HEALTH AND SOCIAL SERVICE INTEGRATION

SUMMIT

WASHTENAW HEALTH INITIATIVE

WHI Steering Committee

- Trish Cortes (CMH)
- Ginny Creasman (AA VAMC)
- Tony Denton (Mich Med)
- Gregory Dill (Wash Cty)
- Jeremy Lapedis (WHP)
- Eve Losman (MM CCMP)
- Jimena Loveluck (WCHD)
- Benjamin Miles (Chelsea H)
- Angela Moore (Community)
- Dena Nagarah (Blue Cross)
- Naomi Norman (WISD)
- Steve Petty (5 Hlthy Twns)
- Alex Plum (Corner)
- Alfreda Rooks (MM {WHI Officer})
- Tendai Thomas (IHA)
- Shekinah Singletery (Trinity)

WHI Strategic Planning Committee

> Ruth Kraut	*Wash Cty Health Dept*.
> Andy LaBarre	*Wash Cty Commissioner*
>Chris Lemon	*AA Area Community Foundation*
>Dena Nagarah	*Blue Cross Complete*
>Steve Petty	*5 Healthy Towns*
>Alfreda Rooks	*Michigan Medicine*

WHI Mission

Improve health, health equity, and healthcare in Washtenaw County and surrounding communities with an emphasis on low income, uninsured and underinsured populations.

Address immediate and underlying barriers to health, including the structural causes of race-based health inequity.

Sectors Represented at the Summit

- Health Care
- Social Service
- Government
- Philanthropy
- Medicaid Health Plans
- Education
- Business
- Community members

Goals

> **DESCRIBE:**

1. **Current health priorities**
2. **State initiatives**
3. **Local organizations**
4. **Community Care Hubs**

> **DO:**

1. **Identify priority areas**
2. **Outline organizational and funding mechanisms**
3. **Plan next steps**

Guiding Principles…

Uncertainty and threats to resources can lead to EITHER:

Separation for individual survival

OR

Organizing for efficient use of shared resources

Build a foundation for the future

Let’s Get Going!

- We’re here to meet each other

- If you didn’t register online, make sure you leave us contact information

Agenda

- History of health and social service integration
- National Call and Demonstration Project
- Community needs assessments

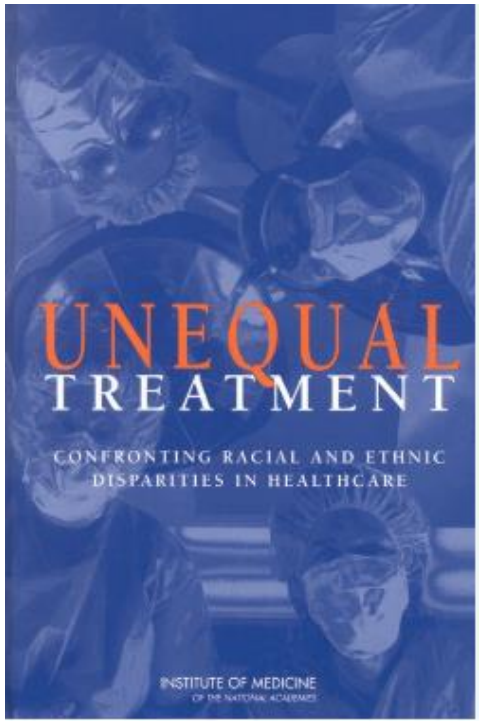
History of Health and Social Services Integration

- Historic separation of public health, social services, health care, behavioral health care
- 1980's - Role of 'social' factors in health increasingly documented
- 2000's –
  - Trials of 'social' interventions to improve health
  - Connections between health and social service sectors
- Mixed results on costs and improved health

Health and Social Services Integration (cont'd)

- 2014 – Affordable Care Act (ObamaCare) transformed the healthcare landscape, providing access to health care for 35 million people.

- Race/ethnic and socioeconomic disparities in health more starkly visible

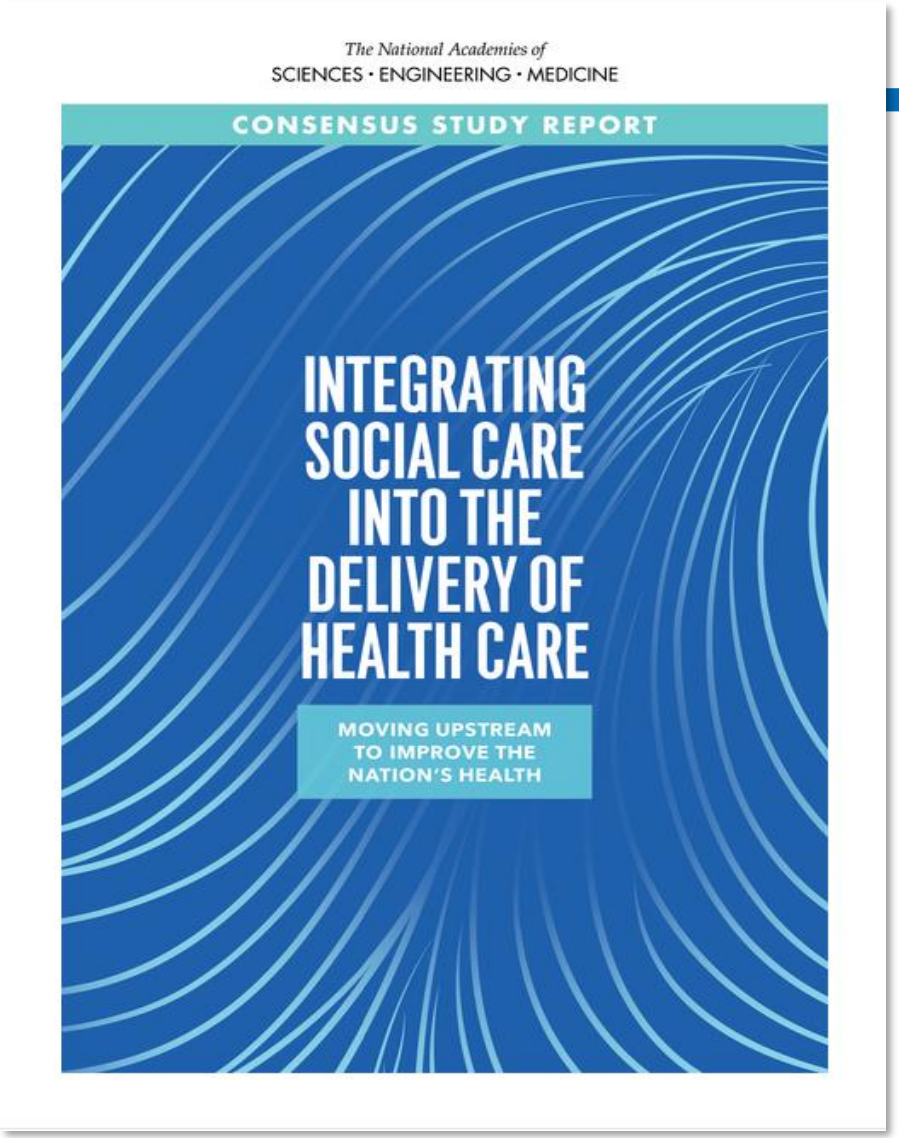


https://aspe.hhs.gov/sites/default/files/documents/8e81cf90c721dbbf58694c98e85804d3/health-coverage-under-aca.pdf

National Call to Action and Demonstration Project

Mid 2010's – demonstrations and system reforms examined unifying administrative structures

NAS 2019 report



Accountable Health Communities

CMS Funded Model 2017-2022

Randomized trial

Accountable Health Communities (AHC) Model Evaluation

Third Evaluation Report

November 2024

Submitted To:
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, MD 21244-1850
Contract # HHSM-500-2014-000371
TO # 75FCMC18F0002

Attn: Shannon O'Connor
Contracting Officer's Representative
Email: Shannon.OConnor@cms.hhs.gov

Submitted By:
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RTI INTERNATIONAL

Accountable Health Communities

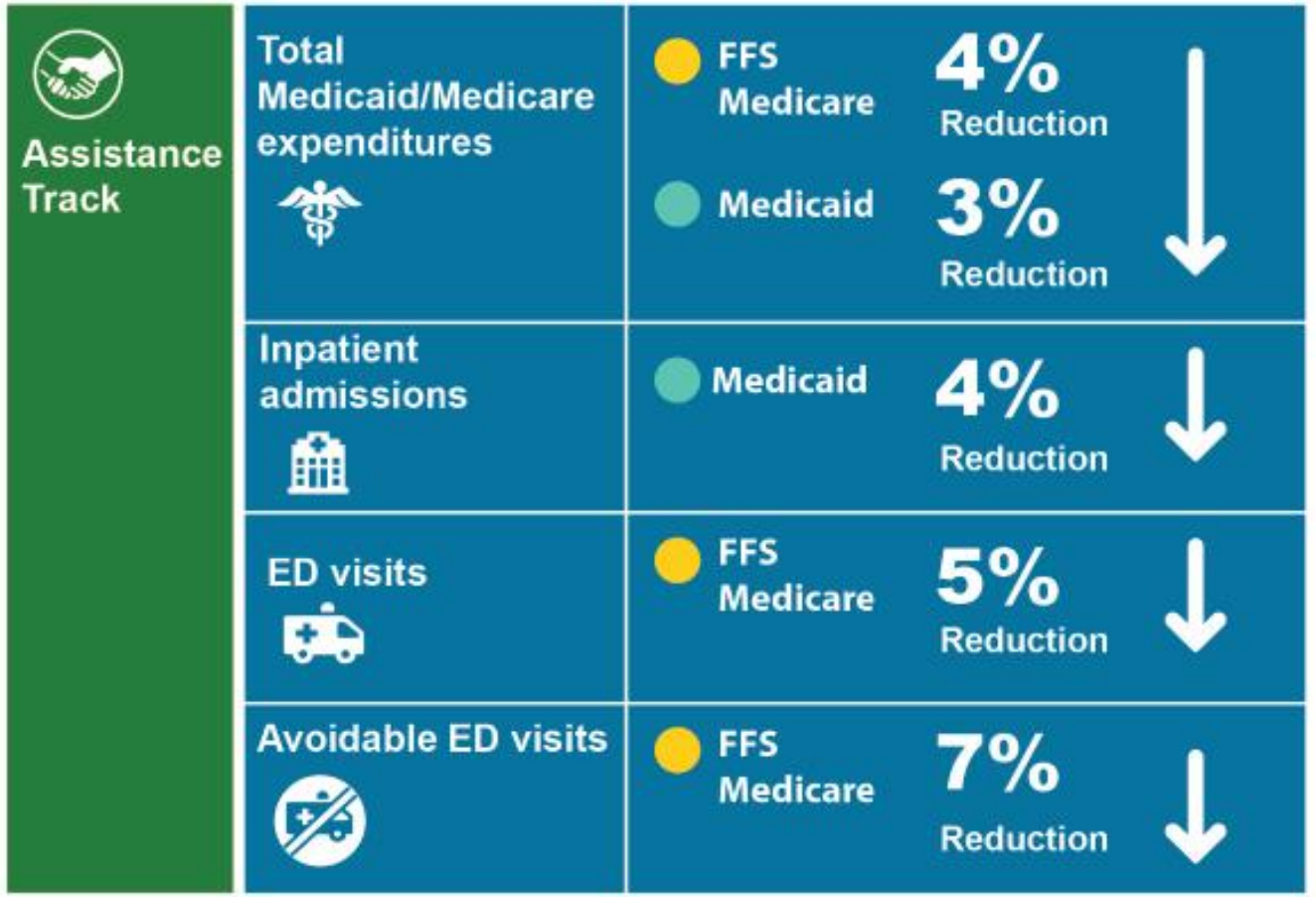
- Medicaid and FFS Medicare beneficiaries with ‘social’ needs and recent ED visits.

- Randomly assigned to:
  - Care navigation across health and social services (ASSISTANCE) vs. usual care

- Care Navigation + Organization Quality Improvement (ALIGNMENT)

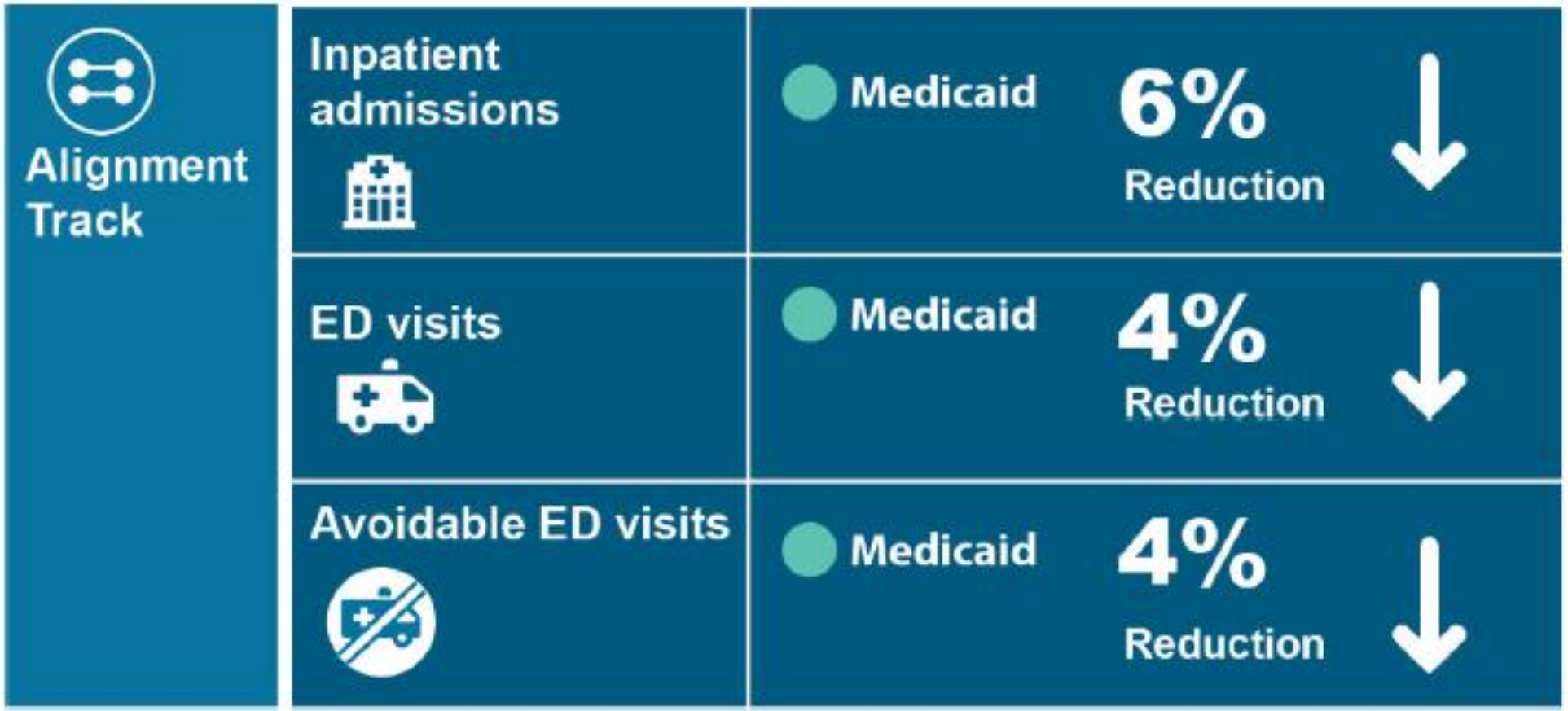
Accountable Health Communities

Exhibit ES-2. Assistance Track Impacts on Expenditures and Hospital Use



Accountable Health Communities

Exhibit ES-3. Alignment Track Impacts on Hospital Use



Stream of new demonstration projects, organizational reforms

We’ll pick up this story after lunch.

But first…

Local needs assessments

Washtenaw County Health Department Community Health Improvement Plan

March 18, 2025

Priority Areas

Mental Health

Key themes:

- Language barriers
- Long wait lists for non-emergency care
- Youth mental health
- Lasting impact of COVID-19 and social isolation

Health Care Access & Navigation

Key themes:

- Language/cultural barriers
- Affordability
- Racism
- Transportation
- Inconvenient appointment times

Access to Healthy Food

Key themes:

- Challenges finding culturally desirable food options
- Access to healthy food options for youth
- Local food deserts

For more data and detailed methodologies, visit www.healthforallwashtenaw.org

Mental Health

Goal: Improve access to comprehensive mental health services for all community members.

Objective 1	**Improve navigation of the mental health care system and coordination of care.**
Objective 2	**Enhance communication and cultural competency between health care providers and community members who speak different languages.**
Objective 3	**Reduce financial barriers to accessing mental health services.**
Objective 4	**Reduce stigma through mental health education and awareness with providers, non-providers, and community members.**

Example WCHD Action Item

Share Wish You Knew campaign materials aimed at mental health stigma reduction with at least 40 unique local community partners in 2025.

Health Care Access and Navigation

Goal: Enhance knowledge and accessibility of health information, resources, and communications

Objective 1	**Expand interpreter services and training to address cultural and language barriers**
Objective 2	**Improve health system and insurance navigation through education of health care providers, community members, and youth.**
Objective 3	**Identify and advocate for the expansion of scarce or limited resources, programs, and services within the community**

Example WCHD Action Item

The Health Department's Maternal Infant Health Program will increase the number of eligible high-risk patients served by 10% in 2025.

Access to Healthy Food

Goal: Increase accessibility and utilization of food resources and nutrition programs by improving awareness about existing community programs

Objective 1	**Improve communication of food related resources**
Objective 2	**Explore barriers to and improve accessibility of existing food resources to better accommodate people currently not able to access them**
Objective 3	**Boost utilization of nutrition programs through coordinated outreach and promotion at schools and with people at risk of food insecurity.**
Objective 4	**Identify necessary nutritional programs for people at risk of food insecurity.**

Example WCHD Action Item

Encourage restaurant managers to sign up for MDHHS's Restaurant Meal Program, doubling the total number of restaurants in Washtenaw that can accept EBT (food stamps) in 2025.

UNITE

Unified Needs Assessment and Implementation Plan Team Engagement

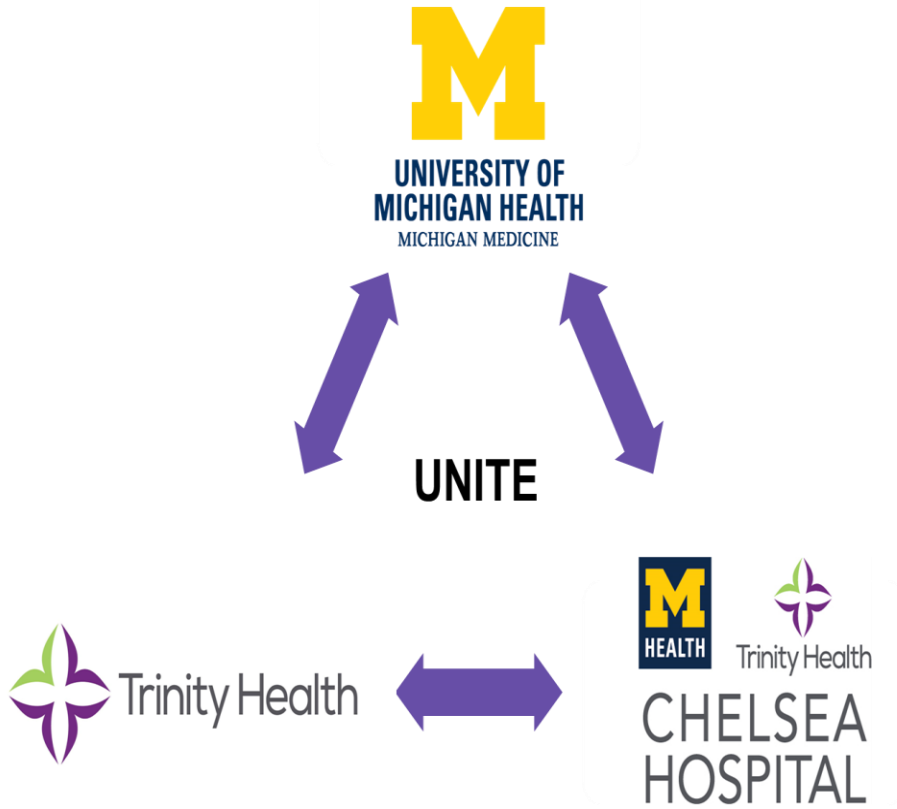
Purpose

Our collaborative exists to promote health and improve the health equity of our community by developing a unified health assessment and implementation plan

Our Community

Greater Washtenaw County

- Washtenaw County
- 5 Healthy Towns (Chelsea, Dexter, Grass Lake, Manchester, and Stockbridge)



Community Health Needs Assessment (CHNA)

What is a Community Health Needs Assessment (CHNA) and Implementation Strategy?

- A process that utilizes community input to identify and prioritize community health needs
- Uses multiple data sources to understand strengths, gaps, and their health and social needs
- Community assets and needs identified through the CHNA are used to develop an implementation strategy
- Findings should inspire collective action and ensure meaningful, effective allocation of resources, within the hospitals and in the community

Source: ISSUU

WASHTENAW HEALTH INITIATIVE

CHNA Priority Areas

Mental Health

- In 2021, there were **47** deaths by suicide and **45** in 2022
- Over **22% (22.5)** of adults are diagnosed with depression
- Adults who binge drink were up from **17.4%** (2018-2020) to **20.5%** in (2020-2022)

Access to Services

- **7.8%** of households do not have a vehicle
- Approximately **8%** of households only have access to cellular internet services
- In 2021, **60.4%** of Latina women, **61.5%** of Black women, and **66.4%** of Asian and Pacific Islander women received adequate prenatal care compared to **72.1%** of White women

Housing

- Approximately 13% of households earn below the Federal Poverty Level (FPL) and another 27% are part of the Asset Limited, Income Constrained, Employed (**ALICE**) population who earn more than the FPL, but less than the basic cost of living
- Nearly **60%** of Black households are either part of the ALICE population or living in poverty
- Nearly **30%** of households are spending **30%** or more of their income on housing

Mental Health (including Substance Use Disorders)

GOAL: Reduce the prevalence and negative impacts of mental illness and substance use in greater Washtenaw County

Chelsea Hospital

- Support and facilitate SRSLY coalitions in Chelsea, Dexter, Manchester and Stockbridge to prevent youth substance abuse and promote mental health. Explore opportunities to replicate this best practice to additional communities.
- Build community capacity to recognize and respond to people experiencing mental health challenges by providing training, reducing stigma, and expanding the use of best practices.

Trinity Health Ann Arbor Hospital

- Implement Narcan vending machines within high traffic areas of the hospital.
- Increase mental health providers/services by expansion of Mental Health Intensive Outpatient (MIOP) programs, centralized intake, and TeleHealth Hub

U-M Health

- Support community organizations that increase access to mental health and substance abuse programs and services regardless of insurance status, via the CHS Grants Program
- Provide screenings and interventions in the community to youth experiencing mental illnesses or suicidal ideation via RAHS

Joint Actions

- Participate in local coalitions and activities related to increasing behavioral health access and addressing root causes
- Support and promote drug take-back events within Washtenaw county medication disposal network

Access to Services

GOAL: Increase health equity and overall health by reducing barriers to accessing services and resources.

Chelsea Hospital

- Operate food assistance programs at the Chelsea Farmers Market, and support market operations by serving as the fiscal agent for the market.
- Community Health Workers assist patients and community residents with accessing services and resources to address social care needs, including transportation and housing.

Trinity Health Ann Arbor Hospital

- Promote and support Trinity Health Ann Arbor Perinatal Wellness Center which offers a safe, inclusive, and nonjudgmental space where women seek social, emotional, and physical support to help with their transition through pregnancy and the postpartum period.
- Develop Trinity Health Ann Arbor Academy to improve awareness and access to services and resources.

U-M Health

- Provide support to pregnant persons and mothers through the Maternal Infant Health Program. The program provides social determinants of health support when necessary.
- Vaccine clinics are provided to the community in locations where there is decreased access and a high density of vulnerable populations at no cost.

Joint Actions

- Utilize FindHelp.org as a resource for transportation, maternal and infant health, food access, primary care, and other resources as needed and necessary.
- Provide Farm Share produce boxes to patients who have food needs and are in need of healthy food access support.

Housing

GOAL: Improve safe, affordable, and stable housing to impact residents experiencing housing instability.

Chelsea Hospital

- Provide financial support to partner organizations to prevent homelessness and address housing instability
- Collaborate with landowners and local governments that want to work towards developing more affordable housing units in the service area

Trinity Health Ann Arbor Hospital

- Explore opportunities for utilizing THAA land for mixed use and/or workforce housing
- Maintain strong partnership with Washtenaw Housing Alliance through in-kind and financial support

U-M Health

- Continue to support Housing Bureau for Seniors to prevent via foreclosure and eviction so older adults may age in place
- Explore opportunities to partner with sustainability programs at U-M Health, utilities and non-profits in order to help make housing safe and affordable

Joint Actions

- Screen patients for housing instability and refer to Community Health Workers or community partners and resources
- Advocate for policies that support the development of more affordable housing units in the greater Washtenaw area

Joint CHNA and Implementation Plan

Trinity Health Ann Arbor + Chelsea Hospital

CHNA: https://www.trinityhealthmichigan.org/sites/default/files/2024-06/CHNA-AA-Chelsea-2024.pdf

CHNA and Implementation Strategy: https://www.trinityhealthmichigan.org/sites/default/files/2024-11/Trinity-Health-Ann-Arbor-and-Chelsea-CHNA-Implementation-Strategy.pdf

University of Michigan Health – Michigan Medicine

CHNA: https://www.uofmhealth.org/sites/default/files/2024%20CHNA%20Grant%20Report_.pdf

CHNA and Implementation Strategy: https://www.michiganmedicine.org/sites/default/files/2024-11/CHNA_Report_2024_FINAL_.pdf

Guiding Principles…

Organizing for efficient use of shared resources

Build a foundation for the future

Foundational Work in our State and Region

SDOH Hubs

Social Determinants of Health Hubs

Michigan Department of Health and Human Services

Tiwanna Hatcher – Strategy Section Manager - MDHHS

Danielle Lepar – Public Health Analyst - MDHHS

MDHHS | Social Determinants of Health

Michigan Department of Health & Human Services

MICHIGAN'S ROADMAP TO HEALTHY COMMUNITIES

Social Determinants of Health (SDOH) Hubs

Washtenaw Health Initiative's Health and Social Services Integration Summit

March 18, 2025

THE GOAL OF THE MDHHS SDOH STRATEGY IS TO:

Improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunity.

MDHHS Michigan Department of Health & Human Services | Social Determinants of Health

SDOH Strategy Phases

PHASE I
Refinement

- **Focus Areas: Housing Stability, Food Security, and Health Equity**
- **IMPROVEMENT** of internal programs and policies
- **ALIGNMENT** of internal initiatives and collated resources

PHASE II
Holistic

HOLISTIC structural interventions:

- Community Information Exchange (CIE)
- Community Health Workers (CHWs)
- Health Equity Partnerships

PHASE III
Innovation

INNOVATIVE, community-driven solutions:

- SDOH Hubs
- Health in All Policies Multi-sectoral Initiatives
- Closing the Disparity Gap

MDHHS Michigan Department of Health & Human Services | Social Determinants of Health

Why are we piloting SDOH Hubs?

01 Integrating Phase I and Phase II SDOH strategies

02 Building on lessons learned from national and state initiatives

03 Aligning efforts at state and local levels

04 Developing foundational infrastructure that can expand over time

MDHHS Michigan Department of Health & Human Services | Social Determinants of Health

SDOH Hub Pilot Framework

Community Engagement

Foster meaningful, sustained community engagement across all phases of intervention planning and implementation.

Governance

Establish criteria, actionable steps, and strategies for partnerships, collaborations, and relationships that result in improved health outcomes over the long term.

Policy & Advocacy

Identify evidence, tools, and resources to enhance communication about policies that affect SDOH with policy makers and other stakeholders.

Data Collection & Storytelling

Embed a consistent SDOH approach to the collection, analysis, and dissemination of quantitative and qualitative data.

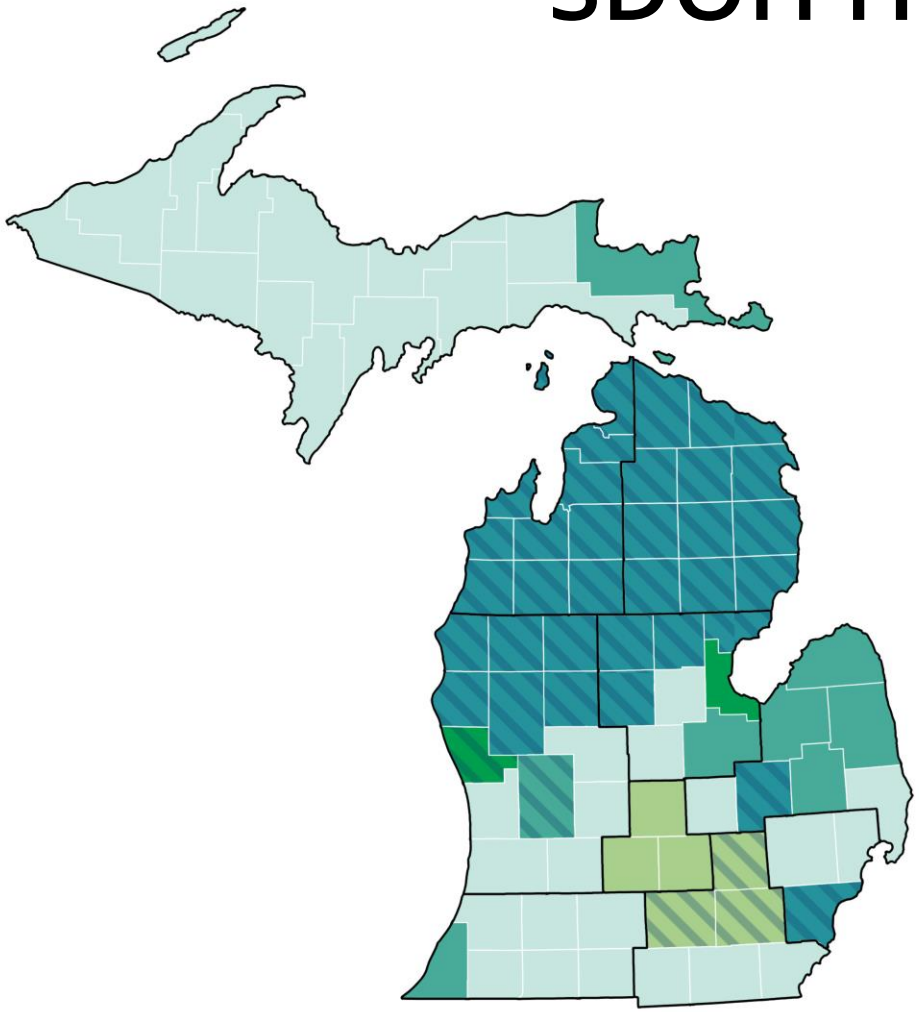
Evaluation & Evidence Building

Advance evaluation and build evidence for strategies that address SDOH to reduce disparities and promote health equity.

Infrastructure

Strengthen and sustain infrastructure such as workforce, training, and access to financial resources required to address SDOH and reduce health disparities.

SDOH Hubs Sites



SDOH Hub Pilot Sites

- **Cohort 1** - Launched January 2024
- **Cohort 2** - Launched March 2024
- **Cohort 3** - Launched May 2024
- **Cohort 4** - *Launching 2025*
- **Regional Health Collaboratives** - *Alignment in 2025*

MDHHS Michigan Department of Health & Human Services | Social Determinants of Health

Developing Foundational Infrastructure

01 Community Health Worker (CHW) training, hiring, and integration

02 Community Information Exchange (CIE) planning and implementation

03 Health in All Policies (HiAP)- implementation of holistic interventions that address SDOH

MDHHS | Social Determinants of Health

Michigan Department of Health & Human Services

SDOH Hubs: Next Steps

SDOH Hubs Coordinating Bodies

MDHHS will continue to convene the SDOH Hubs Advisory Council and Learning Community to support effective technical assistance and cross-pollination of learnings

Measurement and Evaluation

Enhanced focus on unified measurement and evaluation strategies, including story telling, to build the evidence base for integration of health and social care

Continued Collaboration

Continued alignment with the Community Care Hub model and other initiatives to foster strong local networks that connect health and social care

Regional Implementation

Continued exploration of how state-level efforts can inform regional implementation, maintaining flexibility as a core principle

Technical Assistance

MDHHS will continue to provide technical assistance and resources, helping hubs build sustainable models for care coordination

Sustainable Funding Models

Ongoing exploration of sustainable funding models and strategies for leveraging policy support to sustain integration efforts

MDHHS | Social Determinants of Health

Michigan Department of Health & Human Services

MDHHS-SDOH-PolicyandPlanning@Michigan.gov

www.Michigan.gov/SDOH

Thank You

MDHHS Michigan Department of Health & Human Services | Social Determinants of Health

Community Information Exchanges

Janée Tyus – Head of Community Mobilization – IMPaCT

Commissioner – Health Information Technology Comission

Community Information Exchange Update: Leveraging Local Partnerships to Shape State Guidance

March 18, 2025

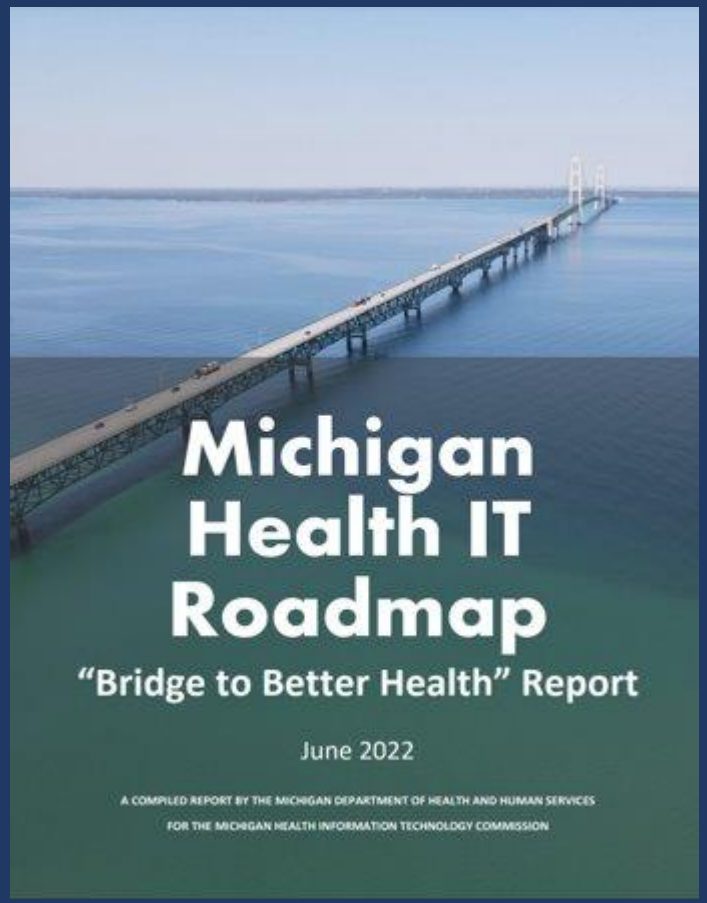

COMMUNITY
IS
STRENGTH.
BE STRONG. LET'S LOOK OUT FOR ONE ANOTHER.

Health Information Technology Report

The Health IT Commission engaged over 300 organizations to update Michigan's health IT strategy between 2020 & 2021.

Key findings included:

- Need to center health & wellness of residents who experience racial disparities or other social vulnerabilities.
- Importance of how social determinants of health affect health care delivery & outcomes.
- Commitment to coordinate care beyond clinical spaces & integrate health-related social care data.



Michigan Health IT Roadmap: Bridge to Better Health Report

Community Information Exchange Intended Result

Community information exchange (CIE) promotes health and social equity and improves the well-being of all Michigan residents by enabling information about people's needs — and the resources available to help them — to flow to the right people at the right time in the right context.

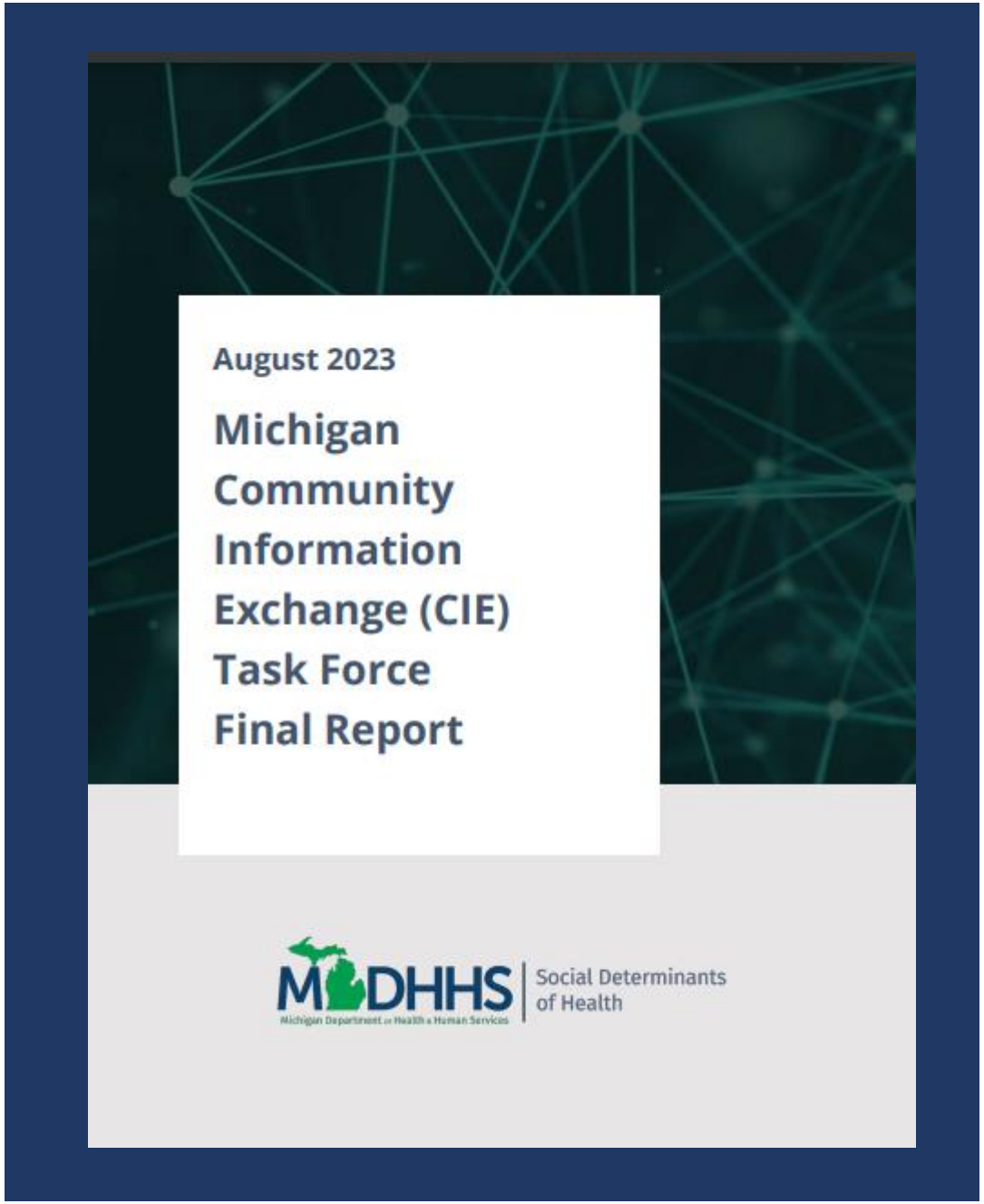
By developing and promoting the ***human, organizational & technological capacities*** to implement CIE initiatives, we will enhance the potential for organizations in different sectors, using different technologies, to coordinate care for their patients and clients.

CIE Task Force Report

The CIE Task Force identified the following domains that support effective implementation of community information exchange:

- Capacities for Data Exchange.
- Resource Directory Information Capacities.
- Longitudinal Data Aggregation Capacities.
- Legal & Ethical Framework.
- Coordinating Entities Capacities.
- Governance.
- Sustainability.

[Michigan Community Information Exchange (CIE) Task Force Final Report]



Consumer Bill of Rights

01 Understand and refuse data collection, sharing & use.

02 Clear and accessible processes.

03 Withdraw from automated process and engage with a human.

04 Object to unfair or discriminatory use of data.

05 Access care without data collection contingencies.

06 Bring data about themselves from one provider/organization to another.

07 Designate an individual who may act on their behalf.

08 Articulate their goals and objectives for health and well-being.

Compiled by the CIE Task Force & Regional Network Collaboratives

CIE Advisory Committee

The CIE Advisory Committee is tasked with developing a proposal for state-wide governance of CIE to establish baseline policy, standards, and core infrastructure, leveraging to the extent possible existing infrastructure in Michigan, in alignment with the recommendations of the CIE Task Force.

1. Develop strategies to facilitate adoption of national social care data interoperability **standards for data exchange**
2. Establish statewide standards and protocols for CIE design and implementation, **use cases**, protocols for informed consent, and evaluation **procedures to ensure equitable outcomes**
3. Recommend a baseline architecture for cross-sector **identity matching** (leveraging existing infrastructure)
4. Propose **mechanisms to enforce** the rights of consumers and CIE participants, through formal representation of affected parties in governance processes, iterating on the established **Consumers Bill of Rights**
5. Identify any statutory and regulatory barriers to the implementation of CIE and, subsequently, **establish a baseline policy framework** for collection, exchange, and use of data in contexts not already governed by HIPAA, FERPA, or 42 CFR p2, along with a corresponding common structure for legal agreements
6. Establishing **minimum standards for Coordinating Entities**
7. Provide **guidance to the implementation of pilots** in alignment with the CIE Task Force recommendations.
8. Provide learnings to ONC, FTC, and CMS to help **guide development of national standards and policies**

https://www.michigan.gov/mdhhs/doing-business/commissions-boards/hitcomm/hitcommlinks/committee-information

CIE Advisory Committee 2025 Priority Areas

These six priority areas align with the:

- Advisory Committee charge and
- Findings from our Social Care Data Governance and Business Case for CBOs Workgroups.

MiTAHIE Planning Project

MDHHS received approval from the Center for Medicaid and Medicare Services (CMS) for a one-year planning period to develop **statewide structured technical assistance and training for health and social care providers** to better serve Medicaid beneficiaries through HIE and CIE.

All project activities will:

- **Strengthen data collection and data standards**, including race and ethnicity data collection practices that align with the Racial Disparities Task Force recommendations and new federal standards; and,
- **Expand IT infrastructure and data exchange capacities** in alignment with the Health IT Roadmap and CIE Task Force Final Report.

MiTAHIE Planning Project Workplan

Information Gathering and Engagement	• Environmental scans. • Outreach and survey.
Analysis and Key Informant Interviews	• Survey analysis. • Provider interviews.
Standards and Application for Funding	• SDOH data standards. • Milestones, meaningful use tiered layers by provider type.

CIE Ecosystem

Additional activities are also happening outside of the Advisory Committee that align with our core deliverables.

COHORT 1 LEAD ORGANIZATION

Greater Flint Health Coalition

Jurisdiction
Genesee County

Overall Goal
To align with the MDHHS SDOH Strategy and utilize a health equity in all policies approach to operate the Mid-Michigan Community Health Access Program (CHAP), a clinical-community linkage hub, that utilizes a community health worker workforce to address person's health related social needs through connections to community-based organizations, leveraging technology and community information exchange capacities.

GREATER FLINT HEALTH COALITION

United Way of Genesee County
Serving Genesee & Shiawassee Counties

FLINT CITY OF FLINT, MICHIGAN

Greater Flint Health Coalition SDOH Hub Profile

Learn More

If you have 10 minutes, explore a CIE micro-toolkit video:

Check out a video or resource in one of the CIE micro-toolkit modules — and share what your ideas for future topics.

If you have 60 minutes, attend a CIE Professional Learning Community session

Join community members working across Michigan to implement CIE initiatives. This informal space provide opportunities to share experiences and learn from each other.

If you are looking for a deep dive, read the CIE Task Force Final Report

Explore the final report to learn more about the seven domains and 33 recommendations for building Michigan's statewide CIE infrastructure.

Thank You

In Lieu of Services

Medicaid Health Plans

Katie Commey - Manager, Strategic Engagement and Planning - MDHHS

Rebecca Gilmore - Section Manager – Managed Care Logistical Support - MDHHS

Addressing Social Determinants of Health in Michigan's Comprehensive Health Care Program

Health and Social Service Integration Summit

March 2025

MDHHS
Michigan Department of Health & Human Services

Objectives

This presentation will provide an overview of the following:

Michigan Department of Health and Human Services' (MDHHS) approach to addressing social determinants of health through the Comprehensive Health Care Program (CHCP).

A new set of nutrition services, called In Lieu of Services (ILOS), for eligible individuals enrolled in Medicaid Health Plans (MHPs).

How MHPs will invest in the communities they serve through a new Community Reinvestment requirement.

MIHealthyLife

MDHHS seeks to bring together the investment, creativity and commitment of the department and its partners – including health plans, providers and communities – to create a more equitable, coordinated and person-centered system of care dedicated to ensuring people a healthier future.

MDHHS
Michigan Department of Health & Human Services

MIHealthyLife

- July 2022: Survey launched for public input.
- Nearly 10,000 responses.
- Identified five pillars to guide MHP rebid.

Serve the Whole Person, Coordinating Health and Health-Related Needs.

Give All Kids a Healthy Start.

Promote Health Equity and Reduce Racial and Ethnic Disparities.

Drive Innovation and Operational Excellence.

Engage Members, Families and Communities.

Strategies to Address SDOH Through CHCP

Example Requirements:

- Screen Medicaid Enrollees for unmet needs.
- Monitor whether Medicaid Enrollees receive services to address their needs.

Example Requirements:

- Invest a portion of Medicaid profits in CBOs.
- Encourage Medicaid Health Plans to offer ILOS.

Example Requirements:

- Encourage use of Community Health Workers (CHWs).
- Require partnerships with community-based organizations (CBOs).

Today's Focus

In Lieu of Services (ILOS)

MDHHS
Michigan Department of Health & Human Services

In Lieu of Services Overview

What are In Lieu of Services (ILOS)?

- ILOS are services a state deems to be **medically appropriate** and **cost effective** when provided as substitutes to other services and settings covered in a state's Medicaid program.
- **ILOS** is administered through Medicaid, which is a health program, so **they must address health-related needs.**

Goals of ILOS

What are MDHHS' Goals in Introducing ILOS?

- Promote availability of services to:
  - **Meet Enrollee needs;**
  - **Improve health; and**
  - **Reduce the future need for medical services.**
- Connect with MDHHS' broader strategy to address SDOH and improve health equity.

Why Focus on Food and Nutrition?

Michigan's ILOS will initially focus on food and nutrition services because:

- Barriers to food and nutrition is a **critical need in communities across Michigan**; and
- Substantial evidence shows that **investing in food and nutrition** significantly **improves health outcomes** and reduces unnecessary health care costs.

ILOS Definitions in Michigan

Medically Tailored Home Delivered Meal	A fresh or frozen home delivered meal which is medically tailored for a specific disease or condition. This ILOS includes support from a certified nutrition professional.
Healthy Home Delivered Meal	A nutritionally-balanced, home delivered meal consisting of a hot, cold, frozen or shelf-stable meal aimed at promoting improved nutrition for the Enrollee.
Healthy Food Pack	A healthy food pack consists of an assortment of medically-tailored or nutritionally-appropriate foods provided to an Enrollee.
Produce Prescription	A voucher for the Enrollee to purchase any variety of fruits and vegetables or plants/seeds that produce fruits and vegetables.

ILOS Eligibility Criteria

Social Risk Factor	**The Enrollee cannot get enough food when they need it.**
+	
Clinical Risk Factors*	**The Enrollee has one of the following:** • **An illness that can be improved with a healthy diet**, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, a substance use disorder or a mental health disorder. • **Been in a hospital or skilled nursing facility** in the last 90 days. • **Are likely to end up in the hospital or another facility** if they cannot access healthy food. • **Are pregnant and currently have, have a history of or are at risk of complications from being pregnant**, including things like diabetes while pregnant, preeclampsia, preterm labor, an infection, a mental health condition. • **Used to be in foster care and is at risk of developing an illness.** • **Are a child that has too much lead in their blood, lives in a stressful environment or will develop an illness without access to healthy food.** • **Are a child eligible for the Children's Special Health Care Services (CSHCS)** program. • **Are an adult eligible for the Persons with Special Health Care Needs (PSHCN)** program. • **A disability.**

**While the social risk factor is the same across all four services, the clinical risk factor that qualifies an Enrollee for an ILOS differs slightly across the services. More detail can be found online.*

Medicaid Health Plan ILOS Offerings

ILOS are optional; Medicaid Health Plans choose whether to offer ILOS, and Medicaid Enrollees choose whether to use ILOS. Several MHPs have already indicated they will implement ILOS.

MHP Elections of ILOS

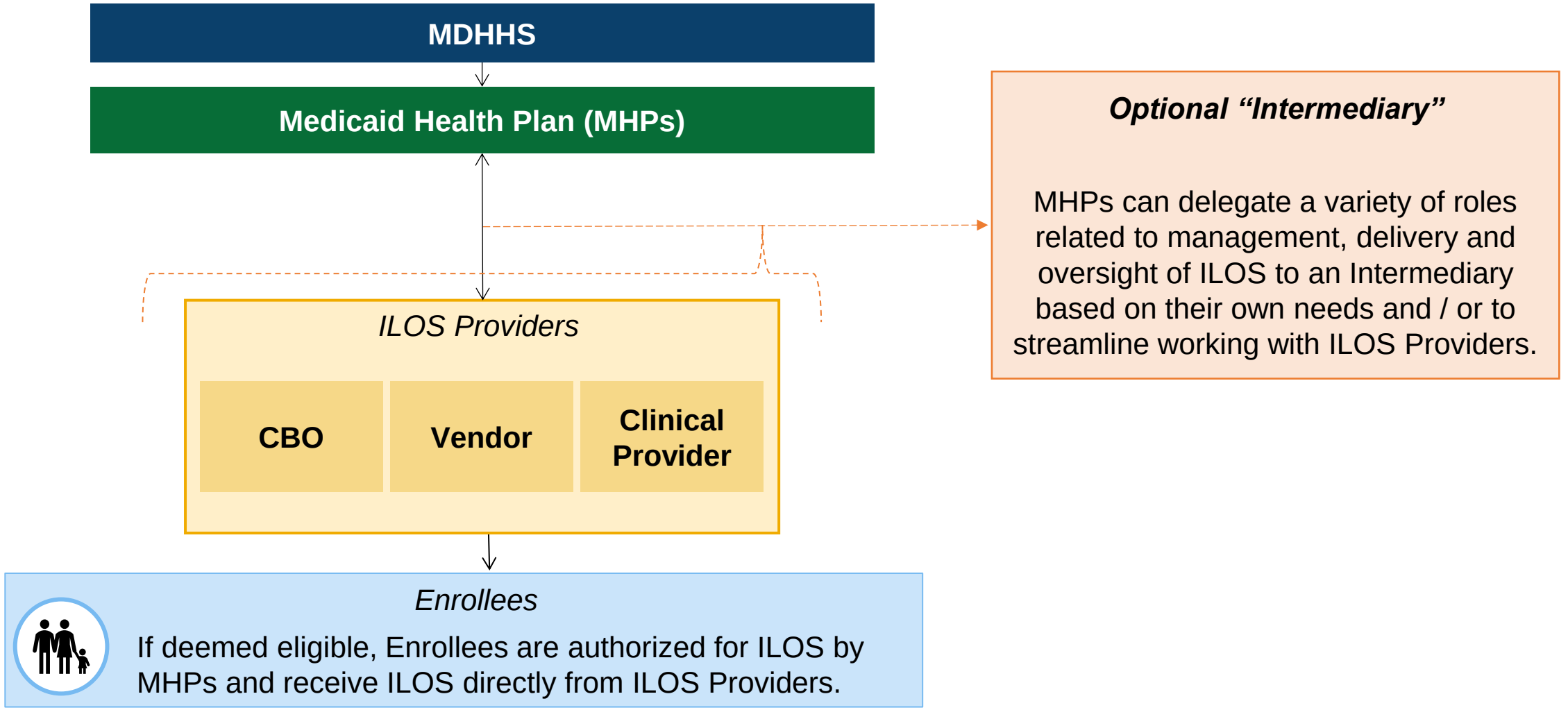
Offering ILOS

- In fiscal year 2025 (October 1, 2024 – September 30, 2025), MHPs may begin offering ILOS at any point during the year following MDHHS-approval of the MHP's ILOS Implementation Plan.
- MHPs are allowed to terminate ILOS once annually at the end of the fiscal year.

ILOS by Region

- MHPs may elect to offer one or more approved ILOS and may choose which of its Region(s) to offer the ILOS. MHPs may choose to offer different ILOS in different Regions.
- MHPs must, however, make the ILOS available for all Enrollees residing within the Region(s) it is electing to offer ILOS.

Illustrative ILOS Roles and Functions



This visual is illustrative – Medicaid Health Plans are responsible for developing processes related to ILOS so workflows may differ as ILOS is implemented.

Potential ILOS Providers

An organization may opt to become an ILOS Provider because providing ILOS aligns with the organization's goals to address food needs and contribute to the health and wellness of Michiganders.

Examples of Entities that May Become ILOS Providers

Community-based Organizations (CBO)

Public and private non-profit organizations that represent a community or significant segments of a community and provide educational, health, social support or other related services to individuals in the community.

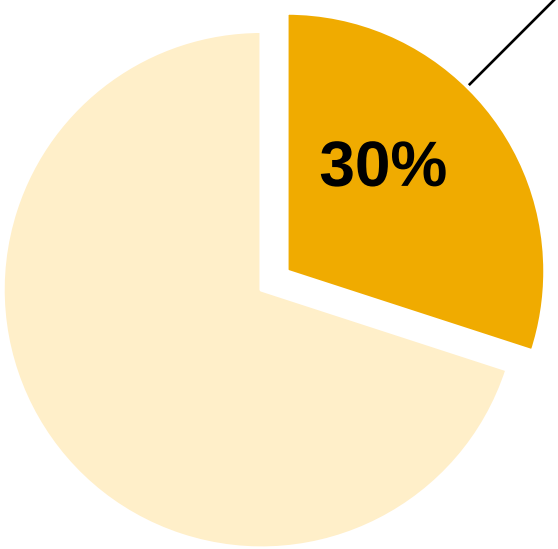
Example ILOS Provider:
Food bank

Vendors

Private, non-profit or for-profit companies that provide nutrition-related goods or services.

Example ILOS Provider:
Companies that provide prepared meals

MHPs are Required to Utilize Locally-Based ILOS Providers



Requirement:

- In fiscal year 2025, at least **30% of each ILOS type must be provided by locally-based ILOS Providers.**
- Over time, this percentage will increase.

Rationale:

- Ensures ILOS are delivered by organizations familiar with Enrollees' communities.
- Support capacity of local organizations—ILOS can provide a more stable funding stream to organizations.

To be a locally-based ILOS Provider, an organization must be:

- A CBO with a physical presence in Michigan, defined as having one (1) or more office locations in Michigan—preferably in the Region(s) the ILOS is being provided—and participate in the Michigan food economy;
- An independent community grocer, headquartered in Michigan; or
- A direct marketing farmer, headquartered in Michigan.

ILOS Provider Capacity Building

The Capacity Connect Initiative (CCI) aims to empower local, community-based food and nutrition providers to deliver ILOS. This initiative offers tailored technical assistance, direct funding, and strategic support to help providers overcome barriers to Medicaid participation.

Direct Funding

- **Applications for funding now open** through April 9, 2025
- Funds for capacity building activities, such as: technology enhancements, business operations development, workforce development / training and education, outreach and convening
- Funding amount varies

Technical Assistance

- **Resources available for both awardees and non-awardees** who are interested in participating in ILOS
- Focused on optimizing program operations and administration

Community Reinvestment

MDHHS
Michigan Department of Health & Human Services

Addressing SDOH Through Community Reinvestment

MDHHS Michigan Department of Health & Human Services

Beginning fiscal year 2026, MHPs must invest 5% of profits in their communities.

OBJECTIVES OF COMMUNITY REINVESTMENT:

- Formalize longstanding reinvestment efforts by MHPs.
- Increase funding in communities to address Medicaid members' SDOH, to ultimately improve health.
- Provide funding to support new and expanded partnerships between CBOs and MHPs, including to build CBO capacity to provide in ILOS.

KEY DETAILS:

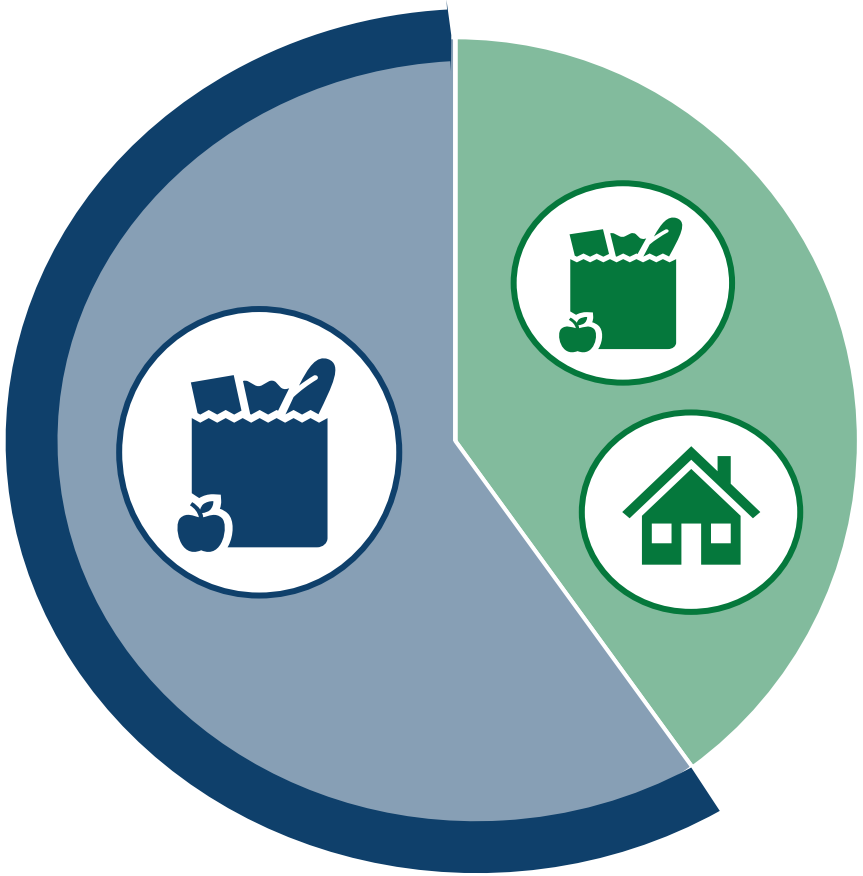
- The first fiscal year MHPs will invest in CBOs is October 1, 2025 - September 30, 2026.
- The Medical Loss Ratio (MLR) report, through which MHPs report financial information, will be used to assess the size of profit each year.
- The majority of Community Reinvestment dollars must fund activities that address food insecurity.

Key Term

Community Reinvestment Obligation:
The amount of the 5% of annual pre-tax profits that MHPs are required to reinvest in the local communities they serve.

Activities that the Community Reinvestment Obligation Can Fund

60% must address food insecurity.



The remaining 40% can address food insecurity and/or housing instability.

The Community Reinvestment Obligation *cannot* pay for services that MHPs are required to pay for or to meet other contract requirements.

Community Reinvestment Support for ILOS

The Community Reinvestment Obligation can help CBOs get ready to offer nutrition-focused ILOS.

- Many Michigan CBOs have expertise delivering services like the nutrition-focused ILOS but may not have worked with healthcare partners or MHPs.
- The Community Reinvestment Obligation can be used to fund infrastructure – ***like billing and data sharing software*** – to make it easier for CBOs to partner with MHPs.

Example Activities that the Community Reinvestment Obligation Can Fund

Examples of what Community Reinvestment dollars *can* fund
Software or technology for a CBO to bill an MHP for providing a nutrition service.
Vehicles for a CBO to deliver nutritious meals to people in the community.
Nutrition counseling services that are provided with a produce prescription ILOS.
Kitchen supplies to support food preparation or operational capacity.
Local housing authority home repairs.
A daytime drop-in service center that provides emergency housing vouchers and helps with housing applications.

Examples of what Community Reinvestment dollars *cannot* fund
Screening for Medicaid members' SDOH.
Care management services.
Community Health Worker services.
Payment for healthy food packs provided as an ILOS.
Gift cards for Medicaid members to access covered Medicaid services.

Organizations that Can Receive the Community Reinvestment Obligation

MDHHS Michigan Department of Health & Human Services

To receive Community Reinvestment funding, an organization must:

✓ **Be a CBO**	CBOs are public and private non-profit organizations that represent a community or significant segments of a community and provide educational, health, social support or other related services to individuals in the community.
✓ **Address SDOH**	The CBO must deliver services, or run programs, that address the SDOH of Medicaid Enrollees in the Region(s) that the MHP's Medicaid Enrollees live in.
✓ **Be in Michigan**	The CBO must have one or more office locations in Michigan, ideally in the Region(s) that the MHP's Medicaid Enrollees live in.

***If* the CBO is focused on addressing food insecurity, it must also participate in the local Michigan food economy (e.g., purchases locally grown, produced or sourced foods).**

The Role of Community Partners in Community Reinvestment

MHPs must consult the communities they serve when deciding what to fund.

- In Regions with Hubs, **MHPs must engage all SDOH Hub Pilot Sites**.
- In Regions without Hubs, **MHPs must engage with external coalitions**—when available—that represent **multiple sectors**, **include individuals who live in the community** and focus on **priorities identified by the community.**

Thank you for your time and partnership in addressing social determinants of health for Michiganders.

Please refer to the MIHealthyLife webpage for resources and any updates on ILOS and Community Reinvestment:

https://www.michigan.gov/mdhhs/mihealthylife

If you have any questions, please contact: MDHHS-ENGAGEMedicaid@michigan.gov.

Break and Networking

Panel Discussion

MiCommunityCare

Ayse Buyuktur – Associate Director of Health and Social Equity Programs – CHRT

Shaina Tinsley – Program Manager - CHRT

Community Health Worker

Michigan Community Health Worker Alliance

Kareem Baig – Executive Director - MiCHWA

Miranda Bargert, Policy Analyst - MiCHWA

MiCHWA

Sustaining Local Community Health Workers

Kareem Baig, Executive Director

Miranda Bargert, Policy Analyst

Questions Addressed During this Session

- What are Community Health Workers(CHWs) and where are they in Washtenaw and Livingston counties?
- What resources are available to support local CHWs?
- How are CHWs funded and how can they be sustained?

What is a Community Health Worker?

A Community Health Worker, or CHW, is a frontline public health worker who is a trusted member of their community and serves as a middle ground between health and social resources and the community.

CHWs use lived experience and/or training where it is needed most and are able to meet neighbors in need where they live, work, play, and worship.

What do Community Health Workers Do?

Increase Cultural Understanding

Advocacy

Client & Community Assessments

Direct Services

Case Management

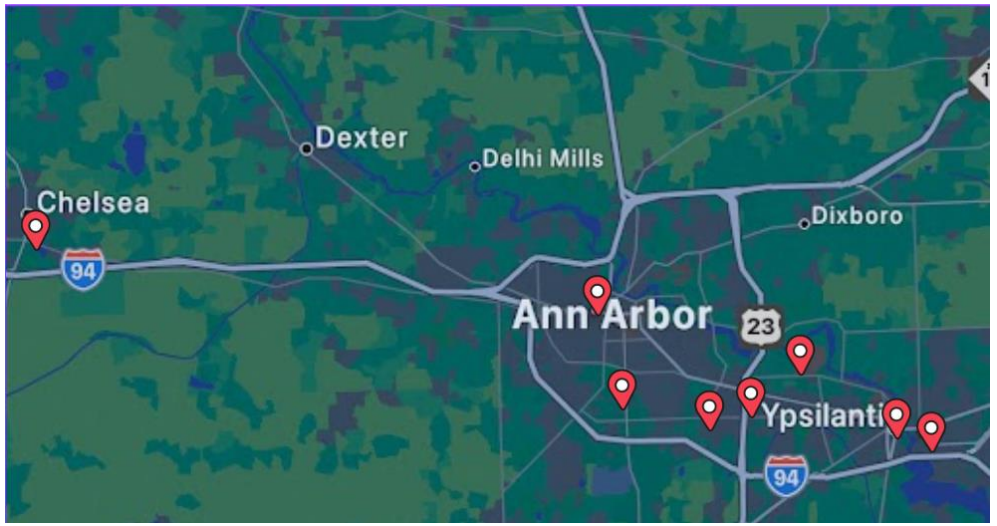
Community Education

Outreach

Coaching & Social Support

Where are local CHWs?

- **Community-Based Organizations**
  - Ypsilanti Meals on Wheels, Jewish Family Services UNIFIED, Shelter Association of Washtenaw County, Washtenaw Health Project
- **Health Systems and Health Centers**
  - Trinity Health Ann Arbor, Michigan Medicine, Chelsea Hospital, Packard Health, Corner Health Center
- **Washtenaw County Health Department**



Washtenaw County CHW Map

Livingston County Map

Resources to support CHWs:

Michigan Community Health Worker Alliance

Since 2011, MiCHWA has worked collaboratively with CHWs, CHW employers and Allies across the State to lead the charge in CHW advocacy, training, registry and sustainability.

- **Education**
  - Certified Community Health Worker Training, Micro-Credentials, Courses and CEUs
- **Workgroups**
  - Michigan CHW Network, Education and Workforce Workgroup, Evaluation Work Group, and Policy Work Group.
- **Professional Advocacy and Policy**
- **MiCHWA Membership and M365**

CHWC
COMMUNITY HEALTH WORKER COALITION
WASHTENAW-LIVINGSTON

Resources to support CHWs:

Washtenaw-Livingston CHW Coalition

The mission of the CHWC is to reduce barriers to care and well-being for Washtenaw and Livingston County members by supporting and advocating for local community health worker programs and social service organizations. We work to support resources and programs within the counties and promote their growth and sustainability by facilitating:

- **Quarterly All-Member Meetings and Newsletters**
- **CHW Networking Events**
- **CHW Training Scholarships *(3 Dispersed, 2 Pending)***
- **Social Care Safety Net Fund for Clients *(36 awards to date)***
- **Professional Development and Sustainability Advocacy Efforts *(17+ Guides)***

CHW Funding and Sustainability

Findings from the 2024 MiCHWA CHW Employer Survey

Figure 10. Percent of Programs Reporting "Less Sustainable" Funding Sources for 2024 (N = 96), 2022 (N = 83), and 2020 (N = 49)

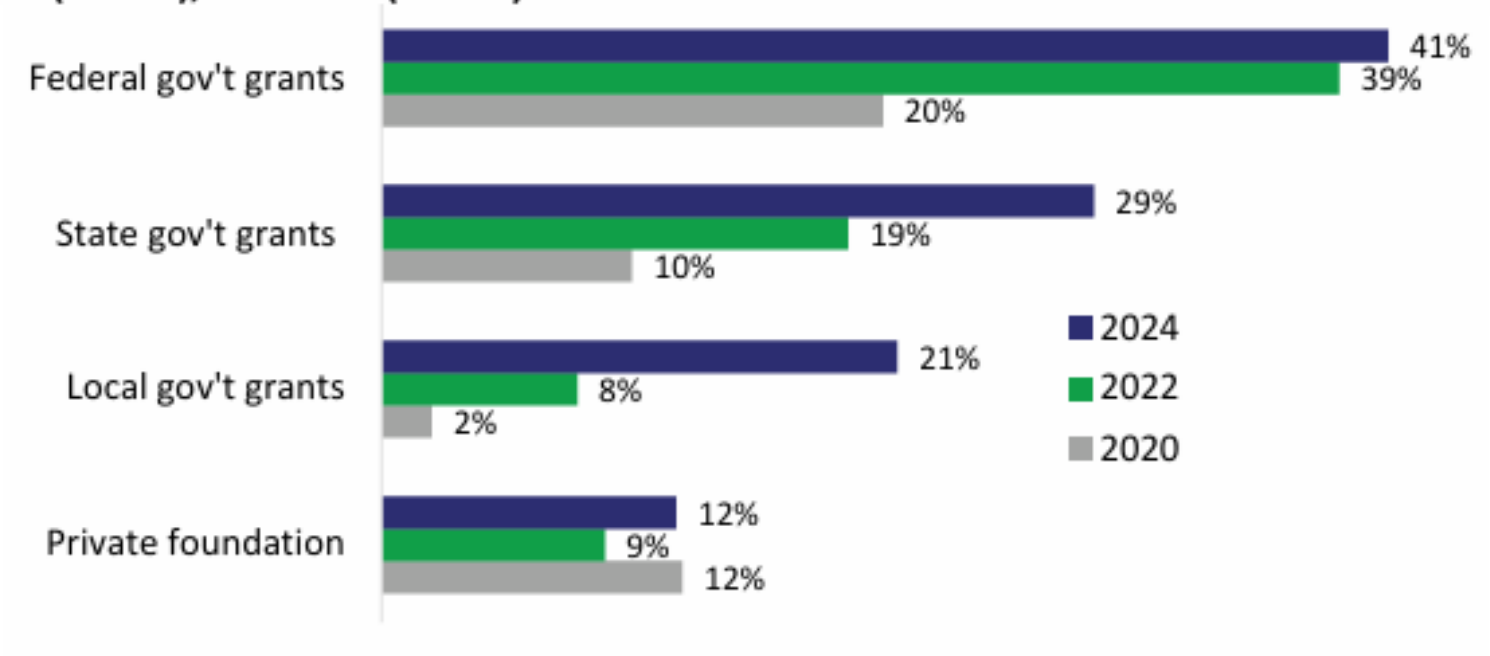
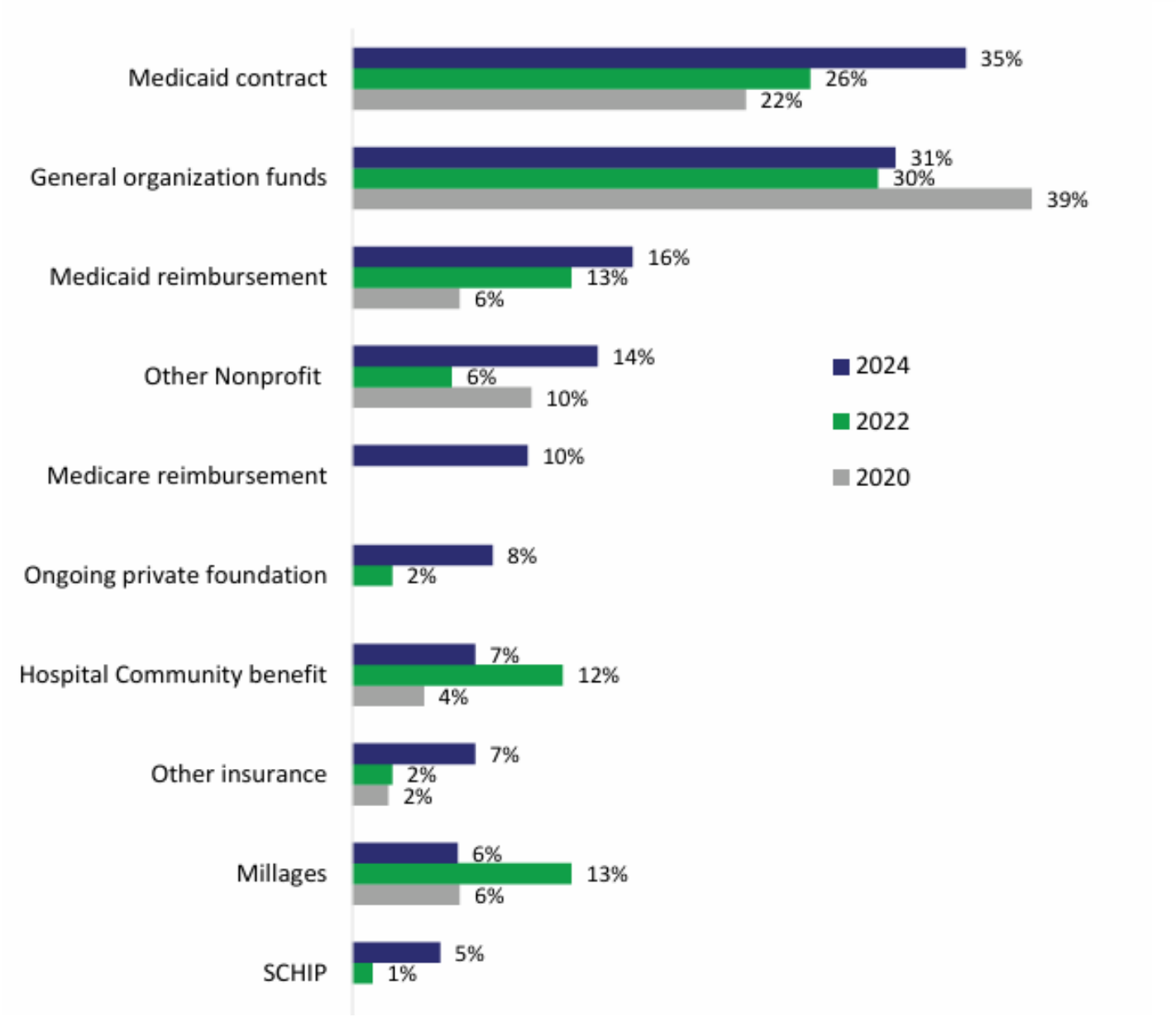


Figure 12. Percent of Programs Reporting "More Sustainable" Funding Sources for 2024 (N = 96), 2022 (N = 83), and 2020 (N = 49)



MMP 23-74: Medicaid Coverage of Community Health Worker (CHW)/Community Health Representative Services

- Effective Date: January 1st, 2024
- CHW services available to beneficiaries include:
  - Health system navigation and resource coordination, including providing information, training, referrals, or support to encourage beneficiary-led efforts to:
    - Access covered services, understand, engage, or re-engage in the health care system, or engage in their own care needs
    - Connect to relevant community resources necessary to promote health, address healthcare barriers, or address health-related social needs
  - Health promotion and education to promote the beneficiary's health or address barriers to physical and mental health care
  - Screening and assessment, which includes the use of standardized, validated tools that do not require a license and that support the identification of needed services

MI Medicaid CHW Registry

MDHHS has designated MiCHWA as the vendor to

- Develop and maintain the MI Medicaid CHW Registry and
- Maintain an approved list of CHW Training Programs and Curricula

Roadmap for CHWs to become Medicaid providers:

Questions?

Contact Miranda: mbargert@michwa.org

Contact Madison: mherrington@michwa.org

info@michwa.org

michwregistry@michwa.org

www.michwa.org/chwc/

MiCHWA

CHWC
COMMUNITY HEALTH WORKER COALITION
WASHTENAW-LIVINGSTON

Lunch and Networking

WASHTENAW HEALTH INITIATIVE

Community Care Hubs

Health and Social Service Integration

Stream of new demonstration projects, organizational reforms

We'll pick up this story after lunch.

Department of Health and Human Services 2022

"**Aligned…systems** that achieve equitable outcomes…

"..**sustainable partnerships** among health care providers, public health system, and community-based organization…"

"..develop **data and financing infrastructure**..."

"..**multistakeholder collaborations**...have flourished.."

"..increasingly provided by **community care hubs**.."

> "..entities supporting a network of CBOs..which centralize administration…"
>
> "..multistakeholder community governance..similar to..Accountable Health Communities model implementations."


Improving Health And Well-Being Through Community Care Hubs

Andre Chappel, Kelly Cronin, Kristie Kulinski, Amelia Whitman, Nancy DeLew, Karen Hacker, Arlene S. Bierman, Samantha Wallack Meklir, Susan C. Monarez, Kate Abowd Johnson, Ellen-Marie Whelan, Douglas Jacobs, Benjamin D. Sommers

NOVEMBER 29, 2022 10.1377/forefront.20221123.577877

https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

CHRT

Addressing Social Needs: Challenges and Opportunities for Social Service Integration

WHI Health and Social Service Integration Summit
March 18th, 2025

Social Service Integration: Expectations vs. Reality

Payers and Health Systems are increasingly expected to:

- Screen for patient social needs
- Refer patients to resources to address those needs
- Effectively track social care services and impacts on clinical care
- Address social determinants of health (SDOH) to improve outcomes

Integration efforts face significant barriers

- Fragmented social service system
- Unsustainable funding sources
- Workforce shortages
- Siloed and incompatible data systems
- Legal and operational complexities limiting partnerships/contracting opportunities

Challenges and Barriers to Integration

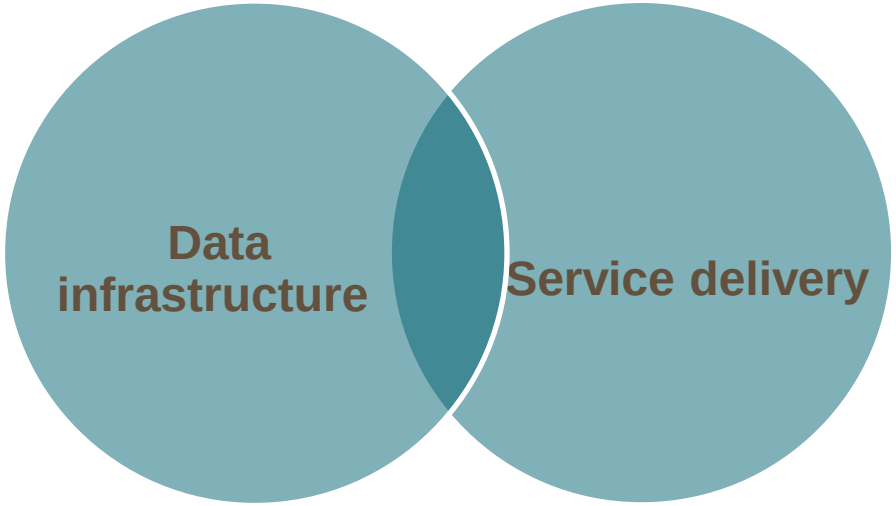
Challenges shared by payers, providers, and community-based organizations

1. Effectively meeting the demand for social care services from individuals/patients
2. Establishing sustainable funding mechanisms to support service delivery
3. Workforce capacity to deliver services
4. Contracting complexities
   - For payers, contracting with numerous CBOs for social services is burdensome
   - For CBOs, contracting directly with payers/providers presents significant challenges (risk assumption, legal fees, costs/staffing of contract management, etc.)
5. Data tracking and closed loop referrals
6. Cross-organization collaboration/reducing duplication/shared services

Elements of Sustainability

CHRT

CHRT



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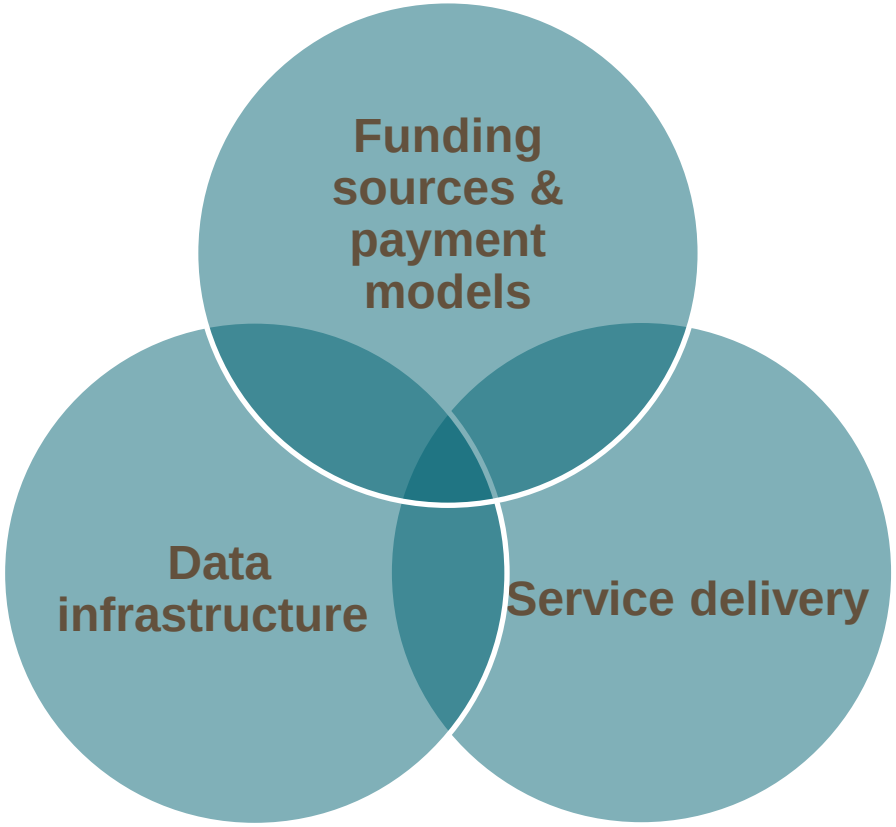

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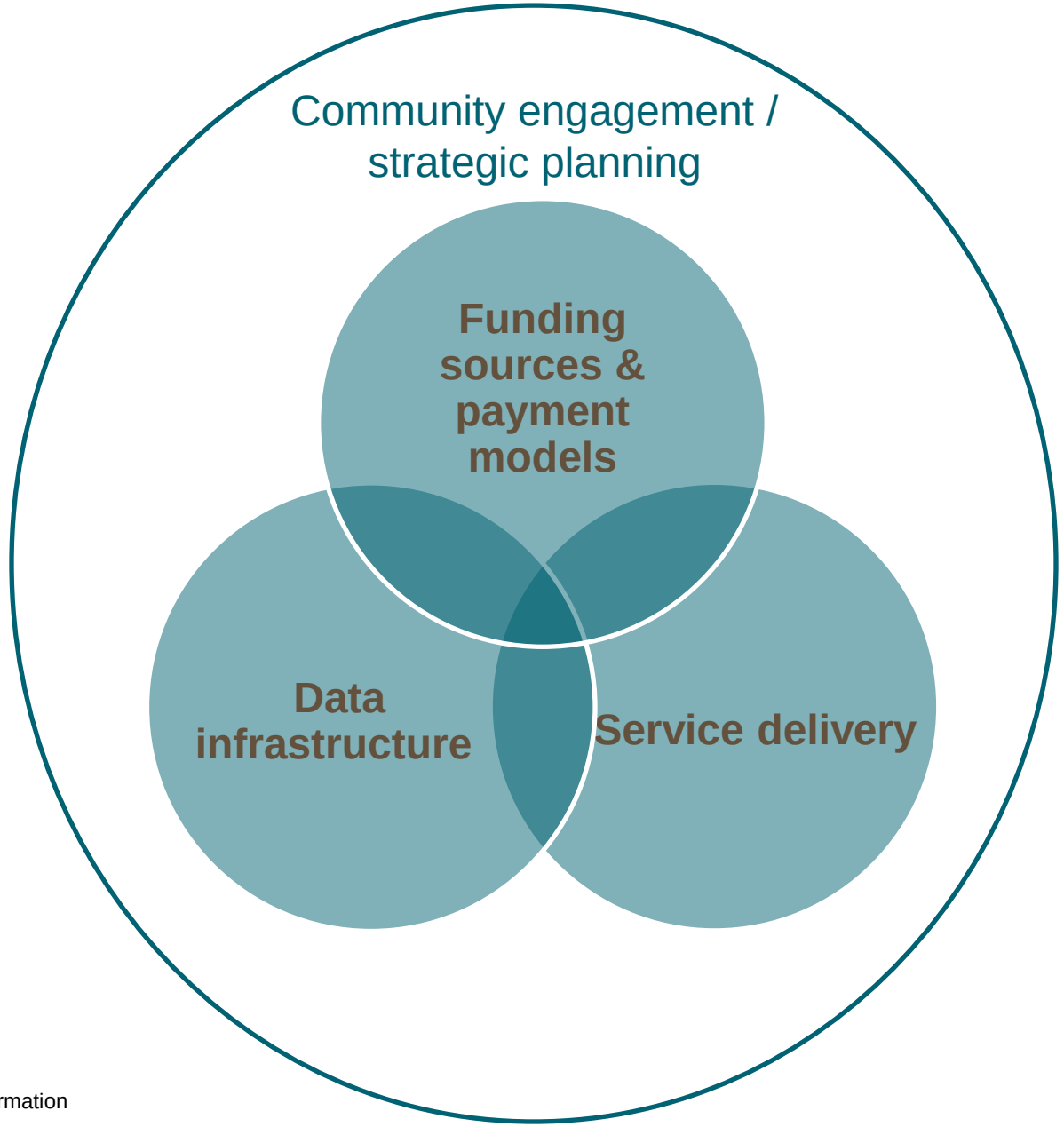

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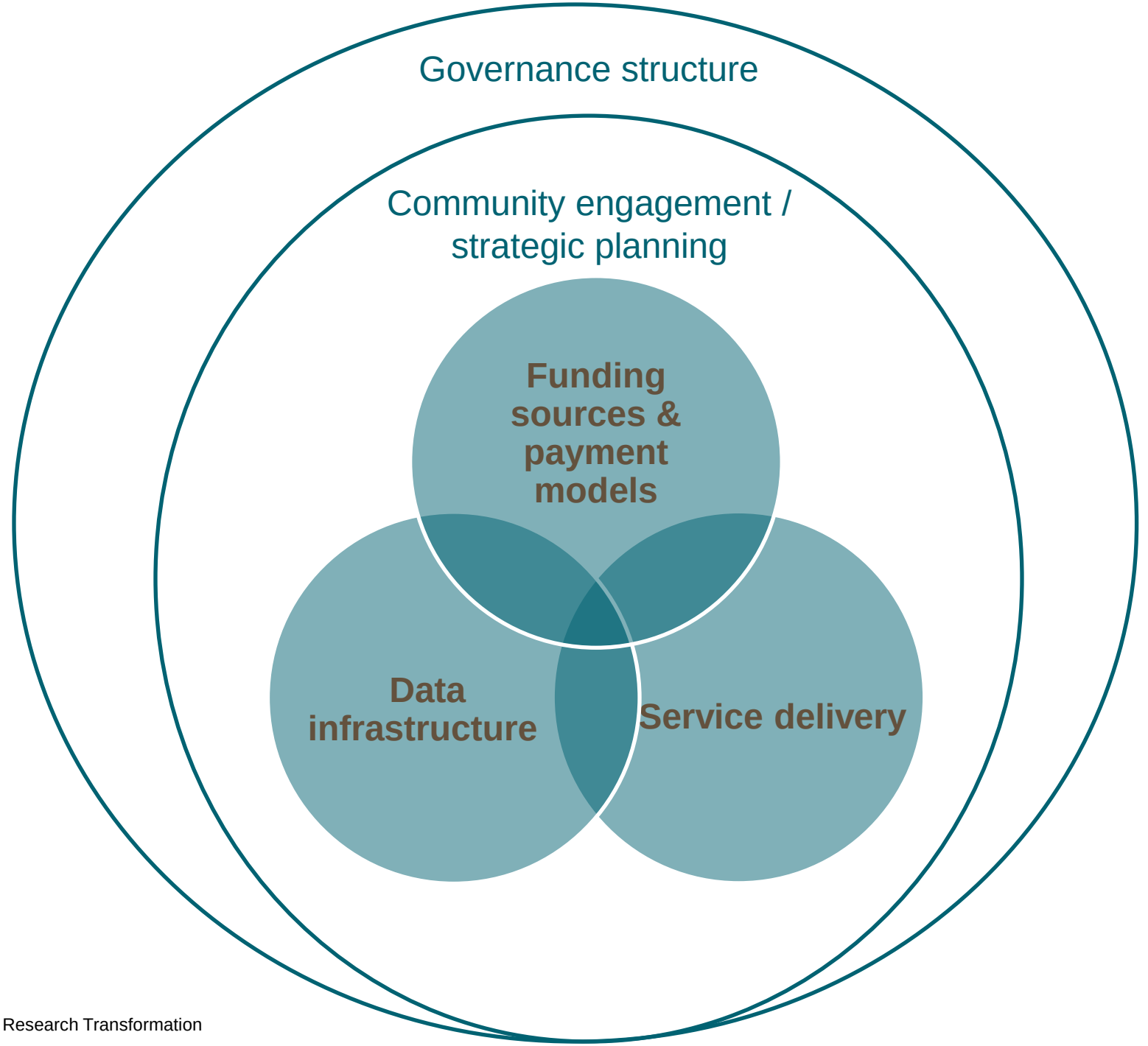

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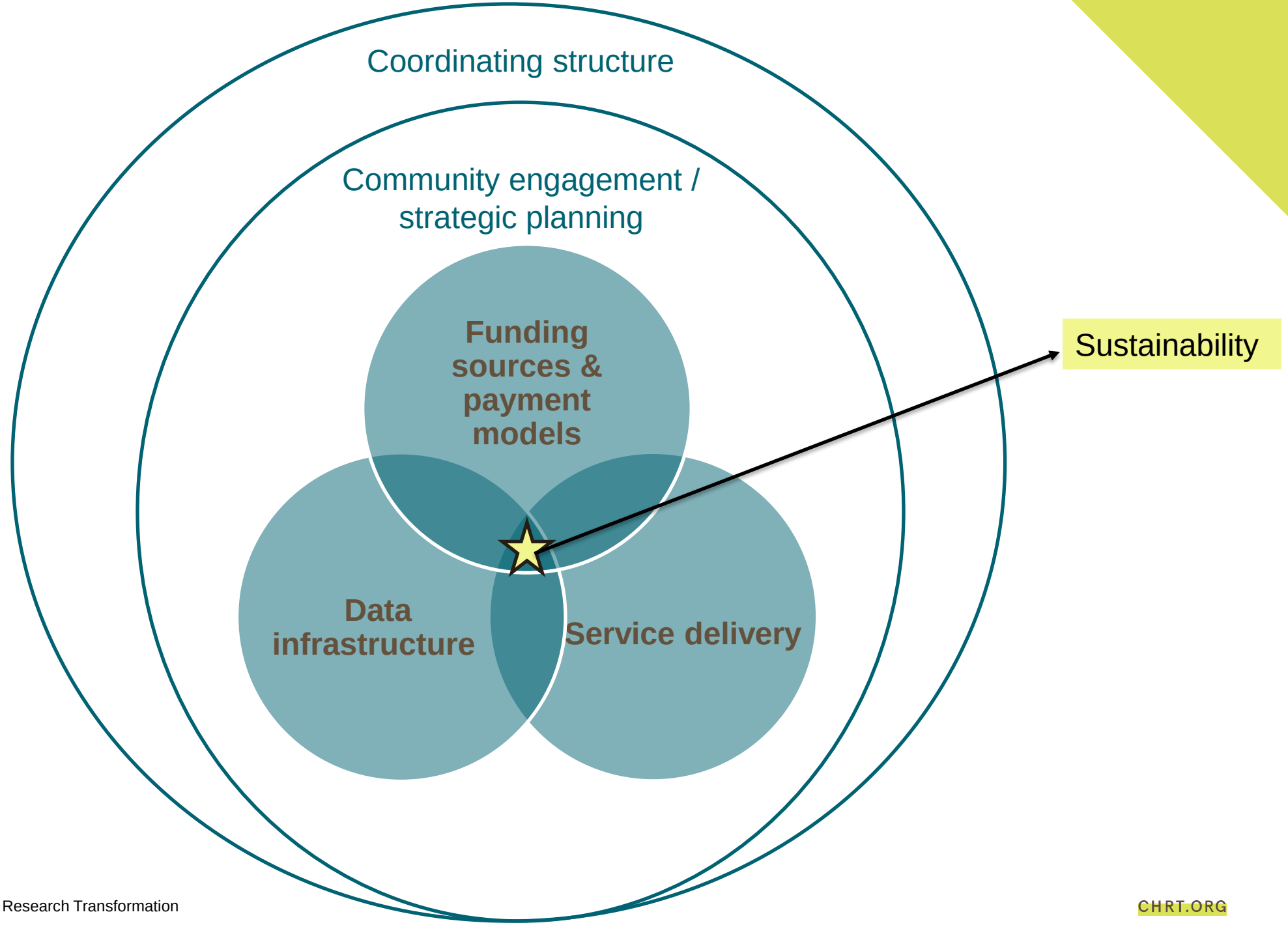


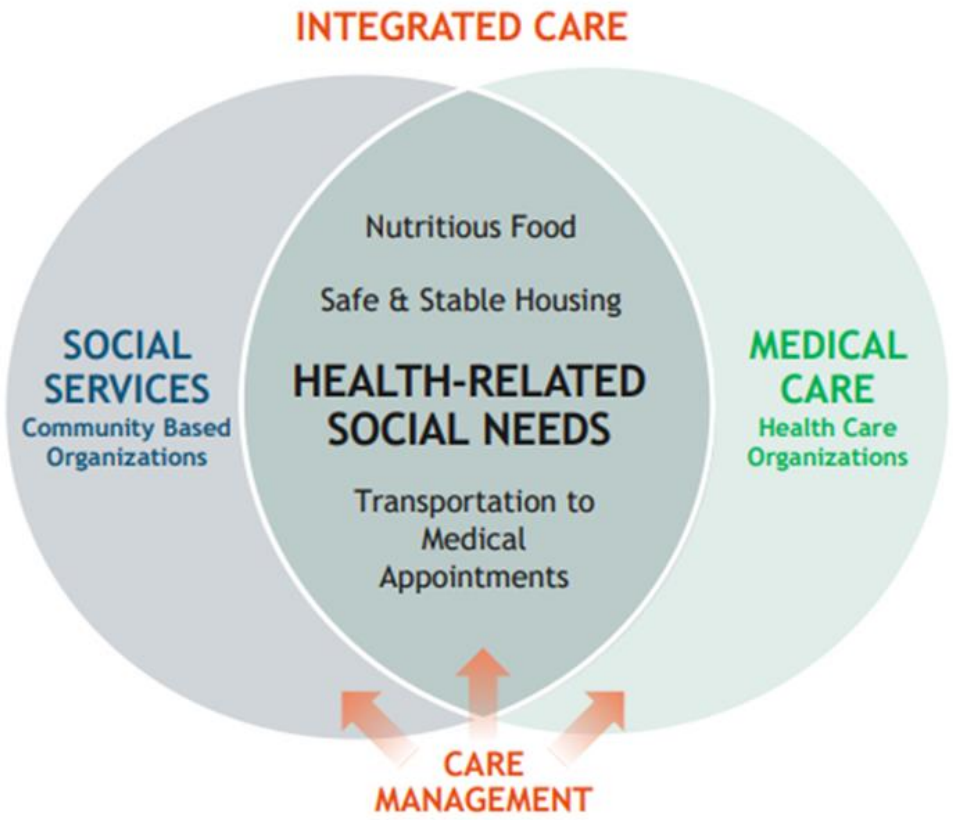


Diagram Source: The Commonwealth Fund

COMMUNITY CARE HUB (CCH)

A formalized structure made up of separate **community-based organizations** and a **central administrative hub** led by an **organizational lead entity**. CCNs offer health industry payers **one-stop contracting** to obtain multiple **social care interventions** for their patients/members.

CCHs offer opportunities for

People: Coordinated and more holistic approach to accessing services through trusted, local organizations in the communities they reside in.

Health Providers/Systems: More efficient referral pathways to address SDoH with effective service-based interventions that can improve health outcomes.

CBOs: Opportunity to improve efficiency through shared services, access to new contracting opportunities and funding streams, and technical support.

Payors: Simplified contracting with CBOs resulting in improved access to standardized social services across a region; improved access to data on member needs and outcomes.

Broader impacts may include more effective investment of funds, access to other funding sources, and coordination and maximization of funding streams.

CCH Functions

- Governance & Executive Leadership
- Strategic Planning
- Business Development
- Contract Negotiation, Signature, & Management
- CBO Recruitment & Retention
- Legal & Compliance
- Fiscal Management
- Data Collection, Management, & Sharing
- Referral Intake & Management
- Technical Assistance for Service Oversight & Quality Improvement

CCHs can help alleviate administrative burdens

- One contract with the central hub enables payers/providers to access social services from multiple CBOs
- Centralized delivery of standardized, evidence-based interventions across a region or wide geographic area
- CBOs are trusted, local organizations that provide services directly in the community they reside in
- Central hub provides shared administrative services to participating CBOs

Effective clinical/community/payer partnerships can lead to improved health outcomes and lower health care costs.

To achieve sustainability, CCHs must:

- Develop legal structures that enable hubs to perform business functions, ensure/enforce service quality standards, and provide the legal authority for contracting.
- Invest in data interoperability infrastructure and successfully implement interoperability functions.
- Adopt strategies and business models for blending and braiding funding streams.
- Design and complete service demonstrations to collect hard data to make the business case to payors.
- Perform market/landscape analysis to identify service lines that offer payors a clear ROI.
- Address workforce capacity (scaling, training, retention) in line with community service demands.

National Examples: Key findings from CCHs in ME, MO, and NY

WASHTENAW HEALTH INITIATIVE

Stakeholder Meeting

Integrating Health and Social Services

December 10th, 2024

Gerard Queally
President & CEO

Kristi Bohling-DaMetz
Director of Aging and Adult Services

Tane Lewis
Community Support Network Manager

Nikki Kmicinski
CEO

Gerard Queally

President & CEO

SKCCP

- 11 community-based organizations, 3 health systems, 1 healthcare advocacy organization, and the Maine CDC Central Public Health District

- Sectors:
  - Public Health
  - Healthcare
  - Housing & Economy
  - Behavioral & Mental Health
  - Social & Familial Services
  - Other

HL4ME's mission is to coordinate and align community resources to improve the health and wellness of the people of Maine.

HL4ME, Maine's Community Care Hub (CCH).

HL4ME's vision is providing Maine people with the skills and resources to take control to build healthier lives.

HL4ME CCH Video

HL4ME CCH – Multi-Sector Network

Health Promotion & Disease Prevention (HP&DP) Programs

- Varying funding sources supporting…
  - Chronic Disease and Pain Management
  - Diabetes Management and Prevention
  - Intellectual and/or Developmental Disability Support
  - Caregiving
  - Falls Prevention
    - Maine Falls Prevention Coalition (MFPC)

"We've come to view CCH network staff as an extension of our own care team." – **FQHC CEO**

Social Care Coordination (SCC) Services

- 4 contracts (2 health systems & 2 health plans) to provide services
  - In-home assessments with high utilizers of the Emergency Room (ER)/Emergency Department (ED)
  - Complex Care Management addressing high ER utilization and high-risk clients with no supports
  - Health Risk Assessments and collection of health and Social Determinants of Health (SDOH) needs

Rural Community Health Improvement Partnership (R-CHIP)/

- Somerset and Kennebec Counties Community Partnership (SKCCP)

Kristi Bohling-DaMetz
Director of Aging and Adult Services

Tane Lewis
Community Support Network Manager

Mid-America Regional Council (MARC)

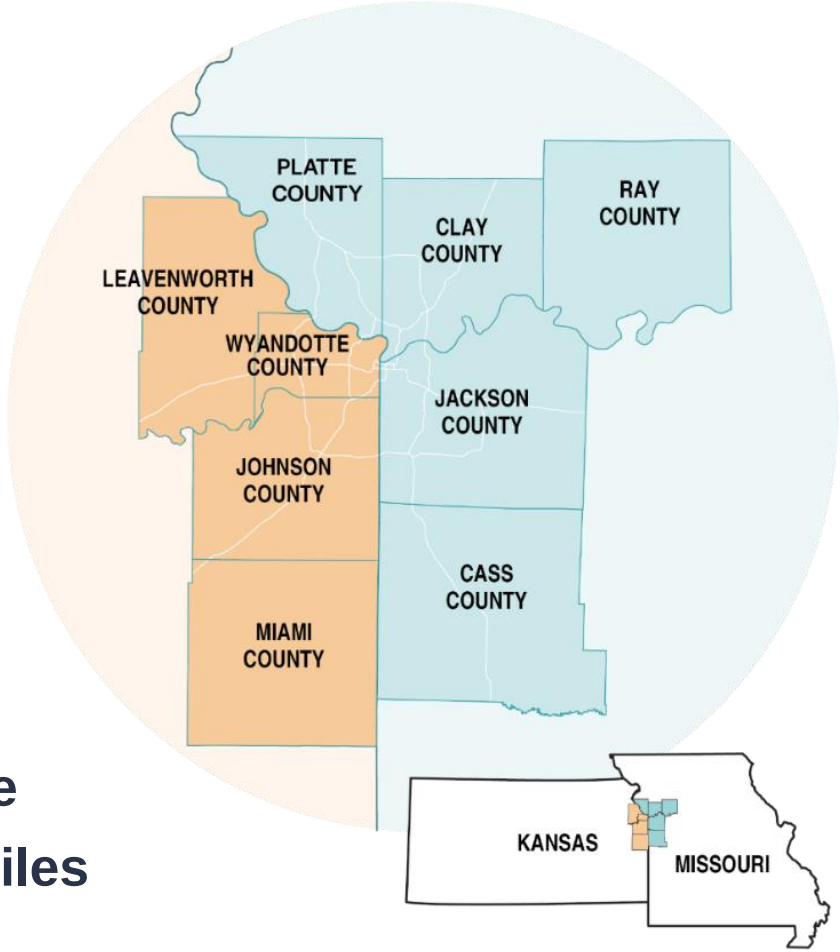
- A nonprofit association of city and county governments
- The federally designated metropolitan planning organization for the Greater Kansas City region
- The designated Area Agency on Aging (AAA) for the Kansas City, Missouri, region
- A forum for the region to work together to advance social, economic and environmental progress
- **MARC operates as the Community Care Hub (CCH) for the regional Community Support Network (CSN) and the statewide ma4 Network**

Mid-America Community Support Network

Community Support Network (CSN)

A Community Integrated Health Network

The Community Support Network (CSN) offers community support services to health care entities and their participants across the Kansas and Missouri bi-state metropolitan region.



Two states

Nine counties

119 cities

2 million people

4,400 square miles

HCE
Concern
Reliable
Capacity

CBO
Concern
Reliable
Funding

CSN

MARC as Community Care Hub (CCH)

Benefits to HCE and CBO partners:

- One-stop shop for contracting, financial administration, IT and cybersecurity oversight
- Centralized intake & referral, service coordination, training, and QA and CQI management
- Data aggregation and reporting

Key Thoughts

Collaboration

- Identify community-based organizations (CBOs) delivering health-related social needs (HRSN) services
- Assist CBOs with the partnership process
- MARC trains CBO facilitators free of charge as needed

Contracts

- Centralized contracts provide consistency across the network
- Commitment builds trust between organizations
- Contracts provide accountability for all partners
- Centralized contracts increase the marketability of the network to third-party funders

Quality Standards

- Ensure fidelity of programs
- Provide uniform policies and procedures, streamlined workflows and oversite
- Allow for accurate reporting of impact and outcomes to Federal, State and Third-Party funders

Lessons learned

- **Standard contracts are critical to quality assurance**
- **Formal contracts can be intimidating - TA required**
- **Start slow and build over time**
- **Network with experienced partners is critical**
- **Expand community support services within the network**
- **Privacy and security standards embedded in network**

It is hard work but impactful and rewarding!

Community Cohesion

*"It is critical that the approach to address health-related social needs reflects **communitywide governance and planning**. By incorporating **input from community leaders** and reflecting the demographic and lived experience of those served, the hub can ensure inclusion of local priorities, goals, and culture. Communitywide governance and planning to address health-related social needs should incorporate input from community leaders and **reflect the demographic diversity and lived experience of the those served by the hub**. HHS agencies, including ACL and the Centers for Disease Control and Prevention (CDC), are accelerating efforts to develop communitywide approaches to address SDOH and inequities through hubs."*

Health Affairs Blog, 11/29/22: Improving Health and Well-Being Through Community Care Hubs, https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

Nikki Kmicinski

CEO

Community Care Hub

Award-Winning Business Model

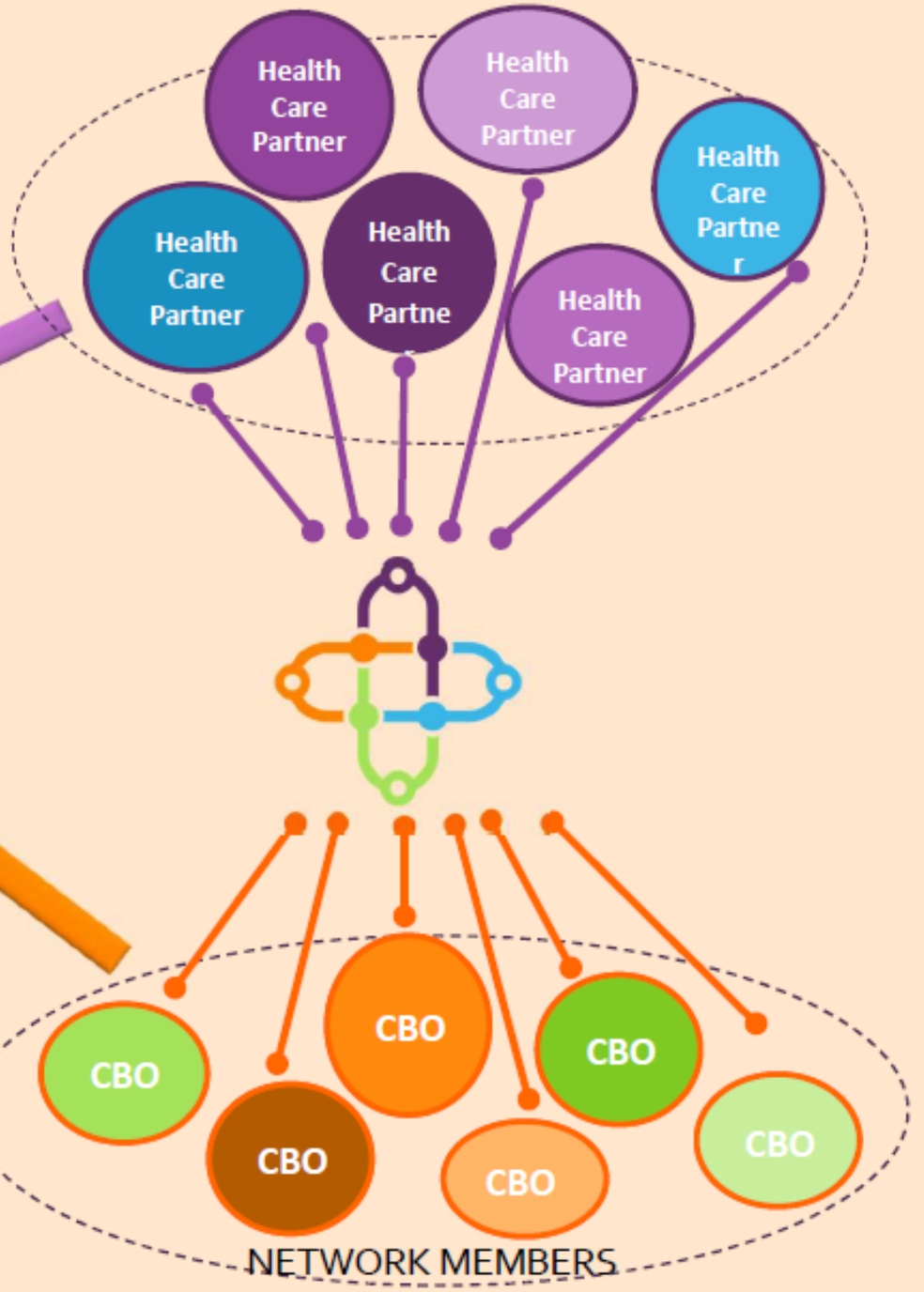
https//:wnyicc.org

Patients / Community Members

- Better Quality of Life
- Improved Outcomes
- Reduced Healthcare Costs

Clinical Care Delivery

Delivery of Services Addressing Health-Related Social Needs



- Food /Meals
- Case Management
- Community Health Coaching
- Falls Prevention
- Chronic Disease Self-Management Programs
- Caregiver Support, Training, & Respite
- Health / SDoH Screening
- Diabetes Prevention Program (DPP)
- Transportation
- Housing Supports
- Nutrition Counseling
- Care Transitions
- Social Isolation Supports
- Care Coordination
- Community Health Integration services
- Child and Family services
- Legal services
- Benefit Navigation and more

120+ Network Members

- County-Based AAAs
- Independent Living Centers
- County-Based Health Departments
- 100+ non-profit Community Based organizations (CBOs)

WNY Integrated Care COLLABORATIVE

www.wnyicc.org

Integrated Care – Mission and Vision

Mission: Better Health with Integrated Care.

Our service-provider network produces **better health** outcomes and quality of life by providing comprehensive, cost-effective, community-based **integrated care**.

Vision: To represent community-based organizations in providing sustainable, high-quality integrated business models for community-based programs and services proven to address social determinants of health.

WNY Integrated Care COLLABORATIVE

Integrated Care's Role in the Network

Advocacy	**Administrative Role and Network Strategy**	**Billing and Invoicing**	**Contracting and negotiations with health plans and payers**
Compliance	**Credentialing / Licensing**	**Reporting and data analysis**	**Medicare Supplier / Provider** **Medicaid Supplier**
Network Collaborations and Engagement	**Outreach and Referral Processing**	**Technical Support and Health IT portal**	**Training Academy**

WNY Integrated Care COLLABORATIVE

Integrated Care – Benefits of Network Membership

Advocacy for CBOs and Network Members;
Pulse on national, state, local trends & policies

Strategy development to support Network

Health IT Portal and data reporting

Referrals to Programs

Compliance and Quality Assurance

Regional Coordination & Network Engagement

Free To Join

www.wnyicc.org

WNY Integrated Care COLLABORATIVE

Integrated Care – Benefits of Network Membership

Free trainings through Integrated Care Training Academy

Earned revenue / Sustainability

Billing and Claims Submission

Ability to enter contracts with health care entities

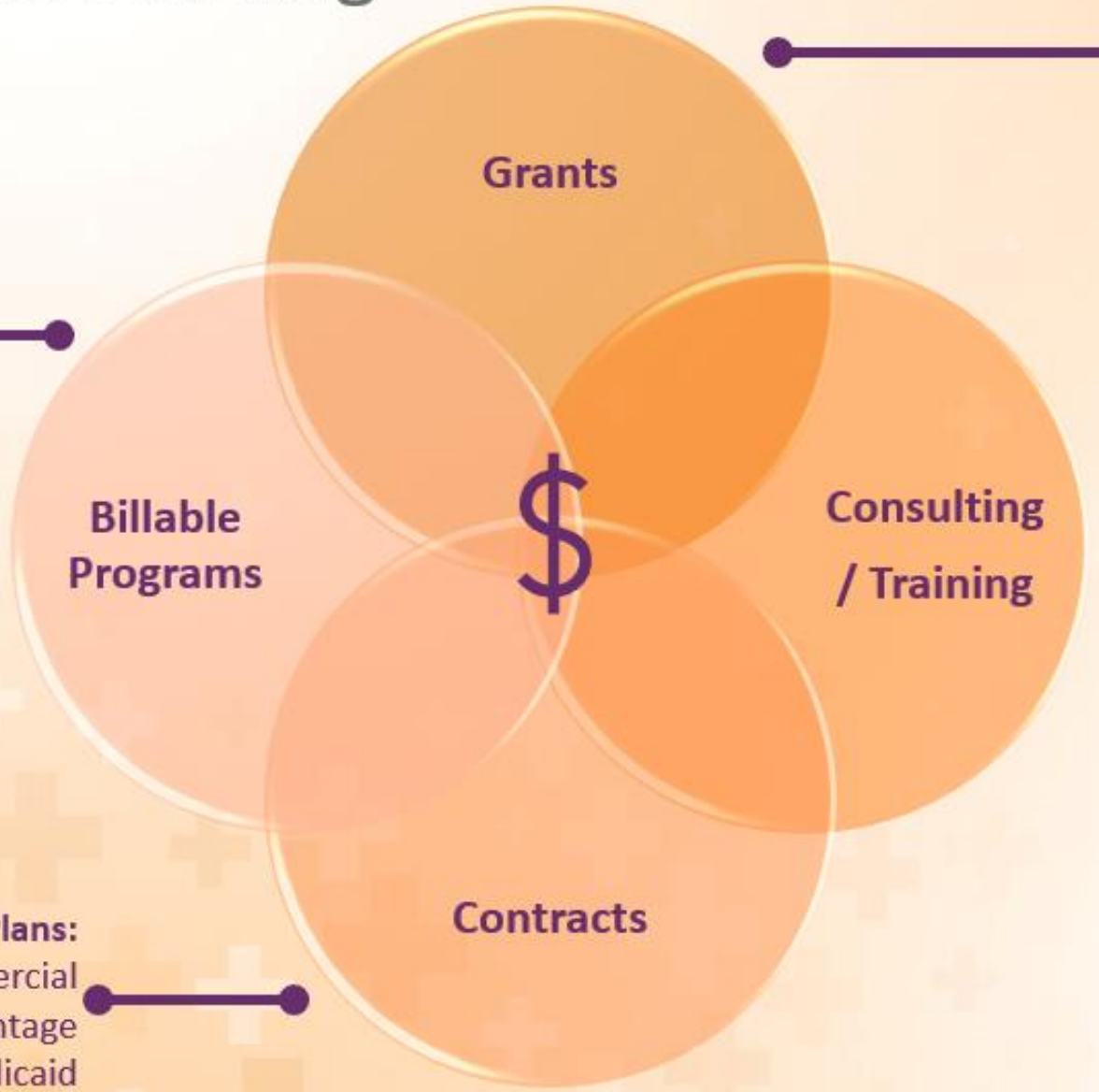
Contracting / Negotiations on behalf of Network

Shared Services

Technical Assistance

WNY Integrated Care COLLABORATIVE

Integrated Care Funding



Local: Foundations
State: NYS Office of Aging; NYS Dept. of Health
Federal: Administration for Community Living; Center of Excellence

Medicare Provider
Medicaid Provider
Diabetes Prevention Program
Diabetes Self-Management
Medical Nutrition Therapy

Other CCH's
Master Trainers: for Evidence-Based Programs

Health Plans:
Commercial
Medicare Advantage
Medicaid

WNY Integrated Care COLLABORATIVE

Integrated Care's Health Plan Contracts

Program	Funding Mechanism
Post-Discharge Meal Delivery Program	MA Plan Supplemental Benefit
Community Health Coaching	MA Plan Program, extension of case management
Healthy IDEAS	MA Plan Program, extension of BH case management
Falls Prevention	MA Plan Supplemental Benefit
Caregiver Support	MA Plan Program, extension of case management
Diabetes Prevention Program	Medicare Part B Benefit
Diabetes Self-Management Training	Medicare Part B Benefit
Medical Nutrition Therapy	Medicare Part B Benefit (i.e. DM/CKD) & added MA Plan Supplemental Benefit for any other diagnosis
Housing Supports and Navigation	NY Medicaid 1115 Waiver program
Nutrition & Food Supports	NY Medicaid 1115 Waiver program
Transportation to HRSN Services	NY Medicaid 1115 Waiver program
Navigation and Enhanced Social Care Management	NY Medicaid 1115 Waiver program

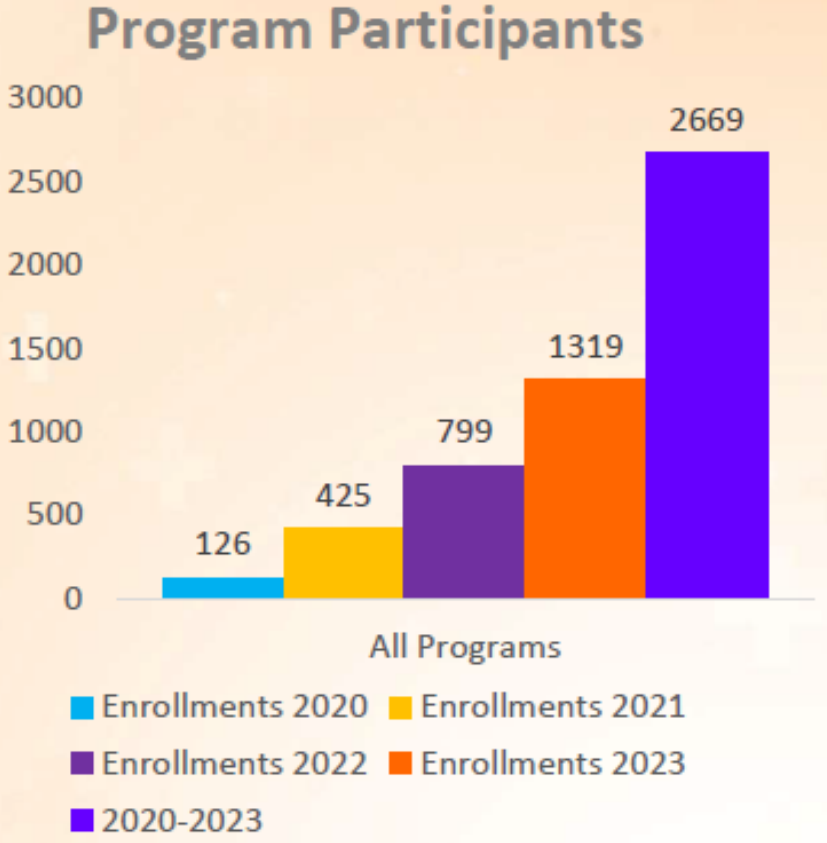
WNY Integrated Care COLLABORATIVE

Integrated Care – Reimbursements to Delivery Partners

- **97%** of Program Delivery completed by **33** community-based organizations
- <u>As of Dec 31, 2023</u>
  - **$520,661** paid out in reimbursements to CBOs
  - **102%** increase in 2023

Integrated Care – Program Outcomes

- **Post-Discharge Meals Program**
  - **1795** Participants received meals 2022+2023
  - **46,094** meals delivered
  - **73%** report that receiving the meals helped prevent a re-admission.
- **Medical Nutrition Therapy**
  - **86%** of completers increased vegetable intake.
  - **90%** made changes in eating habits
- **Healthy IDEAS Outcomes**
  - **85%** of participants:PHQ9 or UCLA Loneliness improve score by 15%
  - **76%** of participants increased their physical and/or social activity through the program.
  - **8** referrals per client made to clinical providers: PCP, Mental Health providers or Registered Dietitians.
- **Community Health Coaching**
  - Average **8** Goals/Interventions per participant
  - **75%** High or Medium Priority Needs with goals to resolve
  - **92%** Resolved or In-Progress
- **Falls Prevention Program**
  - Average **40%** reduction in falls risks
  - **33%** assisted with PERS; **55%** developed MyMobility Plan



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WNY Integrated Care COLLABORATIVE

CCHs throughout Michigan

- Access Health – Muskegon
- Greater Flint Health Coalition
- Health Net – Grand Rapids (Kent County)
- MiCommunityCare – Washtenaw-Livingston
- Jackson Care Hub
- Southeastern Michigan Health Association – Detroit
- Livingston County Human Resources Collaborative
- Calhoun County (Nicole…)
- Oakland County
- SDOH Hubs (Multiple)

Group Discussions

First Discussion

Name <u>one or more specific health needs</u> that might be improved by better integration of health and social services.

Common issues across sectors?

Biggest obstacles?

Second Discussion

For one or more specific needs, ask:

Would an 'Administrative lead' organization improve the current state?

Who is already active in this space?

What are current gaps?

How would lead organization function?

How would success be measured (i.e., measurable outcomes)?

Third Discussion

For one or more topics you've discussed, what are <u>best next steps</u> for individuals or organizations to pursue towards better integration of health and social services?

Who should meet with who about what?

Group Discussion Report Out

Josh closing remarks ***

- Priorities, opportunities, and challenges in current context

Summary and Next Steps

Networking and Card Exchange