POPULATION HEALTH AND INTEGRATED CARE PLAN 2018 - 2020

Mid-State Health Network, Clinical Leadership Committee Approved: February 15, 2018
Mid-State Health Network, Operations Council Approved: April 16, 2018
Mid-State Health Network, Medical Directors Approval: July 20, 2018
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I. Overview/Mission Statement

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Community Health as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, The Right Door (formerly Ionia County CMH), Saginaw County Community Mental Health Authority, Shiawassee County Community Mental Health Authority and Tuscola Behavioral Health Systems. As of October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

The mission of Mid-State Health Network is to ensure access to high-quality, locally-delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.

II. Scope of Plan

As an organization, Mid-State Health Network (MSHN) is committed to increasing its understanding of the health needs of individuals within its 21-county service region and finding innovative ways to achieve the goals of better health, better care and better value by utilizing informed population health and integrated care strategies. The purpose of the MSHN population health and integrated care plan is to establish regional guidance and best practices in these areas as well as describe specific population health and integrated care initiatives currently underway in the MSHN region. The plan will:

- Identify the population served by MSHN and explore key population health needs
- Identify chronic co-morbid physical health conditions that contribute to poor health and drive health costs for individuals with behavioral health disorders
- Describe population health and explore social determinants of health
- Examine key foundational areas necessary to support population health programs and evaluate MSHN's stage of readiness for each area
- Describe current population health and integrated care initiatives underway by MSHN and its CMHSP organizations

The summary section of the plan incorporates all the above and recommends priority steps to drive population health and integrated care efforts across the region. These include:

- Foundational/structural needs
- Address current integrated health program gap areas
- Propose future priority population health and integration initiatives for consideration
- Determine resource and budget requirements
- Propose Committee(s) for strategic planning, monitoring and oversight. This includes joint stratification and complex case (care) management enrollment, processes, quality, resources, etc.
- Steps to measure value and effectiveness through quality, costs, outcomes

III. Definitions

These terms have the following meaning throughout this Population Health and Integrated Care Plan.

1. Behavioral Health: refers to individuals with a Mental Health, Intellectual Developmental Disability, Substance Use Disorder Provider and/or children with Serious Emotional Disturbances

2. Care management: programs that apply systems, science, incentives, and information/data to improve health care practice and assist consumers and their support systems to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.[1]

3. Care Coordination: a set of activities designed to ensure needed, appropriate and cost-effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans. Major priorities for care coordination in the context of a care management plan include:
    - Outreach and contacts/communication to support patient engagement,
    - Conducting screening, record review and documentation as part of evaluation and assessment,
    - Tracking and facilitating follow up on lab tests and referrals,
    - Care planning,
    - Managing transitions of care activities to support continuity of care,
    - Address social supports and making linkages to services addressing housing, food, etc., and

[1] Center for Health Care Strategies: Care Management Definition and Framework, 2007: This definition is used in the MDHHS/PIHP contract to define operations the Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs) are required to fulfill.

- Monitoring, reporting and documentation [2]

4. CMHSP: Community Mental Health Service Program

5. Comorbid Conditions/Comorbidity: The presence of more than one disease or disorder. This may include physical health conditions and behavioral health conditions.

6. Customers/Consumers: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.

7. FQHC (Federally-Qualified Health Center): Community-based health care providers that receive funds from the federal Health Resources & Services Administration to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.

8. HEDIS (Healthcare Effectiveness Data and Information Set): The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care.

9. High Risk: Consumers identified as having 1 or more emergency department visits, no primary care visit within the previous 12 months, 2 or more chronic conditions, psychiatric or physical hospitalization within the previous 12 months.

10. Managed Care Organization: A health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care organizations provide for the delivery of Medicaid health benefits and additional services through contracted arrangements with state Medicaid agencies based on a per member per month (capitation) payment for services.

11. MCIS: Managed Care Information System

12. MDHHS: Michigan Department of Health and Human Services

13. MiHIN: Michigan Health Information Network

14. MHP: Medicaid Health Plan; a managed care organization responsible for administering physical health insurance benefits to Michigan Medicaid enrollees

15. NCQA: The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality by evaluating and reporting on the

[2] This definition of Care Coordination is used in the MDHHS/PIHP contract; for the purpose of this plan it refers to activity that primarily takes place at the local level, carried out by Community Mental Health Service Programs

quality of managed care and other health care organizations in the United States. NCQA provides accreditation to health plans using rigorous standards that are regarded as national best practices.

16. PIHP: Prepaid Inpatient Health Plan; a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders.

17. PHI: Protected Health Information

18. Population Health: the health outcomes of a group of individuals; an approach to healthcare that aims to improve the health of an entire group of people

19. Social Determinants of Health (SDH): conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks

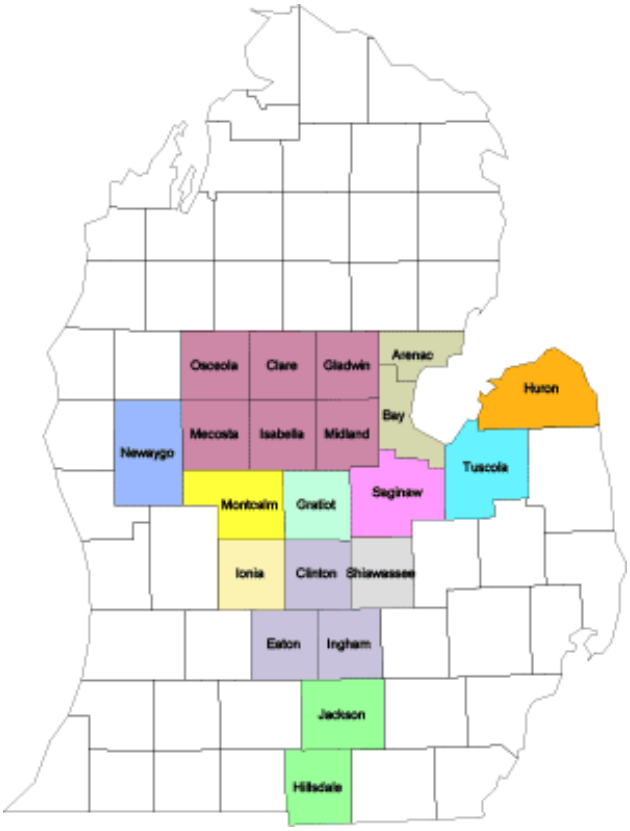
20. SSO: Single Sign On, uses uniquely identified credentials to gain access to approved systems and datasets secured by the State of Michigan.

21. CC360: CareConnect360, software tool developed by Optum for the State of Michigan to query and report from encounters submitted by Fee for service providers, MHPs and PIHPs. Common tool used by MHPs, PIHPs and State of Michigan employees and contractors.

22. SUD: Substance Use Disorder

IV. Mid-State Health Network Population

Mid-State Health Network is the Pre-Paid Inpatient Health Plan (PIHP) for behavioral health services for Region 5 in Michigan, covering a 21-county service area. The composition of MSHN's 21-county service region is diverse, ranging from urban to very rural areas with a total population of 1,637,802 (US Census Bureau, 2016). The percentage of individuals living in poverty in the MSHN region range from 10% to 26.1% by county and 16 of the 21 counties have poverty rates that surpass the national average poverty rate of 12.7%. The 2016 *America's Health Ranking* report rated Michigan's overall health at 34th, in the bottom 30% of the country. Additional population data, poverty information and health ranking status for each of MSHN's 21 counties is available in Appendix A.



CMHSP	Counties Served
Bay-Arenac Behavioral Health	Arenac, Bay
CMH for Clinton, Eaton, Ingham Counties	Clinton, Eaton, Ingham
CMH for Central Michigan	Osceola, Clare, Gladwin, Mecosta, Isabella, Midland
Gratiot Integrated Health Network	Gratiot
Huron Behavioral Health	Huron
The Right Door for Hope, Recovery & Wellness	Ionia
Lifeways CMH	Jackson, Hillsdale
Montcalm Care Network	Montcalm
Newaygo CMH	Newaygo
Saginaw County CMH Authority	Saginaw
Shiawassee County CMH Authority	Shiawassee
Tuscola Behavioral Health System	Tuscola

MSHN partners with 12 local Community Mental Health Service Program (CMHSP) organizations throughout its 21 counties to deliver specialty behavioral health services to eligible Medicaid and Healthy Michigan Plan beneficiaries.

MSHN provides direct oversight of the region's substance use disorder (SUD) treatment and prevention services through contracts with over 100 SUD prevention and treatment programs.

The physical health benefits for Medicaid and Healthy Michigan Plan beneficiaries are managed by eleven (11) Medicaid Health Plan (MHP) managed care organizations throughout the State. Of the 11 MHPs in the State of Michigan, eight (8) of those MHPs provide service coverage to individuals within the 21 counties in the MSHN region.

Health Plan	Counties Covered
Aetna-	Jackson, Hillsdale
Blue Cross Complete-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Meridian-	Jackson, Hillsdale, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
McLaren-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Molina-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Priority Health-	Osceola, Mecosta, Newaygo, Ionia, Montcalm
United Healthcare-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
HAP Midwest-	Shiawassee, Tuscola, Huron

The Medicaid Health Plans manage the mild to moderate behavioral health benefits for Medicaid and Healthy Michigan beneficiaries. MSHN manages the behavioral health services for beneficiaries with severe and persistent mental illness (SPMI).

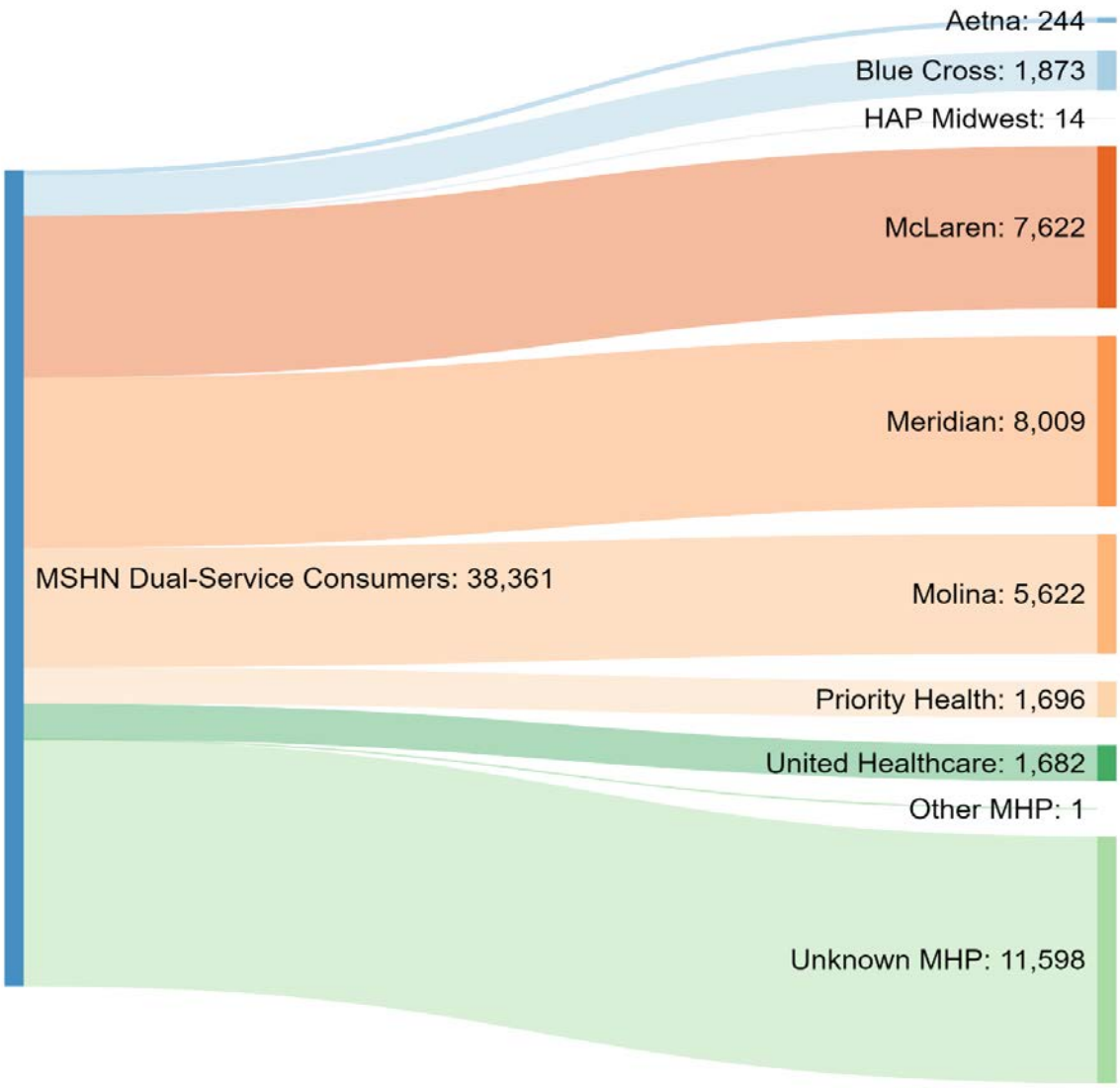
Physical Health **Behavioral Health**

Includes Mild to Moderate Behavioral Health

SPMI, Specialty Benefit, IDD and SUD

Dual-service Medicaid enrollees are those individuals who are receiving services for both physical health needs (through a Medicaid Health Plan) and behavioral health needs through MSHN or one of its CMHSP organizations. In FY2017, dual-service enrollees totaled 38,361 (9.7%) enrollees of the 393,460 individuals served by the MHPs in the MSHN Region.

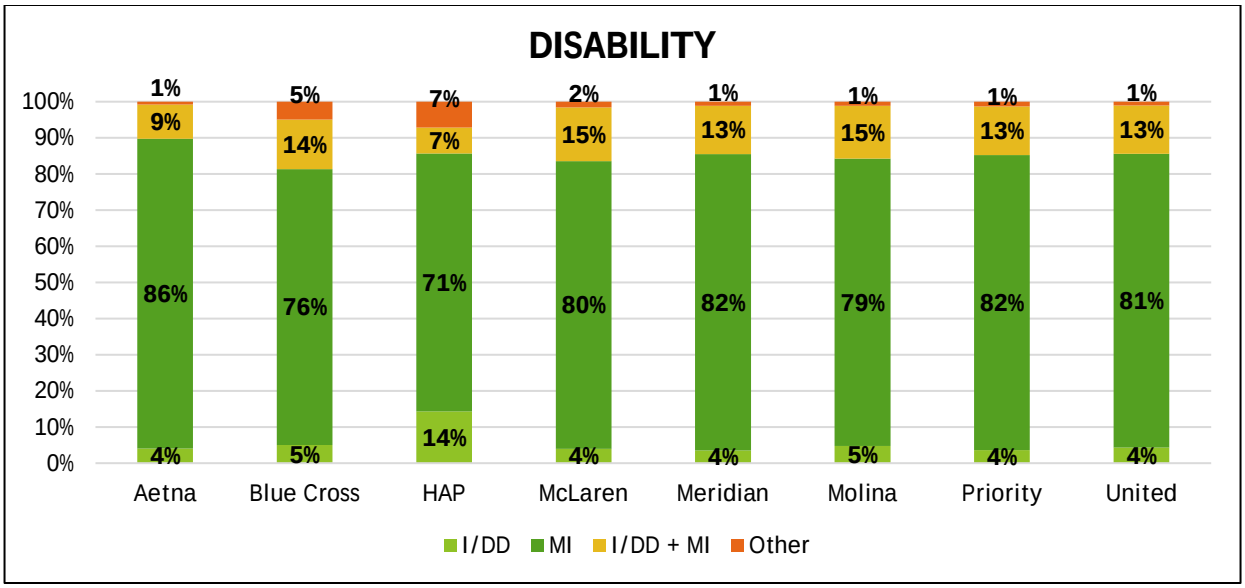
This Diagram displays the 38,361 Dual-Service Medicaid enrollees from Fiscal Year (FY) 2017, and their distribution among the Medicaid Health Plans.



Note: Unknown MHP are those individuals who have not selected a Medicaid Health Plan and/or are part of the MDHHS, Fee for Service population.

Among the dual-service Medicaid enrollees that MSHN serves, over 90% of those individuals have a developmental disability (DD) and/or mental illness (MI).[3]

[3] The designations are based upon the diagnoses attached to Medicaid claims in the past 12 months for all individuals included. If there is an attached I/DD, MI or combination of diagnoses it makes up the first three categories. If there is no I/DD or MI diagnosis in the timefram e attached to a Medicaid claim, the individual is listed as other.



According to the World Health Organization, people with severe mental health disorders have a higher prevalence of many serious chronic diseases and are at a higher risk for premature death as a result of those diseases than the general population. Current data suggests that adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.[4] The premature mortality rate among this population is largely related to cardiovascular, respiratory and metabolic diseases. (In this context, the term Metabolic disease is a collective term referring to diabetes, hypertension and weight gain).

Research consistently shows individuals suffering chronic psychiatric disorders and concurrent chronic lifestyle related physical illnesses consume exponentially more health resources while experiencing significantly diminished health outcomes. A Milliman 2014 study concluded that the existence of chronic illnesses with a comorbid psychiatric disorder increased annual cost by over 300%[5].

Figure 1: Displays the top 5 Behavioral Health Chronic Conditions by the percentage of Medicaid individuals served by CMHSPs within the MSHN region in the past 12 months. (MA Population: 39656)[6]

[4] https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers#sthash.uqTNJccu.dpuf
[5] Milliman 2014 American Psychiatric Association Report
[6] Based on Medicaid claims data; diagnosis listed on claim is capturing the reason for that specific encounter and is not necessarily reflective of a primary diagnosis or condition for the individual

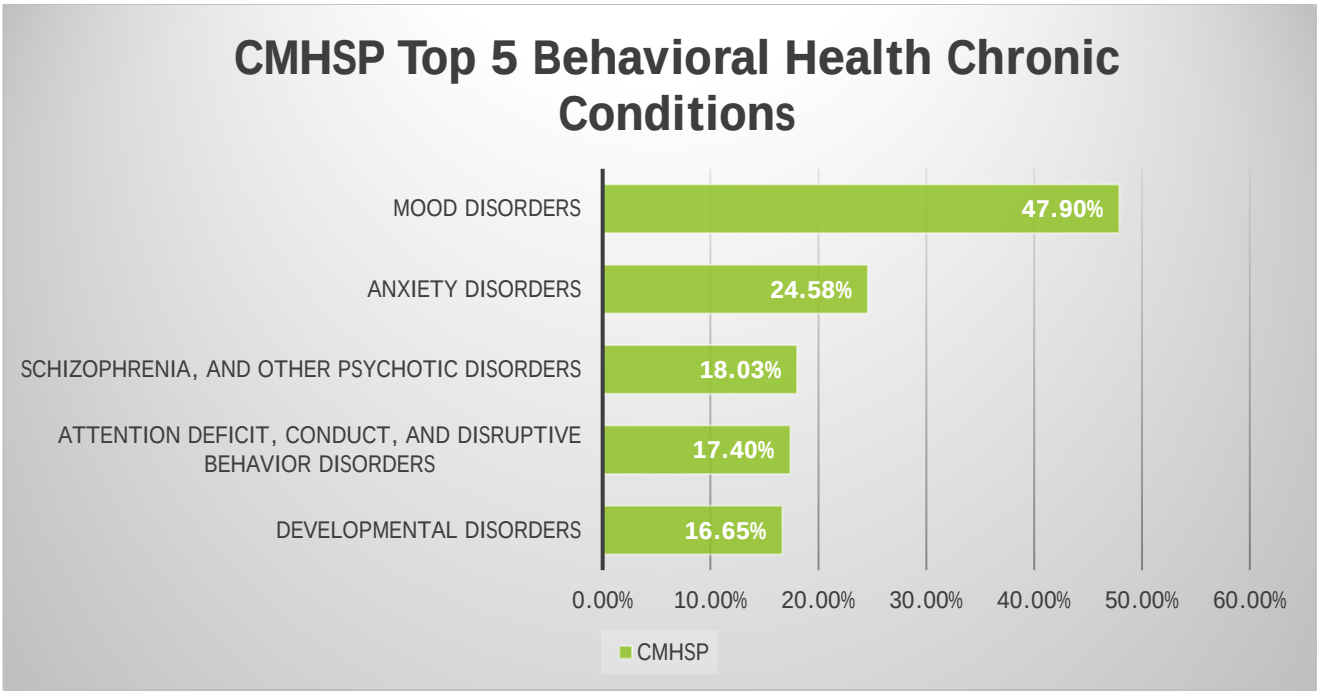


Figure 2: Displays the top 5 Behavioral Health Chronic Conditions by the percentage of Medicaid individuals served by SUD providers within the MSHN region in the past 12 months. (MA Population: 7918)[7]

[7] Based on Medicaid claims data; diagnosis listed on claim is capturing the reason for that specific encounter and is not necessarily reflective of a primary diagnosis or condition for the individual

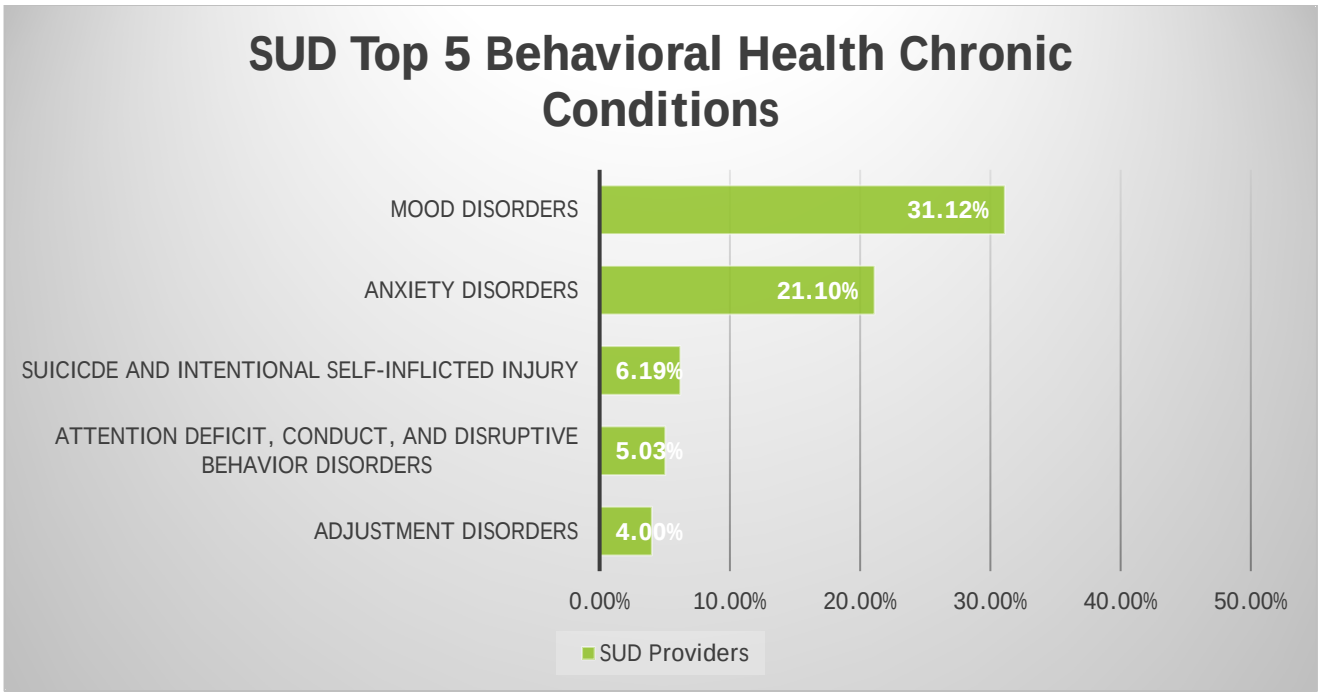


Figure 3: Displays the top 5 Physical Health Chronic Conditions by the percentage of Medicaid individuals served by CMHSPs within the MSHN region in the past 12 months. (MA Population: 39656)

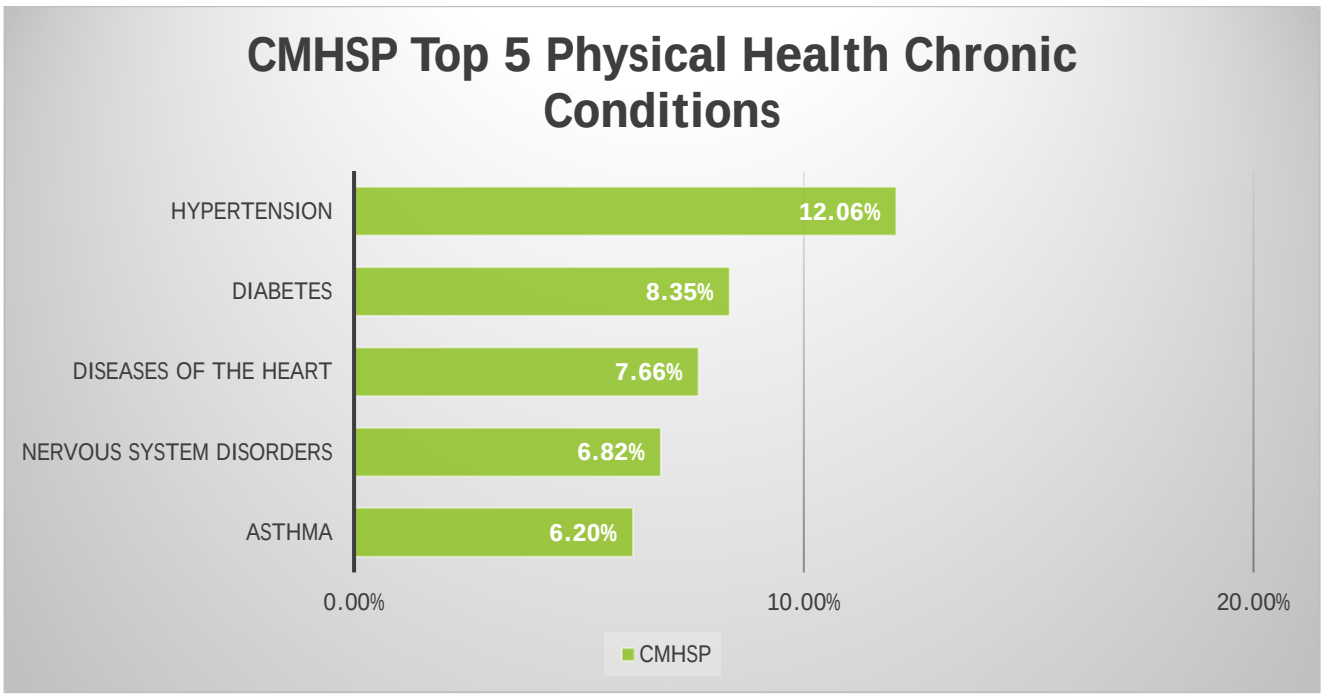
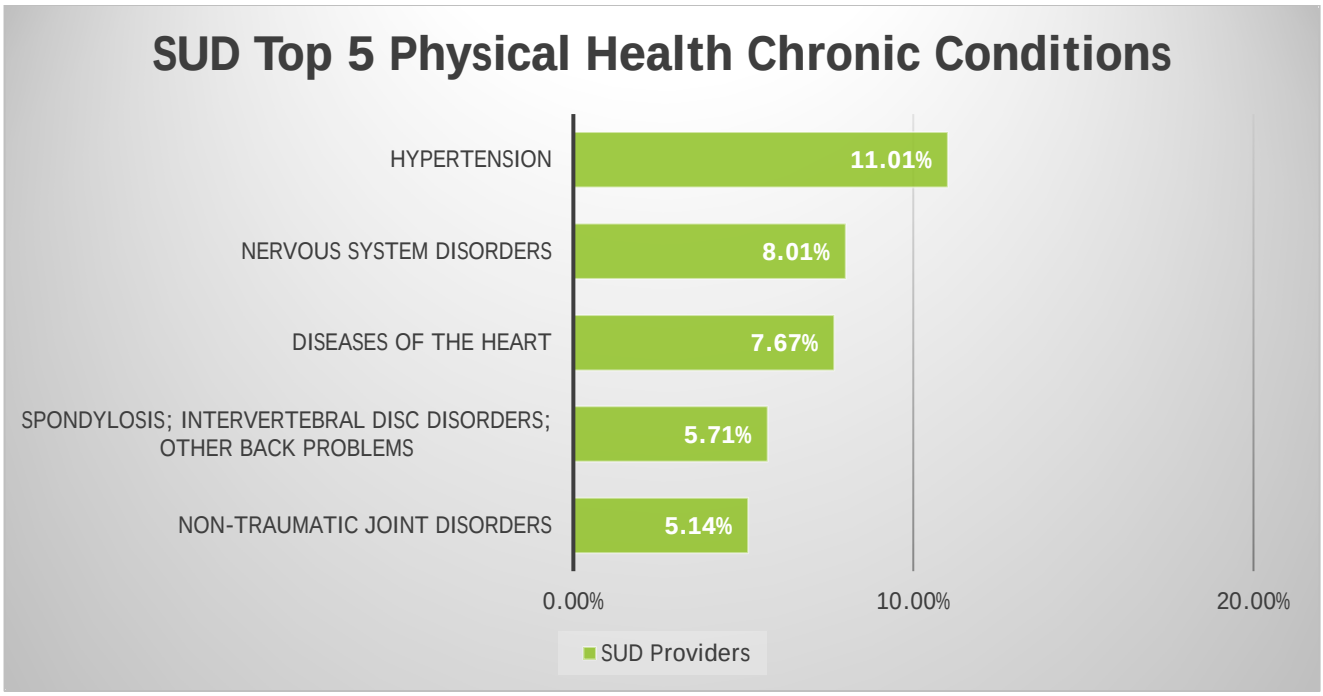


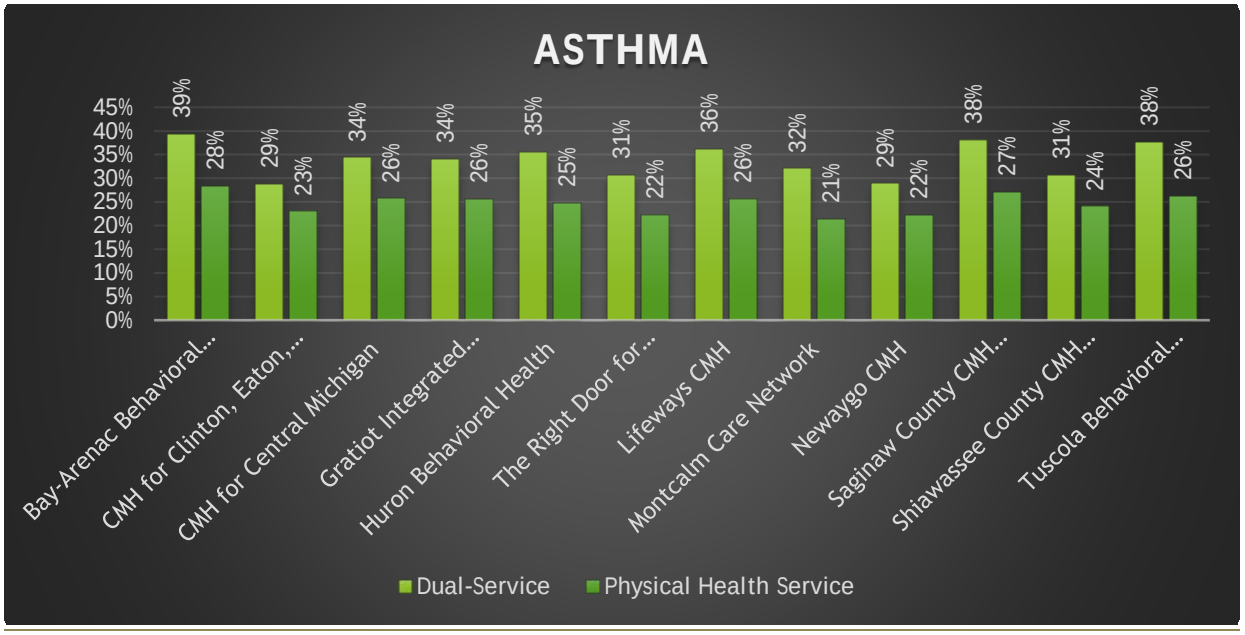
Figure 4: Displays the top 5 Physical Health Chronic Conditions by the percentage of Medicaid individuals served by SUD providers within the MSHN region in the past 12 months. (MA Population: 7918)

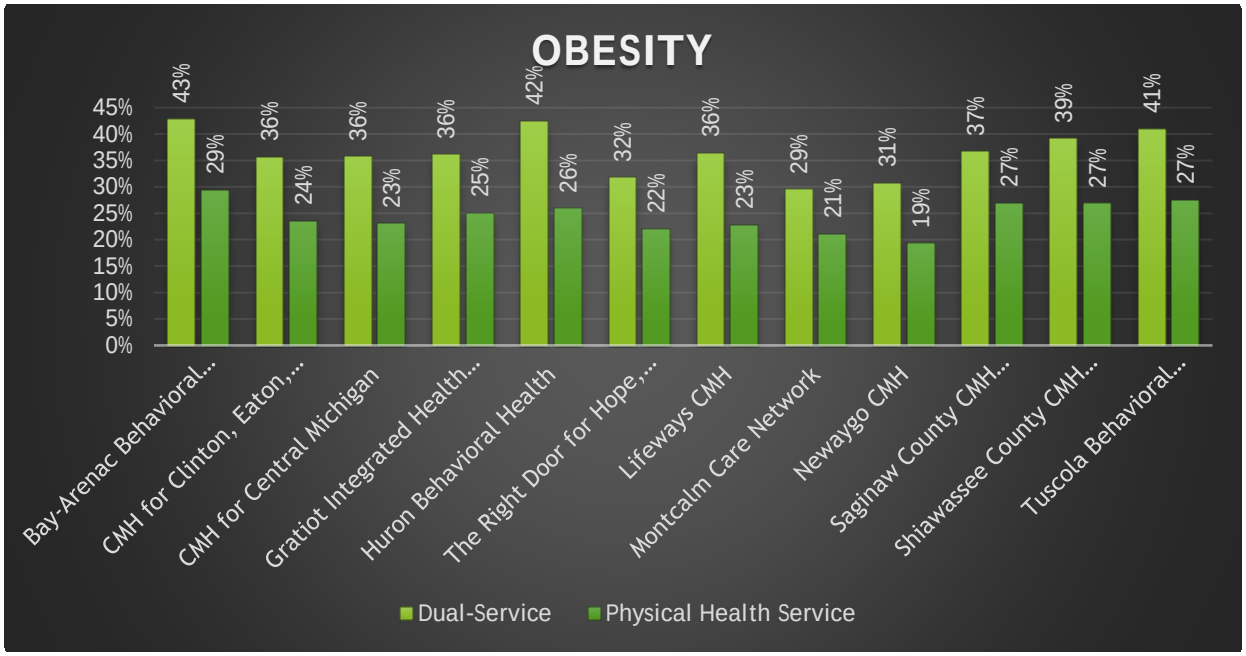


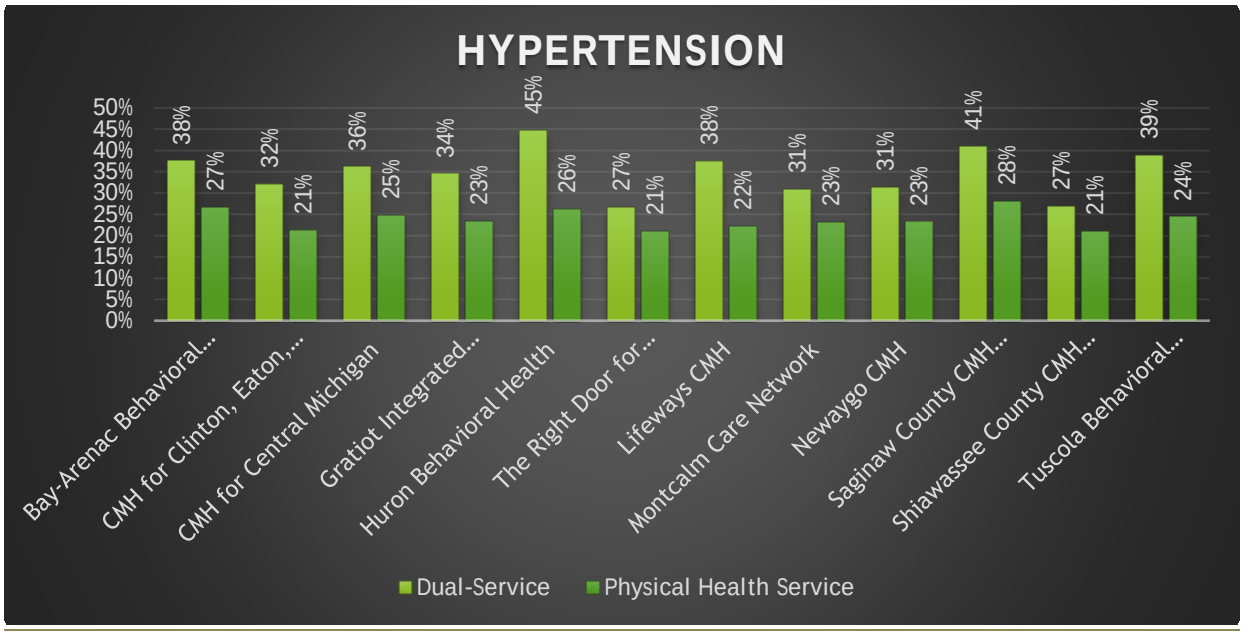
The below chart displays the identified Primary Drug for all individuals (13,271) in FY 2017:

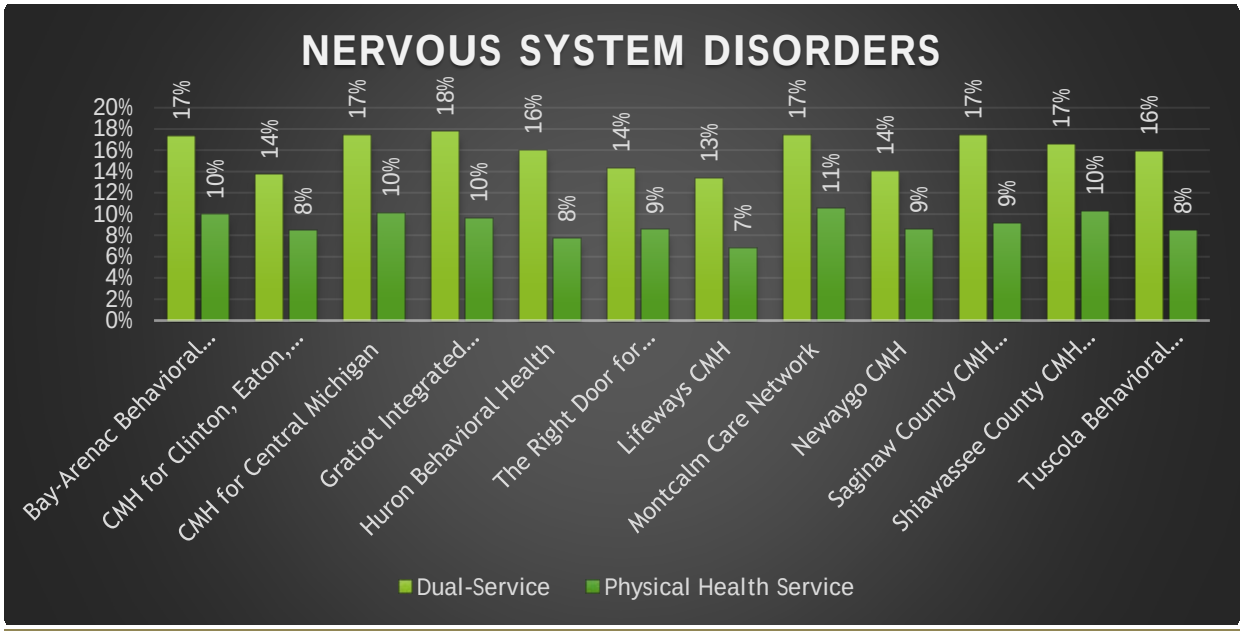
Primary Drug	Client Count	Percentage
Alcohol	4699	35.41%
Heroin	3476	26.19%
Other Opiates/Synthetics	2081	15.68%
Marijuana/hashish	1411	10.63%
Cocaine/Crack	768	5.79%
Methamphetamines	546	4.11%
Benzodiazepines	80	0.60%
None	55	0.41%
Non-prescription Methadone	38	0.29%
Other Sedatives/Hypnotics	35	0.26%
Other amphetamines	23	0.17%
Barbiturates	15	0.11%
Hallucinogens	13	0.10%
Inhalants	13	0.10%
Other Stimulants	13	0.10%
Over-the-Counter Medications	5	0.04%

The following graphs depict the rates of certain chronic diseases in the physical-health Medicaid enrollee population in the MSHN region (n = 355,099) compared to the dual-service Medicaid enrollee population in the MSHN region (n = 38,361).









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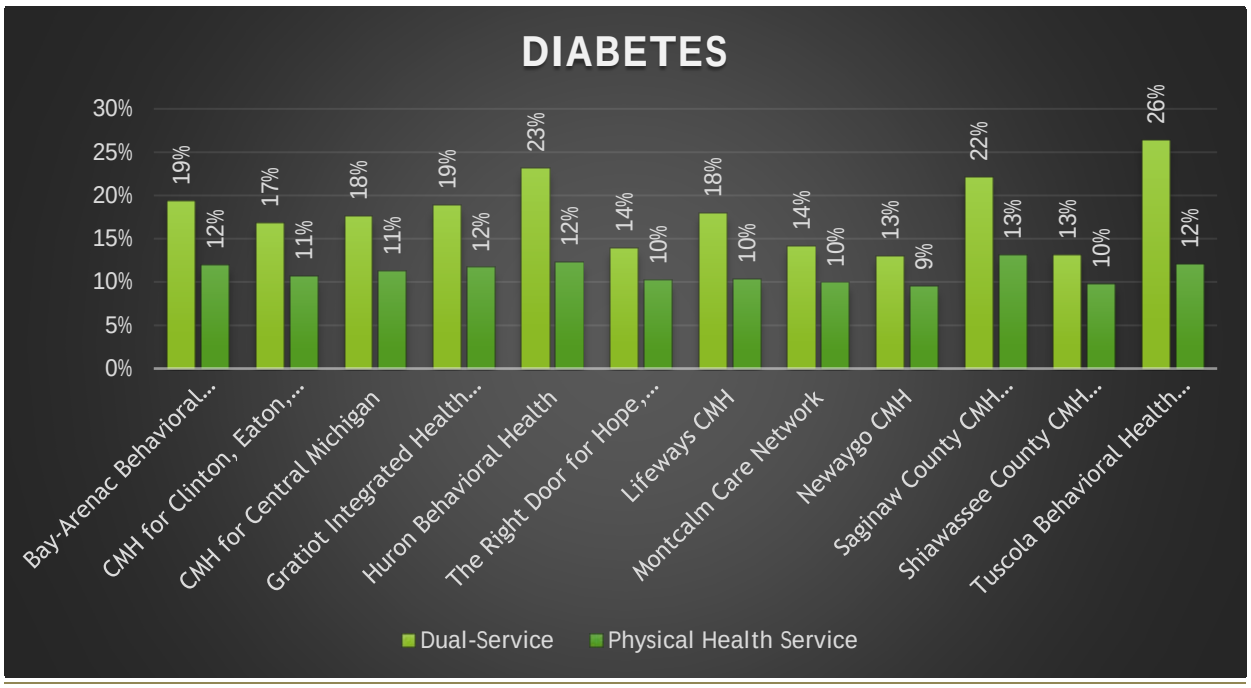
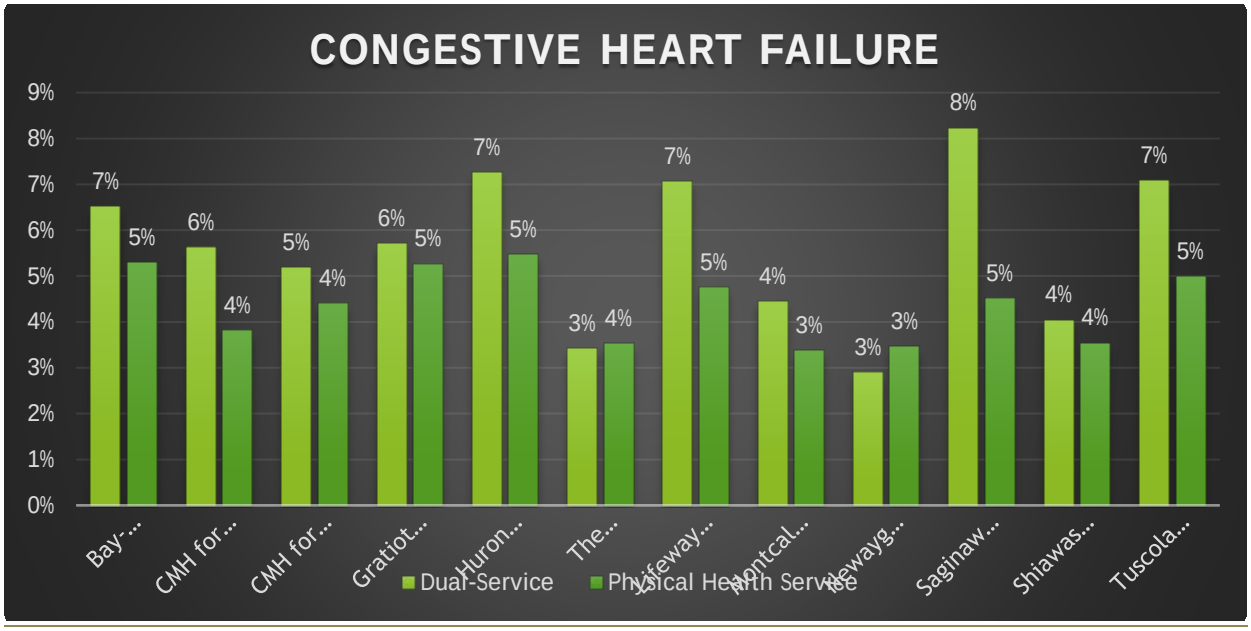
8 Please see Appendix D for Nervous System Disorders diagnostic code set





Given the unique and complex health needs of the dual-service population it is important for MSHN to examine population health strategies, social determinants of health, and opportunities for integrated health service delivery. Improved care management with the Medicaid Health Plans is also vital in order to

decrease inappropriate and disjointed care for dual-service members who often experience multiple chronic physical and behavioral health conditions.

Note: The full MSHN dual-service population data report for FY17 is contained in **Appendix B**.

V. What is Population Health?

Population health is defined as the health outcomes of a group of individuals, including the distribution of those outcomes within the group. It represents a change from individual-level focus of most mainstream medicine, and seeks to complement traditional efforts of public health agencies by addressing a broader range of factors shown to impact the health of different populations. A priority in achieving the aim of Population Health is to reduce health inequities or disparities among different population groups due to, among other factors, the social determinants of health (SDH). According to the Centers for Disease Control and Prevention, social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants of health include things such as: the availability of resources to meet basic needs (e.g. safe housing and food); access to healthcare service; level of education; employment; transportation; social support; language and literacy; and economical and financial resources. Social determinants are not generally included in the traditional health care service delivery system, yet they strongly influence the overall health outcomes of individuals or populations.

From a population health perspective, health has been defined not simply as a state free from disease but as "the capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish, 1996). The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This conceptualization of total person well-being is the foundation for the MSHN vision statement:

> *The vision of Mid-State Health Network is to continually improve the health of our communities through the provision of premier behavioral healthcare and leadership. Mid-State Health Network organizes and empowers a network of publicly-funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region.*

MSHN has operated and implemented the strategic plan under the Triple Aim.

- Better Care;
- Better Quality and;
- Better Value

The successful achievement of the Triple Aim requires highly effective healthcare organizations implement population health and integrated care systems. The backbone of any effective healthcare

system is an engaged and productive workforce/provider network. The Quadruple Aim adds a modification of the Triple Aim to acknowledge the importance of physicians, nurses and all behavioral health employees finding joy and meaning in their work. This 'Quadruple Aim' would add a fourth aim: improving the experience of providing care.

VI. Setting the Foundation

MSHN identified three (3) core elements of effective Population Health Plan:

- Systematic effort to improve health outcomes in sub-populations that share multiple clinical and social attributes
- Reflects the interdependence of biology, behaviors, social, cultural, economic, and environmental factors that impact wellbeing
- Compels healthcare and social service providers and the insurer to envision and develop organized and integrated delivery systems capable of achieving the Quadruple Aim.

Below are core foundational components that enable organizations to be successful in population health and care management**,** as well as a brief description of MSHN's current readiness in each foundational area. (Note: These foundations were presented at the American CMH Association Symposium for Behavioral Health and Primary Care in Washington, DC on January 20,2016. They have been modified here to illustrate MSHN's organizational readiness and current efforts in the areas of population health and integrated care.)

FOUNDATIONAL AREA	MSHN READINESS
Data Informed Strategy • Identify your target population and understand their issues. • Develop a positioning statement that differentiates you from other enterprise distractions.	• MSHN utilizes available data and risk-stratification criteria to identify target population and understand issues impacting health outcomes • Development of Population Health and Integrated Care Plan to articulate strategy toward managing population health concerns
Compensation/Reimbursement and incentives (to move from Volume to Value)	• Current value-based purchasing pilots with select SUD service providers • CMHSP sub-capitation supports value-based approach to managed care efforts
Information Technology • Real-time alerts/notifications and actionable items (ICDP) • Health Information Exchange (HIE) • Website tools for patient engagement (MCIS)	• Utilize Integrated Care Delivery Platform (ICDP) and Admission/Discharge/Transfer (ADT) feeds from participating hospitals to obtain alerts and notifications

FOUNDATIONAL AREA	MSHN READINESS
	• Participate in Health Information Exchanges (HIE) such as VIPR and MiHIN (such as ADTs, Med Rec) • FY19 plans for Managed Care Information Systems patient engagement tools
Identification and management of high-risk and at-risk members • Data Analytics –For identification/population assessment, stratification, prioritization • Claims data and costs	• MSHN utilizes CC360 for identification and care management of shared high-risk members with Medicaid Health Plans • Employs utilization management practices to identify under and over utilization in the population
Development of Person Centered Plan, health goals. • Generates patient activation[9] shared decision making	• Person-Centered Planning occurs at the local level with CMHSP and SUD service providers within the MSHN region • Members are offered supportive wellness services and/or referrals as part of the person-centered planning process to support their health needs •
Care coordination; community support referrals and connections. • Establishing accountability and agreeing on responsibility • Helping with transitions of care • Assessing client needs and goals • Creating a proactive care plan • Monitoring and follow-up, including responding to changes in clients' needs • Supporting self-management goals • Linking to community resources	• Established policies and procedures to ensure care coordination and community referrals happen consistently throughout the region • Clinical leadership committee created additional clinical protocols to ensure implementation of best practices for care coordination within each local CMHSP organization • FY19 MCIS plans to provide self-management tools to track goals • Community resources available on website; linking occurring with MHPs, CMHSPS, SUD Providers

[9] In this context "patient activation" is a conceptual framework that refers to the knowledge, skills and confidence a person has in managing their own health and health care. This should not be confused with the Patient Activation Measure (PAM), an evidence-based psychometric tool which is a licensed product of Insignia Health.

FOUNDATIONAL AREA	MSHN READINESS
Follow disease management protocols, clinical pathways and evidence-based clinical practices/guidelines. http://wwwn.cdc.gov/chidatabase	• Identified specific health monitoring performance metrics (HEDIS measures) and developed corresponding protocols for care management. • Coordination with MHPs to develop protocols for integrated care
Clinical Monitoring and Interventions: • Phone interventions: prompting, education and support • Face-to-face interventions • Alerts • Reassessments	• Clinical monitoring and interventions occurs at local level through partner CMHSP organizations and SUD providers. • CMHSPs and SUD(Pilots) utilizing ICDP for care alert monitoring and interventions
Self-management including prevention and wellness. • Appropriate health education, communication and marketing to promote wellness and self-care • Prevention o Screenings – Cholesterol; Blood Pressure; Glucose, glycosylated hemoglobin or hba1c o Tertiary – Targets persons who already has chronic disease (Disease Mgmt.) to prevent progression and worsening. o Compliance with Care/Disease Management • Health Promotion o Health and wellness marketing o Patient education o Patient communication • Teach use of self-management tools	• CMHSPs & SUD providers supporting health education and communication to beneficiaries • Required annual testing and follow up if not present by primary care physician. Monitoring for testing through ICDP. • FY19 self-management tools to be available and ready for beneficiary use.
Multi Media Support for Patient Care – Information Therapy • Telephonic/Mobile - Audio Content; Health Coaches; Text messages • Telepresence - Real-Time patient care; Consultations • Webcare - Health Advocates • Written – Mailers; Personalized Messaging	• Use of tele-psychiatry services in CMHSP partner organizations • Plan for increased use of patient self-portal through MCIS, Website and mobile device. • Use of automated call reminders through EHR vendor in CMHSP partner organizations.

FOUNDATIONAL AREA	MSHN READINESS
Focus on health determinants • Lifestyle and Behaviors = 51% of Health • Smoking, poor diet, inactivity and alcohol behaviors cause 40% of mortality	• Health determinants routinely screened by CMHSPs and SUDSPs (such as smoking, high-risk factors for communicable diseases) • Members with identified health determinants are offered supportive wellness services and/or referrals as part of the person-centered planning process • Future risk stratifications to include health determinants
Team-based care; integrated care • Patient-centered medical home/Health home o Multidisciplinary Treatment Team o Wellness Services are a central component • Focus on: Nutrition, Exercise, Stress Reduction • Increased Integration among Physical Health and Behavioral Health Providers • Much of BH takes place in PCP office. • Improve screenings.	• CMHSP organizations participate in a variety of local-level integrated care activities include patient-centered medical home practices. Described in further detail later in this plan. • Increased development of SUD service providers in integrated care strategies for co-morbid physical, behavioral health and substance use disorder concerns
Relationships and Partnerships • Critical to building an infrastructure upon which this works and in which clients can move. • Starting up a new way of doing things can often involve knowing "who" to call.	• Strong collaborative relationships with all 8 MHPs that serve the 21-county MSHN region • CMHSP organizations have local partnerships with community health centers, hospitals and primary care practices • Increased care management and care coordination between MHPs, CMHSPs and SUD providers
Transitional Care • Assistance between levels of care • Interim care while waiting to get into a different level of care • Care received when client is stable and may be able to exit care but needs support in doing so	• CMHSP and SUD providers coordination of care between levels of care • Monitoring recovery plans and follow up
Complex case (Care) Management Programs • Collaborative process designed to manage medical/social/mental health conditions more effectively. • Determine needs and create care paths across the care continuum o Network coordination - Communicating with providers of both the physical illness and the	▪ Local-level complex case management occurs within CMHSP organizations and SUD service providers. ▪ Participates in plan-to-plan level care management with MHPs for highest-risk shared members; develop coordination goals and share with CMHSP and SUD providers

FOUNDATIONAL AREA	MSHN READINESS
behavioral health disorder to assure there are no gaps in care and that care transitions occur timely and smoothly • Build core program functions through personnel and processes. o Phone interventions • Prompts for appointment attendance and support for medication, diet or activity adherence o Face to Face interventions ▪ Focus on adherence to medication, diet and activity, prescriptions, mood management and support for improved communication effectiveness about issues attending to the disease o On line supports • Data Analysis, Risk Stratification, Selection, Enrollment • Methods implemented to monitor, intervene, track outcomes and quality measures.	▪ CMHPs utilize cc360 to monitor health conditions and use to educate and follow up on alerts ▪ Developed Population Health and Integrated Care Plan ▪ Protocols used to implement clinical best practices ▪ Risk stratification identified; growing stratification list as program expands
Quality: Evaluation; Performance metrics. • Work with clinical and informatics to Identify target populations and conditions. • Work with clinical to develop and implement interventions, programs. • Measure improvements in health status, service utilization, costs and social functioning.	• Measurement portfolio includes performance metrics related to population health and integrated care. • Performance metrics reviewed by MSHN leadership councils and committees; provide change strategy recommendations for improvement

VII. Current Population Health and Integrated Care Initiatives

A. Coordination with Medicaid Health Plans for High-Risk Shared Members and Follow-Up after Psychiatric Hospitalization

MSHN along with United Healthcare facilitates a state-wide workgroup that includes the ten (10) PIHPs and eight (8) MHPs. The charge of the workgroup is to ensure implementation and compliance with the performance bonus incentive requirements of the PIHP/MHP contract with MDHHS related to Integration of Behavioral Health and Physical Health Services.

The below table indicates the **FY18 Performance Bonus Incentive**.

Category	Description	Criteria/Deliverables
1. **Implementation of Joint Care Management Processes** (50 points)	Collaboration between entities for the ongoing coordination and integration of services	1. Quarterly, each MHP and PIHP will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities. MDHHS will select beneficiaries randomly and review their care plans within CC360. 2. Quarterly, each MHP and PIHP will participate, via the MHP-PIHP Workgroup, in reviewing and validating MDHHS reports that would include but not be limited to the number of care coordination plans, the reasons for closing care coordination plans, and the average length of time for active care coordination plans. 3. The MHPs and PIHPs will work jointly to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS.
2. Follow-up After Hospitalization for Mental Illness within 30 days (FUH) (50 points)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 days.	1. Plans will meet set standards for follow-up within 30 days for each rate (ages 6-20 and ages 21 and older). Plans will be measured against an adult minimum standard of N% and a child minimum standard of N%. See MDHHS measure specification for query, eligible population and additional details. Measurement period will be July 1, 2017-June 30, 2018. The 50 points will be awarded based on MHP/PIHP combination performance measure rates. The total points will be the same regardless of the number of MHP/PIHP combinations for a given entity. For example, a PIHP working with five MHPs will be awarded up to 10 points for each PIHP/MHP combination rate.

The Medicaid Health Plan (MHP) and Pre-Paid Inpatient Health Plan (PIHP) Integrated Health Workgroup identified and agreed to the inclusion of the following stratified risk criteria for the selection of persons requiring the most thoughtful and well-coordinated care between the MHPs and PIHPs:

- Number of emergency department visits in previous 12 months
- No visits to a primary care physician within the last year
- Number of chronic conditions (physical health and behavioral health)
- Number of psychiatric/physical health hospitalizations within the last 12 months

The risk criteria are retrievable through Care Connect 360 (CC360) which results in a list of consumers whose interface (or lack thereof) with the healthcare system as well as the presence of chronic health conditions amounts to ongoing issues related to social determinants of health/wellness, poor access to care, increased risk of utilization of higher cost services, and increased chances of a general worsening of overall physical and psychological well-being.

MSHN participates in monthly care management meetings with each of the 8 MHPs in its region for coordinated service planning and care management activities for shared members who meet the established risk criteria. The purpose of the monthly meetings is to establish primary areas of responsibility between the plans for addressing the health needs of the shared member in a coordinated manner, however this meta-level coordination between the PIHP and MHP does not preclude the CMHSP from also coordinating directly with the MHP as needed. The CMHSPs conduct all local care coordination activities directly with the individual they serve and that person's care providers, medical providers, treating CMH physicians, and MHP. MSHN provides written notification to the CMHSP when a new member is identified for plan-to-plan

coordination. Then, on a monthly basis MSHN care management staff coordinate with identified clinical points of contact at each CMHSP to exchange information and updates regarding the local efforts the CMHSP is engaging in to address the individual's care needs and high-risk factors. [10]

MSHN tracks and monitors the following outcome measures related to care management for high-risk shared members.

A. Reduction in number of visits to ER
B. Reduction in hospital admissions for psychiatric/physical health reasons
C. Number of chronic conditions – Measure of stability, improvement and/or remission
D. Percent of consumers who have had a PCP visit in the last twelve months
E. Referral to a healthcare specialist
F. Reason for closure of care management case
G. Amount of time (in days) spent in a care management plan arrangement
H. Amount of time (in days) open to care management where there has been no consumer engagement

In addition to the monthly care coordination meetings for shared high-risk members, MSHN also participates in ongoing targeted care coordination efforts with its MHP partners to provide comprehensive follow-up care for shared members after an inpatient psychiatric hospitalization when people are often most vulnerable. In partnership with local CMHSP's, MSHN provides inpatient admission notification for shared members to each of its 8 MHP partners within 5 business days. MSHN and the MHP care managers coordinate to determine which plan will be responsible for providing follow-up care within designated timeframes.

MSHN's performance related to **FY17 Performance Bonus & Follow-Up after Hospitalization.**

PIHP	6 to 20 (STANDARD = 70%)	21 to 64 (STANDARD = 58%)
	CURRENT	CURRENT
MSH - Overall Rate	*81.80*	*73.04*
MSH / AET	N/S	N/S
MSH / BCC	N/S	**63.27**
MSH / MCL	**83.72**	**74.63**
MSH / MER	**81.75**	**72.98**
MSH / MOL	**83.33**	**75.18**
MSH / PRI	N/S	**76.92**
MSH / UNI	**77.78**	**64.63**

"N/S" (Not Scored) represents combinations where the numerator was less than 5 and the denominator was less than 30.

[10]This monthly process is being further developed and refined to engage the CMHSP medical directors in a more active role in the care management activities between the PIHP and MHP for the individuals served by their respective CMHSP. Possible activities include participation in member review meetings and provision of feedback regarding development of joint care management plans

B. Development of Population Health and Integrated Care Performance Indicators

With input from its regional councils and committees, MSHN developed a performance measure portfolio based on national healthcare industry standards as part of its strategic plan for FY17-FY18. MSHN utilizes data analytics software to monitor and track these measures regionally as well as by individual performance of each CMHSP. CMHSPs have access to and can view their CMHSP-specific data. Metrics are reviewed quarterly, if not more frequently, by regional MSHN councils and committees for ongoing input into performance improvement strategies. Expanded descriptions for each performance measure, rationale for selection, and accompanying clinical protocols are contained in **Attachment C** of this document.

C. Value-Based Purchasing Pilot Projects for Substance Use Disorder Services

Mid-State Health Network (MSHN) is currently engaged in a pilot project to improve the quality and efficiency of substance abuse treatment through a value based purchasing model for Substance Use Disorder (SUD) services. These incentive-based contracts include additional responsibilities in the continuing treatment and wellness of clients. Engaging clients in a continuous care relationship and encouraging providers to strengthen care coordination are two objectives of this pilot project, both supported by research literature on successful value-based purchasing implementations. Additional objectives of this pilot project include:

- Improved clinical outcomes for at-risk populations
- Expanded care coordination between providers at all levels
- Consistent engagement in an SUD treatment and recovery relationship
- Engagement with primary care
- Reduction in unnecessary emergency department use
- Reduction in inpatient psychiatric care

The pilot project model includes four phases of implementation to fully incentivize participants in model development: Pay for Participation, Pay for Reporting, Pay for Performing, Pay for Success. Provider participation will be incentivized at each phase, with financial incentives evolving from planning, infrastructure development and information gathering, to full implementation of the clinical model. It is anticipated that the pilot will reach full implementation (Pay for Success) in FY19.

D. Regional Opioid Strategic Plan

In 2015, 2,040 individuals died from a drug overdose in Michigan. Opioids, illicit and prescription, were involved in 63.3% of these deaths. Between 1999 and 2015, opioid involved overdose deaths in Michigan

increased more than 10 times, and have increased sharply since 2012. During 2015, adults aged 25 to 34 showed the highest overdose death rates, and males' overdose death rates were higher than female. In response to the opioid public health crisis, MSHN has developed a strategic plan to address opioid misuse and abuse in its 21 counties as well as ensure adequate access to treatment for individuals seeking recovery from opioid use disorder. This multi-pronged approach combines education, prevention, population health strategies, and collaboration with community partners and healthcare providers.

- **Prevention Strategies:**
  - County Prevention Coalitions sponsoring "town hall" educational meetings in their local communities
  - Media Campaigns to promote awareness and reduce stigma
  - Ensuring adequate number of medication drop boxes in each community and providing education regarding safe medication disposal
  - Physician trainings on pain management
  - Promoting the use of MAPS (Michigan Automated Prescription System) with health providers in local communities

- **Project ASSERT:** Project ASSERT is an evidence-based model in which specially trained Recovery Coaches are embedded in health clinics or emergency departments (EDs) to conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT). This program helps reach individuals who often are high utilizers of ED services, but rarely connect to formal treatment and recovery services. Project ASSERT identifies individuals with a potential SUD across race, gender, ethnicity, and age, meeting them at a vulnerable time and offering support from the peer perspective. Project ASSERT is currently in use in the following Region 5 counties: Isabella, Midland, Clare, Gladwin, Gratiot, Mecosta, and Osceola with the following collaborating hospital: MidMichigan Health and Spectrum Health. Additional Project ASSERT initiatives are in the planning stages for implementation in Ingham, Bay, Newaygo, Montcalm, Ionia, Hillsdale, and Saginaw counties.

- **Expansion of MAT -** Medication-Assisted Treatment (MAT) is a standard of care that is broadly recognized as foundational to any comprehensive approach to the national opioid addiction and overdose pandemic. Following the recommendations by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the American Society for Addiction Medicine (ASAM), the National Institute for Drug Abuse (NIDA), the Michigan Department of Health and Human Services (MDDHS)'s Office of Recovery Oriented Systems of Care (OROSC) Treatment Policies #5 and #6, and other state and national directives, MSHN has sought to expand the availability of MAT services and to promote de-stigmatization of MAT in a system that for many decades was rooted in an abstinence-based 12-step model. Current research and brain science has pushed our SUD treatment system to evolve, to adopt a harm reduction approach, and to accept evidence-based best practices including the use of medications like methadone, Suboxone, and Vivitrol in helping clients with Opioid Use Disorder (OUD) move into and sustain long-term recovery.

Towards that end, MSHN has taken the following initiatives: 1) MAT sites have expanded from 10 to 15 including in several new counties; 2) MSHN has adopted a MAT-inclusive policy which as of FY18 bars providers from discriminating against clients on MAT and prohibits misinformation and delegitimizing of MAT as a viable recovery pathway; 3) MSHN spearheaded development of a state-wide MAT-inclusive consensus document that has been adopted by all ten PIHPs; 4) MSHN has supported the development of MAT-inclusive Recovery Residences that were historically closed to clients on MAT;

With the use of OROSC grants, MSHN has engaged in a number of MAT-enhancing activities. These include:

- Basic and Advanced Motivational Interviewing (MI) trainings were held in September and November with a follow-up coaching session in December of FY17.
- Video Assessment of Simulated Encounters-Revised (VASE-R) pre and post tests were given to 38 participants.
- Coaching sessions were held in December 2017 and January 2018 to clarify and enhance incorporation of motivational interviewing practices. The coaching session in February 2018 will finalize the last of the series of three coaching sessions.

➢ **Naloxone-Narcan Regional Availability**

Narcan/naloxone is a full antagonist used for the reversal of opioid overdoses. MSHN has been invested in providing Narcan nasal spray and naloxone injectable kits to the communities that MSHN serves. MSHN began this initiative with the 12 Community Mental Health partners within the MSHN region, providing the Narcan nasal spray kits to be distributed to the community, to law enforcement, and to emergency first responders. After initializing this distribution project, MSHN turned to our contracted Medication Assisted Treatment (MAT) partners to offer the naloxone injectable kits to clients being served within these programs. MSHN received State Targeted Response to Opioid Grant funding to continue to make Narcan and naloxone available throughout the region. As a result of receiving these grant funds, trainings are being held to further distribute this life-saving medication to law enforcement, other human service organizations, and communities in the MSHN region.

E. CMHSP Integrated Health Initiatives

The MSHN Clinical Leadership Committee (CLC) was instrumental in providing guidance and input related to the development of population health and integrated care best practices for implementation in all twelve (12) local CMHSPs in the MSHN region. The CLC recognized that there is a large variance across the CMHSPs regarding size, resources, and number of persons served. Some CMHSPs have the ability to participate in a large number of activities to affect population health while others have fewer resources. In developing the following regional population health best practices, the committee considered these variations to arrive at an agreed-upon plan that was realistic for implementation in all 12 CMHSP organizations.

By 10/1/18: All CMHSP's in the MSHN region will demonstrate the ability to:

- Verify consumer self-reported health conditions either through ICDP, CC360 or direct contact with primary care[11]
- Inform every consumer that the CMHSP is required to coordinate care with their primary care physician.[12]
- Meet the measurements identified through Meaningful Use for patient portals.
- Each CMHSP will identify its high-risk utilizers and develop a plan for stratification as locally determined and defined. MSHN monitors and defines its risk stratification as defined in this plan as high-risk. *(Consumers identified as having 1 or more emergency department visits, no primary care visit within the previous 12 months, 2 or more chronic conditions, psychiatric or physical hospitalization within the previous 12 months)*
- Care Coordination occurs with primary care and behavioral health care
- At least once annually (typically during the pre-planning for person centered planning), staff will utilize electronic data feeds to determine the last time the individual had contact with their primary care physician.
- Each CMHSP will work with its medical directors to review and discuss MSHN priority measures that we will measure and track as a region.
- Each CMHSPs Information Technology Directors and EMR vendors will work together to embed ICDP/CC360 into the electronic medical record to facilitate easier access to integrated health data for practitioners.

In addition to the regional best practices, many CMSHPs participate in additional population health and integrated care activities in their local communities, as resources allow. The table below provides a summary:

Individual CMHSP Population Health and Integrated Care Activities:

Bay-Arenac Behavioral Health

- Implemented a revised nursing model to expand access to healthcare; embedded questions in social work assessments focused on typical chronic co-morbid conditions to identify consumers for referral to nursing staff for health assessment and enhanced coordination of care with primary care providers; embedding questions in person centered planning process regarding health risk profile
- Participating in a performance improvement project involving diabetes screening and coordination with primary care physicians

[11] MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program - 8.4.2 Contract Withholds

[12] MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program - 7.4 Integrated Physical and Mental Health Care; 19.5 Primary Care Coordination;

- Providing funding for the Community Health Assessment
- Key partner for Saginaw Valley State University and Bay County Health Department HRSA grant to add a behavioral health team to a nurse practitioner primary care clinic
- Pilot site for MDHHS, MiHIN and PCE for development of embedding of CC 360 in EHR
- Working with Zenith for potential embedding of the Integrated Health Care Platform in EHR, including risk analysis for poor health outcomes
- Providing wellness classes run by nursing staff
- Implemented electronic lab ordering and receipt of test results with multiple labs
- Contracted with Great Lakes Health Connect for information exchange with regional health center and primary physician clinics
- Collaborative effort to implement a Vivitrol program in the jail with Bay County Jail leadership, Sheriff's Dep't, Courts (judges), Public Health Dep't and SUD providers

CMH for Clinton, Eaton, Ingham Counties

- Have Behavioral Health Consultants (BHC) placed in two Sparrow Hospital Primary Care Practices and one McLaren Primary Care Practice to review screenings based on the Bright Futures Screening Protocol, and consult with patients and provide brief treatment at the clinic. Additionally, BHCs continue to provide onsite behavioral health interventions, including both brief intervention as well as ongoing treatment.
- Have CMHA-CEI Supervised Behavioral Health Consultants embedded in 4 Ingham County Federally Qualified Health Center locations, with Volunteers of America Homeless Shelter Medical Clinic site to be added in 2018. Working towards connecting ICHD and CMHA-CEI Electronic Health Records. SUD specialist will be added to support SBIRT and consultation in the FQHCs in FY18.
- The Ingham County Health Department operates the Birch Health Center (FQHC) located inside our CMHA-CEI Jolly Rd. Building with both CMHA-CEI Behavioral Health Consultant and CMHA-CEI Psychiatric Nurse Case Manager embedded in the clinic. Sparrow Laboratory is now also embedded in the Birch Health Center.
- Have CMHA-CEI Crisis Services Mental Health Therapists embedded into the McLaren-Greater Lansing Hospital Emergency Department daily 2pm to 2am.
- In partnership with Michigan Child Collaborative Care (MC3) offering pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. Currently 75 local providers have been enrolled into MC3, with dozens already utilizing psychiatric consultation.
- CMHA-CEI Wellness Center provides Adult Outpatient Treatment co-located in the Ingham County Health Department Forest Community Health Center.
- CMHA-CEI Wellness Center Mental Health Services provide services within the Cristo Rey Community Center Medical Clinic and in Clinton County at Mid-Michigan Health Department.
- Working on care management pilot projects within CMHA-CEI clinical departments that address chronic illness or emergency department usage to be implemented in FY18.

CMH for Central Michigan

- Co-locating five therapists
- Participating in the Michigan Health Improvement Alliance collaborating with other agencies to achieve a community of health excellence
- Meeting with Great Lakes Health Information Exchange about integrating lab and available physical health data into the EMR

- Accessing State of Michigan web portal, Care Connect 360 that provides population health and data analytics information was pursued. Work will continue this year on these initiatives.
- Meeting with all hospitals in the area and collaborating on several fronts
- Medical Director is now adjunct prof at CMU and is teaching with their med students.
- Having CMU's 3rd and 4th year psych residents with us as a placement site
- Full-time staff located on site at the new Emergency Department that Mid-Michigan Health is building here in Mt. Pleasant
- Meeting with the Mid-Michigan Regional Medical Center and sharing the CC360 data
- Strategizing on how to approach the highest ED users
- Continued development of the MDHHS Integrated Health grant
- Established an Outpatient Orientation session to help educate consumers about the relationship between mind/body
- Promoting use of MI skills for integrated health changes
- Applying for Michigan Health Endowment grants
- Medical Director continues to meet with local Health Plans to explore services to shared consumers.

Gratiot Integrated Health Network

- Adding P.A. to our service array at our satellite office in St. Louis.
- Care Manager analyzing ICDP data, and networking with primary staff on care alerts
- New EMR that adds health and wellness tracking
- Participate in Live Well Gratiot – county wide health and wellness committee
- Peer led smoking cessation classes
- Peers provide Whole Health Action Management
- Peers provide Smoking Cessation groups
- Host site for MSU Mid-Michigan Family Practice Physicians clerkships and residency programs
- Active in Live Well Gratiot sub-committee of the County Collaborative
- Active in Great Start Collaborative health integration activities
- Provider of Substance Use Disorder outpatient service array

Huron Behavioral Health

- Have a co-located FQHC provider at the CMH site and utilize huddles prior to seeing consumers
- Psychiatric consultation is provided to primary care sites as needed or requested
- ADT Feeds come directly to our EHR and the primary worker who is to follow-up
- Staff are documenting coordination of care in progress notes
- Providing healthy lifestyle education through groups
- Integrating wellness and recovery principles into services
- Participating in performance improvement projects involving diabetes and cardiovascular screening
- Nursing staff providing health & wellness classes for consumers focusing on healthy lifestyle changes
- Initiated access into the State of Michigan web portal, Care Connect 360, that provides population health and data analytics information, as well as utilizing ICDP.
- Hosting students working on their advanced nursing degrees (pursuing nurse practitioner certification)
- Taking steps toward implementing a tobacco-free campus (all locations) and providing necessary support to consumers through the transition such as Tobacco Screening and Education and referral to the Quitline as well as assistance to obtain nicotine replacement therapies
- Assisting consumers who do not have a primary care provider connect to a physician by connecting them to either the local FQHC clinic or a private primary care provider of their choice
- Medical Director provides consultation to community primary care physicians as requested.

The Right Door for Hope, Recovery & Wellness

- The Board of Directors established consumer based outcomes related to wellness: 85% of Medicaid Population (Healthy Michigan, Medicare/Medicaid, Medicaid) served are seen annually by a primary care physician OR receive an annual health screen with a nurse from The Right Door for Hope, Recovery and Wellness.
- Strategically providing "physician outreach" whereby the psychiatrist, nurses and clinical leaders meet with local primary care providers to educate, provide consultation and address high utilizing patients.
- Have formal coordination of care agreements with most all Rural Health Clinics in Ionia County; including Sparrow Medical Group Clinic in Ionia and various physician practices.
- Providing lunches for primary care providers in Ionia County with our Medical Director at least annually
- Providing the Medical Director's personal cell phone number to community primary care providers for direct consultation
- In addition to sending medication reviews and evaluation notes, also share lab values with primary care providers
- Publishing a quarterly newsletter on best practices and coordination of care for primary care providers
- Consumers seen by the Medication Services team has their BMI, waist circumference, AIMS testing, and lab orders completed
- Tracking ER visits with our consumers through Zenith and contacting consumer to provide guidance and make sure primary care follow up happens.
- Visiting primary care offices twice monthly with education in form of material, lunch discussions or speakers.
- All primary care referrals receive a health screen to bring both medical and mental health together.
- Primary care offices working with us by providing topics from groups for their consumers.
- One time consults by our providers at the request of the primary care provider.
- Medical Review summaries sent to primary care offices.
- Nurses attend doctor appts with consumer when consumer struggles with knowledge of their medical condition.
- Helping consumers who do not have a primary care provider connect to a new primary care provider by calling their office and setting up first appt.

LifeWays CMH

- Providing Care Management services to consumers enrolled in PBHCI SAMHSA Grant – coordinating care with primary care physicians and specialists
- Co-Location of the Federally Qualified Health Center on site at the LifeWays building
- Participation in our Health Improvement Organization aimed at conducting a community health assessment and developing a community action plan to improve overall health of our community.
- Providing Wellness Wednesday, Learning about Healthy Living – Tobacco and You, Nutrition Exercise Wellness and Recovery (NEW-R) classes, InShape, additional opportunities for exercise, and Stress less events aimed at improving overall health of our consumers.

Montcalm Care Network

- Opened Wellness Works in partnership with Dartmouth University, a combination community fitness facility, program location for In-SHAPE and transitional employment work site; Dartmouth is reporting and benchmarking outcomes; MSU Extension provides nutrition classes
- Operating an embedded primary care practice (Health360 Clinic) in partnership with the Mid Michigan Health Dept.; staffed by a physician's assistant; Utilizing a fully integrated EHR

- Stratifying health risk for all consumers. Assigning individuals with chronic health conditions to Care Pathways and measuring changes in health status.
- Providing comprehensive training to adult and children's case management staff in chronic health conditions.
- Provide comprehensive treatment with nursing and health mentors embedded on the care team.
- Establishment of projects to reduce high emergency room utilization in partnership with local hospitals.
- Protocols for the use of care management tools including VIPR, CC360 and ICDP for individual and population health management.
- Development of a Outcomes Dashboard for stakeholders to report on population health.

Newaygo CMH

- Co-locating clinicians into physical health settings
- Co-locating a clinician into an OBGYN clinic
- Participating in a Process Improvement Project to identify individuals who may need a diabetic screening and linking them back to their PCP.
- Collaborating with a local health care provider and non-profit organization to develop a care model to meet the needs of those with complex mental and/or physical health concerns who are seeking heat/energy assistance.
- Providing education on MATP to local health providers.
- Providing multidisciplinary team care as medically necessary to patients with high behavioral and physical health needs

Saginaw County CMH Authority

- Co-located primary health services; renovating building in fall of FY 2016 to offer pharmacy, lab and primary care; relocated psychiatry, nursing and enhanced health services a new Wellness Center to optimize provider networking
- In year 3 of the PBHCI grant, with implementation of tobacco cessation program Implemented a Children's Health Access Program (CHAP) through a grant from the Michigan Health Endowment Fund; provides community health workers in pediatric practices using the Pathways to Better Health model; when grant ended, brought the attributes into the Community Care HUB
- Awarded a SAMHSA expansion grant for behavioral health consultation in primary care
- Actively utilizing the MSHN Zenith Data Analytics program as well as CC360 to identify at risk groups as well as at risk individuals
- Added behavioral health services to CMU Medical School's Medical Services Family Practice Clinic
- All adults are screened at the front door for chronic health conditions
- Added a mental health consultant to a co-located primary care site
- EMR dashboard now also includes biometrics

  Selected as national site participant in the Cancer Control Community of Practice with National Council and National Behavioral Health Network for Tobacco Use Reduction

Shiawassee County CMH Authority

- Using Care Connect 360 data to demonstrate improvement in both outcome and process measures for one chronic disease identified as a HEDIS measure

- Continuing to work with the PIHP on the HSAG developed PIP r/t monitoring of A1C for individuals prescribed anti-psychotic medications
- Collaborating with local hospital and EMR vendor to support HL7 electronic transfer/upload capabilities for all laboratory and test results; functionality is currently in place with Quest Labs
- Nurse or Medical Assistant performs a brief assessment (including vitals) for all newly enrolled consumers and those coming in for medication reviews
- Nursing supervisor/medical staff provide "brown bag" trainings to case holders related to physical health and integration
- Strong partnership with Shiawassee Community Health Center (patient-centered medical home), who is co-located in the CMHSP, and provides primary care on site to just under one-hundred shared consumers
- Participating in workgroup through Great Start, which is looking at partnering with OB/GYNs and pediatricians to do maternal screening
- CMHSP Medical Director provides ongoing psychiatric consultation with Shiawassee Community Health Center (patient-centered medical home)
- Nursing staff is partnering with Drop-in Center staff and doing wellness classes
- Social worker co-located at Shiawassee Community Health Center, and becoming trained in smoking cessation and will ultimately offer groups at both the FQHC and CMHSP

Tuscola Behavioral Health System

- Integrated primary health clinic on-site through collaboration with local PCP office (TBHS Wellness Clinic)
- Integrated wellness and recovery principles into treatment planning and services
- Implementation of smoke and tobacco free environment for all TBHS direct owned locations with staff support and education provided
- Assessment of primary care needs upon intake and assistance with referral to TBHS Wellness Clinic or PCP of choice
- Completion of on-site combinatorial pharmacogenomic testing for psychotropic and non-psychotropic pharmacological agents
- Addressing dichotomy of primary health and mental health through educational webinars developed and offered to clinicians by nursing and behavioral healthcare consultant staff
- Awarded BCBSM grant funding for development of initiatives to address chronic disease management and medication adherence practices
- Development of Certified Peer Wellness Coach position with full integration into TBHS Wellness Clinic
- Peer Wellness Coach led health initiatives of Cooking Matters series in collaboration with MSU Extension office, community walking group in collaboration with the Caro Area District Library, and peer led smoking cessation series
- Participation in key health indicator measure through HEDIS and CVD screening for identified subset group of service recipients
- Collaboration with law enforcement, Tuscola Emergency Management, Probation, Courthouse staff, Child Advocacy Center and other human service and community organizations for presentation and distribution of Nacan kits
- Staff membership and active involvement in Tuscola County Drug Task Force collaborative
- In meetings and development of an integrated partnership with Caro Community Hospital for additional Wellness Clinic hours/days
- Availability of full, on-site laboratory services for service recipients two days/week

- Plan development of ED penetration rates per service recipient and sub groups with stratification of high utilizers based on LACE scores and recidivism rates through use of ICDP data
- Promoting use of MI skills to encourage positive, integrated healthcare outcomes
- Direct linkage and coordination of service recipient discharge needs with primary care providers through nursing staff as it relates to ongoing pharmacological management and continuity
- Tracking of baseline co-morbid conditions and changes through ongoing episodes of care and education through the Wellness Clinic

Summary & Recommendations

Develop workplan

Includes outcomes as identified in plan

Identify measurable objectives related to outcomes

Identify responsible committee and lead

Monitoring Workplan

Includes monitoring of progress with identified measures in this plan.

- Balanced Scorecard – Quarterly
- Performance Incentive Bonus & MDHHS report submission – Annually, & Quarterly
- Semi-Annual Reports on SUB VBP

Identify Barriers & Targeted Initiatives to Achieving Outcomes

Revise Workplan as Needed

Considerations for Future Development

Incorporation of MiHIN 27 core measures

Regional access to CC360 for all SUD Providers and CMHSP-contracted providers

Regional clinical protocols for addressing determinants of health

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Southwest Michigan Behavioral Health *Population Health & Integrated Care Tactical Plan,*
1 July 2016-31 December 2017

United States Census Bureau, 2016 Census Report

World Health Organization, Premature Death Among People with Severe Mental Disorders, retrieved from: http://www.who.int/mental_health/management/info_sheet.pdf

Appendix A: MSHN Population Data, Per County

County	2016 Population Census	Percent Persons in Poverty	County Health Ranking
Arenac	15,122	20.1	80
Bay	104,747	14.5	34
Huron	31,481	11.7	51
Tuscola	53,338	15.5	40
Saginaw	192,326	18.6	74
Gladwin	25,122	19.8	66
Midland	83,462	11.5	7
Clare	30,358	24.7	72
Isabella	71,282	26.1	50
Gratiot	41,202	16.5	38
Osceola	23,110	18.7	35
Mecosta	43,221	21.3	57
Montcalm	62,974	17.9	32
Newaygo	47.938	16.3	47
Ionia	64,232	14.2	19
Clinton	77,888	10.0	2
Shiawassee	68,554	12.4	30
Eaton	109,160	10.9	16
Ingham	288,051	21.0	56
Jackson	158,460	16.2	55
Hillsdale	45,774	16.6	27
TOTAL	**1,637,802**	Compared to National Poverty Level of 12.7%	N/A

US Census Bureau Quick Facts, www.census.gov/quickfacts

County Health Rankings: http://www.countyhealthrankings.org/app/michigan/2017/overview

Appendix B: MSHN Dual-Service Population Data Report FY17

Introduction

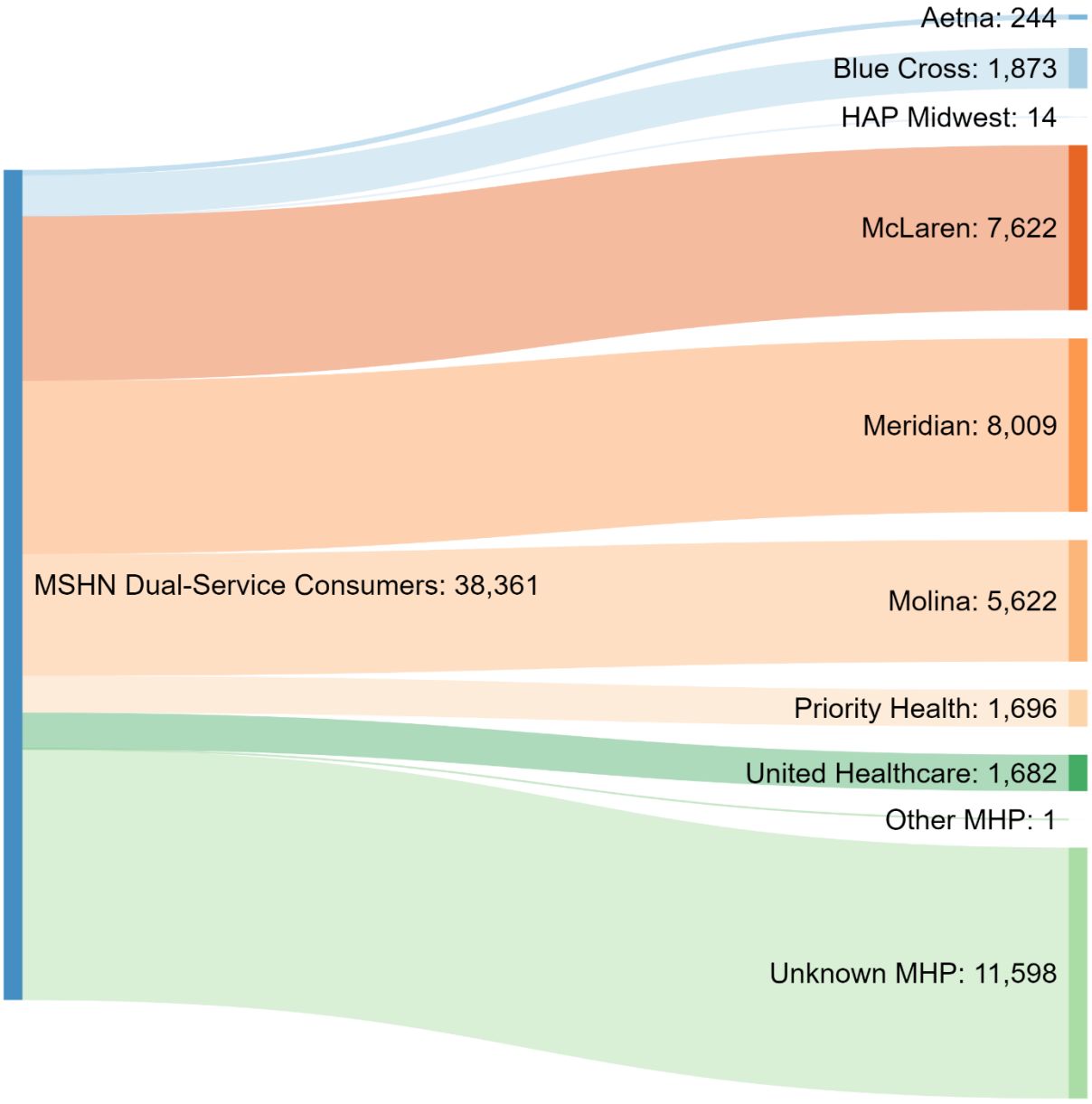
Mid-State Health Network (MSHN) is a Medicaid Managed Care Organization responsible for a portion of Michigan's behavioral health services. Given the prevalence of behavioral health issues in the Medicaid population, it is important for MSHN to examine opportunities to improve coordination with the Medicaid Health Plans (MHP). This will ultimately decrease inappropriate and disjointed care that results from the current fragmented healthcare delivery system.

Dual-Service Medicaid Enrollees

The need for care management is underlined by the large number of dual-service, behavioral and physical, Medicaid enrollees that MSHN serves in Prosperity Regions Four, Five, Six, Seven, and Nine; 38,361 (9.7%) enrollees of the 393,460 served by the MHPs in the MSHN Region.

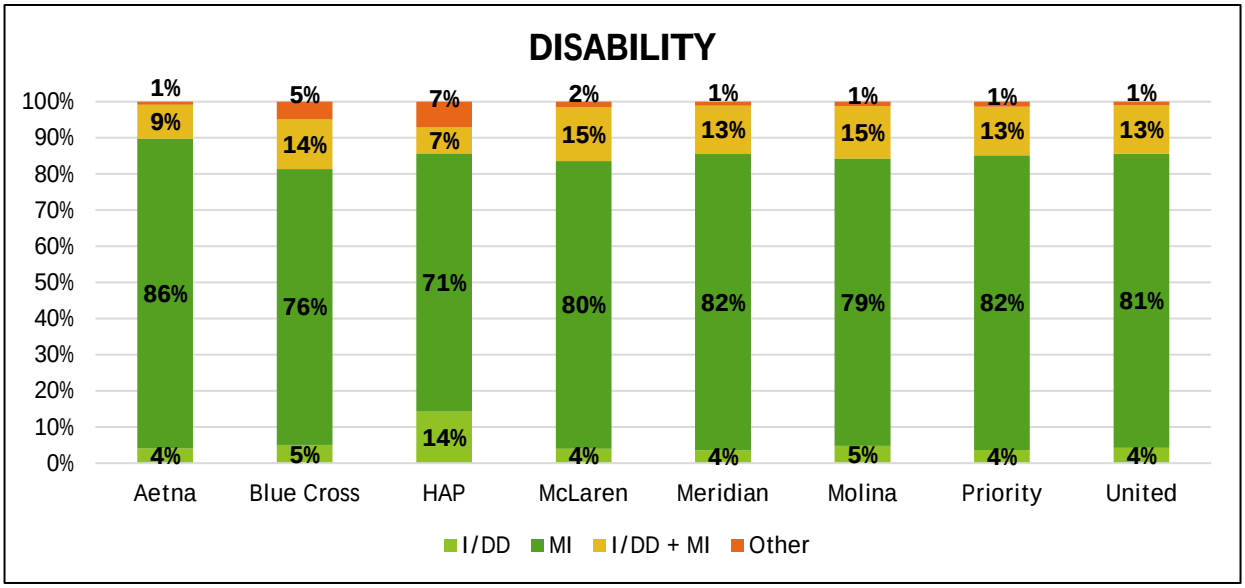
MHP	MSHN MHP Totals	Prosperity Regions				
		Region Four	Region Five	Region Six	Region Seven	Region Nine
Aetna Better Health of Michigan	244	-	2	-	-	242
Blue Cross Complete of Michigan	1873	147	6	181	1267	272
HAP Midwest Health Plan	14	-	-	14	-	-
McLaren Health Plan	7622	503	3863	761	2406	89
Meridian Health Plan of Michigan	8009	1211	2511	722	754	2811
Molina Healthcare of Michigan	5622	888	4143	330	164	97
Priority Health Choice	1696	1688	4	-	4	-
United Healthcare Community Plan	1682	55	829	388	2	408
Other MHP	1	1	-	-	-	-
Unknown MHP	11598	1592	4883	1112	2346	1665
MSHN Prosperity Region Totals	**38361**	**6085**	**16241**	**3508**	**6943**	**5548**

This Diagram displays the 38,361 Dual-Service Medicaid enrollees from Fiscal Year (FY) 2017, and their distribution among the Medicaid Health Plans.

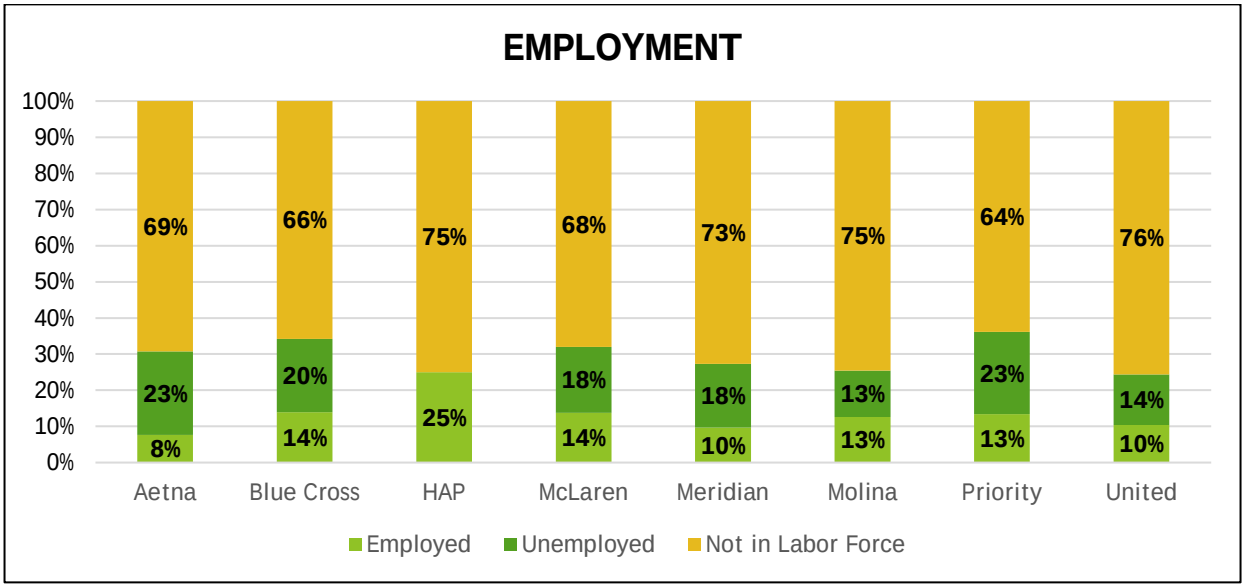


Population Profile:

The social determinants of health, morbidity of chronic health conditions, and rates of service utilization for the dual-service Medicaid enrollees demonstrate the need to deliberately organize patient care activities, and share information to achieve safer and more effective care.



Over 90% of the dual-service Medicaid enrollees have a development disability (DD) and/or mental illness (MI) for all 8 MHPs.



Employment rates for dual-service Medicaid enrollees with all 8 MHPs range from 8% to 25% for consumers with a known employment status; 13% to 23% are unemployed, seeking work; and 64% to 76% are not in the labor force.

The top ten chronic conditions for Dual-Service Medicaid enrollees are the following:[13]

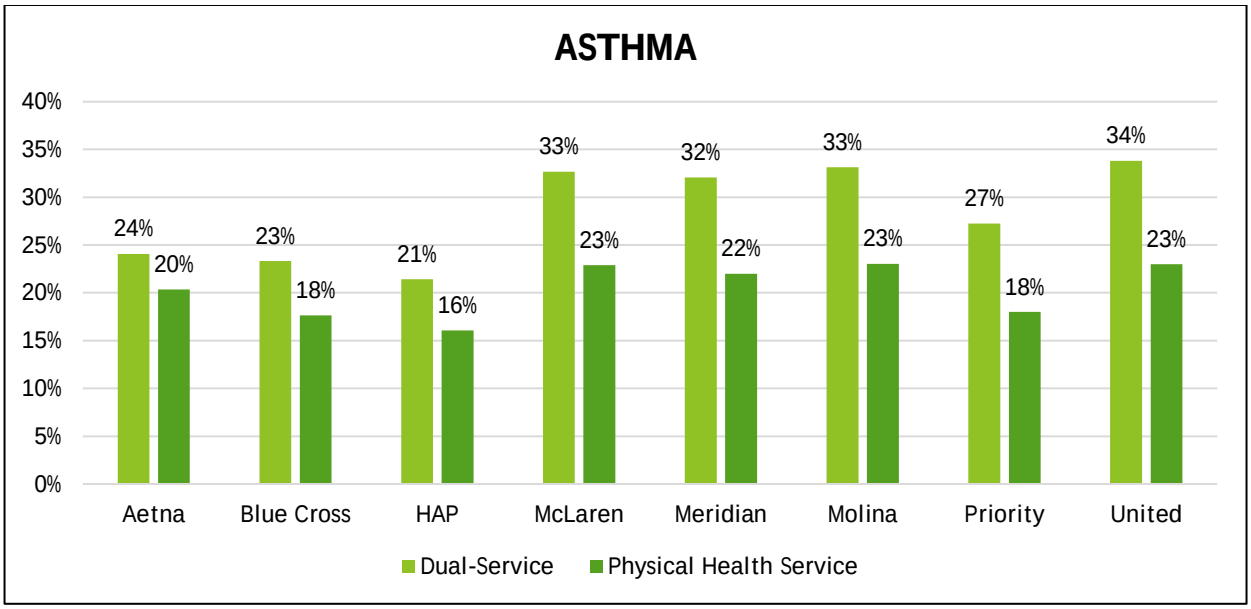
Chronic Condition	Enrollees	Percentage
MOOD DISORDERS	24,692	64%
EYE DISORDERS	19,395	51%
RESPIRATORY INFECTIONS	18,960	49%
ANXIETY DISORDERS	15,496	40%
CONNECTIVE TISSUE DISEASES	13,110	34%
DISEASES OF THE HEART	12,782	33%
NON-TRAUMATIC JOINT DISORDERS	12,493	33%
DISEASES OF THE URINARY SYSTEM	12,558	33%
EAR CONDITIONS	11,506	30%
NERVOUS SYSTEM DISORDERS	10,596	28%

Preventable Morbidity

The high mortality rate among people with behavioral health problems is largely explained by the high prevalence of preventable illnesses.[14] By addressing behavioral and physical conditions, behavioral health symptoms associated with impaired compliance or self-care may be better addressed. This may lead to improved management or treatment of the preventable conditions.

The morbidity rate for the eight health plans physical-health service Medicaid enrollees (n = 38,361) and dual-service Medicaid enrollees (n = 355,099) are the following:[15]

[13] Table displays duplicated count of patients with given diagnoses, using CC2 Level 2 diagnostic grouping.
[14] Parks, J., et al., (2006) Morbidity and Mortality in People with Serious Mental Illness. Retrieved from: http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf
[15] Enrollees' conditions were based on diagnosis codes on any service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McLaren
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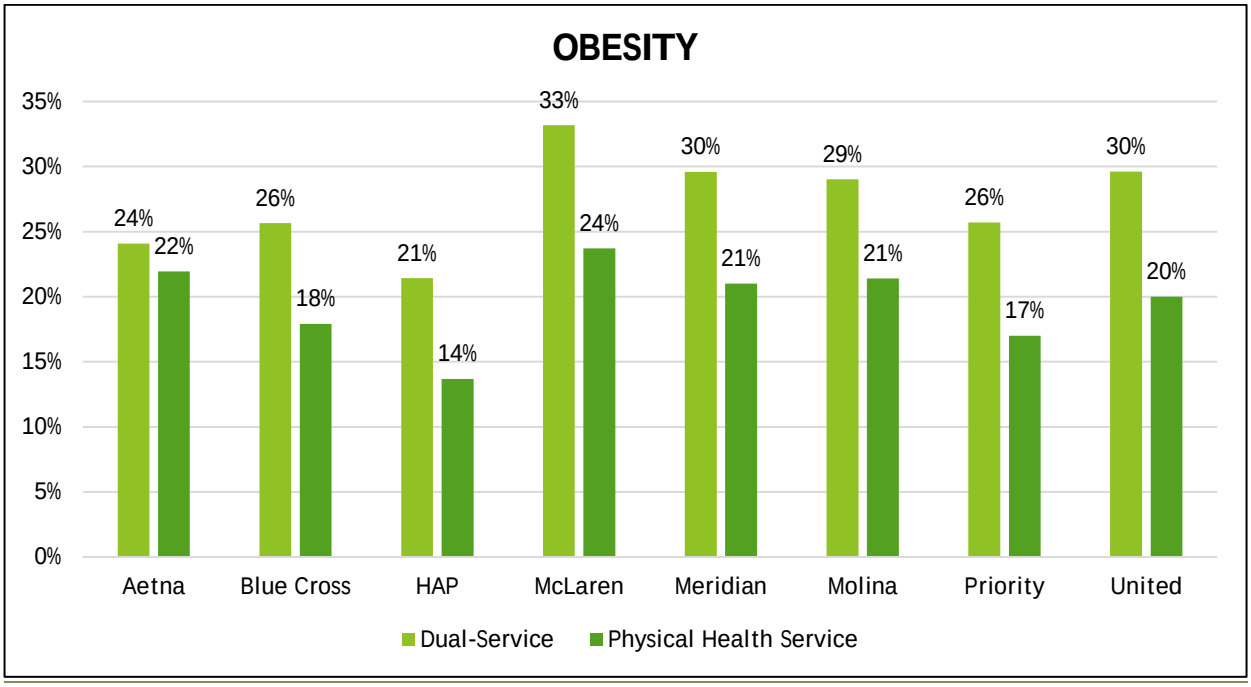
Dual-Service
Physical Health Service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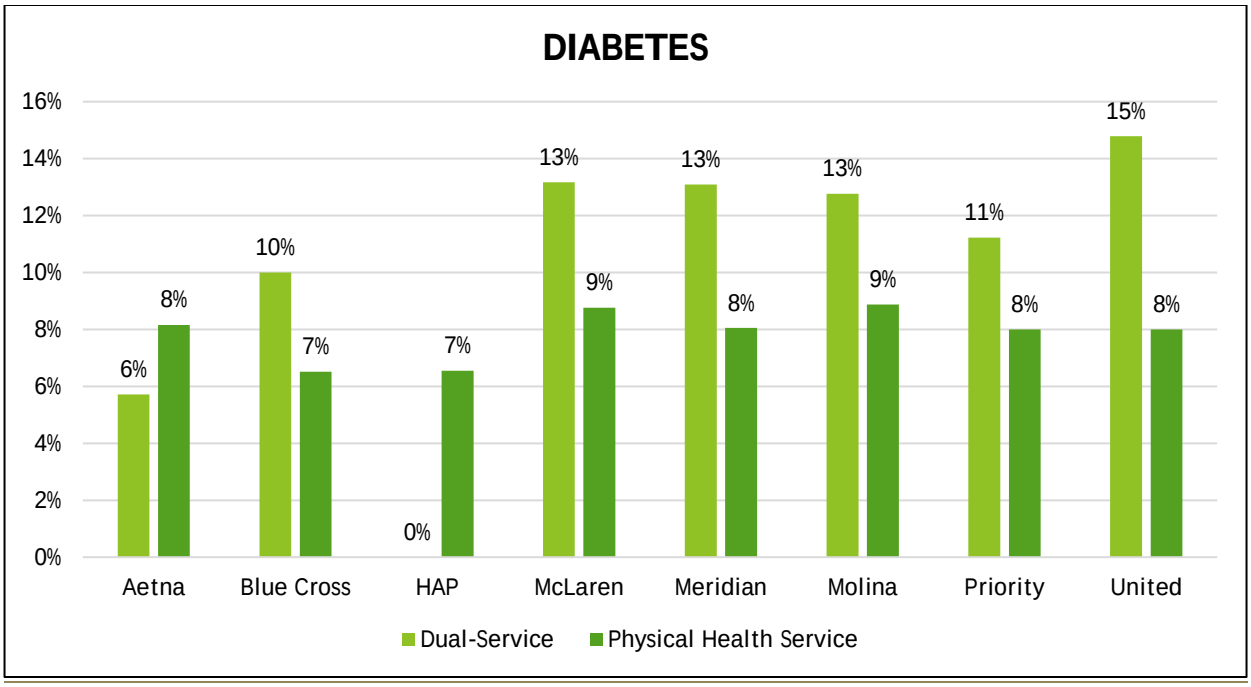
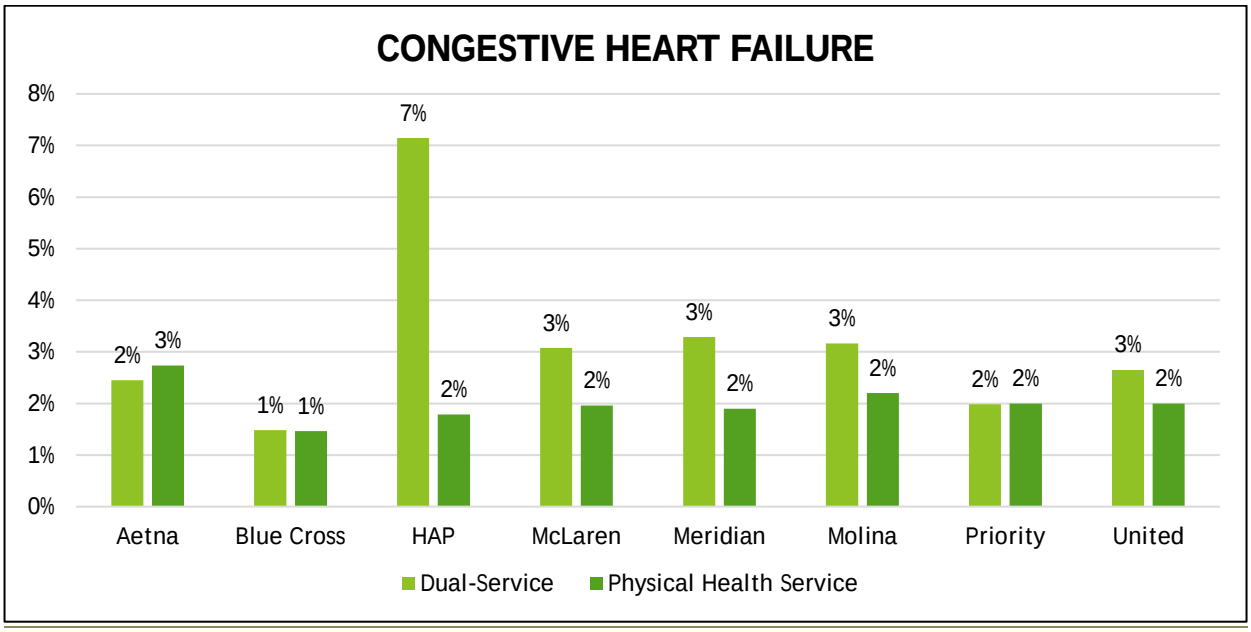
Dual-Service
Physical Health Service

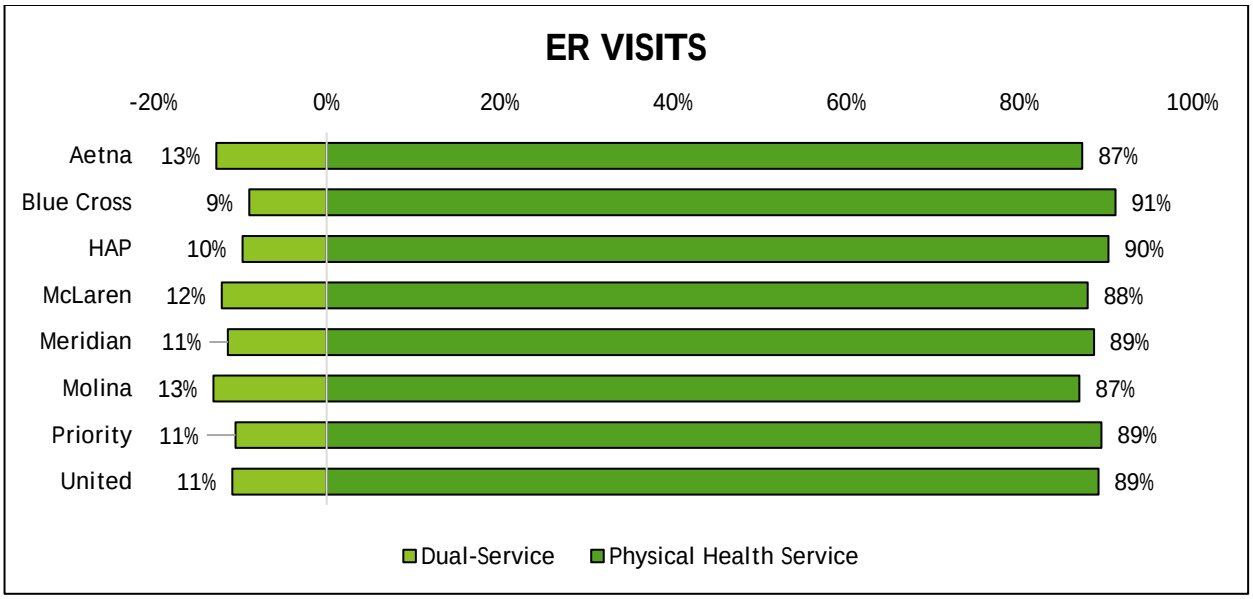




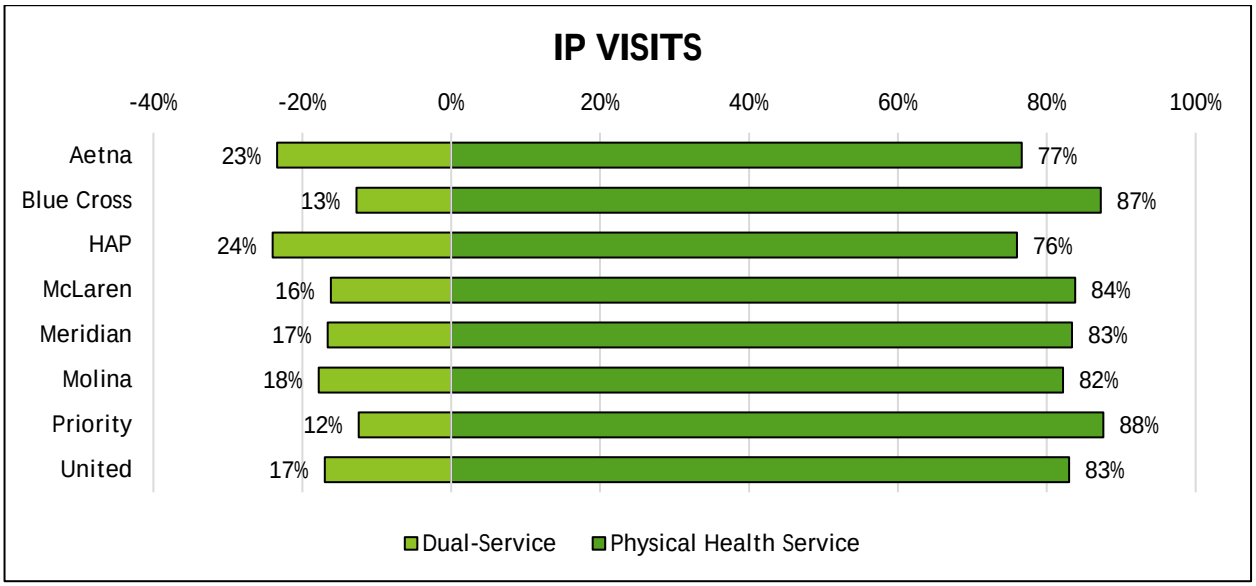
Service Utilization

Targeting high utilizers of emergency room and inpatient services represents an area of potential collaboration between MSHN and the MHPs. While the dual-service Medicaid enrollees make up about 10% of enrollees, they are disproportionately represented in the top 1% of inpatient visit utilizers and emergency room utilizers. [16]

[16] Based on the Medicaid claims from Fiscal Year 2017.



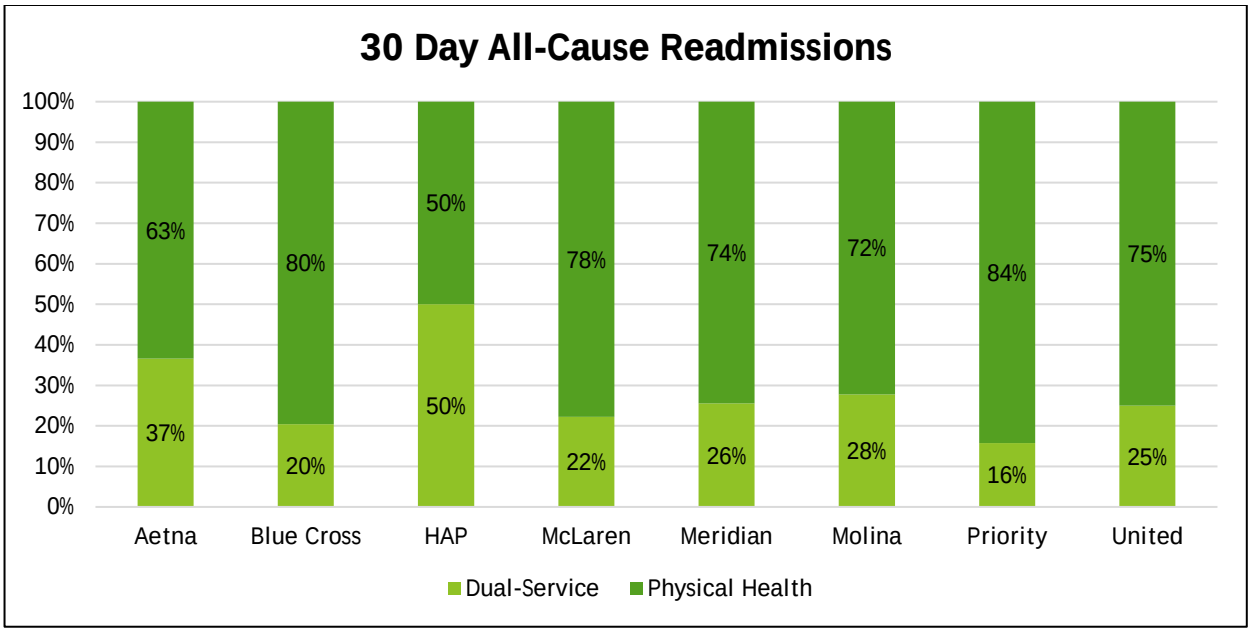
While Dual-Service Medicaid enrollees make up less than 10% of the population served by the MHPs, they account for 9 – 13% of all ER Visits.



While Dual-Service Medicaid enrollees make up less than 10% of the population served by the MHPs, they account for 12 – 24% of all Inpatient Admissions.

Readmissions: In order to reduce the frequent use of high cost services, readmissions should also be minimized by providing follow-up visits after discharge.[17]

[17] Readmissions calculation is based on the dual-service Medicaid enrollees' visits for both hospitalization for physical health needs and inpatient psychiatric hospitalizations in Fiscal Year 2017.

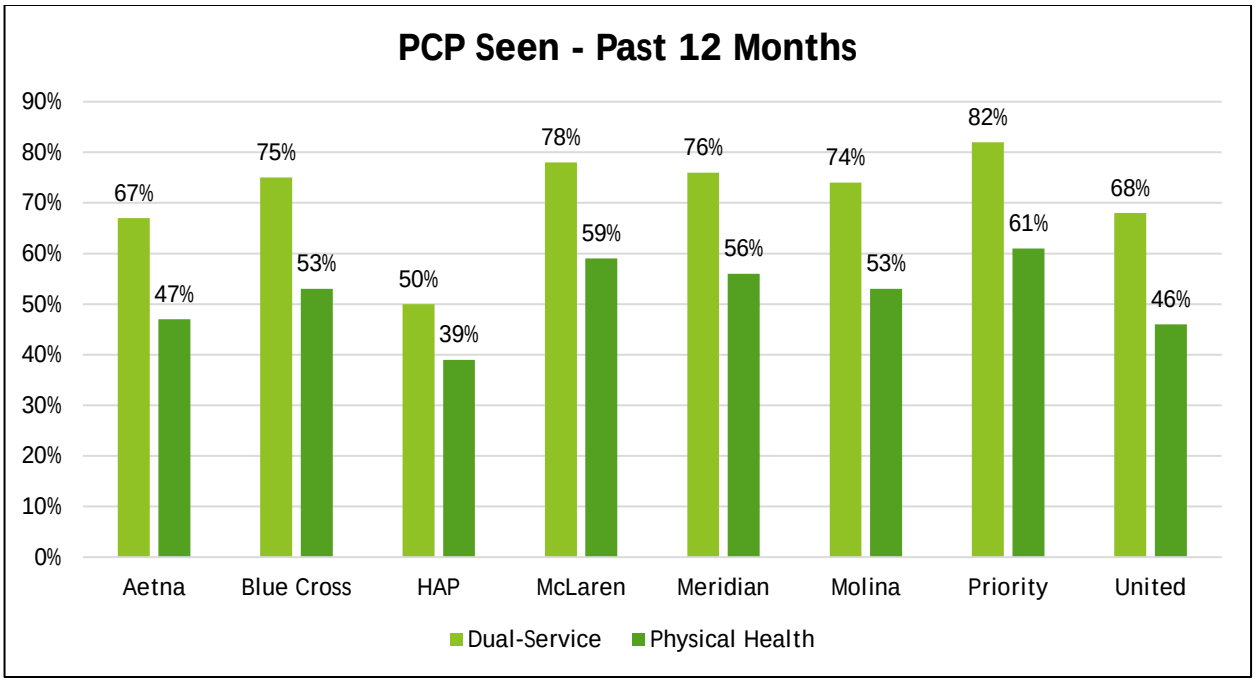


While Dual-Service Medicaid enrollees make up less than 10% of the population served by the MHPs, they account for 16 – 50% of all 30 Day Inpatient Readmissions throughout the MSHN Region.

Engagement in Primary Care

Addressing the needs of people with behavioral health issues requires integrating healthcare services, just as addressing the social determinants of health requires the coordination of behavioral and social services. Engagement with primary care providers (PCP) is crucial to managing chronic conditions and may address gaps in service. An increase in this metric may yield improved care coordination of physical and behavioral health services. [18]

[18] Primary care services are defined here as any Medicaid claim from a provider whose NPPES Provider ID contained one of the following classifications: Family Practice, Internal Medicine, or Pediatrics. We are currently conducting additional analysis to better understand the use of Physicians' Assistants, Nurse Practitioners, and Clinical Nurse Specialists for primary care services among PIHP enrollees. For reference to code sets defining a restricted set of procedures for use with these provider classifications, see ACA Section 5501(a)(2)(A).



This figure demonstrates that Dual-Service Medicaid Enrollees are more likely to have seen a PCP in the past 12 months, than those with Physical Health services.

Appendix C: MSHN Performance Measure Portfolio

Measurement Portfolio: Executive Summary

Context

In order to support a comprehensive approach to performance measurement, Mid State Health Network (MSHN) is proposing a portfolio approach to ensure a well-balanced set of measurements aligned with the region's strategic aims. This summary identifies an initial set of measures for inclusion in this portfolio.

Criteria for Selection

The following criteria were used in selecting measures for use by MSHN. Measures were considered for inclusion if they were:

- Built with Existing Claims Data
- Nationally Standardized Measures
- Aligned with the Triple Aim
- Used in Multiple National Initiatives
- Aligned with the MSHN Strategic Plan

Measures

The following table summarizes the nine measures initially selected for the portfolio. These include five measures that are currently available for reporting and four new additions. Currently available measures are *shown in italics*:

Category	Measure Title	NQF #	Description
Screening and Monitoring for Common Comorbid Health Conditions	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	*1932*	Percent of adults with schizophrenia or bipolar disorder, taking certain anti-psychotic medications, who received a diabetes screening to identify metabolic side effects.
	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	*1927*	Percent of adults with schizophrenia or bipolar disorder, taking certain anti-psychotic medications, who received a screening to identify potential side effects on the cardiovascular system.
	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	1934	Percent of adults with schizophrenia and diabetes who had both a cholesterol and diabetes test.

Engaging Primary Care	*Children and Adolescents Access to Primary Care Practitioners*	*N/A*	Percent of children who had a visit with a primary care practitioner (PCP).
	Adult Access to Primary Care	*N/A*	Percent of adults who had an ambulatory or preventive care visit.
Acute Care	*Follow Up After Hospitalization for Mental Illness*	*0576*	Percent of discharges from psychiatric hospitalizations with a timely follow-up outpatient visit to prevent readmission.
	Plan All-Cause Readmissions (PCR)	1768	Percent of acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days.
Alcohol Prevention & Intervention	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	0004	Percent of patients with new episode of alcohol or other drug (AOD) dependence receiving timely substance abuse services and continuing engagement during initial visits.
Management of ADHD	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	108	This measure reports the percentage of children newly prescribed ADHD medication who received at least three follow-up visits.

Next Steps

Having a well-balanced measurement portfolio and advanced analytic software is only the initial step toward improving care through data driven decisions. Individuals across the organization will need to refine their current work to effectively incorporate this data. This will require action by individuals at all levels of the system including care managers, clinical supervisors, directors, PIHP functional leads, and executives. MSHN is currently defining a clear plan of action that includes the following tasks:

- Communicate selection of measures to stakeholders
- Provide training on each measure to providers
- Develop Measures
  - Define changes needed within analytics platform to meet requirements for each measure
- Implement measures
  - Define details for reporting (format, availability, frequency, and audience)
  - Publish initial measurement output and validate
  - Define provider and PIHP roles in meeting measurement requirements
- Define benchmarks and accountability
- Define performance monitoring cycles and other continuous feedback mechanisms to track and improve performance
  - Consider eventual integration into contract requirements and eventual pay-for-performance initiatives

Appendix D: Nervous System Disorders Code Set

The following were the top 10 frequently occurring ICD-10 diagnostic codes classified as "Nervous System Disorders" as represented in the table on page 15 of this plan:

ICD Code	Name
G43909	MIGRAINE, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS MIGRAINOSUS
G40909	EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS
H2513	AGE-RELATED NUCLEAR CATARACT, BILATERAL
G894	CHRONIC PAIN SYNDROME
H903	SENSORINEURAL HEARING LOSS, BILATERAL
G43009	MIGRAINE WITHOUT AURA, NOT INTRACTABLE, WITHOUT STATUS MIGRAINOSUS
G5601	CARPAL TUNNEL SYNDROME, RIGHT UPPER LIMB
G35	MULTIPLE SCLEROSIS
G809	CEREBRAL PALSY, UNSPECIFIED
G629	POLYNEUROPATHY, UNSPECIFIED