

# Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

## Board Meeting

November 21, 2014, 9:00 a.m. – 12:30 p.m.

### Board of Directors

Robert Fowler

*Chairperson*

Lynn Alexander

*Vice Chairperson*

Timothy Damschroder

*Treasurer*

Cindy Estrada

*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

### Interim Executive Director

Geralyn Lasher

### Section I

- – Agenda for Board meeting
- p. 1 – MHEF Mission Statement
- p. 3 – PA 4 of 2013
- p. 11 – By-Laws
- p. 19 – MHEF Board Member Term Lengths
- p. 21 – MHEF Board Contact List
- p. 23 – Minutes of the October 20, 2014 Board Meeting
- p. 29 – Minutes of the November 3, 2014 Board Meeting

### Section II

- p. 31 – Dr. Corey Waller biographical sketch

### Section III

- p. 33 – MHEF October Financial Statement
- p. 35 – November Work plan

### Section IV

- p. 43 – Revised Open Meeting Policy
- p. 49 – Revised Gift Policy
- p. 51 – Conflict of Interest Review Procedure Policy
- p. 53 – Diversity, Equity, and Inclusion Policy
- p. 55 – Travel Reimbursement Policy
- p. 59 – Robert's Rules of Order Guide
- p. 65 – MHEF November Learning Materials

### Section V

- p. 71 – Grantmaking Committee Report and Grant Recommendations

### Section VI

- p. 91 – Fund Balance Projections in Year 18
- p. 93 – Huntington Report

### Section VII

- p. 97 – Feedback Form
- p. 99 – Schedule for upcoming Board Meetings

### Section VIII

- p. 101 – Traverse City Listening Tour Summary
- p. 109 – Detroit Listening Tour Summary
- p. 117 – Grand Rapids Listening Tour Session Agenda
- p. 119 – Community Priority Health Issues: Grand Rapids



# Michigan Health Endowment Fund

## Board Meeting

November 21, 2014

**The Salvation Army Ray & Joan Kroc Corps Community Center**  
**2500 South Division Avenue SW**  
**Grand Rapids, Michigan 49507**

<b>Draft Distribution Agenda for Board Meeting</b> <b>Room: Worship and Performing Arts Center</b>	
<b>Breakfast</b>	8:30 a.m. – 9:00 a.m.
<b>Opening – Rob Fowler, Board Chair</b> <ul style="list-style-type: none"> <li>● Call to order of regular Board Meeting</li> <li>● Roll call</li> <li>● Approval of agenda</li> <li>● Approval of the minutes</li> </ul> <p><i>Board Book Section I:</i></p> <ul style="list-style-type: none"> <li>– Agenda</li> <li>p. 1 – MHEF Mission Statement</li> <li>p. 3 – P.A. 4 of 2013</li> <li>p. 11 – By-Laws</li> <li>p. 19 – MHEF Board Member Term Lengths</li> <li>p. 21– MHEF Board Contact List</li> <li>p. 23 – Minutes of the October 20, 2014 Board meeting</li> <li>p. 29 – Minutes of the November 3, 2014 Board meeting</li> </ul>	9:00 a.m. – 9:05 a.m.
<b>Public Comment</b> <ul style="list-style-type: none"> <li>● Public Comment: Five-minute limitation on a single representative of an organization; three minutes for individuals representing themselves</li> </ul>	9:05 a.m. – 9:10 a.m.

## Learning Session: Importance of Addressing Emergency Department Super-Utilizers

- Welcome and introduction – Rob Fowler, Board Chair
- Dr. Corey Waller, physician, Spectrum Health.

9:10 a.m. –  
9:45 a.m.

### *Board Book Section II:*

p. 31 –Corey Waller biographical sketch

## Committee Reports

- **Executive and Compensation Committee: Rob Fowler [10 mins.]**
  - Information: Financial report
  - Information: 2015 fund allocation

### *Board Book Section III:*

p. 33 – MHEF October financial statement  
p. 35 – November Work Plan

- **CEO Recruitment Committee: Lynn Alexander [5 mins.]**
  - Information: Update on staff search process
- **Audit Committee: Keith Pretty [5 mins.]**
  - Information: Update on Audit firm selection process
- **Governance Committee: Michael Williams [40 mins.]**
  - Action: Policy recommendations

9:45 a.m. –  
11:45 a.m.

### *Board Book Section IV:*

p. 43 – Revised Open Meetings Policy  
p. 49 – Revised Gift Policy  
p. 51 – Conflict of Interest Review Procedure Policy  
p. 53 – Diversity, Equity, and Inclusion Policy  
p. 55 – Travel Reimbursement Policy  
p. 59 – Robert’s Rules of Order Guide  
p. 65 – MHEF November Learning Materials Summary

- **Grantmaking Committee: Sue Jandernoa [60 min.]**
  - Action: 2014 Pilot Grantmaking ([insert #] applications for consideration)

### *Board Book Section V:*

p. 71 – Grantmaking Committee report and grant recommendations

- **Investment Committee: Tim Damschroder**

- Note: There will not be a verbal report from this committee and no action is needed. Refer to the Board book for informational materials.

***Board Book Section VI:***

p. 91 – Fund Balance Projections in Year 18

p. 93 – Investment Committee report, with Huntington reports

**Closed Session – Rob Fowler, Board Chair**

- Announce closed session. Board may take action following closed session, if necessary.

**Process for Closed Session**

1. State reasons for Closed Session: [from the statute]  
Legal basis: To consider the hiring, dismissal, suspension, or disciplining of Board members or employees or agents of the Fund
  - a. This session: Discuss search process for the position of Chief Executive Officer and negotiations for the position of Chief Operating Officer
2. Take a roll-call vote to go into Closed Session (requires six affirmative votes); results of vote must be announced
3. Excuse the public from the room.
4. Minutes must be taken for the Closed Session. [Duane]

11:45 a.m. –  
11:50 a.m.

**Staff Recruitment**

- **CEO Recruitment Committee: Lynn Alexander**
  - Discuss CEO search process
  - Discuss COO negotiations
  - Other items related to the recruitment process

Any materials will be distributed in the closed session.

11:50 a.m. –  
12:20 p.m.

***Reconvene Open Meeting***

**Next Steps – Rob Fowler**

- Any action needed coming out of the closed session
- Upcoming Board meetings
- Feedback form
  - Refer to Board book

12:20 p.m. –  
12:30 p.m.

***Board Book Section VII:***

p. 97 – Feedback form

p. 99 – Schedule for upcoming Board meetings

**Adjournment**

12:30 p.m.

**Listening Session****Room: Worship and Performing Arts Center*****Board Book Section VIII:***

- p. 101 – Traverse City Listening Tour Summary
- p. 109 – Detroit Listening Tour Summary
- p. 117 – Grand Rapids Listening Tour Agenda
- p. 119 – Community Priority Health Issues – Grand Rapids

1:00 p.m. –  
3:00 p.m.



## Mission Statement

*The mission of the Michigan Health Endowment Fund is to improve the health of Michigan residents and reduce the cost of health care with special emphasis on the health and wellness of children and seniors.*



Act No. 4  
 Public Acts of 2013  
 Approved by the Governor  
 March 18, 2013  
 Filed with the Secretary of State  
 March 18, 2013  
 EFFECTIVE DATE: March 18, 2013

**STATE OF MICHIGAN**  
**97TH LEGISLATURE**  
**REGULAR SESSION OF 2013**

Introduced by Senators Hune and Smith

**ENROLLED SENATE BILL No. 61**

AN ACT to amend 1980 PA 350, entitled “An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts,” by amending the title and sections 218, 401e, and 414b (MCL 550.1218, 550.1401e, and 550.1414b), the title as amended by 1994 PA 169, section 218 as added by 2002 PA 559, section 401e as added by 1996 PA 516, and section 414b as added by 2006 PA 413, and by adding sections 201a, 220, 400, 401m, 410b, 501c, and 620 and part 6A.

*The People of the State of Michigan enact:*

TITLE

An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for the creation of and the powers and duties of certain nonprofit corporations for the purpose of receiving and administering funds for the public welfare; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal acts and parts of acts.

Sec. 201a. Notwithstanding section 201, a health care corporation shall not be formed in this state on or after January 1, 2014.

Sec. 218. A health care corporation shall not do any of the following:

(a) Take any action to change its nonprofit status.

(b) Except as otherwise provided in section 220, dissolve, merge, consolidate, mutualize, or take any other action that results in a change in direct or indirect control of the health care corporation or sell, transfer, lease, exchange, option, or convey assets that results in a change in direct or indirect control of the health care corporation.

Sec. 220. (1) Notwithstanding any provision of this act to the contrary, a health care corporation may establish, own, operate, and merge with a nonprofit mutual disability insurer formed under chapter 58 of the insurance code of 1956, 1956 PA 218, MCL 500.5800 to 500.5840. The surviving entity of a merger described in this subsection is the nonprofit mutual disability insurer. A merger described in this subsection is exempt from the application of sections 1311 to 1319 of the insurance code of 1956, 1956 PA 218, MCL 500.1311 to 500.1319.

(2) The merger of a health care corporation with a nonprofit mutual disability insurer is effective upon completion of both of the following:

(a) The adoption of a plan of merger by the majority of the boards of directors of both the health care corporation and the nonprofit mutual disability insurer. The health care corporation shall include in the plan of merger that beginning in April of the first full calendar year after the adoption of the plan of merger the surviving entity of a merger described in subsection (1) shall use its best efforts to make annual social mission contributions in an aggregate amount of up to \$1,560,000,000.00 over a period of up to 18 years beginning in April of the first full calendar year after the adoption of the plan of merger to a nonprofit corporation created under part 6A. If adopted, the boards of directors shall submit the plan of merger to the commissioner for his or her consideration as provided in subdivision (b). A nonprofit mutual disability insurer is considered to be making its best effort under this subdivision if it makes the annual social mission contribution to a nonprofit corporation created in part 6A when the nonprofit mutual disability insurer's surplus is at least 375% of the authorized control level under risk-based capital requirements.

(b) The approval of the plan of merger by the commissioner. The commissioner shall make a determination to approve or disapprove a plan of merger within 90 days of receipt of the plan, and the commissioner shall not unreasonably withhold approval of a plan of merger submitted under subdivision (a).

(3) Notwithstanding any other provision of this act to the contrary, the directors of a health care corporation may serve as incorporators of the corporate body of, directors of, or officers of the nonprofit mutual disability insurer formed through a merger described in subsection (1).

(4) A merger described in subsection (1) is the dissolution of the health care corporation, and the surviving nonprofit mutual disability insurer assumes the performance of all contracts and policies of the merged health care corporation that exist on the date of the merger, including the participating hospital agreement, and its definition of certificate which excludes as covered services benefits provided pursuant to automobile no-fault or worker's compensation coverage, and all related contract obligations that result from orders relating to hospital provider class plans that are issued by the commissioner after July 1, 2012. However, the officers of a health care corporation may perform any act or acts necessary to close the affairs of the merged health care corporation after the date of the merger.

(5) Notwithstanding anything in this act to the contrary, if the merger of a health care corporation and a nonprofit mutual disability insurer becomes effective as described in subsection (2), the property of the health care corporation is subject to the collection of general ad valorem taxes and applicable specific taxes under the general property tax act, 1893 PA 206, MCL 211.1 to 211.155, beginning December 31, 2013. As provided in section 201, the property of a health care corporation is exempt from taxation before December 31, 2013. This act does not confer an exemption from taxation on a nonprofit mutual disability insurer that merges with a health care corporation.

Sec. 400. (1) Notwithstanding any provision of this act to the contrary, this section applies to the use of a most favored nation clause in a provider contract on and after February 1, 2013.

(2) Subject to subsection (3), beginning February 1, 2013, a health care corporation shall not use a most favored nation clause in any provider contract, including a provider contract in effect on February 1, 2013, unless the most favored nation clause has been filed with and approved by the commissioner. Subject to subsection (3), beginning February 1, 2013, a health care corporation shall not enforce a most favored nation clause in any provider contract without the prior approval of the commissioner.

(3) Beginning January 1, 2014, a health care corporation shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

(4) As used in this section, "most favored nation clause" means a clause that does any of the following:

(a) Prohibits, or grants a contracting health care corporation an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(b) Requires, or grants a contracting health care corporation an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(c) Requires, or grants a contracting health care corporation an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(d) Requires a provider to disclose, to the health care corporation or its designee, the provider's contractual payment or reimbursement rates with other parties.

Sec. 401e. (1) Except as otherwise provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.

(2) Except as otherwise provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the certificate at the option of the sponsor of the plan.

(3) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health care corporation no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(4) A health care corporation shall not discontinue offering a particular plan or product in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each covered individual or group, as applicable, provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the nongroup market or group market, as applicable, by that health care corporation without excluding or limiting coverage for a preexisting condition or providing a waiting period.

(c) Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may become eligible for coverage in making the determination to discontinue coverage and in offering other plans or products.

(5) A health care corporation shall not discontinue offering all coverage in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, of the discontinuation at least 180 days before the date of the expiration of coverage.

(b) Discontinues all health benefit plans issued in the nongroup or group market from which the health care corporation withdrew and, except as allowed under subsection (6), does not renew coverage under those plans.

(6) If a health care corporation discontinues coverage under subsection (5), the health care corporation shall not provide for the issuance of any health benefit plans in the nongroup or group market from which the health care corporation withdrew during the 5-year period beginning on the date of the discontinuation of the last plan not renewed under that subsection.

Sec. 401m. Until January 1, 2014, a health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state regardless of health status.

Sec. 410b. Notwithstanding section 410a(8), for a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, the premium for a group conversion certificate under section 410a shall be determined only by using the rating factors set forth in section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

Sec. 414b. (1) A health care corporation may offer group wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer shall provide evidence of demonstrative maintenance or improvement of the members' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the health care corporation. Any rebate or premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to employers all wellness coverage plans that it markets to employers in this state.

(2) A health care corporation may offer nongroup wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the health care corporation. The member shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators

between the member and the health care corporation. Any rebate of premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to individuals all wellness coverage plans that it markets to individuals in this state.

(3) A health care corporation is not required to continue any health behavior wellness, maintenance, or improvement program or to continue any incentive associated with a health behavior wellness, maintenance, or improvement program.

Sec. 501c. Beginning January 1, 2014, a health care corporation shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the commissioner pursuant to federal law.

Sec. 620. (1) Notwithstanding any provision of this act to the contrary, a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014 by a health care corporation is subject to the policy and certificate issuance and rate filing requirements of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, including the rating factor requirements of section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

(2) For a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, subject to the prior approval of the commissioner, a health care corporation may establish reasonable open enrollment periods.

(3) The commissioner shall establish minimum standards for the frequency and duration of open enrollment periods established under subsection (2). The commissioner shall uniformly apply the minimum standards for the frequency and duration of open enrollment periods established under this subsection to all health care corporations.

(4) A health care corporation offering coverage during an open enrollment period established under subsection (2) shall not deny or condition the issuance or effectiveness of a certificate and shall not discriminate in the pricing of the certificate on the basis of health status, claims experience, receipt of health care, or medical condition.

## PART 6A

### HEALTH ENDOWMENT FUND CORPORATIONS

Sec. 651. As used in this part:

- (a) "Board" means the board of a health endowment fund corporation incorporated under this part.
- (b) "Executive director" means the executive director of a fund appointed by the board.
- (c) "Fund" means a health endowment fund corporation organized as a nonprofit corporation under section 653.

Sec. 652. (1) A health endowment fund corporation shall not be incorporated in this state except under this part.

(2) A board shall adopt a conflict of interest policy. A board member with a direct or indirect interest in any matter before the fund shall disclose the member's interest to the board before the board takes any action on the matter. The board shall record the member's disclosure in the minutes of the board meeting. If a board member or a member of his or her immediate family, organizationally or individually, would derive a direct and specific benefit from a decision of the board, that member shall recuse himself or herself from the discussion and the vote on the issue.

(3) Subject to this subsection, the governor shall appoint the members of a board with the advice and consent of the senate. An individual who is an employee, officer, or board member of a health care corporation; a lobbyist affiliated with a health care corporation; or an employee of a health insurer, health care provider, or third party administrator is not eligible to be appointed and shall not be appointed to a board under this subsection. On or before the expiration of 60 days after the incorporation of a fund under section 653, the governor shall appoint the following initial members of the board with the advice and consent of the senate:

- (a) One member from a list of 3 or more individuals recommended by the senate majority leader.
- (b) One member from a list of 3 or more individuals recommended by the speaker of the house of representatives.
- (c) One member representing the interests of minor children.
- (d) One member representing the interests of senior citizens.
- (e) Two members of the general public.
- (f) One member representing the business community.
- (g) One member from a list of 3 or more individuals recommended by the house minority leader.
- (h) One member from a list of 3 or more individuals recommended by the senate minority leader.

(4) A vacancy on a board shall be filled in the same manner as the initial appointment under subsection (3). Except as otherwise provided in this subsection, a board member shall be appointed for a term of 4 years or until a successor is appointed, whichever is later. For the initial members appointed under subsection (3), 3 members shall be appointed for 2-year terms, 3 members shall be appointed for 3-year terms, and 3 members shall be appointed for 4-year terms.

(5) Six members of a board constitute a quorum for the transaction of business at a meeting of the board. An affirmative vote of 5 board members is necessary for official action of a board.

(6) The business that a board may perform shall be conducted at a meeting of the board that is held in this state, is open to the public, and is held in a place that is available to the general public. However, a board may establish reasonable rules and regulations to minimize disruption of a meeting of the board. At least 10 days and not more than 60 days before a meeting, a board shall provide public notice of its meeting at its principal office and on its internet website. A board shall include in the public notice of its meeting the address where board minutes required under subsection (7) may be inspected by the public. A board may meet in a closed session for any of the following purposes:

(a) To consider the hiring, dismissal, suspension, or disciplining of board members or employees or agents of the fund.

(b) To consult with its attorney.

(c) To comply with state or federal law, rules, or regulations regarding privacy or confidentiality.

(7) A board shall keep minutes of each meeting. Board minutes shall be open to public inspection, and the board shall make the minutes available at the address designated on the public notice of its meeting under subsection (6). A board shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying. A board shall include all of the following in its board minutes:

(a) The date, time, and place of the meeting.

(b) Board members who are present and absent.

(c) Board decisions made at a meeting open to the public.

(d) All roll call votes taken at the meeting.

(8) Board members shall serve without compensation. However, board members may be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board members.

Sec. 653. (1) A charitable purpose nonprofit corporation may be incorporated on a nonstock, directorship basis, under the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192 consistent with this part and, if incorporated under this section, shall be organized to receive and administer funds for the public welfare. The articles of incorporation must include the word "Michigan" and the phrase "health endowment fund" in the name of the fund. As soon as practicable after the incorporation of a fund under this subsection, the fund shall apply for and make its best effort to obtain tax-exempt status under section 501(c)(3) of the internal revenue code, 26 USC 501.

(2) The articles of incorporation of a fund must provide that the fund is organized for the following purposes:

(a) Supporting efforts that improve the quality of health care while reducing costs to residents of this state.

(b) Benefitting the health and wellness of minor children and seniors throughout this state with a significant focus in the following areas:

(i) Access to prenatal care and reduction of infant mortality rates.

(ii) Health services for foster and adopted children.

(iii) Access to healthy food.

(iv) Wellness programs and fitness programs.

(v) Access to mental health services.

(vi) Technology enhancements.

(vii) Health-related transportation needs.

(viii) Foodborne illness prevention.

(c) Awarding grants for a term not exceeding 3 years in duration for projects that will promote the purposes of the fund.

(d) Subsidizing the cost of individual medigap coverage to medicare-eligible individuals in this state who demonstrate a financial need in order to be able to purchase individual medigap coverage.

(3) The board shall establish a comprehensive and competitive process to award grants.

(4) The nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, applies to a fund. If a provision relating to a fund under this part conflicts with other state law, this part controls.

(5) If a fund is eligible to receive social mission contributions under section 220(2), the eligible fund shall implement a program to disburse money to subsidize the cost of individual medigap coverage to medicare-eligible individuals in this state who demonstrate a financial need in order to be able to purchase individual medigap coverage. The commissioner shall develop a means test to be used to determine if a medicare-eligible individual applicant is eligible for the medigap coverage subsidy provided for in this subsection and shall submit the test developed to the attorney general for approval.

(6) If a fund is eligible to receive social mission contributions under section 220(2), beginning on the first day of the third August after the fund receives its initial social mission contribution, and ending on the thirty-first day of the eighth December after the fund receives its initial social mission contribution, the fund shall disburse \$120,000,000.00 to subsidize the cost of individual medigap coverage purchased by medicare-eligible individuals in this state, subject to subsection (5).

(7) A fund is a private, nonprofit corporation organized for charitable purposes and is not a state agency, governmental agency, or other political subdivision of this state. Money of a fund is held by the fund for the purposes consistent with this part and is not money of this state or a political subdivision of this state and shall not be deposited in the state treasury. A member of a board is not a public officer of this state.

Sec. 654. (1) A board shall appoint an executive director to serve as the chief executive officer of the fund. The executive director shall serve at the pleasure of the board. The executive director may employ staff and hire consultants as necessary with the approval of the board. The board shall determine compensation for the executive director and staff employed under this subsection and shall approve contracts under this subsection.

(2) The executive director shall display on the fund internet website information relevant to the public, as defined by the board, concerning the fund's operations and efficiencies, as well as the board's assessments of those activities.

Sec. 655. (1) Subject to this section, a fund may disburse money contributed to the fund each year, not including any interest, earnings, or unrealized gains or losses on those contributions, for the purposes of the fund as described in section 653. A fund may expend a portion of the money contributed to the fund in each year following the initial contribution to the fund according to the following schedule:

- (a) Years 1 through 4, 80%.
- (b) Years 5 through 8, 67%.
- (c) Years 9 through 12, 60%.
- (d) Years 13 through 18, 25%.

(2) On and after the date that the accumulated principal of money held by a fund reaches \$750,000,000.00, the fund shall maintain that amount for investment to provide an ongoing income to the fund. On and after the date that the accumulated principal in the fund reaches \$750,000,000.00, the board shall not allow the accumulated principal of the fund to fall below \$750,000,000.00 due to expenditures made for the purposes of the fund as described in section 653.

(3) A fund may expend money received by the fund from any source in a fiscal year of the fund that is in excess of the amount required to maintain the accumulated principal goals as described in subsection (2), not including any interest, earnings, or unrealized gains or losses on those funds, on the reasonable administrative costs of the fund and for the purposes of the fund as described in this part. The investment of fund money and donations by the fund are under the exclusive control and discretion of the fund and are not subject to requirements applicable to public funds.

(4) A fund may invest accumulated principal in the fund only in securities permitted by the laws of this state for the investment of assets of life insurance companies, as described in chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947.

(5) A fund's articles of incorporation or bylaws must provide for a system of financial accounting, controls, audits, and reports. The board annually shall have an audit of the fund conducted by an independent public accountant firm, and the auditor's audit report and findings shall be submitted to the board. The expense of an audit required under this subsection is considered a reasonable administrative cost under subsection (3).

(6) A fund's articles of incorporation or bylaws must require that the board shall appoint from its members an audit committee consisting of no fewer than 3 members and for the audit committee to contract with an independent auditing firm to provide an annual financial audit in accordance with applicable auditing standards.

(7) The executive director shall do all of the following:

- (a) Review and certify external auditor reports.
- (b) Make external auditor reports available to the board and to the general public.
- (c) Develop and implement corrective actions to address weaknesses identified in an audit report.

(8) The articles of incorporation or bylaws of a fund must require the fund to keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the board, the governor, the senate and house of representatives appropriations committees, and the senate and house of representatives standing committees on health policy a report regarding those accountings.

(9) A fund and its directors, officers, and employees shall fully cooperate with any investigation conducted by this state or a federal agency under its authority under state or federal law, to do any of the following:

- (a) Investigate the affairs of the fund.
- (b) Examine the assets and records of the fund.
- (c) Require periodic reports in relation to the activities undertaken by the fund in compliance with applicable law.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 62 of the 97th Legislature is enacted into law.

This act is ordered to take immediate effect.

*Carol Morey Viventi*

Secretary of the Senate

*Gay E. Randall*

Clerk of the House of Representatives

Approved .....

.....  
Governor



Adopted: March 24, 2014

**BYLAWS**  
**OF**  
**MICHIGAN HEALTH ENDOWMENT FUND**

(A Michigan Nonprofit Corporation)

ARTICLE I  
Board of Directors

Section 1. Directorship. The Fund is organized upon a directorship basis. The property, business and affairs of the Fund will be managed by its Board of Directors.

Section 2. Number, Qualification and Term of Office. The Board of Directors of this Fund will consist of nine persons.

The Governor of the State of Michigan shall appoint the members of the board with the advice and consent of the Michigan Senate. An individual who is an employee, officer, or board member of a health care corporation; a lobbyist affiliated with a health care corporation; or an employee of a health insurer, health care provider, or third party administrator is not eligible to be appointed and shall not be appointed to the board. On or before the expiration of 60 days after the incorporation of the Fund, the Governor shall appoint the following initial members of the board with the advice and consent of the Senate:

- (a) One member from a list of 3 or more individuals recommended by the Senate Majority Leader.
- (b) One member from a list of 3 or more individuals recommended by the Speaker of the House of Representatives.
- (c) One member representing the interests of minor children.
- (d) One member representing the interests of senior citizens.
- (e) Two members of the general public.
- (f) One member representing the business community.
- (g) One member from a list of 3 or more individuals recommended by the House Minority Leader.
- (h) One member from a list of 3 or more individuals recommended by the Senate Minority Leader.

A vacancy on the board shall be filled in the same manner as the initial appointment under this Section 2. Except as otherwise provided in this section, a board member shall be appointed for a term of 4 years or until a successor is appointed, whichever is later. For the initial members appointed under this Section 2, 3 members shall be appointed for 2-year terms, 3 members shall be appointed for 3-year terms, and 3 members shall be appointed for 4-year terms.

Section 3. Resignation, Removal and Vacancies. A Director may resign by written notice to the Governor. The resignation will be effective upon its receipt by the Governor or a subsequent time as set forth in the notice of resignation. A Director may be removed, either with or without cause, by written direction of the Governor.

Section 4. General Powers as to Negotiable Paper. The Board of Directors may, from time to time, authorize the making, signature or endorsement of checks, drafts, notes and other negotiable paper or other instruments for the payment of money and designate the persons who will be authorized to make, sign or endorse the same on behalf of the Fund.

Section 5. Powers as to Other Documents. All material contracts, conveyances and other instruments may be executed on behalf of the Fund by the Executive Director, the Chairperson or any Vice Chairperson, and, if necessary, attested by the Secretary or the Treasurer.

Section 6. Compensation. Directors will serve without compensation but may be reimbursed for actual and necessary expenses incurred by a Director in the performance of his or her official duties as a Board member consistent with policies adopted by the Board.

## ARTICLE II Meetings

Section 1. Annual Meeting. The annual meeting of the Directors of the Fund will be held at the principal office of the Fund during the month of January of each year, or at any other place and date as designated by the Directors for the purpose of installing Directors and electing officers for the ensuing year, presenting to the Directors a copy of the Fund's financial report for the preceding fiscal year and for the transaction of other business properly brought before the meeting.

Section 2. Open Meetings. The business that the board may perform shall be conducted at a meeting of the board that is held in this state, is open to the public, and is held in a place that is available to the general public. However, the board may establish reasonable rules and regulations to minimize disruption of a meeting of the board. At least 10 days and not more than 60 days before a meeting, the board shall provide public notice of its meeting at its principal office and on its internet website. The board shall include in the public notice of its meeting the address where board minutes may be inspected by the public. The board may meet in a closed session for any of the following purposes:

- (a) To consider the hiring, dismissal, suspension, or disciplining of board members or employees or agents of the Fund.
- (b) To consult with its attorney.
- (c) To comply with state or federal law, or regulations regarding privacy or confidentiality.

Section 3. Notice of Meeting. Except as otherwise provided by these Bylaws or by law, and in addition to the public notice described in Section 2 above, written notice containing the time and place of all meetings of the Board of Directors will be given personally, by mail, or by electronic transmission to each Director not less than ten days before a meeting. Notice by electronic transmission will be deemed to have been given when electronically transmitted to the person entitled to the notice or communication in a manner authorized by the person. Notice of a meeting need not state the purpose or purposes of the meeting nor the business to be transacted at the meeting.

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting, except where the Director attends the meeting for the express purpose of objecting to the transaction of any business because the meeting was not lawfully called or convened.

Section 4. Quorum and Voting. Six members of the Board constitute a quorum for the transaction of business at a meeting of the Board. An affirmative vote of 5 Board members is necessary for official action of the Board.

Section 5. Conduct at Meetings. Meetings of the Directors will be presided over by the Chairperson. The Secretary or an Assistant Secretary of the Fund or, in their absence, a person chosen at the meeting will act as Secretary of the meeting.

Section 6. Minutes. The Board shall keep minutes of each meeting. Board minutes shall be open to public inspection, and the Board shall make the minutes available at the address designated on the public notice of its meeting under Section 2. The Board shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying. The Board shall include all of the following in its Board minutes:

- (a) The date, time, and place of the meeting.
- (b) Board members who are present and absent.
- (c) Board decisions made at a meeting open to the public.
- (d) All roll call votes taken at the meeting.

Section 7. Participation by Remote Communication. A Director may participate in a meeting of Directors by conference telephone or other means of remote communication by which all persons participating in the meeting may communicate with

each other. Participation in a meeting pursuant to this section constitutes presence in person at the meeting.

### ARTICLE III Officers

Section 1. Election or Appointment. The Board of Directors will elect a Chairperson, a Vice Chairperson, a Secretary and a Treasurer of the Fund at each annual meeting. The Board will appoint an Executive Director to serve as the chief executive officer of the Fund. The same person may hold any two or more offices, but no officer will execute, acknowledge or verify any instrument in more than one capacity. The Directors may also appoint any other officers and agents as they deem necessary for accomplishing the purposes of the Fund.

Section 2. Term of Office. The term of office of all officers will commence upon their election or appointment and will continue until the next annual meeting of the Fund and until their respective successors are chosen or until their resignation or removal. Any officer may be removed from office at any meeting of the Directors, with or without cause, by the affirmative vote of a majority of the Directors then in office, whenever in their judgment the best interest of the Fund will be served.

An officer may resign by written notice to the Fund. The resignation will be effective upon its receipt by the Fund or at a subsequent time specified in the notice of the resignation.

Section 3. Compensation. Any officer who is an employee of the Fund will receive reasonable compensation for his or her services as fixed by the Board of Directors.

Section 4. Chairperson. The Chairperson will preside over all board meetings and will perform such other duties prescribed by the Board of Directors.

Section 5. Vice Chairperson. The Vice Chairperson will, in the absence or disability of the Chairperson, perform the duties and exercise the powers of the Chairperson and will perform any other duties prescribed by the Board of Directors or the Chairperson.

Section 6. The Executive Director. The Executive Director will be the chief executive officer of the Fund and will have general and active management of the activities of the Fund. The Executive Director will see that all orders and resolutions of the Board of Directors are carried into effect. The Executive Director will execute all authorized conveyances, contracts or other obligations in the name of the Fund except where required by law to be otherwise signed and executed and except where the signing and execution is expressly delegated by the Directors to some other person.

The Executive Director shall serve at the pleasure of the Board. The Executive Director may employ staff and hire consultants as necessary with the approval of the

Board. The Board shall determine compensation for the Executive Director and staff and shall approve contracts under this Section 6.

The Executive Director shall display on the Fund internet website information relevant to the public, as defined by the Board, concerning the Fund's operations and efficiencies, as well as the Board's assessments of those activities.

The Executive Director shall do all of the following:

- (a) Review and certify external auditor reports.
- (b) Make external auditor reports available to the Board and to the general public.
- (c) Develop and implement corrective actions to address weaknesses identified in an audit report.

Section 7. The Secretary. The Secretary will attend meetings of the Board of Directors and record or cause to be recorded the minutes of all proceedings in a book to be kept for that purpose. The Secretary will give or cause to be given notice of all meetings of the Board of Directors for which notice may be required and will perform any other duties prescribed by the Directors.

Section 8. The Treasurer. The Treasurer will oversee the financial activities of the Fund. The Treasurer will perform all duties incident to the office of Treasurer and other administrative duties as may be prescribed by the Board of Directors. All books, papers, vouchers, money and other property of whatever kind belonging to the Fund which are in the Treasurer's possession or under his or her control will be returned to the Fund at the time of his or her death, resignation or removal from office.

#### ARTICLE IV Committees

Section 1. Executive and Compensation Committee. The Board of Directors shall establish an Executive and Compensation Committee consisting of the elected officers of the Board. Minutes of the Executive and Compensation Committee meetings will be made available to the public. The Executive and Compensation Committee, subject to those limitations as may be required by law or imposed by resolution of the Board of Directors, may make recommendations to the Board of Directors regarding the business and affairs of the Fund, but shall not conduct the business that the board may perform.

The Executive and Compensation Committee shall review staff performance and make recommendations to the Board of Directors with respect to compensation and benefits to be paid to the Fund's staff and personnel. Notwithstanding anything contained in this Section 1 to the contrary, the Board of Directors will be responsible for approving compensation and benefits.

Section 2. Audit Committee. The Board shall appoint from its members an Audit Committee consisting of no fewer than 3 members. The audit committee will contract with an independent auditing firm to provide an annual financial audit in accordance with applicable auditing standards.

The Audit Committee will insure that the Fund will keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Board, the Governor, the Senate and House of Representatives appropriations committees, and the Senate and House of Representatives standing committee on health policy a report regarding those accountings.

The Audit Committee will establish and maintain a system of financial accounting, controls, audits, and reports. The Board annually shall have an audit of the Fund conducted by an independent public accountant firm, and the auditor's audit report and findings shall be submitted to the Board. The expense of an audit required under this subsection is considered a reasonable administrative cost of the Fund.

Section 3. Governance Committee. The Board shall appoint a Governance Committee to review and make recommendations to the Board of Directors regarding matters of the Fund's governance, including its Articles of Incorporation, Bylaws, committee structure, and policies and procedures.

Section 4. Other Committees. The Board of Directors may designate other committees as deemed appropriate. The committees will have the authority as delegated to them by the Board of Directors. Notwithstanding the foregoing, all committees shall be advisory in nature and may not transact the business of the board.

Section 5. Procedure. All committees, and each member thereof, will serve at the pleasure of the Board of Directors. Except as provided in the law, the Board of Directors will have the power at any time to increase or decrease the number of members of any committee, to fill vacancies thereon, to change any member thereof, and to change the functions or terminate the existence of any committee. Regular meetings of any committee may be held in the same manner provided in these Bylaws for meetings of the Board of Directors, and a majority of any committee will constitute a quorum at the meeting.

## ARTICLE V Indemnification

Section 1. Indemnification. The Fund will, to the fullest extent now or hereafter permitted by law, indemnify any Director or officer of the Fund (and, to the extent provided in a resolution of the Board of Directors or by contract, may indemnify any volunteer, employee or agent of the Fund) who was or is a party to or threatened to be made a party to any threatened, pending, or completed action, suit or proceeding by reason of the fact that the person is or was a Director, officer, volunteer, employee or agent of the Fund, or is or was serving at the request of the Fund as a director, trustee, officer, partner, volunteer, employee or agent of another corporation, partnership, joint

venture, trust or other enterprise, whether for profit or not for profit, against expenses including attorneys' fees (which expenses may be paid by the Fund in advance of a final disposition of the action, suit or proceeding as provided by law), judgments, penalties, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with the action, suit or proceeding if the person acted (or refrained from acting) in good faith and in a manner the person reasonably believed to be in or not opposed to the best interests of the Fund, and with respect to any criminal action or proceeding, if the person had no reasonable cause to believe his or her conduct was unlawful.

Section 2. Rights to Continue. This indemnification will continue as to a person who has ceased to be a Director or officer of the Fund. Indemnification may continue as to a person who has ceased to be a volunteer, employee or agent of the Fund to the extent provided in a resolution of the Board of Directors or in any contract between the Fund and the person. Any indemnification of a person who was entitled to indemnification after such person ceased to be a Director, officer, volunteer, employee or agent of the Fund will inure to the benefit of the heirs and personal representatives of that person.

## ARTICLE VI Miscellaneous

Section 1. Fiscal Year. The fiscal year of the Fund will end on the last day of December.

Section 2. Amendments. These Bylaws may be amended or repealed by the affirmative vote of a majority of the Directors of the Fund then in office.

Section 3. Loans and Guarantees. The Fund will not provide loans to or guarantee obligations of an officer or Director of the Fund, unless expressly permitted under State law.



## Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

### Board of Directors

Robert Fowler

*Chairperson*

Lynn Alexander

*Vice Chairperson*

Timothy Damschroder

*Treasurer*

Cindy Estrada

*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

### Interim Executive Director

Geralyn Lasher

## Michigan Health Endowment Fund Board Members

### Two-Year Terms

- **Susan Jandernoa, West Olive**  
Term expires 10/1/15
- **Cindy Estrada, Whitmore Lake**  
Term expires 10/1/15
- **Marge Robinson, Southgate**  
Term expires 10/1/15

### Three-Year Terms

- **Jim Murray, Okemos**  
Term expires 10/1/16
- **Michael Williams, Westland**  
Term expires 10/1/16
- **Lynn Alexander, Bloomfield Hills**  
Term expires 10/1/16

### Four-Year Terms

- **Tim Damschroder, Ann Arbor**  
Term expires 10/1/17
- **Keith Pretty, Midland**  
Term expires 10/1/17
- **Rob Fowler, Haslett**  
Term expires 10/1/17



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## Michigan Health Endowment Fund

### Resource Contact List

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Geralyn Lasher  
Michigan Department of Community Health  
lasherg@michigan.gov  
517-241-2112  
201 Townsend St.  
Lansing, MI 48913

Mark Neithercut  
Neithercut Philanthropy Advisors  
mark@neithercutphilanthropy.com  
313-568-9000  
300 River Place, Suite 5000  
Detroit, MI 48207

Jeffrey Padden  
Public Policy Associates, Inc.  
paddenjd@publicpolicy.com  
517-485-4477 (office)  
517-256-6071 (mobile)  
119 Pere Marquette Dr., Suite 1C  
Lansing, MI 48912

Duane Tarnacki  
Clark Hill  
dtarnacki@clarkhill.com  
313-965-8264  
500 Woodward Ave, Suite 3500  
Detroit, MI 48226

**Michigan Health Endowment Fund  
Board Meeting**

Monday, October 20, 2014

UAW-GM Center for Human Resources  
200 Walker Street, Detroit, Michigan 48207

Meeting Minutes

**Call to order**

The board meeting of the Michigan Health Endowment Fund called to order at 11 a.m. by Chairman Robert Fowler.

**Roll call**

Quorum established based on the presence of the following Board Members:

**Board Members present:**

Lynn Alexander  
Tim Damschroder  
Cindy Estrada  
Rob Fowler  
Sue Jandernoa  
Jim Murray  
Keith Pretty  
Marge Robinson  
Michael Williams

**Others present:**

Geralyn Lasher  
Mark Neithercut  
Genevieve Otis  
Jeff Padden  
Laurie Solotorow  
Duane Tarnacki

**Approval of agenda**

Chairman Fowler approves the agenda.

**Review and adoption of the minutes from the previous meeting**

Board Member Estrada moves to approve the minutes from September 15, 2014, board meeting. Board Member Robinson seconds. Motion passes by a vote of nine to zero.

- I. Board Member Murray made a motion to go into closed session to discuss the hiring of an executive director per the statute. Board Member Williams seconds. The Board voted on going into closed session:

Lynn Alexander- affirmative  
 Tim Damschroder- affirmative  
 Cindy Estrada- affirmative  
 Rob Fowler- affirmative  
 Sue Jandernoa- affirmative  
 Jim Murray- affirmative  
 Keith Pretty- affirmative  
 Marge Robinson- affirmative  
 Michael Williams- affirmative

Motion passes by a vote of nine to zero.

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CLOSED SESSION

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### **Reconvene Open Meeting**

#### **CEO Recruitment Committee**

Board Member Alexander reports that candidates for the CEO position have been interviewed and there is nothing further to report as the Board continues to vet the candidates.

#### **Public comment**

There were no public comment cards submitted.

#### **Committee reports**

##### **I. Executive and Compensation Committee**

Chairman Fowler reports the committee has meet to discuss CEO compensation and benefits package. The Board is well positioned to make an offer once a candidate has been selected.

Chairman Fowler reports that the Board received office space recommendations from Ms. Lasher and feels the Board is in a good position to make a decision.

Chairman Fowler states the committee will continue to look at the financial statements and provide updates.

Board Member Murray observes that 11% of MHEF funds invested in the corporate bond portfolio are focused on the telecommunications industry and that the Board is not involved in making investment decisions.

Chairman Fowler states that third parties will be invited via RFP to bid for administrative functions, bookkeeping and grantmaking services.

## II. Grantmaking Committee

Board Member Jandernoa reviewed the process the committee used to determine the grant recommendations.

Board Member Jandernoa states that none of the 11 grant proposals were declined. The Grantmaking Committee is recommending five grants for funding, two need additional information, and four need revisions for board action in November.

Board Member Jandernoa reports the committee discussed when the grants will be paid. The committee agreed that half of the grant will be paid immediately and the second half will be paid when a progress report is received. The committee will work with each grantee to determine a payment schedule.

Ms. Lasher reviewed the 11 grant proposals:

### Food Bank Council of Michigan

Requests a grant of \$4.8 million for support of a program to deliver fruits and vegetables through a new mobile distribution system with a related education program focused on nutrition.

The Grantmaking Committee recommends \$5 million to support this program.

### Area Agencies on Aging Association of Michigan

Requests a grant of \$5 million for support of the expansion of a fall prevention program and a diabetes management program for senior adults in Michigan.

The Grantmaking Committee recommends \$5 million to support this program.

### Easter Seals – Michigan Inc.

Requests a grant of \$4.7 million for support of the design and launch of a trauma screening and assessment program for Michigan children. .

The Grantmaking Committee recommends \$4.8 million to support this program.

### Michigan Recreation and Park Association

Requests a grant of \$5 million to increase levels of physical activity and health of Michigan residents by connecting people with affordable and accessible places to be active.

The Grantmaking Committee recommends \$1.1 million to support the development of fitness-based community programs.

State Alliance of Michigan YMCAs

Requests a grant of \$5 million for support of a project to empower 14 communities across the state to build coalitions that will work with community stakeholders to define community health needs and implement evidence-based solutions.

The Grantmaking Committee recommends \$3 million to support this program contingent on collaboration on a revised budget.

Michigan Primary Care Association

Requests a grant of \$5 million for support of a project to hire, train, and integrate care liaison workers into primary care teams in health centers throughout Michigan.

The Grantmaking committee recommends additional discussions with the possibility of funding the initial work.

Michigan Association of United Ways

Requests a grant of \$5 million for support of the expansion and integration of the Children’s Healthcare Access Program and the 2-1-1 service. .

The Grantmaking Committee recommends additional discussions and information with the possibility of recommending \$3.3 million to support these programs.

Michigan Fitness Foundation

Requests a grant of \$5 million to support health-promoting behaviors for Michigan residents, especially youth and seniors, through improved nutrition and increased physical activity.

The Grantmaking Committee recommends additional discussions and one-on-one collaborations.

Michigan Association of Community Mental Health Boards

Requests a grant of \$3.4 million for support of programs to provide behavioral health services to children in doctors’ offices and wellness education to older adults.

The Grantmaking Committee recommends additional discussions on metrics, goals and outcomes.

Michigan Alliance of Boys and Girls Clubs

Request a grant of \$5 million to fund the “Great Health Starts Here” program that seeks to improve the health of Michigan’s at-risk youth by strengthening their connection to local health care systems.

The Grantmaking Committee recommends additional discussions on the financial structure for the November Board meeting.

Michigan Association for Local Public Health

Requests a grant of \$4.9 million for support of a community-based prevention framework focused on childhood obesity, immunizations, and oral health.

The Grantmaking Committee recommends additional discussion on the financial structure and Federal approval of the State Innovation Model.

III. Board Action

Food Bank Council of Michigan

Board Member Murray moves to approve the Grantmaking Committee recommendation of \$5 million. Board Member Robinson seconds. Motion passes by a vote of nine to zero.

Area Agencies on Aging Association of Michigan

Board Member Robinson moves to approve the Grantmaking Committee recommendation of \$5 million. Board Member Alexander seconds. Board Members Murray and Damschroder oppose. Motion passes by a vote of seven to two.

Easter Seals – Michigan Inc.

A motion to approve the grant was moved and seconded. After discussion and housekeeping amendments Board Member Williams moves to withdraw his motion to approve the grant application. Board Member Alexander withdraws her second. The proposal is referred back to the Committee for further action.

Michigan Recreation and Park Association

Board Member Alexander moves to approve the Committee's recommendation of \$1.1 million. Board Member Williams seconds. Motion passes by a vote of nine to zero.

State Alliance of Michigan YMCAs

No action taken. The application is referred back to the Committee for further Board consideration in 2014.

Michigan Primary Care Association

Board Member Robinson moves to take no action until more information is received. Board Member Estrada seconds. Board Member Williams opposed. Motion passes by a vote of eight to one.

Michigan Association of United Ways

Board Member Damschroder moves to take no action until more information is received. Board Member Williams seconds. Motion passes by a vote of nine to zero.

Michigan Fitness Foundation

No action taken. The application is referred back to the Committee for further development and Board consideration in 2014.

Michigan Association of Community Mental Health Boards

No action taken. The application is referred back to the Committee for further development and Board consideration in 2014.

Michigan Alliance of Boys and Girls Clubs

No action taken. The application is referred back to the Committee for further development and Board consideration in 2014.

Michigan Association for Local Public Health

No action taken. The application is referred back to the Committee for further development and Board consideration in 2014.

**Next steps:**

- I. Upcoming Board meetings  
Board Chair Fowler stated the next Board meeting is scheduled for November 21, 2014 and the December meeting is tentatively scheduled for December 15, 2014 in Lansing.

**Adjournment**

Board Member Williams moves to adjourn the meeting. Board Member Murray seconds. Motion passes by a vote of nine to zero. Meeting adjourns at 1:10 p.m.

Respectfully submitted,

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Secretary of the meeting

**Michigan Health Endowment Fund**  
**Board Meeting**  
Monday, November 3, 2014  
Small Business Association of Michigan  
120 N. Washington Square, Suite 1000, Lansing, Michigan 48933

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**Meeting Minutes**

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**Call to order**

The board meeting of the Michigan Health Endowment Fund called to order at 2:01 p.m. by Chairman Robert Fowler.

**Roll call**

Quorum established based on the presence of the following Board Members:

**Board Members present:**

Lynn Alexander  
Rob Fowler  
Sue Jandernoa  
Jim Murray  
Michael Williams

**Participating by phone:**

Tim Damschroder  
Cindy Estrada  
Keith Pretty  
Marge Robinson

**Others present:**

Rick King  
Geraldyn Lasher  
Genevieve Otis  
Laurie Solotorow  
Duane Tarnacki

**Approval of agenda**

Chairman Fowler states the purpose of the Board meeting.

**Review and adoption of the minutes from the previous meeting**

Chairman Fowler states the minutes from the October meeting will be adopted at the November 21<sup>st</sup> meeting.

**Public comment**

There were no public comment cards submitted.

- I. Board Member Jandernoa made a motion to go into closed session to discuss the hiring of an executive director per the statute. Board Member Pretty seconds. The Board voted on going into closed session:

Lynn Alexander- affirmative  
 Tim Damschroder- affirmative  
 Cindy Estrada- affirmative  
 Rob Fowler- affirmative  
 Sue Jandernoa- affirmative  
 Jim Murray- affirmative  
 Keith Pretty- affirmative

Marge Robinson- not present for vote  
 Michael Williams- not present for vote

Motion passes by a vote of seven to zero.

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CLOSED SESSION

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**Reconvene Open Meeting**

**CEO Recruitment Committee**

Board Member Alexander makes a motion to authorize the executive and compensation committee to enter into negotiations for a particular candidate for the COO position. Board Member Jandernoa seconds. Motion passes by a vote of nine to zero.

**Adjournment**

Board Member Murray moves to adjourn the meeting. Board Member Williams seconds. Motion passes by a vote of nine to zero. Meeting adjourns at 3:00 p.m.

Respectfully submitted,

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Secretary of the meeting



**R. Corey Waller MD**, Center for Integrative Medicine, Spectrum Health Medical Group

R. Corey Waller MD, MS, FACEP, ABAM, is an addiction, pain, and emergency medicine specialist. He is the medical director of the Spectrum Health Medical Group Center for Integrative Medicine, the medical staff chief of pain medicine to the Spectrum Health Hospital System, as well as substance use disorder medical director at Network 180.

Dr. Waller earned a master's degree in neuromolecular biology at Southwest Texas State University and earned his medical degree at the University of Texas Medical School in San Antonio. Dr. Waller completed his emergency medicine residency at Thomas Jefferson University in Philadelphia.

Dr. Waller's special interests include understanding the biopsychosocial and financial impact on society of emergency department super utilizers, pregnant patients with a substance use disorder, and the complex interaction of pain and addiction.



# Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

## Board of Directors

Robert Fowler  
*Chairperson*

Lynn Alexander  
*Vice Chairperson*

Timothy Damschroder  
*Treasurer*

Cindy Estrada  
*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

## Interim Executive Director

Geralyn Lasher

## MHEF Statement of Activities as of October 31, 2014

### Operating Activities:

Income	Month of October	Year-to-Date
Funds Contributed from Blue Cross Blue Shield		\$100,000,000.00
<b>Total Income from Operating Activities</b>	<b>\$0.00</b>	<b>\$100,000,000.00</b>

### Operating Expenses

Professional Services	\$179,516.10	\$912,590.47
Memberships	\$0.00	\$24,650.00
Meetings and Facilities	\$5,172.02	\$19,655.75
Supplies		\$164.80
Postage/Shipping	\$5.75	\$1,092.11
Bank Charges	\$57.00	\$402.00
Filing Fees		\$850.00
Insurance - Liability	\$16,242.00	\$16,242.00
<b>Total Operating Expenses</b>	<b>\$200,992.87</b>	<b>\$975,647.13</b>

Net Operating Income (Loss)	(\$200,992.87)	\$99,024,352.87
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### Investment Activities:

Realized Gain (Loss) on Investments	(\$1,542.23)	(\$10,667.70)
Unrealized Gain (Loss) on Investments	\$402,595.84 **	(\$122,887.42)
Interest Earned - Includes Paid and Accrued Interest	\$689,363.42 **	\$1,458,875.78
Interest Paid on Investment Purchases *	(\$411,317.42) **	(\$411,317.42)
Dividends	\$149.25	\$752.85
Reduction in Investment Value *	(\$808,818.01) **	(\$808,818.01)

Net Income (Loss) from Investment Activity	(\$129,569.15)	\$105,938.08
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Change in Net Assets	(\$330,562.02)	\$99,130,290.95
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\* Note: Working with broker to clarify these amounts

\*\* Note: Monthly amounts for October include reclassification of investment activities

# Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

## Board of Directors

Robert Fowler  
*Chairperson*

Lynn Alexander  
*Vice Chairperson*

Timothy Damschroder  
*Treasurer*

Cindy Estrada  
*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

## Interim Executive Director

Geralyn Lasher

## MHEF Statement of Financial Position October 31, 2014

### Assets:

Chemical Bank Cash Balance	\$9,049,510.27
Huntington Investments:	
Huntington Investments - At Fair Market Value	\$89,623,065.13
Accrued Interest Earned - Receivable from Huntington	\$457,715.55
Total Value of Huntington Investments	\$90,080,780.68
<b>Total Assets</b>	<b>\$99,130,290.95</b>

### Liabilities:

\$0.00

### Net Assets:

Unrestricted Assets	\$79,130,290.95
Restricted Assets	\$20,000,000.00
<b>Total Net Assets</b>	<b>\$99,130,290.95</b>

<b>Total Liabilities and Net Assets</b>	<b>\$99,130,290.95</b>
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**MHEF 30-DAY WORK PLAN**  
 (November 1 – November 30, 2014)  
 (November 4, 2014 Update)

<b>I. Investments</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Short-term investment options	1. Review short-term investment options 2. Prepare recommendations for Board review/approval	Investment committee	May	Approve short-term options at May meeting - <b>DONE</b>
<input checked="" type="checkbox"/> Ensure appropriate composition of Investment Committee	1. Chair/Exec reviews committee composition to ensure that endowment investment is represented 2. Appoint outside individuals with endowment experience to committee?	Rob/Tim	May/June	Approve new investment committee members (if appropriate) - <b>DONE</b>
<input checked="" type="checkbox"/> Review responsibilities under UPMIFA and implications of perpetuity	1. Review committee responsibilities as outlined in charter and ensure that they align with UPMIFA 2. Develop initial spending policy	Investment committee/ Legal counsel	June/July	Approve spending policy - <b>DONE</b>
<input checked="" type="checkbox"/> Chief Investment Officer	1. Consider hiring CFO/CIO or an outsourced CIO 2. Consider role of new CEO in hiring of the CFO/CIO 3. Consider Woodrow Tyler, who helped develop the UAW VEBA as a possible interim CIO 4. Make recommendation to the Board	Investment committee	June/July	Board reviews rationale and makes decision regarding hiring vs. outsourcing <b>DONE – Board decided at 6.16.14 meeting to hire a CFO with CIO experience.</b>
<input type="checkbox"/> Audit RFP	1. Prepare and approve RFP for MHEF auditor - <b>DONE</b> 2. Develop list of prospective audit firms and manage solicitation process - <b>DONE</b> 3. Review proposals - <b>DONE</b> 4. Identify firm(s) for interviews – <b>DONE</b> 5. Select firm in consultation with CEO	Audit committee/Public Policy Associates	August – January	Audit firm to be selected in January
<input type="checkbox"/> CFO Search	1. Create job description for CFO - <b>DONE</b> 2. Provide draft job description to the Kittleman firm - <b>DONE</b> 3. Support recruitment process as necessary	Investment committee/Kittleman	July – November	Board approves CFO job description at July meeting - <b>DONE</b>

**MHEF 30-DAY WORK PLAN**  
 (November 1 – November 30, 2014)  
 (November 4, 2014 Update)

<b>I. Investments</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input type="checkbox"/> Interview individual(s) for CFO position	1. Identify candidates for CFO position 2. Provide candidates to incoming CEO for review 3. Make recommendation to the Board	Investment committee	October-December	Board approves hire at December meeting

<b>II. Mission/Strategy</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Conduct Board member interviews	Schedule and conduct interviews with Board members	Board members/Neithercut Philanthropy Advisors	May/June	<b>DONE</b>
<input checked="" type="checkbox"/> Summarize feedback	Prepare summary of gathered information	Board members (where clarification is necessary)	Early June	<b>DONE</b>
<input checked="" type="checkbox"/> Meet with Exec Committee	Discuss results of survey and prepare draft mission statement	Executive and Compensation committee/Neithercut Philanthropy Advisors	Mid-June	<b>DONE</b>
<input checked="" type="checkbox"/> Approve mission statement	Present proposed mission statement to board for discussion and approval	Rob	June Board meeting	Board approves mission statement - <b>DONE</b>
<input checked="" type="checkbox"/> Begin development of grantmaking strategies	1. Based on approved mission, develop initial draft of strategies 2. Begin development of a process for each grantmaking strategy	Rob/Geralyn/Sue	July	Broad strategy agreed to by team - <b>DONE</b>
<input checked="" type="checkbox"/> Executive & Compensation Committee revisits broader mission statement	1. Identify origin, values, etc. and develop broader more defined mission statement 2. Present to Board for review/approval	Executive & Compensation committee/Neithercut Philanthropy Advisors	August	E&C Committee approved values and goal and will present to board at September Board meeting - <b>DONE</b>

**MHEF 30-DAY WORK PLAN**  
(November 1 – November 30, 2014)  
(November 4, 2014 Update)

<b>III. Grantmaking</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Present revised paper detailing Board discussion for grantmaking	Prepare paper outlining grantmaking decisions/assumptions	Sue	May	Discussed at the May 19 Board meeting - <b>DONE</b>
<input checked="" type="checkbox"/> Revise 2014 grant making plan	<ol style="list-style-type: none"> <li>1. Using feedback from May and June Board meetings, develop draft plan for 2014 grantmaking</li> <li>2. Review plan with grantmaking committee</li> </ol>	Grantmaking committee/Neithercut Philanthropy Advisors	July	Grantmaking committee revised and approved strategy on July 7. Recommending to Board for approval at July 21 meeting. - <b>DONE</b>
<input checked="" type="checkbox"/> Implement 2014 grantmaking plan.	<p><i>Based on plan approved by Board:</i></p> <ol style="list-style-type: none"> <li>1. Determine list of prospective applicants - <b>DONE</b></li> <li>2. Cull list based on objective criteria related to grantmaking goals - <b>DONE</b></li> <li>3. Conduct structured discussions with invitees</li> <li>4. Draft formal RFP to be sent to invited applicants - <b>DONE</b></li> <li>5. Review applications - <b>DONE</b></li> <li>6. Recommend funding for strongest proposals - <b>DONE</b></li> </ol>	Grantmaking committee/Public Policy Associates/Neithercut Philanthropy Advisors/ GERALYN	July-October	At each Board meeting, report on implementation process. At October Board meeting, present funding recommendations.
<input type="checkbox"/> Develop 2015 grantmaking strategy and program	<p><i>Based on plan approved by Board:</i></p> <ol style="list-style-type: none"> <li>1. Orient grantmaking committee to strategic approach to successful grantmaking – <b>DONE</b></li> <li>2. Work with grantmaking committee to develop focus areas, goals, processes, and MHEF role</li> <li>3. Develop recommendation to Board for 2015 grantmaking</li> </ol>	Grantmaking committee/Neithercut Philanthropy Advisors	July-November	Board reviews/approves 2014 grants at October-December meetings  Review with Board at January 2015 Board meeting

**MHEF 30-DAY WORK PLAN**  
(November 1 – November 30, 2014)  
(November 4, 2014 Update)

<b>IV. Listening and Communications</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Meet with possible contractors for listening sessions	1. Define possible approaches for listening session(s) 2. Outline the activities, timing, and proposed outcome(s)	Geralyn	May/June	<b>DONE</b>
<input checked="" type="checkbox"/> Solicit proposals	Ask for proposals from a limited number of potential contractors	Geralyn	June	<b>DONE</b>
<input checked="" type="checkbox"/> Select a contactor	Prepare recommendation to Board	Geralyn	June/July	Board approves plan at June Board meeting. <b>DONE</b>
<input type="checkbox"/> Develop plan for listening tour	1. Develop goals, strategy, approach - <b>DONE</b> 2. Create MHEF communications points - <b>DONE</b> 3. Identify communities, partners, venues - <b>DONE</b> 4. Schedule sessions/engage Board members - <b>DONE</b> 5. Market each session - <b>DONE</b> 6. Conduct sessions - <b>DONE</b> 7. Analyze results/present to Board	Geralyn/Public Sector Consultants	July - December	Minimum of 2-3 Board members attend each session Sessions aligned with Board meetings when possible Sessions held as scheduled Presentation at December Board meeting

<b>V. Staffing/ ED Search</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Contract with Kittleman	Develop and review contract	Geralyn/Clark Hill	May	Approve contract at May 19 board meeting - <b>DONE</b>
<input checked="" type="checkbox"/> Create position description for CEO	Approve Kittleman's position description	Rob/Geralyn/Kittleman	June	Approval of CEO position description - <b>DONE</b>
<input type="checkbox"/> Determine employee benefits	Identify benefits for MHEF CEO and implications for staff benefits	Rob/Executive & Compensation committee	September/October	Developed benefits analysis for CEO position and presented to Board Chair

**MHEF 30-DAY WORK PLAN**  
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 (November 4, 2014 Update)

<b>V. Staffing/ ED Search</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input type="checkbox"/> Staffing plan	Develop tentative staffing plan for MHEF	Executive & Compensation committee	October/ November	Presented initial staffing plan to committee but further action is on hold until CEO is in place
<input type="checkbox"/> Create job descriptions	Create job descriptions outlining roles and responsibilities of staff	Executive & Compensation committee	October/ November	On hold until staffing determinations are made
<input type="checkbox"/> Human Resources manual	Develop an initial Human Resources policies/employee manual for review by incoming CEO	Rob/Executive & Compensation committee	October/ November	On hold until staffing determinations are made. Will most likely be developed by MHEF staff
<input type="checkbox"/> Review tentative staffing plan with incoming CEO	Present plan to incoming CEO, revise as appropriate.	Incoming CEO/Executive & Compensation committee	November	Board reviews/approves at December meeting, pending CEO placement

<b>VI. Governance</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Committee charges established and approved	Define committees and appoint Board members to lead/participate in committees	Michael	May	Approved at May 19 meeting <b>DONE</b>
<input checked="" type="checkbox"/> Job descriptions for officers and Board members	Create/finalize job descriptions for officers and Board members	Geralyn/Neithercut Philanthropy Advisors	Early June	Board approves at June 16 meeting <b>DONE</b>
<input checked="" type="checkbox"/> Committee Chairs and members appointed	New committees begin operation	Committee chairs	June –July	All will have met at least once by end of July <b>DONE</b>
<input checked="" type="checkbox"/> Policies and procedures for MHEF	1. Identify necessary policies and procedures for MHEF operations and governance 2. Develop policies/procedures for review and approval	Rob/Geralyn/Governance committee/Clark Hill	June – August (initial) September + (ongoing)	Board to approve policy manual in September - <b>DONE</b>

**MHEF 30-DAY WORK PLAN**  
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<b>VI. Governance</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input type="checkbox"/> Meeting minutes taken at Board and committee meetings	1. Board Secretary takes and publishes meeting minutes for Board meeting 2. If requested, PPA team takes and publishes meeting minutes for committee meetings. Otherwise, the committee Chair arranges for minutes to be taken.	Rob/Board Secretary/ Committee chairs/Public Policy Associates	Ongoing	Approval of minutes at the next meeting of the committee or via e-mail prior to meeting

<b>VII. Administration</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Attorney retained	Interim ED and Board Chair recommend a law firm to the Board	Geralyn/Rob	June	Board approves law firm selection at June meeting <b>DONE</b>
<input checked="" type="checkbox"/> Accounting	1. Provide accounting support until an accounting firm is retained 2. Arrange new bookkeeping support	Geralyn/Public Policy Associates	July-November	<b>DONE</b>
<input type="checkbox"/> Consultation on the strategic positioning of the MHEF in philanthropy and health	1. Help develop goals for the MHEF's relationships and roles in the industry 2. Identify opportunities to achieve the goals (events, meetings, etc.). Memberships in Council of Michigan Foundations, Grantmakers in Health, Council on Foundations.	Geralyn/Rob	Ongoing	Board actions as necessary

**MHEF 30-DAY WORK PLAN**  
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VII. Administration				
Activities	Tasks	MHEF Staff/Board	Timeline	Board Decision/Status
<input type="checkbox"/> Support for Board and committees to develop and maintain momentum toward achieving their goals	<ol style="list-style-type: none"> <li>1. Assist Chairs/interim ED with development of agendas, logistics, meeting support, and follow up</li> <li>2. Meetings include: Board planning sessions, Board meetings, weekly Board information calls, committee meetings, weekly leadership updates, and other meetings as necessary</li> <li>3. Support between meetings includes: background research, writing informational pieces, consultation with group chairs, and creating summaries</li> </ol>	Geralyn/Rob/ Committee chairs/ Public Policy Associates/Neithercut Philanthropy Advisors	Ongoing	Five committees operating
<input type="checkbox"/> Office space	<ol style="list-style-type: none"> <li>1. Identify possible locations for MHEF offices - <b>DONE</b></li> <li>2. Create list of all office services, systems, supplies, hardware, and software needed for office - <b>DONE</b></li> <li>3. Prepare temporary office space and other needs for CEO start - <b>DONE</b></li> <li>4. Review permanent office space options with CEO and solidify arrangements</li> </ol>	Geralyn/Rob/Clark Hill	July/August/ September  September/ October  December	Board reviews recommendations  Present temporary option to Board at October meeting
<input type="checkbox"/> Computers and software	<ol style="list-style-type: none"> <li>1. Determine appropriate number of workstations</li> <li>2. Arrange for network installation</li> <li>3. Identify appropriate equipment (e.g., computers, monitors, printers, etc.)</li> </ol>	Geralyn	November/ December	
<input type="checkbox"/> Office furniture and equipment	Determine number of workspaces and necessary furniture items	Geralyn	November/ December	
<input type="checkbox"/> Grantmaking software	<ol style="list-style-type: none"> <li>1. Identify grantmaking software options (e.g., Foundant, GIFTS, etc.)</li> <li>2. Select grantmaking software</li> </ol>	Geralyn/Grantmaking committee	October/ November	

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<b>VII. Administration</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input type="checkbox"/> Communications firms identified and hired	1. Identify communications and branding firms - <b>DONE</b> 2. Contract with communications firm 3. Contract with branding firm 4. Develop branding (e.g., logo, etc.) for MHEF – <b>Sample logos created</b> 5. Develop communication strategy 6. Develop branding	Geralyn/Executive & Compensation committee	August/September	Truscott Rossman selected for communications  Brogan & Partners selected for branding

<b>VIII. Learning (PPA Team Lead: Jeff Leads)</b>				
<b>Activities</b>	<b>Tasks</b>	<b>MHEF Staff/Board</b>	<b>Timeline</b>	<b>Board Decision/Status</b>
<input checked="" type="checkbox"/> Learning plan revised	1. Review notes of Board discussion 2. Identify priority topics 3. Identify potential presenters 4. Develop other learning opportunities 5. Draft plan 6. Present to Board for review/approval	Geralyn/Rob	May/June	Board reviews/approves at June 16 meeting <b>DONE</b>
<input type="checkbox"/> Present 2014 learning opportunities	1. Present 5-6 opportunities at each Board meeting, such as: <ul style="list-style-type: none"> <li>• Listening sessions</li> <li>• Presentations</li> <li>• Readings</li> <li>• Site visits</li> <li>• Conferences</li> <li>• Websites/videos</li> </ul>	Geralyn/Rob/Public Policy Associates/Governance committee	Ongoing	Opportunities presented at each Board meeting since July 21.

# MICHIGAN HEALTH ENDOWMENT FUND

## OPEN MEETINGS

### RULES AND PROCEDURES

#### **I. Meetings of the Board of Directors**

All meetings of the Board of Directors of Michigan Health Endowment Fund (“MHEF”) shall be held in compliance with Public Act 4 of 2013 (the “Act”) and these rules. The business that a board may perform shall be conducted at a meeting of the Board that is held in Michigan, is open to the public, and is held in a place that is available to the general public. At least 10 days and not more than 60 days before a meeting, the board shall provide public notice of its meeting at its principal office and on its internet website. The board shall include in the public notice of its meeting the address where board minutes may be inspected by the public. The business that a board may perform means formal meetings of the Board in which the Board transacts business of the Board by voting. Meetings or forums where Board members gather information and discuss policy, but do not vote, are not formal meetings.

#### **II. Committees**

As further provided in MHEF’s bylaws, committees shall be advisory in nature and may not transact the business of the Board. Committee meetings are not formal meetings of the Board and are not required to be open meetings, except in the discretion of the Committee Chair.

#### **III. Meeting Materials**

At the time of posting a Notice of a Board Meeting, MHEF shall post on its website relevant materials to be considered by the Board at the meeting, if available. Hard copies of board meeting materials will be available to members of the general public at the meeting.

#### **IV. Minutes**

Minutes of meetings of the Board of Directors and of committees shall be prepared by the Secretary and/or a designee, in accordance with the Act. Board and committee minutes shall be open to public inspection, and MHEF shall make the minutes available at the office address designated on the public notice of the meeting. MHEF shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying. Board and committee minutes shall include the date, time and place of the meeting, members who are present

and absent, board decisions made at a meeting open to the public and all roll call votes taken at the meeting.

Minutes shall be submitted to the Board or committee for approval at the next regular meeting after the meeting to which the minutes refer and will be open to public inspection as provided above after their approval.

The Secretary or designee may audiotape a Board meeting to aid in the preparation of minutes of the meeting. Once the meeting minutes have been approved by MHEF, the audiotape of the meeting shall be destroyed.

## V. Conduct of Meetings

### A. Meetings to be public

1. All meetings of the Board shall be open to the public, and members of the general public shall have a reasonable opportunity to be heard in accordance with these rules, except that all or part of a meeting may be closed to the public in accordance with the Act.
2. All non-closed meetings of the Board shall be open to the media, freely subject to recording by radio, television or photographic services at any time, provided that such arrangements do not interfere with the orderly conduct of the meetings.
3. One or more Directors may participate in a meeting of Directors by conference telephone or other means of remote communication by which all persons participating in the meeting may communicate with each other; provided that at least one Director is physically present at the site of the open meeting which is available to the general public so that members of the public may participate in person.

### B. Agenda

Each meeting shall proceed pursuant to an agenda prepared in advance of the meeting by the Chairperson or a designee, with the following order of business:

1. Call to Order
2. Roll Call
3. Approval of Agenda
4. Public Comment
5. Approval of Minutes of Prior Meeting(s)

6. Other Business

7. Adjournment

Dates of future scheduled meetings will be identified on the agenda.

Consideration of other specific items of business may take place at such point in the meeting as the Board may determine, and shall be listed on the meeting agenda.

The agenda shall be distributed to Board members in advance of the meeting.

C. Quorum and Voting

Six members of the Board constitute a quorum for the transaction of business at Board meetings. In the absence of a quorum, a lesser number may adjourn any meeting to a later time or date with appropriate public notice. An affirmative vote of five board members is necessary for official action of the Board.

D. Presiding Officer

The presiding officer shall be responsible for enforcing these rules of procedure and for enforcing orderly conduct at meetings. The Chairperson will ordinarily act as presiding officer. The Board shall appoint one of its members Vice-Chairperson, who shall preside in the absence of the Chair. In the absence of both the Chairperson and the Vice-Chairperson, the remaining Board members shall elect one of their number to preside.

E. Disorderly Conduct

The presiding officer may call to order any person who is being disorderly by speaking out of order or otherwise disrupting the proceedings, failing to be germane, speaking longer than the allotted time or speaking vulgarities. Such person shall be seated until the presiding officer determines whether the person is in order.

If the person so engaged in presentation is called out of order, he or she shall not be permitted to continue to speak at the same meeting except by express leave of the Board. If the person shall continue to be disorderly and disrupt the meeting, the presiding officer may order the removal of the person from the meeting by law enforcement personnel or other persons as appropriate. No person shall be removed from a public hearing except for an actual breach of the peace committed at the meeting.

**VI. Closed Meetings.**

A. Purpose

Closed meetings may be held only for the reasons authorized in the Act.

B. Calling a closed meeting

The Board by roll call vote of all Board members elected may call a closed session. The roll call vote and purpose(s) for calling the meeting shall be entered into the minutes of the open part of the meeting at which the vote is taken.

C. Minutes of closed meeting

A separate set of minutes shall be taken by the Secretary or designee at the closed session. These minutes will be retained by the Secretary, shall not be available to the public, and shall only be disclosed if required by a civil action. These minutes may be destroyed one year and one day after approval of the minutes of the regular meeting at which the closed session was approved.

**VII. Discussion and voting**

A. Conduct of discussion

The presiding officer shall preserve order and decorum. The presiding officer, at his or her discretion, may permit any person to address the Board during its deliberations.

B. Voting Method

The Board shall take action by way of motions. No motion may be acted upon until it has been duly seconded by a Board member. The vote on motions shall be by "yes" or "no," and will be taken by voice vote or, upon the request of any Board member or the discretion of the presiding officer, a roll call vote, with names called alphabetically. Following each vote, the chair shall announce that the motion carried or failed by a vote of \_\_\_ affirmative votes to \_\_\_ negative votes. The minutes shall indicate whether a motion passed or failed. At the discretion of the chairperson, Board members may be given the privilege of explaining for the record any vote.

A Board member voting in the majority on an issue may move for a reconsideration of the vote on that question at that meeting or the next succeeding meeting of the Board. When a motion to reconsider fails, it cannot be renewed.

**VIII. Citizen Participation**

The following rules govern statements by members of the public during the periods of Board meetings reserved for such comments or in which such comments are permitted:

- A. The presiding officer shall recognize members of the public who indicate a desire to address the Board. Where a large number of speakers is expected, a sign-up system may be employed to insure that all are provided with the opportunity to speak.
- B. No individual's comment shall exceed three minutes without the express permission of the presiding officer. If an individual is speaking on behalf of an organization, such individual may speak for up to five minutes, but no other representative of such organization will be recognized.
- C. Each speaker shall begin his or her comments by identifying himself or herself by name and address.
- D. Individuals addressing the Board shall take into consideration and be governed by the rules of common courtesy. The presiding officer may terminate the comments of a person who violates such rules.
- E. Public comments, including questions, should be addressed to the presiding officer. Board members may question or respond to speakers, but are not obligated to do so. The presiding officer may, but is not obligated to, call upon MHEF staff, employees or officers, if present, to respond to a question or comment from a member of the public, or may refer such questions or comments to MHEF staff, employees or officers for consideration.

## **IX. Miscellaneous**

### **A. Amendment of rules**

The Board may alter or amend these rules at any time by a vote of the Board.

### **B. Suspension of rules**

These rules may be suspended for a specified portion of a meeting by the vote of the Board, except that Board actions shall conform to state statutes.



# Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

## Board of Directors

Robert Fowler  
*Chairperson*

Lynn Alexander  
*Vice Chairperson*

Timothy Damschroder  
*Treasurer*

Cindy Estrada  
*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

## Interim Executive Director

Geralyn Lasher

## Michigan Health Endowment Fund Acceptance of Benefits from Vendors or Grant Seekers

Michigan Health Endowment Fund (the "Fund") recognizes that directors, non-director committee members, officers, and employees of the Fund have professional and personal relationships from which they may receive certain benefits; however, in their capacity as directors, non-director committee members, officers, and employees of the Fund, they may not knowingly accept any gift or item of value from any person if the offer or acceptance of the gift or item of value could reasonably be construed to be an attempt to influence action on an actual or prospective grant from, or contract with, the Fund. An "item of value" would include, but not be limited to, tickets to sporting events, performances, fundraisers, and other events, provided, however, that reasonable meals and beverages furnished in conjunction with the business and affairs of the Fund will not be prohibited. Further, it is not appropriate for a representative of the Fund to accept honoraria, gifts, or similar means of payment for speaking engagements or other appearances. In that regard, travel and related expenses of Fund representatives will be paid or reimbursed in accordance with approved policies.



# Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

## Michigan Health Endowment Fund Conflict of Interest Review Procedure

### Board of Directors

Robert Fowler  
*Chairperson*

Lynn Alexander  
*Vice Chairperson*

Timothy Damschroder  
*Treasurer*

Cindy Estrada  
*Secretary*

Susan Jandernoa

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Michael Williams

### Interim Executive Director

Geralyn Lasher

1. Legal counsel and staff will review completed conflict of interest questionnaires and identify whether there are any potential conflicts.
2. Legal counsel and staff will report to the Governance Committee and the full Board whether there are any potential or current conflicts.
3. Staff will update the Disclosure List, which summarizes the entities that have been disclosed by Board members as potentially giving rise to conflicts of interest or the appearance of conflicts of interest. The Disclosure List will include a brief description of the entity and identify the affiliated Board member.
4. The Disclosure List will be distributed to the Governance Committee, Grantmaking Committee, and Executive and Compensation Committee, as well as staff of the MHEF.
5. The Governance Committee will be the primary monitor for reviewing conflicts of interest, although staff will assist with the process. Each Board member also has an ongoing obligation to disclose additional affiliations or potential conflicts as they arise.
6. If the Executive and Compensation Committee becomes aware of a potential contract or arrangement between the MHEF and a Board member (or family member) or an entity that is affiliated with a Board member or a family member, the committee will refer the conflict to the Governance Committee to consider.
7. As the Grantmaking Committee receives and reviews grant applications, it will notify the Governance Committee of any entities on the list that have applied for grants. In addition, if the Grantmaking Committee is considering distributing funds to an entity that has not submitted a formal grant application, it will notify the Governance Committee.
8. The Governance Committee will make a notation on the Disclosure List regarding entities that have applied for or are being considered for a grant.
9. The Governance Committee will review and consider all potential conflicts that have been brought to its attention and present its recommendations to the full Board. The Governance Committee will review and consider comparability data as appropriate.

Date: \_\_\_\_\_



# Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

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## Interim Executive Director

Geralyn Lasher

# Michigan Health Endowment Fund

## Diversity, Equity, and Inclusion Policy

### DRAFT – October 2, 2014

The Board of Directors is committed to diversity, equity, and inclusion in achieving the MHEF's mission. By ensuring equal opportunity for Michigan residents irrespective of race, ethnicity, religious beliefs, gender, sexual orientation, gender identity or expression, age, medical condition, or mental or physical disability, to be engaged in the Fund's work, the MHEF will access a wide range of ideas, information, perspectives, and experiences.

The Board charges the CEO to develop and implement a plan to ensure that these principles are essential elements of the MHEF's administration and grantmaking. This will include practicing equal opportunity through:

- Promoting equal opportunity in Fund business transactions.
- Recruiting and employing qualified staff that reflect the diversity of the community, county, and region.
- Providing grants to organizations that reflect the communities they serve. This is done in a manner that demonstrates equality of skills, talents, and diversity on both staff and Board levels.
- Contracting with diverse qualified vendors, contractors, and consultants.

The Board will annually evaluate the CEO regarding the Fund's administration of the equal opportunity plan.



## Michigan Health Endowment Fund Travel Reimbursement Policy

**DRAFT – August 26, 2014**

### Board of Directors

Robert Fowler  
*Chairperson*

Lynn Alexander  
*Vice Chairperson*

Timothy Damschroder  
*Treasurer*

Cindy Estrada  
*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

### Interim Executive Director

Geralyn Lasher

#### 1. Necessity of Travel

Any person requesting to travel on behalf of the Michigan Health Endowment Fund shall demonstrate how their proposed travel will benefit the organization.

#### 2. Authorization and Approval

All travel requires prior approval by a reviewing party, unless otherwise impractical:

- Approval for directors and officers of the Fund will come from the CEO of the Fund.
- Approval for the CEO of the Fund will come from the Treasurer of the Fund.
- Approval for staff will come from the traveler's supervisor.
- Approval for consultants, contractors, and speakers will come from the CEO of the Fund.

#### 3. Expense Reports and Receipts

To receive reimbursement of funds, a signed written expense report, including itemized original receipts for each expense, must be provided within 30 days of the conclusion of travel.

The CFO of the fund is responsible for reviewing and approving expense reports.

#### 4. Travelers Eligible for Reimbursement

Travelers eligible for reimbursement include any person traveling at the request of the Fund, including, but not limited to, Board members, staff, consultants, contractors, and speakers.

Board members are also eligible for reimbursement for travel expenses incurred during travel to and from Board meetings consistent with Part 6A, Sect. 651.8 of Public Act 4 of 2013.

**5. Travelers Ineligible for Reimbursement**

Travelers ineligible for reimbursement include spouses, partners, and children unless traveling at the request of the CEO or Board Chair.

**6. Air Travel**

The Fund will reimburse the actual and reasonable cost of coach travel.

Authorized persons traveling at the request of the Fund will take advantage of discounts available through advanced booking, unless impractical.

Travelers are permitted to accept Frequent Flyer miles and delayed flight compensation.

**7. Auto Rentals**

The Fund will reimburse automobile rentals consistent with the reasonable mid-size rate.

**8. Personal Auto**

The Fund will reimburse personal automobile use consistent with the IRS mileage rate.

Reimbursement for personal automobile use may not exceed the lowest available round trip coach rate.

**9. Ground Transportation**

The Fund will reimburse the actual reasonable costs of public transportation, courtesy vans, cabs, etc.

**10. Parking and Tolls**

The Fund will reimburse the reasonable costs of parking and tolls.

**11. Lodging**

The Fund will reimburse lodging at the single room rate for the actual cost of standard accommodations, unless prior approval is granted from the CEO.

The Federal per diem rate for the location will be used as a benchmark.

**12. Meals**

The Fund will reimburse the actual reasonable cost of meals.

The Federal per diem rate for the location will be used as a benchmark.

### **13. Entertainment and Business Meetings**

The Fund will reimburse reasonable expenses for business-related activity if approved in advance.

### **14. Other**

The Fund will reimburse reasonable business-related Internet, phone, and fax costs incurred during hotel stays.

### **15. Personal Travel**

Travelers may incorporate personal travel with Fund business trips if they meet the following criteria:

- The schedule of the trip does not interfere with the business of the Fund.
- Business trip costs are not increased due to the addition of personal travel.
- The traveler is responsible for any additional costs related to personal travel.



## ROBERTS RULES CHEAT SHEET

To:	You say:	Interrupt Speaker	Second Needed	Debatable	Amendable	Vote Needed
Adjourn	"I move that we adjourn"	No	Yes	No	No	Majority
Recess	"I move that we recess until..."	No	Yes	No	Yes	Majority
Complain about noise, room temp., etc.	"Point of privilege"	Yes	No	No	No	Chair Decides
Suspend further consideration of something	"I move that we table it"	No	Yes	No	No	Majority
End debate	"I move the previous question"	No	Yes	No	No	2/3
Postpone consideration of something	"I move we postpone this matter until..."	No	Yes	Yes	Yes	Majority
Amend a motion	"I move that this motion be amended by..."	No	Yes	Yes	Yes	Majority
Introduce business (a primary motion)	"I move that..."	No	Yes	Yes	Yes	Majority

The above listed motions and points are listed in established order of precedence. When any one of them is pending, you may not introduce another that is listed below, but you may introduce another that is listed above it.

To:	You say:	Interrupt Speaker	Second Needed	Debatable	Amendable	Vote Needed
Object to procedure or personal affront	"Point of order"	Yes	No	No	No	Chair decides
Request information	"Point of information"	Yes	No	No	No	None
Ask for vote by actual count to verify voice vote	"I call for a division of the house"	Must be done before new motion	No	No	No	None unless someone objects
Object to considering some undiplomatic or improper matter	"I object to consideration of this question"	Yes	No	No	No	2/3
Take up matter previously tabled	"I move we take from the table..."	Yes	Yes	No	No	Majority
Reconsider something already disposed of	"I move we now (or later) reconsider our action relative to..."	Yes	Yes	Only if original motion was debatable	No	Majority
Consider something out of its scheduled order	"I move we suspend the rules and consider..."	No	Yes	No	No	2/3
Vote on a ruling by the Chair	"I appeal the Chair's decision"	Yes	Yes	Yes	No	Majority

The motions, points and proposals listed above have no established order of preference; any of them may be introduced at any time except when meeting is considering one of the top three matters listed from the first chart (Motion to Adjourn, Recess or Point of Privilege).

## PROCEDURE FOR HANDLING A MAIN MOTION

**NOTE:** Nothing goes to discussion without a motion being on the floor.

### Obtaining and assigning the floor

A member raises hand when no one else has the floor

- The chair recognizes the member by name

### How the Motion is Brought Before the Assembly

- The member makes the motion: *I move that (or "to") ...* and resumes his seat.
- Another member seconds the motion: *I second the motion* or *I second it* or *second*.
- The chair states the motion: *It is moved and seconded that ... Are you ready for the question?*

### Consideration of the Motion

1. Members can debate the motion.
2. Before speaking in debate, members obtain the floor.
3. The maker of the motion has first right to the floor if he claims it properly
4. Debate must be confined to the merits of the motion.
5. Debate can be closed only by order of the assembly (2/3 vote) or by the chair if no one seeks the floor for further debate.

### The chair puts the motion to a vote

1. The chair asks: *Are you ready for the question?* If no one rises to claim the floor, the chair proceeds to take the vote.
2. The chair says: *The question is on the adoption of the motion that ... As many as are in favor, say 'Aye'. (Pause for response.) Those opposed, say 'Nay'. (Pause for response.) Those abstained please say 'Aye'.*

### The chair announces the result of the vote.

1. *The ayes have it, the motion carries, and ...* (indicating the effect of the vote) or
2. *The nays have it and the motion fails*

### WHEN DEBATING YOUR MOTIONS

1. Listen to the other side
2. Focus on issues, not personalities
3. Avoid questioning motives
4. Be polite

## HOW TO ACCOMPLISH WHAT YOU WANT TO DO IN MEETINGS

### MAIN MOTION

You want to propose a new idea or action for the group.

- After recognition, make a main motion.
- Member: "Madame Chairman, I move that \_\_\_\_\_."

### AMENDING A MOTION

You want to change some of the wording that is being discussed.

- After recognition, "Madame Chairman, I move that the motion be amended by adding the following words \_\_\_\_\_."
- After recognition, "Madame Chairman, I move that the motion be amended by striking out the following words \_\_\_\_\_."
- After recognition, "Madame Chairman, I move that the motion be amended by striking out the following words, \_\_\_\_\_, and adding in their place the following words \_\_\_\_\_."

### REFER TO A COMMITTEE

You feel that an idea or proposal being discussed needs more study and investigation.

- After recognition, "Madame Chairman, I move that the question be referred to a committee made up of members Smith, Jones and Brown."

### POSTPONE DEFINITELY

You want the membership to have more time to consider the question under discussion and you want to postpone it to a definite time or day, and have it come up for further consideration.

- After recognition, "Madame Chairman, I move to postpone the question until \_\_\_\_\_."

### PREVIOUS QUESTION

You think discussion has gone on for too long and you want to stop discussion and vote.

- After recognition, "Madam President, I move the previous question."

### LIMIT DEBATE

You think discussion is getting long, but you want to give a reasonable length of time for consideration of the question.

- After recognition, "Madam President, I move to limit discussion to two minutes per speaker."

**POSTPONE INDEFINITELY**

You want to kill a motion that is being discussed.

- After recognition, "Madam Moderator, I move to postpone the question indefinitely."

**POSTPONE INDEFINITELY**

You are against a motion just proposed and want to learn who is for and who is against the motion.

- After recognition, "Madame President, I move to postpone the motion indefinitely."

**RECESS**

You want to take a break for a while.

- After recognition, "Madame Moderator, I move to recess for ten minutes."

**ADJOURNMENT**

You want the meeting to end.

- After recognition, "Madame Chairman, I move to adjourn."

**PERMISSION TO WITHDRAW A MOTION**

You have made a motion and after discussion, are sorry you made it.

- After recognition, "Madam President, I ask permission to withdraw my motion."

**CALL FOR ORDERS OF THE DAY**

At the beginning of the meeting, the agenda was adopted. The chairman is not following the order of the approved agenda.

- Without recognition, "Call for orders of the day."

**SUSPENDING THE RULES**

The agenda has been approved and as the meeting progressed, it became obvious that an item you are interested in will not come up before adjournment.

- After recognition, "Madam Chairman, I move to suspend the rules and move item 5 to position 2."

**POINT OF PERSONAL PRIVILEGE**

The noise outside the meeting has become so great that you are having trouble hearing.

- Without recognition, "Point of personal privilege."
- Chairman: "State your point."
- Member: "There is too much noise, I can't hear."

## COMMITTEE OF THE WHOLE

You are going to propose a question that is likely to be controversial and you feel that some of the members will try to kill it by various maneuvers. Also you want to keep out visitors and the press.

- After recognition, "Madame Chairman, I move that we go into a committee of the whole."

## POINT OF ORDER

It is obvious that the meeting is not following proper rules.

- Without recognition, "I rise to a point of order," or "Point of order."

## POINT OF INFORMATION

You are wondering about some of the facts under discussion, such as the balance in the treasury when expenditures are being discussed.

- Without recognition, "Point of information."

## POINT OF PARLIAMENTARY INQUIRY

You are confused about some of the parliamentary rules.

- Without recognition, "Point of parliamentary inquiry."

## APPEAL FROM THE DECISION OF THE CHAIR

Without recognition, "I appeal from the decision of the chair."

## Rule Classification and Requirements

Class of Rule	Requirements to Adopt	Requirements to Suspend
Charter	Adopted by majority vote or as proved by law or governing authority	Cannot be suspended
Bylaws	Adopted by membership	Cannot be suspended
Special Rules of Order	Previous notice & 2/3 vote, or a majority of entire membership	2/3 Vote
Standing Rules	Majority vote	Can be suspended for session by majority vote during a meeting
Modified Roberts Rules of Order	Adopted in bylaws	2/3 vote



**Board of Directors**

Robert Fowler  
*Chairperson*

Lynn Alexander  
*Vice Chairperson*

Timothy Damschroder  
*Treasurer*

Cindy Estrada  
*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

**Interim Executive Director**

Geralyn Lasher

## Learning Materials Update

November 21, 2014

## Conferences/Meetings/Educational Opportunities

### Grantmakers in Health

#### 2015 Grantmakers in Health Annual Conference on Health Philanthropy

Theme: Pathways to Health

Austin, Texas

March 4 – 6, 2015

JW Marriott Austin Texas

Preconference Session: The Art & Science of Health Grantmaking

March 4, 2015

<http://tinyurl.com/pdmquyl>

### Harvard School of Public Health

#### Beyond the Affordable Care Act: The Next Frontiers for U.S. Health Reform

Harvard University faculty will offer key lessons and evidence from the ACA's implementation, focused on the impact reform is having on the health care industry, local and state government, and business. This program will enhance participants' capacity to anticipate and address health policy shifts that will impact their organizations.

Harvard University

April 27 – 29, 2015

Boston, Massachusetts

<https://ecpe.sph.harvard.edu/programs.cfm?CSID=ACA0415&pg=cluster&CLID=1>

# Learning Materials

## Focus: Health Care Costs and Cost Reduction

### Graphics

#### Health Care Costs: A State-by-State Comparison

Louise Radnofsky

*Wall Street Journal* report, April 8, 2013

1 page each

Article and Links to Maps and Table: <http://tinyurl.com/pbq4o5r>

Maps: <http://tinyurl.com/o3zr3on>

Table: <http://tinyurl.com/pz6ttsj>

**Summary:** The most recent state-level data (2009) on average per-capita spending for hospital care, physician services, and prescription drugs are listed by state in a table and illustrated in a set of maps. The tabulations and map also include data for state-level adult obesity rates. Michigan is listed as having the fifth highest adult obesity rate among the states, but Michigan also is listed as having the fifth lowest average per-capita spending for physician and other clinical services.

### Articles/Research Reports

#### Health Care Costs in Michigan: Drivers and Policy Options

Citizens Research Council of Michigan, May 2013

91 pages

<http://tinyurl.com/poxu55y>

**Summary:** This report is a comprehensive analysis of all of the well-known factors that contribute to health care costs and how these factors apply to specific conditions in the State of Michigan. Policy options that may be implemented in Michigan are also presented for each of these factors. Factors that contribute to rising health care costs that are discussed include prices for services, levels of utilization, health behaviors, chronic disease, payment systems, administrative costs, malpractice insurance, certificate of need rules, technology, no-fault auto insurance, and end-of-life care. This report addresses general issues that affect all health care systems and providers in the state and, thus, excludes any discussion of how direct state health care expenditures, such as for state government employee health insurance costs or Medicaid, could be modified. This report was prepared prior to Medicaid expansion through the Healthy Michigan program.

#### Health Care Costs: A Primer, Key Information on Health Care Costs and Their Impact

The Henry J. Kaiser Family Foundation, May 2012

34 pages

<http://tinyurl.com/n5oa2ec>

**Summary:** This is a comprehensive summary of the major factors associated with health care costs in the United States and factors that contribute to growth in health care costs. Key topics covered include recent health care costs in the U.S., what health expenditures pay for and who pays for them, why

health care costs are growing faster than the overall economy, and some suggestions for reducing the level of spending, if not the rate of growth.

### **Improving Health While Reducing Cost Growth: What is Possible?**

Mark McClellan, Alice M. Rivlin, and Leonard D. Schaeffer

The Brookings Institution, April 11, 2014

24 pages

<http://tinyurl.com/nwp6a2o>

**Summary:** Three strategies for avoiding wasteful health care spending are examined: (1) reduce inefficiencies in health care spending by moving away from paying for volume of services to quality of outcomes; (2) address lack of competition by raising incentives for consumers to choose cost-effective treatments and providers; and (3) improve population health by shifting the emphasis away from sickness and treatment towards prevention and healthy living. Successful examples of each approach are examined and simulations of the impact on changes in future health care spending are presented with forecasts to 2020, 2030, and 2040 for each. Some of the approaches are promising, but definitive recommendations are not presented due to the limited extent of currently available data.

### **Cracking the Code on Health Care Costs: A Report by the State Health Care Cost Containment Commission**

Hon. Michael Leavitt and Hon. Bill Ritter, Jr.

State Health Care Cost Containment Commission, The Miller Center, University of Virginia, Charlottesville, VA, January 2014

Executive summary, 12 pages; full report, 116 pages

Executive Summary: <http://tinyurl.com/pxvsbqy>

Full Report: <http://tinyurl.com/p3u3vzc>

**Summary:** States play a major role in influencing health care and its delivery system. States have a number of policy levers that can influence the pursuit of increased health care system efficiency and enhanced quality as well as reduced wastefulness and unreasonable price increases. These levers include how states manage Medicaid, children's health insurance programs, and their own employees' health plans; state laws involving scope of practice, insurance regulation, and malpractice; availability (or its lack) of pricing and quality information; public health policies and initiatives; and the opportunity for governors to work with legislators and other stakeholders to promote change.

### **8 Facts that Explain What's Wrong with American Health Care**

Sarah Kliff

Vox Media, September 2, 2014

12 pages

<http://tinyurl.com/mfgwsg9>

**Summary:** Included are brief summaries of several fundamental aspects of the American health care system and their impacts on health care costs. Health care cost issues include U.S. health spending as a percentage of the total economy, utilization and costs, how financial incentives promote higher costs, the cost of federal health programs, and wasteful health care spending. Links to other data and videos are also provided.

**Commentary: Common sense health care reforms can save billions**

David Hutton

Bridge, August 19, 2014

1 page

<http://tinyurl.com/mzr2eat>

**Summary:** Important health care cost savings may be realized by focusing on the value of the treatment or drug, not just its cost, and these changes could (and should) be incorporated into health care insurance redesign.

**A Modified “Golden Rule” for Health Care Organizations**

Creagh Milford and Timothy Ferris

*Mayo Clinic Proceedings*, volume 87, issue 8 (August 2012): pages 717-720, Mayo Foundation for Medical Education and Research, Rochester, MN

<http://tinyurl.com/ll9dhm3>

**Summary:** Using the experience of a large, integrated health system in Boston, Massachusetts, the authors describe the most salient features of an Accountable Care Organization (ACO) that is designed to reduce health care costs, particularly for Medicare and Medicaid patients. In this approach, cost containment is a shared risk among groups of physicians who are rewarded for adopting group-wide initiatives, meeting external quality criteria, and limiting the growth of medical expenses, mainly by referring patients to specialists who are also participating in the ACO. A key feature of this article is a chart that clearly illustrates 20 tactics for improving quality and reducing costs in each of three health care settings—primary care, specialty care, and hospital care.

## Focus: Children’s Health

### Journal Article

**Reducing Sugar-Sweetened Beverage Consumption by Providing Caloric Information: How Black Adolescents Alter Their Purchases and Whether the Effects Persist**

Sara N. Bleich, Colleen L. Barry, Tiffany L. Gary-Webb, and Bradley J. Herring, *American Journal of Public Health*. Posted online on October 16, 2014. Article only available to subscribers.

<http://tinyurl.com/lulesbt> (abstract only)

**Summary:** Reducing Sugar-Sweetened Beverage Consumption by Providing Caloric Information. *Advances*, online monthly newsletter from the Robert Wood Johnson Foundation, October 16, 2014.

<http://tinyurl.com/p9mmd9>

**Summary:** Posters listing the caloric content of beverages, the amount of sugar in beverages, and the amount of exercise needed to burn off those calories were posted at six stores in Baltimore, Maryland. Analysis of beverage purchases by African-American adolescents demonstrated significant reductions in the caloric content of beverages purchased where posters were displayed. Reduced consumption of sugary beverages continued below the original baseline amounts even after the posters were removed, thus demonstrating impact of providing adolescents with information on their purchase of sugar-sweetened drinks.

## Video

### **The Need for Healthier Beverage Recommendations**

Mary Story and Tracy Fox

*Advances*, online monthly newsletter from the Robert Wood Johnson Foundation, October 16, 2014

<http://tinyurl.com/ou236k5>

**Summary:** This is a brief discussion of the need for and the potential use of healthy beverage guidelines.

## Focus: Health Information Technology

### Slide Show

#### **15 Game-Changing Wireless Devices to Improve Patient Care**

David Lee Scher, MD, and Neil Chesanow

Medscape In Focus, October 23, 2014

WebMD, 17 slides

<http://tinyurl.com/kt3xyy4>

**Summary:** Most Baby Boomers and Gen Xers prefer to age at home, but an overwhelming majority believe that today's remote monitoring technology is not sufficiently advanced to predict a potential adverse event and alert a monitoring provider before disaster strikes at home. This slide show indicates that remote monitoring devices available right now refute this belief and “hold the promise of revolutionizing patient care in hospitals, in nursing homes, and at home.” Remote monitoring also provides the potential benefit of preventing hospital- or nursing-home-acquired infections.



APPLICANT: EASTER SEALS–MICHIGAN INC.

SYNOPSIS: Requests a grant of \$4.7 million for support of the design and launch of a trauma screening and assessment program for Michigan children. **The Grantmaking Committee recommends that the Board award a grant of \$4.1 million.**

BACKGROUND:

Easter Seals was founded in 1919 as the National Society for Crippled Children. The organization changed its name to Easter Seals in 1967, after that name had become synonymous with the stickers or “seals” used for fundraising and marketing purposes during the Easter season. The organization has evolved through the years and now helps people of all ages with disabilities — particularly behavioral, physical, and developmental challenges.

Last year, Easter Seals launched a new program called the Brain Health Center, which focuses on implementing recent scientific breakthroughs on brain health to help people lead lives that are more productive.

Easter Seals–Michigan (ESM) is a 501(c)(3) autonomous affiliate of the national Easter Seals organization. ESM served 9,000 people in 2013 at its 10 service centers in Oakland and Macomb counties, and in Flint and Grand Rapids. The organization employs 380 people and has an operating budget of \$41 million, most of which comes from the Oakland County Community Mental Health Association.

CURRENT REQUEST:

*Project Description*

Easter Seals–Michigan requests a grant of \$4.7 million for support of the design and launch of a trauma screening and assessment program for Michigan children.

ESM explains that trauma experienced early in life can lead to significant health problems later. For example, ESM cites research indicating that early trauma is closely associated with adult obesity, substance abuse, hypertension, and diabetes. Approximately 70 million Americans have suffered some type of cognitive condition, and these individuals have a 40 percent greater chance of developing other serious health conditions later in life.

ESM proposes to design a Web-based assessment tool that teachers, pediatricians, and others can use to conduct an initial screening of a child suspected of having experienced a childhood trauma. As part of the project, this tool would be marketed to schools, health centers, and primary care physicians across the state. ESM projects that 10,000 screenings would occur during the proposed three-year project, and they estimate that 6,670 of these screenings would require further face-to-face assessments by ESM staff. Based on the screenings, ESM would design an appropriate health management plan for each child.

ESM has collaborated with the Southwest Michigan Children’s Trauma Assessment Center (CTAC) at Western Michigan University on the development of this program. CTAC has trained ESM staff, who have conducted 70 assessments to date. ESM will conduct the proposed face-to-face assessments at four of their existing sites in Oakland, Macomb, Kent and Genesee counties, and at 10 other partner sites (four of which are yet to be identified).

### Sustainability

In terms of the project’s long-term outcome, ESM projects that thousands of Michigan youth will lead healthier adult lives due to the early identification and treatment of youth trauma. ESM anticipates the project will be sustainable because the pilot project will provide the funding to build the infrastructure to support the continuum, including the screening and referral website, the training resources, the marketing activities, the evaluation activities and initial capacity expansion for assessment services, treatment services, and navigation support. The community education outreach will have lasting impact on awareness with healthcare professionals, and ESM plans to bill third party payors for other assessment and treatment related activities. Finally, ESM feels that this project will support efforts for benefit reimbursement for the continuum of trauma care informed care for children.

### Budget

The budget for the proposed project totals \$5.3 million, of which ESM is requesting \$4.7 million. The balance is expected from third-party insurance and the Michigan Department of Human Services. The budget includes:

\$1,900,000	16 staff persons for mobile trauma teams
\$1,300,000	Trauma assessments at partner sites
\$225,000	Screening rooms at 10 sites
\$245,000	Program management
\$100,000	Outreach
\$100,000	Community education

### FINANCIAL:

For the fiscal year ending September 30, 2013, Easter Seals–Michigan had total revenue of \$39 million and total expenses of \$37 million, according to its certified financial audit. Total net assets were \$623,254.

### DISCUSSION:

The proposed project seems to be a very good fit with the interests of the Michigan Endowment Health Fund because it:

- Incorporates some of the latest thinking on brain health and adverse childhood experiences (ACEs), which Faith Mitchell of Grantmakers in Health identified as one of the most promising trends in health philanthropy.

- Proposes the use of web-based screening in pediatrician offices is an innovative use of technology.
- Is a promising example of the integration of physical and mental health services.

Staff had concerns, however, regarding the fact that:

- The proposed rapid expansion of the program, especially given that this is a relatively new field for the agency.
- ESM has done 70 of the advanced trauma assessments in the past, and proposes to do more than 2,150 over the next few years using a large number of new staff members at many new sites.
- Some of the proposed new sites have not identified.

With mental health needs being a priority area for the fund, staff felt the grant to Easter Seals-Michigan would be a good fit. Therefore, staff asked ESM to consider a less rapid rollout with a reduced budget of \$4.1 million. In response, ESM has agreed to consider focusing this program on eight sites instead of 14, and conducting 7,755 initial screenings instead of 10,000.

#### 11/5/12 Update:

*At the Board of Director's meeting on October 20, 2014, the Board voiced concerns in two areas:*

1. *Whether ESM can sustain the number of staff that will be added to support the project once the project ends, and:*
2. *Whether the organization could sustain managing the amount of money that would be awarded with the approved grant.*

*MHEF staff had a conversation with representatives from ESM following the board meeting, during which ESM provided additional information to address these concerns. The organization has a comprehensive business infrastructure and has an average annual revenue of \$39 million and daily average cash on hand between \$1 and \$2 million. Currently 80 percent of every dollar of revenue is allocated toward staff.*

*ESM has neurodevelopmental assessment (NDA) operating successfully at one site and is interested in replicating that at other sites through this grant. The new-hire staff necessary to support the expansion of these programs will be retained through a number of activities including internal fundraising efforts, DHS demonstrated support for neurodevelopmental assessment, funding through local partnerships (e.g. PIHP) and the new ESM Foundation that is being established through their strategic plan that will be centered on meeting unmet needs in the community (including brain health).*

#### RECOMMENDATION:

**The Grantmaking Committee recommends the Board award a grant of \$4.1 million to Easter Seals–Michigan for support of the design and launch of a trauma screening and assessment program for Michigan children in eight trauma sites including: ESM direct**

**service sites, Upper Peninsula, Isabella County (Chippewa Site), and Kalamazoo County (CTAC Main Site).**

PROJECT SCHEDULE:

Begin Date  
December 1, 2014

End Date  
September 30, 2017

11/13/14

## Easter Seals Michigan (ESM)

### ESM Organizational Information:

- 95 Years of sustained services in Michigan
- \$41.0 Million Revenue (Includes \$2.0 million fundraising)
- Daily Average Cash on Hand Between \$1.0 million and \$2.0 Million
- Serving over 9,000 Consumers annually, annual growth of 15% over five years
- Continuous financial progress, over the past five years ESM annual revenues have grown by 21%, Assets by 67%, and Net Assets (equity) has grown by over 200% resulting from accumulative reported net income. Meanwhile ESM has a 100% Liquidity.
- Long history of successful fundraising for innovative services and advocating for unmet needs in the communities (i.e. Autism services)
- Dedicated team to support rigorous monitoring to track impactful outcomes, such as reduction of healthcare costs (see QI/UM below).
- Brain Health is the essence of 95% of the mental health services ESM provides.
- ESM employs a strategic marketing approach to innovative projects.

### Business Operations Infrastructure (39 FTE Listed Below):

- Accounting, Finance, Budgeting, Treasury (5 FTE) / Account For 85 Program Divisions, Including 320 Cost Centers
- Billing (3 FTE) / Paneled with 25 Primary Insurers (3<sup>rd</sup> Party Billings)
- Contract & Grants (1 FTE) / Reporting and Compliance
- IT/IS (6 FTE) / Includes Five Electronic Medical Record System Interface and/or Direct Programing, Virtual options for over 350 Staff, Office and in the Community Services
- Human Resources (5 FTE) / Employment, Benefits, Training over 400 FTE Employees managing 20% Turnover (below industry standard)
- QI/UM (9 FTE) / All matters of Compliance, Accreditations, Utilization and Outcomes
- Facilities (3.5 FTE) / Ten Sites (15 buildings)
- Marketing and Development (6.5 FTE) / Program marketing, media communications, philanthropic operations.

### Grant Considerations:

- ESM Direct Service Provider, not pass through agency.
- Launching Programs is a core strength of ESM (noting 85 current diverse programs and service types and costs centers)
- Comprehensive business infrastructure currently operational at ESM (detailed above)
- Brain Health Program request: 3- Year Program (to secure outcomes to promote sustainability, thereby annual outlay (risk) for ESM less than 2-year pilots.
- NDA (Neurodevelopmental Assessment) has been operational at one site (with initial support from Flinn Foundation) pilot since 2013, perfecting the service and providing readiness (Train the Trainer), MHEF request essentially for scale up and increase Statewide impact, and expand outcomes data necessary for sustainability.
- Funding Opportunities for Sustainability and Staff Retention:
  - DHS demonstrated support for NDA (level 3), advocacy and expansion.
  - For CTA (level 2) some service components currently covered under 3<sup>rd</sup> party insurers (as paneled provider negotiate fee for service revenue)
  - PIHP's funding (promoted funding through our current partnerships, all locations counties)
  - ESM Fundraising strengths, currently directed to new service site, available in three years for sustainability
  - Strategic Plan mandate for new Foundation centered on meeting unmet needs in the community (including funding for Brain Health)
  - ESM outcomes will be used to support sustainability by demonstrating the efficacy of the Brain Health project in order to advocate for additional sources of revenue (i.e. Medicaid health plans).
  - ESM has a dedicated spokesperson for Brain Health education and outreach.



## Easter Seals Michigan

2399 E. Walton Blvd.  
Auburn Hills MI 48326  
248.475.6400 phone  
248.475.6402 fax  
www.essmichigan.org

September 20, 2014

Laurie Solotorow  
Director of Philanthropic Services  
Neithercut Philanthropy Advisors LLC  
300 River Place  
Suite 5000  
Detroit, MI 48207

Dear Ms. Solotorow,

Thank you for the opportunity to provide additional information for this extraordinary opportunity. Within this document you will find our response, as well as additional attached information of further support documentation.

Easter Seals Michigan (ESM) has built a comprehensive financial/operational model to project services under this statewide outreach program. Naturally projection models are based upon assumptions which will drive the number of people served and the type of services. The information below is based upon both the original outreach in our grant application, and then amendments to such outreach as you have requested.

\* \* \* \*

### **1. We have some concern regarding your proposed increase in assessments from 70 to 6,000+. Is this realistic?**

Item number 2. (*below*) provides additional insight to the process under this program. We do see where your assumption of 70 to 6,000+ may have occurred; this however needs further clarification. The 70 above represents the number of Neurodevelopmental Assessments (NDA) we have conducted at our sole assessment site over a start-up period of just over one year. In our projection model this NDA service, a very comprehensive assessment with multiple professionals involved for a full day conducted in one-way observation laboratories, actually goes from the 70 to 2,150 in our proposal, not 6,000.

The 2,150 NDA's is the sum of the full three year program with 14 sites online by years two and three. Keeping in mind, the NDA is conducted only when the initial web scoring, or a subsequent Complex Trauma Assessment (CTA), indicates that a NDA is necessary. To address what is the 6,000+ you mentioned, this was referring to CTA, which is more of a two and a half to three hour assessment (testing), conducted by one professional and more than one child at a time can be concurrently administered the CTA. This would follow if a web scoring suggested a necessary second step for the child.

In summary, our original application suggests we would target 10,005 children for the web test. We assume then that as many as 6,670 may score into the CTA, and from either the web score or the results of the CTA, as many as 2,150 would go to the comprehensive NDA (labor intensive/laboratory based, thereby more costly, assessment). The program is designed to dive deeper if necessary based

on each level of assessment. This program does assume that through targeted marketing and outreach, for example targeting children in the foster care system (DHS), will result in as many as 60% needing further testing (CTA), yet a much smaller percentage will need the comprehensive NDA (say 20%).

**Reference Document:** *Our model does allow for a summary report which is attached. This summary shows the outreach for three geographic program options discussed in number 3. (below). If you refer to this schedule the top option #1 (original proposal/14 sights) depicts how the outreach is building over the three years. Here you will find over the three year span, quarter by quarter, as sites come online, how we assume to build to the 10,005 children tested with the web-tool, and those 6,670 we assume will test into the CTA, and the 2,150 who test into the NDA.*

## 2. Please provide more detail around how you will conduct a process evaluation of this project.

### **Overall Summary:**

ESM plans to evaluate the process at each point of contact electronically, through Assura software and through ESM's Electronic Medical Record:

- Initial point of contact (through Assura) at various sites (e.g. schools, doctor offices, etc):
  - Total number of children referred through the various referral sources
  - Number of children referred from each referral source/type of referral source
  - Basic demographic data collected
- Second phase will be used to evaluate severity of trauma exposure. More specifically we would be able to gather:
  - Out of those the program coordinator was able to contact and facilitate an initial assessment (TSCC or TSCYC), the percentage of children referred for a more intensive trauma assessment (based on number referred initially)
  - Percentage of those children unable to be contacted by the program coordinator
  - Out of those the program coordinator was able to contact, the number of children scoring in each of the three levels
    - Level 1: Referral to some type of behavioral health services at ESM or another provider
    - Level 2: Referral to ESM coordinated Trauma Assessment
    - Level 3: Referral to ESM coordinated Neurodevelopmental Assessment
- Third phase will be used to evaluate the follow up to the assessments conducted for Level's 1, 2, and 3:
  - ESM will collect the Treatment Recommendation Plan's for each assessment conducted to ensure that the families have a plan moving forward.
  - Where an external provider conducted the assessment, a consent form will be developed in order to share this information.

### **Are the targeted users able to use the screening service effectively?**

It is important to note that there will be a screening tool used (through Assura) to collect basic demographic information and also an assessment tool (TSCC and TSCYC) that will be administered by the program coordinator used to determine severity of trauma symptoms.

**Screening Tool:** The technology used for the screening tool will allow monthly tracking utilization of screening which will include but will not be limited to the number of children referred through the various referral sources, and other basic demographic information (e.g. age, residence, gender, etc). ESM will also evaluate this goal by adding survey questions to the initial screening tool (within the Assura software) that provide feedback on ease of use, and track those that started screening, but did not complete. Therefore ESM will be able to work with families individually if they did not complete the screening, and also collect trends and work with partner agencies in order to make improvements to the screening tool.

**Assessment Tool:** The technology used for the assessment tool used (through Psychological Assessment Resources, Inc. – the Trauma Symptom Checklist for Children [TSCC] and the Trauma Symptom Checklist for Young Children [TSCYC]) will allow ESM to evaluate the severity of trauma exposure. Overall ESM will be able to evaluate the number of children who completed the assessment and based on those numbers, the percentage of children who were assessed in each of the three levels.

### **Are screenings being performed accurately by the users?**

The Assessment tools incorporate two validity scales for underresponse and hyperresponse, which are scored as part of the TSCC and TSCYC assessments and are incorporated into each test report provided.

### **Do they find it convenient and valuable?**

Based on The National Child Traumatic Stress Network review of the TSCC in 2005, they indicated that the therapists and researchers at the treatment center they were working with at the time, identified that the tool was very useful in obtaining information regarding trauma symptoms that each child reported. In order for ESM to gather satisfaction with this tool, ESM will provide survey questions at the end of each assessment to provide feedback on convenience of use. These surveys will provide a Likert scale response 1-5. This scale will also provide open feedback questions to identify barriers to completion of assessments and overall experience for future improvement.

### **Is there an increase in the utilization of the screening service over time?**

As identified in the summary above, the screening tool that collects basic demographic information will allow for tracking utilization of this tool over time. The assessment tools (TSCC and TSCYC) (subscale scores only) will be tracked through ESM's electronic medical record, where specific information from this assessment can be entered electronically and tied to each person's medical record. This will allow ESM to pull data and reports that link the demographics to the clinical subscales provided based on the assessment and explore not only the utilization of the assessment service over time but also explore the ages of children, county of residence, etc.

### **Is there an increase in the utilization of both levels of assessment over time?**

As identified above, ESM will be able to evaluate if both the screening tool and assessment tools increased in utilization over time using the Assura Software and ESM's electronic medical record. ESM program coordinators will manage outreach in working with individuals and families to overcome barriers of completing assessments (via the program coordinators administering the assessment tool over the phone, sending the families the paper tool and having them return it, or going out to their homes to assist the families in taking the assessment). Program coordinators will coordinate with families, DHS, and other identified partners throughout the process. ESM will also attempt to schedule assessments within a two week time frame following the screening. In the event that ESM does not see an increase in the utilization of assessments, ESM will use target market strategies to identify populations best served by project.

### **Is there an increase in the utilization of treatment services over time?**

ESM provides trauma informed care services for internal referrals. ESM also has established a network of trauma informed providers with a barrier free referral process to address capacity and cities where ESM does not provide treatment. Based on each assessment conducted in each level (1, 2, or 3), a Treatment Recommendation Plan will be developed whether by ESM or a partner agency. ESM will create a consent form to allow for exchange of information for shared individuals in the pilot project. This will also allow ESM to collect the Treatment Recommendation Plans for each assessment conducted to ensure that the families have a plan moving forward. This will provide ESM the information to evaluate if there is an increase of treatment service utilization over time. ESM and partner, CTAC, are also currently working on creating an initiative surrounding trauma informed care training for clinicians in an effort to increase workforce in this specialty area.

## Are children performing better as a result of this program?

ESM will provide outreach to track individuals completing assessments tools at three month, six month and 12 months intervals by using one or two of the following: Child Adolescent Functioning Scale, or Ages and Stages Questionnaire to track improvement, depending on age. ESM would first need to establish a baseline based on the tool chosen to determine target outcomes. This baseline data would be gathered for six months where the targeted outcomes could be identified and monitored. ESM information exchange with other partners in the project will assist in providing data from these tools and program coordinators and the data manager will also work with partners on obtaining this information.

**Reference Document:** *A Basic Flow of the Brain Health – Trauma Assessment program is attached.*

### 3. Please outline how you might scale back the project for an initial roll-out. For example, is it possible to focus on the **ESM direct serve sites plus the Upper Peninsula site** identified in Table 3 on page 9 of the application for a **total budget of \$3,000,000**?

As mentioned above we have a model to support our outreach and related costs. We have used this model to provide three program options summarized on the attached "Three Program Option" schedule:

Option One: The original application (provided for ease of comparing the two additional options below).

**Summary Option One:** Grant Funding of \$4,747,000, funding 14 sites, three year program, web outreach, 10,005 children, assumed to result in 6,670 first level assessments (CTA), and 2,150 (NDA).

Option Two: Revised application as requested by MHEF (herein), including only **ESM direct serve** and later inclusion of the **Upper Peninsula**.

**Summary Option Two:** Grant Funding of \$3,447,000, funding 6 sites, three year program, web outreach, 6,335 children, assumed to result in 4,223 first level assessments (CTA), and 1,408 (NDA).

**Additional information:** The question is raised as to whether this program, reduced in scope as defined, can be done under a total budget of \$3,000,000. Based upon the assumptions in our financial model, funding would optimally fall in the **range of \$3,447,000** for this scope of outreach.

Option Three: Revised application increasing the suggested scope in Option 2, including **ESM direct serve, Upper Peninsula, and two additional requested sites: Isabella County (Chippewa Tribal Partner) and Kalamazoo County (CTAC-Main Direct Partner Site)**.

**Summary Option Two:** Grant Funding of \$4,092,000, funding 8 sites, three year program, web outreach, 7,755 children, assumed to result in 5,170 first level assessments (CTA), and 1,723 (NDA).

**Additional information:** In the event the MHEF decides to reduce this pilot program from the original application statewide scope, we have a third option we respectfully request be considered. This option includes ESM direct serve, Upper Peninsula, and further keeping in-scope the main location of CTAC in Kalamazoo County and the Isabella County site at the Chippewa Indian tribal facility.

Both of these organizations present opportunities to strengthen the outreach and success of this pilot program: CTAC most notably for continuing in our professional current collaboration of brain health services and the benefit of their established research infrastructure and demonstrated expertise in trauma assessments, and the Chippewa site (after Tribal Elder approval) when included, provides for access into tribal population and further advancement of this partnership we are currently developing in this mid-Michigan region.

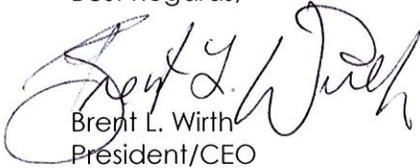
**Reference Document:** All quantitative numbers under the three options above can be traced to the attached "Three Program Option" schedule, as mentioned in number 1. (above). This schedule provides the quarterly build-up of children given to the outreach efforts for the combined geographic areas defined under the options.

\* \* \* \*

In an effort to provide you with documentation to forward our application, we have provided the required Grant Budget schedules for ALL of the Three Program Options above. We hope this helps in your review.

Please let us know if you have any additional questions or concerns; and of course, thank you for considering Easter Seals Michigan!

Best Regards,

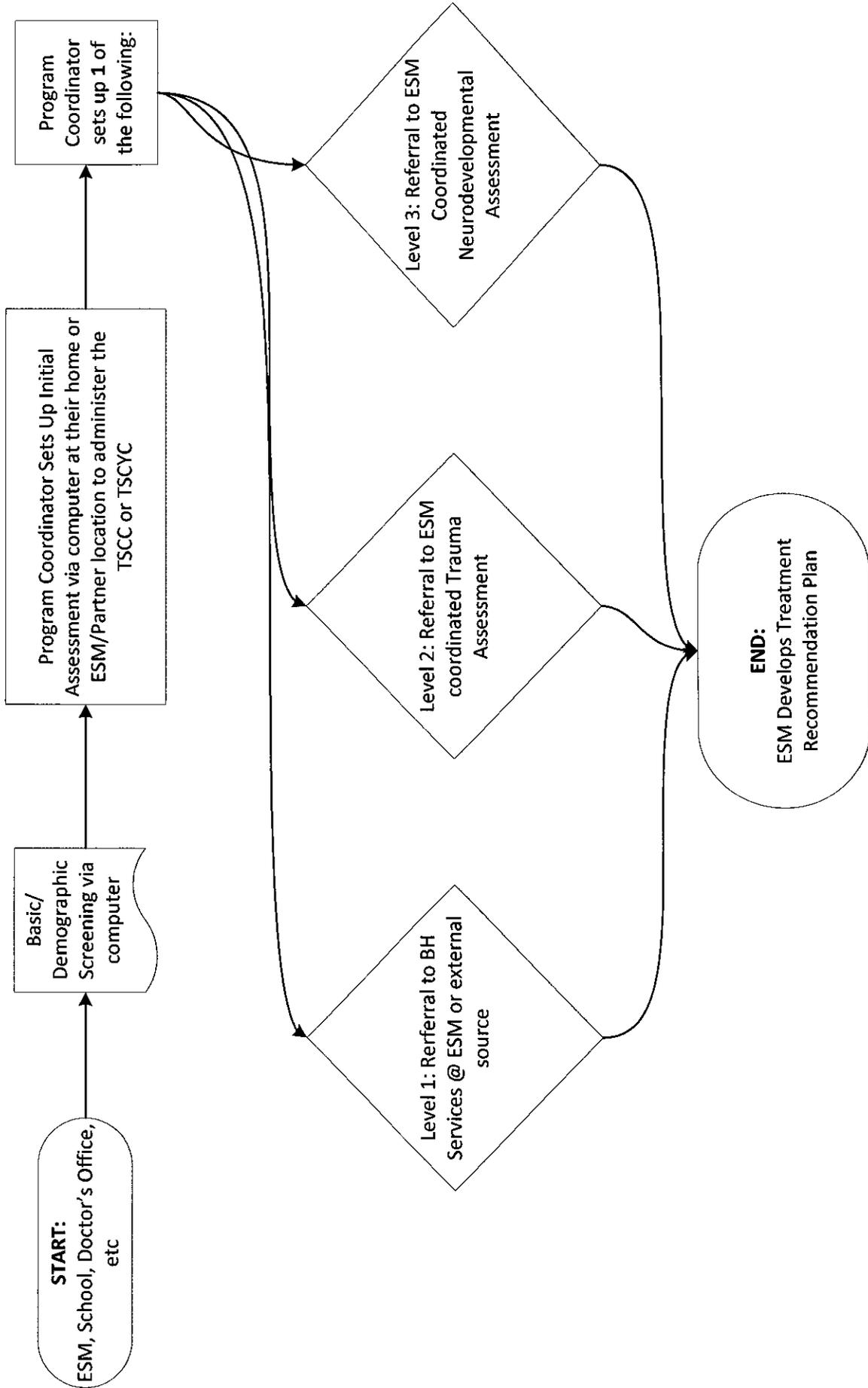


Brent L. Wirth  
President/CEO

CC: GERALYN Lasher, Interim Executive, Michigan Health Endowment Fund  
Easter Seals Michigan Leadership Team



# ESM – Brain Health - Trauma Assessment BASIC FLOW



**GRANT BUDGET**

Below is a listing of standard budget items. Please provide the project budget in this format and in this order.

A. Organizational fiscal year: **Easter Seals Michigan (ESM) Fiscal Year: October 1st to September 30th**

B. Time period this budget covers: **Award Date (Assumed Mid-November 2014) Requesting Three Years of Funding for Services Commencing January 1, 2015 through December 31, 2017**

C. For a CAPITAL requests: **Direct service Capital Costs included below total \$225,000 in year one for build-out of Trauma Assessments and Observation Labs, including one-way observation windows, furniture, required fixtures, and consultation space in nine locations throughout Michigan. These new labs will be located in nine counties including, ESM sites in Macomb, Genesee, and Kent Counties, Partner Sites in Wayne, Grand Traverse, Isabella, and Ingham Counties, and one location in the UP. The cost per site is estimated at approximately \$25,000, nine sites therefore \$225,000. When combined with the existing labs in five sites, the total of 14 locations will be the community locations for conducting the nearly 7,000 CCTA assessments, and over 2,100 NRD assessments.**

D. Expenses: include a *description and the total amount* for each of the following budget categories, in this order:

Expense Categories	Amount requested from this Organization	Total project expenses	3 Year Breakdown			Description
			Year 1 November 2014 thru December 2015	Year 2 January 2016 thru December 2016	Year 3 January 2017 thru December 2017	
Salaries/Wages:						
ESM Program Management	\$ 249,000	\$ 249,000	\$ 83,000	\$ 83,000	\$ 83,000	1 FTE Program Manager & 20% SED Director
ESM Direct Service Staff	\$ 1,897,290	\$ 1,897,290	\$ 431,290	\$ 733,000	\$ 733,000	Total 16 FTE, including 1 FTE Clinical Supervisor & 3 Mobile Trauma Teams phased in (Each including 3 FTE Master Level Clinicians, 1 FTE Occupational Therapist, 1 FTE Speech Therapist)
ESM Evaluation/Outcome Staff (8% Evaluation Costs)	\$ 369,000	\$ 369,000	\$ 107,000	\$ 131,000	\$ 131,000	3 FTE Program Coordinator/Data Specialists & 1 FTE Continuous Quality Improvement Specialist
ESM Support Staff	\$ 111,000	\$ 111,000	\$ 37,000	\$ 37,000	\$ 37,000	Billing/Finance Revenue Specialist (DHS/3rd Party Billable Services)
<b>TOTAL ESM Direct Labor</b>	<b>\$ 2,626,290</b>	<b>\$ 2,626,290</b>	<b>\$ 658,290</b>	<b>\$ 984,000</b>	<b>\$ 984,000</b>	<b>TOTAL ESM LABOR</b>
Payroll Taxes	\$ 178,588	\$ 178,588	\$ 44,764	\$ 66,912	\$ 66,912	FICA
Fringe Benefits	\$ 530,511	\$ 530,511	\$ 132,975	\$ 198,768	\$ 198,768	FTE ESM Benefit Package
Consultants and Professional Fees: Contract Direct Labor (Partners)	\$ 1,333,831	\$ 1,333,831	\$ 194,500	\$ 522,444	\$ 616,888	Fee For Service (Partner Onsite Trauma Assessments: CCTA at \$150 Per Unit & NRD at \$1,300 Per Unit)
Travel	\$ 70,000	\$ 70,000	\$ 20,000	\$ 28,000	\$ 22,000	Travel For Partner Site Staff Training, Partners Audits, Quality Reviews, Transportation Costs For Mobile Trauma Teams
Equipment	\$ 27,000	\$ 27,000	\$ -	\$ -	\$ -	Trauma Observation and Recording Devices (nine sites)

Supplies	\$ 36,000	\$ 36,000	\$ -	\$ -	Computer Supplies
Printing and Copying	\$ -	\$ -	\$ -	\$ -	Part of Marketing Outreach & Community Education Below
Postage and Delivery	\$ -	\$ -	\$ -	\$ -	Part of Marketing Outreach & Community Education Below
Rent: Partner Sites	\$ 91,200	\$ 91,200	\$ 33,600	\$ 33,600	Dedicated Partner Site Trauma Labs rental, Observation and Conference Space
Evaluation: Web Applications	\$ 54,600	\$ 54,600	\$ 13,200	\$ 13,200	Trauma Assessment Web Tools & Technology & Data Collection Software (Note: Evaluation Staff in Salaries Above)
Marketing: Outreach	\$ 100,000	\$ 100,000	\$ 40,000	\$ -	Statewide marketing targeted outreach promoting web tools and this community resource and available services.
Other: Community Education - Trauma Informed	\$ 100,000	\$ 100,000	\$ 40,000	\$ -	Education outreach on Child Trauma, collateral materials, PSA, distribution costs
Other: Capital Costs	\$ 225,000	\$ 225,000	\$ -	\$ -	One-time Capital Costs (defined in C. above)
<b>Total Revenue (from below)</b>	<b>\$ (625,799)</b>				Billable services
<b>Total amount requested</b>	<b>\$ 4,747,220</b>	<b>\$ 5,373,019</b>	<b>\$ 1,926,924</b>	<b>\$ 1,935,368</b>	

E. Revenue: include a description and the total amount for each of the following budget categories, in this order; please indicate which sources of revenue are committed and which are pending.

1. Grants/Contracts/Contributions	Year 1	Year 1	Year 1	Description
State Government: DHS Department of Human Services	\$ 75,460	\$ 168,960	\$ 181,280	Estimated 33% Of Children qualifying for NDA Assessments billed to DHS at \$600 (represents approximately 40% true cost of service)
Other: 3rd Party Insurance	\$ 34,700	\$ 79,400	\$ 86,000	Estimated that 30% of the children qualifying for the CCTA screens will have 3rd party insurance coverage for parts of the screening, and collectable at approximately \$100
<b>Total Revenue</b>	<b>\$ 110,160</b>	<b>\$ 248,360</b>	<b>\$ 267,280</b>	

Billable Services	Year 1
\$ 425,699	
\$ 200,100	
<b>\$ 625,799</b>	

**GRANT BUDGET (Revised)**

**INCLUDES: ESM Direct Service Sites, Upper Peninsula**

Below is a listing of standard budget items. Please provide the project budget in this format and in this order.

A. Organizational fiscal year: **Easter Seals Michigan (ESM) Fiscal Year: October 1st to September 30th**

B. Time period this budget covers: **Award Date (Assumed Mid-November 2014) Requesting Three Years of Funding for Services Commencing January 1, 2015 through December 31, 2017**

C. For a CAPITAL requests:  
Direct service Capital Costs included below total \$125,000 in year one for build-out of Trauma Assessments and Observation Labs, including one-way observation windows, furniture, required fixtures, and consultation space in six locations throughout Michigan. These new labs will be located in nine counties including, ESM sites in Macomb, Genesee, and Kent Counties, Partner Sites in Wayne, one location in the UP. The cost per site is estimated at approximately \$25,000, five sites therefore \$125,000. When combined with the existing labs in one site, the total of 6 locations will be the community locations for conducting the nearly 4,200 CCTA assessments, and over 1,400 NRD assessments.

D. Expenses: include a description and the total amount for each of the following budget categories, in this order:

Expense Categories	Amount requested from this Organization	Total project expenses	3 Year Breakdown			Description
			Year 1 November 2014 thru December 2015	Year 2 January 2016 thru December 2016	Year 3 January 2017 thru December 2017	
Salaries/Wages:						
ESM Program Management	\$ 249,000	\$ 249,000	\$ 83,000	\$ 83,000	\$ 83,000	1 FTE Program Manager & 20% SED Director
ESM Direct Service Staff	\$ 1,897,290	\$ 1,897,290	\$ 431,290	\$ 733,000	\$ 733,000	Total 16 FTE, including 1 FTE Clinical Supervisor & 3 Mobile Trauma Teams phased in (Each including 3 FTE Master Level Clinicians, 1 FTE Occupational Therapist, 1 FTE Speech Therapist)
ESM Evaluation/Outcome Staff (8% Evaluation Costs)	\$ 289,000	\$ 289,000	\$ 91,000	\$ 99,000	\$ 99,000	3 FTE Program Coordinator/Data Specialists & 1 FTE Continuous Quality Improvement Specialist
ESM Support Staff	\$ 132,000	\$ 132,000	\$ 44,000	\$ 44,000	\$ 44,000	Billing/Finance Revenue Specialist (DHS/3rd Party Billable Services)
<b>TOTAL ESM Direct Labor</b>	<b>\$ 2,567,290</b>	<b>\$ 2,567,290</b>	<b>\$ 649,290</b>	<b>\$ 959,000</b>	<b>\$ 959,000</b>	<b>TOTAL ESM LABOR</b>
Payroll Taxes	\$ 174,576	\$ 174,576	\$ 44,152	\$ 65,212	\$ 65,212	FICA
Fringe Benefits	\$ 518,593	\$ 518,593	\$ 131,157	\$ 193,718	\$ 193,718	FTE ESM Benefit Package
Consultants and Professional Fees: Contract Direct Labor (Partners)	\$ 130,278	\$ 130,278	\$ 7,778	\$ 52,500	\$ 70,000	Fee For Service (Partner Onsite Trauma Assessments: CCTA at \$150 Per Unit & NRD at \$1,300 Per Unit)
Travel	\$ 70,000	\$ 70,000	\$ 20,000	\$ 28,000	\$ 22,000	Travel For Partner Site Staff Training, Partners Audits, Quality Reviews, Transportation Costs For Mobile Trauma Teams

Equipment	\$ 15,000	\$ 15,000	\$ -	\$ -	\$ -	Trauma Observation and Recording Devices (nine sites)
Supplies	\$ 36,000	\$ 36,000	\$ -	\$ -	\$ -	Computer Supplies
Printing and Copying	\$ -	\$ -	\$ -	\$ -	\$ -	Part of Marketing Outreach & Community Education Below
Postage and Delivery	\$ -	\$ -	\$ -	\$ -	\$ -	Part of Marketing Outreach & Community Education Below
Rent: Partner Sites	\$ 26,400	\$ 26,400	\$ 9,600	\$ 9,600	\$ 9,600	Dedicated Partner Site Trauma Labs rental, Observation and Conference Space
Evaluation: Web Applications	\$ 54,600	\$ 54,600	\$ 13,200	\$ 13,200	\$ 13,200	Trauma Assessment Web Tools & Technology & Data Collection Software (Note: Evaluation Staff in Salaries Above)
Marketing: Outreach	\$ 70,000	\$ 70,000	\$ 10,000	\$ -	\$ -	Statewide marketing targeted outreach promoting web tools and this community resource and available services.
Other: Community Education - Trauma Informed	\$ 65,000	\$ 65,000	\$ 5,000	\$ -	\$ -	Education outreach on Child Trauma, collateral materials, PSA, distribution costs
Other: Capital Costs	\$ 125,000	\$ 125,000	\$ -	\$ -	\$ -	One-time Capital Costs (defined in C. above)
<b>Total Revenue (from below)</b>	<b>\$ (405,439)</b>	<b>\$ 3,852,736</b>	<b>\$ 1,336,230</b>	<b>\$ 1,332,730</b>	<b>\$ 1,183,776</b>	Billable services
<b>Total amount requested</b>	<b>\$ 3,447,297</b>					

E. Revenue: include a description and the total amount for each of the following budget categories, in this order; please indicate which sources of revenue are committed and which are pending.

1. Grants/Contracts/Contributions	Year 1	Year 1	Year 1	Year 1	Description
State Government: DHS Department of Human Services	\$ 53,680	\$ 111,540	\$ 113,520	\$ 113,520	Estimated 33% Of Children qualifying for NDA Assessments billed to DHS at \$600 (represents approximately 40% true cost of service)
Other: 3rd Party Insurance	\$ 24,400	\$ 50,700	\$ 51,600	\$ 51,600	Estimated that 30% of the children qualifying for the CCTA screens will have 3rd party insurance coverage for parts of the screening, and collectable at approximately \$100
<b>Total Revenue</b>	<b>\$ 78,080</b>	<b>\$ 162,240</b>	<b>\$ 165,120</b>	<b>\$ 165,120</b>	

Billable Services	Year 1
\$ 278,739	
\$ 126,700	
<b>\$ 405,439</b>	

**OPTION 3 (Additional Consideration)**

**GRANT BUDGET (Revised)**

**INCLUDES: ESM Direct Service Sites, Upper Peninsula, Isabella County (Chippewa Site), Kalamazoo County (CTAC Main Site)**

Below is a listing of standard budget items. Please provide the project budget in this format and in this order.

A. Organizational fiscal year: **Easter Seals Michigan (ESM) Fiscal Year: October 1st to September 30th**  
 B. Time period this budget covers: **Award Date (Assumed Mid-November 2014) Requesting Three Years of Funding for Services Commencing January 1, 2015 through December 31, 2017**

C. For a CAPITAL requests:  
 Direct service Capital Costs included below total \$150,000 in year one for build-out of Trauma Assessments and Observation Labs, including one-way observation windows, furniture, required fixtures, and consultation space in six locations throughout Michigan. These new labs will be located in nine counties including, ESM sites in Macomb, Genesee, and Kent Counties, Partner Sites in Wayne, Isabella, and one location in the UP. The cost per site is estimated at approximately \$25,000, six sites therefore \$150,000. When combined with the existing labs in two sites, the total of 8 locations will be the community locations for conducting the nearly 5,200 CCTA assessments, and over 1,700 NRD assessments.

D. Expenses: include a description and the total amount for each of the following budget categories, in this order:

Expense Categories	Amount requested from this Organization	3 Year Breakdown			Description
		Year 1 November 2014 thru December 2015	Year 2 January 2016 thru December 2016	Year 3 January 2017 thru December 2017	
Salaries/Wages:					
ESM Program Management	\$ 249,000	\$ 83,000	\$ 83,000	\$ 83,000	1 FTE Program Manager & 20% SED Director
ESM Direct Service Staff	\$ 1,897,290	\$ 431,290	\$ 733,000	\$ 733,000	Total 16 FTE, including 1 FTE Clinical Supervisor & 3 Mobile Trauma Teams phased in (Each including 3 FTE Master Level Clinicians, 1 FTE Occupational Therapist, 1 FTE Speech Therapist)
ESM Evaluation/Outcome Staff (8% Evaluation Costs)	\$ 369,000	\$ 107,000	\$ 131,000	\$ 131,000	3 FTE Program Coordinator/Data Specialists & 1 FTE Continuous Quality Improvement Specialist
ESM Support Staff	\$ 132,000	\$ 44,000	\$ 44,000	\$ 44,000	Billing/Finance Revenue Specialist (DHS/3rd Party Billable Services)
<b>TOTAL ESM Direct Labor</b>	<b>\$ 2,647,290</b>	<b>\$ 665,290</b>	<b>\$ 991,000</b>	<b>\$ 991,000</b>	<b>TOTAL ESM LABOR</b>
Payroll Taxes	\$ 180,016	\$ 45,240	\$ 67,388	\$ 67,388	FICA
Fringe Benefits	\$ 534,753	\$ 134,389	\$ 200,182	\$ 200,182	FTE ESM Benefit Package
Consultants and Professional Fees: Contract Direct Labor (Partners)	\$ 682,499	\$ 97,222	\$ 266,388	\$ 318,888	Fee For Service (Partner Onsite Trauma Assessments: CCTA at \$150 Per Unit & NRD at \$1,300 Per Unit)
Travel	\$ 70,000	\$ 20,000	\$ 28,000	\$ 22,000	Travel For Partner Site Staff Training, Partners Audits, Quality Reviews, Transportation Costs For Mobile Trauma Teams
	<b>Total project expenses</b>	\$ 249,000	\$ 1,897,290	\$ 369,000	
		\$ 249,000	\$ 1,897,290	\$ 369,000	
		\$ 132,000	\$ 132,000	\$ 132,000	
		\$ 180,016	\$ 180,016	\$ 180,016	
		\$ 534,753	\$ 534,753	\$ 534,753	
		\$ 682,499	\$ 682,499	\$ 682,499	
		\$ 70,000	\$ 70,000	\$ 70,000	

Equipment	\$ 18,000	\$ 18,000	\$ -	\$ -	\$ -	Trauma Observation and Recording Devices (nine sites)
Supplies	\$ 36,000	\$ 36,000	\$ -	\$ -	\$ -	Computer Supplies
Printing and Copying	\$ -	\$ -	\$ -	\$ -	\$ -	Part of Marketing Outreach & Community Education Below
Postage and Delivery	\$ -	\$ -	\$ -	\$ -	\$ -	Part of Marketing Outreach & Community Education Below
Rent: Partner Sites	\$ 45,600	\$ 45,600	\$ 16,000	\$ 16,000	\$ 16,000	Dedicated Partner Site Trauma Labs rental, Observation and Conference Space
Evaluation: Web Applications	\$ 54,600	\$ 54,600	\$ 13,200	\$ 13,200	\$ 13,200	Trauma Assessment Web Tools & Technology & Data Collection Software (Note: Evaluation Staff In Salaries Above)
Marketing: Outreach	\$ 85,000	\$ 85,000	\$ 25,000	\$ 25,000	\$ -	Statewide marketing targeted outreach promoting web tools and this community resource and available services.
Other: Community Education - Trauma Informed	\$ 85,000	\$ 85,000	\$ 25,000	\$ 25,000	\$ -	Education outreach on Child Trauma, collateral materials, PSA, distribution costs
Other: Capital Costs	\$ 150,000	\$ 150,000	\$ -	\$ -	\$ -	One-time Capital Costs (defined in C. above)
<b>Total Revenue (from below)</b>	\$ (496,319)	\$ 4,588,757	\$ 1,632,158	\$ 1,632,158	\$ 1,628,658	Billable services
<b>Total amount requested</b>	\$ 4,092,438					

E. Revenue: include a description and the total amount for each of the following budget categories, in this order; please indicate which sources of revenue are committed and which are pending.

1. Grants/Contracts/Contributions	Year 1	Year 1	Year 1	Description
State Government: DHS Department of Human Services	\$ 63,800	\$ 135,740	\$ 141,680	Estimated 33% Of Children qualifying for NDA Assessments billed to DHS at \$600 (represents approximately 40% true cost of service)
5. Other: 3rd Party Insurance	\$ 29,000	\$ 61,700	\$ 64,400	Estimated that 30% of the children qualifying for the CCTA screens will have 3rd party insurance coverage for parts of the screening, and collectable at approximately \$100
<b>Total Revenue</b>	\$ 92,800	\$ 197,440	\$ 206,080	

Billable Services	Year 1
State Government: DHS Department of Human Services	\$ 341,219
5. Other: 3rd Party Insurance	\$ 155,100
<b>Total Revenue</b>	\$ 496,319



## Projected Balance in year 18

Assumptions: Receive Annual Cap each year (deduct \$50 million from year 2031 for 2014 payment above cap)

Spending Level		Rate of Return								
		Yrs. 1-4	Yrs. 5-8	Yrs. 9-12	Yrs. 12-18	6%	5%	4%	3%	2%
80%	67%			60%	25%	\$ 1,121,430,799.02	\$ 1,042,414,566.64	\$ 970,320,381.83	\$ 904,476,446.18	\$ 844,278,407.66
70%	67%			60%	25%	\$ 1,191,032,285.97	\$ 1,102,056,974.30	\$ 1,021,360,805.35	\$ 948,096,427.82	\$ 881,505,417.24
60%	60%			60%	25%	\$ 1,308,646,102.66	\$ 1,204,517,116.70	\$ 1,110,549,773.76	\$ 1,025,671,759.52	\$ 948,925,459.80
50%	50%			50%	25%	\$ 1,510,753,039.07	\$ 1,384,531,509.01	\$ 1,270,894,061.48	\$ 1,168,503,398.79	\$ 1,076,165,534.01
40%	40%			40%	25%	\$ 1,712,859,975.48	\$ 1,564,545,901.32	\$ 1,431,238,349.20	\$ 1,311,335,038.06	\$ 1,203,405,608.22
30%	30%			30%	25%	\$ 1,914,966,911.89	\$ 1,744,560,293.63	\$ 1,591,582,636.92	\$ 1,454,166,677.33	\$ 1,330,645,682.43
20%	20%			20%	20%	\$ 2,150,421,738.77	\$ 1,956,871,989.11	\$ 1,783,205,099.50	\$ 1,487,216,767.51	\$ 1,487,216,767.51
10%	10%			10%	10%	\$ 2,419,224,456.11	\$ 2,201,480,987.75	\$ 2,006,105,736.93	\$ 1,830,698,996.36	\$ 1,673,118,863.44
0%	0%			0%	0%	\$ 2,688,027,173.46	\$ 2,446,089,986.39	\$ 2,229,006,374.37	\$ 2,034,109,995.95	\$ 1,859,020,959.38

**Note: Maximum Spending:**

Years 1-4	80%
Years 5-8	67%
Years 9-12	60%
Years 12-18	25%

Spending Level		\$750 million Account Value Attained (est. end Yr)						Total Spending	
Yrs. 1-4	Yrs. 5-8	Yrs. 9-12	Yrs. 12-18	6%	5%	4%	3%	2%	
80%	67%	60%	25%	Year 15 (2028)	Year 16 (2029)	Year 16 (2029)	Year 17 (2030)	Year 17 (2030)	\$ (821,300,000.00)
70%	67%	60%	25%	Year 15 (2028)	Year 15 (2028)	Year 16 (2029)	Year 16 (2029)	Year 17 (2030)	\$ (794,300,000.00)
60%	60%	60%	25%	Year 15 (2028)	Year 15 (2028)	Year 15 (2028)	Year 16 (2029)	Year 16 (2029)	\$ (743,500,000.00)
50%	50%	50%	25%	Year 14 (2027)	Year 13 (2026)	Year 14 (2027)	Year 14 (2027)	Year 15 (2028)	\$ (642,500,000.00)
40%	40%	40%	25%	Year 12 (2025)	Year 12 (2025)	Year 12 (2025)	Year 13 (2026)	Year 13 (2026)	\$ (541,500,000.00)
30%	30%	30%	25%	Year 10 (2023)	Year 11 (2024)	Year 11 (2024)	Year 12 (2025)	Year 12 (2025)	\$ (440,500,000.00)
20%	20%	20%	20%	Year 10 (2023)	Year 10 (2023)	Year 10 (2023)	Year 11 (2024)	Year 11 (2024)	\$ (312,000,000.00)
10%	10%	10%	10%	Year 9 (2022)	Year 9 (2022)	Year 9 (2022)	Year 10 (2023)	Year 10 (2023)	\$ (156,000,000.00)
0%	0%	0%	0%	Year 8 (2021)	Year 9 (2022)	Year 9 (2022)	Year 9 (2022)	Year 9 (2022)	\$ -

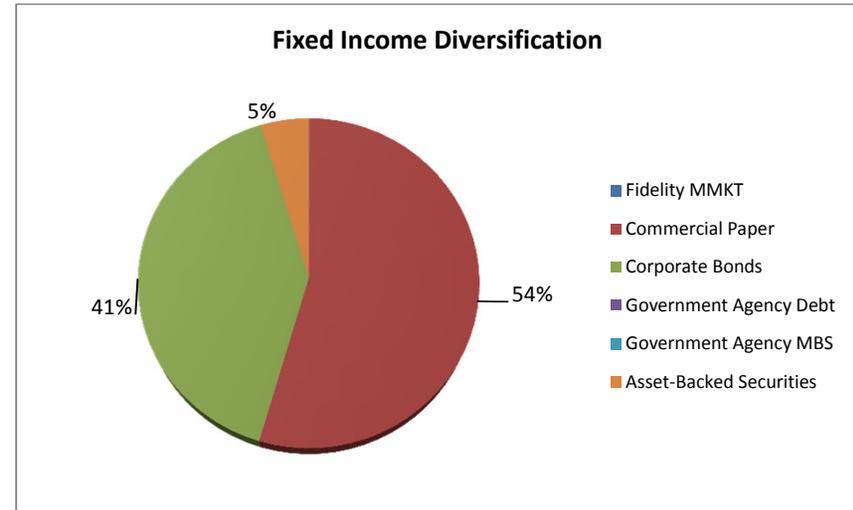
**PA No. 4, Part 6A Sec. 655. (2)**

On and after the date that the accumulated principal of money held by a fund reaches \$750,000,000.00, the fund shall maintain that amount for investment to provide an ongoing income to the fund. On and after the date that the accumulated principal in the fund reaches \$750,000,000, the board shall not allow the accumulated principal of the fund to fall below \$750,000,000 due to expenditures made for the purposes of the fund as described in section 653

## Summary of Investments MI Health Endowment Fund 10-31-2014

### Fixed Income Diversification

Description		Percentage
Fidelity MMKT	\$ 6,628.03	0%
Commercial Paper	\$ 48,883,315.00	55%
Corporate Bonds	\$ 36,479,559.77	41%
Government Agency Debt	\$ -	0%
Government Agency MBS	\$ -	0%
Asset-Backed Securities	\$ 4,253,562.33	5%
<b>Total</b>	<b>\$ 89,623,065.13</b>	<b>100%</b>

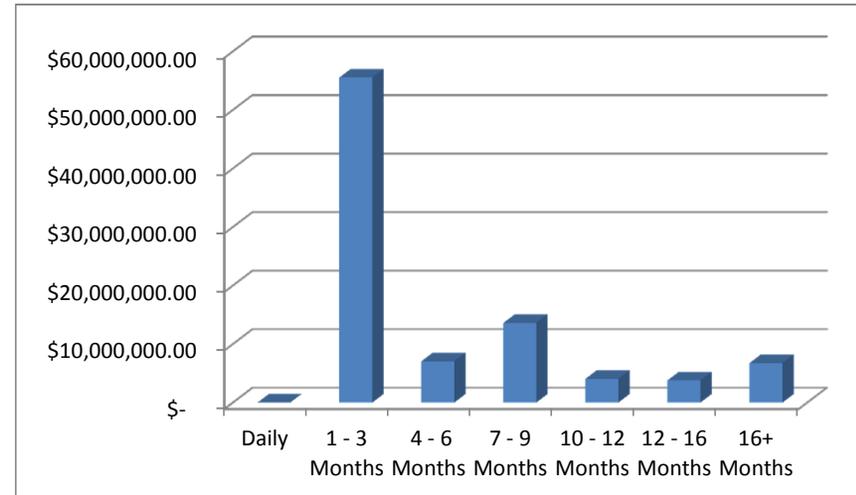


### Portfolio Analysis

Description	
Weighted Average Yield	0.62%
Weighted Average Life in Years / Duration	0.39

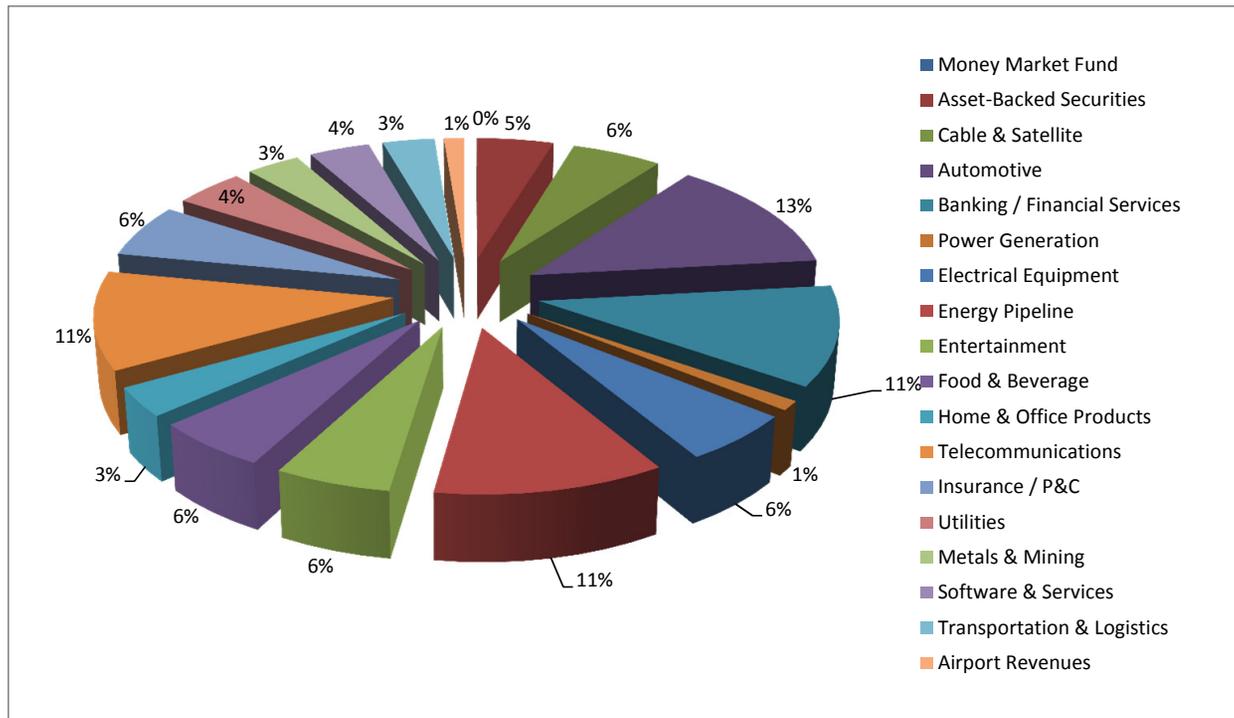
### Maturity Schedule

Description		Percentage
Daily	\$ 6,628.03	0%
1 - 3 Months	\$ 55,548,609.63	61%
4 - 6 Months	\$ 7,078,734.73	8%
7 - 9 Months	\$ 13,626,424.13	15%
10 - 12 Months	\$ 4,078,777.13	4%
12 - 16 Months	\$ 3,817,486.50	4%
16+ Months	\$ 6,788,095.50	7%
<b>Total</b>	<b>\$ 90,944,755.65</b>	<b>100%</b>



**Portfolio Diversification Report  
MI Health Endowment Fund 10-31-2014**

Industry Description	Market Value	Percentage
Money Market Fund	\$ 6,628.03	0%
Asset-Backed Securities	\$ 4,253,562.33	5%
Cable & Satellite	\$ 4,999,000.00	6%
Automotive	\$ 11,585,270.10	13%
Banking / Financial Services	\$ 10,148,030.60	11%
Power Generation	\$ 982,644.00	1%
Electrical Equipment	\$ 4,999,400.00	6%
Energy Pipeline	\$ 9,951,557.34	11%
Entertainment	\$ 4,999,450.00	6%
Food & Beverage	\$ 4,999,450.00	6%
Home & Office Products	\$ 3,020,070.00	3%
Telecommunications	\$ 9,988,000.00	11%
Insurance / P&C	\$ 5,415,137.00	6%
Utilities	\$ 3,899,415.00	4%
Metals & Mining	\$ 3,000,831.00	3%
Software & Services	\$ 3,363,558.00	4%
Transportation & Logistics	\$ 2,881,820.48	3%
Airport Revenues	\$ 1,129,241.25	1%
<b>Total</b>	<b>\$ 89,623,065.13</b>	<b>100%</b>



**Portfolio Positions**  
**MI Health Endowment Fund 10-31-2014**

Description	Industry	Credit Rating	Maturity			Yield	Maturity Value	Market Value	Principal Cost	\$ Gain/Loss	Acrd Int Paid	Coupon Int Earned (Acrd
			Maturity	Mths								Int)
Fidelity Prime	Money Market Fund	AAA	Daily	0.03	0.10%	\$ 6,628.03	\$ 6,628.03	\$ 6,628.03	\$ -	\$ -	\$ -	
						\$ 6,628.03	\$ 6,628.03	\$ 6,628.03	\$ -	\$ -	\$ -	
CBS CORP DISC COMML PAPER	Entertainment	A2 / P2	11/17/2014	1.00	0.29%	\$ 5,000,000.00	\$ 4,999,450.00	\$ 4,999,194.44	\$ 255.56	\$ -	\$ -	
DEUTSCHE TELEKOM DISC COMML PAPER	Telecommunications	A2 / P2	11/24/2014	1.00	0.24%	\$ 5,000,000.00	\$ 4,999,250.00	\$ 4,998,166.67	\$ 1,083.33	\$ -	\$ -	
ENBRIDGE US DISC COMML PAPER	Energy Pipeline	A2 / P2	11/20/2024	1.00	0.35%	\$ 5,000,000.00	\$ 4,999,350.00	\$ 4,998,881.94	\$ 468.06	\$ -	\$ -	
VODAFONE GROUP DISC COMML PAPER	Telecommunications	A2 / P2	5/14/2015	7.00	0.48%	\$ 5,000,000.00	\$ 4,988,750.00	\$ 4,984,933.33	\$ 3,816.67	\$ -	\$ -	
HITACHI CAP AMER DISC COMML PAPER	Electrical Equipment	A2 / P2	11/19/2014	1.00	0.34%	\$ 5,000,000.00	\$ 4,999,400.00	\$ 4,998,961.11	\$ 438.89	\$ -	\$ -	
DTE CAPITAL CORP DISC COMML PAPER	Utilities	A2 / P2	11/20/2014	1.00	0.40%	\$ 3,900,000.00	\$ 3,899,415.00	\$ 3,899,501.67	\$ (86.67)	\$ -	\$ -	
GENERAL MILLS INC DISC COMML PAPER	Food & Beverage	A2 / P2	11/18/2014	1.00	0.23%	\$ 5,000,000.00	\$ 4,999,450.00	\$ 4,999,329.17	\$ 120.83	\$ -	\$ -	
NISSAN MTR ACCEP DISC COMML PAPER	Automotive	A2 / P2	11/21/2014	1.00	0.24%	\$ 5,000,000.00	\$ 4,999,350.00	\$ 4,999,300.00	\$ 50.00	\$ -	\$ -	
SUNCORP MTWY LTD DISC COMML PAPER	Banking / Financial Services	A1 / P1	11/5/2014	1.00	0.28%	\$ 5,000,000.00	\$ 4,999,900.00	\$ 4,994,750.00	\$ 5,150.00	\$ -	\$ -	
TIME WARNER CBL DISC COMML PAPER	Cable & Satellite	A2 / P2	12/1/2014	2.00	0.18%	\$ 5,000,000.00	\$ 4,999,000.00	\$ 4,998,966.67	\$ 33.33	\$ -	\$ -	
						\$ 48,900,000.00	\$ 48,883,315.00	\$ 48,871,985.00	\$ 11,330.00	\$ -	\$ -	
AMERICAN INTL GROUP INC 2.37500%	Property & Casualty Insur.	Baa2 / BBB+	8/24/2015	9.00	0.79%	\$ 1,000,000.00	\$ 1,011,840.00	\$ 1,012,829.58	\$ (989.58)	\$ 7,982.64	\$ 4,420.14	
BNP PARIBAS US MEDIUM TERM NT 5.12500%	Banking / Financial Services	Baa2 / BBB+	1/15/2015	3.00	0.66%	\$ 500,000.00	\$ 504,055.00	\$ 504,571.56	\$ (516.56)	\$ 11,388.89	\$ 7,545.14	
DEUTSCHE BK FINL LLC MTN 5.37500%	Banking / Financial Services	Baa3 / BBB	3/2/2015	5.00	0.70%	\$ 1,500,000.00	\$ 1,521,780.00	\$ 1,523,428.23	\$ (1,648.23)	\$ 29,114.58	\$ 15,677.08	
DUN & BRADSTREET CORP DEL NEW 2.87500%	Software & Services	BBB- / BBB	11/15/2015	12.00	0.85%	\$ 3,300,000.00	\$ 3,363,558.00	\$ 3,368,983.58	\$ (5,425.58)	\$ 10,541.67	\$ 43,747.92	
ENERGY TRANSFER PRTRNS L P 5.95000%	Energy Pipeline	Baa3 / BBB-	2/1/2015	4.00	0.68%	\$ 2,854,000.00	\$ 2,888,419.24	\$ 2,891,480.25	\$ (3,061.01)	\$ 70,755.42	\$ 42,453.25	
FORD MOTOR CREDIT CO LLC 12.00000%	Automotive	Baa3 / BBB-	5/15/2015	7.00	0.67%	\$ 1,130,000.00	\$ 1,196,297.10	\$ 1,198,724.41	\$ (2,427.31)	\$ 17,326.67	\$ 62,526.67	
FORD MOTOR CREDIT CO LLC 2.75000%	Automotive	Baa3 / BBB-	5/15/2015	7.00	0.64%	\$ 1,100,000.00	\$ 1,110,945.00	\$ 1,112,440.79	\$ (1,495.79)	\$ 3,865.28	\$ 13,948.61	
FORD MOTOR CREDIT CO LLC 4.20700%	Automotive	Baa3 / BBB-	4/15/2016	18.00	1.00%	\$ 4,100,000.00	\$ 4,278,678.00	\$ 4,289,298.77	\$ (10,620.77)	\$ 64,203.49	\$ 7,666.09	
GOLDMAN SACHS GROUP INC 5.12500%	Banking / Financial Services	Baa1 / A-	1/15/2015	3.00	0.62%	\$ 1,500,000.00	\$ 1,512,570.00	\$ 1,513,835.26	\$ (1,265.26)	\$ 35,447.92	\$ 22,635.42	
MERRILL LYNCH CO INC MTN BE 5.00000%	Banking / Financial Services	Baa2 / A-	1/15/2015	3.00	0.60%	\$ 1,596,000.00	\$ 1,609,725.60	\$ 1,610,388.77	\$ (663.17)	\$ 36,796.67	\$ 23,496.67	
NEWELL RUBBERMAID INC 2.00000%	Home & Office Products	Baa3 / BBB-	6/15/2015	8.00	0.59%	\$ 3,000,000.00	\$ 3,020,070.00	\$ 3,026,267.51	\$ (6,197.51)	\$ 1,666.67	\$ 22,666.67	
PENSKE TRUCK LEASING CO L P 3.12500%	Transportation & Logistics	Baa3 / BBB-	5/11/2015	7.00	0.60%	\$ 2,849,000.00	\$ 2,881,820.48	\$ 2,886,836.08	\$ (5,015.60)	\$ 10,386.98	\$ 42,042.53	
PRUDENTIAL COVERED TRUST 2.99700%	Life Insurance	Baa1 / A	9/30/2015	10.00	0.73%	\$ 3,000,000.00	\$ 2,292,120.00	\$ 2,309,287.50	\$ (17,167.50)	\$ 16,983.00	\$ 5,806.69	
XSTRATA FINANCE CANADA LIMITED NOTE 02.85000%	Metals & Mining	Baa2 / BBB	11/10/2014	1.00	0.70%	\$ 3,000,000.00	\$ 3,000,831.00	\$ 3,023,917.55	\$ (23,086.55)	\$ 10,925.00	\$ 40,612.50	
TRANSALTA CORP	Power Generation	Baa3 / BBB-	1/15/2015	3.00	0.78%	\$ 975,000.00	\$ 982,644.00	\$ 994,383.00	\$ (11,739.00)	\$ 2,361.81	\$ 13,636.46	
AXIS CAP HLDGS	Property & Casualty Insur.	Baa1 / A-	12/1/2014	2.00	0.49%	\$ 500,000.00	\$ 502,105.00	\$ 506,700.00	\$ (4,595.00)	\$ 7,027.78	\$ 11,899.31	
CNA FINANCIAL CORP NOTES 5.850%	Property & Casualty Insur.	Baa2 / BBB	12/15/2014	2.00	0.27%	\$ 1,600,000.00	\$ 1,609,072.00	\$ 1,610,891.99	\$ (1,819.99)	\$ 19,240.00	\$ 35,360.00	
PETROBRAS INTERNATIONAL FINANC 02.87500%	Integrated Oils	Baa1 / BBB-	2/6/2015	4.00	0.95%	\$ 2,057,000.00	\$ 2,063,788.10	\$ 2,079,092.18	\$ (15,304.08)	\$ 25,955.34	\$ 13,799.04	
WAYNE CNTY MICH ARPT AUTH REV REV BDS	Airport Revenues	A2 / AA-	12/1/2014	2.00	0.57%	\$ 1,125,000.00	\$ 1,129,241.25	\$ 1,129,369.73	\$ (128.48)	\$ 13,945.31	\$ 24,609.37	
						\$ 36,686,000.00	\$ 36,479,559.77	\$ 36,592,726.74	\$ (113,166.97)	\$ 395,915.12	\$ 454,549.56	
BA MTG SECS INC SER 2003-8 CL 2-A-1	Residential MBS	A	1.20	14.00	3.00%	\$ 1,375,043.00	\$ 1,393,555.80	\$ 1,394,380.28	\$ (824.48)	\$ 5,211.49	\$ 1,031.28	
RESIDENTIAL FUNDING SER 04-S4 CL 2A2	Residential MBS	A	1.20	14.00	3.42%	\$ 550,989.00	\$ 554,795.60	\$ 556,499.83	\$ (1,704.23)	\$ 1,951.70	\$ 413.24	
RESIDENTIAL FUNDING SER 04-S4 CL 2A3	Residential MBS	A	2.20	24.00	3.93%	\$ 1,373,727.00	\$ 1,378,257.08	\$ 1,389,182.42	\$ (10,925.34)	\$ 4,829.44	\$ 1,030.29	
GSR MTG TR 2004-10F SER 2004-10F CL 1A-5	Residential MBS	A	1.70	19.00	3.46%	\$ 921,590.00	\$ 926,953.85	\$ 934,550.25	\$ (7,596.40)	\$ 3,409.67	\$ 691.18	
						\$ 4,221,349.00	\$ 4,253,562.33	\$ 4,274,612.78	\$ (21,050.45)	\$ 15,402.30	\$ 3,165.99	

**\$ 89,813,977.03 \$ 89,623,065.13 \$ 89,745,952.55 \$ (122,887.42) \$ 411,317.42 \$ 457,715.55**

@ NFS statement does not include the accrued interest for cusps with @

## Projected Balance in year 18

Assumptions: Receive Annual Cap each year (deduct \$50 million from year 2031 for 2014 payment above cap)

Spending Level		Rate of Return								
		Yrs. 1-4	Yrs. 5-8	Yrs. 9-12	Yrs. 12-18	6%	5%	4%	3%	2%
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**Note: Maximum Spending:**

Years 1-4	80%
Years 5-8	67%
Years 9-12	60%
Years 12-18	25%

## –Michigan Health Endowment Fund–

### Board Meeting

November 21, 2014

### Attendee Feedback

1. Are you a member of the MHEF Board? \_\_\_\_Yes \_\_\_\_No

2. Using the scale provided, please rate your agreement or disagreement with each of the following statements. For each statement, please circle one number.

	Disagree strongly			Agree strongly	
a. The meeting topics were the right ones to discuss.	1	2	3	4	5
b. We used our meeting time effectively.	1	2	3	4	5
c. I had sufficient opportunity to contribute my ideas.	1	2	3	4	5
d. I felt my voice was heard.	1	2	3	4	5
e. The meeting was facilitated well.	1	2	3	4	5
f. What I learned at the meeting makes me better prepared to play my role as a Board member.	1	2	3	4	5
g. The facilities were appropriate.	1	2	3	4	5
h. Overall, the meeting advanced the work of the MHEF Board.	1	2	3	4	5

*Please use the back if you need more space for your answers to the following questions.*

3. What was the best part of the meeting?

4. What would have made this meeting more valuable?

5. What do you see as the next priorities for Board learning or action?

*Thank you for your participation and input!*



# Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

## Board of Directors

Robert Fowler  
*Chairperson*

Lynn Alexander  
*Vice Chairperson*

Timothy Damschroder  
*Treasurer*

Cindy Estrada  
*Secretary*

Susan Jandernoa

Keith Pretty

James Murray

Marge Robinson

Michael Williams

## Interim Executive Director

Geralyn Lasher

## Michigan Health Endowment Fund

### Public Calendar 2014-2015

#### December

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December 17, 2014 – Board Meeting (Location to be Determined)

#### January

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January 29-30, 2015 – Board Meeting and Planning Session (Location to be Determined)

#### March

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March 19, 2015, 9-12 p.m. – Board Meeting (Location to be Determined)

#### May

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May 21, 2015, 9-12 p.m. – Board Meeting (Location to be Determined)



# Michigan Health Endowment Fund

## Listening Tour Summary: *Traverse City*

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October 14, 2014

### INTRODUCTION

There were 36 people who attended the listening tour session at Grand Traverse Resort in Acme, Michigan, on October 14, 2014. Participants were asked to share their perspectives on priority health issues, challenges to addressing those issues, and innovative and promising approaches taking place in their communities. A summary of the discussion is provided below.

### DISCUSSION OF PRIORITY HEALTH ISSUES

Participants were presented with a list of priority health issues that were identified through community health needs assessments in the region. They were asked to comment on the health concerns they think are most important and to add any health issues they thought were missing from the list.

#### ***What are the most important issues for the health and wellness of children and older adults?***

Participants agreed with the list of priority issues and stated that nothing should be taken off the list because all of the issues are important. Participants expanded on several priority issues, and they shared a handful of other issues not identified in the community health needs assessments. Many of the issues raised affect both children and older adults, including access to quality care, prevention, and good nutrition. Issues around long-term care related only to older adults. Some participants' comments are provided below as examples of the discussion.

#### *Access to Care*

- Primary care physicians, behavioral and mental health providers, and dental care providers are limited, especially in rural areas.
- Specialists and obstetrical care are very limited, especially outside of the Traverse City area. Munson Medical Center is the only neonatal intensive care unit (NICU) in northern Michigan. Many expectant mothers with high-risk pregnancies have to travel a long distance to receive specialized care. After the birth, if the infant stays in the NICU, the mother may have to stay as well—away from her home and support network.
- Transportation is an issue for many people, especially for older adults and those in rural areas. This further limits people's access to an already small selection of health care providers.
- Care coordination and case management are particularly important for older adults with chronic conditions and those who leave a long-term care setting. Effective care coordination ensures access to community-based services and specialized care.

#### *Prevention*

- There needs to be an investment in prevention and promoting wellness so that people will focus on their long-term health rather than only addressing immediate health crises.
- Immunizations are important for everyone, especially the very young and the elderly. Michigan's immunization rates are decreasing. Michigan needs to reverse this trend by identifying the

communities with lower immunization rates and focus educational awareness efforts in those communities.

- To reduce the risk of foodborne illnesses, more education about the importance of, and instructions on, hand washing should be encouraged for all ages.
- More physical activity is necessary for people of all ages, including children. Childhood obesity is a growing concern. More businesses and employers could consider offering wellness programs to encourage more physical activity among their employees. School facilities may provide another option for offering physical activity programs in the community.
- Good health starts in the womb. A pregnant mother's physical and mental health, as well as her environment, can affect her child's risk for obesity and other health concerns later in life.
- A healthy environment encourages a healthier lifestyle. There should be more focus on the built environment and development that encourages good decisions and more physical activity, including safe routes to school.
- Education about how to access care, how to use available care appropriately, and how to use preventive care, is necessary for those who are newly insured through private insurance or Healthy Michigan. Many people have insurance now for the first time, but they do not have information on how to navigate or effectively use the health care system. Some individuals with coverage may continue to use the emergency room for preventive and general medical care.

### *Nutrition*

- Good nutrition should start early and be supported in the schools. Promoting fresh food and good nutrition with children will help establish healthy eating habits for a lifetime. Schools could bring in more local food sources to enhance school lunch options. They could also provide school gardens and garden education programs.
- Good nutrition is critical for maintaining long-term health and keeping older adults in their own homes longer, instead of a long-term care or nursing facility.
- Physicians could consider writing more prescriptions for fruits and vegetables.
- Farmers' markets should all accept EBT (electronic benefit transfer) cards, and they should all participate in Double Up Food Bucks. This program allows families who receive food assistance to purchase twice as many fruits and vegetables for the same cost. ([www.doubleupfoodbucks.org/](http://www.doubleupfoodbucks.org/))

### *Long-Term and In-Home Care for Older Adults*

- Long-term care facilities are not available to many older adults.
- Although many older adults prefer to remain in their homes, chronic diseases, dementia, and physical impairments, such as vision and hearing loss, affect their ability to do so.
- Most older adults prefer to remain in their own homes for as long as possible, while having quick access to medical facilities. Older adults may live alone, out in the country, and isolated from others. In-home health care providers and other community-based services are important but not always available to support the older adults who would like to remain independent in their homes.

### *Other Priority Health Issues*

- Tobacco use rates in the region are double the state's rate. The region's rate may be influenced by its large Medicaid and low-income populations, which are known to have higher tobacco use rates.
- Michigan should be more proactive so that it can positively respond to emerging health risks such as Ebola and enterovirus D68.
- There are many federal resources and benefits available to military personnel and widows/widowers of those in the military, but these resources are left "sitting on the table" because eligible people are

unaware of them. Increasing the use of these earned benefits could significantly increase cash flow to the area.

## **DISCUSSION OF CHALLENGES**

Participants shared barriers that prevent children and older adults from achieving good health and wellness, and they suggested indicators that could show if these challenges are being addressed. The main challenges identified include families facing multiple issues, lack of an integrated systems of care approach, inadequate access to services, and limited transportation. One topic that was mentioned only once, but received plenty of support from the audience, was the lack of, but desperate need for, an improved data infrastructure. Some of the challenges identified are described below.

### ***What barriers are preventing children and older adults from achieving good health?***

#### *Families with Multiple and Complex Challenges*

- Poverty and the social determinants of health are major issues that underlie many of the health concerns identified. If these issues are addressed and people are not in poverty, then many of the health concerns, including obesity, will decrease. People will have access to healthy fresh foods because healthy food is much easier to get when it is affordable.
- Toxic stress is affecting many children in the region. Challenges such as domestic abuse, substance abuse, and poverty all affect a vulnerable child's developing brain. Toxic stress can hinder a children's normal brain development, which affects their ability to get and remain healthy in the long term.
- Almost half of the elders in the native community are raising grandchildren. There is not adequate support to help these multigenerational families, whose primary caregivers were often products of forced boarding school. Due in large part to the disruption of their families at a young age, there are misunderstandings about effective parenting and education needs among these caregivers.
- When a child is diagnosed with a chronic disease, it is often a diagnosis that affects the whole family. The whole family, including other children, may have to travel long distances to access one child's specialty care. Parents may have to take time off from work, and they may risk losing their jobs to get to medical appointments for their child. Many families wait until there is very serious health problem before taking the child to the doctor because they cannot afford the cost or the time to go to an appointment. This leads to health issues that are far more costly and more difficult to treat.
- Many families do not want to access services because they fear consequences, such as having their children taken away. This leaves many families isolated, without the support they need, and increases the likelihood of abuse and neglect. Service providers need to emphasize building respectful relationships with families to help address this fear.
- Substance and drug abuse affect parents' ability to prioritize their and their family's health. Instead, they are focused on getting their next "fix." Most individuals who use substances began using tobacco, drugs, or alcohol before they were 18 years of age. The earlier a child starts using alcohol, the more likely they are to become an alcoholic. If addiction and mental health are addressed in adolescence, there will be fewer adult substance abusers, making it easier for parents to make their lives and their families' lives healthier and happier.

#### *Lack of an Integrated Systems of Care Approach*

- There is a major focus on the health care system, without recognizing the large set of services and supports that work with children and older adults outside of the health care system. These services

and systems need to be interconnected and supported by each other. Case managers and care coordinators can help weave community-based services into health care.

- People with complex needs may be seen primarily in one system, but they often need something from another specialized program. There needs to be better alignment between services, but there is no good communication or referral process across the different systems to ensure coordinated care. Some organizations are meeting to learn from each other and learn about available resources, but this needs to occur across the community and region. If all of the services and supports in the region are involved, it will result in a better alignment of community resources for everyone.

#### *Services Unavailable to Those Who Need Them*

- Although there are more infant mental health providers than there have been in the past, it is not adequate to meet the needs of the community. Also, this service is only available to those in Medicaid, and not to those with private insurance. There are no private providers of this service for families with private insurance, however, and many preschool aged and young children need behavioral health service, regardless of their insurance provider.
- There are no significant efforts to develop programs that teach self-care skills for older adults. This is a needed service to help ensure older adults can remain in independent in their homes for as long as they want to be there. This is especially a challenge in rural communities.
- Home health care providers are not available in the area to provide necessary care that keeps people independent and in their homes for longer. This leaves older adults relying unnecessarily on the hospital for routine medical care and may increase emergency room visits.

#### *Limited Transportation*

- Transportation was repeatedly reported as a major challenge that keeps people from being able to consistently access services, supports, appointments, and other health care needs.
- Many people need multiple services that are in different locations, but do not have transportation available to access all of the needed care.
- People want to be able to stay at home as long as they can, which costs less than being in a long-term or nursing care facility; however, older adults also want to have quick access to health care when they need it. Some older adults cannot safely drive, but do not have another way to get to their medical appointments. Outside of Traverse City, an ambulance ride to the hospital can take 30 minutes or longer.

#### *Other Challenges*

- Data systems from different organizations cannot “talk” to each other. This affects the organizations’ ability to coordinate care and services with each other and make it a seamless system for the user. For example, it is difficult to address reading proficiency when information about a student’s early childhood experiences is not available.

#### ***What key indicators would tell the board that these issues and challenges have been successfully addressed?***

Participants suggested several indicators, some of which should already be available, that would show if progress is being made in the health of their communities. Some indicators were general recommendations and not tied to a specific data set.

- Community health assessments would reflect a healthier community. They should show that access to care is being better addressed, as well as progress on other current priority issues.
- Death rates are reported by each local health department and can be used to show the overall health of the community.

- There are several tracked health indicators that could be used to show that Michigan is becoming a fit state, rather than the fattest state. These indicators include a decrease in the obesity rate, a decrease in the smoking and tobacco use rate, reduced chronic disease rates, and lower rates of hospitalization.
- Fewer emergency room (ER) admittance and readmittance rates would show that people are addressing health care needs before they become emergencies.
- If substance use is addressed in adolescents, there would be fewer addicted adults. There are surveys in Michigan that show usage rates of middle- and high-school students.
- The Great Start Collaborative (GSC) is working on the goal, shared by Head Start, to ensure that children are born healthy. The GSC has a data set that organizations are using to monitor this goal.
- The National Guard monitors the medical readiness of soldiers and reserves. Right now, physical fitness scores show that this population is not physically fit. The test includes being able to run two miles in a certain amount of time, and maintaining a certain weight for a person's height (BMI).
- Availability of long-term care, in-home health care, and hospice care could be tracked to assess access to care for older adults.
- If hospitals went through a planned redesign where they are reimbursed for community education, health education, transportation, and food as medicine ("farmacy"), instead of reimbursed based on volume of care, it would be a sign that some challenges have been addressed.
- An increase in the number and percentage of eligible individuals (veterans and widows/widowers of veterans) getting their federal benefits would indicate improvement in the community as a whole.
- A focus on long-term indicators and on prevention should be encouraged, instead of focusing on short-term program results.

## **DISCUSSION OF INNOVATIVE AND PROMISING APPROACHES**

Participants shared the following information about programs and approaches underway to address the health and wellness of children and older adults. Additionally, one participant suggested that better efforts should be made to ask people why they are having the problems they are having. Another participant emphasized the importance of respect and care that providers must have and show to those they serve.

### ***What innovative and promising practices are being used for children?***

- Healthy Futures offered through Munson Healthcare is a primary prevention program from pregnancy to early childhood. It works to connect several services together and destigmatize the use of services by offering it to everyone in the community instead of being based on income. Since the program began working to improve service collaboration, enrollment in the program has increased. (For more information: [www.munsonhealthcare.org/healthy-futures-online](http://www.munsonhealthcare.org/healthy-futures-online))
- Munson Medical Center provides child life specialists who work with a family when their child is hospitalized and is going through medical treatment. A child life specialist is a member of the interdisciplinary team and provides a familiar face at all appointments to give comfort and continuity from one appointment to the next. The child life specialist makes sure the family understands what treatment is coming next and provides education and information about what to do after the family leaves the facility. (For more information: [www.munsonhealthcare.org/infantsandchildren](http://www.munsonhealthcare.org/infantsandchildren))
- Teen Pathways Community HUB is a school-based health model funded through a transformation health care grant. It uses outreach and community health workers to connect teens and families to the resources they need in the community. It uses a hands-on, accountable approach that a resource directory alone cannot provide.
- Whole Family Connection is an online, self-directed 2-1-1 service. North Ottawa Community Hospital is working with the United Way to locate this online service in their ER department. It will

allow individuals and families immediate access to screening criteria as a first step to access community resources, and provide consultation services by a social worker when the family is in crisis. (For more information: [www.wholefamilyconnectionottawa.com/HTML/Interface/frameset-main-r.htm](http://www.wholefamilyconnectionottawa.com/HTML/Interface/frameset-main-r.htm))

- Designed by the Traverse City Great Start Collaborative, 5 to ONE is a system of connected resources for families in a rural setting with a “no wrong door” approach. It serves a five-county area with a one-stop-shop of resources that provide support to families and follow-up on service referrals to ensure people are connected to the services they need. This information is communicated back to the referral source. (For more information: [www.greatstartkids.com/](http://www.greatstartkids.com/))
- Safe Families for Children provides a safe place for children to go when parents and caregivers are hospitalized and their children do not have another place to go. It is a voluntary program for families that uses screened and approved host families. (For more information: [www.safe-families.org/](http://www.safe-families.org/))
- The Grand Traverse Women, Infants, and Children (WIC) Clinic packs in as many services as possible for families all in one visit. Families have transportation challenges and busy lives, and they cannot get into the clinic very often, so WIC works to make each visit as useful as possible. The clinics are nurse-based so they can offer immunizations and fluoride varnishes. The clinic offers referrals to Early Head Start, Head Start, and the Intermediate School District, as well as providing assistance to sign up for Medicaid and other available programs. (For more information: [www.co.grand-traverse.mi.us/departments/health/WIC.htm](http://www.co.grand-traverse.mi.us/departments/health/WIC.htm))
- FoodCorps, a part of AmeriCorps, is providing nutrition education in schools in partnership with the Michigan Good Food Charter. Research shows that when kids try a food multiple times, they will choose it in the lunch line. This is helping bring items like kale chips to the menu in area schools. (For more information: [www.foodcorps.org](http://www.foodcorps.org) and [www.michiganfood.org/](http://www.michiganfood.org/))

### ***What innovative and promising practices are being used for older adults?***

- Goodwill Industries is helping get fresh food into meals through Meals on Wheels. (For more information: [www.goodwillnmi.org/food/goodwill-food-services/](http://www.goodwillnmi.org/food/goodwill-food-services/))
- Leelanau County Commission on Aging has more than 80 members who come together to share information and resources, so as to make the best use of available funds to serve more people.
- The PACE program (Program of All-inclusive Care for the Elderly) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. PACE is in Southern Michigan already and there are efforts to bring it to other areas in Michigan, including the Grand Traverse area. It is a community-based model that addresses primary care and transportation challenges. (For more information: [www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html](http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html))
- The use of telemedicine for congestive heart failure in rural areas has made a big impact on readmittance rates. Transportation is a barrier and keeps people from getting the follow-up care they need for this chronic disease. When telemedicine is available, however, patients can call in their weight and get medication adjustments as needed. A midlevel provider reviews their information on a daily or weekly basis.
- The Northwest Michigan Health Department encourages healthier eating and nutrition by ensuring EBT machines are available at farmers’ markets, by educating families about Double Up Food Bucks, and by offering cooking demonstrations to show people how to use different vegetable offerings. Due to reductions in funding, however, the cooking demonstrations are no longer provided.
- Meals on Wheels has been around for over 30 years. It is proven effective at helping to keep older adults in their homes and out of nursing and hospital facilities. A dietician creates balanced healthy meals with fresh food, and volunteers go into homes to deliver the food. The volunteers often know if

there is a problem in a person's home and they can contact a family member or 9-1-1 if necessary.  
(For more information: [www.mealswheelslove.org/](http://www.mealswheelslove.org/))



# Michigan Health Endowment Fund

## Listening Tour Summary: *Detroit*

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### INTRODUCTION

Over 130 people attended the fifth listening tour session at the UAW-GM Center for Human Resources in Detroit on October 20, 2014. Participants were asked to share their perspectives on priority health issues, challenges, and innovative and promising approaches. A summary of the discussion is provided below.

### DISCUSSION OF PRIORITY HEALTH ISSUES

Participants were presented with a list of health issues identified in hospitals' community health needs assessments completed throughout Southeast Michigan<sup>1</sup> in the last two years. They were asked to comment on the issues they saw as most important and identify any issues they thought were missing from the list.

#### ***What are the most important issues included on the list?***

Participants identified primary care, population health, and health literacy as the most important overall. Some of the participants' comments are provided as examples of this discussion.

- County health rankings provide additional data about community health issues. Many hospitals have service areas that overlap, so their community health needs assessments are reporting similar information.
- Addressing the mental health needs of the population is a primary health promotion strategy.
- A major next step in addressing access to health care is improving the health literacy of those who are gaining access to health care and are not familiar with insurance terminology and chronic diseases.

#### ***What is missing from the list?***

Participants said long-term care, creating true integrated health care models, dental health, and addressing the social determinants of health were missing from the list of health issues.

- Dental health is part of overall health and well-being, especially for children. Dental health needs to be incorporated into primary care services for children.
- The integrated health care model can be used to address social determinants of health in the primary care setting. Moving toward an integrated health system with an early intervention approach saves a lot of resources in the end (for example in the criminal justice and child welfare systems).
- Long-term care, whether it is provided in the home, community, or institution, is missing.
- Seniors will use ancillary care more often; how is that care supported when it is not covered by medical insurance?

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<sup>1</sup> Community health needs assessments for Southeast Michigan were collected from hospitals in Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, and Wayne counties.

### ***What are the important issues for the health and wellness of children?***

Participants identified the following issues as most important for the health and wellness of children: eliminating silos, health education, access to healthy foods, and immunizations. Some of the participants' comments are provided as examples of the discussion on these issues.

#### *Eliminate Silos*

- There are many silos in the current system—medical, mental health, and education—that don't connect. When a child is seen in a pediatrician's office, more emphasis is needed on examining the context of the child's life.
- Working with partners across silos reduces costs and produces better outcomes. We have a tremendous opportunity to talk about how to innovate, incubate, evaluate, and replicate what works. The silos we have are perpetuated by fiscal structures; we need payment reform to change the situation.
- To address pervasive poverty and other social determinants of health, we need to break down silos and work together.

#### *Health Education*

- Health education could be expanded to school-based health programs in order to create a healthy environment. Kids are missing school because their health needs are not being met. Michigan has the worst student-to-school-nurse ratio in the nation; school nurses and school-based health centers can make a big difference.
- There are a number of health issues that can be addressed using a comprehensive health curriculum, such as the Michigan Model. The Michigan Model curriculum teaches children skills to prevent chronic health conditions and be on a healthier path.
- Public health and education need to come together. Education is prevention. Parents are not teaching [health promotion] to their children; there needs to be a greater emphasis on health education in schools.

#### *Access to Healthy Foods*

- Children need better access to fresh fruits and vegetables. Parents need to have better access to stores, which includes transportation to stores and the money to buy healthy food.
- Recommendations for healthy school meals have not been implemented, because it is becoming a political issue. There needs to be more discussion about what kids are eating at school. Hunger and food insecurity affect more children than people may realize, such as children in families that appear to be financially secure.

#### *Immunizations*

- More focus needs to shift onto immunizing at-risk children and educating parents. There needs to be better effort to go into the community to administer immunizations.
- Preventable diseases are on the rise, and a larger focus on vaccine-preventable diseases is needed.

### ***What are the important issues for the health and wellness of older adults?***

Participants identified the following as the important issues for older adults in the region: access to care (including medical, mental and oral health care), health literacy, livable communities, and addressing basic needs.

### *Access to Care*

- To improve access, there needs to be a service that meets seniors in their homes to provide education on how to take their medications properly and explain the changes that are coming with Medicare.
- Adults in Detroit are experiencing the effects of aging faster than adults in other areas of the state. For example, a 55-year-old in Detroit has similar needs to a 65-year-old in another part of the state, but a 55-year-old does not have supplemental Medicare coverage to help pay to address his/her needs. This population is paying \$8,000 to \$9,000 out of pocket annually. Insurance coverage is still a problem.
- Seniors are not given any resources through the Affordable Care Act for oral health services. There is a huge need in the senior population to access these services.
- Older adults with serious mental illnesses need access to health care, especially those living in long-term care facilities.
- Mental health issues are not just a concern for those who live alone in their homes; there is social isolation within facility settings, too. Long-term care workers' pay is not sufficient, so there is constant turnover that affects the care and social well-being of individuals in the facility.
- Patients need comprehensive, coordinated health care in the current system. Eight-day stays (in a long-term care facility), the current median length of stay for older adults, is not sufficient for comprehensive care to take place with a longitudinal perspective.

### *Health Literacy*

- Many seniors have an outdated understanding of Medicare and they do not know about the changes being made. Seniors need someone to go to their homes or senior centers to explain the changes.
- The older population (50+) wants to use technology, but they need to be trained. This population is not getting trained by their children.

### *Livable Communities*

- Livable communities have traits that get people outside in safe ways, such as having sidewalks that are in good condition. Livable communities give seniors the opportunity for social interaction with others in the community.

### *Basic Needs*

- If a person doesn't have food on the table or good nutrition, nothing else is going to matter. There are a lot of people who cannot afford to buy medications or be safe in their home. Financial support needs to go towards basic needs and the social determinants that influence health.

### ***What are the important issues for the health and wellness of both children and older adults?***

Participants in Detroit said initiatives need to use the collective impact model to address health issues in the region. As one of these participants said:

- There are some very promising initiatives across the country using the collective impact model. The model uses common metrics and goals to get organizations on the same page and make sure their contributions result in progress. The MHEF could support a backbone organization with dedicated paid staff that communicates and coordinates numerous community organizations moving toward one goal. There is an immense amount of communication necessary to connect everyone in ways that help them to work together.

## DISCUSSION OF CHALLENGES

Participants were asked to describe the barriers that are preventing children and older adults from achieving good health and wellness. The main challenges identified by session participants are described below.

### *Access*

- Services need to co-locate to improve access. For example, over half of women in the region are enrolled in Women's, Infants and Children (WIC) services; the Nurse Family Partnership may need to co-locate with WIC to get women into both services in order to have greater impact. Community health workers and extension workers could co-locate to help address other issues, such as obesity.
- Provide immunizations, WIC services, and other services to reduce infant mortality in one location ("one-stop shopping"). The perspective of those who are receiving the services needs to be considered to improve the process.
- Applications for Medicare, Medicaid, and dental services are being completed, but there are long wait times to receive services. Meals on Wheels and home care are other examples of services with long wait times. Older adults or people in crisis cannot wait for months to receive services. People will end up in the emergency room because their issue was not addressed.
- In-home services are extremely important to improve the quality of life for older adults and special populations, such as those with amyotrophic lateral sclerosis (ALS).
- When trying to resolve health issues, we must consider the child and caregiver/parent together, as well as integrated care for children and families.
- Transportation is a huge barrier, whether it is an older adult needing to get a prescription filled or a child being able to stay after school for an activity.
- Consumers lack confidence in how to engage with the health care system; they do not know how to navigate the system or how to reach out to nontraditional partners, like food pantries.

### *Communication*

- More work is needed to create registries. Families end up in different physician practices or different pharmacies. There should be one registry to get up-to-date information, such as when an individual had his/her last physical exam.
- There is a lot of fragmentation in the health care system. Consumers do not know how important it is to engage with the system; they go to closest facility rather than the facility where they are most known. Patient evaluations are unnecessarily repeated by a number of providers. The necessary exchange of health information is not occurring in Southeast Michigan.

### *Physical Infrastructure*

- One of the biggest barriers to health is the physical infrastructure (livable communities). We can have the best medicine in the world, but if there are not walkable and livable communities, then individuals cannot get outside and be active to improve their health status. Consumers cannot get to a doctor appointment because they do not have adequate transportation; we need to get out of an autocentric focus.

### *Language*

- Difference in language is a barrier; this region continues to grow in diversity. For example, there are 100 different languages spoken in the school system in Macomb County. Language can present a huge divide between a patient and his/her physician, prohibiting health education. There is not sufficient interpretation, and a lot of communities are left behind.

### *Health Care Workforce Issues*

- More of the health care workforce needs to be prepared to work with older adults. We are losing geriatric specialists; all health care workers need to know how to work with older adults.
- Last year, the state legislature passed insurance reform for families who have a child with autism; however, the problem of human infrastructure still exists. Trained professionals are needed to work with families to provide the behavioral training (for example, counseling for adapting to different environments) that children need. We need to work with universities to fill that gap.

### *Payment*

- Payment reform is a major challenge. The health system is paying for the wrong things; we are over-emphasizing sick care and not supporting services in the home.

### ***What key indicators would tell the board that these issues and challenges have been successfully addressed?***

- Only 20 percent of health is related to medical care; there is another 80 percent that is related to socioeconomic factors that contribute to an individual's health. We should not measure just the medical side of things. When it comes to competitive bids that will be released for funding, the MHEF needs to ask applicants to provide the metrics they are proposing to measure their outcomes and be very clear that they need metrics before receiving any funding.
- There are not good metrics to measure overall health. The metrics used now are not being used effectively. For example, the mortality rate is one of the most common outcome measures for health, but that is not a nuanced metric; you are either alive or dead. There are no patient-reported outcome measures. Individuals do not have the information they need to make good choices about their health.
- There is inadequate root cause analysis to help us ensure appropriate interventions. For example, when looking at individuals with no medications at hospital discharge, we should look at whether this population is more likely to be readmitted than the population discharged with 20 medications.

## **DISCUSSION OF INNOVATIVE AND PROMISING APPROACHES**

Participants shared the following information about programs and approaches underway that are working well to address the health and wellness of children and adults.

### ***What is working well to address the health and well-being of children?***

- The Generation With Promise program provides skill-based training, resources, and tools for families to put healthy eating into action. The program partners with Gleaners Community Food Bank and other nontraditional partners; these partnerships are in it for the long haul. The program staff have skill training and resources available to them, and they are culturally competent. Staff are going into communities and changing the culture around food.
- School nurses have been shown to contain health care costs and improve the health of children. School nurses focus on the health promotion of children from birth to 26 years old, including children with special needs. One program in Michigan documented a reduction in emergency room visits and an increase in access to care. This same program worked with Gleaners to conduct cooking classes with families; provide health screenings, referrals, coordination of patient care; and help families find a medical home. Population-based school nurse services are missing from our schools; they provide nurse services to all students, their families, and the community.
- School-based health centers provide primary care services to at-risk children. They offer a continuum of care and health education. For example, the Henry Ford Health System's school-based health centers deliver primary care to children and can help develop a medical home for them. In addition,

centers offer mobile clinics, medication delivery programs, nurse services, and use electronic medical records.

- The Nurse Family Partnership sends registered nurses into homes of low-income, first-time mothers to provide care, support, and parenting education. Home visits occur before birth and continue regularly through the child's second birthday. The program is evidence-based; data is collected and aggregated weekly and reported monthly.
- Marathon Oil, the Detroit-Wayne County Health Authority, and the City of Detroit Department of Health and Wellness are working together to develop and implement a plan to address asthma for children living within the 48217 zip code on the southwest side of the city. This area has the worst air quality in the state.
- The Motion Coalition is a collaboration of 25 agencies working together to address child obesity in Detroit. All of the partners are excited to work together for change in the community.
- The Henry Ford Health System is using community health workers (CHWs) to help reduce infant mortality. CHWs cost less and are able to help vulnerable women by identifying barriers and addressing the needs that the health care system does not have the time or know-how to do. CHWs are not just used to address infant mortality, but also chronic diseases like diabetes. Residents trust CHWs in the communities where they serve.
- Hospice of Michigan's Pediatric Early Care program is designed for children and families who need help finding resources and navigating the medical system. The initial program was launched in 2000 in Grand Rapids; another program was launched in Southeast Michigan in 2013. Social workers with master's degrees are working with families in these regions. The program is getting so many referrals now, more resources are needed to provide services across the state and train caregivers.
- Make Your Date Detroit is a program to reduce preterm birth through a unique collaboration of hospitals, insurance companies, and the legislature. The program provides access to prenatal care to women in Detroit, making sure patients get what they need and the services are covered. This program focuses on evidence-based practices that reduce infant mortality, a huge issue in Southeast Michigan.
- Starfish Family Services has had a children's wellness home health initiative for the last 30 years. It reaches about 1,000 infants and young children. The program walks families through gateways to various programs, reducing trauma for infants who are in multiple systems. The program helps parents and caregivers develop a mutually satisfying relationship with their children by reducing stress and anxiety for moms and improving interaction between child and parent. The program supports the mother through her reproductive years, making sure she is physically and mentally healthy, as these issues affect outcomes for children. The innovative program employs clinicians with master's degrees who are trained in infant development.
- A fruit and vegetable prescription program in Southeast Michigan addresses the major intersection between population health and healthy food. Physicians prescribe fruits and vegetables to patients, instead of, or on top of, medications. Health and food system partners are very active in this initiative. Many areas identified in the community health needs assessment are siloed, but have a common denominator—food. Missing from the conversation today is food and the local food system here in Detroit. Issues for high-risk populations include physically getting to healthy food access points and bringing local healthy food into our health care systems. There have been great outcomes with the Fruit and Vegetable Prescription Program, which has expanded from one to three sites. It is a great collaborative effort with collective impact that is addressing social determinants today.
- The Detroit Wayne Mental Health Authority System of Care is a delivery model for children's services. This system reduces silos and brings partners together. For example, when working with children who have suffered sexual assaults, all partners make sure the child is not traumatized again during interactions with service providers. Peer mentors are a very important component to the system of care because kids in the system typically do not listen to older people. Similarly, family

peers are important because families who are dealing with emotional disturbance will listen to other families who have successfully navigated the system.

- The Wayne Children’s Healthcare Access Program (WCHAP) is based on a model in Denver, Colorado. WCHAP brings partner organizations together with the specific focus of helping families access a wide range of services—medical and nonmedical—for their children. The WCHAP program has a 13–30 percent return on investment with high levels of patient satisfaction.

### ***What is working well to address the health and well-being of adults?***

- Time banks are service exchange programs within a community that provide resources to both children and adults. Whether a senior needs transportation home after being discharged from a hospital or a child needs mentoring or home visiting services, time banks allow that to happen. Time banks are sustainable and can build their own revenue sources.
- Area Agencies on Aging (AAAs) provide a variety of cost-effective, evidence-based programs to help seniors with disease management and addressing transportation gaps. The AAAs have collaborated with the Regional Transit Authority and other partners to facilitate necessary and convenient transportation for older adults. The AAAs also provide geriatric care managers and resource advocates (someone who can assist with enrollments) to examine quality of care, socialization, and nutrition issues, and can connect people to the right resources in the community.
- The Coalition for Oral Health for the Aging hosts “Dental Days” to increase the utilization of oral health resources. Public Act 161 allows dental hygienists to provide preventive services in long-term care facilities.
- Mobility Management Services provides information to seniors on transportation and can help them get assistance with driving cessation.
- Elder Law of Michigan connects with seniors to provide a safe link to community resources. It provides seniors with technology and teaches them its key benefits. Elder Law also helps seniors find resources and refers them to services. Home visits are conducted in addition to regular phone calls.
- An at-home, prehospital support program was launched seven years ago by Hospice of Michigan and funded by the Robert Wood Johnson Foundation. The program is designed for chronically ill seniors. The program contracts with insurers and systems, like the Detroit Medical Center, to take care of the sickest of the sick. Registered nurses, social workers, spiritual care advisors, and other providers go to the patient’s home to develop a care plan for the patient and his/her caregivers and provide services. The Blue Cross Blue Shield of Michigan Foundation conducted a study examining two years of program data and showed a 30–37 percent reduction in costs.

### ***What is working well to address the health and well-being of both children and adults?***

- The Oakwood Healthcare System’s Healthy Communities Initiative engages partners and helps them work together to have collective impact. Oakwood is currently implementing the initiative in Wayne, Westland, Dearborn, and Taylor. The initiative is implementing multiple evidence-based programs. City leaders have embraced the initiative, putting themselves on the line to be models for their communities and organizing regular events, such as “Walk and Talk with Your Mayor.”
- The Urban Neighborhoods Initiative in the Springville Village in southwest Detroit has started to redevelop city parks and green spaces to improve community wellness. The initiative is using a multipronged approach to design walkable neighborhoods and safe community parks that every member of the community can enjoy.



# Michigan Health Endowment Fund

## *Listening Tour*

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### AGENDA

November 21, 2014

1:00 – 3:00 PM

The Salvation Army Kroc Center  
Grand Rapids, Michigan

- 1:00 PM     **Welcome and overview of the MHEF**  
*Rob Fowler, Board Chairperson, Michigan Health Endowment Fund*
- 1:15         **Discussion of Priority Health Issues**  
*Participants will be asked to review and provide comments on a list of issues that have been identified through community health needs assessments completed in the region.*
1. *What “jumps out” to you in this list of priority health issues? Are these the issues that you think are most important? Is there anything missing?*
  2. *Which issues do you think are most important for the health and wellness of children and why? What are some of the factors contributing to these issues?*
  3. *Which issues do you think are most important for the health and wellness of older adults and why? What are some of the factors contributing to these issues?*
- 1:30         **Discussion of Challenges**  
*Participants will be asked to describe the challenges facing their community in addressing priority health issues.*
4. *Given the issues that you have identified, what barriers are preventing people from achieving good health? As you answer this question, please think about children, older adults, and minority populations in particular.*
  5. *What key indicators would tell the board that these issues and challenges have been successfully addressed?*
- 1:50         **Discussion of Innovative and Promising Approaches**  
*Participants will be asked what is working well in their community to address the issues they have identified. As they answer the following questions, participants will be asked to describe how people and organizations are working collaboratively; what outcomes or benefits are being achieved; and how quality and cost are being affected.*
6. *What is working well to address the health and well-being of children? What innovative and promising approaches are underway?*
  7. *What is working well to address the health and well-being of older adults? What innovative and promising approaches are underway?*

2:40      **Special Topics**

*Priority areas for the Michigan Health Endowment Fund include infant mortality, wellness and fitness programs, access to healthy food, technology enhancements, health-related transportation needs, and foodborne illness prevention. Participants will be asked to describe special challenges or innovative and promising approaches related to these areas that have not been covered in the discussion.*

2:50      **Additional Comments and Concluding Remarks**

*MHEF board members may use this time to ask for additional comments and clarification from participants, and will describe next steps.*

3:00      **Adjourn**

# Community Priority Health Issues

As part of the Affordable Care Act, nonprofit hospitals are required to conduct a community health needs assessment every three years. The needs assessment must include input from people representing the broad interests of the community served. Hospitals must document the priority health issues identified by the community and make a written report widely available to the public. The first round of these needs assessments was completed during 2012 and 2013. Public Sector Consultants Inc. compiled information from community health needs assessment reports available online from 30 hospitals in the following counties:

Allegan	Ionia	Mason	Muskegon	Osceola
Barry	Kent	Mecosta	Newaygo	Ottawa
Berrien	Lake	Montcalm	Oceana	VanBuren

The priorities that were identified in the hospital needs assessments are listed below, with priorities that were identified most often listed first. The number of hospitals identifying the priority in a community health needs assessment report is noted in parentheses.

- Access to health care (32), including:
  - Affordable care for the uninsured, low income, and working poor
  - Availability of primary care and/or urgent care providers
  - Availability of providers who accept Medicaid
  - Transportation
- Mental and behavioral health (15), including:
  - Depression
  - Availability of mental health care providers
- Obesity (15)
- Health education and communication (14), including:
  - Health literacy
  - Increasing awareness of existing resources
  - Patient-provider communication
- Substance use and abuse, including alcohol, tobacco, and illegal substances (13)
- Disparity (12), including disparities in student risk factors and protective factors, prenatal care, and overall racial disparities
- Nutrition (12), including:
  - Access to healthy foods
  - Nutrition education
- Chronic disease (7)
- Dental health (7)
- Need for a coordinated community approach to health issues (7)
- Preventive care and activities (7)
- Focus on specific populations (5), including:
  - Low-income
  - Native American
  - Hispanic
  - Children and youth
  - Seniors
  - Women's health services
- Physical activity (5), including:
  - Access to resources for physically activity—specifically wheelchair and adaptive sports programs
- Cardiovascular health (4), including:
  - High blood pressure
  - Cardiac disease
  - Cardiac rehabilitation
- Diabetes (4)
- Teen pregnancy (3)
- Cancer (2)
- Sexually transmitted infections (2)

Other priorities identified in only one community health needs assessment in the region were improving the quality care for all community members, specialty care, and lab testing.