Kraut is providing final program evaluation and recommendations at June 2 Steering Committee.
Unassigned	
16. **Hospice Care**	• The group is conducting an assessment of end-of-life care in Washtenaw County, a process flow for starting hospice care from the health system perspective, and a brief overview of best practices for end-of-life care (e.g., Gundersen model) to use as a guide for developing recommendations for improving end-of-life care in the community. • Additional community members are being recruited to join this project including clinicians and representatives from Blue Cross Blue Shield of Michigan and the Michigan Primary Care Transformation Project (MiPCT).