Michigan Health Endowment Fund
201 Townsend Street, Lansing, MI 48913

Michigan Health Endowment Fund Meeting

March 19, 2015

8:30 a.m. – 11:00 p.m. Board Meeting

Radisson Hotel, 111 N. Grand Avenue, Lansing, MI 48933

Michigan Health Endowment Fund Board Meeting
March 19, 2015
Radisson Hotel, 111 N. Grand Avenue, Lansing, Michigan, 48933

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.

8:00 a.m. – 8:30 a.m.	**Breakfast**
8:30 a.m. – 11:00 a.m.	**Board Meeting** **Opening—Rob Fowler** • Call to order of regular Board Meeting • Roll call • Approval of agenda, page 3 • Approval of Feb. 9, 2015 minutes, page 24 • Public Act 4 of 2014, page 4 • Bylaws, page 11 • Open Meetings Rules and Procedures, page 18
8:40 a.m. – 8:50 a.m.	**Public Comment** Public Comment: Five-minute limitation on a single representative of an organization; three minutes for individuals representing themselves
8:50 a.m. – 9:10 a.m.	**CEO Report, Paul Hillegonds**
9:10 a.m. – 9:55 a.m.	**Learning Presentation from Public Sector Consultants** 2014 Listening Tour Report, page 34
9:55 a.m. – 10:05 a.m.	**Executive and Compensation Committee: Rob Fowler** • Financial report, pages 26-27, 30-31
10:05 a.m. – 10:10 a.m.	**Audit Committee: Keith Pretty**
10:10 a.m. – 10:15 a.m.	**Governance Committee: Michael Williams**
10:15 a.m. – 10:20 a.m.	**Investment Committee: Tim Damschroder** • Huntington statement, pages 28-29, 32-33
10:20 a.m. – 10:55 a.m.	**Grantmaking Committee: Sue Jandernoa**
10:55 a.m.	**Next Steps—Rob Fowler**
11:00 a.m.	**Adjourn**

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

Clerk of the House of Representatives

Approved .....

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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

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
Board Meeting
Monday, February 9, 2015
Small Business Association of Michigan, 120 N. Washington Sq. Ste. 1000, Lansing, MI 48933

Meeting Minutes

Call to order
The board meeting of the Michigan Health Endowment Fund was called to order at 8:04 a.m. by Chairman Robert Fowler.

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

Board Members present:
Rob Fowler
James Murray

Participating by phone:
Lynn Alexander
Tim Damschroder
Cindy Estrada
Sue Jandernoa
Keith Pretty
Marge Robinson

Absent:
Michael Williams (attempted to call into the meeting but had technical difficulties)

Others present:
Geralyn Lasher
Mary Stier
Duane Tarnacki (by phone)

Approval of agenda:
Chairman Fowler approves the agenda.

Review and approval of the minutes from the previous meeting
Board Member Murray moves to approve the minutes from January 30, 2015, board meeting. Board Member Alexander seconds. Motion passes by a vote of eight to zero.

Public comment:
There was no public comment.

Vote on Chief Executive Officer:

Board member Alexander moves to nominate Paul Hillegonds as the new Chief Executive Officer of the Michigan Health Endowment Fund as recommended by the search committee. Board Member Jandernoa seconds. Motion passes by a vote of eight to zero.
Due to technical difficulties, Member Michael Williams was unable to call in during the vote, but reached Chairman Fowler following the meeting to indicate his full support for Paul Hillegonds as CEO.

Adjournment
Board Chair Fowler moves to adjourn the meeting. Board Member Murray seconds. Motion passes by a vote of eight to zero. Meeting adjourns at 8:07 a.m.

Respectfully submitted,

_____
Secretary of the meeting

MHEF Statement of Financial Position
January 31, 2015

ASSETS	
Chemical Bank	$ 6,789,613.26
Huntington Investments	
Investment - At Fair Market Value	83,488,597.99
Accrued Interest Earned - Receivable from Huntington	371,963.04
Total Value of Huntington Investments	83,860,561.03
Prepaid Insurance Expense	10,828.00
Total Assets	$ 90,661,002.29
LIABILITIES AND NET ASSETS	
Liabilities	
Accounts Payable	$ 7,224.72
Net Assets	
Unrestricted Net Assets	70,653,777.57
Restricted Net Assets	20,000,000.00
Total Net Assets	90,653,777.57
Total Liabilities and Net Assets	$ 90,661,002.29

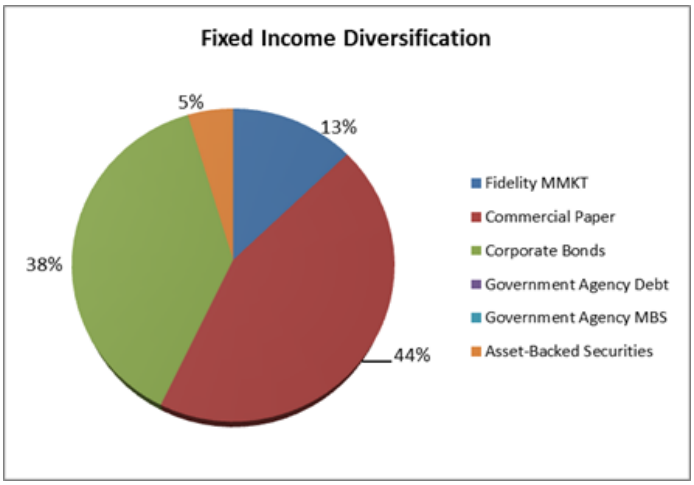
MHEF Statement of Activities
as of January 31, 2015

	Current Month	Year-to-date
Operating Activities:		
REVENUE		
Funds Contributed from Blue Cross Blue Shield	$ -	$ -
OPERATING EXPENSES		
Professional services	7,224.72	7,224.72
Grant expenses	1,250,000.00	1,250,000.00
Memberships	-	-
Meetings and facilities	1,388.80	1,388.80
Supplies	-	-
Printing and postage	-	-
Bank charges	66.95	66.95
Filing fees	-	-
Insurance expense	1,353.50	1,353.50
Total Operating Expenses	1,260,033.97	1,260,033.97
Net Operating Income (Loss)	(1,260,033.97)	(1,260,033.97)
Investment Activities:		
Realized Gain (Loss) on Investments	(20,227.31)	(20,227.31)
Unrealized Gain (Loss) on Investments	(52,024.98)	(52,024.98)
Interest earned - includes paid and accrued	162,282.05	162,282.05
Dividends	257.06	257.06
Net Income (Loss) from Investment Activity	90,286.82	90,286.82
Change in Net Assets	$ (1,169,747.15)	$ (1,169,747.15)

Summary of Investments
MI Health Endowment Fund 1-31-2015

Fixed Income Diversification

Description		Market Value	Percentage
Fidelity MMKT	$	10,739,904.91	13%
Commercial Paper	$	36,988,800.00	44%
Corporate Bonds	$	31,842,158.84	38%
Government Agency Debt	$	-	0%
Government Agency MBS	$	-	0%
Asset-Backed Securities	$	3,917,734.24	5%
Total	**$**	**83,488,597.99**	**100%**

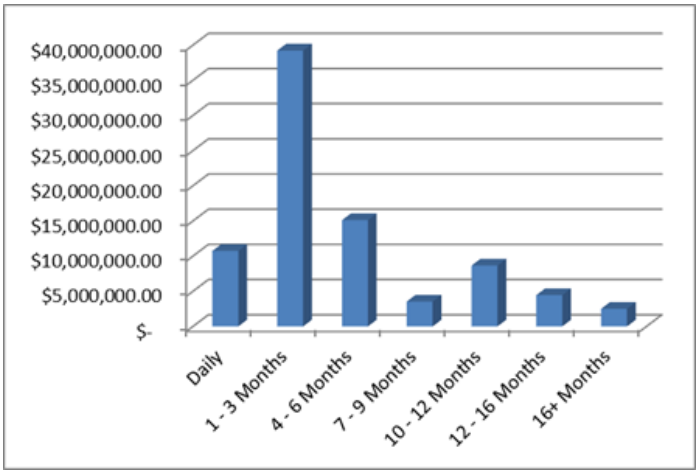


Portfolio Analysis

Description	
Weighted Average Yield	0.66%
Weighted Average Life in Years / Duration	0.38

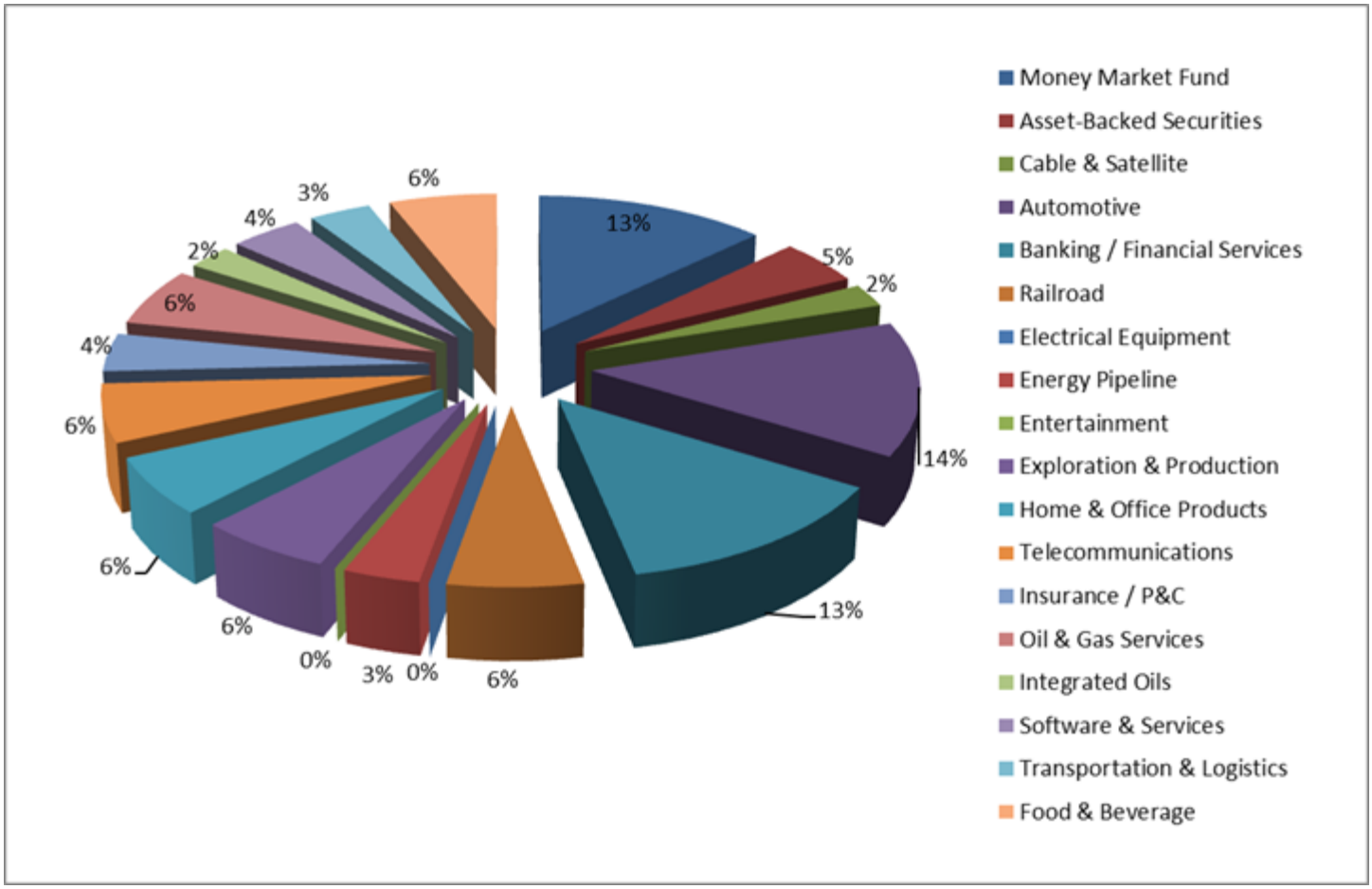
Maturity Schedule

Description		Maturity Value	Percentage
Daily	$	10,739,904.91	13%
1 - 3 Months	$	39,220,305.67	47%
4 - 6 Months	$	15,106,711.01	18%
7 - 9 Months	$	3,545,910.00	4%
10 - 12 Months	$	8,659,672.50	10%
12 - 16 Months	$	4,453,177.50	5%
16+ Months	$	2,515,232.00	3%
Total	**$**	**84,240,913.59**	**100%**



Portfolio Diversification Report
MI Health Endowment Fund 1-31-2015

Industry Description		Market Value	Percentage
Money Market Fund	$	10,739,904.91	13%
Asset-Backed Securities	$	3,917,734.24	5%
Cable & Satellite	$	1,999,500.00	2%
Automotive	$	11,517,829.50	14%
Banking / Financial Services	$	10,931,800.51	13%
Railroad	$	4,999,650.00	6%
Electrical Equipment	$	-	0%
Energy Pipeline	$	2,854,000.00	3%
Entertainment	$	-	0%
Exploration & Production	$	4,985,750.00	6%
Home & Office Products	$	4,998,250.00	6%
Telecommunications	$	4,995,200.00	6%
Insurance / P&C	$	3,285,740.00	4%
Oil & Gas Services	$	4,999,050.00	6%
Integrated Oils	$	2,051,857.50	2%
Software & Services	$	3,347,553.00	4%
Transportation & Logistics	$	2,866,578.33	3%
Food & Beverage	$	4,998,200.00	6%
Total	**$**	**83,488,597.99**	**100%**



MHEF Statement of Financial Position
February 28, 2015

ASSETS	
Chemical Bank	$ 6,736,700.60
Huntington Investments	
Investment - At Fair Market Value	83,594,660.79
Accrued Interest Earned - Receivable from Huntington	279,090.34
Total Value of Huntington Investments	83,873,751.13
Prepaid Insurance Expense	9,474.50
Total Assets	$ 90,619,926.23
LIABILITIES AND NET ASSETS	
Liabilities	
Accounts Payable	$ 13,628.00
Net Assets	
Unrestricted Net Assets	70,606,298.23
Restricted Net Assets	20,000,000.00
Total Net Assets	90,606,298.23
Total Liabilities and Net Assets	$ 90,619,926.23

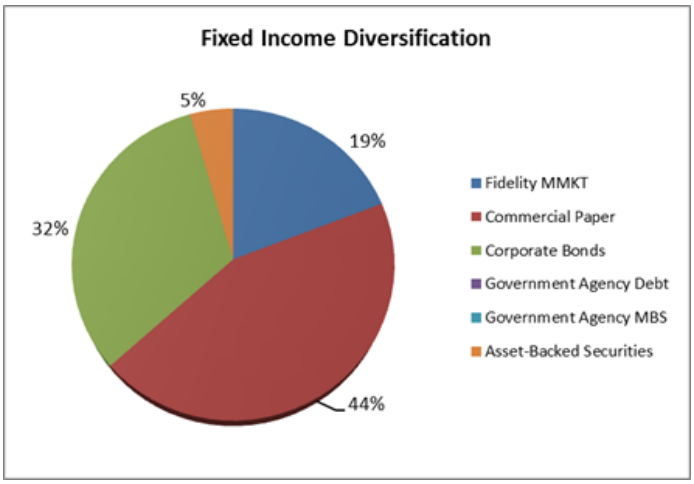
MHEF Statement of Activities
as of February 28, 2015

	Current Month	Year-to-date
Operating Activities:		
REVENUE		
Funds Contributed from Blue Cross Blue Shield	$ -	$ -
OPERATING EXPENSES		
Professional services	57,440.16	64,664.88
Grant expenses	-	1,250,000.00
Memberships	-	-
Meetings and facilities	2,100.00	3,488.80
Supplies	-	-
Printing and postage	-	-
Bank charges	69.95	136.90
Filing fees	-	-
Insurance expense	1,353.50	2,707.00
Total Operating Expenses	60,963.61	1,320,997.58
Net Operating Income (Loss)	(60,963.61)	(1,320,997.58)
Investment Activities:		
Realized Gain (Loss) on Investments	(24,585.86)	(44,813.17)
Unrealized Gain (Loss) on Investments	(42,371.03)	(94,396.01)
Interest earned - includes paid and accrued	80,524.23	242,806.28
Dividends	143.73	400.79
Net Income (Loss) from Investment Activity	13,711.07	103,997.89
Change in Net Assets	$ (47,252.54)	$ (1,216,999.69)

Summary of Investments
MI Health Endowment Fund 2-28-2015

Fixed Income Diversification

Description		Market Value	Percentage
Fidelity MMKT	$	15,981,272.90	19%
Commercial Paper	$	36,989,550.00	44%
Corporate Bonds	$	26,890,892.61	32%
Government Agency Debt	$	-	0%
Government Agency MBS	$	-	0%
Asset-Backed Securities	$	3,732,945.28	4%
Total	**$**	**83,594,660.79**	**100%**

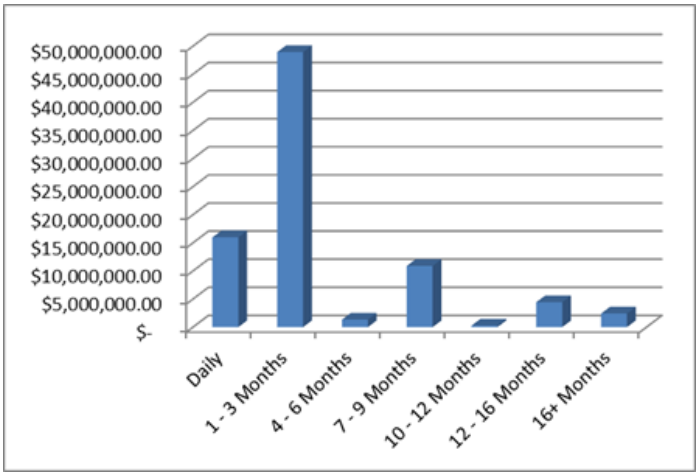


Portfolio Analysis

Description	
Weighted Average Yield	0.59%
Weighted Average Life in Years / Duration	0.25

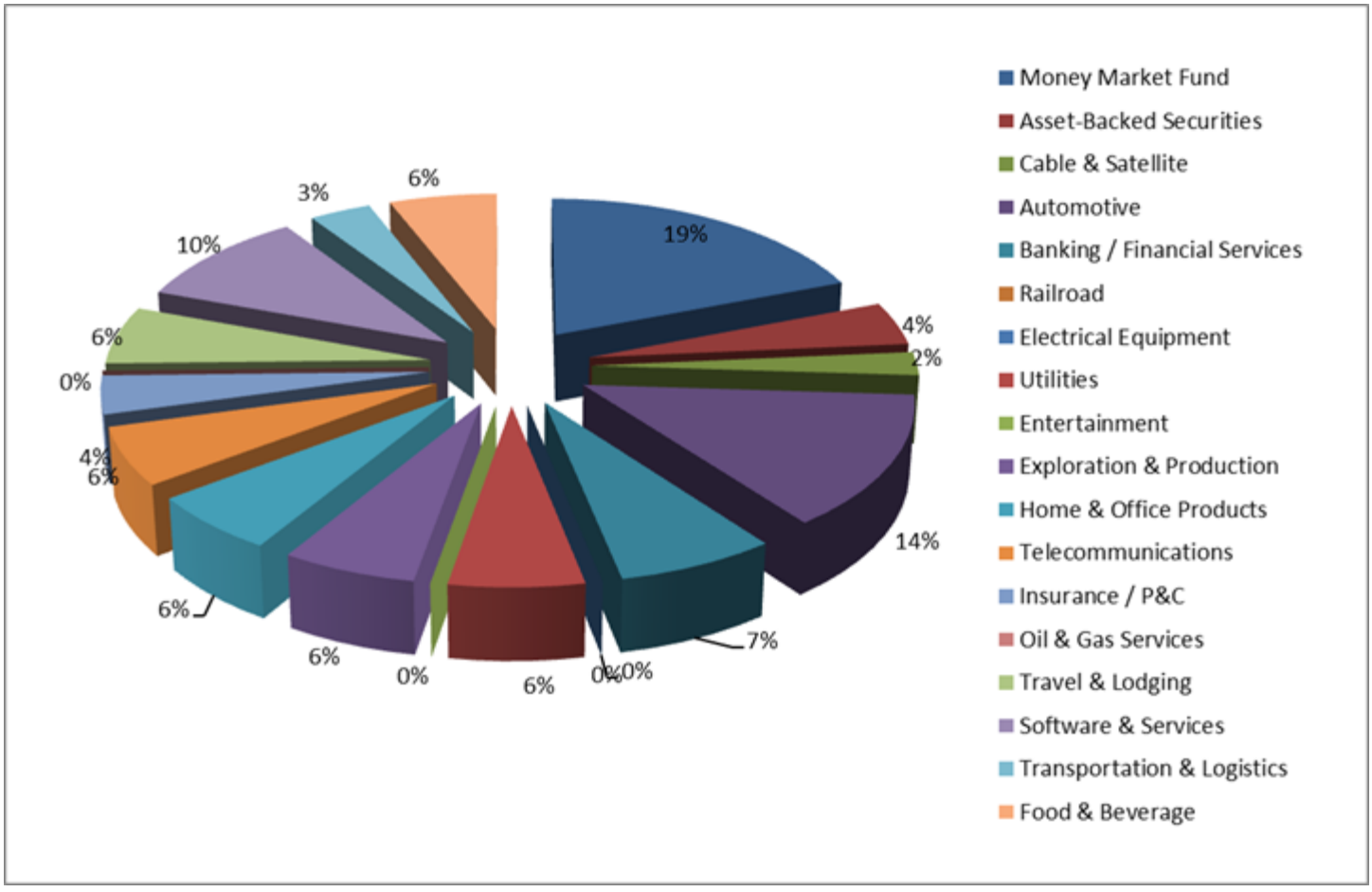
Maturity Schedule

Description		Maturity Value	Percentage
Daily	$	15,981,272.90	19%
1 - 3 Months	$	48,937,691.80	58%
4 - 6 Months	$	1,345,599.00	2%
7 - 9 Months	$	10,895,238.50	13%
10 - 12 Months	$	281,479.00	0%
12 - 16 Months	$	4,445,920.50	5%
16+ Months	$	2,431,134.00	3%
Total	**$**	**84,318,335.70**	**100%**



Portfolio Diversification Report
MI Health Endowment Fund 2-28-2015

Industry Description		Market Value	Percentage
Money Market Fund	$	15,981,272.90	19%
Asset-Backed Securities	$	3,732,945.28	4%
Cable & Satellite	$	1,999,800.00	2%
Automotive	$	11,491,323.00	14%
Banking / Financial Services	$	5,914,207.98	7%
Railroad	$	-	0%
Electrical Equipment	$	-	0%
Utilities	$	4,999,450.00	6%
Entertainment	$	-	0%
Exploration & Production	$	4,997,850.00	6%
Home & Office Products	$	4,998,900.00	6%
Telecommunications	$	4,996,800.00	6%
Insurance / P&C	$	3,282,542.50	4%
Oil & Gas Services	$	-	0%
Travel & Lodging	$	4,998,000.00	6%
Software & Services	$	8,341,119.00	10%
Transportation & Logistics	$	2,861,450.13	3%
Food & Beverage	$	4,999,000.00	6%
Total	**$**	**83,594,660.79**	**100%**



Michigan Health Endowment Fund

2014 Listening Tour Report

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Prepared for
Michigan Health Endowment Fund

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During the summer and fall of 2014, Public Sector Consultants (PSC) conducted six public forums on behalf of the Michigan Health Endowment Fund (MHEF). To ensure that people in different regions of the state were given a chance to participate, sessions were held in Detroit, Grand Rapids, Lansing, Marquette, Midland, and Traverse City. More than 300 people participated in total. MHEF board members used each session as an opportunity to increase their understanding of health issues and the resources available to address them, particularly those issues affecting children and the elderly. The information gleaned from these sessions, described in this report and in the detailed summaries of each session, will assist the MHEF board in carrying out its grantmaking responsibilities.

This report describes the format used to solicit input, summarizes participants' comments regarding priority health issues and challenges, and highlights some of the innovative approaches that were described by participants. A summary of each of the sessions is available on the Michigan Health Endowment Fund website (www.healthendowmentfund.org) and provides more detail on the health issues, challenges, and examples of innovative and promising practices shared by participants.

LISTENING TOUR FORMAT

Public notices of the listening tour were disseminated by the MHEF through statewide organizations and associations, and through media releases. The schedule and location for each session were also posted on the MHEF website. The sessions were open to anyone who wished to participate, without charge. People were encouraged to register online, but walk-ins were also accepted. Agendas for each session were posted in advance on the registration website.

The format for each session consisted of an overview of the MHEF purpose and activities to date, presentation of a list of priority health issues identified in community health needs assessments conducted by hospitals and community partners in the region, and a facilitated discussion. These discussions used questions designed to solicit participants' perspectives on important health issues for children and older adults, the barriers preventing these populations from achieving good health, and innovative and promising approaches that are working well to address their health and well-being. Participants were also asked to suggest key indicators or measures that might be used to track progress in addressing the issues and challenges they identified. (A list of indicators and measures that were suggested is attached to this report.)

COMMUNITY PRIORITIES

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. PSC compiled the priorities from community health needs assessments available online for hospitals in each region. These priorities were presented in a handout as a starting point or "trigger" for the discussion. The issues listed below are the ones that were identified most often in the hospital community health needs assessments across all regions.

1. Access to care
2. Obesity and overweight
3. Mental and behavioral health
4. Substance abuse
5. Diabetes
6. Infant mortality and infant health
7. Nutrition
8. Cardiovascular health
9. Chronic disease
10. Health education
11. Physical activity
12. Cancer

13. Racial health disparities
14. Dental and oral health
15. Children's health
16. Preventive care and activities
17. Coordinated community health

DISCUSSION OF PRIORITY HEALTH ISSUES

Participants in the listening tour sessions were asked to comment on the issues they thought were most important to the health and wellness of children and older adults, and identify any issues they thought were missing on the list of priorities from community health needs assessments. They were also asked to describe factors contributing to the issues they identified. In their responses, participants did not assign priority to the issues on the list. Rather, they expanded upon the priorities identified through community health needs assessments by providing additional detail and raising other health issues. Their comments are summarized below.

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

During the discussions, some participants would identify an issue as important for the health and wellness of children, while other participants would raise the same issue as one affecting older adults. Others identified issues they said affected both populations. The issues identified as relevant to both populations were access to care, prevention and health promotion, mental health, substance abuse, and oral health.

Access to Care

Participants in every region of the state said access to medical, dental, and mental health services is an issue for many children and older adults. Even in the age of the Affordable Care Act, they said there is still a lack of insurance coverage for certain services. For example, Medicare does not cover routine dental hygiene services or short-term rehabilitation services for older adults. Also, people do not understand the complexities of health insurance and do not know how to optimally navigate the health care system. They may not be aware of the resources available to them, such as federal resources and benefits for military personnel and widows/widowers of those in the military. Improving health literacy will be important in addressing access to care, particularly for those who are gaining access to health care and are unfamiliar with the health insurance system.

During the discussions, participants pointed out that issues with access and transportation are magnified in rural areas because there are not enough health care workers or facilities to provide services, and people have difficulty traveling to the resources that are available. Participants said there are not enough primary care physicians, specialists, behavioral and mental health providers, or dental care providers to meet needs. In addition, many rural areas no longer have a hospital system nearby to provide services such as labor and delivery care for expectant mothers or neonatal intensive care for high-risk infants. Distance and lack of transportation make it particularly difficult for families and older adults in rural areas to get to services.

Prevention and Health Promotion

Some participants expressed the concern that there needs to be more investment in prevention and promotion of wellness in general. People should be encouraged to focus on long-term health, rather than only addressing immediate health crises. Infrastructure or policy changes are needed to make the healthy choice the easy choice, from supports for breastfeeding infants to environments conducive to physical and social activity for older adults. The majority of comments regarding prevention and health promotion for children and seniors related to physical activity, access to healthy food, and immunizations.

Physical Activity

Regular physical activity positively affects many health outcomes for children and older adults, and is necessary for people of all ages. Participants said there are not enough opportunities for safe physical activity at schools and in communities across the state. Livable communities have traits that get people outside in safe ways, such as having sidewalks and parks that are in good condition, which provide opportunities for not only physical activity, but also social interaction with others in the community.

Access to Healthy Food

Good nutrition should start early in life and is critical for maintaining long-term health. Participants pointed out that many children and older adults struggle with insufficient access to healthy food, which may lead to poor health outcomes for both populations, and lower educational attainment for children. Older adults and parents of children need better access to stores and alternative food outlets, like farmers' markets and community gardens. Better access includes transportation to the outlet, money to buy healthy food, and the know-how and ability to prepare the food for consumption.

Immunizations

Immunizations are important for everyone, especially the very young and the elderly. Some participants noted that immunization rates in Michigan are decreasing. Schools are seeing an increase in illnesses that were once rare, such as whooping cough and measles. This trend could be reversed by identifying communities with lower immunization rates and focusing educational awareness efforts and immunization campaigns on children and seniors in those communities.

Mental Health

Participants across the state said mental health is finally coming to the forefront and being recognized as a major health issue for both children and adults. Mental health problems are often related to other health issues, including substance abuse, eating disorders, suicide, and unhealthy sexual behaviors. Addressing mental health needs of the population should be considered as a primary health promotion strategy.

Some participants noted that mental health issues have been linked to early childhood experiences. Families with the most challenges need help in the first three years of a child's life to break intergenerational cycles of trauma and violence. As one participant said, "When children get support at younger ages, their issues will not be manifested in substance abuse or alcohol dependence later in life." A few participants pointed out the importance of providing services for children and youth in ways that facilitate their use of services. Since children are dependent on others for transportation, services may need to be taken to children. The mental health of parents—especially of those caring for children with their own mental health challenges—also needs to be considered and addressed.

Among the adult population, there is a stigma associated with receiving mental health services, yet there is a high rate of depression and suicide among seniors. More programs are needed to help educate the population and reach out to those individuals suffering from poor mental health. Mental health issues are not just a concern for seniors living alone; there is social isolation within facility settings, too. In rural areas, mental health issues for older adults are compounded by limited availability of mental health providers and difficulties accessing services.

Substance Abuse

Substance abuse disorders are implicated in many health issues, from birth through the end of life. Some participants said substance abuse prevention is one of the keys to healthy birth outcomes. Some expressed concern that many babies and toddlers are adversely affected by alcohol and drug exposure directly and indirectly, but they are not being seen for behavioral and developmental effects of exposure until they reach preschool and kindergarten. Other participants noted substance abuse often begins in adolescence, but is not being addressed until much later in adult years, when it is more difficult to treat. A few participants cautioned that efforts to reduce tobacco consumption must continue as organizations work to

address other types of substance abuse prevention and treatment. They said tobacco use rates are particularly high in northern Michigan and among low-income populations.

Oral Health

In some regions, participants noted that oral health was not—but should be—included in the priority health issues identified through community health needs assessments. Oral health is an important issue for a person's overall health and well-being; it is essential for good nutrition, self-esteem, and prevention of systemic health problems. Some participants said oral health should be incorporated into primary care services for children. Others noted access to dental health care is limited for older adults by lack of dental insurance following retirement, and Medicare does not provide coverage for dental hygiene care. As a result, hundreds of low-income seniors seek treatment in emergency departments every month due to oral health issues.

What health and wellness issues are important particularly for children?

Participants identified infant health, school-based health services, and health education as issues with particular relevance for the health and wellness of children.

Infant Health

Birth outcomes have an impact on early childhood development and affect infants throughout their entire life. The risk of poor birth outcomes is higher for African Americans. Participants said it is important to address the health of the mother before pregnancy, access to prenatal care, and the social determinants of health for families and their children. Access, availability, and education on family planning options are important to all women—including teens—to limit unintended pregnancies, which can jeopardize the health and economic well-being of women and families.

School-based Health Services

Participants said children experience many barriers to learning because their health needs are not being met. There is a need for social workers, registered nurses, and other health care professionals in schools, but school districts do not have the resources to meet the demand. A few participants pointed out that Michigan is ranked 49th in the country for its student-to-nurse ratio; 76 percent of school districts do not have a school nurse. School districts end up relying on untrained school personnel to help chronically ill children with tasks like monitoring blood sugar levels.

Health Education

Some participants said greater emphasis on health education is needed in schools. 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.

What health and wellness issues are important particularly for older adults?

Discussion participants identified chronic disease and care coordination, long-term care and in-home care, and other concerns associated with aging as particularly important for the health and wellness of older adults.

Chronic Disease and Care Coordination

Diabetes, obesity, and other chronic conditions are health concerns for many older adults. Participants said care coordination and case management are important for seniors with chronic conditions and those who leave a long-term care setting. Effective care coordination ensures access to community-based services and specialized care.

Long-term Care and In-home Care

In some regions, participants said long-term care for seniors—whether provided in the home, community, or institution—was missing in the list of priority health issues identified through community health needs assessments. Long-term care facilities are not available to many older adults, and high rates of turnover in long-term care facilities affects the availability of services. While many seniors prefer to remain in their homes, chronic diseases, dementia, and physical impairments affect their ability to do so. In-home health care providers and other community-based services are important but not always available to support older adults who would like to remain independent in their homes.

Concerns Associated with Aging

Some discussion participants noted that dementia was not mentioned specifically in the list of issues from community health needs assessments. They said there already is a huge number of people with dementia, and as baby boomers age, there will be an overwhelming need for help with dementia, Alzheimer's disease, and other cognitive illnesses. Collaboration and coordination of services is important for individuals with impaired cognitive function to ensure that they are receiving the right care at the right time.

People are living longer. Participants pointed out that end-of-life and advance care planning can help families save money and improve a person's quality of life as they age. This is true for all older adults, including those with special needs.

Other concerns identified by participants included meeting the basic needs of seniors (such as food, housing, and safety); providing outreach services to older adults in their homes; and preventing premature deaths due to falls.

DISCUSSION OF CHALLENGES

Participants were asked to describe the barriers that are preventing children and older adults from achieving good health and wellness. The challenges identified by participants were similar across all regions and often reflected the earlier discussion of priority health issues. Comments are summarized below under the following categories: limited availability and accessibility of services; lack of an integrated, systems of care approach; failure to address social determinants of health; disinvestment in prevention and health promotion; and poor data and communication.

Limited Availability and Accessibility of Services

Access to services is determined by both the availability of and ease of access to services. Participants in every region mentioned limited availability of services either in the discussion of barriers or in the discussion of priority health issues. Their concerns included shortages of providers—family practice physicians, geriatric specialists, physician assistants, nurse practitioners, mental health workers and psychiatrists, school health nurses and social workers, hospital-based health educators, and infant mental health specialists—and types of services, such as in-home services for the elderly and at-risk families, community mental health services, and school health services. Limited availability results in long wait times for services. There is a wide disparity in available resources across communities.

Limited or no transportation was reported as a major barrier to health and wellness in every region; it affects children and the elderly in both rural and urban areas of the state. Families have difficulty scheduling time away from work to transport young children to appointments; older adults may not be able to drive themselves safely to an appointment or to pick up prescriptions. In rural areas, lack of transportation is compounded by the distance to services. As one participant in Marquette said, "A trip that would take someone with a car 25 minutes, would take two hours by bus for someone who does not

have a vehicle." A few participants suggested co-locating services to improve accessibility for families with young children as well as the elderly. One participant noted that distance also inflates the cost of delivering home-based services in rural areas, since providers have to travel farther between home visits.

In Southeast Michigan in particular, the diversity of the population is growing rapidly; there are 100 languages spoken in the school system in Macomb County. Without sufficient interpretation services, language can present a huge barrier between a patient and his/her service provider.

A few participants noted consumers lack confidence in how to navigate the health care system or reach out to nontraditional partners, such as food pantries. In rural areas, participants said many people do not have computers, and cell phone service and internet bandwidth are inconsistent, which limits both health care consumers' and service providers' ability to obtain information.

Lack of an Integrated, Systems of Care Approach

The need for an integrated, systems of care approach was a common theme in the comments made by participants during listening tour sessions. An integrated system would better address the whole family's needs and link them with the care they need to be well. Participants said there is a major focus on the health care system, without recognizing the large set of services and supports for children and older adults outside of the health care system. These services and systems need to be interconnected and supported by each other. Within a community's system of care, services should be aligned instead of siloed, individual programs that duplicate efforts and increase costs. Participants said integrated systems that build relationships among organizations and service providers in a community increase individual program success and make it easier for people to navigate among the different services.

While participants recognized that there are many programs that offer great value and serve needy populations, some said it is time to think differently about the organization and delivery of services because complex social issues cannot be solved from one angle. They suggested that people need to work together in communities to create a common vision and set goals that are multilevel, cross-sector, and have an impact on the health of the whole community in multiple areas like access, housing, education, and employment.

Some participants identified a need for backbone organizations that can help coordinate and integrate all of the various programs and services available in a community. These integrator organizations help different organizations work together to align their goals. But time and money are not often available to encourage this collaborative work, leaving integration to be considered after the fact and not well coordinated.

Failure to Address Social Determinants of Health

The system of care needs to take into consideration the social determinants of health, which are often a significant barrier to health and wellness. More than once, a participant cited research showing that 60 percent of an individual's health status is influenced by social determinants and only 10 percent by medical care. Poverty and racism were mentioned specifically as significant contributors to poor health and health disparities for both children and older adults.

Participants pointed out that many children and older adults experience complex challenges and multiple barriers to health and wellness. These may include low socioeconomic status, multiple chronic conditions, physical disabilities, substance abuse, mental health challenges, developmental delays, and lack of transportation. Families who are unemployed and living in poverty often have to focus only on surviving, rather than taking preventive action to become or stay healthy. Things like dental care and prenatal care are not priorities for many of these families. Many children in poverty rely mainly on food provided at

school for their meals during the week, and are left hungry on the weekends. Food insecurity can seriously affect a child's ability to stay healthy and succeed in school.

Disinvestment in Prevention and Health Promotion

Some participants said that a lack of a culture of health—and disinvestment in prevention and health promotion—is a barrier to the health and wellness of children and older adults alike. They lamented that the built environment is not conducive to good health; when communities are not walkable and livable, individuals cannot be active to improve their health status. Policies often do not take into account community health. For example, community health should be considered before allowing the development of fast food restaurants, which does not incentivize people to make healthy food choices. Others said there is a general lack of health literacy and health engagement in our communities.

As one participant said, "Treatment needs are enormous, so prevention gets lost even though it is the best bang for the buck." Participants noted that school nurse positions have been cut across the state; recess and physical education have been dramatically reduced, leaving less time for children to exercise throughout the day; less time in the school day is given to health education compared to other academic subjects; and health promotion is not one of the eight mandated public health services, so these positions are often the first to be cut by local health departments when funding is tight. They also noted that the fee-for-service health care reimbursement system, which rewards the volume of medical services rather than nonmedical interventions, is a huge barrier to prevention and health promotion. Without investment in a preventive care model, none of the priority health issues that have been identified are going to improve.

Poor Data and Communication

Some participants said better use of data is necessary to identify and address health issues and the contributing factors in communities. A few noted that technology with predictive analytics could be used to help providers understand and address community health issues, but small medical practices and community organizations cannot afford that type of technology.

Participants also noted that there is not enough communication and exchange of health information among system partners. Service providers do not always know what services and resources are available in their community to offer appropriate referrals and coordinated care for children and older adults. Some participants said Health Information Exchanges or registries could be better utilized to ensure that medical services are not being duplicated for individual patients. Others cautioned that the health information exchange model only fits large providers; smaller, grassroots organizations do not have access to it. Other mechanisms are necessary to support more communication, education, and awareness of resources among smaller organizations. A few participants stressed that it is not possible to implement a systems of care approach without the ability to collect and access information across life domains—physical, mental, and socioeconomic.

DISCUSSION OF INNOVATIVE AND PROMISING APPROACHES

Participants shared their knowledge of programs and approaches that are working well to address the health and wellness of children and older adults. Some of the examples given were similar across regions, while others were specific to the region and the represented communities. Many of the programs that were described included collaboration among multiple community partners as a key component. At least one participant in every session mentioned the collective impact model as a promising approach that takes collaboration to the next level; it uses common metrics and goals to align organizations and make sure their contributions result in progress for the community as a whole. The model is being implemented across the country and in some Michigan communities.

Many of the programs and initiatives mentioned by participants are listed below to give a sense of the depth and breadth of efforts underway. More details, along with additional programs, can be found in the summary of each listening tour session.

Infant and Child Health

- Evidence-based and promising-practice, home-visiting programs develop trusting relationships where learning and change occurs, which subsequently improves the health and well-being of children and families. Home-visiting programs mentioned include Early Head Start; Nurse Family Partnership; Infant Mental Health; Maternal Infant Health Program; and the Maternal, Infant, and Early Childhood Home Visiting Program.
- Strong Beginnings, a partnership of six agencies, is working to improve maternal and child health. Community health workers are a key component of the model, which includes home visiting, clinical services, therapeutic services, a fatherhood program, breastfeeding support, and services to connect families to needed resources.
- Make Your Date Detroit is a program to reduce preterm birth by ensuring access to prenatal care for women in Detroit through a unique collaboration of hospitals, insurance companies, and the Legislature.
- Starfish Family Services has had a children's wellness home health initiative for the last 30 years. The program walks families through gateways to various programs and supports the mother through her reproductive years, making sure she is physically and mentally healthy.
- Healthy Futures, offered through Munson Healthcare, is a primary prevention program from pregnancy to early childhood. It works to connect several services and destigmatize the use of services by offering it to everyone in the community instead of basing eligibility on income.
- Munson Medical Center provides child life specialists who work with a family when their child is hospitalized or going through medical treatment. A child life specialist is a member of the interdisciplinary team, 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.
- Safe Families for Children provides a safe place for children to go when parents and caregivers are hospitalized; it is a voluntary program for families that uses screened and approved host families.
- The Grand Traverse Women, Infants, and Children (WIC) Clinic packs in as many services as possible for families all in one visit. The clinics are nurse-based, so they can offer immunizations, fluoride varnishes, and referrals to Early Head Start, Head Start, and the Intermediate School District. They also provide assistance to sign up for Medicaid and other available programs.

School-based Health Services

- Kent School Services Network is a countywide community school initiative created to ensure students are healthy and learning. Health and human services staff, along with coordinating resources, help reduce the inequities that exist for the most vulnerable children.
- Coordinated school health teams help address many health issues affecting youth—such as obesity, diabetes, immunizations, tobacco and substance abuse, preventive health care and education, and mental health issues.
- The Adolescent Health Center Program in Michigan links children with routine care and provides mental health services. Some of these centers are located within schools.
- Teen Pathways Community HUB is a school-based health model that uses outreach and community health workers to connect teens and families to the resources they need in the community.

Health Education

- The Michigan Model for Health is an evidence-based, nationally recognized curriculum for kindergarten through 12th grade. This curriculum includes parent involvement and focuses on the four components of changing health behaviors: knowledge, skills, self-efficacy, and environmental support.
- Supplemental Nutrition Assistance Program (SNAP) education provides education on healthy food and physical activity to families in poverty, including families with children participating in early readiness programs.
- Saginaw Valley State University places students in schools to provide health information to students. This gives college students experience and practice, while providing the school with cost-effective support.
- In Clare County, a group of community programs work together to provide health educators at food distribution sites while families wait for food. Many families in this region deal with food insecurity, and some of these families are especially difficult to reach because they are not well connected to other social welfare programs.
- In Isabella County, the intermediate school district also provides health education at food distribution sites. The information provided is targeted to older adults so they know what to eat for their age and the importance of being active.

Prevention and Health Promotion

- The Generation With Promise program partners with Gleaners Community Food Bank and other nontraditional partners to provide skill-based training, resources, and tools for families to put healthy eating into action.
- In Southeast Michigan, some physicians are prescribing fruits and vegetables to patients, instead of (or in addition to) medications. Health and food system partners are very active in this initiative.
- The Ottawa County Food Policy Council provides education on health, cooking, and gardening, and local food pantries are providing more access for people who need and desire healthy food options.
- The Northwest Michigan Health Department encourages healthier eating and nutrition by ensuring Electronic Benefit Transfer machines are available at farmers' markets and educating families about Double Up Food Bucks.
- Fit Kids 360 is an evidence-based, family-centered approach to improving the health of children and their families by providing children with education on behavioral health issues, nutrition, and physical activity.
- The YMCA offers several evidence-based health promotion programs, including LiveWise program for early Alzheimer's patients, LIVE**STRONG** (for cancer survivors), a diabetes program, Enhance Fitness for older adults, and Moving for Better Balance for chronic disease prevention.
- The Urban Neighborhoods Initiative in Detroit's Springville Village 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.

Mental Health Services

- Kalamazoo Community Mental Health is working with the University of Michigan on a project to improve pediatricians' access to psychiatric consultation.

- The Infant Mental Health Home Visiting Program offered through community mental health agencies has been designated a promising program. It is unique in that psychotherapy is provided to both the infant/child and the parent.
- Mental health first aid is provided in high schools in the Sault Ste. Marie school districts to help students learn how to identify and respond to signs of mental health and substance abuse issues.

Access

- Studies indicate nurse practitioners provide high-quality care and can alleviate the shortage of primary care physicians. Grand Valley State University has an academic nurse-managed center serving both children and older adults that could serve as a model for more centers.
- Healthy Kids Dental is a collaboration between Delta Dental of Michigan and Medicaid. The program adds to the fee paid by Medicaid, which encourages dentists to take Medicaid patients by bringing their reimbursement closer to the standard fee. This program could be replicated for older adults.
- Time banks are service exchange programs within a community that can provide resources to both children and adults, such as transportation home for an older adult after being discharged from a hospital or home visiting services for a child.
- Area Agencies on Aging (AAAs) provide a variety of cost-effective, evidence-based programs to help seniors with disease management and transportation needs. 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 to examine quality of care, socialization, and nutrition issues, and connect people to the right resources in the community.
- Elder Law of Michigan provides seniors with technology and teaches them its key benefits, and also helps connect seniors to community resources.
- 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 emergency 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.
- 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.

Integrated Systems of Care

- Cherry Health has implemented successful programs to improve chronic care through the integration of services, including medical, dental, and mental health care. The Cherry Health model of care has been proven to reduce hospital and emergency department use and save money.
- Spectrum Medical Group provides home-based care; comprehensive care plans for its patients using a team approach; 24-hour access to team members; home safety assessments; medication education; and financial planning services. There has been a 45-percent reduction in the number of admission days and emergency department visits for patients.
- The Michigan Health Information Alliance (MiHIA) in Central Michigan is one of three state Chartered Value Exchanges (CVEs) authorized by the U.S. Department of Health and Human Services. CVEs are a diverse group of stakeholders that act as a collective nonprofit organization to improve health and health delivery in their region. One of MiHIA's projects is to implement

Choosing Wisely, an initiative to identify how physicians can prevent unnecessary medical utilization.

- MiHIA also runs the Saginaw Pathways to Better Health to connect at-risk persons, including older adults, to needed health and social services in order to improve their health, increase their utilization of primary care services, and decrease the cost of their health care. This program creates hubs that link people to community health workers who coordinate access to other needed medical and social services. The community health workers are employed through community organizations, such as hospitals and Federally Qualified Health Centers.
- Children's Healthcare Access Programs in Kent and Wayne Counties link children and their families to pediatric medical providers, and provide resources to help medical providers offer all of the components of a medical home. These programs ensure that families are aware of available services and help them acquire any necessary referrals.
- Oakwood Healthcare System's Healthy Communities Initiative engages partners and helps them achieve collective impact. The initiative is implementing multiple evidence-based programs in Wayne, Westland, Dearborn, and Taylor.

Home Health and Long-term Care

- Meals on Wheels 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 can contact a family member or 9-1-1 if necessary.
- Community-based Care Transitions is available through a handful of programs in Michigan, including the Tri-County Office on Aging. This program does not provide a new service; rather, it links services together. The program helps transition older adults from the hospital to their home and addresses social and economic conditions that may be affecting health outcomes. A discharge planner meets the individual at the hospital and a social worker follows up with them in their home to address follow-up care, prescriptions, end-of-life care, and other needs.
- 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 underway to bring it to other areas in Michigan.
- The North Dakota project for families coping with Alzheimer's helps keep adults with Alzheimer's disease in their homes longer and reduces calls to 9-1-1. Providers work with the whole family, educating them to call an Alzheimer's helpline instead of 9-1-1 when their family member needs assistance. The program is being piloted in three Michigan counties.
- An at-home, prehospice support program was launched seven years ago by Hospice of Michigan and funded by the Robert Wood Johnson Foundation (RWJF). The program is designed for chronically ill seniors and 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 that showed a 30 to37 percent reduction in costs.

Data Sharing and Communication

- Great Lakes Health Connect has formed a successful organization for health information exchange between hospitals in Michigan. Patient records, such as advance care plans, can be accessed in real time so that providers, including emergency department staff, know patients' choices.

- The United Way in Midland collaborates with Saginaw Valley State University to get a statistically significant sample for the Behavior Risk Factor Survey (BRFS) for the county. The BRFS provides the health issues affecting the community, especially for older adults and those in poverty.
- The Quality Aging Matrix is being used by a collaborative made up of 25 organizations for older adults. They collect data from seven organizations to be put in the matrix. Part of the role of the collaborative is to communicate with organizations about what the data show and why it is important. The data are being used to improve care and identify gaps in services.
- The Michigan Coordinated School Health Association manages the Michigan Profile for Healthy Youth, a survey of students that helps schools identify district needs and track successes at the school district level.

Conclusion

Participants in the listening tour sessions provided a wealth of information for MHEF board members' consideration. The ideas shared regarding priority health issues, barriers and challenges that prevent children and older adults from achieving good health, and innovative approaches has expanded the board's understanding of health issues and the resources available to address them. The information will assist the MHEF board as it continues development of its grantmaking strategy.

In closing remarks, a few participants offered the following suggestions for the board to consider as it moves forward.

- Health outcomes and health factors are different from each other, but are both important. Often the best way to improve health outcomes is by addressing the underlying health factors.
- Collaboration is key to successful, transformative, and sustainable health improvement efforts and should be encouraged and supported.
- Documentation of outcomes is critical. The structure of the MHEF grants should give grantees adequate time to implement and evaluate their efforts.
- The MHEF could offer opportunities for people to submit additional examples of innovative practices, perhaps through the MHEF website. For example, Lotus Star in Arizona created an award for innovative health ideas—groups submitted service descriptions that were collected and put into a searchable database, and some organizations received recognition for their innovative approaches.
- Universities across Michigan are conducting research on a myriad of health and wellness topics. The MHEF could utilize the expertise within universities to support the work of the MHEF.
- The Robert Wood Johnson Foundation (RWJF) provides funding to help support healthy communities. The MHEF board could research and model their grantmaking on the approaches taken by RWJF and other similar foundations.

Attachment
Suggested Indicators for Tracking Progress

Participants suggested the following indicators might be used to show that issues and challenges affecting the health and wellness of children and older adults have been successfully addressed. Some participants identified data sources, population surveys, or other resources that could provide useful data. Other participants suggested specific measures or indicators without identifying a particular data source. And some participants talked about ways that health data collection and analysis could be improved.

Data Sources and Population Surveys

- The Michigan Youth Behavior Risk Survey (YBRS) is part of a nationwide surveying effort led by the Centers for Disease Control and Prevention (CDC) to monitor students' health risks and behaviors in six categories identified as most likely to result in adverse outcomes. These categories include unintentional injury and violence, tobacco use, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancy or disease, dietary behaviors, and physical inactivity. (www.michigan.gov/mde/0,4615,7-140-28753_64839_38684_29233_41316---,00.html)
- The Michigan Profile for Healthy Youth (MiPHY) is an online student health survey offered by the Michigan Department of Education and Community Health that provides student results on health risk behaviors, including substance use, violence, physical activity, nutrition, sexual behavior, and emotional health in seventh, ninth, and 11th grade. The survey also measures risk and protective factors most predictive of alcohol, tobacco, and other drug use and violence. (www.michigan.gov/mde/0,4615,7-140-28753_64839_38684_29233_44681---,00.html)
- The County Health Rankings released by the Robert Wood Johnson Foundation and University of Wisconsin measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, air and water quality, income, and teen births in nearly every county in America. (www.countyhealthrankings.org) These rankings are a good way to measure the overall wellness of a community.
- Vital statistics on birth and death rates are provided to the state by local health departments. This information gives a snapshot of the health trends in Michigan counties for infant and maternal health, as well as the leading causes of death. (www.michigan.gov/mdch/0,4612,7-132-2944_4669---,00.html)
- The Commonwealth Fund's Scorecard on State Health System Performance, 2014, assesses states on 42 indicators of health care access, quality, costs, and outcomes over the 2007–2012 period. (www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard)
- The Michigan Behavioral Risk Factor Surveillance System is composed of annual, state-level telephone surveys of Michigan residents, aged 18 years and older. These annual, state-level surveys, also known as Michigan Behavioral Risk Factor Surveys (MiBRFS) act as the only source of state-specific, population-based estimates of the prevalence of various behaviors, medical conditions, and preventive health care practices among Michigan adults. MiBRFS results are used by public health agencies, academic institutions, nonprofit organizations and others to develop and evaluate programs that promote the health of Michigan citizens. (www.michigan.gov/mdch/0,1607,7-132-2945_5104_5279_39424---,00.html)
- The Supplemental Nutrition Assistance Program (SNAP) through the U.S. Department of Agriculture Food and Nutrition Service, administers the SNAP Food Security (SNAPFS) survey to program recipients on their consumption of fresh fruits and vegetables and physical activity levels. (www.fns.usda.gov/sites/default/files/Measuring2013Sum.pdf)

- The community health needs assessments completed by non-profit hospitals must document the priority health issues identified by the community in a written report widely available to the public. Future needs assessments, required every three years, should show progress on priority health issues.
- Electronic Health Records (EHR) could be a source of data on improvement in children's and older adults' health. They could be used, for example, to track body mass index (BMI) of a specific population or to track smoking cessation.
- The Great Start Collaborative (GSC) is working on a 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 specified amount of time, and maintaining a certain weight for a person's height.

Specific Measures

Infant and Child Health

- Infant mortality rates and birth weights
- Incidence of childhood disabilities
- Negative behavior in children, such as bed wetting and self-mutilation
- Rates of depression and suicide among adolescents
- Adolescent tobacco use, sexual behavior, community conditions, and interactions with friends and peers
- School attendance
- Number of children expelled from school
- Increased graduation rates, decreased disciplinary rates, and decreased student absenteeism
- Number of children placed in foster care and number of children reunited with their families
- Rates of maternal depression
- Emergency department utilization

Access to Services

- Wait times for intake and receipt of services
- Fewer restrictions on eligibility for services based on residence
- Consumer knowledge about the health care system and how to navigate it
- Increases in the rate of lower-income populations accessing health care services
- Lower emergency room (ER) admittance and readmittance rates
- Increased use of palliative care
- Availability of long-term care, in-home health care, and hospice care
- An increase in the number and percentage of eligible veterans and widows/widowers of veterans receiving their federal benefits

Prevention and Health Promotion

- Amount of fresh, healthy food being served in schools and long-term care facilities
- Number of trained chefs who cook with fresh food in schools and senior centers
- Number of food banks that provide a variety of nutritional options for their clients
- Decrease in the obesity rate
- Decrease in the smoking and tobacco use rate
- Reduced chronic disease rates
- Lower rates of hospitalization

Social Determinants of Health

- Rates of crime, air pollution, and other health determinants
- Lower numbers of phone calls placed to the public safety phone system and other police and human service agencies
- Morbidity and mortality rates by race and socioeconomic status
- Implementation of reimbursement for hospitals' community and health education services, transportation, and food as medicine ("farmacy") services, rather than reimbursement based on volume of care

Suggested Improvements

- Measures should be used to monitor socioeconomic factors that contribute to an individual's health, not just medical outcomes.
- Better metrics are needed to measure overall health; mortality rates are not very nuanced. 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.
- A focus on long-term indicators and prevention should be encouraged, instead of focusing only on short-term program results.
- Outcome measures alone are not enough; risk factors, program activities, and outputs also need to be monitored to inform future programs and initiatives.
- Many measures are collected and tracked within system silos; it is important to share data that may provide valuable insights where systems, such as housing and health, intersect.
- Indicators need to be measured at the level of an initiative's engagement with the population, which is not necessarily at the county level.