Northern Michigan Public Health Alliance:
Chief Health Strategist in the Northern Michigan
Community Health Innovation Region and Beyond...

Michigan Premier Public Health Conference
Bay City, Michigan          October 10, 2018
The Alliance was formed to strengthen the regional public health system and improve population health
Michigan Plan for Improving Population Health
State Innovation Model
Community Health Innovation Region
Chief Health Strategist
Public Health 3.0
Health in All Policies
Michigan Public Health Advisory Commission Report
Population Health
Culture that Supports Equity
Cross Sector Community Partners
Public Health 1.0
- Tremendous growth of knowledge and tools for both medicine and public health
- Uneven access to care and public health

Public Health 2.0
- Systematic development of public health governmental agency capacity across the United States
- Focus limited to traditional public health agency programs

Public Health 3.0
- Engage multiple sectors and community partners to generate collective impact
- Improve social determinants of health

<table>
<thead>
<tr>
<th>Period</th>
<th>Event/Report</th>
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<tbody>
<tr>
<td>Late 1800s</td>
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<tr>
<td>1988 IOM</td>
<td>The Future of Public Health report</td>
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<td>Recession</td>
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<td>Affordable</td>
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<tr>
<td>2012 IOM</td>
<td>For the Public’s Health reports</td>
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<tr>
<td>Care Act</td>
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Public health leaders should embrace the role of **Chief Health Strategist** for our communities.

Public Health Departments Should Engage with Community Stakeholders, both public and private, to **Form Vibrant Structured, Cross-sector Partnerships**.

Timely, reliable, granular-level and **Actionable Data** and clear **Metrics** to document success in public health practice should be developed to guide, focus, and assess the impact of **Prevention Initiatives**, including those **Targeting the Social Determinants of Health And Enhancing Equity**.
LINKS COMMUNITY SERVICE ORGANIZATIONS, employers, and governmental agencies to each other and to the local medical care system so medical and non-medical services can be better coordinated, and: 1) provide COMPREHENSIVE SOLUTIONS TAILORED TO THE NEEDS OF INDIVIDUALS and 2) the COMMUNITY IS BETTER ABLE TO INVEST IN THE UPSTREAM SOCIO-ECONOMIC AND ENVIRONMENTAL DETERMINANTS OF HEALTH

Examines systemic causes of local inequities in socioeconomic and health status and prioritizes equity and the reduction of inequities and works to BUILD A COMMUNITY CULTURE THAT SUPPORTS THE PURSUIT OF EQUITY

Engages in COMMUNITY-LEVEL SYSTEMS CHANGE EFFORTS and develops and IMPLEMENTS STRATEGIES TO ADDRESS IDENTIFIED HEALTH AND SOCIAL NEEDS that lead to over utilization of emergency departments

Leverages community health workers, patient navigators, and/or referral coordinators to improve tracking and monitoring the initiation, follow-up, and outcomes of a completed linkage; The CHIR reviews the most common linkages and their outcomes as a foundation for the IDENTIFICATION OF SYSTEMS-LEVEL SOLUTIONS TO THE RISK FACTORS CONTRIBUTING TO POOR HEALTH OUTCOMES and incorporates the analysis into its decision-making processes

Plays a lead role in the ongoing and SYSTEMATIC ANALYSIS OF COMMUNITY HEALTH NEEDS ASSESSMENT information
Backbone Organizations in Community Health Innovation Regions (CHIRs) serve as **Chief Health Strategist** to **build community capacity to drive improvements in population health**
CLINICAL-COMMUNITY LINKAGES MODEL

COMMUNITY NEEDS ASSESSMENT

COMMUNITY HEALTH IMPROVEMENT PLAN
Collaborate with a broad array of allies... including those at the neighborhood level and non-healthcare sectors ...to build healthier and more vibrant communities
Evolution of CHIR Community Partners

**2017**
- Health Care
- Community Services & Supports
- Health Advocacy/Promotion
- Payers/Insurers
- Public Health
- Business

**2018**
- Health Care
- Community Services & Supports
- Health Advocacy/Promotion
- Funder
- Education
- Payers/Insurers
- Public Health
- Business
Social Ecological Model and the NMCHIR

Community
Health
Assessment &
Improvement
Work Group

Societal

Community

Relationships

Individual

Clinical
Community
Linkages Work
Group
WHAT IS THE RESULT?
More Constituents at a Healthy Weight

WHAT WILL BEGIN TO HAPPEN?
- Physical Activity Increases
- Healthy Eating Increases
- Bouts of Depression Decrease

WHAT WE NEED TO DO TO MAKE AN IMPACT?
- Improve Social Determinants of Health
  - Affordable Accessible Healthy Food
  - Opportunities for Active Living
  - Creative, Accessible Transit Options
  - Affordable Housing
- Integrate Community System Conditions
  - Align Policies, Practices, Efforts with Challenge Goals
  - Coordinate Local Services, Programs & Efforts
  - Offer Relevant & Accessible Quality Programs & Support
  - Be Responsive to Constituent Voice
CHIEF HEALTH STRATEGIST PRACTICE

Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death.

Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.
Affordable Accessible Healthy Food

Affordable Healthy Housing

Creative Accessible Transit Options

Opportunities for Active Living

Increasing the availability of affordable, creative, and accessible transportation options

Adopting a Health in Housing approach with partners to increase affordable and healthy housing

Working on policies for well-designed communities that promote active living and improve walk/bike-ability

Aligning policies and practices to promote healthy food access
Build a more integrated, effective health system through collaboration between clinical care and public health.
Community Health Access Program

Pathways Community HUB

Accountable Health Communities

= COMMUNITY connections
HUB staff assist clients in accessing local resources

- Medical Care
- Dental Care
- Transportation
- Healthy Food
- Healthy Lifestyle
- Education
- Affordable Housing
- Utilities
- Translation
## Screening/Referral/Enrollment into HUBS

| Screens conducted (electronic and paper) | 23,819 |
| Individuals referred to the HUBS (15% of those screened) | 3,601 |
| Individuals enrolled in HUB services (31% of those referred) | 1,122 |

### Pathway Opened

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<tr>
<th>Pathway Opened</th>
<th>Number</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Physical and Mental Health</td>
<td>290</td>
<td>28%</td>
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<tr>
<td>Health Insurance</td>
<td>102</td>
<td>10%</td>
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<tr>
<td>Food</td>
<td>137</td>
<td>14%</td>
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<tr>
<td>Employment</td>
<td>44</td>
<td>4%</td>
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<tr>
<td>Housing</td>
<td>117</td>
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<tr>
<td>Utilities</td>
<td>126</td>
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<tr>
<td>Family Care</td>
<td>58</td>
<td>6%</td>
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<tr>
<td>Education</td>
<td>75</td>
<td>7%</td>
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<tr>
<td>Transportation</td>
<td>81</td>
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<td>1030</td>
<td>100%</td>
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### Pathway Closed and Complete

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<thead>
<tr>
<th>Pathway Closed and Complete</th>
<th>Number</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Physical and Mental Health</td>
<td>57</td>
<td>15%</td>
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<tr>
<td>Health Insurance</td>
<td>53</td>
<td>14%</td>
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<tr>
<td>Food</td>
<td>70</td>
<td>18%</td>
</tr>
<tr>
<td>Employment</td>
<td>13</td>
<td>4%</td>
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<tr>
<td>Housing</td>
<td>29</td>
<td>7%</td>
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<tr>
<td>Utilities</td>
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<tr>
<td>Family Care</td>
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<tr>
<td>Education</td>
<td>43</td>
<td>11%</td>
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<tr>
<td>Transportation</td>
<td>35</td>
<td>9%</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>381</td>
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Top Pathways
1. ACCESS TO CARE
2. Education (Health)
3. Utility Assistance
4. HOUSING
5. FOOD ASSISTANCE
6. Employment
7. TRANSPORTATION
8. Education (Adult)
9. Social Services
10. Financial Assistance

Top Reasons for Using Emergency Department
- Lack of ACCESS TO CARE
- Lack of TRANSPORTATION

Top Social Determinants (ABLe Change)
- Active Living
- AFFORDABLE HOUSING
- HEALTHY FOOD
- TRANSPORTATION
- Social Cohesion
54% of visits from Medicaid clients in Northern Michigan were for non-urgent needs.
Strategic Sustainability Planning

- Expansion of CHIR activities into new regions
- Community Health Assessment alignment from local funders
- Partnerships: Northern Health Plan, community foundations and others
- Federal and state grants
- Community Health Worker Reimbursement
- Statewide scale up of electronic screening tool - integrated in MiBridges
- Contracts with Medicaid Health Plans
- Backbone Organization funding
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