



# Increasing Equity and Improving Population Health Through Cross-Sector Engagement

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ENGAGING PARTNERS

2019 COMMUNITIES JOINED IN ACTION (CJA)  
NATIONAL CONFERENCE – APRIL 24-26, 2019

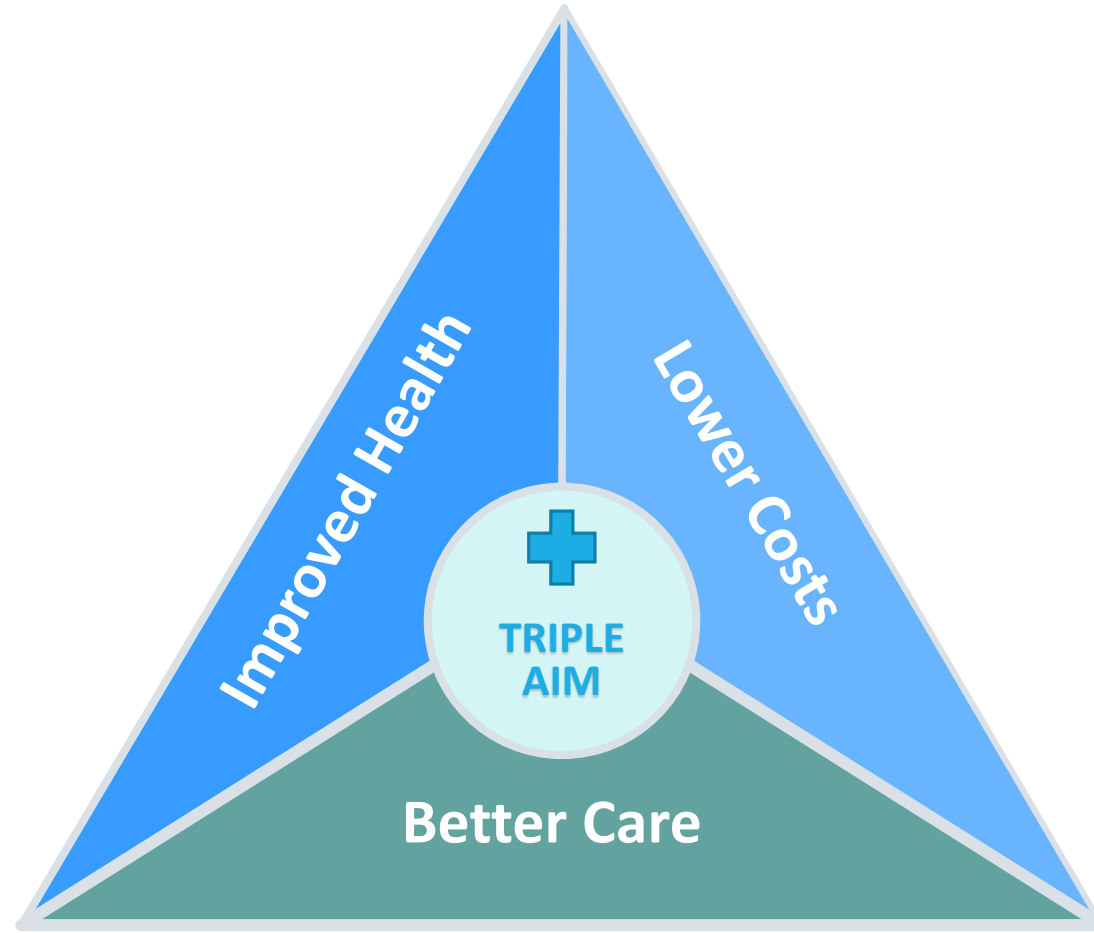
# Presentation Objectives

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1. Describe the Northern Michigan Community Health Innovation Region's (NMCHIR) approach to improving health equity across a 10-county rural region through cross-sector engagement.
2. Describe the NMCHIR's efforts advocating with public and private partners for services and policies necessary to improve health equity and increase population health.
3. Describe the role of the Northern Michigan Public Health Alliance – a partnership of seven local health departments – as the backbone organization of the NMCHIR.

# Michigan State Innovation Model (SIM)

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# NMCHIR

SIM funds are dedicated to five pilot sites in Michigan.

The Northern Michigan Community Health Innovation Region (NMCHIR) is our rural pilot.



# 10 County Region – Northwest MI

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**303,996**  
people



**4,722**  
square miles



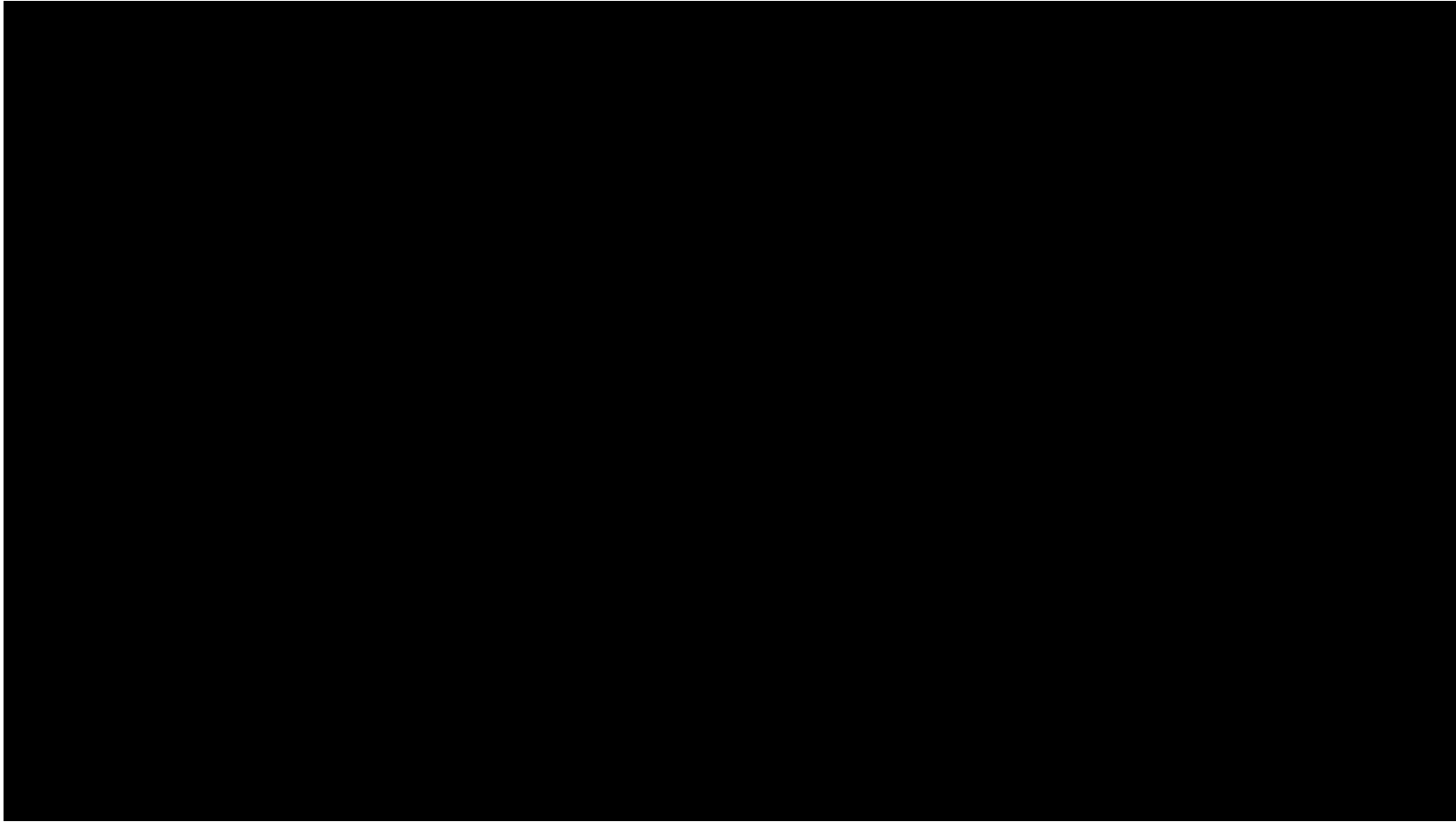
**70%**  
rural



**63.7**  
people per  
square mile

# What Influences Health

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# Community Health Innovation Region

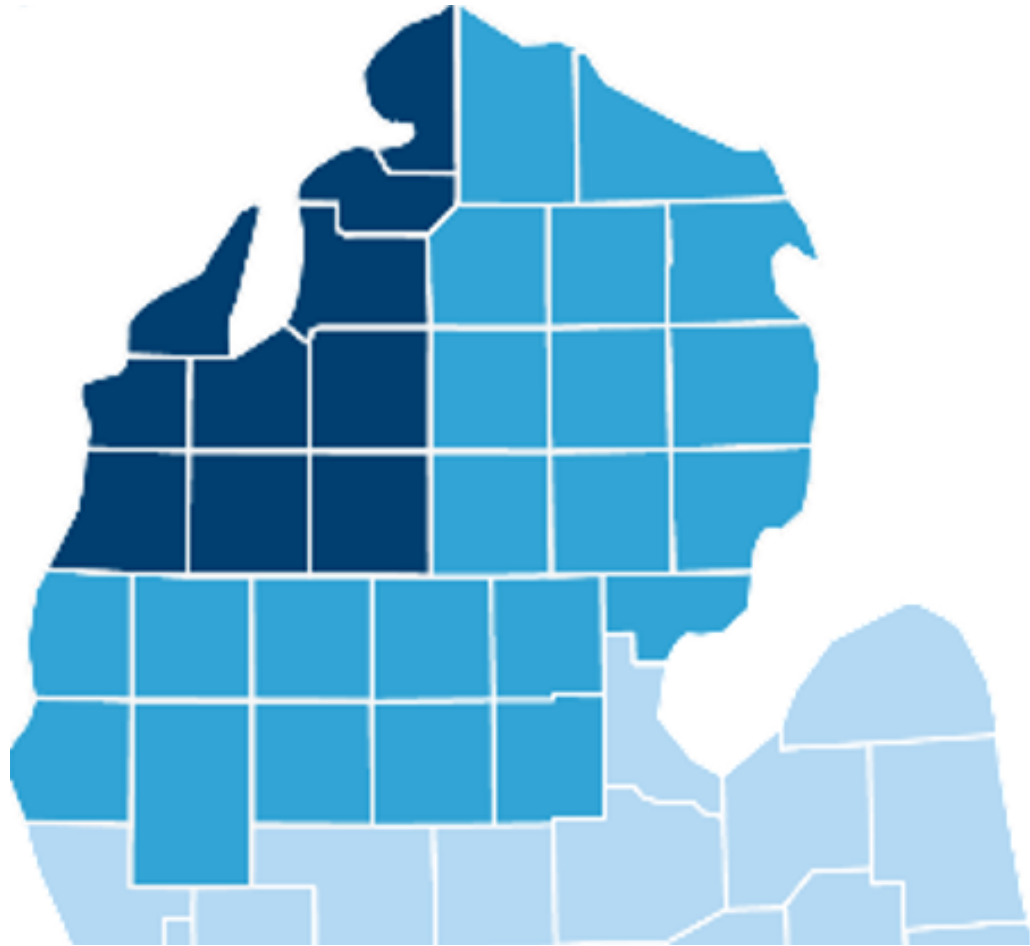




Our Backbone Organization is the Northern Michigan Public Health Alliance.

The Alliance was formed to strengthen the regional public health system and improve population health. The Alliance consists of 7 local health departments covering 32 counties.





-  **Conducted Assessments**
-  **Awarded Grants**
-  **Implemented Programs**
-  **Established Teams**
-  **Created Solutions**

Public health leaders are the **Chief Health Strategist** for our communities

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

Public Health leaders collect **Actionable Data** and clear **Metrics** to document success in public health practice. They assess the impact of **Prevention Initiatives**, including those **Targeting the Social Determinants of Health And Enhancing Equity**.



A Shared Vision.  
A Culture of Health.



Backbone Organizations in Community Health Innovation Regions (CHIRs) serve as **Chief Health Strategist** to **build community capacity to drive improvements in population health**

# Mobilizing Partners to Address Social Determinants of Health

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## ENGAGING STEERING COMMITTEE MEMBERS

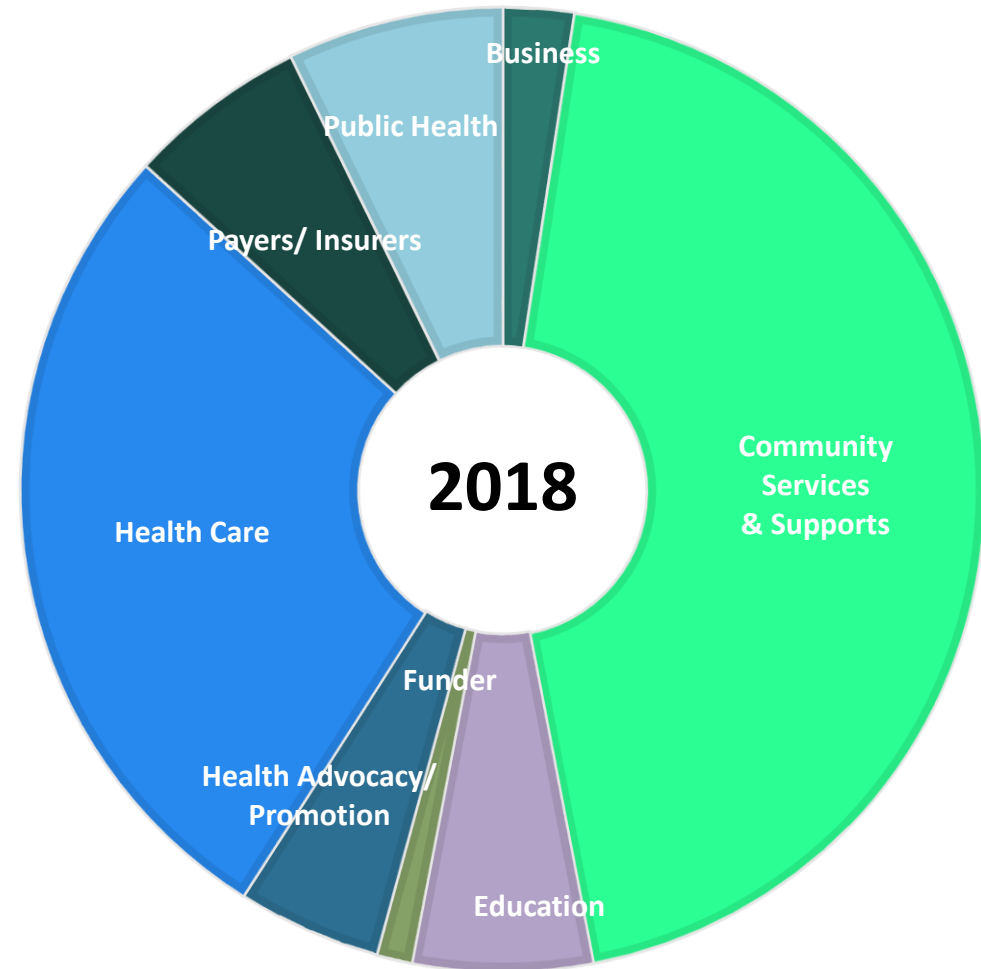
Required members were:

- ASCs,
- CMHs,
- Hospitals,
- LHDs
- MHPs

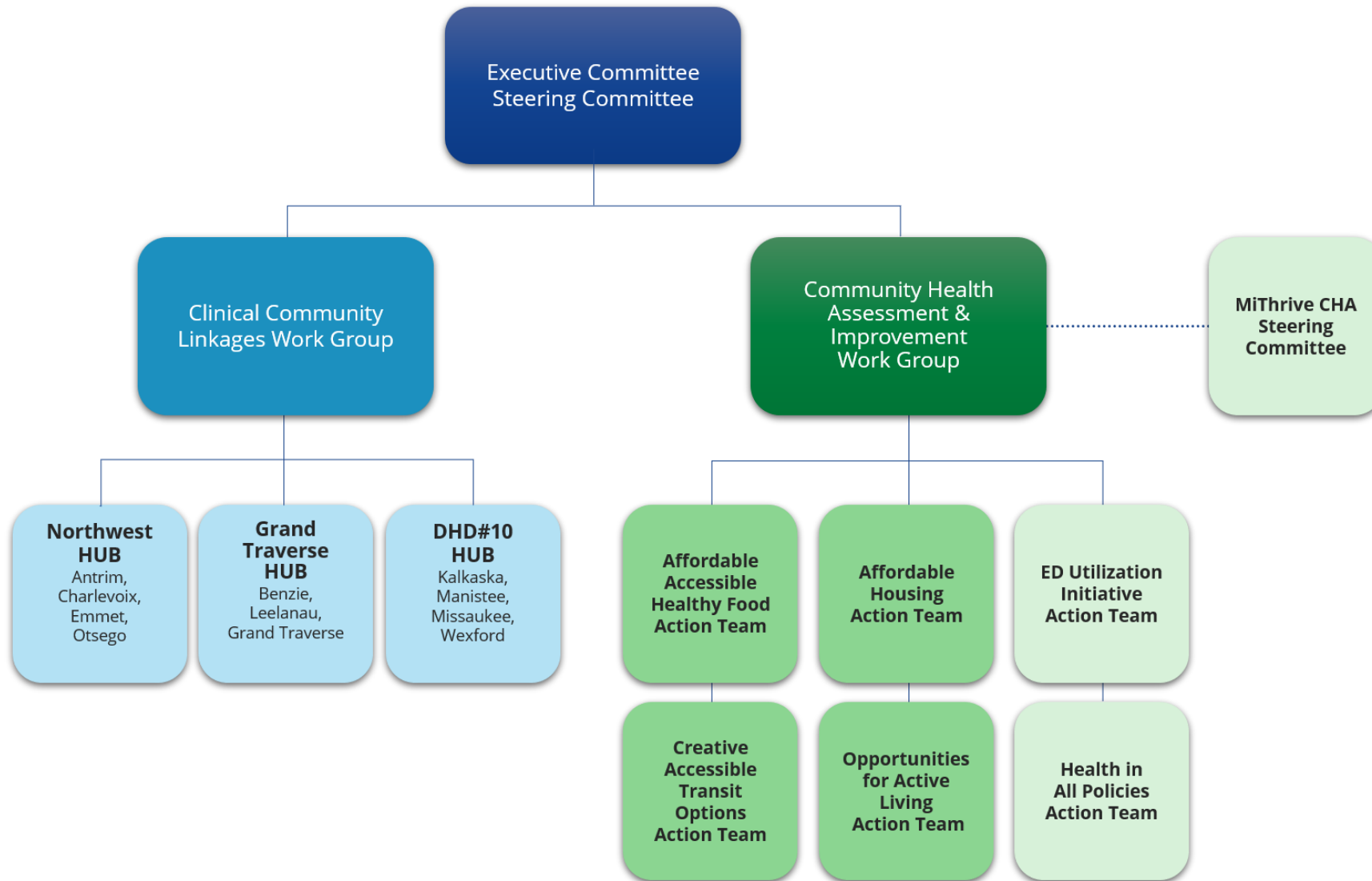
We asked a representative to contact their partners and decide together which agencies would represent their sector on the Steering Committee. This gave them control over who represented their sector in the community.

- ❖ Changing the narrative on what impacts health: housing, food, utilities, other basic needs
- ❖ Use and present data that is useful to our communities
- ❖ Build Trust, Listen to partners

# Evolution of CHIR Community Partners



# Member and Partner Roles

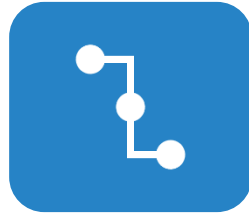


# Member and Partner Roles

Our partners initiate the process with clients by doing the following:



Administer our  
web-enabled SDoH  
screening tool  
(36 PCMH sites)



Make and receive  
referrals to our  
clinical community  
linkages model



Collect input  
from constituents

Participate in our  
Communication  
Plan Roll Out

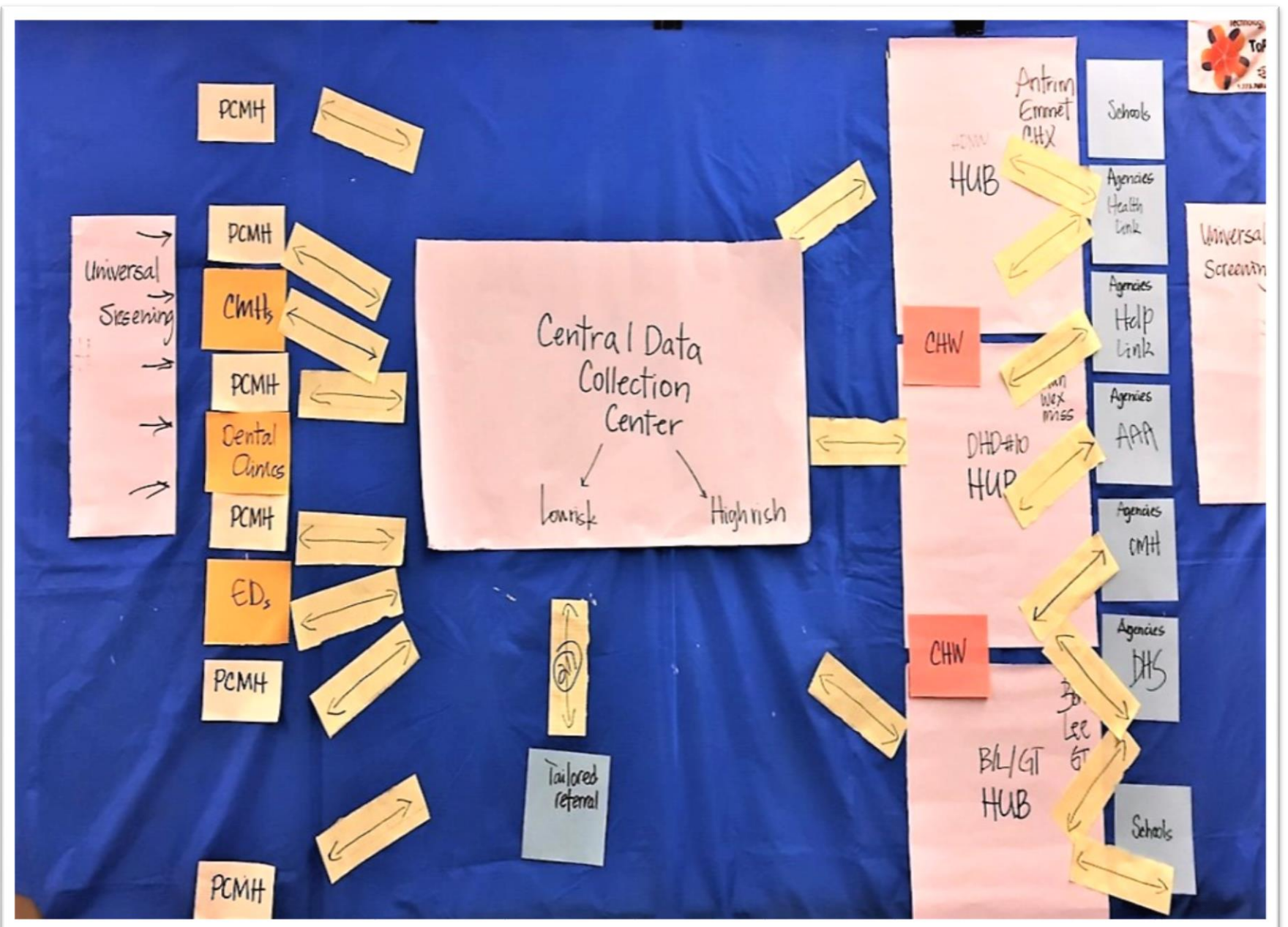


Implement strategies to  
increase equity and  
population health

Conduct Organizational  
Assessments to assess  
how embedded systems  
change is in their own  
organization.

# COLLABORTIVE PLANNING

Build a more  
integrated,  
effective health  
system through  
collaboration  
between clinical  
care and public  
health



ENGAGING PARTNERS....  
Bringing People into our Work and  
Changing Decision Making Structures and Community Systems

## *ABLE Change Framework*

*Developed by Drs. Pennie Foster-Fishman and  
Erin Watson at Michigan State University*

# *ABLE Change Framework*

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The model is based upon that premise that communities can achieve transformative results when they:

- make local system and community conditions the intentional targets of their change initiatives,
- pursue the effective implementation of their efforts, and
- build a community engagement infrastructure that supports real-time learning and action across diverse stakeholders and sectors.

# During ABLe Change Framework training:

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From June 2017 through January 2018, 90 Cross Sector partners agreed to complete six days of training in the **ABLe Change Framework**.

90 cross sector partners:

- Identified barriers to equity facing residents that impact their health and disease
- Participated in pulse interviews with hundreds of people who struggle financially
- Collected input through Community Boards
- Ultimately set the goal to increase access to health care, improve population health and remove barriers to basic needs.

## 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

# Community Health Innovation Region





# COMMUNITY *connections*

IN PARTNERSHIP...

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# What is **COMMUNITY** connections

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## A FREE PROGRAM

Connecting adults, children, and families to community resources

## BY PROFESSIONALS

Community Health Worker, Registered Nurse, or Social Worker



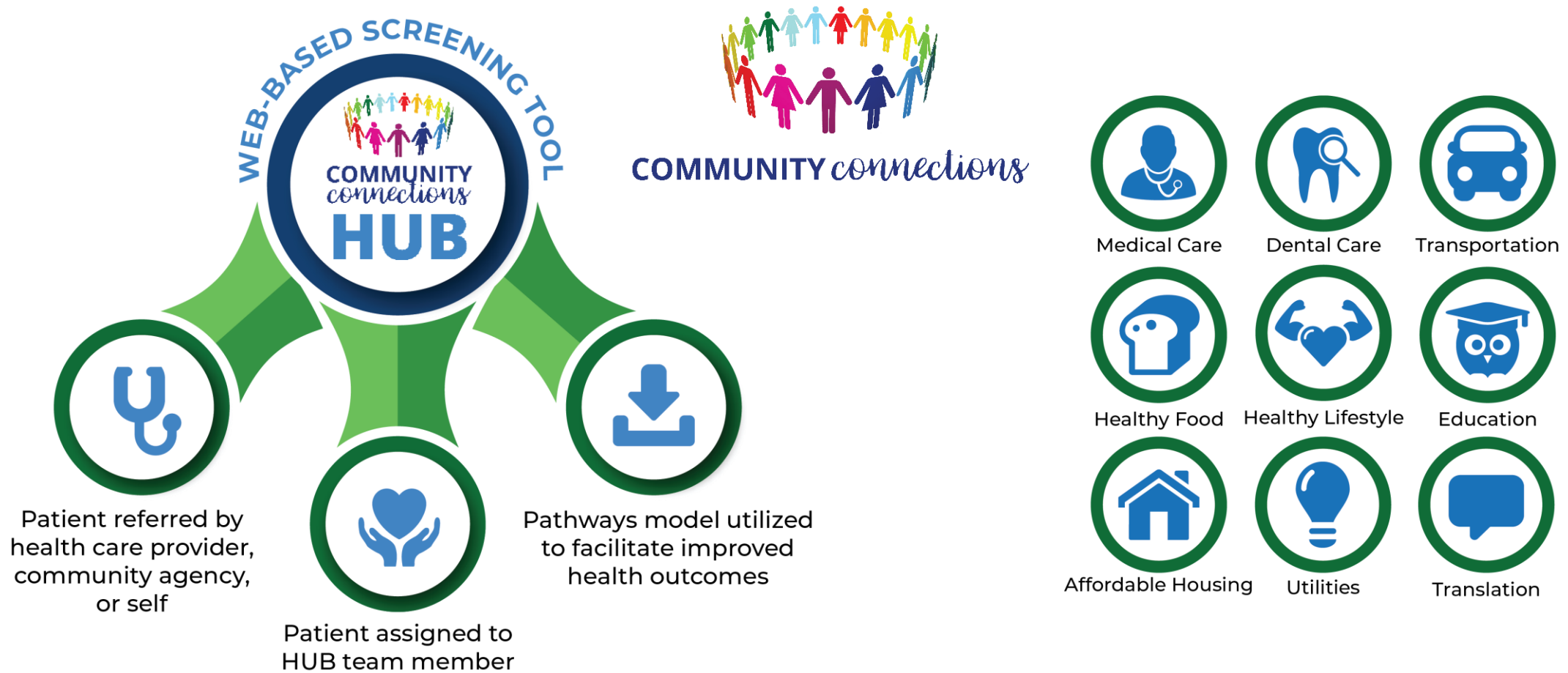
## ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Like food, housing, transportation, physical and mental health

## THROUGH MULTIPLE CHANNELS

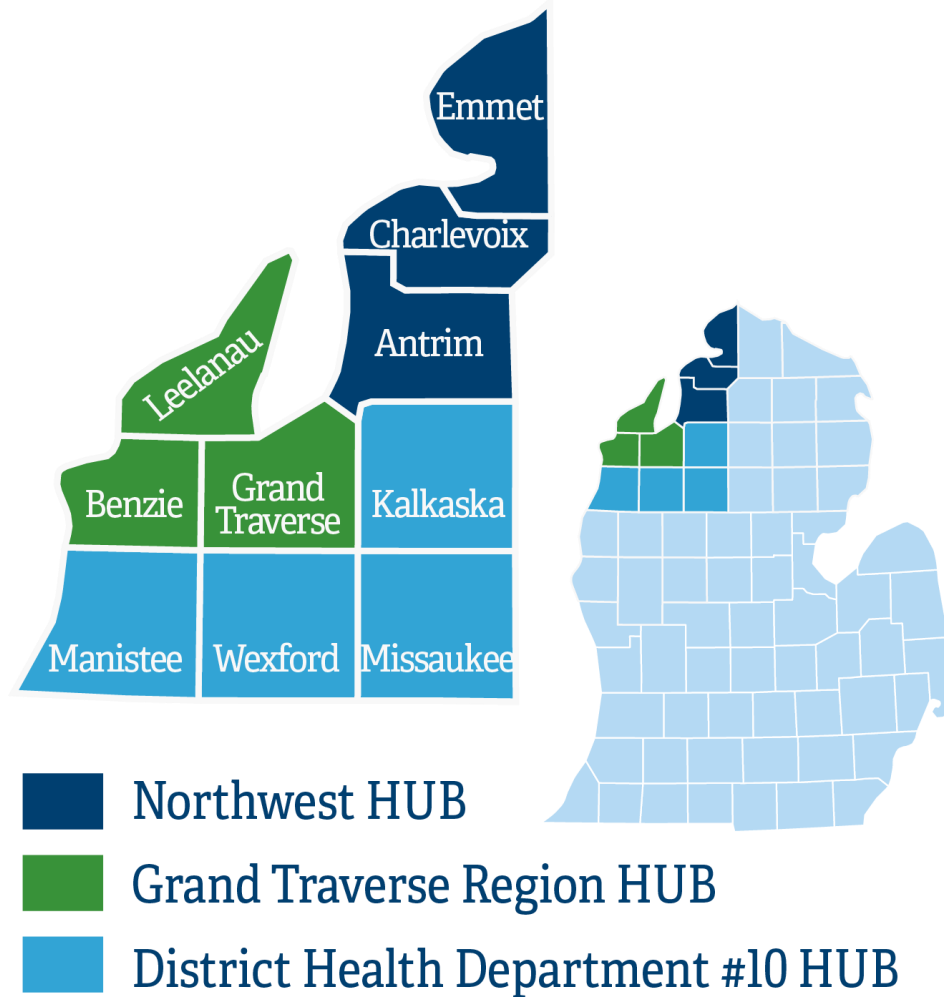
Phone calls, home visits, and office visits

# Clinical-Community Linkages Model



# Community Based Access Point

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# Screening Questions

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01

POOR PHYSICAL HEALTH?

02

POOR MENTAL HEALTH?

03

COULDN'T SEE A DOCTOR?

04

NOT ENOUGH FOOD?

05

WORK OR INCOME?

# Screening Questions

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06

HOUSING?

07

CHILD CARE?

08

MORE EDUCATION?

09

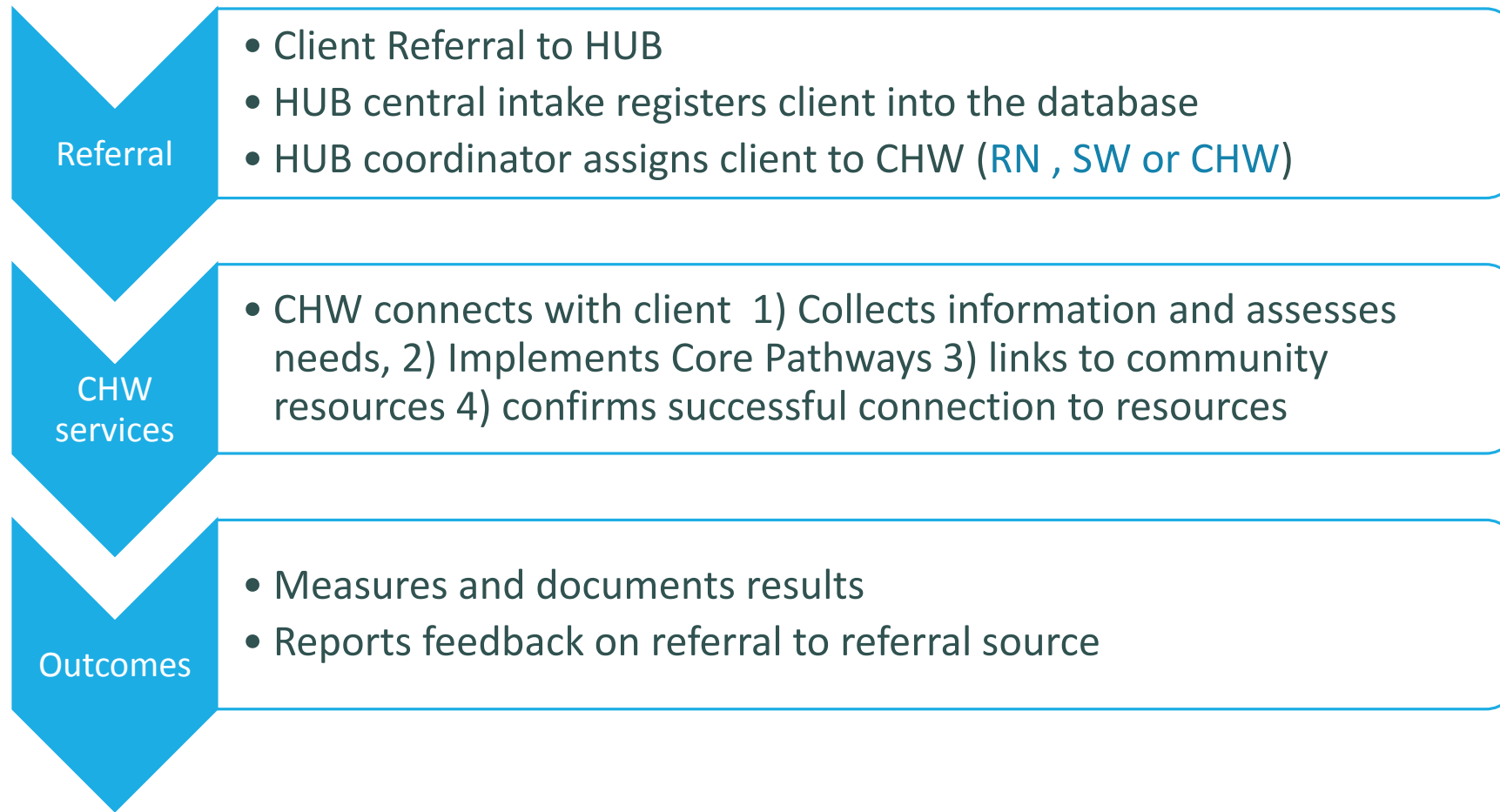
RELIABLE TRANSPORTATION?

10

UTILITY BILLS PAID?

# Pathways Community HUB process

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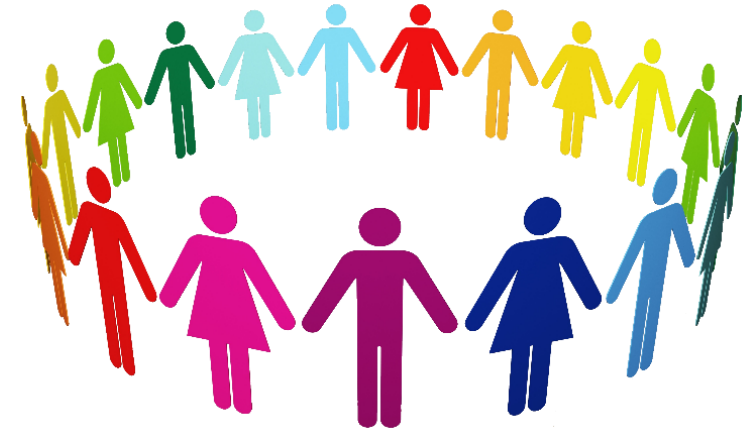
# 2018 PCMH Screenings

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**22,485** Screenings Completed in PCMH and CBO offices

**11,210** Completed Screenings with Needs (50%)

**2,396** Number of completed screenings who identified needs, wanted assistance and provided consent (21%)

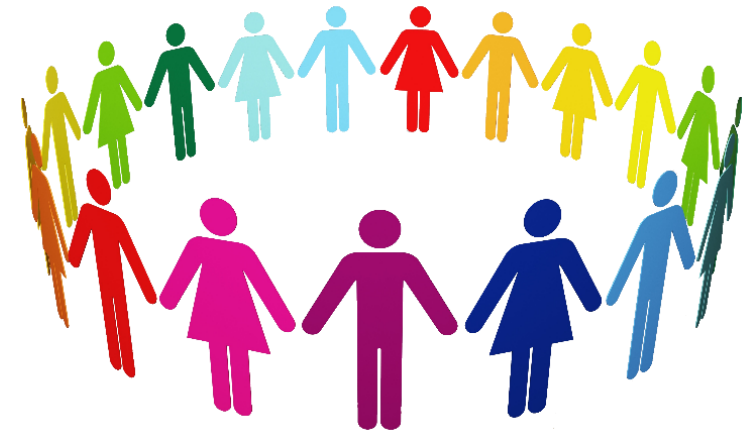


# Acceptance Rates for 2018

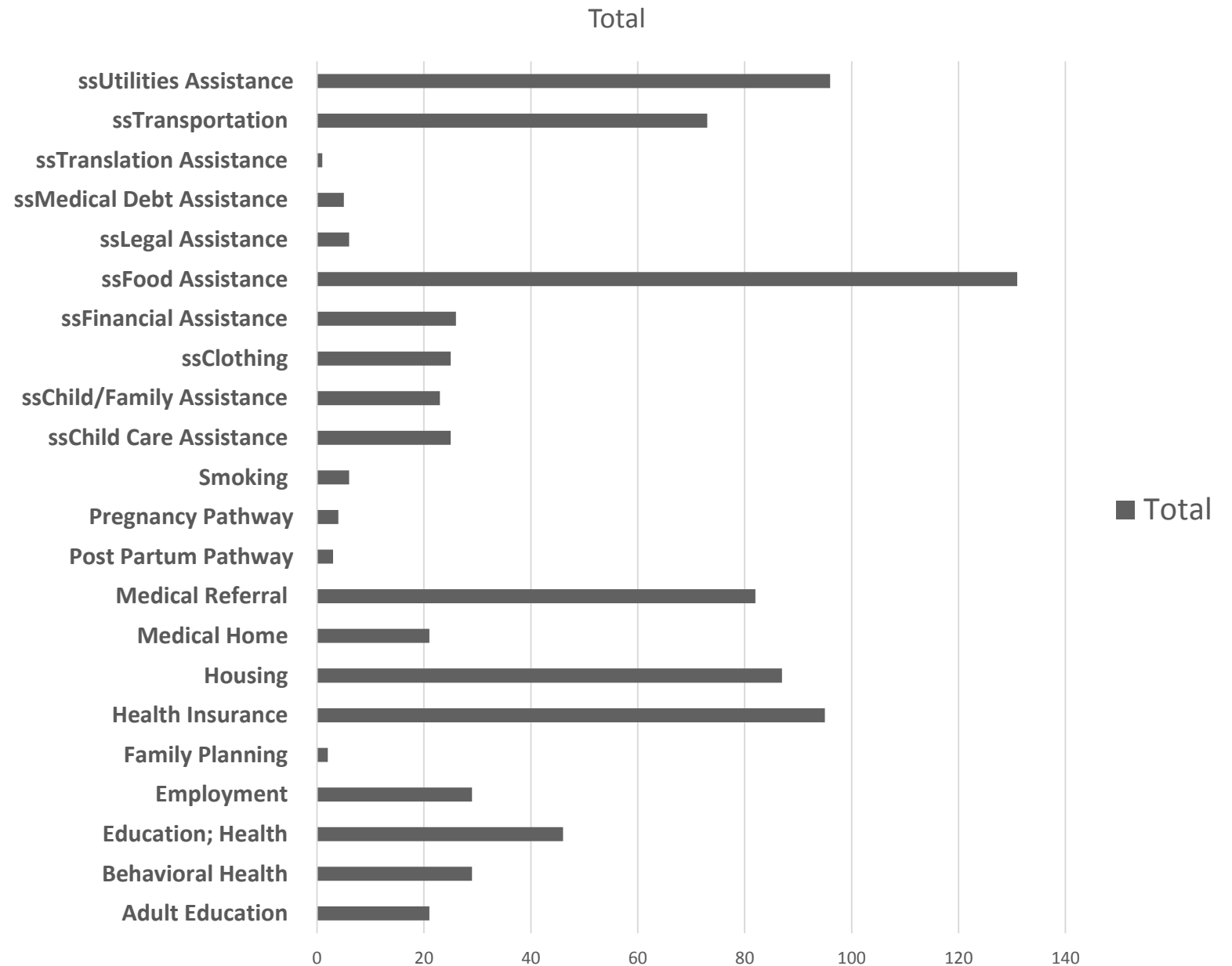
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**31%** we never make contact with.

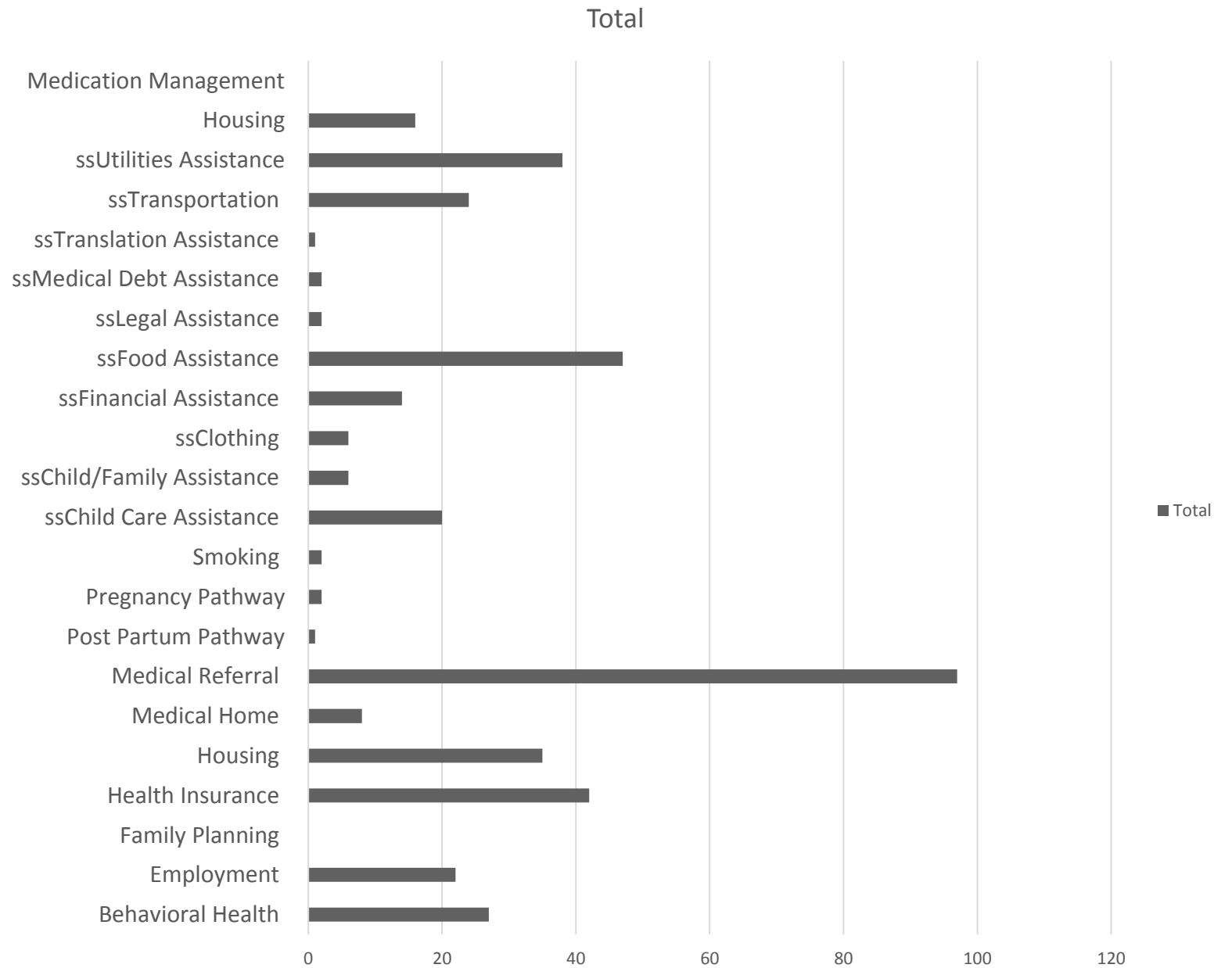
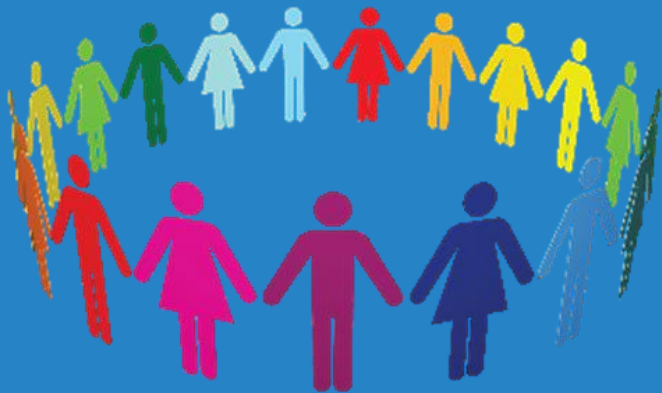
**73%** (average) accept services of those who we actually talk to and offer services



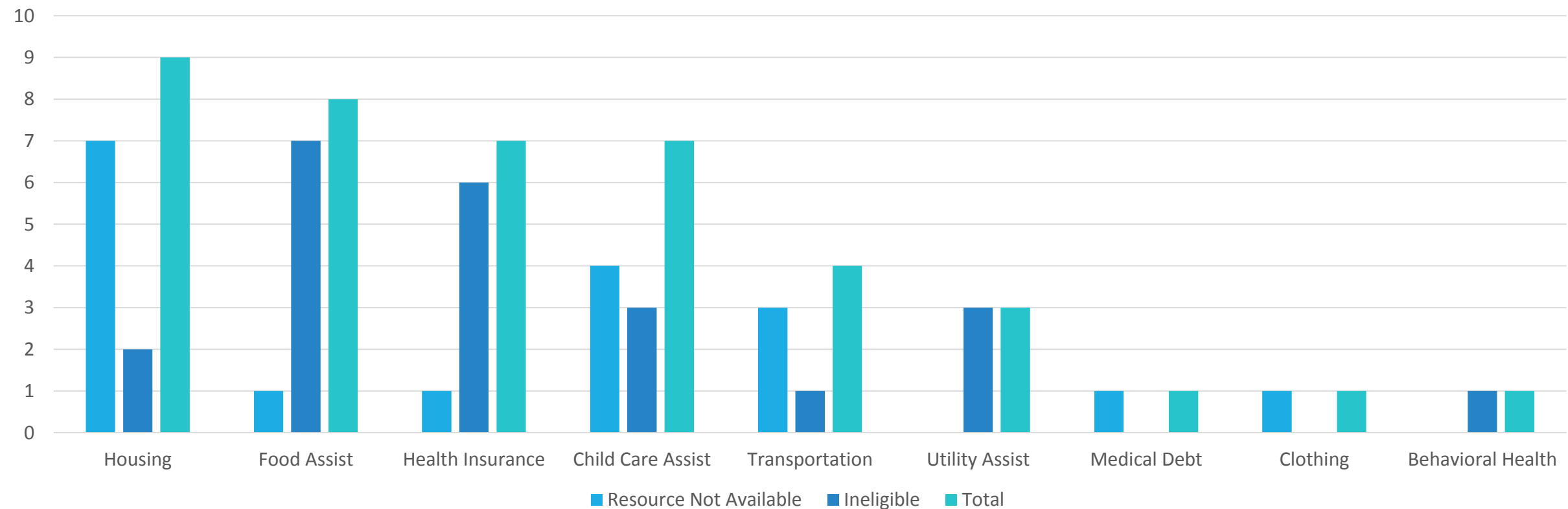
# Pathways Complete and In Progress – 10 Counties 2018



# Pathways Incomplete 10 Counties 2018



# Pathways Incomplete – No Resource or Ineligible 10 Counties 2018



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.

# Regional & Local Action

Using the ABL e Change framework

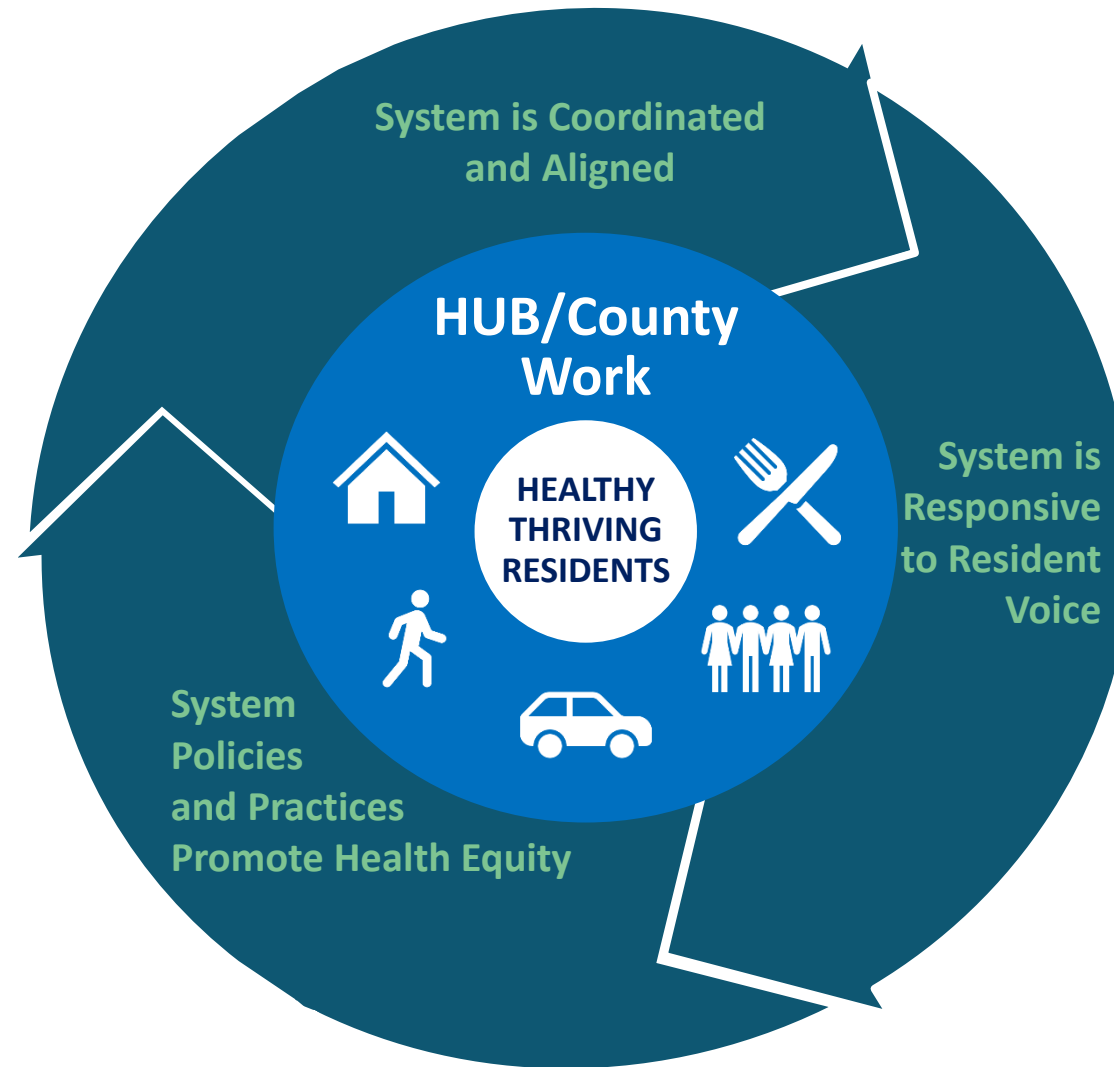


# Improving Health In Northern Michigan

## GOAL 1:

### Transform Counties

Improve community  
conditions promoting  
health within 10  
regional counties



## GOAL 2:

### Transform the System

Improve within and cross-  
sector system alignment and  
responsiveness

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

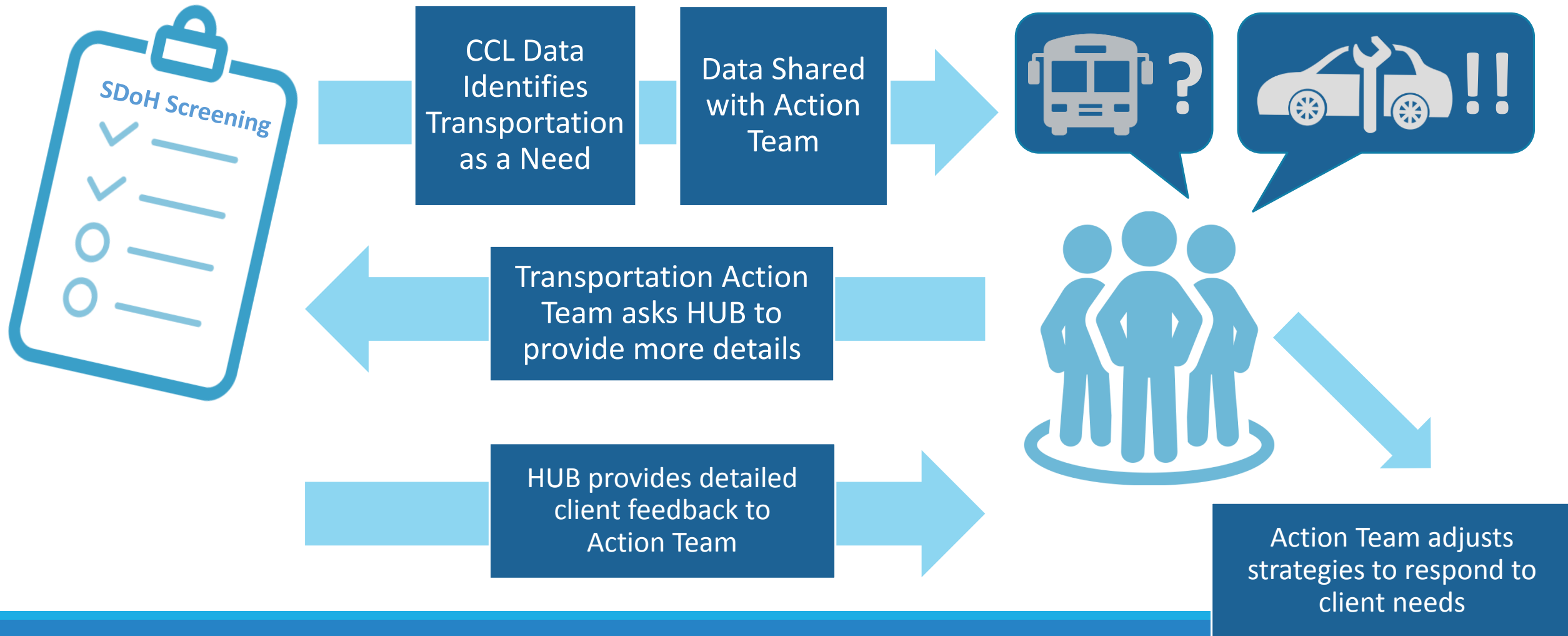
Adopting a Health  
in Housing approach  
with partners to  
increase **affordable and**  
**healthy housing**

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**



# Opportunity to Create Feedback Loops



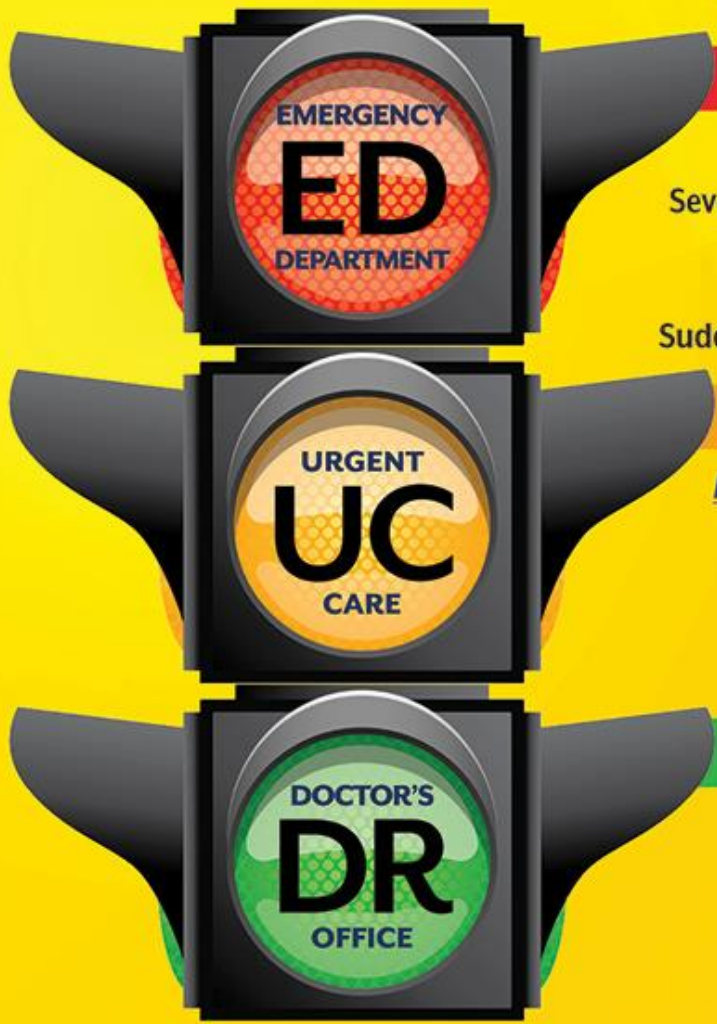


# Healthy Affordable Housing Team

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54%  
of visits from  
Medicaid clients  
in Northern  
Michigan were  
for  
non-urgent  
needs

# WHEREFORCARE



## GO TO HOSPITAL EMERGENCY DEPARTMENT

**ED**  
DEPARTMENT

ISSUE IS LIFE-THREATENING - CALL 911 OR GO TO ER

Severe Chest Pains Radiating to Arm/Jaw	Seizures, Choking, Poisoning
Difficulty Breathing	Serious Accident or Injury
Slurred Speech, Facial Paralysis	Bleeding That Won't Stop
Sudden Head Pain, Blurred/Double Vision	Sudden Severe Pain

## CALL AFTER HOURS # OR GO TO URGENT CARE

**UC**  
CARE

ISSUE IS NOT LIFE-THREATENING BUT NEEDS ATTENTION NOW

Sprains, Strains, Minor Fractures	Minor Burns or Cuts
Eye Infections	Minor Rashes
Urinary Tract Infections	Vomiting
Sore Throat, Ear Ache, Bad Cough	Fever, Persistent Diarrhea

## CALL DOCTOR'S OFFICE

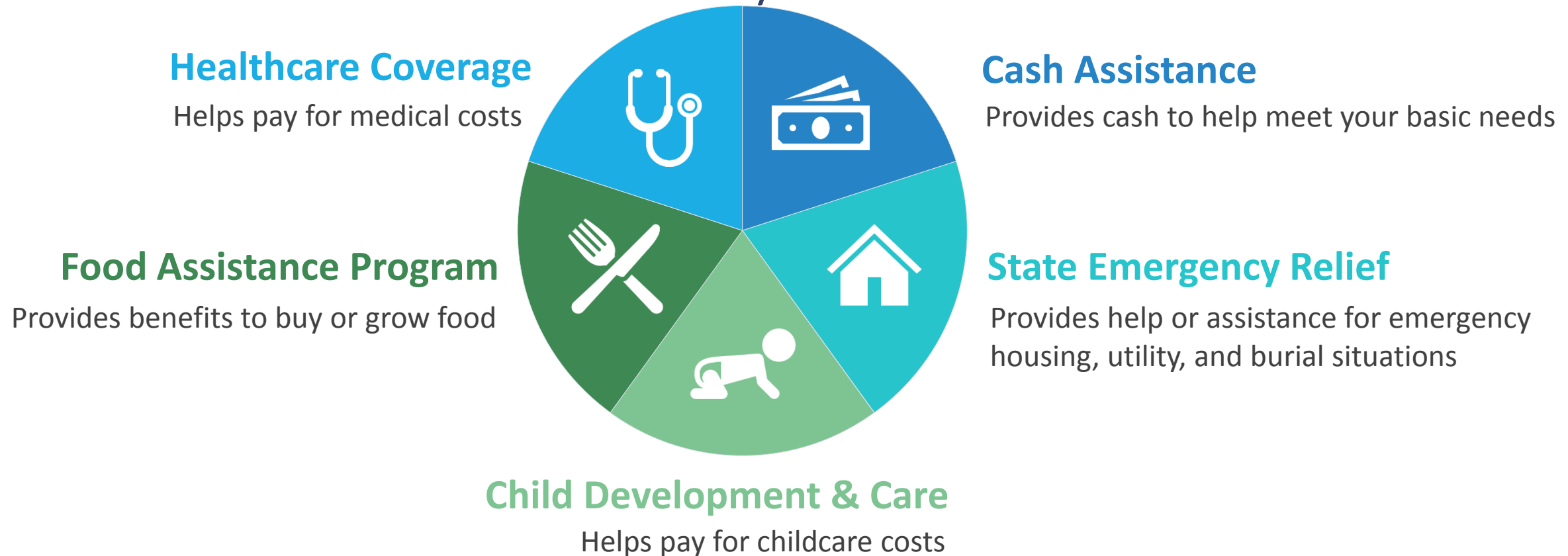
**DR**  
OFFICE

ISSUE CAN WAIT FOR DOCTOR'S APPOINTMENT

Cold or Flu Symptoms	Yearly Screenings
Simple Aches and Pains	Vaccinations
Minor Injuries	Prescription Refills
Pregnancy Tests	Referrals

# MiBridges/211 Database

A streamlined and dynamic application for multiple programs and community resources



# Summary: Engaging Partners

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**Choosing a Backbone Organization:** An Alliance with a long history of collaboration and population based health focus. 7 local health departments with high credibility in their communities.

**Engaging NMCHIR Steering Committee:** Many factors considered in collaboration with MDHHS – alignment with prosperity region, hospital systems, health department jurisdictions, and footprint of other community providers.

**ABLE Change Framework Training:** We identified a training framework that would move us towards Community and Systems change. We engaged many, many community partners around this framework and launched our CHIR work with the framework training.

**Clinical Community Linkages:** Early on, we engaged our Physician Organizations to assure solid connections to our Patient Centered Medical Homes. We also engage our Medicaid Health plans. Several providers sit on our Steering Committee and Clinical Community Linkages Workgroups.

**Regional and Local Action Groups:** Partnered with established Community Health Needs Assessment (MIThrive) process. Used the ABLe Change process to launch local workgroups to carry out improvement strategies. Community Connections HUB data provides real time data to inform their strategies.

# Resources:

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**Northern Michigan Community Health Innovation Region (NMCHIR)**

<https://northernmichiganchir.org/>

**Michigan's State Innovation Model**

[www.michigan.gov/SIM](http://www.michigan.gov/SIM)

**ABLE Change Framework:**

<http://www.ablechange.msu.edu/>

**Health in All Policies:**

<https://www.cdc.gov/policy/hiap/resources>

**Technology of Participation:**

<http://top-facilitation.com/>

**Pathways Community HUB Institute**

<https://pchi-hub.com>

# Thank you!

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**Lisa Peacock , MSN, WHNP-BC**, Health Officer, Health Department of Northwest Michigan and Benzie Leelanau District Health Department

[l.peacock@nwhealth.org](mailto:l.peacock@nwhealth.org)

**Jenifer Murray, MPH, BSN, RN**, JHM Consulting LLC & Manager--Clinical Community Linkages, Northern Michigan Community Health Innovation Region

[jenifer.murray@gmail.com](mailto:jenifer.murray@gmail.com)