Washtenaw Health Initiative

Steering Committee Meeting – September 15, 2014
2:00 p.m. – 3:30 p.m.

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

5 min.	Welcome	Marianne Udow-Phillips
15 min.	Review Meeting Materials	Marianne Udow-Phillips
70 min.	Discussion	Bob Guenzel, Norman Herbert

Additional Information (**notify us in advance if calling in**): Call: 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 *(unable to attend)*
Robert McDivitt
Ellen Rabinowitz
Pam Smith
Doug Strong
Marianne Udow-Phillips
Brent Williams

Work Group Chairs:
Tom Biggs *(unable to attend)*
Liz Conlin
Gregory Dalack
Ruth Kraut
Marcia Valenstein

Guests:
Jack Billi *(unable to attend)*
Tony Denton
Bob Gillett *(unable to attend)*

CHRT Staff:
Nancy Baum
Theresa Dreyer
Patrice Eller
Josh Fangmeier
Andrew Jessmore
Ezinne Ndukwe
Claire Peters
Carrie Rheingans
Melissa Riba
Erin Shigekawa
Mary Smiley

**project status reports will be sent separately*

Next Steering Committee Meeting: October 3, 2014, 3:00 – 4:30 p.m.

WASHTENAW HEALTH INITIATIVE

Steering Committee Meeting Materials

September 15, 2014

Future Direction of the WHI: CHRT Staff Recommendations

Introduction

Over the past six months, the WHI Steering Committee has heard perspectives on future directions from the WHI planning group along with leaders of key health care groups that have had a major role in the WHI and/or that have provided funding to the WHI. A consistent message has emerged from these conversations along with the evaluations that have been done of the WHI over the past two years: the participants and community leaders find the WHI to be valuable and to provide something that no other entity currently does in Washtenaw County. As the Steering Committee considers the future direction of the WHI, it is important to understand where that value lies and what the best niche is for the WHI as we move beyond the initial launch of the major coverage provisions of the ACA. This memo provides the CHRT staff view on these points and makes specific recommendations for going forward.

Background

When the WHI was launched at the end of 2010, there was a natural "burning platform" that was evident: the ACA had recently been enacted and the major coverage provisions were scheduled to take effect less than four years later. Based on what had happened with the precursor to the ACA in Massachusetts, it was apparent to local health leaders that the county would need some lead time to plan and be prepared for the launch of these coverage provisions. As a result, the WHI was formed. While WHI leadership always talked about the WHI as being necessary even if there was no ACA (particularly given the legal challenges that led up to the Supreme Court decision in June of 2012), the ACA was clearly the motivation for the relatively quick movement to form work groups and get projects moving within the WHI.

The ACA's coverage provisions were primarily oriented towards expanding coverage to the uninsured though the health insurance exchanges for the moderate to low income population and through Medicaid for the population below 138% of poverty. As a result, that focus became the target population to be addressed by the WHI as well.

Since the launch of the WHI, 16 of projects have been undertaken across the county addressing primary care, mental health and substance use, dental care, care coordination, safety net providers and enrollment and eligibility in Medicaid and the exchange. These initiatives have been directed at more than 50,000 County residents.

September 2, 2014

WHI Future Direction

The first open enrollment in the ACA exchange population was completed in March, and ACA related Medicaid enrollment (Healthy Michigan Plan) launched in April 2014. With this first phase of the ACA coming to a close this year, the question has been raised as to whether or not the WHI continues to be needed. In order to provide input to the Steering Committee, feedback was solicited from the Planning Group in February of 2014 and various other stakeholder groups over the several months from March through July of 2014. These feedback sessions combined with the earlier evaluations that have been done of the WHI have provided some consistent messages. Specifically:

1. There has been uniform agreement that participants in the WHI would like it to continue.
2. There has been consensus that the WHI provides a unique role in the community that is not currently otherwise provided by another entity.
3. The WHI is particularly valued for providing:
    - The one place in the community where cross organization and cross sector health care leadership comes together to discuss major health issues in the community;
    - A voluntary, community wide focus on planning and strategic thinking about the needs of the county with regard to health, social supports and medical care;
    - An opportunity for key health leaders (in particular, the three health system CEOs) to hear about major health and care priorities of key stakeholders in the community and where action can be taken to be responsive to these priorities;
    - A neutral setting for critical issues to be addressed by interested parties on a voluntary basis in a facilitated process;
    - Data, information, policy analysis, and technical support to help provide an understanding of major health trends in the community, statewide and nationally.

Focus Going Forward

While the ACA was the impetus for the launch of the WHI, the completion of the first year enrollment does not signal the end to the challenges and opportunities presented by the ACA. Indeed, the availability of demonstration projects and new strategies designed to transform health care at the state and local level (e.g. the SIM grant, various components of the Healthy Michigan program and other grant opportunities in the ACA) along with initiatives to reduce the cost of care are likely to only increase over the foreseeable future creating both considerable opportunities for innovation and pressures on the entire system to respond relatively quickly and effectively. Indeed, unanticipated events such as the challenges currently by faced by the VA underline the value of having a group of community leaders already formed and working together to be able to provide local solutions to significant cross sector health issues. While these new challenges and opportunities presented by the ACA specifically and health care reform more generally do not provide the single point-in-time-date-certain burning platform that was provided by the start of the coverage expansion on January 2014, they do mean that having a group like the WHI will be extremely valuable in the county for the foreseeable future.

Recommendations

In light of these observations and the feedback from others, staff proposes that the WHI continue with a slightly modified scope and mission to reflect on what is uniquely provided by the WHI and to take into account the likely future direction of health care reform. Specifically, we recommend that:

1. The WHI continue as a voluntary, informal effort largely as it is currently structured;
2. The projects undertaken by the WHI have all of the following features:
    - Be health/medical care related initiatives;
    - Have a primary need for planning/strategic direction;
    - Require a multi-organization and often but not exclusively, cross sector effort;
    - Are not already being undertaken by another entity in the community and/or do not have a natural home with another organization in the community.
3. The target population to be served by the WHI be broadened to encompass any population that would benefit from an initiative that would meet the criteria in 2 above. The low income and uninsured population should, however, continue to be a priority population;
4. Key roles to be provided by the various involved entities would be:
    - The Steering Committee: strategic oversight and prioritization of projects and help with funding, as well the ability to respond quickly to major cross sector changes in the health care environment;
    - The Planning Group: information and best practices sharing along with surfacing new project ideas for consideration by the Steering Committee;
    - CHRT staff, on behalf of the WHI: facilitation of the steering committee and the planning group, data and information gathering and evaluation, policy analysis, and technical support. Staff support for the initiative groups through the planning and strategy development phase;
    - WHI member entities: the leadership, facilitation and implementation of initiatives developed through the WHI planning process;
5. Membership to the Steering Committee should be reviewed to assure that it reflects the scope of work likely to be undertaken in the next phase of the WHI (in particular: consumer representation seems notably absent).
6. A leadership succession plan for the WHI Steering Committee needs to be put in place.
7. All the existing projects should continue as is (one is coming to a natural conclusion: Reduced Fee Dental Initiative) and the new ones listed on Attachment I, pp. 5-8 should be added.
8. The WHI direction, mission and approach should be reviewed by the Steering Committee on an annual basis.

WASHTENAW HEALTH INITIATIVE

Recommendations for Moving Forward

Recommended by CHRT Staff

Theme/ Topic	Recommendation	Recommender(s)	Popu-lation(s)	WHI Role(s)	Comments
Mental Health	Focus on the needs of those with mild to moderate mental illness and substance use disorders. Assess current demand and capacity, identify barriers and develop a plan to overcome identified barriers.	• Planning Group • Washtenaw County Public Health • Washtenaw Community Health Organization • Coordinated Funders • VA Ann Arbor Healthcare System	Whole county population, with a focus on low-income, Medicaid, and uninsured	• Convene stakeholders • Gather and analyze data • Facilitate the identification of gaps in care • Analyze benefits policies to identify potential barriers to care	• The WHI Mental Health group is currently analyzing community capacity at 4 safety net clinics • The WHI Mental Health group is assessing the value of a community resource guide, whether it should be modified or updated, and how best to disseminate it and keep it updated. • VA would like to be involved too
Eligibility/ Enrollment	Coordinate an effort to bring together those who do Medicaid enrollment to identify opportunities to align their work better and communicate more clearly about eligibility paths	Coordinated Funders	Low-income	• Coordinate groups/agencies conducting benefits enrollment • Identify best practices • Make recommendations for service improvement	
Needs Assessment	Bring together and help integrate the groups that are creating Community Health Needs Assessments and plans to maximize impact	• University of Michigan Health System • Saint Joseph Mercy Health System • Chelsea Community	Whole county population	• Convene stakeholders • Determine all entities that conduct assessments • Facilitate alignment of data collection	• VA would like to be involved too • Currently, Washtenaw County Public Health, health systems, Washtenaw Community Health Organization, coordinated funders, Blueprint

		Hospital • Washtenaw County Public Health • Coordinated Funders			for Aging, Blueprint for Homelessness all conduct assessments
	Revise needs assessments of dental services, care coordination, and enrollment	• Ruth Kraut • Washtenaw Health Plan	Focus on low-income, uninsured, Medicaid	• Gather and analyze data • Facilitate the identification of service gaps	There may be value in updating other needs assessments, such as primary care
Veterans and their Families	Facilitate connections to other health institutions and community resources for the VA and those they serve (and their families) in the county	VA Ann Arbor Healthcare System	• Veterans • Veterans' families	• Convene community partners so they can: ○ Identify treatment options for veterans, and their families, who do not qualify for VA care ○ Develop recommendations for the coordination of care between VA/non VA settings for veterans ○ Assist in the education of community agencies to screen for veteran status and refer veterans to the VA	
Newly Insured	Develop a county-wide plan for providers to identify, reach out to, educate, and engage newly insured individuals and families	Planning Group	Newly insured (who are predominantly low-income)	• Create a new working group • Facilitate the assessment and plan development stages • Data and technical assistance	8 of 12 tables at the 2/18 Planning Group identified this need
End of Life Care	Improve end of life care in the community with a focus on increasing the use of and standardization of advance directives	WHI Hospice Group	Whole county population	• Convene stakeholders • Identify current advance care planning processes in each setting • Identify best practices	This would be a similar process to the WHI's Detox Protocol Project

				• Monitor and evaluate implementation	
State Innovation Model (SIM)	Serve as SIM Backbone Organization for a potential Washtenaw County Community Health Innovation Region	• Jack Billi • University of Michigan Faculty Group Practice • Huron Valley Physician Association • Integrated Health Associates (IHA)	Whole county population	The WHI would serve the roles identified by the State Innovation Model	MDCH will hear back from CMS by October 31, 2014

Not Recommended by CHRT Staff

Theme/ Topic	Recommendation	Recommender(s)	Population(s)	WHI Role(s)	Comments
Health Policy Infor-mation	WHI serve as an information source for local policymakers (i.e. Board of Commissioners)	Yousef Rabhi	Whole county population	• Conduct health impact assessments	Health department doing this already; new Board of Health passed Washtenaw County Board of Commissioners 7/10/14
Obesity	WHI facilitate county-wide obesity reduction planning	• Rob Casalou • Health systems	Whole county population, with a focus on the low-income	• Assess obesity trends • Develop interventions focused on low-income population	Health department doing this already
Remaining Uninsured	WHI facilitate county-wide planning for services for newly insured and remaining uninsured populations	• Washtenaw Health Plan • Planning Group	Remaining uninsured	• Assess # remaining uninsured • Assess current state of services • Identify gaps in services • Identify best practices	Washtenaw Health Plan doing this already
Aging	WHI facilitate county-wide planning for services for aging population	Planning Group	Aging population	• Assess current state • Identify gaps • Make recommendations to address gaps	Blueprint for Aging covers aging population. Multiple stakeholders; Coordinated Funders support

WHI PRIORITIES 2014-2016

I. Assure access to comprehensive and coordinated care for the low-income, uninsured and Medicaid populations.

A. Continue to monitor and support the implementation of the Affordable Care Act.

There are four elements of this work:

(1) Continue, through the work of the WHI Medicaid Outreach and Enrollment Workgroup, to monitor and support enrollment in Medicaid and in private insurance through the Healthcare.gov marketplace;

(2) At the request of the WHP, support its efforts to assure that there is a community system for access to medical care for those still uninsured;

(3) Continue through the work of the Care Net group to provide coordinated care management across the health systems;

(4) Continue to support dental initiatives; reassess the need for additional dental services after the County Public Health Dental Clinic is opened.

B. Reform the community's response to mental health and substance abuse. This work includes:

(1) Continue to work with the WCHO and CSTS to assure that Community Mental Health resources are understandable and accessible;

(2) Work with providers to assure that new benefits available through the Affordable Care Act to mildly and moderately mentally ill persons will be made available in a coordinated and cost effective manner.

(3) Continue the work of the Detox and Opioid Workgroups to develop a coordinated response to substance abuse in the community.

II. Community Health Needs Assessment (CHNA). Work with the County Health Department and the major hospital systems to develop a single Community Health Needs Assessment that meets the needs of all stakeholders.

III. New Projects. The WHI shouldn't undertake additional projects at this time. Rather, new projects (i.e., projects not listed in I and II above) should be developed in conjunction with the hospital systems and the County Health Department and should flow from the CHNA. It seems that there are both mission questions (see part IV) and capacity questions that should be resolved before the WHI moves beyond its current role of community health planning with a focus on comprehensive and coordinated care for low income residents of Washtenaw County.

IV. Strengths and challenges. The WHI has brought together a number of community and health care leaders in a constructive environment to discuss collaborative approaches to community health issues focused on the underserved and those with unmet mental health and dental needs. One especially valuable example is that the WHI provides a mechanism for the UMHS and SJMHS to share information and to identify projects where they can work collaboratively to benefit the community. CHRT's expertise and support has been critical to this success.

However, as the WHI moves into its next phase, there are significant organizational questions (beyond the substance of the next phase of the WHI's work) that should be addressed. These questions include:

1. What structure does WHI need to accomplish the work identified in I through III above?

2. Should the WHI remain focused on low income health care needs? If it expands, should it expand into population health planning or into planning for private pay patients or both?

3. Regardless of the scope of the WHI's work (see #2), how should new projects be proposed? How should they be selected and prioritized? Who should have responsibility for tracking and reporting on progress; and for identifying and addressing problems and barriers?

4. How should the WHI interface with the WHP in its role as the designated agency for Coordinated Funding Planning for safety net health needs?

5. How should the WHI change if the SIM grant is funded and Washtenaw County is chosen as a pilot? (How will the County and its provider agencies respond to the SIM requirements to develop a multi-payer, all-population approach to health care?)

6. What is the ongoing/future role of community leadership of the WHI process?

As I understand the current WHI structure (a 70-person "Planning Committee"; a 20 person "Steering Committee"; and 11 or so affiliated subject area workgroups) it's not clear to me that it is ideally structured to address these organizational questions. I'd encourage the WHI to reconvene some version of the structure subgroup (that was created in the fall of 2013 and then put on hold) to address these questions along with any other similar questions that are raised.

Bob Gillett
rgillett@lsscm.org
8/19/14

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

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.

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 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.

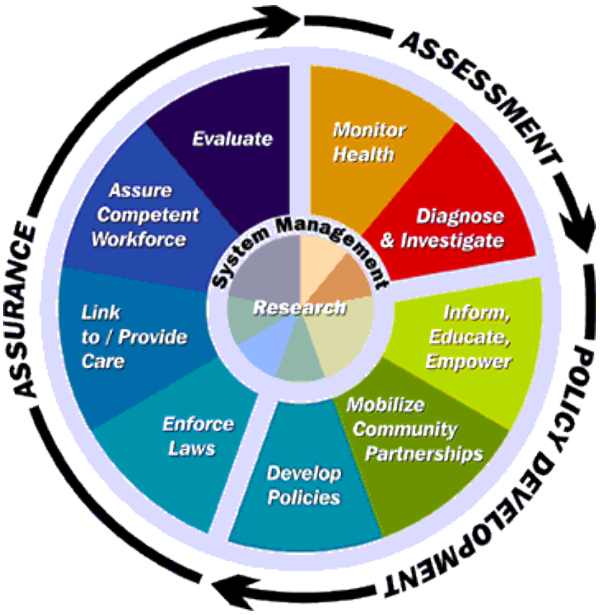
The 3 Core Functions and 10 Essential Public Health Services

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

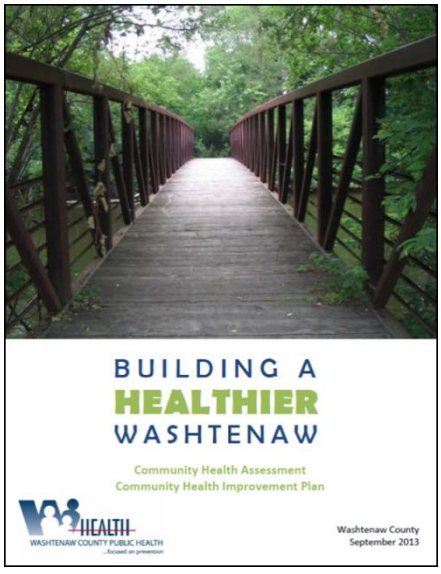
- Collect, analyze, and disseminate data on health factors, outcomes, and disparities in Washtenaw County.
- Establish long term health objectives and monitor progress.

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.

Coordinated Funding

Lessons from a Place-Based Grantmaking Collaborative

The Ann Arbor Area Community Foundation • United Way of Washtenaw County
Washtenaw County • City of Ann Arbor • Washtenaw Urban County

tcc group

Executive Summary

About the Coordinated Funding Model

In the fall of 2010, three grantmakers in Michigan – the Ann Arbor Area Community Foundation, the United Way of Washtenaw County, and the Joint Office of Community and Economic Development (representing Washtenaw County, the City of Ann Arbor, and the Washtenaw Urban County Executive Committee) – agreed to coordinate the leadership and funding of the region's human service programs in order to maximize community impact. The funders combined nearly $10 million over a two-year pilot program that focused on six areas: safety-net health, hunger relief, housing and homelessness, aging, early childhood, and school-age youth.

The local grantmakers adopted a funding model with three distinct components designed to prevent gaps and avoid redundancies in services while streamlining application and reporting procedures for grantees. This effort involved better sharing of information, closer work with local nonprofits to establish common community goals, and increased cooperation in funding decisions. "Knowing what other funders in the area are doing helps so that we're not overinvesting or underinvesting," said Deb Jackson of the United Way of Washtenaw County.

The process for granting operating funds included a pre-qualification phase (the RFQ process) that closely examined the financial reports, governance practices, and operational policies of all applicants. Following training and technical assistance during the process, applicants completed a streamlined online submission.

During the subsequent RFP process, the funders incorporated the perspectives of the applicants when determining the measurable, community-wide outcomes for each priority area. Instead of collecting data on hundreds of diverse impact goals, the grantees were asked come to a consensus on a finite set of outcomes. These "community-wide outcomes" allowed the funders, local policy-makers, and Washtenaw County a more manageable way to evaluate programmatic results.

"The big-picture idea here is we can make more of an impact on the areas of greatest need in our community by working together instead of acting as independent funding entities," said Neel Hajra of the Ann Arbor Area Community Foundation. With this understanding, the shared goals of the coordinated funding model were to:

- Leverage each funder's investment in local nonprofits
- Minimize duplicative work and effort for nonprofits applying for funding
- Reduce overlap and eliminate redundancies between funding entities
- Create shared, community-level measurement of human services outcomes
- Maximize the effectiveness of funds invested in targeted critical human services for the growing number of citizens struggling to meet basic needs

Over two years, programming grants totaling $8.2 million were awarded to 40 nonprofit organizations. During the same period, the grantmakers identified and funded a Planning and Coordinating Agency (PCA) for each of the six priority areas to ensure effective collaboration among local nonprofits. In all, the Planning and Coordinating Grants totaled $620,000. Finally, Capacity-Building Grants were provided to improve nonprofits' long-term strength and viability. A separate RFP process was held for these funds with a total of $550,000 awarded. "It was important to develop a model that would leverage and stretch our funding as much as possible," noted Bill Brinkerhoff, Chairman of the United Way of Washtenaw County Board of Directors.

Findings from the Evaluation

In 2011, the grantmakers received a generous grant from the RNR Foundation that made possible a third party evaluation of Coordinated Funding. The Coordinated Funding partners retained TCC Group, a management consulting firm that works with funders and nonprofits across the country, to assess the overall effectiveness of the coordinated funding model, identify both expected and unanticipated outcomes, and examine evidence of community-level impact to date.

The support provided by the coordinated funders came at a crucial time for Washtenaw County nonprofits. The collaborative effort helped maintain public funding levels and was instrumental in preventing a $260,000 cut to the County's human services budget, and $160,000 to the City of Ann Arbor's human service funding. Employees in the public sector indicated that continuing government grants for human services was more feasible with the knowledge that coordinated model reduced administrative costs. "The amount of overall funding stayed stable amidst the downturn," noted one grantee. "Hats off to leadership for trying to keep funding as stable as they could."

Based on TCC Group's evaluation, the region's nonprofit sector was found to be stronger. The data showed that grantees had increased their evaluation capacity and were better able to measure meaningful outcomes. Surveys showed that grantees had a greater ability to understand strategic and deliberate outcomes. Grantees also collaborated across agencies to share information and further strengthen program delivery. In fact, 84% of survey respondents reported helping peers learn about opportunities to improve their programs, and 87% said that they sought joint funding and advocacy opportunities.

The evaluation also found that the area's grantmakers were increasingly effective. Forty-three percent of grantees agreed or strongly agreed that relationships with funders had improved. "We are much more systematic now that collaboration has become our primary strategy," said one funder. The funders also noted that they had a better context for decision-making when sharing information about community needs in the six main funding areas. Mary Jo Callan, Director of the Office of Community and Economic Development, said "Three or four heads are better than one. We now have a much better understanding, perspective, and history of what the sector has going for it and what its challenges are. We now have a more robust and comprehensive intelligence on individual agency challenges."

Given the data available, the evaluation focused on process findings, as opposed to specific community outcomes. **TCC found that the optimum measure of outcomes is still under debate.** The original outcomes were chosen to augment information already collected, as funders started the program specifically to decrease grantee reporting burdens. However, these program-level outcomes were, in effect, "outputs" – the number of people reached by services. Furthermore, outcome categories continued to be debated. Applicants that did not fit easily into the categories felt left out of the process. Additional community discussion is needed to build consensus around the outcomes that should be included and the level of measurement required.

Stakeholders also had mixed thoughts about capacity-building funding. While some saw the program as valuable, others felt it was limited. Furthermore, organizations were unclear as to when it was appropriate to apply for capacity-building funding. TCC Group recommends clarifying the intention around the use of these grants.

Overall, the majority of survey respondents supported the PCAs' role and thought the entities were well positioned to lead. Finally, the Planning and Coordinating Agencies were seen as operating at varying levels of efficiency. While some PCAs were established leaders within their specific issue areas, others were newly created and had difficulty building trust with peer organizations. PCAs had varying experience and ability to act as facilitators between nonprofits and funders. However, the agencies themselves believed they gained a greater awareness of the sector and felt less siloed in their work due to the peer learning provided by the coordinated funding model.

Replication

An important focus for this evaluation was to understand how the funding model could be recreated in other geographic areas. TCC has identified some helpful community assets and early successes that aided the implementation of this model, which may prove useful to others considering engaging in such a collaborative effort:

- Local government entities provide a portion of the funding without significant restrictions beyond geography
- Government agencies take initial steps to streamline their collective processes
- The community has a relatively high level of resources compared to need
- The community has developed some collaborative plans that focus on shared outcomes for areas of need
- A spirit of cooperation already exists among local nonprofits
- Funding agencies have a history of mutual communication and collaboration
- Grantmaking staff are able to dedicate the necessary time to the model

Based on the overall findings of the evaluation, the five boards representing the Washtenaw Coordinated Funder partners have approved a third-year extension to the pilot program, contingent on satisfactory performance and available funding. The full report provides more in-depth findings from the process evaluation. This report is shared with the hope that it may lead to fruitful discussion and concrete steps to strengthen nonprofit organizations in other region and inform similar coordinated funding efforts.

TCC Group would like to thank the Coordinated Funders for their assistance during this evaluation, in particular Neel Hajra, Mary Jo Callan, Bill Brinkerhoff, and Deb Jackson. This evaluation was conducted with support from the RNR Foundation. We also would like to acknowledge the generous time and thoughtfulness of the interviewees and survey respondents who provided the data necessary to carry out the evaluation.

About TCC Group

For more than 30 years, TCC Group has provided strategic planning, program and grants management, evaluation, and capacity-building services to foundations, nonprofit organizations, corporate community involvement programs, and government agencies. In this time, the firm has developed substantive knowledge and expertise in fields as diverse as education, arts and culture, community and economic development, human services, health care, the environment, and children and family issues. From offices in New York, Philadelphia, and San Francisco, the firm works with clients nationally and across the globe. Services include business planning, organizational assessment and development, research, feasibility studies, organizational evaluation, board development, restructuring and repositioning, as well as grant program design, measurement, and management. TCC Group has extensive experience working with funders to plan, design, manage, and evaluate initiatives to strengthen the capacity of nonprofit organizations.

tcc group

WASHTENAW COORDINATED FUNDING

COMMUNITY-LEVEL OUTCOMES (2014 – 2016)

Community Priority Area	Community-Level Outcome	Measurement Tool(s)
Early Childhood	**Increase the developmental readiness of children with high needs* so they can succeed in school at the time of school entry.** **Children with high needs are defined as: children from birth through kindergarten entry who are from low-income families (i.e., at or below 200% FPL) or otherwise in need of special assistance and support. Specifically those who have disabilities or developmental delays; those who are English learners; those who are migrant, homeless, or in foster care; and/or those who are the children of teen mothers.*	Kindergarten Entry Assessment (KEA)
School-Aged Youth	**Increase the high school graduation rate of economically disadvantaged youth.*** **Economically disadvantaged youth are defined as those who qualify for the free or reduced lunch program, or youth from families with incomes below 185% of the federal poverty limit (FPL).*	MI School Data
School-Aged Youth	**Increase the physical and emotional safety of economically disadvantaged youth* in their homes, schools and communities.** **Economically disadvantaged youth are defined as those who qualify for the free or reduced lunch program, or youth from families with incomes below 185% of the federal poverty limit (FPL).*	Michigan Profile for Healthy Youth (MiPHY), and WISD Senior Exit Survey
Safety Net Health and Nutrition	**Increase access to health services and resources for low-income residents.*** **Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*	Medicaid Green Book, and the American Community Survey (ACS)
Safety Net Health and Nutrition	**Decrease food insecurity* for low income residents.**** **Food insecurity is defined as the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.* ***Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*	Feeding America Survey
Housing and Homelessness	**Reduce the number of people who are experiencing homelessness.** *The target population for programs that align with this outcome is persons at or below 30% AMI.*	Point-in-Time (PIT) Count, and Homeless Management Information System (HMIS)
Aging	**Increase or maintain independent living factors for vulnerable, low income* adults who are 60 years of age and older.** **Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).* *Note: Geographic Catchment and Housing Area Priorities are rural townships, subsidized housing units, mobile home communities, and community dwellers who reside alone.*	Older Adult Survey

Success by 6 Great Start Collaborative
Early Childhood

Community-Level Outcome

Increase the developmental readiness of children with high needs* so they can succeed in school at the time of school entry.

**Children with high needs are defined as: children from birth through kindergarten entry who are from low-income families (i.e., at or below 200% FPL) or otherwise in need of special assistance and support. Specifically those who have disabilities or developmental delays; those who are English learners; those who are migrant, homeless, or in foster care; and/or those who are the children of teen mothers.*
Measured by the pilot program of the Kindergarten Entry Assessment (KEA).

Program Strategy #1:
Parent Engagement and Education
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Prioritizes families with highest need
- Uses a tested and proven program design
- Adheres to structure and content of program model to ensure fidelity
- Is culturally responsive to parents
- Focuses on family strengths rather than deficits
- Effectively educates parents about parenting, child health and development in all domains (including language development and communication)
- Incorporates one or more of the protective factors of the Strengthening Families Approach: parental resilience; social connections; knowledge of parenting and child development; concrete support in times of need; and social and emotional competence of children
- Staffed with professionals trained in the program design who are credible with target families
- Includes strategies to reach and connect with families with high need
- Includes a curriculum-based assessment used to inform instruction, monitor progress and evaluate the program

Program Outcome:
Increase the number of parents developing measurably stronger parenting skills and knowledge of child development, as measured by program attendance.

Program Strategy #2:
Access to High-Quality Early Learning
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Provide scholarships to children and their families to give them access to high-quality early care and learning programs
- Scholarships can be used to access programs that participate in a quality improvement or rating system, such as NAEYC accreditation and Great Start to Quality, or use a recognized research-based curriculum

Scholarship programs must include:

- Clear eligibility requirements
- Prioritize children with highest need

Program Outcome:
Increase the number of children with high needs participating in high-quality child care and preschool programs, as measured by program attendance.

Program Strategy #3:
Strengthen Social Emotional Health
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Must meet the DHHS criteria for an evidence-based program model and have recognized positive outcomes for child development and school readiness. Programs include:
  - Child FIRST
  - Early Head Start-Home Visiting (EHSHV)
  - Early Start (New Zeeland)
  - Family Check-Up
  - Healthy Families America (HFA)
  - Home Instruction for Parents of Preschool Youngsters (HIPPY)
  - Nurse Family Partnership (NFP)
  - Parents as Teachers (PAT)
  - Play and Learning Strategies (PALS)
  - Project 12-Ways/SafeCare
- Evidence-based curricula should include a curriculum-based assessment used to inform instruction, monitor progress and evaluate the program

Program Outcome:
Increase the number of parents participating in home visiting programs, as measured by program attendance.

Washtenaw Alliance for Children and Youth
School-Aged Youth

Community-Level Outcome

Increase the high school graduation rate of economically disadvantaged youth.*

**Economically disadvantaged youth are defined as those who qualify for the free or reduced lunch program and/or youth from families with incomes below 185% of the federal poverty limit (FPL).*
Measured by the % of students who graduate high school from MISchoolData; the % of students attending/absent from school from MISchoolData; and the % of students proficient in reading and math on Michigan Merit Exam.

Program Strategy #1:
Intervention Programming to Foster Literacy and Academic Success
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Provide interventions to foster literacy and academic success
- Academic-focused programs led by trained tutors using evidence-based approaches that are aligned with school-curriculum
- Family engagement
- Attendance initiatives
- Positive peer groups
- Mentoring
- Educational support, including enrollment assistance/advocacy, accessing tutoring services, test preparation, credit recovery, academic monitoring and other activities to achieve educational goals
- Programs offered outside the classroom and in summer

Program Outcome:
Increase the number of days youth attend school, as measured by PowerSchool or report cards.

Program Outcome:
Increase the number of youth showing academic improvement of at least one grade level, as measured by a research-based and normed pre/post assessment for the specific area being targeted, to be chosen by the agency (see the QRI, TABE, or National Assessment of Educational Progress as examples).

Program Strategy #2:
21st Century Skills Programming
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Engage youth in programming that supports the development of 21st Century skills that help them graduate from high school
- Strategies, curriculum and opportunities should build competencies in the areas of:
  - Learning and Innovation Skills: Creativity and Innovation; Critical Thinking and Problem Solving; and Communication and Collaboration
  - Information, Media and Technology Skills: Information Literacy; Media Literacy; and ICT (Information, Communications and Technology) Literacy
  - Life and Career Skills: Flexibility and Adaptability; Initiative and Self-Direction; Social and Cross-Cultural Skills; Productivity and Accountability; and Leadership and Responsibility
- Programs offered outside the classroom and in summer

Program Outcome:
Increase the number of youth who increase/improve their 21st Century Learning Skills, as measured by a research-based and normed pre/post assessment for the specific area being targeted, to be chosen by the agency (see the Youth Experiences Survey 2.0 as an example).

Washtenaw Alliance for Children and Youth
School-Aged Youth

Community-Level Outcome

Increase the physical and emotional safety of economically disadvantaged youth* in their homes, schools and communities.

**Economically disadvantaged youth are defined as those who qualify for the free or reduced lunch program and/or youth from families with incomes below 185% of the federal poverty limit (FPL).*

Measured by the # of youth arrested or seen at juvenile court for a violent offense; the # of runaway reports filed with local law enforcement agencies; the # of students expelled from school as reported on MiSchool Data; the % of students who felt depressed in last 12 months from MiPHY; the % of students who ever seriously considered attempting suicide from MiPHY; and the % of students who feel safe at school from WISD Senior Exit Survey.

Program Strategy #1:
Out-of-School Programming
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Ensure safe out-of-school and community time through structured, supervised spaces and activities for youth
- Curriculum on social-emotional and other life skills as well as harm reduction approaches, family-focused services and crisis resources
- Programming will prioritize high-risk hours (evenings and weekends)
- Culturally competent staff and staff trained in positive youth development practices
- Plan for communication and coordination with schools and other systems in which youth are involved

Program Outcome:
Increase the number of youth without law enforcement contact or illegal behavior, as measured by Youth Self Report.

Program Outcome:
Increase the number of youth who report feeling safe at home, as measured by Youth Self Report.

Program Strategy #2:
Programming that Facilitates Youth-Adult Relationships
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Build relationships between youth and positive, supportive adults who serve as role models, supporters, advocates and/or mentors; relationship is not academic-based
- Provide for regular contact between mentors and mentees for a minimum of one year
- A youth-driven approach that focuses on the needs of youth and aims to develop their competence and potential
- Interactions may focus on helping the youth reach a goal. Other relationships may be more open-ended and include participation in a variety of activities
- Adults receive specific training with clear expectations and on-going support
- Established processes for monitoring and closing of relationships
- In group settings, the adult-to-youth ratio is not greater than 1:4

Program Outcome:
Increase the number of youth who report at least one adult outside of their immediate family, as a result of participation in the program, who provides practical and emotional support, as measured by Youth Self Report.

Program Outcome:
Increase the number of youth without law enforcement contact or illegal behavior, as measured by Youth Self Report.

Program Strategy #3:
Existing On-Site School Programming
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Support safe school environments through existing on-site programming
- Focused on conflict resolution, restorative practices, positive interactions and violence prevention
- Efforts foster accountability, community safety and skill development
- Use of "circles" to explore issues and enhance communication
- Promotion of alternative disciplinary responses such as circles, peer juries, mediation, counseling, and community service
- Student engagement initiatives
- Builds the social competency skills of youth

Program Outcome:
Increase the number of youth who report feeling safe in school, as measured by Youth Self Report.

Program Outcome:
Increase the number of youth who show gains in social competency skills and behaviors, as measured by pre/post-test survey (see Social Competence Teen Survey for an example).

Washtenaw Health Plan

Safety Net Health and Nutrition

Community-Level Outcome

Increase access to health services and resources for low-income residents.*

**Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*
Measured by proxies for "access" such as the Medicaid Green Book to indicate Medicaid enrollment at a county level, and/or the American Community Survey to report annually on the level of insurance coverage. To measure "access", funded agencies should report program level data that indicates changes in their payer mix (e.g. numbers of uninsured, Medicaid and commercial pay patients) in a pre-ACA and post-ACA context, and/or use proxies for actual access to care (percentage of people who are able to access care) based on detailed surveys in other communities.

Program Strategy #1:
Benefits Advocacy
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Assessing eligibility for and assisting eligible clients in enrolling in public benefits (e.g. Medicaid, ACA Marketplace enrollment with subsidies, SNAP, WIC, food programs, etc.)
- Provide application assistance
- Talk to members and leaders in targeted communities to learn about community health needs and issues
- Facilitate referrals to eligibility assistance staff
- Track aggregate outcomes of referrals among departments and partners
- Use the results of data collection efforts to make improvements and updates to existing practices and programs

Program Outcome:
Increase the enrollment or re-enrollment of eligible people in publicly funded programs, including Medicaid, SNAP benefits, WIC, congregate meals, summer food programs, etc., as measured by program-level data (i.e., participant tracking).

Program Strategy #2:
Accessing Care Services
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Expanded primary care and adult dental care provider service hours
- Enhanced primary care and adult dental care provider capacity to serve patients by adding staff
- Enhanced primary care and adult dental care provider capacity to serve patients through the development of electronic medical records
- Enhanced primary care and adult dental care provider capacity to serve patients through changes to office protocols to serve more patients more efficiently
- Provide care management or care navigation activities that are designed to help patients access all of the services that they are eligible for

Program Outcome:
Increase access to primary care and adult dental care services for the uninsured and for those newly insured under the Affordable Care Act (ACA), as measured by program payer data that indicates changes in the payer mix (e.g. numbers of uninsured, Medicaid and commercial pay patients) in a pre-ACA and post-ACA context.

Program Outcome:
Increase in patient volume, as measured by program-level data (i.e., participant tracking).

Community-Level Outcome

Increase access to health services and resources for low-income residents.*

**Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*
Measured by proxies for "access" such as the Medicaid Green Book to indicate Medicaid enrollment at a county level, and/or the American Community Survey to report annually on the level of insurance coverage. To measure "access", funded agencies should report program level data that indicates changes in their payer mix (e.g. numbers of uninsured, Medicaid and commercial pay patients) in a pre-ACA and post-ACA context, and/or use proxies for actual access to care (percentage of people who are able to access care) based on detailed surveys in other communities.

Program Strategy #3:
Care Coordination
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Provide referrals to services AND care navigation and management services, OR integrated health strategies such as the co-location of different service providers in one location, the establishment of comprehensive "health homes" or "patient centered medical homes"

If Coordinated Care program:

- Routine screenings for other health problems conducted in a primary care setting
- A referral relationship between primary care and other service settings
- Routine exchanges of information between treatment settings to bridge cultural differences, as allowed by law
- Primary care providers to deliver behavioral health interventions using brief algorithms
- Connections are made between the patient and resources in the community

If Co-Located Care program:

- Medical services and other health services located in the same facility
- A referral process for medical cases to be seen by behavioral and other specialists
- Enhanced informal communication between the primary care provider and other health providers due to proximity
- Consultations between the behavioral/other health and medical providers to increase the skills of both groups

If Integrated Care program:

- Medical services and other health services located either in the same facility or in separate locations
- One treatment plan with non-medical and medical elements
- Typically, a team working together to deliver care, using a prearranged protocol
- Teams composed of a physician and one or more of the following: physician's assistant, nurse practitioner, nurse, case manager, family advocate, and behavioral health therapist
- Use of a database to track the care of patients who are screened into behavioral or other health services

Note: The Coordinated Funders will not fund stand-alone mental, behavioral and non-medical health services that are not clearly coordinated.

Program Outcome:

Increase care coordination between primary care providers and mental, behavioral and dental health providers, substance abuse recovery services, diabetes education, food pantries, transportation assistance, baby services, etc., as measured by numbers of patients seeking and receiving these services, and/or by the percentage of patients who report by survey that care coordination services helped them get what they needed.

Washtenaw Health Plan
Safety Net Health and Nutrition

Community- Level Outcome

Decrease food insecurity* for low income residents.**

**Food insecurity is defined as the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.*

****Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*

Program Strategy #1: Hunger Relief [NON-COMPETITIVE FUNDING]

Distribute at least 6 million pounds of food, at least 50% of which is protein, fruits and vegetables, through Food Gatherers' network of food pantries and meal programs.

Program Outcome:

Increase the consumption of fruits and vegetables among targeted low-income populations (at or below 200% FPL) at organizations that also provide fresh/perishable food distribution, as measured by nutrition risk assessments and consumer surveys.

Program Strategy #2: Community-Based Food Access [COMPETITIVE FUNDING]

Research indicates that programs may have the following best practice components:

- Provide nutrition interventions (i.e. screenings, assessments, and counseling and/or education) in combination with the distribution of healthy food (including protein, fruits and vegetables)
- Program participants should reside in the 48197 and 48198 zip codes
- Models may include backyard and community gardens, Community Supported Agriculture shares, programs that increase access to local farmers' markets, and other community-based food assistance programs.

Note: The Coordinated Funders will not fund direct operating costs for food pantries, meal programs, education-only programs or school-based food pantries.

Program Outcome:

Increase the consumption of fruits and vegetables among targeted low-income populations (at or below 200% FPL) at organizations that also provide fresh/perishable food distribution, as measured by nutrition risk assessment and consumer survey adopted by Food Gatherers.

Program Outcome:

Decrease nutritional risk for low income (at or below 200% FPL) residents, as measured by nutrition risk assessment and consumer survey adopted by Food Gatherers.

Program Strategy #3: Home-Bound Food Distribution [COMPETITIVE FUNDING]

Research indicates that programs may have the following best practice components:

- Distribute home-delivered meals to all eligible low-income people. Eligibility means a person must be home-bound (i.e., is unable to leave his/her home under normal circumstances), unable to participate in a congregate nutrition program because of physical or emotional difficulties, or unable to obtain food or prepare complete meals
- Use written eligibility criteria which prioritizes serving persons in greatest need
- Demonstrate cooperation with congregate and other home delivered meal programs in the program area
- Program must be able to provide at least five days worth of meals per week to clients
- Make liquid meals available to program participants when ordered by a physician
- Complete a prioritizing pre-screen for each individual placed on the waiting list
- Document client assessment data
- Comply with applicable food safety requirements for the preparation and transport of meals

Note: The Coordinated Funders will not fund direct operating costs for food pantries.

Program Outcome:

Decrease nutritional risk for low income (at or below 200% FPL) residents, as measured by the reduction or elimination of waiting lists.

Washtenaw Housing Alliance
Housing and Homelessness

Community-Level Outcome

Reduce the number of people who are experiencing homelessness.

The target population for programs that align with this outcome is persons at or below 30% AMI.

Program Strategy #1: Homelessness Prevention [COMPETITIVE FUNDING]	Program Strategy #2: Emergency Shelter, Transitional Housing and/or Homelessness Outreach [COMPETITIVE FUNDING]	Program Strategy #3: Rapid Rehousing (RRH) [COMPETITIVE FUNDING]	Program Strategy #4: Permanent Supportive Housing (PSH) [COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components: • Provide financial assistance and support services to quickly stabilize those most at-risk of homelessness • Intake and assessment through Housing Access of Washtenaw County (HAWC) • Housing search assistance as needed • Housing placement services as needed • Linkage to appropriate support services as needed • Progressive engagement approach to case management	**Research indicates that programs may have the following best practice components:** • Provide short-term, housing-focused interventions designed to move people into permanent housing • Intake and assessment through HAWC or coordination through existing system of care • Engage people experiencing homelessness in support services through targeted outreach • Transitional housing is recommended only for youth and those in substance abuse recovery	**Research indicates that programs may have the following best practice components:** • Provide financial assistance and support services to quickly re-house and stabilize those currently experiencing homelessness • Intake and assessment through HAWC • Housing search assistance • Housing placement services • Housing support services • Progressive engagement approach to case management • A Housing First model in which "housing assistance without preconditions or service participation requirements, and rapid placement and stabilization in permanent housing are primary goals"	**Research indicates that programs may have the following best practice components:** • Provide homeless persons with safe, decent, affordable housing units attached to the supports and case management necessary to keep people with significant challenges (such as mental illness, and substance use disorder) housed • Intake and assessment through HAWC • Progressive engagement approach to case management • A Housing First model in which "housing assistance without preconditions or service participation requirements, and rapid placement and stabilization in permanent housing are primary goals"
Program Outcome: Increase the number of people who maintained housing for at least 6 months after receiving direct financial assistance for housing-related payments and/or housing stabilization services, as measured by HMIS.	**Program Outcome:** Increase exits to permanent and/or positive housing (including RRH and PSH), as measured by HMIS.	**Program Outcome:** Increase the number of people who remained stably housed for 6 and 12 months after service intervention, as measured by HMIS.	**Program Outcome:** Increase number of people who remained stably housed for 6 and 12 months after service intervention, as measured by HMIS.
Program Outcome: Increase the number of people who remained stably housed for 6 and 12 months after service intervention, as measured by HMIS.	**Program Outcome:** Increase or maintain income and/or benefits, as measured by HMIS.	**Program Outcome:** Increase exits to permanent and/or positive housing (including RRH and PSH), as measured by HMIS.	**Program Outcome:** Increase exits to permanent and/or positive housing (including RRH and PSH), as measured by HMIS.
	Program Outcome: Decrease the length of time homeless (which includes time spent in ES and TH), as measured by HMIS.	**Program Outcome:** Increase or maintain income and/or benefits, as measured by HMIS.	**Program Outcome:** Increase or maintain income and/or benefits, as measured by HMIS.

Blueprint for Aging

Aging

Community-Level Outcome

Increase or maintain independent living factors* for vulnerable, low income adults who are 60 years of age and older.**

**Independent living factors are defined within the categories of financial stress, housing stress, health care stress, mood stress, social stress, and other stress including stress related to transportation and personal care.*

***Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*

Note: Geographic Catchment and Housing Area Priorities are rural townships, subsidized housing units, mobile home communities, and community dwellers who reside alone.

Program Strategy #1:
Senior Crisis Intervention
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Case management
- Wrap-around approach
- Person-centered crisis planning
- In-home and telephone contact with client
- Motivational interviewing
- Short-term (less than 6 months) intensive services
- Re-assessment for continuation/discharge

Program Outcome:
Increase the provision of critical needs to vulnerable, low income (at or below 200% FPL) older adults, as measured by the Washtenaw County Senior Snapshot.

Program Strategy #2:
Senior System Navigation
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- Resiliency approach
- Protective factor development
- Person-centered planning
- Systematic assessment
- Service coordination
- Transitional care
- Monitoring
- In-home or community-based services (i.e., adult day programs, senior centers, etc.)
- Motivational interviewing
- Short-term (less than 6 months) or long-term (typically up to 9 months) services that are less intensive than crisis intervention

Program Outcome:
Decrease risk and increase protective factors of vulnerable, low income (at or below 200% FPL) older adults, as measured by the Washtenaw County Senior Snapshot.

Program Strategy #3:
Senior Social Integration
[COMPETITIVE FUNDING]
Research indicates that programs may have the following best practice components:

- In-home or community-based services (i.e., adult day programs, senior centers, etc.)
- Systematic assessment
- Telephone monitoring
- Information, resources and referral to other community programs
- Motivational interviewing
- Individual or group format
- Services for 6 months or longer

Program Outcome:
Decrease social isolation and increase meaningful engagement of vulnerable, low income (at or below 200% FPL) older adults, as measured by the Washtenaw County Senior Snapshot.

WASHTENAW COORDINATED FUNDING

SYSTEM STRATEGIES (2014 – 2016)

Community-Level Outcome	Corresponding System Strategies – Not Funded Through RFP
EARLY CHILDHOOD **Increase the developmental readiness of children with high needs so they can succeed in school at the time of school entry.**	• Conduct a resource map to collect county wide data on the number of families being served by parenting engagement programs, ASQs and home visiting programs for future planning and goal setting. • Establish a baseline of the number and percent of Washtenaw county high need children with the developmental skills ready to succeed in kindergarten. • Promote the use of the Kindergarten Entry Assessment with Washtenaw County school districts. • Identify improvements in the community support system to assist families receiving services. • Identify and support policy changes to increase funding for programs for 0-3 year olds. • Study research-based early literacy programs that are effective for the target population.
SCHOOL-AGED YOUTH **Increase the high school graduation rate of economically disadvantaged youth.**	• Professional development referencing the Weikart Youth Work Methods. • Advocate for shared priorities. • Collect and report data on common measures, such as Senior Exit Survey and Youth Program Quality Assessment. • Introduce and support career readiness skills in the classroom and through off-site programming.
SCHOOL-AGED YOUTH **Increase the physical and emotional safety of economically disadvantaged youth in their homes, schools and communities.**	• Create partnerships with schools on which individual agencies can build. • Advocate for shared priorities. • Collect and report data on common measures, such as MiPHY and the Senior Exit Survey. • Participate and represent the needs and voice of youth in community health initiatives. • Increase coordination and collaboration with the Ypsilanti Community School District.
SAFETY NET HEALTH & NUTRITION **Increase access to health services and resources for low-income residents.**	• Ensure alignment and improve service coordination of benefits enrollment and advocacy to give more people access to insurance and SNAP benefits, thereby increasing access to clinics. • Coordinate with other Coordinated Funding Priority Areas, WHI Work Groups and Steering Committee, Health Improvement Plan Priorities, Health Systems, Private Providers, Public Health, CSTS, Community Food Security Programs, the Substance Use Disorder System and the Washtenaw Alliance for Children and Youth (WACY). • Advocate for the integration of behavioral health services into primary care. • Enhance primary care and adult dental care provider capacity to serve the uninsured and newly insured under the Affordable Care Act (ACA), as measured by the Washtenaw Health Initiative's Primary Care Work Group's goals in Primary Care Capacity and Safety Net Clinic Coordination.

WASHTENAW COORDINATED FUNDING

SYSTEM STRATEGIES (2014 – 2016)

Community-Level Outcome	Corresponding System Strategies – Not Funded Through RFP
SAFETY NET HEALTH & NUTRITION **Decrease food insecurity for low income residents.**	• Ensure alignment and improve both service coordination and training of both private and public food resources (e.g., pantry clients have access to SNAP benefits, pantries have access to Summer Food and other federal funding sources, etc.). • Facilitate alignment, coordination, and prioritization of high capacity food distribution programs so that all areas of the county are able to access nutritious food. • Coordinate with community food security and access programs (e.g., on food policy work and on community agriculture). • Advocate for the retention of SNAP benefits. • Coordination between Food Gatherers and community-based food access programs.
HOUSING & HOMELESSNESS **Reduce the number of people who are experiencing homelessness.**	• Provide coordinated access to the homelessness system of care (HAWC). • Increase availability and accessibility of housing stock in Washtenaw County that is affordable for extremely low-income persons and families (<30% AMI). • Increase integration among Planning and Coordination bodies for mutual work on community outcomes. • Improve the use of data throughout the Housing and Homelessness system of care. • Establish a sustainable revenue source for support services. • Leverage robust partnerships with the mainstream system (Workforce Development, Department of Human Services, etc.) to enhance services and supports available to those experiencing, or at risk of, homelessness. • Decrease the number of re-entries into homelessness system. • Coordinate services and data collection/analysis between senior eviction prevention service providers and housing providers. • Coordinate with federal funding streams dedicated to rapid re-housing and permanent supportive housing services. • Maintain and encourage outreach and engagement as a component of each program strategy.
AGING **Increase or maintain independent living factors for vulnerable, low income adults who are 60 years of age and older.**	• Deploy a common assessment and outcome web-based information system for Coordinated Funding providers serving older adults. • Advance provider capacity through cross-agency case conferencing and certification or evidence-based interventions. • Establish Washtenaw County baseline by partnering with the Health Department and University of Michigan to administer Older Adult Survey and develop ArcGIS maps. • Actively participate with other Planning and Coordinating entities to ensure alignment, improve the referral system, and coordinate services across the funding areas. • Work with public agencies to establish sustainable funding for older adult programming in the county. • Build evaluation capacity and contribute to the literature on best practices. • Coordinate services and data collection/analysis between senior eviction prevention service providers and housing providers.

Defining EXCELLENCE in the 21st Century
Ann Arbor • Flint • Jackson • Toledo

VA Ann Arbor Healthcare System

A 60 Year Tradition of Providing Outstanding Care to Veterans

About the Facility

Since 1953, the VA Ann Arbor Healthcare System (VAAAHS) has provided high quality, cost effective tertiary care to Veterans residing in Michigan and northwestern Ohio. VAAAHS is a major tertiary care referral care center for Veteran in the lower peninsula of Michigan and northwestern Ohio, with Community-based Outpatient Clinics (CBOC) in Toledo, Ohio, and Jackson and Flint, Michigan. We consider it our privilege to serve the Veterans healthcare needs in any way we can.

Healthcare System Facts

- 105 acute care beds distributed among Medicine, Surgery, Critical Care and Psychiatry; 40 Community Living Center (nursing home) beds
- 61,712 Veterans utilized the Healthcare System in Fiscal Year (FY) 2013
- 5,728 inpatient episodes provided in the hospital and community living center during FY 2013
- 550,948 outpatient visits at the four campuses combined during FY 2013
- Employer of over 2,300 full-time equivalent employees and 1,404 Volunteers
- Annual operating budget of over $400 million
- Implemented Robotic Surgery Program in 2013

Program Highlights

- Neurosurgery
- Cardiac Surgery
- Hemodialysis
- Chemotherapy
- Radiation Oncology
- Substance Use Disorder
- Veteran Empowerment and Recovery (VEAR) Center (Mental Health)
- Mental Health Intensive Case Management
- Army Wounded Warrior Advocate
- Traumatic Brain Injury
- Outpatient Spinal Cord Injury
- Visual Impairment Services Team
- Home-based Primary Care
- Health Services Research & Development (HSR&D)
- Serious Mental Illness Treatment Research & Evaluation Center (SMITREC)
- Geriatric Research, Education, and Clinical Center (GRECC)
- Patient Aligned Care Teams (PACT) & Demonstration Lab
- Hospital Outcomes Program of Excellence (HOPE) Initiative
- Invasive Cardiology
- Invasive Radiology

Facilities

- The Ann Arbor campus includes a hospital, outpatient clinics, an extended care facility, a radiation therapy facility, two research buildings, five administrative outbuildings, two parking garages, and an energy center.
- The facility includes state-of-the-art ambulatory care clinics, operating rooms, cardiac catheterization suite, intensive care units, laboratory, and diagnostic facilities.

Innovation

- Awarded national Patient Aligned Care Team (PACT) demonstration lab
- Nationally funded for capability grant "Redesigning the System of Care for Hospitalized Medicine Patients"
- Partner in VISN 11 Veterans Engineering Resource Center (VERC) for systems redesign
- Implementing Veteran Centered Care initiatives based on Planetree model
- Recipient of National Center for Patient Safety "Gold Award"
- One of eleven VA medical facilities to implement the new telehealth initiative, Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO)

Education

- Affiliated with the University of Michigan Schools of Medicine, Dentistry, and Nursing, as well as nearly 40 other colleges and universities. More than 1,200 people receive training here each year.
- Most VAAAHS physicians hold joint teaching appointments at the University of Michigan.

Research

- 404 active studies in clinical research, basic science, health services, and rehabilitation.
- Host site of Health Services Research and Development (HSR&D) Center of Innovation, Geriatric Research, Education and Clinical Center (GRECC), and Serious Mental Illness Treatment Research and Evaluation Center (SMITREC)

Accreditations & Recognition

- Joint Commission
- Commission on Accreditation of Rehabilitation Facilities, for Compensated Work Therapy, Homeless Program, and Psychosocial Rehabilitation and Recovery Center (PRRC)
- College of American Pathologists (CAP)
- Blood Bank - FDA and CAP accredited
- American College of Radiation Oncology
- Commission on Cancer
- Nuclear Regulatory Commission
- Cancer Program accredited by the American College of Surgeons
- Accredited Pastoral Care Program
- Planetree Silver Recognition for Significant Advancement in Patient Centered Care

How Can WHI Partner with the VA Ann Arbor Healthcare System

- Provide treatment options for Veterans who do not qualify for VA services
- Coordinate care management services across settings when Veteran has complex health issues and receives both VA and non-VA care
- Educate community hospitals/clinic staff about VA services, routinely screen patients for Veteran status, and inform them/ refer to VA services when appropriate/needed
- Continued support of low-cost dental care options for Veterans not eligible for VA Dental Care
- Provide treatment options for Veterans' family members
- Inform Veteran family members about potential effects of deployment and reintegration to family life

U.S. Department of Veterans Affairs

VA Dental Insurance Program (VADIP)
Fact Sheet

The Department of Veterans Affairs provides comprehensive dental care to Veterans who meet eligibility standards; however, the benefit is not available to many Veterans. VA would like all Veterans and beneficiaries to have access to good oral health. Good oral health is more than just a nice smile or ability to chew favorite foods – it impacts a person's overall health throughout his or her life.

VA's Dental Insurance Program (VADIP) offers enrolled Veterans and beneficiaries of VA's Civilian Health and Medical Program (CHAMPVA) the opportunity to purchase dental insurance at a reduced cost. VA is offering this service through Delta Dental and MetLife.

VADIP is a three-year, national pilot program to assess the feasibility and advisability of providing a premium-based dental insurance plan to eligible individuals. The program is mandated by Public Law 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010.

Eligibility for VADIP

Veterans enrolled in the VA health care program and CHAMPVA program beneficiaries are eligible to participate in VADIP. Participation in VADIP will not affect Veterans' eligibility for VA dental services and treatment.

Dependents of Veterans, except those eligible under CHAMPVA, are not eligible for VADIP; however, separate coverage options may be offered dependents by the insurance carrier.

For more information about VADIP.

Dental Plan Information

VA has contracted with Delta Dental and MetLife, private insurers, to administer the dental insurance program.

IB 10-580
Revised: February 2014
OMB control number 2900-0789
OMB EXP. Date: 01/31/2017

Beginning November 15, 2013, individuals interested in participating in VADIP may complete an application online, over the phone or by mail. A direct link to each provider's VADIP webpage is available from www.va.gov/healthbenefits/VADIP. The following table shows contact information for each provider.

PROVIDER	TOLL-FREE NUMBER	WEBSITE	MAILING ADDRESS
Delta Dental	**1-855-370-3303**	**www.deltadentalvadip.org**	**Correspondence Delta Dental of California Federal Government Programs PO Box 537013 Sacramento, CA 95853-7013**
MetLife	**1-888-310-1681**	**www.metlife.com/VADIP**	**MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282**

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is 15 minutes per response, including the time for reviewing instructions, and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: VHA Clearance Officer (10B4); Department of Veterans Affairs; 810 Vermont Ave. NW; Washington, DC 20420. DO NOT SEND YOUR APPLICATION TO THIS ADDRESS.

Coverage under VADIP begins January 1, 2014, and will be provided throughout the United States and its territories. The initial participation period will be at least 12 calendar months. Afterward, VADIP beneficiaries can renew their participation for another 12-month period or be covered month-to-month, as long as the participant remains eligible for coverage and VA continues VADIP.

Multiple plan options will allow participants to select a plan that provides benefits and premiums that meet their dental needs and budget. The offered plans vary and may include diagnostic, preventative, surgical, emergency and endodontic/restorative treatment. Each participant will pay a fixed monthly premium for coverage, in addition to any copayments required by his or her plan.

For more information on VADIP, visit www.va.gov/healthbenefits/VADIP and click the insurer's link for specific information regarding registration, rates and services, or call Delta Dental at 1-855-370-3303 or MetLife at 1-888-310-1681.

IB 10-580
Revised: February 2014
OMB control number 2900-0789
OMB EXP. Date: 01/31/2017

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.

SIM Preliminary Capacity Survey

The Michigan Department of Community Health is building on *Michigan's Blueprint for Health Innovation* developed over the past year by developing a pilot testing approach. The Center for Medicare and Medicaid Innovation has released funding to assist states implement their innovation plans. In order to apply for this funding, the Michigan Department of Community Health has developed a survey designed to determine where in Michigan there is interest in, and capacity to test the delivery system and payment reforms described in the *Blueprint for Innovation*. The goals of this survey are two-fold:

1) Learn about organizations within communities that have interest and ability to participate in a pilot test as an Accountable Systems of Care or a Community Health Innovation Region backbone organization.
2) Understand how the State might use grant funds to increase local capacity to participate in a test pilot.

The survey will be used by the Department of Community Health for planning purposes only. Responding to the survey does not guarantee selection as a test site; nor does it bind the respondent in any way. Should Michigan apply for and receive a federal grant, there will be an additional formalized assessment process to guide investment decisions. This process may include a site visit.

Who should respond?

- Organizations that are interested in playing a leading role within a Community Health Innovation Region or Accountable System of Care
- Respondents should be leaders in their organization with expertise about system capabilities and the authority to make a commitment to testing the models within their communities

Before completing the survey, organizations should:

- Read Chapter E of the *Blueprint for Health Innovation*.
- Explore collaborative partnerships for testing the model
- Review the SIM Overview webinar presented on May 7, 2014.
- Mark your calendar for an informational webinar: June 12, 2014 from 3:00 to 4:30pm. Click here and enter "mphisim" in the Event Material field to view registration instructions and other background materials.

Should you need to save and return to this survey later, or if you feel another member of your organization would be better able to answer a question, please be sure to save the validation code shown. *The survey will close on June 25th.*

Please call or email Clare Tanner at ctanner@mphi.org, (517) 324-7381, if you have any questions.

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

General Information **Page 2 of 15**

1. First Name: Carrie
2. Last Name: Rheingans
3. Title: Washtenaw Health Initiative Project Manager
4. Name of your organization: Center for Healthcare Research & Transformation
5. Email Address: crheinga@umich.edu
6. Website: http://washtenawhealthinitiative.org
7. List zip codes of the populations served by your organization: 48103, 48104, 48105, 48108, 48109, 48118, 48130, 48190, 48197, 48198, and the Washtenaw County parts of 48137, 48158,48167, 48168, 48169, 48170, 48176, 48178, 48189, 48191, 49236, 49240.
8. In what capacity does your organization have interest in participating in Michigan's State Innovation Model test?
   - ☐ Accountable System of Care
   - ☐ Community Health Innovation Region

[Based on responses to the last question (question 8), respondents will be electronically advanced to the Accountable Systems of Care or Community Health Innovation Region portions of the survey.]

➢ Community Health Innovation Region continued here

A **Community Health Innovation Region** is a community-based organizing mechanism comprised of cross-sector stakeholders that work together at the local level for better health and health care at lower costs. Given the complex nature of the health system and the substantial impact of nonclinical factors on health and health care (social, economic, behavioral, and environmental), no one sector can achieve these outcomes alone; rather, broad health system partnerships are needed. To be effective and sustained over time, these partnerships take a collective impact approach, with a long-term commitment to a common agenda, shared measures, and effective strategies for engaging the community in improving health and the health care delivery system while containing costs.

Organizational Description and Governance **Page 12 of 15**

2. What term below best describes your organization? Select <u>all that apply</u>.
   - ☐ Chartered Value Exchange
   - ☐ Regional Health Improvement Collaborative
   - ☐ Local Public Health Department
   - ☐ Multi-purpose Collaborative Body
   - ☐ Health Information Exchange
   - ☐ Other (*A text box asking,* "Please provide a description of your organization." *will appear*)

The Washtenaw Health Initiative (WHI) is a voluntary, non-governmental collaborative of cross-sector stakeholders working together to improve the health of Washtenaw County's low-income, uninsured, and Medicaid recipients. WHI includes more than 70 provider, payer, safety net, and service organizations representing over 170 members focused on identifying community health

needs, emphasizing primary care over emergency care, and increasing communication to improve access to—and the quality of—care in the county.

The goals of the WHI are to:

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

The WHI began in 2010 when a retired health system CEO spoke with community leaders about what the passage of the Patient Protection and Affordable Care Act (ACA) meant for county residents. A 12-member steering committee, chaired by two prominent community leaders, formed to clarify the initiative's goals and scope, and to identify organizations and individuals to participate.

The steering committee formed work groups organized around primary care; dental care; mental health and substance use disorders; social determinants of health; and Medicaid outreach, eligibility, and enrollment. Workgroup members:

- Acquired and analyzed local data from multiple sources to define the current state of—and identify gaps in—access and care provision for the county's low-income population.
- Drafted recommendations to address identified gaps.
- Have since launched 16 community-based projects, resulting in increased enrollment in Medicaid and other public programs, allowed use of sliding fee scales at dental clinics, coordinated care across various health systems, and much more.

An evaluation of the overall initiative and each project is under way, and the workgroups continue to add projects as the environment changes and new opportunities are identified.

The WHI does not have a Board of Directors and bylaws, since it is a voluntary coalition. The Steering Committee acts as a Board but it is not a separate legal entity. CHRT provides all administrative and structural support to the WHI (including managing finances in a separately designated account). CHRT does have a Board.

Steering Committee members, positions, and organizations: Rob Casalou, President and Chief Executive Officer, St. Joseph Mercy Ann Arbor, Livingston and Saline; Nancy Graebner, President and Chief Executive Officer, Chelsea Community Hospital; Leo Greenstone, M.D., Associate Chief of Staff for Ambulatory Care, VA Ann Arbor Healthcare System; Robert Guenzel, Retired Administrator, Washtenaw County; Norman Herbert, Retired Treasurer, University of Michigan; Peter Jacobson, J.D., M.P.H., Professor of Health Law and Policy and Director of the U-M Center for Law, Ethics, and Health, University of Michigan School of Public Health; Eric Kurtz, Executive Director, Washtenaw Community Health Organization; Robert Laverty, Retired President and Chief Executive Officer, Saint Joseph Mercy Health System; Robert McDivitt, F.A.C.H.E., VHA-CM, Medical Center Director, VA Ann Arbor Healthcare System; Ellen Rabinowitz, Public Health Officer, Washtenaw County Public Health, and Executive Director, Washtenaw Health Plan; Pam Smith,

President and Chief Executive Officer, United Way of Washtenaw County; Doug Strong, Chief Executive Officer, University of Michigan Hospitals and Health Centers; Marianne Udow-Phillips, Director, Center for Healthcare Research & Transformation, and Brent Williams, M.D., M.P.H., Associate Professor of Internal Medicine, University of Michigan Health System

3. Does your organization have a Board of Directors and bylaws?
   - ☐ Yes
   - ☐ No

4. Does your organization use a **collective impact model**?
   - ☐ Yes (*A text box asking, "*Please describe your experience implementing a **collective impact model.***" *will appear*) see below for response
   - ☐ No

   Collective impact models are described in chapter B (page 40) Michigan's *Blueprint for Health Innovation*.
   The Washtenaw Health Initiative (WHI) reflects the five collective impact model conditions for success described in Michigan's Blueprint for Health Innovation as follows:

1. Infrastructure or, as described in the SIM, backbone organization.
   The Washtenaw Health Initiative is housed in the Center for Healthcare Research & Transformation (CHRT), a non-profit health policy center located at the University of Michigan with a mission to promote evidence-based care delivery, improve population health, and expand access to care. CHRT is viewed as a neutral facilitator because it is not a provider or advocacy organization.

   CHRT's staffing support originally included six staff members providing ad hoc support to various WHI work groups. With funding from various WHI partner organizations, CHRT hired one full-time project manager as WHI membership—and resource needs—increased. The WHI project manager coordinates CHRT staff involvement and supports the WHI's activities as community-based projects are implemented. Additionally, 12 CHRT staff members provide various levels of support with data acquisition and analysis, policy analysis, and convening and facilitating project activities.

2. Common agenda:
   WHI members collectively assessed access to care and coverage, as well as the health, of Washtenaw County's low-income population. Members identified gaps and, working across organizations and institutions, agreed on actions to bridge those gaps. Numerous projects were developed, each addressing one of the community-identified needs.

3. Shared measurement:
   The WHI steering committee set community-level measures of success. WHI project teams and individual member organizations report information in alignment with these measures, which are described in more detail in response to question 9.

4. Continuous communication:
   The WHI leadership body includes 14 high-level leaders (listed above in question 2) who meet monthly to review project progress, monitor data relating to the measures of success, and troubleshoot as necessary. These leaders value their seat at the table—sending a lower-level delegate is not acceptable. Monthly meetings are facilitated by CHRT Director Marianne Udow-Phillips. In addition, CHRT staff routinely communicate with the WHI's 175 members through regular newsletters and website postings, as well as respond to ad hoc member requests.

5. Mutually reinforcing activities:
   WHI member organizations drive the initiatives that address the community-identified problems, and member organizations and their staff members only participate in those projects that reinforce and align with their work. In some cases, involvement in the WHI has allowed for deeper collaborations between member organizations, outside of WHI-specific work.

5. What sources of funding support your current collaborative population health improvement work in the community? Select <u>all that apply</u>.
   - ☐ Private philanthropy
   - ☐ State grants
   - ☐ Community foundations
   - ☐ Local business
   - ☐ Local government
   - ☐ Other public funding (*A text box asking, "*Please specify other types of public funding that support your organization.*" will appear at the end of the list*)
   - ☐ Payers
   - ☐ Membership dues
   - ☐ Community benefits
   - ☐ Social impact bonds
   - ☐ Other (*A text box asking, "*Please specify what other types of funding support your organization.*" will appear at the end of the list*) The Washtenaw Health Initiative secures funding from a small number of its member organizations to offset the administrative costs of the full-time dedicated staff. In addition, the WHI Finance Committee (a subgroup of the Steering Committee) assists each community-based project team in securing necessary resources, which may include external funding. The WHI itself is not a funding body, but the Finance Committee reviews WHI project team proposals and helps facilitate connections to other funding bodies as necessary.
   - ☐ None

Partners **Page 13 of 15**

6. Please list the partners that are actively engaged with your organization (select <u>all that apply)</u>.
   - ☐ Primary care providers
   - ☐ Safety-net Clinics
   - ☐ Behavioral health/ substance abuse service providers

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

- ☐ Hospitals/ health systems
- ☐ Payers
- ☐ Long-term care community supports organizations
- ☐ Local public health department
- ☐ Schools
- ☐ Early childhood programs
- ☐ Social services organizations
- ☐ Higher education and professional training
- ☐ Business/ healthcare purchasers
- ☐ Community members
- ☐ Local government
- ☐ Other (*A text box asking, "*Please describe the other types of entities which are actively engaged with your organization.*" will appear at the end of the list*) VA Ann Arbor Healthcare System, law enforcement, ambulance providers, hospice providers

7. How does your organization engage community members, especially vulnerable populations, in your work?
   The WHI's mission is to serve the community's low-income individuals by improving access to health coverage and to coordinated, integrated care. These vulnerable populations are engaged through our community-based projects. Two current project examples reflect how vulnerable low-income populations are engaged:

   1. Blue Cross Complete Pilot - Community Health Advocates (CHA), who are well-known by fellow community members that receive special training in healthcare, to work with newly covered patients to 1) ensure they visit their primary care provider within 60 days of enrollment, and 2) address gaps in patient care. CHAs have experience navigating the health care system and provide valuable feedback to the WHI about project operations and future plans.

   2. Community Outreach - Extended outreach for health care coverage is conducted in the community through our local United Way, a WHI member organization, providing a cash match to secure two AmeriCorps members to assist community members with enrollment in state benefits, including Medicaid. Their work is carried out in several locations across the county, to better reach the people who need enrollment assistance.

Community Intervention Experience **Page 14 of 15**

8. Please indicate the types of initiatives requiring broad community coalitions that your organization has led.
   - ☐ Tobacco use reduction
   - ☐ Obesity reduction/healthy living initiatives
   - ☐ Community-wide advanced care planning
   - ☐ Child health: prevention and wellness

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

- ☐ Chronic disease prevention and/or management
- ☐ Infant mortality reduction
- ☐ Mental health/ substance abuse
- ☐ Violence reduction
- ☐ Efforts to integrate community and healthcare services (*A text box asking, "*Please describe your organization's experience with integrating community and healthcare services.*" will appear at the end of the list*) The WHI has two projects that integrate community and healthcare services: Care Net and the Blue Cross Complete Pilot.

  Care Net is a network of 85 medical care managers from patient-centered medical home practices, behavioral health settings, and social service organizations. These care managers communicate with each other through an email list and meet regularly to receive skills training on topics they request, such as motivational interviewing.

  The Blue Cross Complete Pilot uses Community Health Advocates (CHA), who are well-known community members that receive special training in healthcare, to work with newly covered patients to 1) ensure they visit their primary care provider within 60 days of enrollment, and 2) address gaps in patient care. These duties may include assisting patients to navigate various community services (such as transportation) to better utilize healthcare services.

- ☐ Health in all policies
- ☐ Community development initiatives
- ☐ Electronic Information Systems/data sharing (*A text box asking, "*Please describe your organization's experience with Electronic Information Systems and data sharing.*" will appear at the end of the list*) The WHI's Primary Care Safety Net project team has identified ways that local safety net clinics can work together across the community to address common problems. The group includes both clinics that are independent of a health system and those that are health system outpatient clinics. The WHI Primary Care Safety Net project team has facilitated the conversion of two of the independent organizations (which includes nine clinic sites) to the same electronic medical record as another independent community clinic.
- ☐ Collaborative Community Health Needs Assessments
- ☐ Community wide strategic planning
- ☐ Community health dashboards
- ☐ Performance reporting
- ☐ Integration with local public health departments
- ☐ None
- ☐ Other (*A text box asking, "*Please describe your organization's experience with other community interventions.*" will appear at the end of the list*) As noted in question 2, the VA Ann Arbor Healthcare System is not only a representative on our Steering Committee and is involved in our strategic planning, the VA is also integral to several WHI projects, especially related to mental health.

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

The WHI is also currently leading a community-wide effort to combat our community's increasing opioid problem. We have convened stakeholders from impacted sectors, such as public schools, mental health and substance use disorder providers, public libraries, law enforcement, treatment centers, and the community mental health agency. The group is drafting a multi-level intervention strategy that will guide and coordinate efforts across the community.

9. Describe your organization's experience with the collection, analysis, and communication of community-level health data:

The WHI collects data annually related to WHI measures of success (below). The WHI Steering Committee compiles and reports this data back to the community, including to funders, WHI member organizations, and the general public, through its annual report.

WHI Measures of Success

i. By the end of 2014, reduce Ambulatory Care Sensitive Condition[1] rates from 164.9 per 10,000.
ii. By the end of 2014, reduce overall emergency department utilization for the priority population from 18,194[2] visits per year by reducing non-urgent conditions (e.g., dental pain, chronic pain, upper respiratory infection, asthma, mental health and substance use)
iii. Increase the percentage of dentists who accept Medicaid patients.
iv. Increase in the number of primary care practitioners who accept Medicaid/safety net sites serving the priority populations.
v. Increased availability of ancillary providers to serve the priority populations.
vi. Increase the percentage of the priority population who are able to identify a "usual source of care," inclusive of care coordination of mental health and substance abuse services.
vii. By 2014, enroll 50 percent of the 2,400 Washtenaw County residents eligible but not enrolled in Medicaid
viii. Reduce the complexity and time it takes for individuals to enroll in Medicaid.
ix. By mid-year 2013, in concert with the state of Michigan, have enrollment structures in place prepared to handle the approximately 13,000 individuals likely newly eligible for Medicaid.
x. Assure that all individuals enrolling in Medicaid have an identified primary care practitioner and that there is some feedback mechanism from the primary care provider that a visit has occurred.
xi. Assure that post 2014, the remaining uninsured individuals have an assigned primary care practitioner.

In addition, WHI project teams conduct assessments and provide reports relating to the specific issues those projects are addressing. These data are disseminated among project teams, working

[1] Ambulatory Care Sensitive Conditions are conditions for which the hospitalization could have been prevented if managed appropriately as part of outpatient care.
[2] Data is from WHI Financial Model for FY 2010 (July 2010-June 2011) and includes visits for Washtenaw County residents covered by Medicaid, Medicare, WHP or are uninsured. The data includes adults and pediatrics as well as non-mental health and mental health-related visits.

groups, and the larger county community, as needed. Project teams also report monthly progress to the WHI Steering Committee.

➢ All Respondents continue here

SIM Planning Activity **Page 15 of 15**

1. Has your organization begun to have conversations with any of the following types of entities regarding collaboration in the SIM initiative? Select <u>all that apply</u>.
   - ☐ Healthcare payers
   - ☐ Purchasers
   - ☐ Primary care practices
   - ☐ Safety-net clinics
   - ☐ Medical specialists (*A text box asking, "*Please list the types of specialists with which your organization has begun to discuss collaboration in the SIM initiative.*" will appear at the end of the list*)
   - ☐ Medium to large hospitals
   - ☐ Critical access hospitals
   - ☐ Home health agencies
   - ☐ Behavioral health providers
   - ☐ Skilled nursing facilities
   - ☐ Long-term care community supports organizations
   - ☐ Health information exchanges
   - ☐ Local public health department
   - ☐ School systems
   - ☐ Early childhood programming
   - ☐ Social services organizations
   - ☐ Philanthropy
   - ☐ Higher education and professional training
   - ☐ Business
   - ☐ Local government
   - ☐ Other (*A text box asking, "*Please list the other types of entities with which your organization has begun to discuss collaboration in the SIM initiative.*" will appear at the end of the list*) VA Ann Arbor Healthcare System, law enforcement, ambulance providers, hospice providers
   - ☐ None

2. In order to assist your organization to successfully fulfill the role of an Accountable System of Care or a Community Health Innovation Region, what types of assistance or investment should be made available by the State?
   The Washtenaw Health Initiative would benefit from networking and consultation on the measures of success the State of Michigan seeks. In addition, depending on the needs for further data reporting and integration with the relevant ASC entities, the WHI may need

investment for additional staffing, as well as training for additional data management activities.

3. Please tell us anything else you think we should know regarding the participation of your organization and/or community as a State Innovation Model pilot site.

- The WHI is not a separate 501(c)3 nonprofit, but a voluntary collaborative.
- The two major health systems in our CHIR already work together through our organization. Although each currently uses different health information exchanges (HIE), those HIEs are merging, therefore allowing for easier data sharing between our local health systems.
- We are coordinating with the Huron Valley Physician Association, Integrated Health Associates, and the University of Michigan Hospital and Health Systems, which are all submitting survey responses as ASCs. All of these organizations are actively involved in the Washtenaw Health Initiative.
- There are 26 MiPCT practices in Washtenaw County, and many other PCMH-designated practices that are members of various physician groups (including those listed above) with which the WHI works.

Below is a letter of support from the WHI's co-sponsors to MDCH Director Haveman from December 31, 2013.

James Haveman, Director
Michigan Department of Community Health
Capitol View Building
201 Townsend Street
Lansing, Michigan 48913

Dear Mr. Haveman,

As co-sponsors of the Washtenaw Health Initiative (WHI), we urge you to consider including the WHI as a pilot site for a backbone organization for a Community Health Integrated Region (CHIR) in the State Innovation Model (SIM) grant proposal the state is submitting. The WHI is a voluntary, county-wide collaboration focused on how to improve access to coordinated care for the low-income, uninsured, and Medicaid populations.

Since its inception, our two health systems, St. Joseph Mercy Health System in Washtenaw County and the University of Michigan Health Systems, have worked closely together as we strongly believe the collaboration and commitment of time and resources between our organizations and in partnership with the VA and other key community groups, is the only way to effectively increase access to care for our most vulnerable population. As such, the WHI has the well-organized infrastructure and experience to carry out the responsibilities of a CHIR and aligns with the SIM principles and proposed activities.

We speak often about the WHI when we talk to our peers across the state. We are proud of the work we have done on the ground in our community, and especially proud that it is organized in a

way that it continues to make a positive difference for those with the least resources. The WHI extends the reach and impact of our organizations and our community partners in improving access to health care of the community.

We encourage you to learn more about the WHI, its partners and accomplishments to date by visiting the website at http://washtenawhealthinitiative.org/. We are happy to answer any questions to help you understand why we strongly feel the WHI can easily serve as a backbone organization for the Community Health Integrated Region in our area.

Sincerely,
Robert Casalou
President & Chief Executive Officer
St. Joseph Mercy of Ann Arbor, Livingston & Saline
Doug Strong
Chief Executive Officer
University of Michigan Hospitals and Health Centers

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

THE BELOW NOT APPLICABLE TO THE WASHTENAW HEALTH INITIATIVE

➢ Accountable Systems of Care Continue Here

In **Accountable Systems of Care**, providers are organized to communicate efficiently, coordinate patient care across multiple settings, and make joint investments in data analytics and technology. Through clinical integration – supported by formal governance and contractual relationships – providers co-create tools, workflows, protocols, and systematic processes to provide care that is accessible to patients and families, supports self-management, is coordinated, and incorporates evidence-based guidelines.

Population Served — Page 3 of 15

1. Approximately how many patients (with all types of insurance) are provided primary care by providers in your organization?
2. Approximately what percentage of this population are Medicaid beneficiaries?
3. Approximately what percentage of this population are Medicare beneficiaries?
4. Approximately what percentage of this population has commercial insurance?

Organizational Description and Governance — Page 4 of 15

5. What term below best describes your organization? Select <u>all that apply.</u>
   - ☐ Health System
   - ☐ Physician Hospital Organization or Physician Organization
   - ☐ Accountable Care Organization
   - ☐ Organized System of Care
   - ☐ Clinically Integrated Network
   - ☐ Health Plan
   - ☐ Other (*A text box asking, "*Please provide a description of your organization.*" will appear at the end of the list*)

6. Does your organization have a Board of Directors and bylaws?
   - ☐ Yes
   - ☐ No

Network Composition — Page 5 of 15

7. How many primary care provider practices (physicians, nurse practitioners, and physician assistants) are affiliated with your organization?

8. What proportion of affiliated primary care practices has attained Patient-Centered Medical Home status?

9. If your organization were to form an ASC to participate as a Test Pilot, with what types of entities would you partner (i.e., entities that would accept risk and/or share in savings)? Select <u>all that apply</u>.

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

- ☐ Primary care practices
- ☐ Federally Qualified Health Center
- ☐ Specialists (*A text box asking "*Please list types of affiliated specialists" *will appear at the end of the list*)
- ☐ Medium to large hospital
- ☐ Critical Access Hospital
- ☐ Home health agency
- ☐ Behavioral health provider (*A text box asking "*Would this behavioral health provider be a Community Mental Health Services Provider- (yes/no) *will appear at the end of the list*)
- ☐ Skilled nursing facility
- ☐ Other (*A text box asking "*Please list what other types of entities your organization might partner with to form an Accountable System of Care" *will appear at the end of the list*)

10. Can you think of a specific entity within your community that is well-suited to serve as a 'backbone organization' for a Community Health Innovation Region?
    a. Yes (*A text box asking "*Please name this entity and, if possible, provide a contact" *will appear*)
    - ☐ No
    - ☐ Unsure

Complex Care Coordination **Page 6 of 15**

11. Is your organization working with partners on any of the following? Select all that apply.
    - ☐ Arrangements between specialists and primary care providers for timely referral and follow-up expectations and processes?
    - ☐ Chronic care management processes
    - ☐ Care transitions

Page 7 of 15

12. Please tell us whether your organization has systematically addressed any of these areas by checking all that apply for each focus area.

	Our organization has developed or adapted care protocols to address this area	**Our organization has provided training/ coaching to practices on this topic**	**Our organization tracks performance in this area**
Addressing at-risk pregnancy	☐	☐	☐
Integration of behavioral health and primary care	☐	☐	☐
Addressing super-utilizers of the emergency department or hospital	☐	☐	☐

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

Management of multiple chronic disease	☐	☐	☐
Other (*A text box asking,* "Please describe your organization's other targeted interventions or activities" *will appear)*	☐	☐	☐

Health Information Technology and Data Analytic Capacity **Page 8 of 15**

The following section should be completed by someone with knowledge of your organization's Health Information Technology data infrastructure and capacity. If you need to save and return to this survey later, or if another member of your organization would be better able to address this topic, please **be sure to save the validation code shown.**

Page 9 of 15

13. Please tell us about integration of health information technology across your organization by checking the most appropriate response under each Health Information Technology topic.

	Our organization has an integrated solution currently	**Our organization is working towards an integrated solution across settings**	**Our organization is not working on an integrated solution**
Electronic Health Record	☐	☐	☐
Personal health record/patient portal	☐	☐	☐
Electronic registry	☐	☐	☐
Electronic care management documentation system	☐	☐	☐
Health Information Exchange	☐	☐	☐

14. Please provide information about your data infrastructure by checking all the electronic/analytic capabilities your organization has currently:
    - ☐ Identify high risk patients needing complex care management
    - ☐ Track and report total cost of care (across all settings) for patients attributed to affiliated primary care providers
    - ☐ Identify patients admitted/discharged or transferred to an Emergency Department or hospital affiliated with your organization
    - ☐ Identify within 24 hours patients admitted/discharged or transferred to an Emergency Department or hospital NOT affiliated with your organization, but where your patients commonly go
    - ☐ Report clinical performance data to payers
    - ☐ Other (*A text box asking,* "Please describe the data analytic capabilities currently in place in your organization" *will appear at the end of the list*)
    - ☐ Unknown

    Please tell us anything else you think we should know regarding your organization's Health Information Technology and data analytic capacity.

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

Payment Model Innovation **Page 10 of 15**

The following section should be completed by someone with knowledge of your organization's finances and strategic planning. If you need to save and return to this survey later, or if another member of your organization would be better able to address this topic, please **be sure to save the validation code shown.**

Page 11 of 15

15. How comfortable is your organization with the following payment options (assuming the details, such as capitation rates, calculation of performance, patient attribution, etc., can be worked out fairly)?

	Our organization has experience contracting in this way	**Our organization is interested in negotiating this type of payment arrangement**	**Our organization is not interested in participation in this payment model**
Partial capitation for a defined set of services	☐	☐	☐
Global capitation for defined populations, or target conditions	☐	☐	☐
Bundled payments for episodes of care	☐	☐	☐
Shared savings with only upside risk	☐	☐	☐
Shared savings with both upside and downside risk	☐	☐	☐

Please tell us anything else you think we should know regarding your organization's experience with payment model innovation.

[Accountable System of Care Respondents electronically advanced to SIM Planning Activity questions page 15 of 15]

FOR REVIEW PURPOSES ONLY – DO NOT SUBMIT THIS SURVEY
SURVEY IS AVAILABLE ONLINE: https://dataentry.ibem-is.org/surveys/?s=hjvKDhgtvn

WASHTENAW HEALTH INITIATIVE

Select State and National Coalitions: WHI Comparison Examples

Original questions:

- How does the WHI compare to other coalitions across the country?
- What can we learn from them about the key elements that make those coalitions work?
- Is there anything we should change about how the WHI operates, to be more in alignment with other successful coalitions?

CHRT staff reviewed coalitions across Michigan and the United States, pulling examples of different types of coalitions to highlight the variety in each type of coalition. This is not an exhaustive list of all health-related coalitions in the country, but rather a representative sample. Coalitions were included that met the following criteria:

- Health related
- Goal of improving health care access or health status of a population
- Community collaborations
- Multi-sector
- Measure some outcomes

Health care quality and purchasing coalitions, or those that are strictly business-focused, were not included.

Washtenaw Health Initiative *(for comparison)*						
Examples	**Mission**	**Funding**	**Population Focus**	**Staffing**	**Operating Structure**	**Focus Issue(s)**
Washtenaw Health Initiative *(Washtenaw County, Michigan)*	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	• Health systems • Foundations • Public • Grants	Low-income residents of the county, including uninsured and Medicaid recipients	1 full-time dedicated staff support, plus other technical and administrative assistance	• Voluntary (no bylaws) • Non-governmental • Steering Committee • Issue working groups • Project teams	• Primary Care • Mental Health • Substance Use Disorders • Dental Care • Insurance Coverage • Care Coordination

Health Issue Coalition/Task Force/Working Group
This type of group forms to address a specific health issue. Group size and meeting frequency varies among groups, as do staffing models. Generally, the larger the group, the more likely it is to be supported by a paid staff person, usually based at a health department or health system. The goals of this type of group are specific to the health issue being addressed.

Examples	Mission	Funding	Population Focus	Staffing	Operating Structure	Focus Issue(s)
Healthy Pontiac, We Can! *(Pontiac, Michigan)* http://www.healthypontiac.org/	Healthy Pontiac, We Can! wants to help the Pontiac community eat healthy, get active, and live tobacco-free. Healthy Pontiac, We Can! asked residents what they do to be healthy and what they need from their community to be healthy. Looking at these answers and other available information, the group wrote a plan to support residents needs in eating healthier, moving more, and avoiding tobacco in Pontiac.	Michigan Department of Community Health grant	All city residents	Part-time staff from the health department	• Governmental (health department) • Community advisory board • Topical subcommittees	• Obesity (increase physical activity, healthy eating) • Tobacco use reduction
Hennepin County Children's Mental Health Collaborative (HCCMHC) *(Hennepin County, MN)*	The HCCMHC is a catalyst for improving children's lives by serving as convener, coordinator, advisor and advocate for community efforts to increase access to and resources for high quality mental health services for children and families. http://www.hccmhc.com/	Originally established by award funding from state legislation for Children's Mental Health Collaboratives, lost state funds in 2011 due to cuts.	Children up to age 18 with an emotional or behavioral disturbance or who are at risk of suffering an emotional or behavioral disturbance	"Collaboration team" of 4 staff (not FT) and outside research consultants	• Governance group of 18 voting • members • Ad Hoc Work Groups and • Standing Committees	• Children's mental health • Early childhood development
Minnesota Diabetes and Heart Health Collaborative *(Statewide)*	Work together to improve diabetes and heart health outcomes and health equity by using consistent messages, developing educational resources, and advancing best practices to support healthy behaviors in the community http://mn-dc.org/	• In-kind contributions from member organizations • National Association of Chronic Disease Directors grant to the Minnesota Department of Health	Minnesota diabetics and prediabetics and those at risk for heart disease	No dedicated staff, but co-chaired by volunteers from the two lead organizations	• Nonprofit partnership convened by Stratis Health and MN state Department of Health • Co-led by state Diabetes Prevention & Control Program and Medicare Quality Improvement Organization	• Offer consistent, coordinated, evidence-based diabetes messages • Promote best diabetes practices • Coordinate initiatives • Share knowledge and expertise • Stretch limited resources to achieve common goals

Coordinating Collaborations
These groups can be very geographically large, and are sometimes an entire organization. Some are membership-based groups, and some are voluntary coalitions. Some of these groups are led by local health departments and receive funding from foundation and other sources. Member agencies can include health, mental health, social service organizations that provide a wide variety of services, and may contain safety net providers or nonprofit agencies that strive to increase access to coordinated health and social services for low-income communities. Most also have health system involvement. An overarching steering committee contains representatives (usually the chair or co-chairs) of any constituent working groups or coalitions. This type of group has high-level outcomes and measures, which includes the measures from any subgroups. The subgroups may focus on health issues or social determinants of health. This type of group has often has multiple dedicated administrative staff members, who support a variety of initiatives, task forces, and working groups. The staff members may be housed by a governmental agency, like a health department, or may be its own organization.

Examples	Mission	Funding	Population Focus	Staffing	Operating Structure	Focus Issue(s)
AccessHealth SC *(Statewide)* http://www.scha.org/accesshealth-sc	Our mission is to support communities in creating and sustaining coordinated data-driven provider networks of care that provide medical homes and ensure timely, affordable, high quality healthcare services for low income uninsured people in South Carolina.	Sponsorship from: • Health plans • Banks • Consulting firms • Law firms • Accounting firms	Low-income, uninsured South Carolinians	2 full-time staff members of the South Carolina Hospital Association	Program of the South Carolina Hospital Association	• Developing networks of care • Coordinating care
Capital Care Collaborative *(Wake County, North Carolina)*	The Capital Care Collaborative (CCC) is a membership of safety net providers working collaboratively to develop initiatives to improve the health of the region's medically underserved. Mission: To increase access to appropriate levels of care for, and improve health outcomes http://www.capitalcarecollaborative.com/	• Universities • Foundations • Health/human service departments	Wake County uninsured and underserved	9 full-time staff members	• Non-governmental • Steering Committee	• Increase access to medical, mental health, and human services for the uninsured • Reduce ED visits • Assist with receipt of disability/Medicaid benefits
Coordinated Collaborative Care *(Fayette County, GA)*	Coordinated Collaborative Care (C3) shares clients with the goal of providing adequate, coordinated resources to empower clients/patients to make long-term lasting change that supports healing and optimum health http://www.fayettefactor.org/coordinated-collaborative-care-c3.html	No outside funding; each member organization contributes staff time	Fayette County, GA uninsured population	Each member organization contributes staff time	• Nonprofit • Informal collaborative	Provide coordinated care that serves and monitors the needs of the patient. Deliver a high level of care that is comparable to those with access to mainstream health and wellness care

Examples	Mission	Funding	Population Focus	Staffing	Operating Structure	Focus Issue(s)
Emergency Department Care Coordination Coalition *(Milwaukee, WI)*	By linking patients to medical homes and decreasing duplicative emergency room tests and procedures, this initiative is working to improve the quality, coordination and cost-effectiveness of care for Milwaukee's vulnerable population. http://mkehcp.org/care-coordination-2/emergency-department-care-coordination/	• Member contributions and support • Philanthropy	Milwaukee residents who are established patients with a specialty care access program (SAUP) safety net clinic, low income, and unable to secure public or private insurance	One full time dedicated staff member (Milwaukee Partnership Executive Director)	• Public-Private Partnership (Milwaukee Health Care Partnership) • Board of Directors • Committees Working groups	Decrease avoidable ED visits and related hospitalizations, reduce duplicative ED tests and procedures, and connect high-risk individuals with health homes and other health resources
Greater Detroit Area Health Council (GDAHC) *(Metro Detroit, Michigan)*	We improve the health and wellbeing of people living in southeast Michigan by solving health problems that can be addressed only through multi-sector collaboration. http://www.gdahc.org/	• Member-ship dues (organizations are the member unit) • Grants	• Residents in 7-county area • Organizations in 7-county area	12 full-time staff members	• Nonprofit • Board of Directors • Committees and task forces	• Decrease healthcare costs • Improve healthcare quality • Improve population health
Greater Flint Health Coalition *(Genessee County, Michigan)* http://www.gfhc.org/index.asp	To improve the health status of Genesee County residents and to improve the quality and cost effectiveness of the health care delivery system. It is both a community /institutional partnership and multifaceted collaboration, with a board that is a broad reflection of the community's leadership-including government, hospitals, labor, business, insurers, physicians, education, consumers and the faith-based community.	• Health plans • Health systems • Unions • Academic institutions • Banks • Professional associations • County government	All residents in the county	9 full-time staff members	• Nonprofit • Board of Directors • Project and Program Teams • Committees	• Decrease healthcare costs • Improve healthcare quality • Improve population health • Improve access to care

Examples	Mission	Funding	Population Focus	Staffing	Operating Structure	Focus Issue(s)
Muskegon Community Health Project *(Muskegon County, Michigan)* http://www.mchp.org/	The Muskegon Community Health Project, in partnership with Mercy Health Partners, is an inclusive, community-based, decision-making not-for-profit agency that has as its mission improving health care and its delivery in Muskegon County and in the surrounding West Michigan region. Our mission is to facilitate community identification and resolution of health issues, oversee the evaluation and coordination of activities to improve health outcomes, and initiate health-related projects, providing support and oversight when other community resources are not available.	Funded through Mercy Health Partners community benefit	All residents in the county	17 full-time staff members (for this project and the health system's community benefit program)	• Nonprofit • Board of Directors • Many health issue-specific coalitions are members	• Access to care • Community health needs assessments • Alcohol and other drugs and tobacco use • Health disparities
Power of We Consortium *(Ingham County, Michigan)*	The PWC's mission and vision, respectively, are to improve the quality of life and self-sufficiency of all residents in Ingham County, and to create a healthy community through collaboration. http://powerofwe.org/	• County funding for their human service collaborative body • AmeriCorps and matching funds	All residents in the county	4 full-time staff people, and provide AmeriCorps members to area human services agencies	• Governmental • Overarching coordinating (steering) committee • Subcommittees are each a separate coalition with a separate focus • 200 member organizations	Overall community wellbeing, focusing on: • Education & youth • Economic opportunity • Infrastructure & transportation • Racial equity & healing
Voices of Detroit Initiative (VODI) http://voicesofdetroitinitiative.org/	To provide affordable access to effective healthcare for the uninsured and under-insured through organized delivery systems.	• Based at Wayne State University, which gives in-kind support • Grants for programs	Wayne County patients of federally qualified health centers and free clinics, with a focus on the uninsured and those under 200% of federal poverty guidelines	3 full-time staff members	• Nonprofit • Committees and task forces	• Access to coverage • Access to care

Emergency Preparedness Coalition

Most of these coalitions arose after 2005, in the aftermath of Hurricane Katrina. The federal government made a big push for preparedness, including providing funds for communities to come together to create action plans to address emergencies. Many of these coalitions are driven by local health departments, and are grant funded.

U.S. Department of Health and Human Services (HHS) has defined healthcare coalitions as: A collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations. The purpose of a healthcare coalition is a healthcare system-wide approach for preparing for, responding to, and recovering from incidents that have a public health and medical impact in the short and long-term. The primary function of a healthcare coalition is sub-state regional healthcare system emergency preparedness activities involving the health and medical members. This includes planning, organizing, equipping, training, exercises and evaluation. Initial federal guidance from U.S. Department of Health and Human Services: http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf

Examples	Mission	Funding	Population Focus	Staffing	Operating Structure	Focus Issue(s)
Kansas Preparedness Healthcare Coalitions *(Statewide)*	Development of healthcare coalitions (HCCS) became a federal preparedness cooperative agreement requirement in 2012. In Kansas, a decision was made to create seven HCCs to minimize the burden of meeting this requirement at the local level. http://www.kdheks.gov/cphp/hcc.htm	Federal grants	Entire resident population	State health department staff	• Governmental (health department) • Steering Committee • Committees and task forces	Emergency preparedness
MESH, Inc. (formerly Managed Emergency Surge for Healthcare) *(Marion County, Indiana)*	To enable healthcare providers to respond effectively to emergency events, and remain viable through recovery. To ensure effective all-hazards emergency preparedness and delivery of high quality healthcare services http://www.meshcoalition.org/	• Federal grants • Supported by "Subscribing Healthcare Partners" and "Coalition Partners" • Revenue sources as of 2012 Annual Report: ○ 56% grants and donations ○ 44% Fee for Service	Entire resident population	County health department staff	• Nonprofit, public-private partnership • Executive leadership • Board of Directors	Coordination of emergency preparedness resources for healthcare sector

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

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

Charter

2014 Statement of Commitment

The mission of the Washtenaw Health Initiative (WHI) 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

The Washtenaw Health Initiative is a voluntary, county-wide collaboration of local leaders and organizations designed to improve the coordination and delivery of health care for low-income, uninsured, and Medicaid populations in Washtenaw County. Participating individuals and organizations recognize that we have a responsibility to assist those in our community who lack access to high-quality health care.

The leadership of the undersigned organization supports WHI's goals and mission as set forth in the attached Mission Statement. As a Charter Member of WHI, the organization understands that WHI's success depends on the active engagement and support from all sectors of our community. Otherwise, the promise of health care access for low-income, uninsured, and Medicaid populations cannot be achieved.

By becoming a voluntary Charter Member, we pledge to work with other members to help make WHI a success. Our signatures below express our commitment to develop and implement solutions that will improve access to high quality health care for everyone in our community.

At a minimum, we commit to assigning our staff to participate on appropriate WHI committees and other WHI activities. We will also provide in-kind contributions, including data, which will help identify opportunities for increased access to health care. To the extent possible, we will identify and offer financial resources.

We will also promote WHI programs through our newsletter, social media, web and other outlets. In return, WHI will recognize Charter Members' leadership and involvement in its marketing efforts.

Our organization appreciates that time is short and requires continued momentum to accomplish WHI's vital goals. Working together, we can make access to health care a reality for underserved populations in Washtenaw County.

_____
Organization

_____ _____
Executive Director (date) Member, Board of Directors (date)

_____ _____
WHI Co-chair (date) WHI Co-chair (date)

WASHTENAW HEALTH INITIATIVE

Measures of Success

WHI Goals:

1. Increase and maintain insurance coverage for low-income, uninsured and Medicaid recipients in Washtenaw County
2. Improve their access to coordinated, integrated care
3. Develop a voluntary collaborative, community-based, health planning model that can be replicated in other communities across Michigan and the nation

Below is a list of the measures that will be monitored to assess progress on goals 1 and 2.

Measures of Success (2014 and beyond)	Interim Measures (by end of 2013)
Capacity Building and Coordination of Health Care	
1. By the end of 2014, reduce Ambulatory Care Sensitive Condition[1] rates from 164.9 per 10,000	a. Increase full-time equivalent primary care providers at safety net sites in Washtenaw County compared to 2011 baseline b. Increase number and proportion of newly enrolled Blue Cross Complete members who see a primary care provider within 90 days of enrollment compared to 2011 baseline c. Additional measure for Care Navigation project TBD once project is fully defined d. Reduce emergency department utilization for acute dental care relative to 2011 baseline. e. Design, test and disseminate the substance use protocol, and educate X physicians in the community on its use
2. By the end of 2014, reduce overall emergency department utilization for the priority population from 18,194[2]visits per year by reducing non-urgent conditions (e.g. dental pain, chronic pain, upper respiratory infection, asthma, mental health and substance use)	
3. Increase access to services for Medicaid patients and the uninsured. Increased access can include, for example:	
a. An increase in the percentage of dentists who accept Medicaid patients;	a. Currently no project or short-term measure addresses Medicaid expansion, however, the reduced fee dental initiative has a goal to increase access for the uninsured. Its' short term measure: By June 2013, recruit 12 dentists for reduced fee dental initiative who see 1-2 patients per month (144 annually).
b. An increase in primary care practitioners who accept Medicaid/safety net sites serving the priority populations;	a. Increase full-time equivalent primary care providers at safety net sites in Washtenaw County compared to 2011 baseline
c. Increased availability of ancillary providers to serve the priority populations.	a. Establish program and begin to make referrals through Blue Cross Complete to social service providers b. Mental Health measure TBD once project is

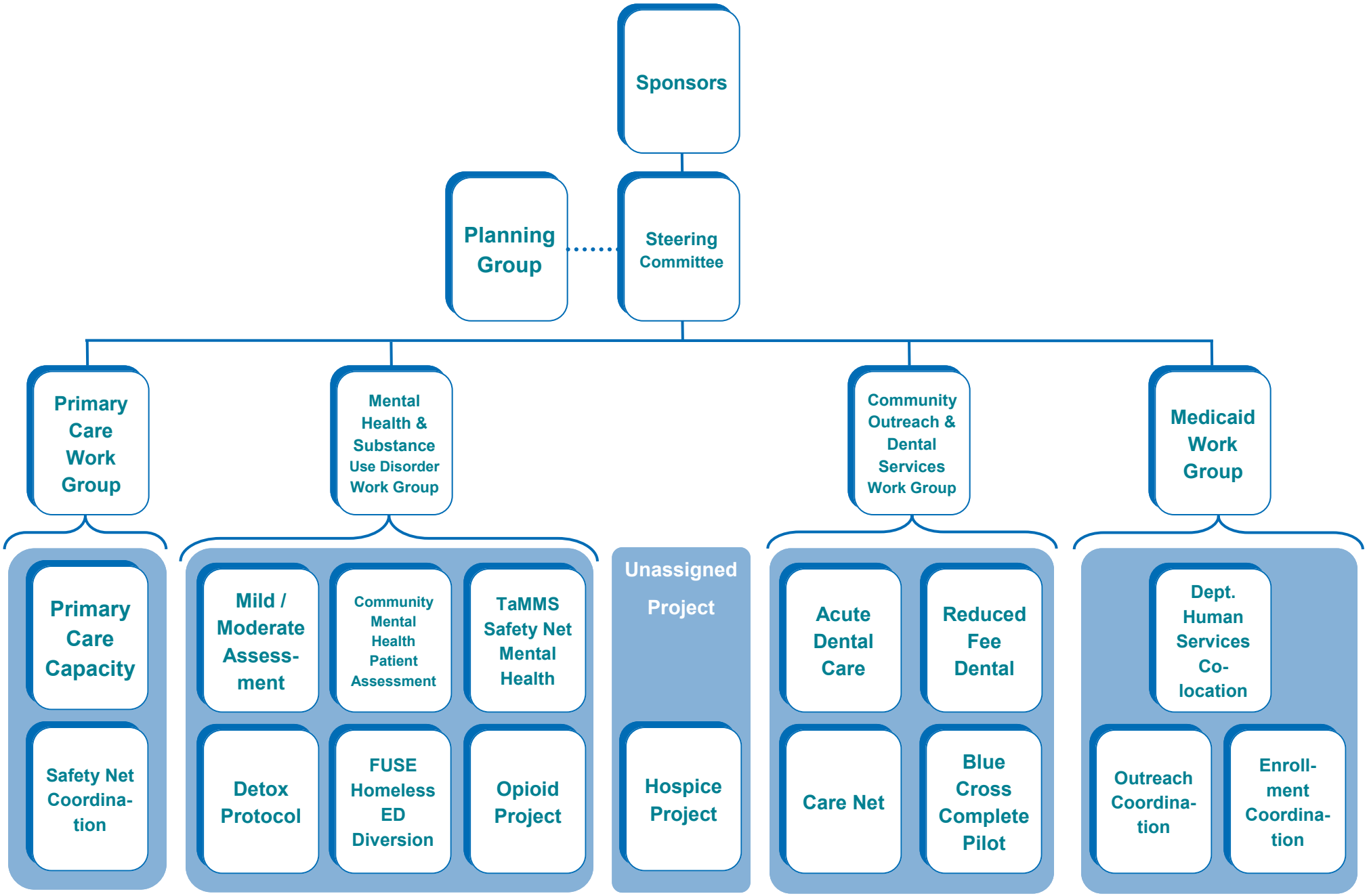
[1] Ambulatory Care Sensitive Conditions are conditions for which the hospitalization could have been prevented if managed appropriately as part of outpatient care.

[2] Data is from FY 2010 (July 2010-June 2011) and includes visits for Washtenaw County residents covered by Medicaid, Medicare, WHP or are uninsured. The data includes adults and pediatrics as well as non-mental health and mental health-related visits.

	fully defined
4. Increase the percentage of the priority population who are able to identify a "usual source of care" from, inclusive of care coordination of mental health and substance abuse services (e.g., increase the number of primary care physicians who have onsite social work services, nutritional counseling and the like).	a. Increase number and proportion of newly enrolled Blue Cross Complete members who see primary care provider within 90 days of enrollment compared to 2011 baseline b. Establish program and begin to make referrals through Blue Cross Complete to social service providers
Eligibility, Enrollment and Outreach	
5. By 2014, enroll 50 percent of the 2,400 Washtenaw County residents eligible but not enrolled in Medicaid)	a. Increase enrollment of those Washtenaw County residents who are Medicaid eligible but not enrolled by 50 percent
6. Reduce the complexity and time it takes for individuals to enroll in Medicaid.	
7. By mid-year 2013, in concert with the state of Michigan, have enrollment structures in place prepared to handle the approximately 13,000 individuals likely newly eligible for Medicaid.	a. WHI provides input to state on exchange implementation
8. Assure that all individuals enrolling in Medicaid have an identified primary care practitioner and that there is some feedback mechanism from the primary care provider that a visit has occurred.	a. Increase in number and proportion of newly enrolled Blue Cross Complete members who see primary care provider within 90 days of enrollment compared to 2011 baseline
9. Assure that post 2014, the remaining uninsured individuals have an assigned primary care practitioner.	a. Increase full-time equivalent primary care providers at safety net sites in Washtenaw County compared to 2011 baseline

The following will be collected to assess progress towards goal 3:

Number of participating organizations and members
Number of hours of WHI-related work of participating organizations
Self-reports of changes in organizational effectiveness and collaboration


Sponsors
Planning Group
Steering Committee
Primary Care Work Group
Mental Health & Substance Use Disorder Work Group
Community Outreach & Dental Services Work Group
Medicaid Work Group
Primary Care Capacity
Safety Net Coordina-tion
Mild / Moderate Assess-ment
Community Mental Health Patient Assessment
TaMMS Safety Net Mental Health
Detox Protocol
FUSE Homeless ED Diversion
Opioid Project
Unassigned Project
Hospice Project
Acute Dental Care
Reduced Fee Dental
Care Net
Blue Cross Complete Pilot
Dept. Human Services Co-location
Outreach Coordina-tion
Enroll-ment Coordina-tion

Current WHI Projects

Work Group	Project	Phase* 1	2	3	4	5	6	7	8	Expected End (if any)
Primary Care	Primary Care Capacity	■	■	■	■	■	■			Ongoing
	Safety Net Coordination	■	■				■			Ongoing
Medicaid	DHS Co-Location	■	■	■		■	■	■		Ongoing
	Outreach Coordination	■	■	■			■	■		Ongoing (cyclical)
	Enrollment Coordination	■	■	■			■	■		Ongoing (cyclical)
Community Outreach & Dental Services	Acute Dental Care Referral Pilot	■	■	■	■	■	■			November 2014
	Reduced Fee Dental Initiative	■	■	■	■	■	■	■		Conduct new needs assessment in 2Q15
	Care Net	■	■	■	■	■	■			Ongoing
	Blue Cross Complete Pilot	■	■	■	■	■	■			December 2014
Mental Health & Substance Use Disorder	Mild/Moderate Assessment	■								October 2014
	Community Mental Health Patient Assessment	■								June 2015
	TaMMS Safety Net Mental Health	■	■	■	■	■				December 2015 (?)
	FUSE Homeless ED Diversion	■	■	■		■	■			December 2015
	Substance Use Disorder Detox Protocol	■	■	■						(currently revising) ongoing
	Opioid Project	■	■							To be determined
Unassigned	End of Life Care	■	■							To be determined

Dark blue boxes indicate which phase(s) the project has completed, or is in at the moment.

***Phases:**

1. **Needs Assessment** – initial data gathering/assessment, identify gaps
2. **Concept Development** – identification of best practices to fill identified gaps
3. **Detailed Design** – project details identified (project team, team leader, financials/budget, identify funding, etc.)
4. **Financial Review** – as necessary, project proposals are reviewed by the WHI finance committee
5. **Implementation** – beginning months of a project operation
6. **Operation** – the ongoing activities of the project
7. **Evaluation** – outcome and process data is collected and reported
8. **Complete** – the project is no longer needed, the funding has ended, or is otherwise no longer in operation

WASHTENAW HEALTH INITIATIVE

November 2012

Dear Community Partners,

We are pleased to share with you some of our early successes with the Washtenaw Health Initiative (WHI). The WHI kicked off in January 2011, and over the first two years, we've made a positive impact for our community members who are Medicaid recipients, are low-income, or lack health insurance.

A key feature of the WHI is its voluntary nature. As of November 2012, more than 90 people participate voluntarily in WHI working groups. From July 2011 through June 2012, more than 8,200 hours were dedicated to the effort all across the county, from safety net medical and dental clinics to various community outreach locations. Another key feature of the WHI is the facilitation and research support provided by the Center for Healthcare Research & Transformation.

The WHI has worked to leverage and coordinate financial and human resources throughout this community to support the various initiatives. We thank our numerous funders, and especially our two major sponsors: St. Joseph Mercy Health System and the University of Michigan Health System.

Next year's work will consist of continuing the planning and pilot project implementation that has begun, as well as potentially developing new ideas to improve access to coverage and better coordinate care for our community's most vulnerable.

Thank you for your participation and support of the Washtenaw Health Initiative. We look forward to working with you to continue these successes in 2013 and beyond.

Sincerely,

Robert Guenzel

Norman Herbert

WASHTENAW HEALTH INITIATIVE

The Washtenaw Health Initiative

In late 2010, community leaders agreed on the importance of developing local solutions to the problems of today while focusing on planning for the future. The Washtenaw Health Initiative (WHI) had its formal start with a planning group meeting in January of 2011, as community leaders came together to discuss how best to help Washtenaw County plan and prepare for implementation of the Patient Protection and Affordable Care Act of 2010. With the sponsorship of both the University of Michigan Health System and Saint Joseph Mercy Health System, a 12-member steering committee was formed. From January to March 2011, the planning group expanded to include more than 40 people from multiple community sectors working together to assess the state of health care for Medicaid recipients, low-income residents, and the uninsured in the county. By July 2011, this group made recommendations to improve access and coordination of care for these populations. The WHI has grown from 40 participants representing 20 organizations to more than 70 participants from more than 40 organizations.

A Community Effort

We are particularly pleased and proud to acknowledge the generous and tireless support of our funders and community members. To date, WHI members provided more than 8,200 volunteer hours in support of WHI projects. The WHI received more than $25,000 and another $86,000 has been committed by our generous community partners:

- Ann Arbor Area Community Foundation
- City of Ann Arbor
- City of Ypsilanti
- Individual donors
- Saint Joseph Mercy Health System
- University of Michigan Health System
- Washtenaw County Board of Commissioners
- United Way of Washtenaw County

We are especially grateful for the University of Michigan Health System and Saint Joseph Mercy Health System, without whose sponsorships we would not succeed.

Our Goals

With a focus on Washtenaw County's Medicaid recipients, low-income residents and the uninsured, the WHI is working toward two major goals for these priority populations:

- Increasing and maintaining insurance coverage.
- Improving access to coordinated, integrated care.

Additionally, the WHI seeks to be a model and a resource for other communities considering how best to serve the needs of its most vulnerable citizens.

Our Accomplishments

Since inception, the WHI has made considerable progress toward our goals.

Increasing and Maintaining Coverage

The WHI found that approximately 2,700 residents were eligible but not enrolled in Medicaid. To address this, Department of Human Services caseworkers were co-located within the Washtenaw Health Plan offices to streamline eligibility determination and enrollment. As a result of this new process, more than 1,700 people in our community enrolled in the state's Medicaid program for the first time or were able to maintain their coverage with the help of these caseworkers. In addition, this program employs two full-time AmeriCorps members who determined eligibility, enrolled residents for Medicaid and other benefits, as well as educated organizations about eligibility for benefits at more than 40 locations.

Improving Access to Coordinated, Integrated Care

The WHI is improving access to care through better coordination and integration of care. Specific accomplishments include:

- Worked with a major dental plan to clarify policies that prevented dentists in Washtenaw County from using sliding-fee scales for their uninsured patients. This enabled the creation of a new reduced-fee dental program. Since June 2012, six dentists agreed to see low-income patients using an income-based fee scale. In the first four months of operation, 19 patients were enrolled in the program.
- Conducted a detailed analysis of safety net clinics' capacity to accommodate new primary care patients. The project team developed a detailed business case that is now being considered by the sponsors. The goal is to augment staff in four safety net clinics in the county. Once fully integrated, the intent is for these clinicians to handle an estimated 15,000 additional primary care visits per year.
- Developed a countywide protocol to streamline the referral process for substance use detoxification and treatment process for patients in the safety net setting.
- Developed a pilot program to improve access to primary care providers among those newly enrolled in Medicaid. This will be tested in one safety net clinic in 2013 and includes assessment and referral for social service needs as well as processes to improve the likelihood of the newly enrolled receiving their first visits with their primary care providers within 90 days of enrollment.

Building a Model for Community Collaboration and Planning

Additionally, the work of the WHI generated many collaborative activities with WHI partners, demonstrating the synergy that is occurring in Washtenaw County thanks to this initiative:

- Co-wrote and submitted a $10 million Centers for Medicare & Medicaid Services Innovation grant in collaboration with the University of Michigan Health System and the University of Michigan Depression Center.
- Facilitated connections between Washtenaw County and the Michigan Department of Community Health that enabled successful submission of a Screening, Brief Intervention, Referral and Treatment grant. This grant will place care managers in local safety net settings to assist residents struggling with substance use.
- Received several inquiries from other communities to learn more about the WHI and how they might replicate the effort in their own communities.
- WHI activities have been highlighted in 15 publications.

Looking Ahead

In just a year and a half, the WHI accomplished a great deal; however, there remains much to be accomplished. Projects on the horizon include:

- Supporting primary care clinicians in diagnosis, treatment, and management of depression symptoms.
- Enhancing the capacity of the dental care safety net to provide acute and on-going care for uninsured and Medicaid patients.
- Improving care coordination across the county by supporting care and case managers from many systems to interact and work together on a regular basis.
- Developing a tool kit for other communities that wish to implement their own voluntary, community-based efforts.

Throughout the next year, the WHI will continue to reassess the needs of the community and develop additional projects to address emerging needs. We look forward to continuing our work improving health care coverage and access to care on behalf of Washtenaw County, and especially its most vulnerable citizens.

For more information, contact:
Carrie A. Rheingans, MPH, MSW
Washtenaw Health Initiative Project Manager
www.washtenawhealthinitiative.org
crheinga@umich.edu
Phone (734) 998-7567
Fax (734) 998-7557

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.