MDHHS: FY21 Budget Executive Recommendation

Policy and Planning Administration

March 4, 2020

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Building on the success of the State Innovation Model

Person-centered care

>300 medical practices (2,000+ primary care providers) participated in the Patient-centered Medical Home (PCMH) Initiative with a commitment to **improving care delivery and care coordination**

Community coordination

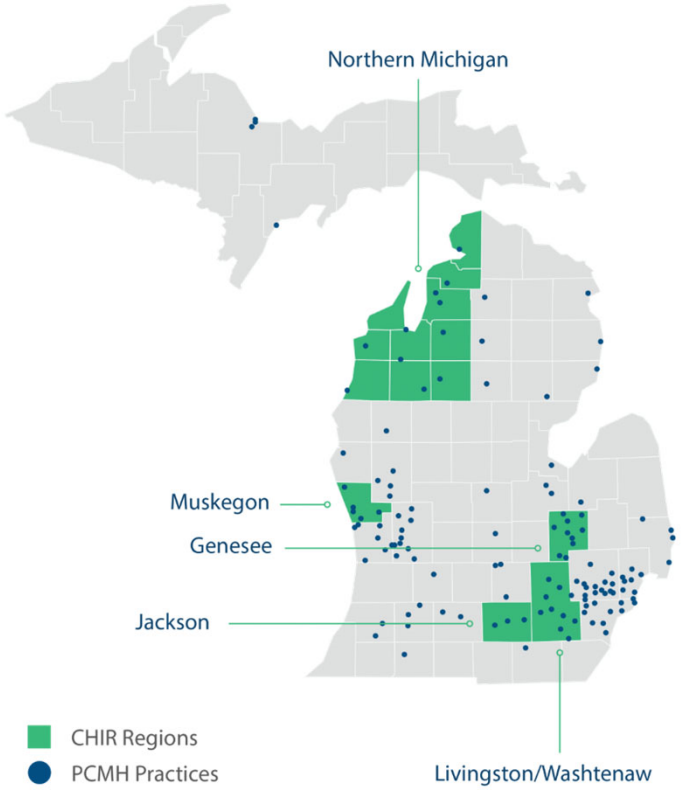
Community Health Innovation Regions (CHIRs) in five areas across the state formed collaboratives **to build cross-sector partnerships** and create a **shared plan to improve community health.**

Alternative payment models

In partnership with Medicaid health plans (MHPs), SIM **increased adoption of alternative payment models** (APMs) to sustain the focus on **value-based care**

Using and sharing data

SIM funded significant improvements in Michigan's health information exchange, including building out **local screening and referral hubs** to identify social needs and refer people to services



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CHIRs Impacts on Community Approaches

74% of respondents report integrating a stronger focus on social determinants of health in the work they do because of their involvement with a CHIR.

60% of organizations' leaders* report initiating or making changes in their own agency's policy, procedures, or practices as a result of CHIR involvement in 2019.

*includes CEOs and program directors

*"The real value is there as **you start to see the link and the overlap in how you can help each other**, which in turn starts to drive your costing factors down. When you start to share resources and you have doctors talking to people running nonprofits, and people running nonprofits talking to executives from The United Way… **the strength of that network is something that you can't measure**. "*

- Partner, Social Sector

*"The thing that was unexpected was that there were multiple organizations within the community that were already working on the same thing. [The CHIR project] **identified the fact that there are some gaps between organizations in the community**…Rather than reinvent the wheel and have [our organization] try to take the lead, we just said, 'how could we help you make sure that these people are connected?"*

- Homeless Services

*"Once **we really figured out…how disjointed systems really affect the resident through their eyes**, [by] interviewing residents and sharing stories of when the system worked well and when it failed, it really **provided a better picture of what we needed to change**."*

- CHIR Staff

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MI Bridges

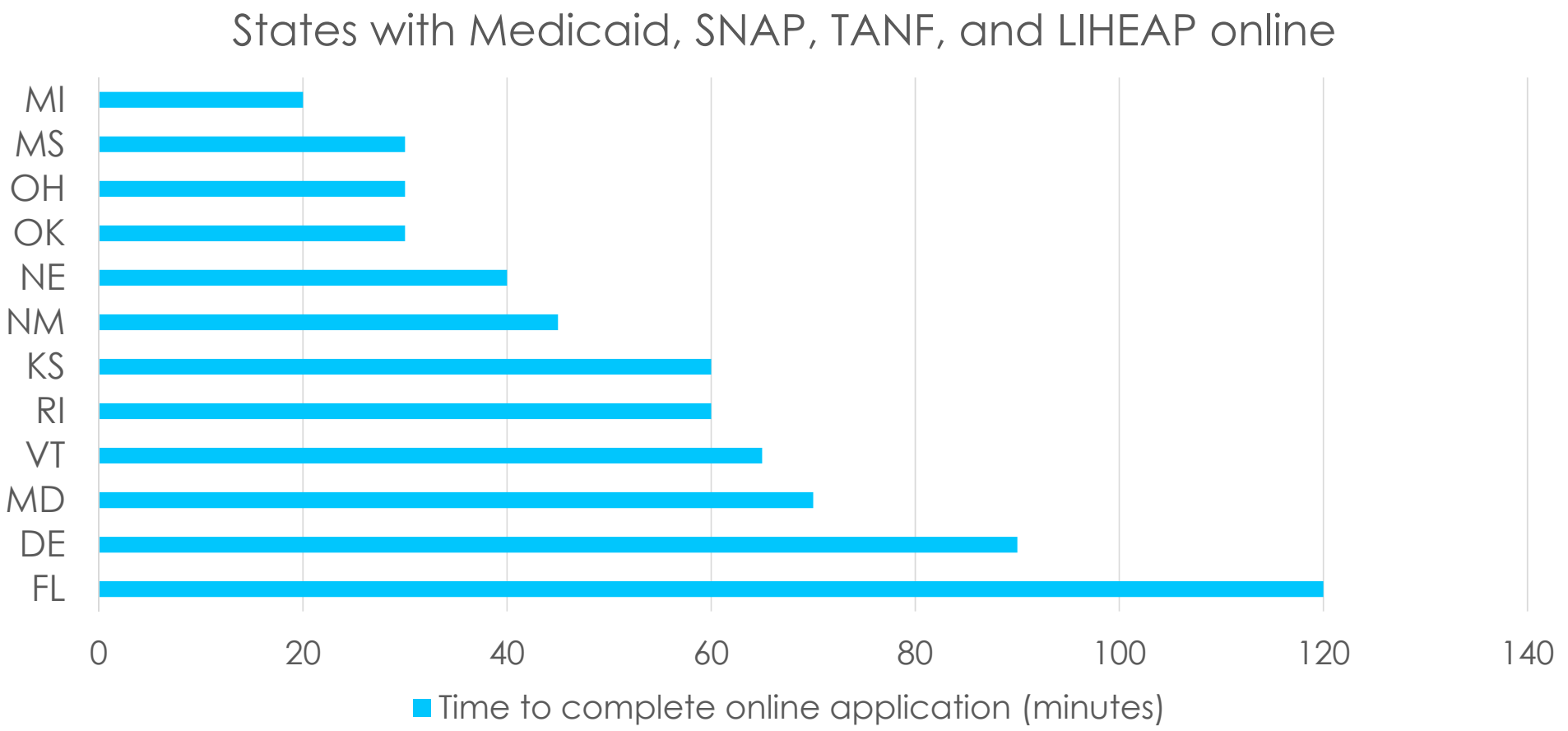
Overview

MI Bridges has served as the center of a comprehensive, multi-year transformative initiative in Michigan to better integrate health and human services resources in an effort to improve resident outcomes.

Activities

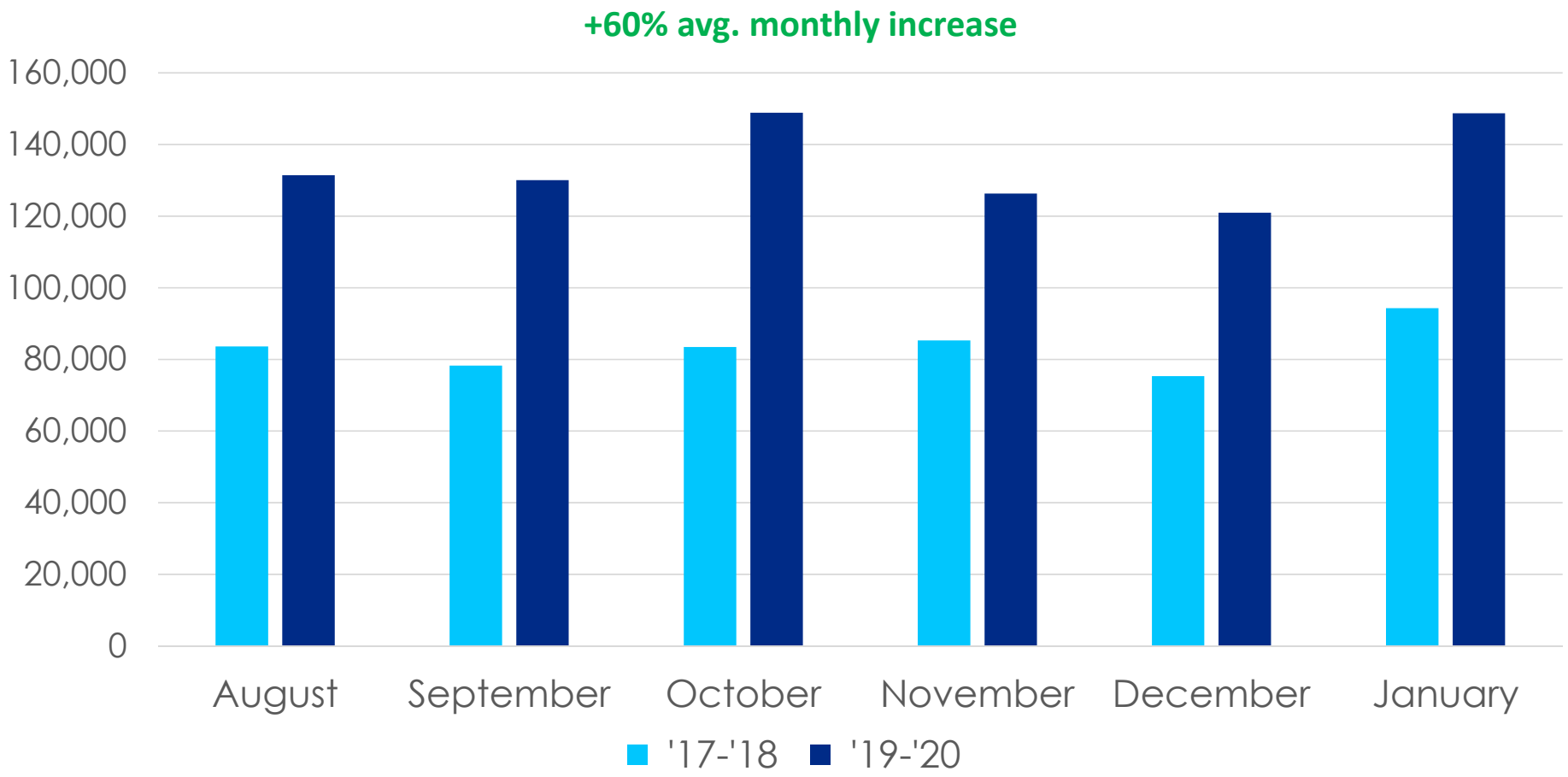
- Coordinated User Engagement and Testing
- Developed Community Organization Partnerships
  - Over 700 organizations have become MI Bridges community partners to support residents statewide
- Provided Community Partner Training
  - Trained over 5,000 community partner staff and volunteers to assist residents using MI Bridges since 2018
- Implemented innovative approaches to delivering benefits programs
  - Successfully piloted a redesigned renewal form and process for the department's largest public benefits programs
- Supported MDHHS Internal Readiness and Staff Training

MI Bridges is one of the quickest online applications in the country…



Source: "Bringing Social Safety Net Benefits Online: Examining online platforms for all 50 states", by Code for America

Online Benefits Applications Submitted: Old MI Bridges vs. New



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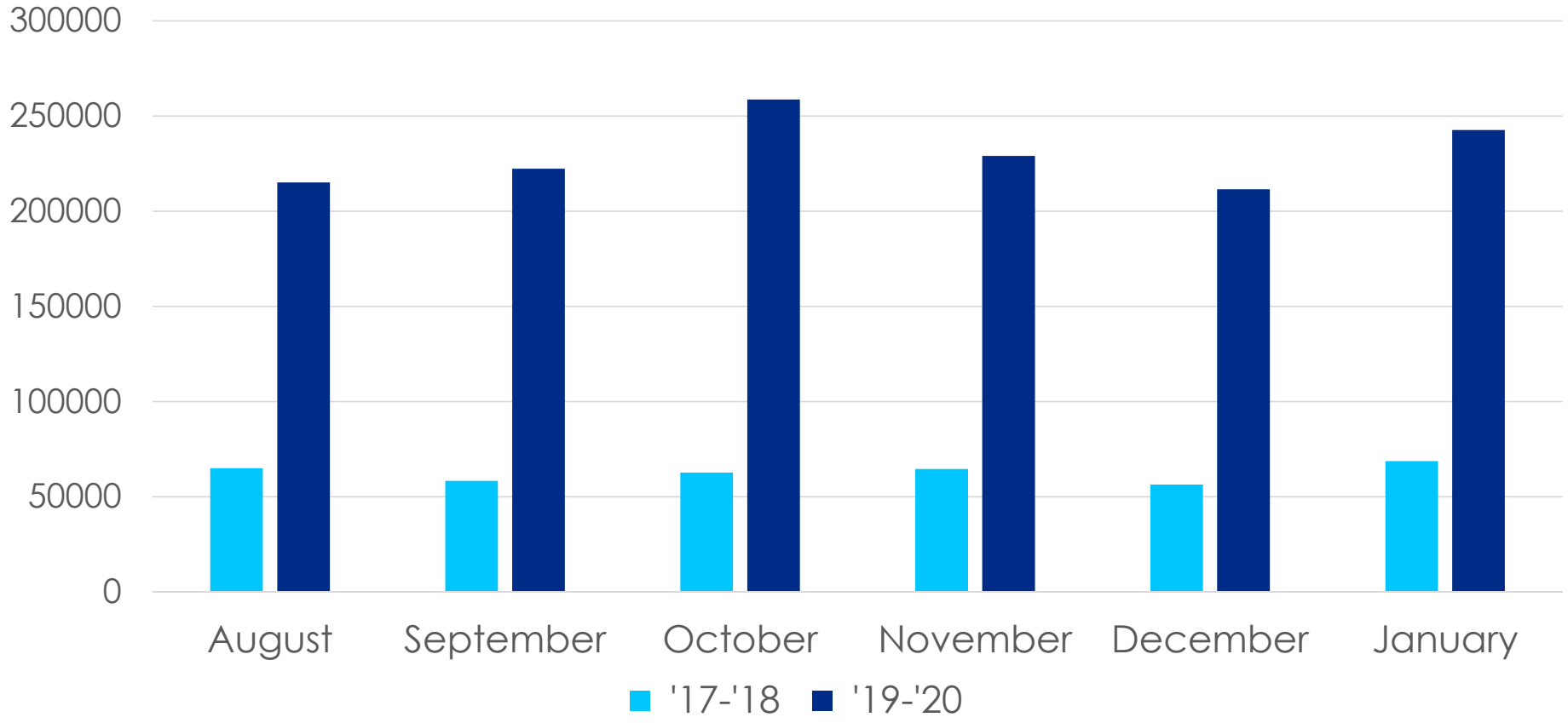
Documents Submitted Electronically: Old MI Bridges vs. New

+270% avg. monthly increase



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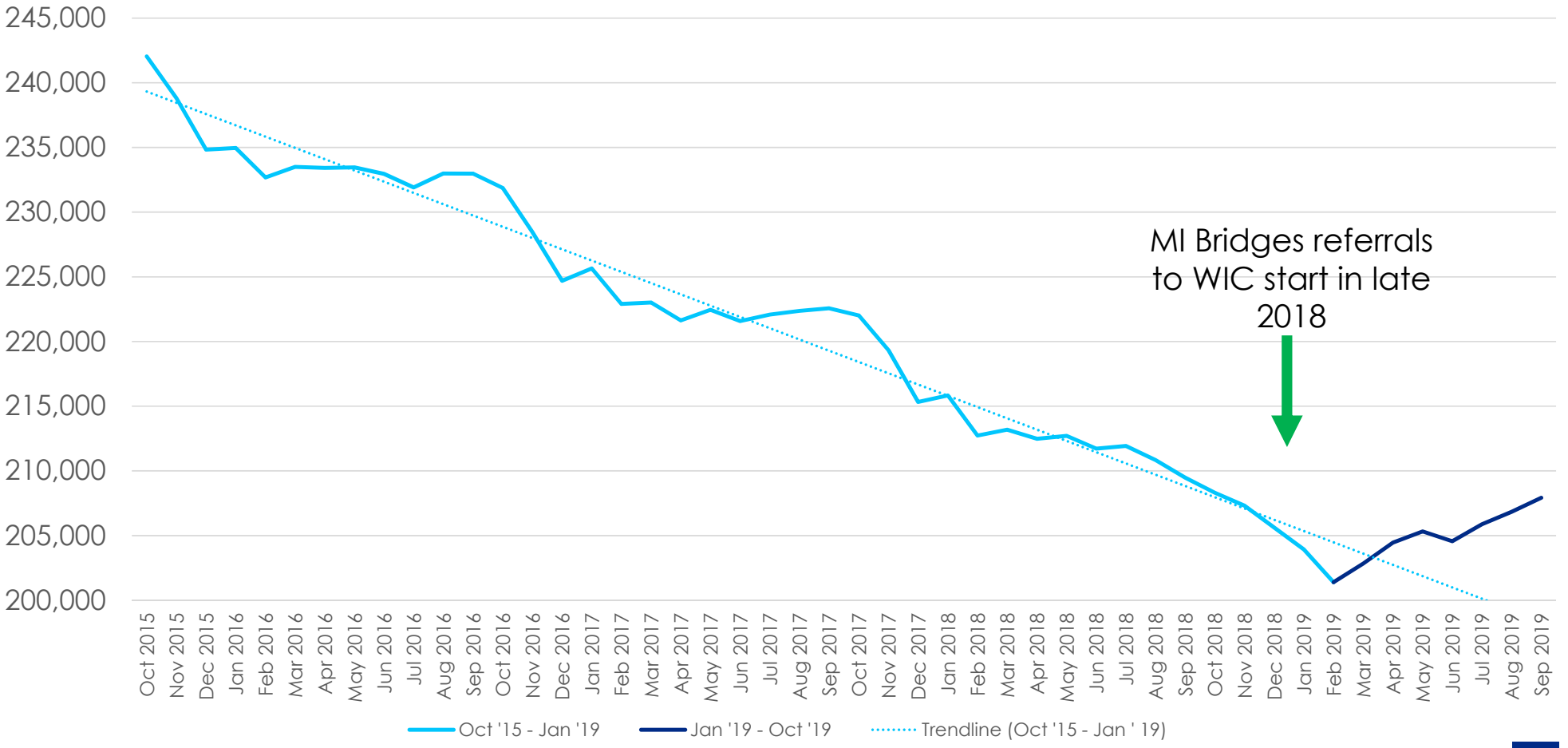
Michigan WIC Enrollment FY16 - FY19



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Office of Equity & Minority Health

Mission

To provide a persistent and continuing focus on assuring health equity and eliminating health disparities in Michigan's populations of color.

Activities

Focused on improving:

- Race/ethnicity data
- Awareness about health disparities
- Government strategies to address health disparities and health equity
- Access to quality healthcare
- Capacity for communities to address health disparities & social determinants of health

Submitted annual Public Act 653 (Minority Health Bill), Health Equity Report, to Michigan legislators & distribution to internal and external stakeholders.

OEMH will pilot an Equity Impact Assessment to a policy, practice or budget allocation process in FY20

Healthcare Workforce

Health Professional Shortage Area Designations in Michigan

- 324 Primary Care Health Professional Shortage Areas
- 305 Dental Health Professional Shortage Areas
- 299 Behavioral Health Professional Shortage Areas

Recruitment and Retention in 2019

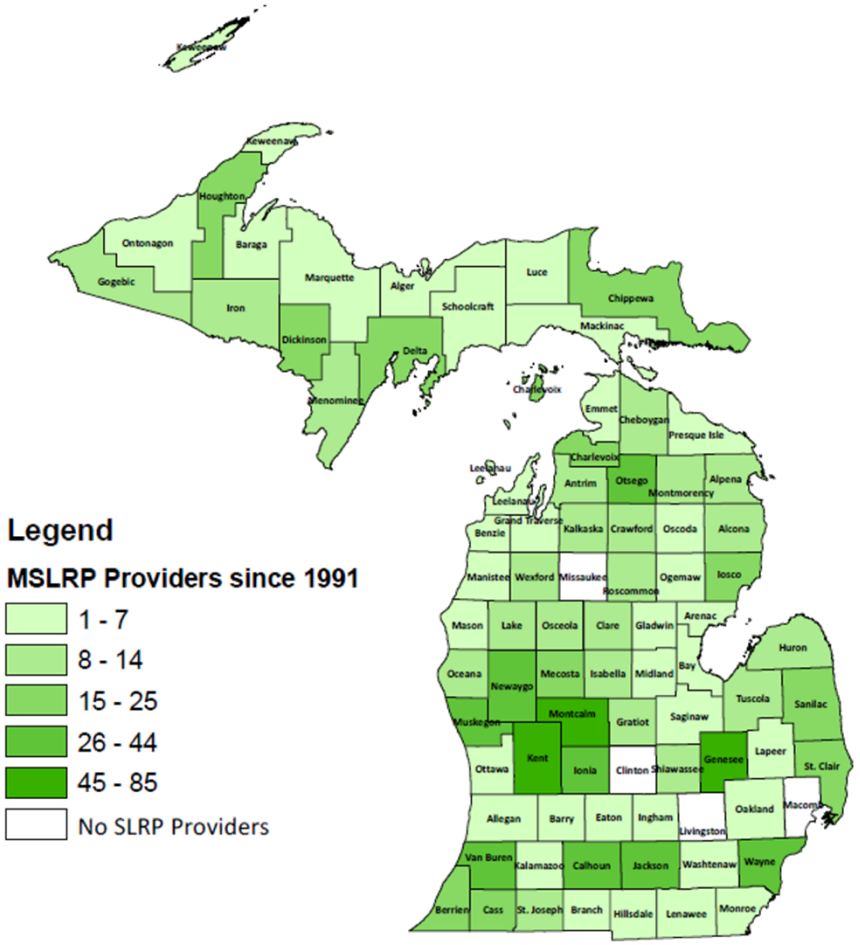
- 369 providers awarded educational debt relief through federal programs
- 84 providers awarded educational debt relief through state programs
- 37 International Medical Graduates serving in Michigan through visa waivers

Nursing Education, Training, and Practice

- 580 nurses provided online transition to practice training in communication and/or safety
- 25 community health or primary care nursing clinical placements sites developed, pilot tested and evaluated

Michigan State Loan Repayment Program

- This program provides recruitment and retention incentives for primary care providers to practice in underserved areas of Michigan.
- Since 1991, the program has placed 1,031 providers, with 68% placed in rural counties.
- Pays off up to $250,000 in medical education debt for 10 years of service in underserved areas of Michigan.
- Program focus includes increasing the number of Psychiatrists statewide and Obstetric providers in northern Michigan.



$11.7M Gross | $7.1M GF

Preventive Investments in Social Determinants of Health

Context

- Housing, food, job, and other factors drive **40% of health outcomes**
- Federal funding for Michigan innovation (CHIRs) is ending
- Patchwork of SDOH tools creates waste & confusion
- **We can invest now, or risk losing what we have built**

Response

- **Establish a statewide screening and referral infrastructure**
- **Scale a strong, coordinated community infrastructure**
- **Evaluate what we do**

Expected impact

- Greater access to services that improve health
- Better health outcomes, lower medical costs

Social Determinants of Health

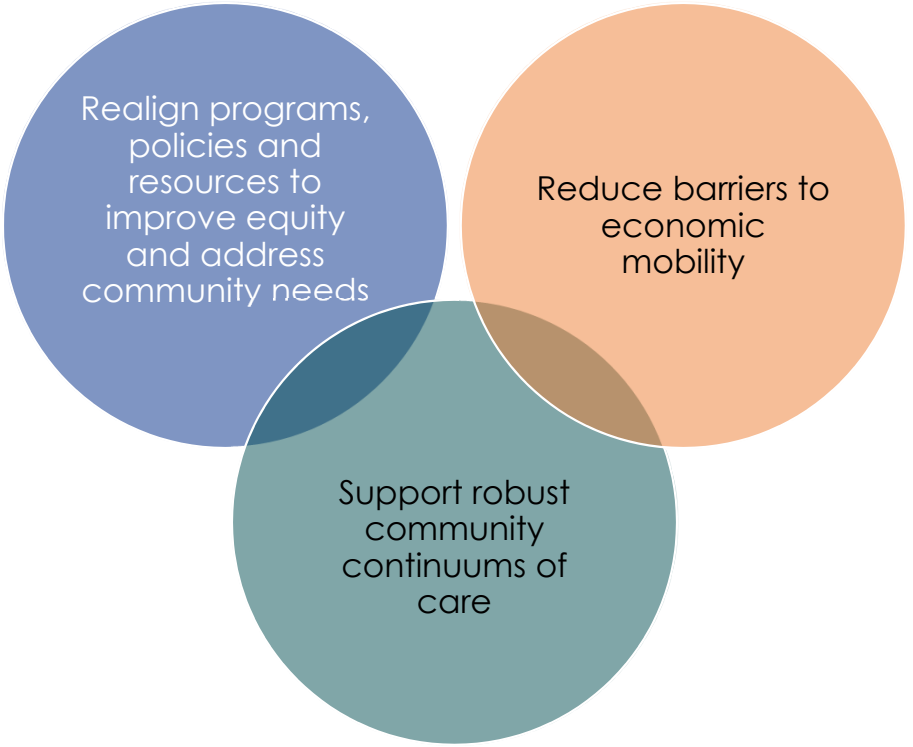
Social Determinants of Health are the conditions in which people are born, grow, live, work, and age that shape health.

We can improve health outcomes for individuals, families, and communities by addressing their food and nutrition, housing, and other social determinants of health needs – and raise their overall quality of life at the same time.

Our Goal

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

Three Strategic Pillars



Social Determinants of Health Strategy

Realign to improve equity and address community directed SDOH needs

- Utilize equity impact assessment to review MDHHS programs & policies
- Leverage community needs/health assessments to direct program spending
- Integrate department data to target interventions

Reduce barriers to economic mobility

- Increase cross enrollment in assistance programs
- Address barriers to food assistance programs
- Leverage public-private partnerships to address food access issues
- Work collaboratively with LEO & MSHDA
- Streamline homelessness services
- Expand access to homelessness prevention programs
- Incorporate health & homelessness data into local systems
- Expand funding available to address housing needs

Support robust community continuums of care

- Implement social needs screening system
- Support local continuums of care
- Align CHWs efforts to support referrals & local connections
- Embed SDOH interventions in Home Visiting

Social Determinants of Health Strategy

Challenge	Response	Expected Impact
Food	▪ Increase enrollment in food assistance programs, particularly those serving mothers and children ▪ Partner to increase the number of stores that accept food assistance programs, and establish grocery stores in food deserts	• Reduction in chronic health conditions like diabetes and obesity • Improved maternal and infant health • Decreased health expenditures
Housing	▪ Better target housing vouchers to most in-need people and families ▪ Expand homelessness prevention efforts, such as eviction diversion programs	• Decreased rates of homelessness • Reduction in medical expenses and Emergency Department usage
Employment, transportation and other needs	▪ Establish standardized screening and referral system to identify needs and connect people with available resources ▪ Build connections between health and human services providers to deliver more seamless supports	• Improved participation in existing supports programs • Increased access to services • Improved health outcomes • Reduction in individual and community poverty

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