MSHN
Mid-State Health Network

Performance Bonus Integration of Behavioral Health and Physical Health Services (PBIP)

PIHP – MDHHS Reporting Format - Contract Withholds: 8.4.2.1.2

Qualitative Narratives *(October 1, 2018 – September 30, 2019)*

Due to MDHHS by: 11/15/2019

Metric: Increased Participation in Patient-Centered Medical Homes (50%)

Ensuring member access and engagement to a primary care provider, increasing participation in patient-centered medical homes, and comprehensive and coordinated service delivery continued to be targeted priorities for MSHN during FY19. This narrative report will summarize the broad-level population health activities performed by the PIHP as well as the extensive integrated health efforts and achievements of MSHN's member Community Mental Health Service Provider (CMHSP) organizations during FY19.

- **Use of HEDIS Measures to Monitor Health Outcomes and Engage in Quality Improvement**
  Throughout FY19 MSHN continued to monitor and perform quality improvement activities for a portfolio of 10 HEDIS performance measurements related to access/availability of care, effectiveness of care, and chronic disease management. *MSHN regional performance through FY19 Q3 met or exceeded State and National benchmarks on 7 out of 10 measures (please see attachment of performance measures)*

- **Ongoing use of regional clinical protocols to increase member participation in primary care and patient-centered medical homes**
  All participating CMHSPs in Region 5 utilize regional clinical protocols for frontline staff to ensure that all individuals receiving services from the PIHP/CMHSP are consistently offered connections to a Primary Care Physician (PCP) or patient-centered medical home and that behavioral health and physical health services are person-centered and well-coordinated at the point of delivery to the individual. Clinical protocols include:
    - CMHSP care managers are consistently utilizing CC360 and/or other health information technology to identify care gaps for members on their caseload
    - CMHSP care managers are trained to support and assist members in accessing a primary care physician/patient-centered medical home
    - Local CMHSPs ensure that care managers are coordinating with primary care providers for members on their caseload
    - Persons served by the CMHSP are provided with education about the advantages of engaging in ongoing, preventative primary care
    - Persons served by the CMHSP are provided with support to maintain insurance coverage

- **Use of health information technology (HIT) to facilitate data sharing, monitor population health and facilitate coordination of care**

  Each of the 12 MSHN CMHSP organizations have access to and utilize CC360 as well as an integrated care delivery platform (ICDP) through Zenith Technology Solutions. ICDP users receive customized care alerts regarding their members including a primary care report which allows them to identify members who have not seen a PCP in the last 12 months. In addition, MSHN was able to partner with MDHHS to offer two SUD Providers access to CC360 during FY18 as part of a value-based purchasing pilot which has continued through FY19. The SUD Providers use CC360 to ensure coordination of care with the CMHSP and physical healthcare providers. MSHN also participates in MiHIN and VIPR health information exchanges to enhance care coordination for its members. During FY19 MSHN also began the process of incorporating ADT feeds into its electronic managed care system used by all MSHN-contracted SUD providers with the goal of increasing coordinated service delivery across SUD providers, behavioral health providers and physical health providers. The anticipated implementation for this will be during FY20.

- **Member CMHSP participation in patient-centered medical homes and other coordinated systems of care in their local communities**

  The CMHSP member organizations that comprise region 5 have each participated in extensive integrated health activities throughout FY19. Summarized below are activities of each CMHSP as related to patient-centered medical home participation, coordinated systems of care, increasing access to services, and health data sharing across multiple sectors:

  <u>Bay-Arenac Behavioral Health</u>

  - Pilot site for MDHHS, MiHIN and PCE for development of embedding of CC360 in EHR
  - Working with Zenith Technologies for potential embedding of the Integrated Health Care Platform in EHR, including risk analysis for poor health outcomes
  - Utilize 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
  - 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
  - Enhanced 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
  - Providing funding for the Community Health Assessment
  - Providing wellness classes run by nursing staff

- 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

Community Mental Health Association of Clinton, Eaton, Ingham (CMHA-CEI)

- CMHA-CEI has Behavioral Health Consultants (BHCs) placed in two MSU/Sparrow Family Medicine Residency Programs and one McLaren Family Medicine 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 services, including both brief intervention as well as ongoing treatment
- CMHA-CEI's Families Forward Program, in partnership with Michigan Child Collaborative Care (MC3) is offering pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. Currently, over 300 local providers have been enrolled into MC3.
- CMHA-CEI has partnered with the Ingham Community Health Centers to develop and implement a model of Primary Care Behavioral Health for its network of health centers. Currently integrated care is offered in all ICHC locations.
- CMHA-CEI has 6 Behavioral Health Consultants embedded in 6 Ingham County Federally Qualified Health Center (FQHC) locations and provides clinical supervision to 8 behavioral health staff employed by the FQHC.
- Ingham County Health Department (ICHD) and CMHA-CEI have established protocols for electronic exchange of Health Records for shared consumers.
- Additionally, during FY19 the partnership between Ingham County Health Department (ICHD) and CMHA-CEI has expanded and now includes SUD services as part of the integrated care behavioral health services available to meet patient needs.
- Ingham County Health Department (ICHD) operates the Birch Health Center (FQHC) located inside the CMHA-CEI Jolly Road building with both a CMHA-CEI Behavioral Health Consultant and CMHA-CEI Psychiatric Nurse Case Manager embedded in the clinic.
- In partnership with McLaren-Greater Lansing, CMHA-CEI has a Crisis Services Mental Health Therapist embedded in the McLaren-Greater Lansing Hospital Emergency Department on a daily basis from 2pm to 2am.
- CMHA-CEI's Wellness Counseling Center provides adult behavioral health services and is co-located in the Ingham County Health Department Forest Community Health Center.
- CMHA-CEI's Wellness Counseling Center provides adult behavioral health services within the Cristo Rey Community Center's Primary Care Clinic.
- All clinical programs within CMHA-CEI have developed integrated care pilots to further promote integrated care for consumers of CMHA-CEI.

Community Mental Health of Central Michigan (CMHCM)

- Co-located CMH staff in primary care clinic at Isabella Citizen's for Health (FQHC)
- Mid-Michigan Community Health Services operates a primary care clinic on-site at CMHCM's Midland office
- Participating in the Michigan Health Improvement Alliance collaborating with other agencies to achieve a community of health excellence
- Collaborate with all hospitals in the area on several fronts including strategies to address overutilization of emergency services
- Full-time CMHCM staff located on site at the new Emergency Department that Mid-Michigan Health is building here in Mt. Pleasant
- Through the use of Adult Block Grant funding, incorporated an integrated health dashboard in the electronic medical record that shows outcomes and monitors health indicators over time for consumers
- Provided extensive training for our nurse care managers and case holders on integrated health practices, including case to care management
- Implemented team huddles and will be working toward caseload alignment within our teams for improved team-based care
- Use ADT data and track daily for follow-up
- Implemented healthy living opportunities in local clubhouses
- 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

- CMH Nurse Practitioner providing physical health care services to consumers and general public in St. Louis satellite office.
- Member of Live Well Gratiot, a county-wide health and wellness committee
- Host site for Medical Residents, Medical Interns, and Psychiatric Interns and RN students.
- Crisis Therapist is co-located in the ED of Mid-Michigan Medical Center –Gratiot.
- CMH Therapist located in St. Louis primary care clinic provides therapy to mild-to-moderate population
- Care Manager analyzing ICDP data, and networking with primary staff on care alerts.
- Electronic Medical Record designed to add health and wellness reports
- Peer led smoking cessation classes
- Participating in performance improvement projects involving diabetes and cardiovascular screening.
- Nurses attend medical appointments with consumers who struggle with knowledge of their medical condition and/or understanding of the course of treatment

- Increased integrated SUD services to include Medically Assisted Treatment (MAT)

Huron Behavioral Health (HBH)

- Co-located FQHC provider at the CMH site
- CMH staff work in the emergency department of local hospitals for Emergency Services provision
- HBH is currently negotiating integration with McLaren Thumb Region (MTR) to expand telepsychiatry services in the ER. MTR has newly implemented 24/7 telepsychiatry in the emergency department and they are willing to allow HBH consumers to utilize this service. It is expected that this may assist in diverting psychiatric inpatient placements, as real-time medication adjustments can be made when consumers present to the ER in psychiatric distress
- During FY 2019, HBH hosted two vaccination clinics in partnership with the Huron County Health Department, offering Hepatitis A, Measles, Tetanus, and other vaccinations to consumers and the general public. All interested parties were offered an opportunity to use their insurance to cover the cost; however, if an individual did not have insurance or if they had a co-pay, the health department utilized grant funding to offer the vaccination free of charge.
- Participating in a performance improvement projects involving diabetes and cardiovascular screening
- Nursing staff in conjunction with clinical staff provide health & wellness classes for consumers focusing on healthy lifestyle changes
- Hosting students working on their advanced nursing degrees (pursuing nurse practitioner certification)
- Implemented a tobacco-free campus (all locations) and provide Tobacco Education/Support
- Assisting consumers who do not have a primary care provider by connecting them to either the co-located FQHC clinic or a private primary care provider of their choice
- Medical Director provides consultation to community primary care physicians as requested
- HBH's Intensive Crisis Stabilization Service has been fully operationalized, beginning January 2019, and allows for additional hospital diversion efforts by providing crisis de-escalation in the home, community, and local schools.
- ADT notifications are responded to by primary clinical staff within at least one business day. HBH policy requires that the primary clinician attempt to make contact with the consumer directly after an ADT notification has been received to review health needs and to coordinate care, as needed

Lifeways CMH

- Center for Family Health (FQHC) operates a primary care clinic on-site at the Lifeways building and Lifeways staff are co-located at other Center for Family Health clinic locations
- Provide Care Management services to consumers enrolled in Primary Behavioral Health Care Integration (PBHCI) SAMHSA Grant, coordinating care with primary care physicians and specialists
- Participate in local Health Improvement Organization aimed at conducting a community health assessment and developing a community action plan to improve overall health of the community.
- During FY19 implemented clinical processes to use care alerts and respond accordingly (emergency room and hospital admission alerts, etc)
- Implemented a Continuity of Care Documentation (CCD) exchange between Lifeways EMR and Henry Ford Health Systems in order to enhance coordinated service delivery with local physical healthcare providers.
- Added a full-time wellness coach that does classes, creates wellness plans, etc.
- Collaborated with MSU to conduct education courses on diabetes, etc.
- Full time RN care manager and full time MA care coordinator work with individuals with complex needs to coordinate care across providers
- Lifeways behavioral health clinician is embedded at Hillsdale Hospital for consultation for non-emergency behavioral health issues.
- Each person presenting to Lifeways Access center is triaged by a Medical Assistant who finds out if the person has a primary care doctor and if not links them. The MA collects basic vital signs for all individuals as well as facilitates screenings such as PHQ9, etc.

Montcalm Care Network

- Fully integrated primary health clinic located on-site in the Montcalm Care Network CMH building
- Continued to operate 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; Michigan State University Extension provides nutrition classes.
- Added a Pediatric Nurse and Children's Case Manager to increase integrated healthcare for children.
- Trained Children's staff in health and wellness protocols; targeting obesity and reducing emergency room overuse.
- Co-sponsoring health prevention classes at the Wellness Center with community hospital partners (United Lifestyles) on topics such as Diabetes Education.
- Offering consultation and training to mid-level practitioners on psychiatric conditions and prescribing to increase the Primary Care Community's comfort level in treating persons with mild/moderate mental health conditions; sponsoring education on prescription drug abuse.

- Implemented a Health Stratification system and Care Pathways for persons with chronic health conditions to identify at risk individuals and target strategies to increase self-management.
- Producing a health outcome dashboard for stake holders to track population health impact.

Newaygo CMH

- Co-located CMH clinicians into primary care settings as well as an OBGYN clinic
- Ongoing negotiations during FY19 with Spectrum Health to expand the number of CMH clinicians embedded at additional Spectrum Health primary care locations
- Providing education on Medication Assisted Treatment Practices to local healthcare providers.
- NCMH has also implemented a Quadrant IV model of care specific to Adult Team Services. This service involves a team approach in which consumers having intensive mental health, behavioral health, substance abuse needs and/or medical needs are referred to this team of staff for intervention. This team working with referred consumers consists of a case manager, a nurse and a master's level therapist. This team works in close partnership with consumers and other medical providers involved in treatment to provide coordinated, non-duplicative care for the consumer as well as make referrals and/or advocate that referrals are made to community health related resources. This also includes health information exchange between all involved providers to ensure that consumers get the indicated care they need, when and where they want it.
- Utilize health care alerts generated by ICDP related to diabetes screening and diabetes monitoring for high-risk individuals.
- Utilize health care alerts to identify individuals who have not seen a primary care provider (PCP). Identified individuals are encouraged/assisted to schedule appointment with their chosen PCP or offered referrals when they do not have an identified PCP
- NCMH provides health education to all consumers about the importance of primary and preventive care; NCMH supports individuals in addressing identified barriers to accessing primary care such as assisting with resources and transportation
- Incorporated ADT feeds into electronic medical record and trained clinicians around timely follow-up with persons served. Clinicians are trained to identify and address patterns of high emergency room utilization by providing education and encouraging preventive physical health services

Saginaw County CMH Authority (SCCMHA)

- Ongoing co-location with Great Lakes Bay Health Centers (GLBHC) within the SCCMHA Health Home and psychiatric clinic. Over 500 SCCHMA adults currently identify the GLBHC provider(s) as their primary care physician and receive physical health care services within the Health Home. Laboratory draw services, dietician and pharmacy are available to consumers in one convenient location.

- Great Lakes Health Centers provides routine access to their Dental Bus. SCCMHA adult consumers can schedule an appointment to receive an oral screening and preventive exam. The GLBHC Dental Bus travels to SCCMHA and parks adjacent to SCCMHA's Health Home for easy access.
- SCCMHA is participating in a 5-year expansion grant as a sub recipient to MDHHS's SAMHSA grant award, "Promoting the Integration of Primary and Behavioral Health Care (PIPBHC)". The target groups are adults with SMI and children with SED. Our participation will serve as an opportunity to expand the base of experience SCCMHA acquired working in the PBHCI (Primary and Behavioral Health Care Integration) SAMHSA 4-year grant. SCCMHA and Great Lakes Bay Health Centers are identified as partners in this project and are focusing on improving the coordination of care. Working with Great Lakes Bay Health Connect, MiHIN and PCE, development of technological solutions is underway to advance the accessibility of health data to inform day to day clinical decision making.
- SCCMHA, as part of its PIPBHC project, has developed and is piloting a value-based payment model to support the transformation of nursing services within the SCCMHA provider network. This model emphasizes the use of physical health screening and supports the delivery of care coordination efforts that are intended to improve the overall health of SCCMHA consumers.
- SCCMHA has been invited to join a value-based learning community, hosted by CMHAM and will submit the pilot project that is being implemented as part of our PIPBHC grant as our project for learning.
- SCCMHA continues to refine the use of physical health encounter data within ZENITH/ICDP along with its EHR data to create daily clinic documents that identify consumers who may be overdue for an A1c lab test, recently admitted to the ED or needing follow-up with their primary care provider.
- SCCMHA is participating with Michigan Public Health Institute in a local project that promotes a cross sectional development of solutions to support women with Opioid Use Disorder (OUD) who give birth to infants with Neonatal Abstinence Syndrome (NAS). The workgroup consists of members of the Great Start Collaborative, DHHS, local substance use providers and women with lived experience. A Safe Plan of Care has been drafted for pre-pregnancy planning to improve birth outcomes and support healthy families.
- SCCMHA is serving as the fiduciary for the Region 5 Perinatal Collaborative. The Michigan Health Information Alliance (MiHIA), is working as the project director for the region. The Region 5 Collaborative has successfully implemented SCRIPTS training in several counties to reduce or mitigate smoking, which is a known contributor to low birth weight and miscarriage. The Collaborative is focusing on expanding SCRIPTS to additional counties, addressing implicit bias and promoting Centering Pregnancy and Centering Parenting with health system and medical health providers within Region 5.
- Increased number of TF-CBT trained staff in our network.
- Received grant to sustain Mental Health First Aid/Youth Mental Health First Aid Training.

Shiawassee Health and Wellness

- 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
- 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 at the CMH building 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
- SHW Medical Director provides ongoing psychiatric consultation with Great Lakes Bay Health Center (patient-centered medical home)
- Nursing staff is partnering with Drop-in Center staff and doing wellness classes
- Social worker becoming trained in smoking cessation and will ultimately offer groups at both the FQHC and CMHSP
- Nurse or Medical Assistant performs a brief assessment (including vitals) for all newly enrolled consumers and those coming in for medication reviews

The Right Door for Hope, Recovery, and Wellness

- Strategically providing "physician outreach" whereby the CMH 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 educational 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 to coordinate care.
- Publishing a quarterly newsletter on best practices and coordination of care for primary care providers.
- 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.
- One-time psychiatric consults by our providers at the request of the primary care provider.
- 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.

- Consumers seen by the Medication Services team have their BMI, waist circumference, AIMS testing, and lab orders completed.
- 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.
- Integrated Health Block Grant funded for 2 years, will be funded 2 additional years to provide education, referrals, healthy food pantry.

Tuscola Behavioral Health Services (TBHS)

- Integrated primary health and behavioral care clinic on site
- Sponsored wellness initiatives for service recipients aimed at improving overall health via grant funding
- Full Primary Care Provider service integration with McLaren Caro Regional Hospital for PCP service delivery one day/week.
- Integration of Peer Wellness Coach into Wellness Clinic.
- Awarded Blue Cross Blue Shield of Advancing Medication Adherence grant.
- Development and implementation of strategies specifically relating to medication/prescription synchronization and discharge reconciliation.
- Development and implementation of point of care testing as it relates to chronic disease management.
- Development and implementation of strategies to increase medication literacy.
- Utilization of technology as it relates to point of administration compliance for medication adherence.
- Multiple community presentations and community trainings for Narcan distribution and administration (e.g. Law Enforcement, Health Department, School Districts).
- Review of CC360/Zenith physical healthcare claims data and strategizing utilization of data.
- Development and implementation of medication literacy tool and stratified interventions.
- Collaboration with Michigan State University Extension for Healthy Cooking and Dining with Diabetes classes.
- Review and dissemination of ADT feed into electronic health record daily.
- Assessment of primary care physician engagement and need on consumer intake. Immediate referral to on-site TBHS Wellness Clinic, if indicated.
- Partner in Rural Communities Response Program planning grant.
- Ongoing tobacco/smoke free environment for all campus and owned/operated residential sites.
- Coordination of care through ongoing collaboration with primary care physicians as it relates to lab value outcomes and co-morbid panel interventions

Metric: Identification of Enrollees Who May be Eligible for Services Through the Veteran's Administration (50%)

- **MSHN's Veteran Navigator (VN) and Outreach to Veterans and to Provider Networks**
  MSHN has had a VN since October of 2016. MSHN's current Veteran Navigator has been within the Region 5 PIHP since May 2018 and is an experienced Masters-level trainer and a United States Army Veteran.

  Based on the MDHHS Veteran Strategic Plan the following five goals action steps were distilled in an Action Plan to maintain forward progress of Veteran and Military Family outreach efforts within the PIHP region.

  1. Increased awareness of and access to publicly funded behavioral health care service providers in the local community.
  2. Increased communication, collaboration and coordination of services between the publicly funded behavioral health care system, VA services, and Veteran support services in the region.
  3. Reduction of stigma for Veterans and Military family members who feel stigma in seeking behavioral health services and stigma that can be reinforced within the public behavioral system.
  4. Reduction in the number of suicide within the Veteran and military family community.
  5. Veterans and Military families will identify feeling better equipped to function effectively within their community and social environments. Satisfaction will be based on services and the effectiveness of the system.

  MSHN developed a promotional brochure to disseminate information about the Veteran Navigator position and to provide contact information for providers and individual veterans. This brochure is used by CMHSPs and SUD providers when referring veterans to the MSHN VN. The brochure also contains information about the 21-county network and the Veteran Crisis Line. This brochure is available to CMHSPs and MSHN's SUD provider network for distribution to consumers and their local communities. The promotional brochure can also be found on MSHN's website here.

  The MSHN VN also developed a Veteran Resource Guide that is available on MSHN's website to assist CMHSPs and SUD Providers when answering common questions/concerns for Veterans, Service Members, and Military families.

  The MSHN VN has worked with five Veteran Treatment Courts within Region 5 (Eaton, Ingham, Ionia, Jackson, and Saginaw Counties) and with the Department of Veterans Affairs Justice Outreach (VJO) Specialists to provide support and ensure resources are available to Veterans and Service Members in the legal system. The VN has attended treatment court team meetings and provides input when reviewing individual veteran compliance and participation in mental health and SUD treatment. The VN also integrated with the five Veterans Coalition Action Teams (VCATs) to coordinate services in the region for Veterans and Military Families and has worked extensively with Michigan Veterans Affairs Agency (MVAA) to coordinate care, support and services within the region.

  The VN has attended several meetings with MDHHS's Director of Faith Based Initiatives in an effort to work with community faith leaders who wish to support Veterans, Service Members, and Military Families within their congregation/parish. This initiative equips faith leaders to directly contact

MSHN's VN when they identify individuals in need of Behavioral Health and Substance Use Disorder services, peer support, or other veteran related issues.

- **Military Competency Trainings for MSHN's Provider Network**
  MSHN developed a one-hour Military Cultural Competency Training for network providers that was adopted by BHDDA to be used by all VNs throughout the State. Military culture can be a barrier to seeking help for Behavioral Health and Substance Use Disorder treatment; a trained network of providers can reduce these barriers and improve access for Veterans, Service Members, and Military Families. The availability of this training was promoted through SUD Quarterly Provider meetings and local CMHSP training coordinators. This training has been delivered at 3 different locations in the 21-county region and resulted in 94 individuals completing the training.

  In September, the VN coordinated the development of a one-day training, *Opioid and Substance Use Disorders in the Military/Veteran Population,* with PsychArmor Institute. This training will be delivered in FY20 to network providers at three separate locations to make them accessible to all 21 counties in MSHN's provider network. This training is targeted toward those who work in SUD Treatment, Prevention, and Recovery; and will educate network providers on the unique diagnostic features, barriers, and challenges when working with Veterans and Military Families.

- **Outreach by VN to CMHSPs and SUD Providers**
  The availability of the VN as a resource to Veterans, Servicemembers, and Military Families is communicated through annual reviews for CMHSPs and SUD Providers within Region 5. The VN also attends several local prevention/suicide coalitions, maintains contact with access and training personnel at several CMSHPs/SUD providers, and acts as the liaison when providers have questions or concerns about availability of services through the VA or PIHP networks.

  The VN has connected with several SUD Providers in the Region 5 network to identify Peer Recovery Coaches who are also veterans to explore the possibility of developing a veteran peer recovery network. In August, the VN identified a network provider who could pilot a veteran peer group, and a contract was developed to begin the delivery of services in FY 20. Outcomes from this pilot program will help to develop/guide future expansion of the veteran peer network.

- **Engagement by VN with VCATs**
  The MSHN VN developed relationships with Veteran Community Action Teams (VCATs) 4, 5, 6, 7 and 9 that serve veterans in MSHN's region. The VN has attended at least one quarterly meeting for each of the VCATs and discussed how the VN can assist Veterans and Military Families in the community. The VN is part of the leadership team for Region 7 and has presented at meetings focused on military culture and veteran employment, as well as, participating in events focused on quality of life for veterans.

- **Level of Involvement on TriCare Panel**

  MSHN VN has found few CMHSPs and SUD Providers that are willing to be paneled/credentialed with TRICARE though individual clinicians within organizations may be. The largest barriers for organizations in paneling/credentialing with TRICARE are *The Credentialing/Paneling Process is Very Difficult or Cumbersome* and *The Reimbursement Rates for TRICARE are too low*. Outreach to Humana Military by the VN has not identified a way to streamline the contracting process for network providers.

- **Population Health and Integrated Care efforts with local VA Hospitals and Clinics/CBOCs**

  The VN has established contacts within Ann Arbor, Battle Creek, and Saginaw Veterans Affairs Medical Centers in order to coordinate care for Veterans and Service Members in Region 5. Processes vary between the three VA Medical Centers, and the MSHN VN has established relationships within each of these systems to improve access to services for veterans through the VA or the PIHP. The VN attends meetings and speaks regularly with various members of the Department of Veterans Affairs to include community mental health coordinators, veteran justice outreach coordinators, HUDVASH/clinical therapists, suicide prevention specialists, and community care coordinators.

  MSHN VN has attended community coordination of care meetings in Ann Arbor, Battle Creek, Detroit, and Saginaw to improve processes and access for veterans in need of Behavioral Health and Substance Use Disorder services. MSHN VN has attended several Peer Support Groups and SUD Support Groups at the Lansing CBOC to promote awareness of the VN position and availability of Behavioral Health and Substance Use Disorder services in Region 5.

  MSHN's VN has explored opportunities to expand the number of SUD Providers that are willing to contract with the VA under the MISSION Act. The VN has attended meetings with the Director and Deputy Director of Battle Creek VA, as well as, several Town Hall meetings to identify a simplified contracting method for network providers.

- **Veteran Resource Guide**

  MSHN's VN has maintained a Veteran Resource database that serves as an internal source to meet the needs of Veterans, Service Members, and Military Families; this database is reviewed and updated annually. The intent of the database is to catalog and categorize BH/SUD, resources, and supports that are available at the community and regional levels. This will allow the VN to anticipate and meet the needs of Veterans and Military Families for any given situation within the region. The VN updates this database annually and has expanded this database to ensure that resources and supports are in place for Veterans, Service Members, and Military Families.

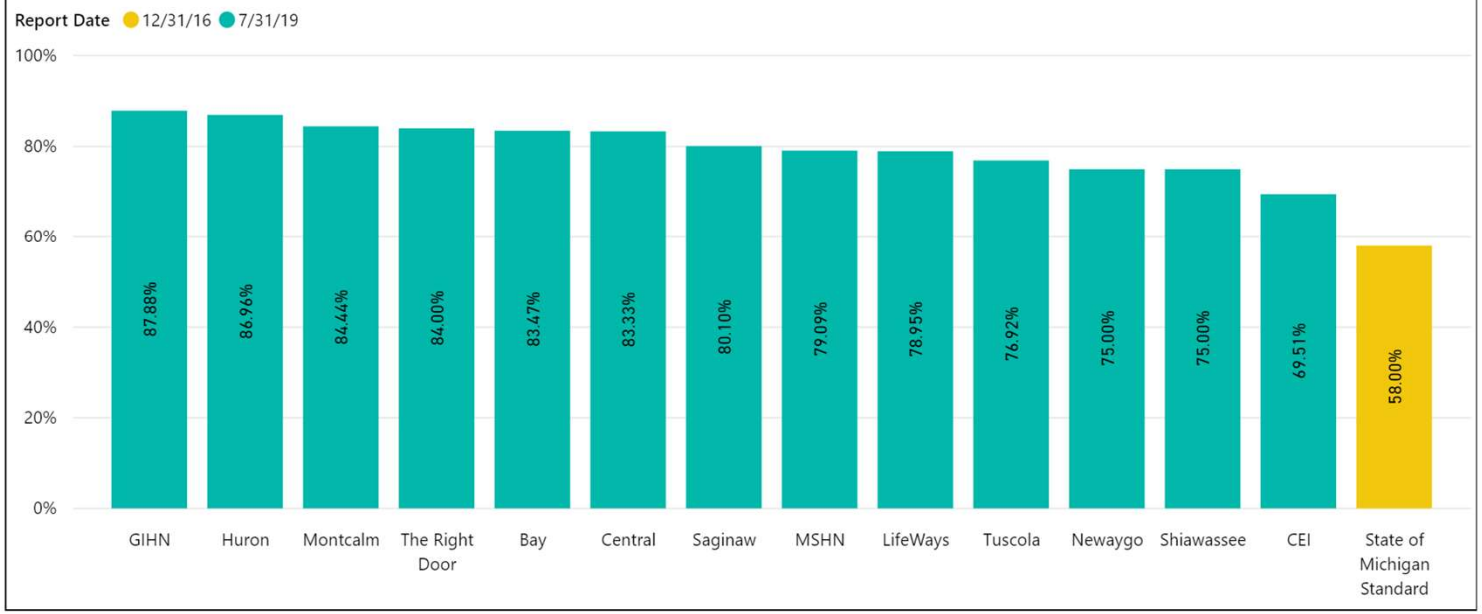
Microsoft | Power BI

MSHN Priority Measures

View in Power BI

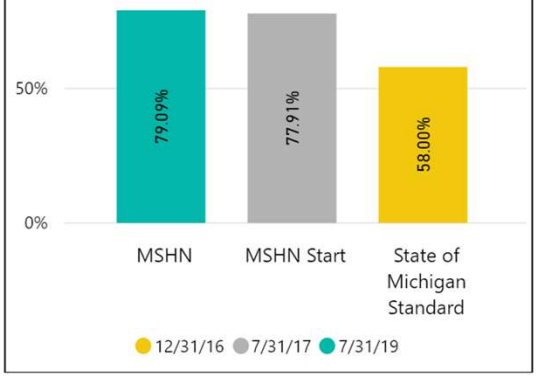
Last data refresh:
9/20/2019 12:39:27 PM Eastern Standard Time
Downloaded at:
9/20/2019 12:43:50 PM Eastern Standard Time

Follow-Up After Hospitalization Adult



Organization	Yes	No	Percentage
Bay	20	101	83.47%
CEI	50	114	69.51%
Central	17	85	83.33%
GIHN	4	29	87.88%
Huron	3	20	86.96%
LifeWays	44	165	78.95%
Montcalm	7	38	84.44%
MSHN	217	821	79.09%
Newaygo	4	12	75.00%
Saginaw	41	165	80.10%
Shiawassee	17	51	75.00%
State of Michigan Standard			58.00%
The Right Door	4	21	84.00%
Tuscola	6	20	76.92%

FUH Adult -Trend



Measure Description: The percentage of discharges for members with 21 years or 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 a mental health practitioner.

Rates Reported: The percentage of discharges for which the member received follow-up within 30 days of discharge.

Numerator Statement: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

Denominator Statement: Members with 21 years or 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 a mental health practitioner.

Exclusions: Exclusions Exclude discharges followed by readmission or direct transfer to a non acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Last updated: 9/20/2019
Steward: Quality Improvement Council
Update frequency: monthly extract of data from ICDP.
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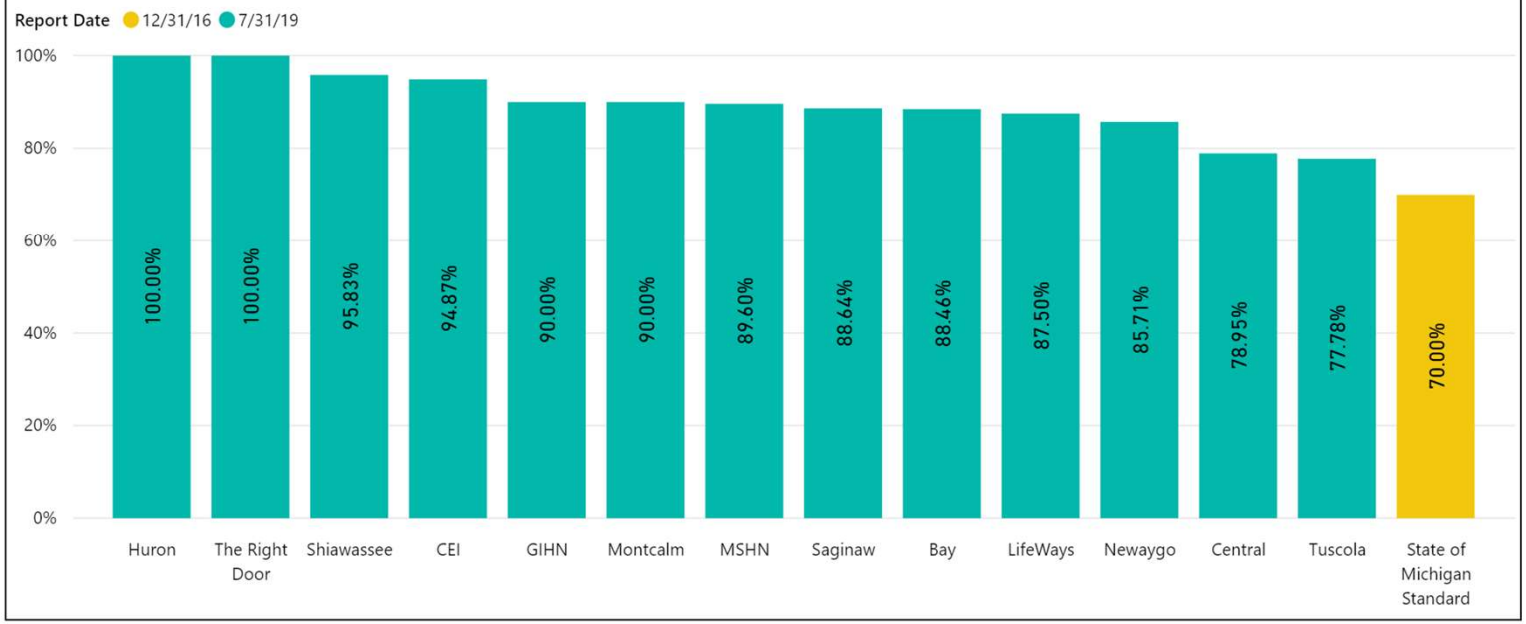
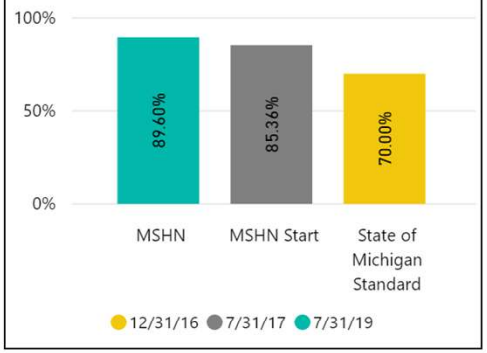
Follow-Up After Hospitalization Child



Organization	Yes	No	Percentage
Bay	3	23	88.46%
CEI	2	37	94.87%
Central	4	15	78.95%
GIHN	2	18	90.00%
Huron	0	7	100.00%
LifeWays	5	35	87.50%
Montcalm	1	9	90.00%
MSHN	26	224	89.60%
Newaygo	1	6	85.71%
Saginaw	5	39	88.64%
Shiawassee	1	23	95.83%
State of Michigan Standard			70.00%
The Right Door	0	5	100.00%
Tuscola	2	7	77.78%

FUH Child-Trend



Measure Description: The percentage of discharges for members with 6 years - 20 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 a mental health practitioner.

Rates Reported: The percentage of discharges for which the member received follow-up within 30 days of discharge.

Numerator Statement: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

Denominator Statement: Members with 6 years - 20 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 a mental health practitioner.

Exclusions: Exclusions Exclude discharges followed by readmission or direct transfer to a non acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

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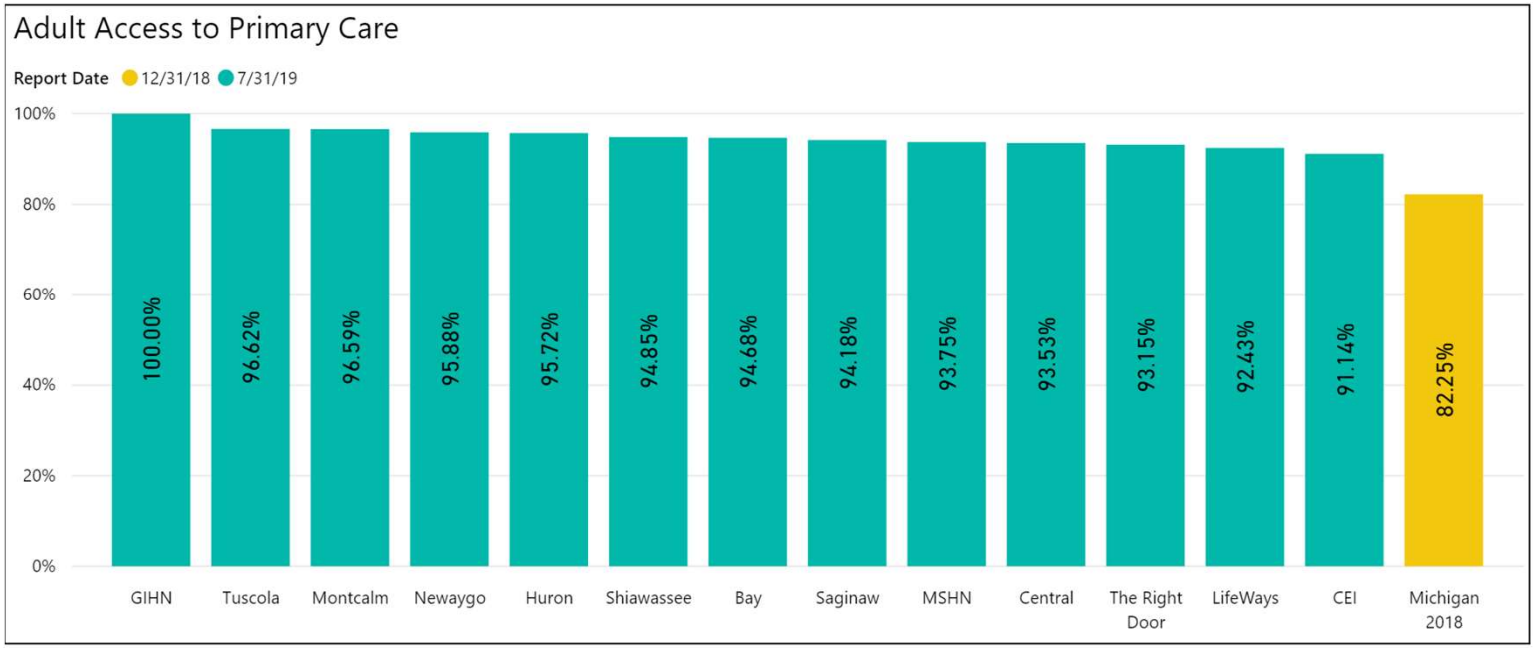
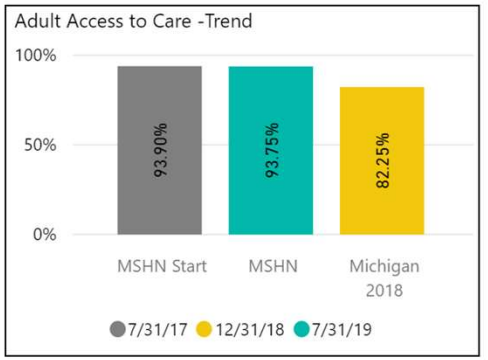
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions



Organization	Yes	No	Percentage
Bay	89	1583	94.68%
CEI	208	2140	91.14%
Central	171	2473	93.53%
GIHN	0	394	100.00%
Huron	17	380	95.72%
LifeWays	135	1649	92.43%
Michigan 2018			82.25%
Montcalm	13	368	96.59%
MSHN	832	12472	93.75%
Newaygo	16	372	95.88%
Saginaw	120	1941	94.18%
Shiawassee	25	460	94.85%
The Right Door	25	340	93.15%
Tuscola	13	372	96.62%



Measure Description: The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.a) Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.b) Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Numerator Statement: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.

Denominator Statement: Any consumer 20 years of age or older as of the end of the measurement year(e.g., December 31) who have at most one month gap in coverage during each year of continuous enrollment.

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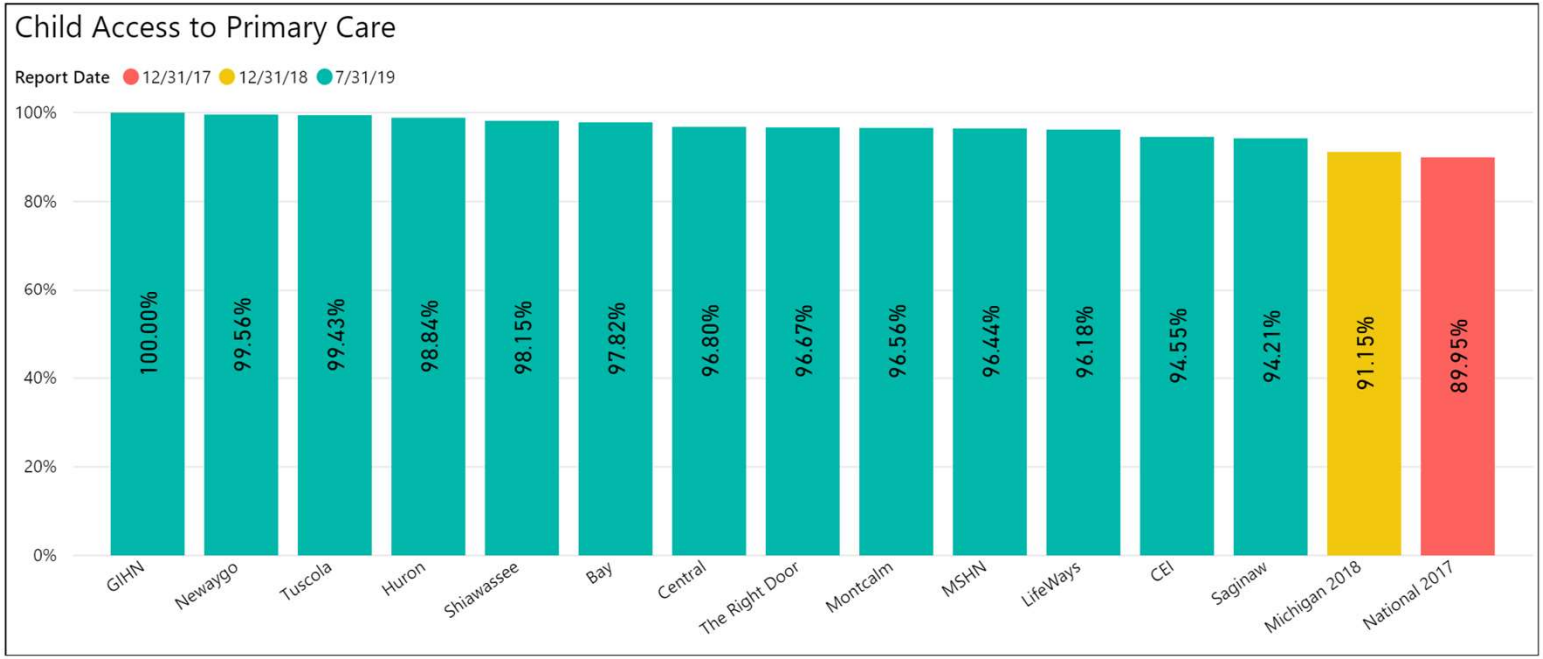
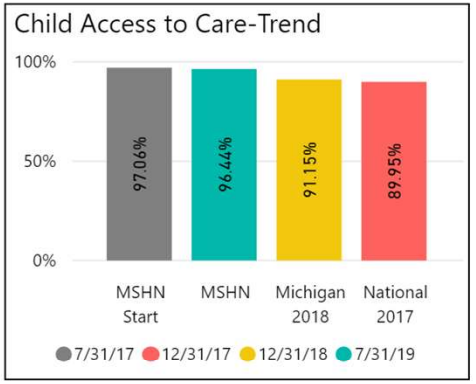
Steward: Utilization Management Committee

Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions



Organization	Yes	No	Percentage
Bay	15	672	97.82%
CEI	51	884	94.55%
Central	28	846	96.80%
GIHN	0	171	100.00%
Huron	1	85	98.84%
LifeWays	24	604	96.18%
Michigan 2018			91.15%
Montcalm	10	281	96.56%
MSHN	194	5254	96.44%
National 2017			89.95%
Newaygo	1	227	99.56%
Saginaw	50	813	94.21%
Shiawassee	5	266	98.15%
The Right Door	8	232	96.67%
Tuscola	1	173	99.43%



Measure Description: The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.a) Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.b) Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Numerator Statement: For 12–24 months, 25 months–6 years: One or more visits with a PCP during the measurement year.For 7–11 years, 12–19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year.

Denominator Statement: Any consumer 12 months to 19 years of age as of the end of the measurement year(e.g., December 31) who have:a) At most one month gap in coverage during the measurement year for ages 12 months to 6 years.b) At most one month gap during the reporting year and the previous year for ages 7 years to 19 years.

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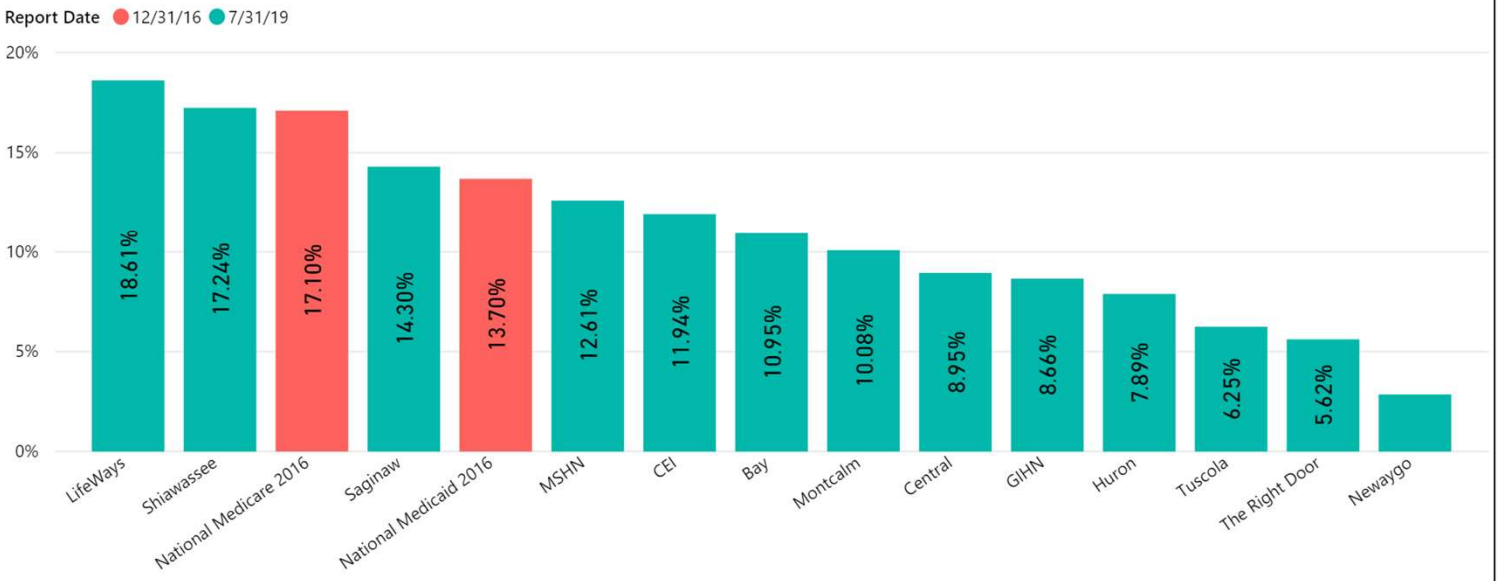
Steward: Utilization Management Committee

Update frequency: monthly extract of data from ICDP.

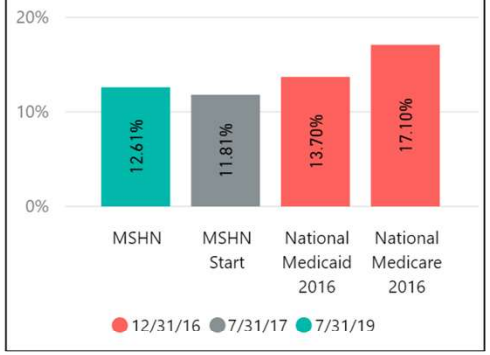
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Plan All-Cause Readmission



Organization	Yes	No	Percentage
Bay	37	301	10.95%
CEI	69	509	11.94%
Central	45	458	8.95%
GIHN	11	116	8.66%
Huron	6	70	7.89%
LifeWays	118	516	18.61%
Montcalm	12	107	10.08%
MSHN	447	3098	12.61%
National Medicaid 2016			13.70%
National Medicare 2016			17.10%
Newaygo	2	68	2.86%
Saginaw	106	635	14.30%
Shiawassee	30	144	17.24%
The Right Door	5	84	5.62%
Tuscola	6	90	6.25%

Plan All-Cause Readmission-Trend



Measure Description: For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Denominator Statement: An acute inpatient discharge on or between start date and end date of the measurement year.Member must be continuously enrolled.

Numerator Statement: At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Exclusions: Any acute inpatient hospital discharges with a principal diagnosis of pregnancyInpatient stays with discharges for death.

Last updated: 9/20/2019
Steward: Utilization Management Committee
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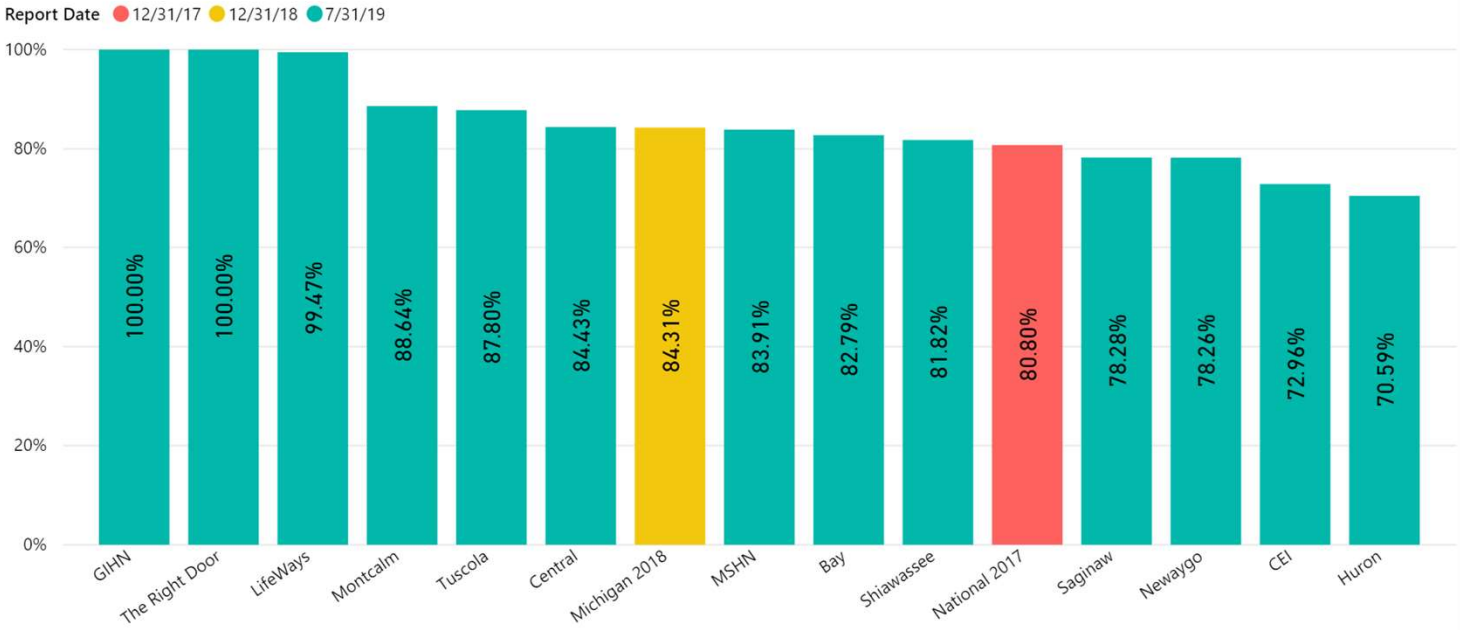
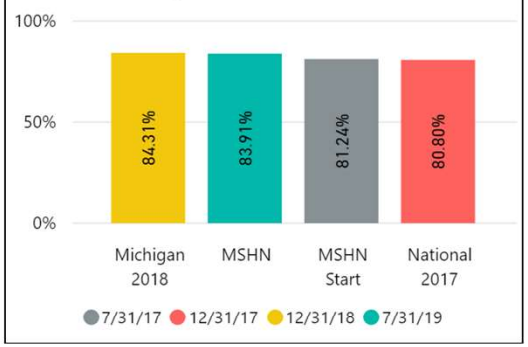
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Diabetes Screening



Organization	Yes	No	Percentage
Bay	101	21	82.79%
CEI	116	43	72.96%
Central	103	19	84.43%
GIHN	18	0	100.00%
Huron	24	10	70.59%
LifeWays	187	1	99.47%
Michigan 2018			84.31%
Montcalm	39	5	88.64%
MSHN	928	178	83.91%
National 2017			80.80%
Newaygo	18	5	78.26%
Saginaw	227	63	78.28%
Shiawassee	27	6	81.82%
The Right Door	32	0	100.00%
Tuscola	36	5	87.80%

Diabetes Screening-Trend



Measure Description: The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder,who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator Statement: One or more glucose or HbA1c tests performed during the measurement year.

Denominator Statement: Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

Exclusions: Exclude patients with diabetes during the measurement year or the year prior to the measurement year. Exclude patients who had no antipsychotic medications dispensed during the measurement year.

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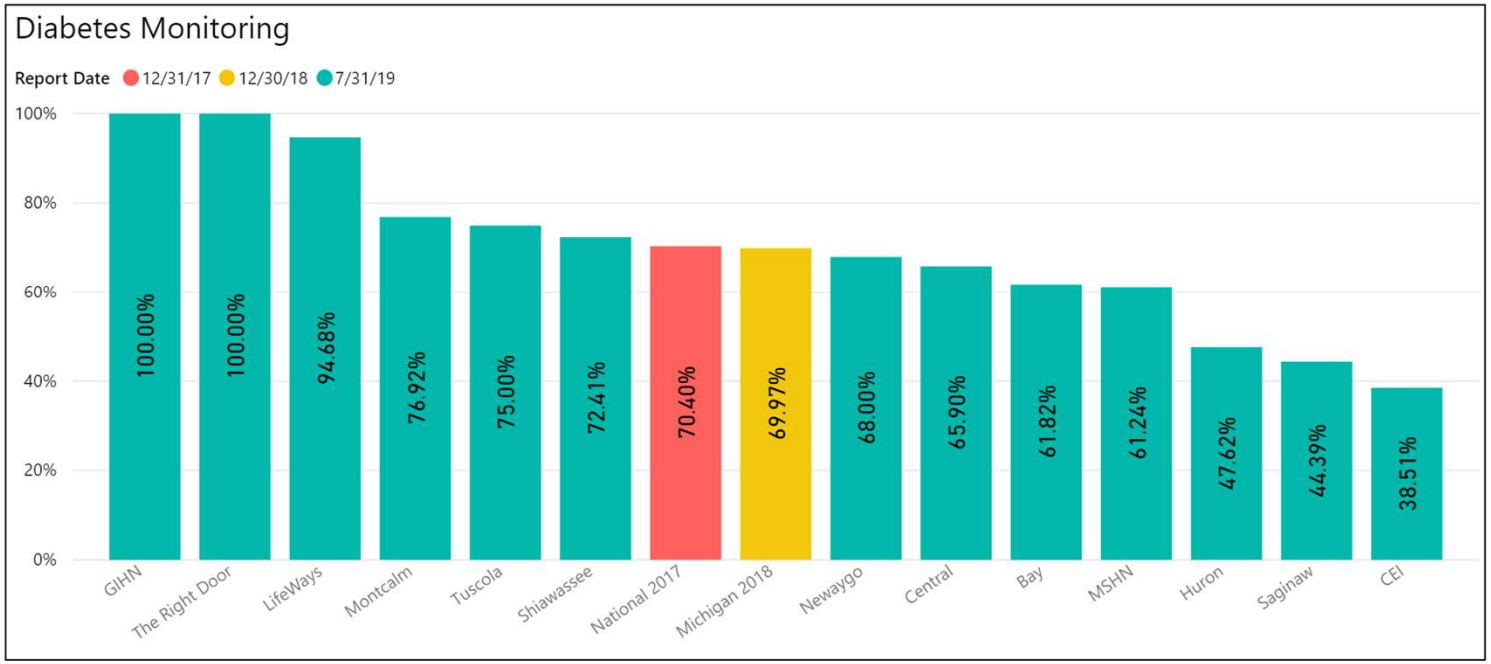
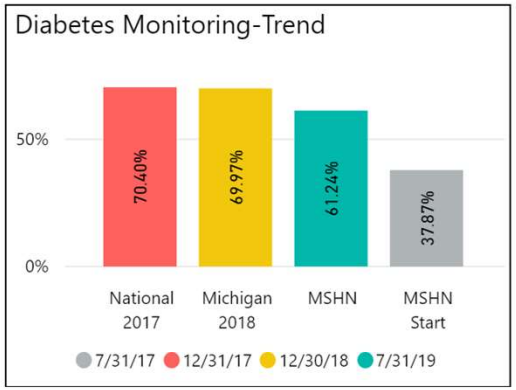
Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions



Organization	Yes	No	Percentage
Bay	68	42	61.82%
CEI	57	91	38.51%
Central	114	59	65.90%
GIHN	20	0	100.00%
Huron	10	11	47.62%
LifeWays	89	5	94.68%
Michigan 2018			69.97%
Montcalm	30	9	76.92%
MSHN	542	343	61.24%
National 2017			70.40%
Newaygo	17	8	68.00%
Saginaw	83	104	44.39%
Shiawassee	21	8	72.41%
The Right Door	15	0	100.00%
Tuscola	18	6	75.00%



Measure Description: This measure is used to assess the percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c (HbA1c) test during the measurement year.

Numerator Statement: A hemoglobin A1c (HbA1c) test and a low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.

Denominator Statement: Medicaid members 18 to 64 years during the measurement year with schizophrenia and diabetes.

Exclusions: Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

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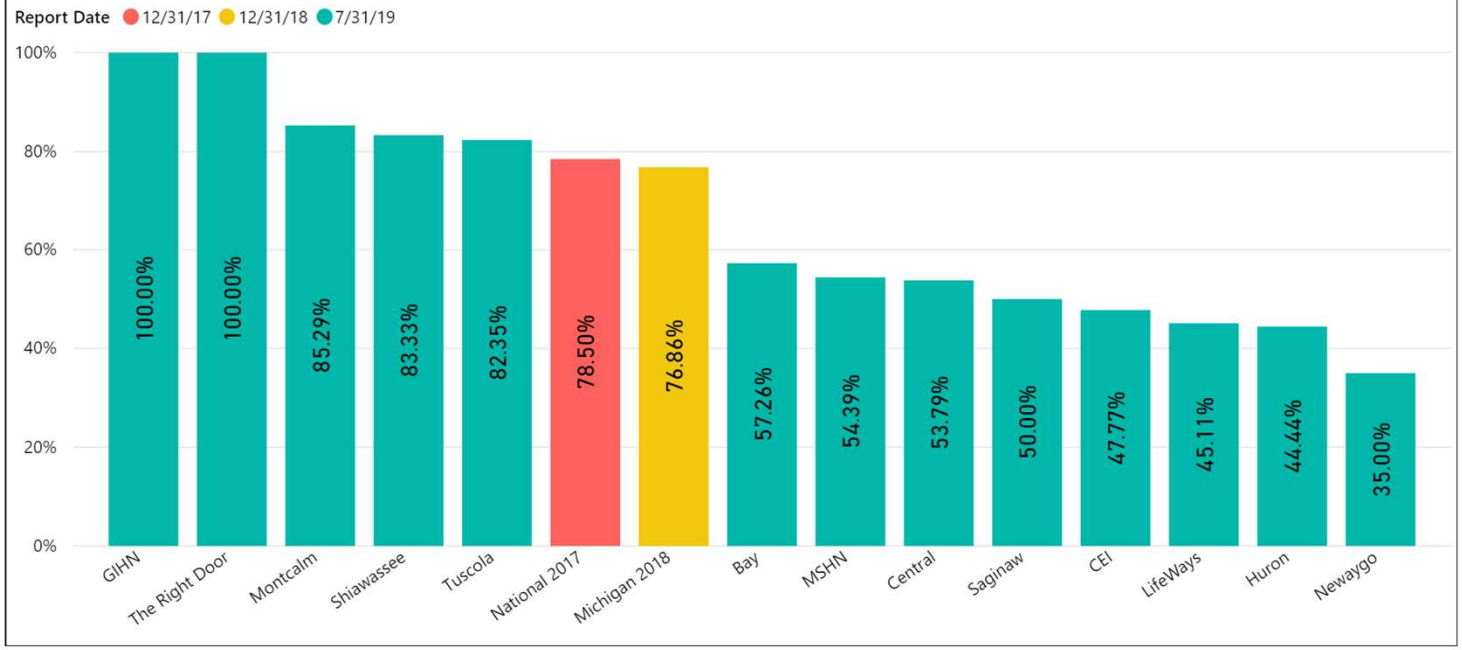
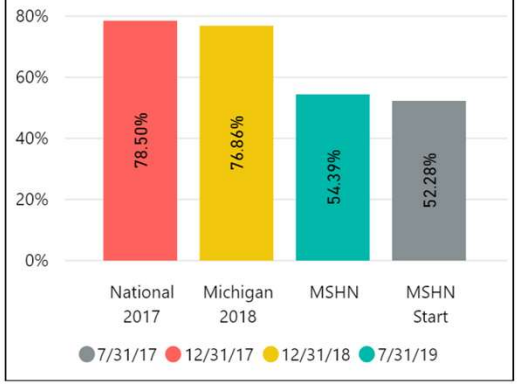
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Cardiovascular Screening



Organization	Yes	No	Percentage
Bay	67	50	57.26%
CEI	75	82	47.77%
Central	71	61	53.79%
GIHN	13	0	100.00%
Huron	12	15	44.44%
LifeWays	83	101	45.11%
Michigan 2018			76.86%
Montcalm	29	5	85.29%
MSHN	557	467	54.39%
National 2017			78.50%
Newaygo	7	13	35.00%
Saginaw	130	130	50.00%
Shiawassee	20	4	83.33%
The Right Door	22	0	100.00%

Cardiovascular Screening-Trend



Measure Description: The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.

Numerator Statement: Individuals who had one or more LDL-C screenings performed during the measurement year.

Denominator Statement: Individuals ages 25 to 64 years of age by the end of the measurement year with a diagnosis of schizophrenia or bipolar disorder who were prescribed any antipsychotic medication during the measurement year.

Exclusions: Individuals are excluded from the denominator if they were discharged alive for a coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) (these events may occur in the measurement year or year prior to the measurement year),nor diagnosed with ischemic vascular disease (IVD)(this diagnosis must appear in both the measurement year and the year prior to the measurement year),chronic heart failure,nor had a prior myocardial infarction (identified in the measurement year nor as far back as possible).

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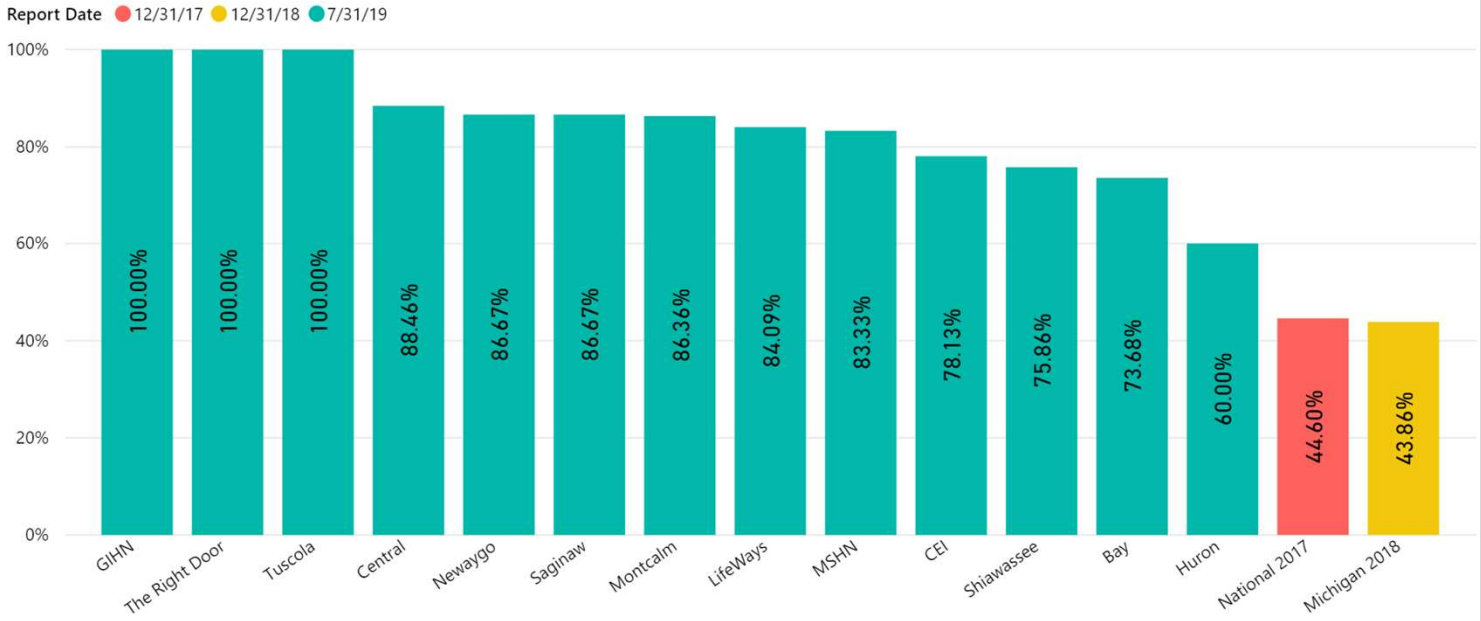
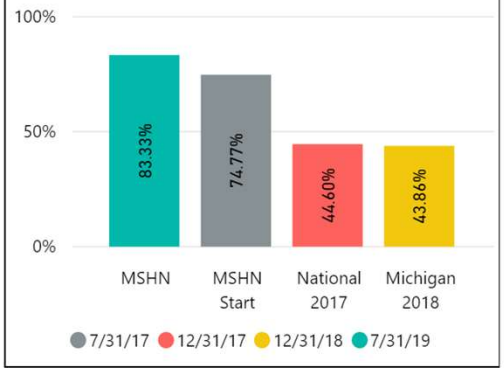
Follow-Up Children ADHD Initiation Phase



Organization	Yes	No	Percentage
Bay	42	15	73.68%
CEI	50	14	78.13%
Central	46	6	88.46%
GIHN	7	0	100.00%
Huron	3	2	60.00%
LifeWays	37	7	84.09%
Michigan 2018			43.86%
Montcalm	19	3	86.36%
MSHN	330	66	83.33%
National 2017			44.60%
Newaygo	13	2	86.67%
Saginaw	65	10	86.67%
Shiawassee	22	7	75.86%
The Right Door	15	0	100.00%
Tuscola	11	0	100.00%

Follow-Up ADHD Initiation-Trend



Measure Description: The percentage of children (6-12 years of age) newly prescribed ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Denominator Statement: All children in the 6-12 years of age range who were dispensed an ADHD medication during the 12-month Intake Period.Members must be continuously enrolled for 120 days prior to the earliest prescription dispensing date through 30 days after the earliest prescription dispensing date.

Numerator Statement: An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date.

Exclusions: Members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the earliest prescription dispensing date.

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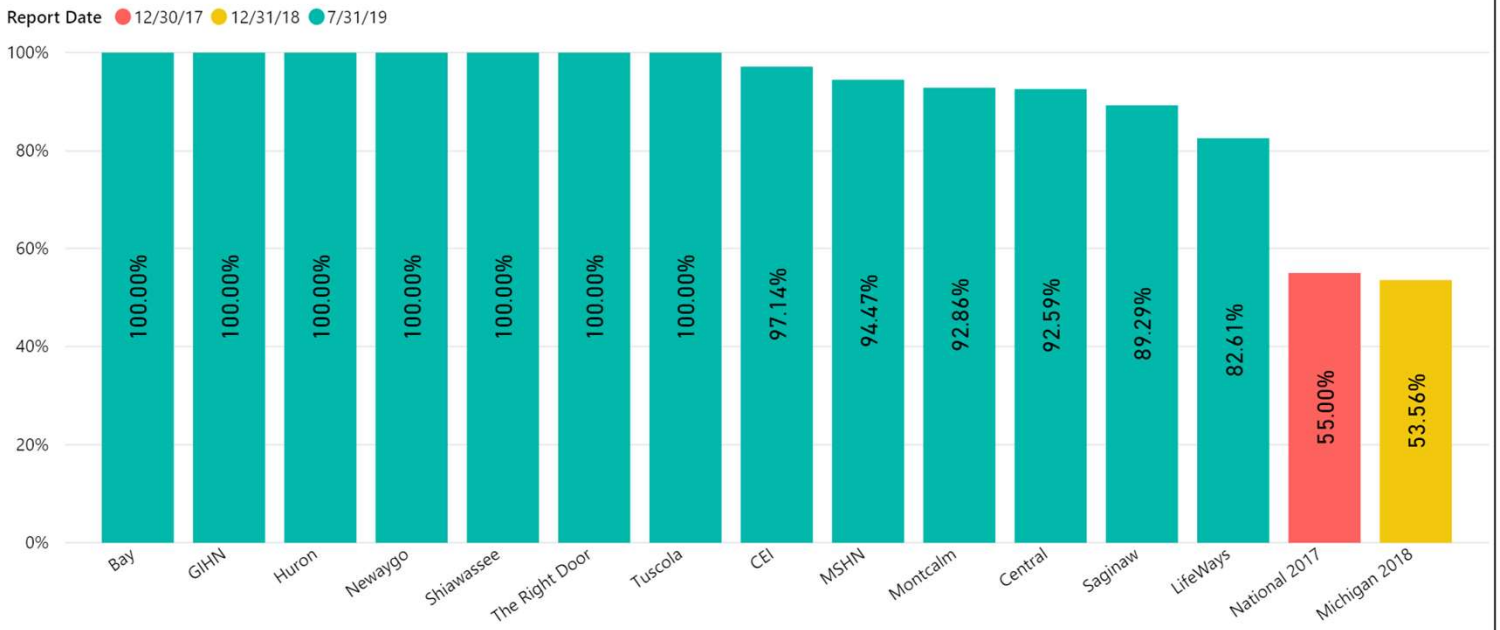
Update frequency: monthly extract of data from ICDP.

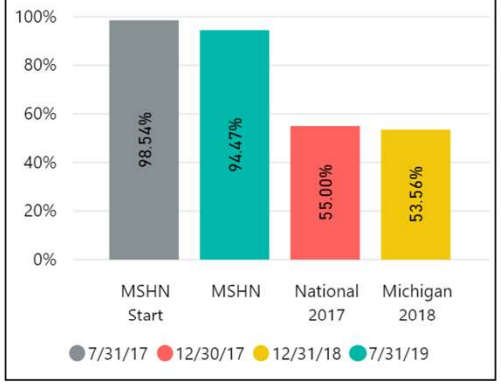
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Follow-Up ADHD Children Continuation & Monitoring Phase



Organization	Yes	No	Percentage
Bay	31	0	100.00%
CEI	34	1	97.14%
Central	25	2	92.59%
GIHN	4	0	100.00%
Huron	1	0	100.00%
LifeWays	19	4	82.61%
Michigan 2018			53.56%
Montcalm	13	1	92.86%
MSHN	188	11	94.47%
National 2017			55.00%
Newaygo	8	0	100.00%
Saginaw	25	3	89.29%
Shiawassee	13	0	100.00%
The Right Door	10	0	100.00%
Tuscola	5	0	100.00%

Follow-UP ADHD C&M-Trend



Measure Description: The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits within 270 days (9 months) after the Initiation Phase ended.

Denominator Statement: All eligible population of initiation phase.Members must be continuously enrolled for 120 days prior to the earliest prescription dispensing date and 300 days after the earliest prescription dispensing date.Member must fill prescriptions to provide continuous treatment for at least 210 days out of the 300-day period.

Numerator Statement: Numerator Statement compliant for Initiation Phase, and at least two follow-up visits from 31–300 days (9 months)

Exclusions: Members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through end date of the measurement year.

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