OVERVIEW OF HEALTH AND SOCIAL CARE COORDINATION EFFORTS IN MICHIGAN

Adapted from Overview of CIE Efforts May 2022

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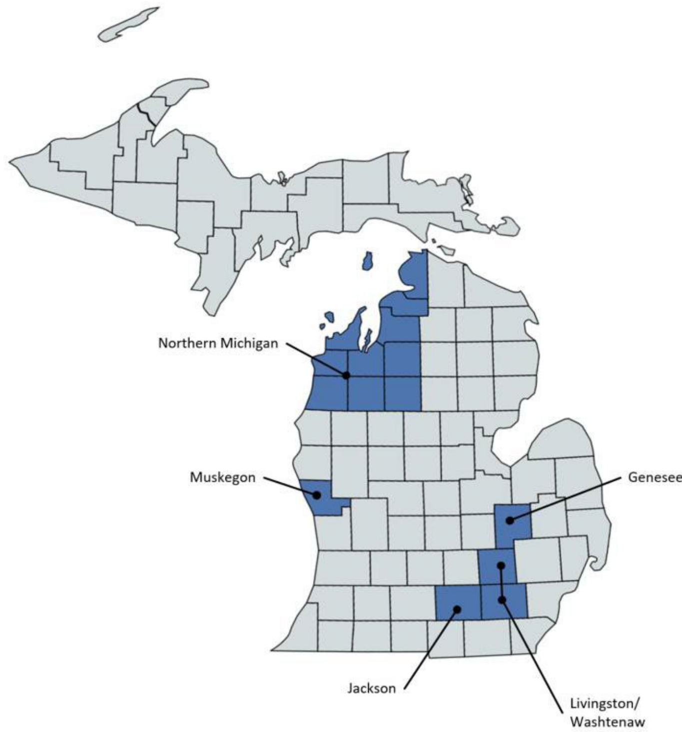
Background: CHIR Programs in Michigan

In Michigan the CDC's Clinical Community Linkages (CCL) strategy[1] was implemented through the State Innovation Model (SIM).[2] Michigan's SIM grant concluded on January 31, 2020, however, the Community Health Innovation Regions (CHIR) program has continued to advance CIE in their respective regions. A claims analysis completed in 2021 documented the success of this work through significant reduction in utilization and cost for CHIR participants in 4 of the 5 regions.3

A CHIR is a unique model for improving the wellbeing of a region and reducing unnecessary medical costs through collaboration and systems change. CHIRs engage a broad group of stakeholders to identify and address factors that affect residents' health, such as housing, transportation, and food insecurity, as well as access to high-quality medical care.[4]



[1] https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf
[2] https://innovation.cms.gov/innovation-models/state-innovations
[3] https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder93/Section_1144.pdf?rev=a1fe80e3558d4d778960e7b86d70e297
[4] https://michirlearning.org/about-chirs

Jackson Care Hub

THE JACKSON CARE HUB (HUB) CONSISTS OF TWO PARTS:

(1) a social services screening and navigation application linked to the new and comprehensive Michigan 2-1-1 database and

(2) an IT infrastructure that connects community agencies to one another and to the shared community electronic health record. The Hub supports each step in a common core workflow co-designed by community service agencies (identify, assess, assist, and follow-up)

THE SOCIAL DETERMINANTS OF HEALTH (SDOH) SCREENING TOOL

The Jackson CHIR has developed a virtual Hub that hosts the social determinants of health SDOH screening tool for community agencies to use. An identical screening tool integrated with the Jackson Community Electronic Medical Record (an Epic platform) provides the linkages necessary to minimize duplication in screening and effectively coordinate services to address individuals' needs. Once specific SDOH domain needs are identified, whether screening occurred at a medical practice or by any community provider, the Hub's short assessment module provides additional questions to enable staff to determine severity and acuity of need and more precisely match need to best available community resource.

Identify:
The results of completed screenings will be exchanged between the screening and referring systems to allow the results to be visible to subsequent users in either system. When a specific domain need is identified by the screening tool, the screener may be prompted to complete a few "assessment" questions for that domain which will allow them to get a more precise estimate of the level of need.

Assess:
Once a domain need is identified, the Hub software can guide staff through an assessment process that will determine level of needs, find best options for resources to assist in meeting needs, address client preferences for care, and obtain client consent for sending referrals. The Hub also enables assessment and tracking of self-sufficiency in each core SDOH and functional domain through the Arizona Self-Sufficiency Matrix.

COMMUNITY AND PROVIDER REFERRAL PLATFORM

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Assistance can be provided directly (for example, if the client presents to an agency that is able to provide the desired service) or through the closed-loop referral system embedded in the Hub. The Hub can send a standard electronic referral message ('task') to any connected community provider which will show up on their dashboard in the HUB. The agency will have three business days (72 hours) to reach out to the individual; 'urgent' referrals are to be addressed within 24 hours. To ensure accountability, there is an escalation phase built into the Hub to notify the user's supervisor if these deadlines are not met.

FOLLOW-UP

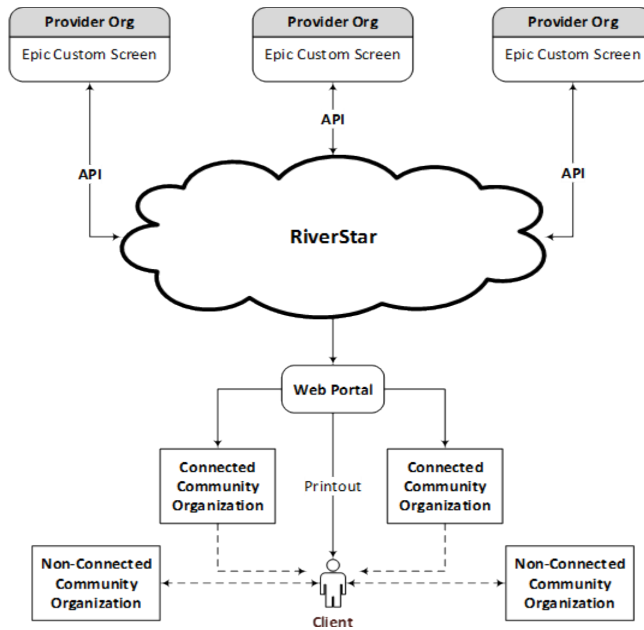
The resource provider receiving the referral can update the status of the referrals, make notes and see other identified needs through a referral dialogue window. There is also a referral dashboard for each Hub client where an agency involved in care coordination for an individual can view the full screening results, referrals, and the status of those referrals. Each referral message is assigned a status (Received, work started, redirected, waitlisted, scheduled appointment, unable to meet need, referral complete) that is changed by staff as care progresses.

When service is complete a message is sent to the referral initiator. This process creates a closed-loop referral system that enables tracking of the referral progress and completion and identifies any gaps in services. The Hub also allows users to provide feedback regarding their experience with the use of the system.

TECHNOLOGY

Jackson Care Hub is a cloud-based application that serves as a middleware between the providers and the connected community organizations for referrals. The Jackson Care Hub will serve as a repository for shared data entered in the screening tool as well as the referral and reporting platform.

1. This is a cloud-based Integration Platform as a Service (iPaaS) hosted and supported by RiverStar.
2. This type of system allows for rapid development and flexibility, cost minimization for IT maintenance and management, and ease of extending the application to industry or community partners.
3. A custom screen is built into Epic that interfaces with the Jackson Care Hub through an API (data transferred via XML)
4. Community organizations interface with the Jackson Care Hub through a secure web portal. Community organizations without portal access remain "non-connected":



"Connected" organizations receive electronic notifications while "non-connected" organizations contact information is given as a printout to the client.

5. RiverStar uses load-balanced web servers with auto-failover and a mirrored database. The servers are also split across regions for disaster protection and have point-in-time database recovery that supports disaster recovery. If RiverStar were to lose both regional data sites, they could recover from the mirrored data at a third site.

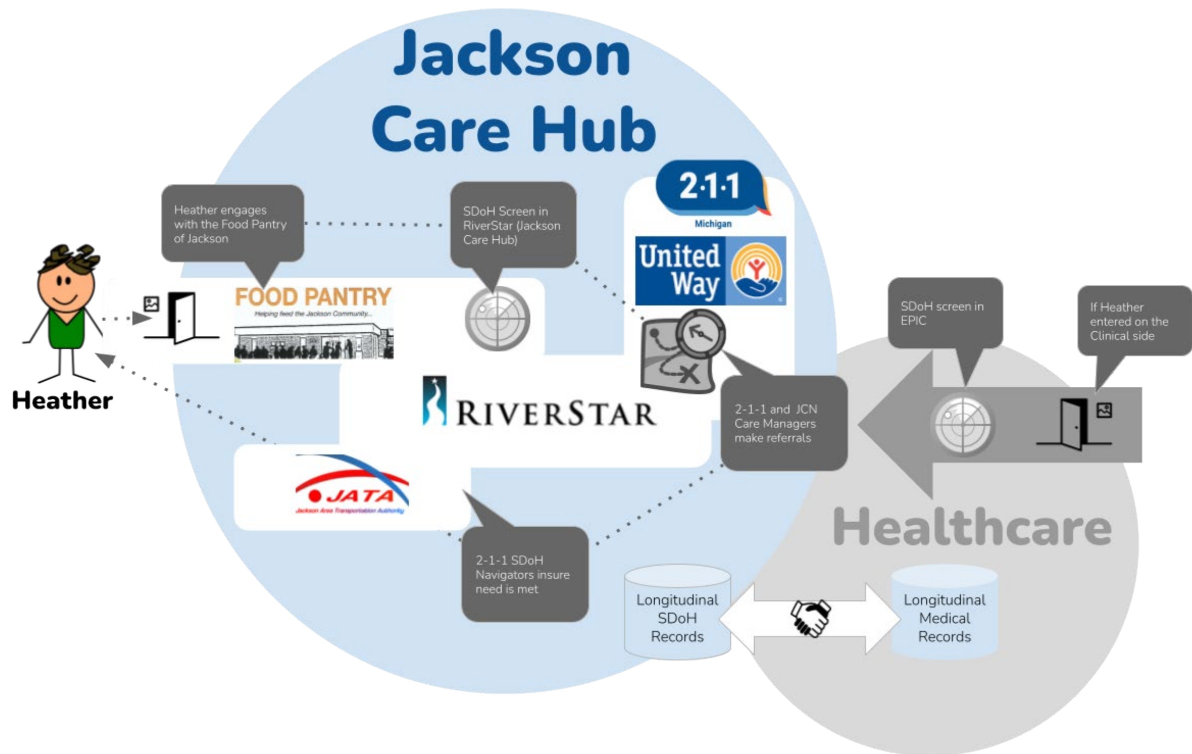
Reporting

Reports on core metrics is used to help identify process improvements to both the community and the medical entities. This supports understanding of resource gaps in the community and ensure there is a continued progress towards system change in addition to service provision. Partners can also review the progress with the individuals utilizing and receiving services through the Hub to ensure user and individual satisfaction. Reports can be exported to Excel, PDF, and CSV

Case Example: What this looks like at the individual level in Jackson, MI

Heather might show up at a homeless shelter, her primary care office, a food pantry, or a local human services nonprofit seeking help. Those organizations will all use the same assessment tool to screen her for various needs, such as healthcare, transportation, housing, food, and employment, not just the specific need she came in for. If this is a clinical door the SDOH needs screening will be done using the EPIC screening tool – a screening tool embedded in the EPIC EHR. If through a Community service they will use Jackson Care Hub / River Star

SDOH screening tool. A navigator (2-1-1 United Way) and a Care Manager (Jackson Health Network) will review the identified needs and refer her to various local or state services that have been mapped as part of the region's inventory of community resources. The receiving organization will enter information back into the system, indicating whether she made it to the food pantry or employment office he was referred to, allowing the staff at the original screening organization to know if her needs were or were not met, and to follow up with Heather appropriately.



Northern Michigan

The Northern Michigan Community Health Innovation Region (NMCHIR) is responsible for supporting 10 counties in the northwest lower peninsula of Michigan supported by the Northern Michigan Public Health Alliance (NMPHA) which leads and facilitates the development of a common agenda, shared measurement, mutually reinforcing activities, and continuous communication.

The NMCHIR developed and implemented a web-enabled, tablet-based screening and referral platform. Platform functionality allows locations to screen patients for SDOH using tablet devices,

refer patients on for community navigation services and ultimately coordinate care between community navigation and clinical service providers as needed.

The screening and referral platform is not tied to a specific screening source and can be expanded as needed with minimal modification for use across the spectrum of health care and community service organizations.

Genesee County

The Genesee Community Health Innovation Region (CHIR) is a partnership of a broad collection of multi-sector organizations, including three Accountable Systems of Care with 60+ Patient Centered Medical Homes (PCMH) practices, six Medicaid health plans, three hospitals, 30+ community-based organizations, and a Regional Health Information Exchange. Serving as the backbone of the Genesee CHIR organization, the Greater Flint Health Coalition (GFHC) provides leadership and guidance while working to leverage cross-sector partnerships that address population health and connect patients with relevant community and social services that address the social determinants of health (SDOH).

In establishing a technology solution to support Clinical Community Linkages, the Genesee CHIR investigated the existing technology infrastructure and data measurement systems in place amongst their partners in Genesee County. Based upon the diversity of the electronic medical record (EMR) and care coordination platforms currently in use and the associated investment into these software systems and their organizational interoperability, Genesee CHIR members concluded that creating a single CCL care coordination technical platform, while desirable, would be cost prohibitive and years in the-making.

The Social Determinants of Health (SDOH) Screening

To promote the SDOH screening process, the Genesee CHIR created a standard SDOH screening tool. The SDOH screening tool is being used by all three ASCs (Accountable Systems of Care) and one FQHC (Federally Qualified Health Center), encompassing 64 PCMH (Patient Centered Medical Home) practices within the Genesee region comprised of over 120 providers. Many of them have incorporated the SDOH screening tool into their various EMRs or ASC Care Coordination platforms. As a result of screening efforts by physicians, practice embedded care managers, and community health workers, over 30,160 screens have been administered to individual patients in Genesee County through mid-2019.

Information gathered from SDOH screens allows physicians to gain a clearer picture of the patient's health status as well as guide care coordination activities in the practice setting and direct the

strategy of the SIM Clinical Community Linkage Initiative in how to connect individuals most effectively to necessary resources.

The Social Determinants of Health (SDOH) Repository

The Genesee CHIR collects the SDOH screening results from the ASC's participating PCMH practices within a central repository which allows the Genesee CHIR to aggregate and analyze screening results to track SDOH needs identified in the community.

The Community Referral Platform

To support the development and technical integration of the overall community clinical linkages referral processes, the Genesee CHIR has implemented its Community Referral Platform (CRP). The Community Referral Platform supports a closed-loop referral system with a tracking and monitoring mechanism which includes the initiation, follow-up, and outcomes of referrals between participating PCMH providers and the CHIR CCL Hub as well as the CCL Hub and community/social service agencies.

United Way for Southeast Michigan + Henry Ford + Gleaners + HAP Health Alliance Plan

In August 2021 United Way for Southeastern Michigan began a CIE in parallel development with Michigan 211 (subsidiary of the Michigan Association of United Ways). Henry Ford Health System and Gleaners Community Food Bank of Southeastern Michigan will be the first two groups to use the "hub".

The stated goals for the CIE are:

- Better connect at-risk populations with basic needs assistance and other support
- Improve health and social outcomes
- Lower costs for health systems

United Way is also using the hub to connect residents in Wayne County with other social services via self-referral, including transportation, financial services/tax prep, and subsidized childcare.

Grand Rapids-based technology company BrightStreet Group LLC is supporting both the regional and statewide 211 buildouts into the CIE.[5]

[5] https://www.gcfb.org/united-way-tests-out-new-hub-to-bridge-data-divide-between-health-and-human-services-071321/

MiBridges

MiBridges is the MDHHS platform for connecting people to resources.

30,000 resources are accessible via app, 2-1-1, or by connecting with a community navigator within a participating community partner.

MDHHS actively seeks to onboard community partners in 3 ways

- As an Access Partner - Provide computers, tablets, or mobile devices for clients to use MI Bridges and promote MI Bridges
- Referrals for Services - Receive referrals sent from customers using MI Bridges
- Navigation Partners - Provide one-on-one assistance to MI Bridges users and promote MI Bridges.

MDHHS / MI Bridges is working to engage CBOs to act in those roles as well as view agency metrics and MI Bridges referrals.[6] As with others MiBridges collaborates with Mi 2-1-1 [7] for CBO connectivity and an easy access door (calling 2-1-1) into the system.

Michigan Community Network

There is not much public facing information available, but a collaboration exists between Healthify and Blue Cross under the name "Michigan Community Network"

The Michigan Community Network homepage is hosted on the Healthify website and is self-defined as follows: "The **Michigan Community Network** is a group of payers, providers, and community-based organizations who've come together to spark unprecedented collaboration to meet the social needs of residents of Michigan. Health plans and CBOs throughout the state are connecting to provide whole-person care to the most vulnerable members of the community".[8]

From a 2021 post on the Healthify website there is evidently a CIE effort under way seeking to "empower community organizations [in service of SDOH]", and providing a common platform shared by "health plans and payers, so they can work together to coordinate nonclinical care for their members"[9]

[6] https://newmibridges.michigan.gov/s/isd-partnershiplanding?language=en_US
[7] https://www.mi211.org/
[8] https://get.healthify.us/michigan-community-network-signup
[9] https://www.healthify.us/healthify-insights/the-michigan-community-network-where-social-services-meet-healthcare-to-improve-patient-outcomes

Midland/Bay County

For the past two years, originally initiated as part of the Bridge to Belonging project, Northeast Michigan 211 (NEMI211) and MyMichiganHealth have been exchanging patient referrals and interventions using the Northeast 211 CIE Hub. While originally focused on Social Isolation, the referrals have grown to span several SDOH domains and have now processed referrals for over 500 patients.

A new effort to expand this process to include Bay County Health Department, Bay County ISD, and United Way of Bay County is underway.

Kalamazoo/Southwest 211

Since August 2022, Michigan Child Protective Services has been piloting a SDOH referral process with Southwest 211 (aka Gryphon Place) to refer families who have been referred to CPS but do not meet criteria for direct intervention by CPS. CPS sends referrals weekly to the Gryphon Place CIE Hub, and subsequently 211 social navigators conduct outreaches to the families, document any assistance provided, and the hub securely shares the information back to CPS. Over 500 families have been referred to the hub since the pilot began.