MSHN
Mid-State Health Network

Performance Bonus Incentive Pool (PBIP) Joint Metrics for the Integration of Behavioral Health and Physical Health Services

PIHP – MDHHS Reporting Format - Contract Withholds: 8.4.2.1.2

Qualitative Narratives *(October 1, 2019 – September 30, 2020)*

Due to MDHHS by: 11/15/2020

Metric: Increased Participation in Patient-Centered Medical Homes Characteristics:

Ensuring member access and engagement to a primary care provider and increasing participation in patient-centered medical homes continued to be targeted priorities for Mid-State Health Network (MSHN) during FY20. This narrative report will summarize the broad level population health activities and regional initiatives performed by MSHN in the areas of comprehensive care, patient-centered practices, coordination among multiple systems of care, accessible services, quality, and safety.

Additionally, the 12 Community Mental Health Service Program (CMHSP) Participants in Region 5 continue to be engaged in extensive integrated health systems of care in their local communities using the patient-centered medical home model with the individuals they serve. The table included on pages 6-11 of this report provides a summary of the efforts and achievements of each CMHSP during FY20 related to the five Patient-Centered Medical Homes Characteristics.

1. Comprehensive Care

MSHN is committed to increasing its understanding of the comprehensive health needs of individuals within its 21-county service region and finding innovative ways to achieve the goals of better health, better care, better value, better provider systems, and better health equity (i.e. the Quintuple Aim) by utilizing informed population health and integrated care strategies. To support these goals, MSHN has a comprehensive Population Health and Integrated Care Plan 2020-2022 which was developed with input from the region's medical directors, councils and committees, and approved by the MSHN board of directors. 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. Elements of comprehensive care which are addressed in the plan include:

- Epidemiological data for the population served by MSHN PIHP and its CMHSP Participants
- Identification of chronic co-morbid physical health conditions that contribute to poor health and drive health costs for individuals with behavioral health disorders
- Description of the concepts of population health, social determinants of health, health disparities, health equity, and identification of specific factors that impact the population in the MSHN region
- Strategic priorities for 2020-2022 related to improving health outcomes and reducing health disparities
- Recommendations for strategic planning, monitoring and oversight of integrated care and population health activities

- Steps to measure value and effectiveness through quality, costs, outcomes

2. Patient-Centered

MSHN is engaged in a number of regional initiatives to enhance patient-centered care within its CMHSP and Substance Use Disorder Service Provider (SUDSP) networks including the following:

- Building Peer Wellness Coach Workforce Capacity- During FY20 MSHN applied for and was awarded MDHHS Adult Mental Health Block Grant funding to offer Whole Health Action Management (WHAM) regional trainings in FY21. WHAM is an evidence-based model that uses peer support specialists to engage persons served in chronic disease self-management. Peers trained in WHAM use motivational interviewing techniques to assist individuals with developing and achieving person-centered health goals.

- Improving Health Equity- A key aspect to patient-centered care is ensuring all individuals have the resources and opportunities needed to be healthy, especially individuals belonging to groups that have been historically marginalized and socially disadvantaged. MSHN together with its CMHSP and SUDSP networks are committed to the goals of reducing health disparities for marginalized and vulnerable populations and continuous improvement in health equity. During FY 20 MSHN endeavored in a number of tasks toward understanding and reducing health disparities for persons served:

  - Analyzed regional service penetration rate data by county and race/ethnicity to identify areas of the PIHP region where increased outreach and engagement efforts might be needed for minority groups
  - Began to conduct focus groups and learn from people of color and other at-risk groups about their experiences with access to care and the healthcare system
  - Built additional data analysis capability into all existing population health reports in order to monitor outcomes relative to race/ethnicity
  - Began sharing health disparity data with CMH and SUD providers specific to their organizations in order to better inform patient-centered care for the individuals they serve

3. Coordinated Care

As described in further detail in pages 6-11, each CMHSP in the MSHN region participates in integrated systems of care with other healthcare partners in their local communities. This ensures that individuals receive highly coordinated care at the point of service delivery. MSHN engages in broad level activities to promote and improve coordination among multiple systems of care including payers, physical healthcare providers, behavioral healthcare providers, and substance use prevention and treatment providers. During FY20, MSHN engaged in the following activities and initiatives related to coordinated systems of care:

- Use of health information technology (HIT) to facilitate data sharing and coordination of care- Each of the 12 CMHSP participants 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. MSHN also participates in MiHIN and during FY20 MSHN was one of a few organizations statewide to pilot a new care coordination data system, MIDIGATE. During FY20 MSHN also continued the work of incorporating ADT feeds into its electronic managed care information 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 completion for this is FY21.

- Care Coordination with Medicaid Health Plans- During FY20, MSHN opened integrated care plans for 90 individuals in partnership with 8 Medicaid Health Plans (Blue Cross Complete, Meridian Health Plan, Molina, United Health Care, Aetna, HAP Empowered, Priority Health, and McLaren). FY20 outcomes for individuals involved in PIHP/MHP care coordination were as follows:
  - 75% of care plans were closed successfully (some goals or all goals were met)
  - 63.6% of individuals experienced a reduction in Emergency Department (ED) utilization as compared to the 12-month period prior to being opened for care coordination

- Ongoing use of regional clinical protocols to increase coordination between primary care and behavioral health- All CMHSP participants 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 case managers consistently utilize CC360 and/or other health information technology to identify care gaps for members on their caseload
  - CMHSP case managers are trained to support and assist members in accessing a primary care physician/patient-centered medical home
  - Local CMHSPs ensure that case managers coordinate 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, preventive primary care
  - Persons served by the CMHSP are provided with support to maintain health insurance coverage

4. Accessible Services

MSHN and its CMHSP and SUDSP networks are involved in numerous initiatives throughout MSHN's 21- county service area aimed at reducing barriers and expanding access to behavioral health services, physical health services, substance use treatment, and other necessary resources for vulnerable individuals. All 12 CMHSP participants have on-site primary care clinics located at the CMHSP or CMHSP behavioral health staff are co-located in Federally Qualified Health Centers (FQHC) and primary care settings. Pages 6-11 of this report include

additional information about innovative initiatives to expand access to services by some of MSHN's CMHSP participants. Examples include on-site pharmacy and laboratory services, medication home delivery, and providing personal mobile hotspots to consumers in rural areas to enable participation in telehealth during the COVID-19 pandemic. The following are examples of initiatives to improve accessibility to services that MSHN and its network providers have engaged in during FY20:

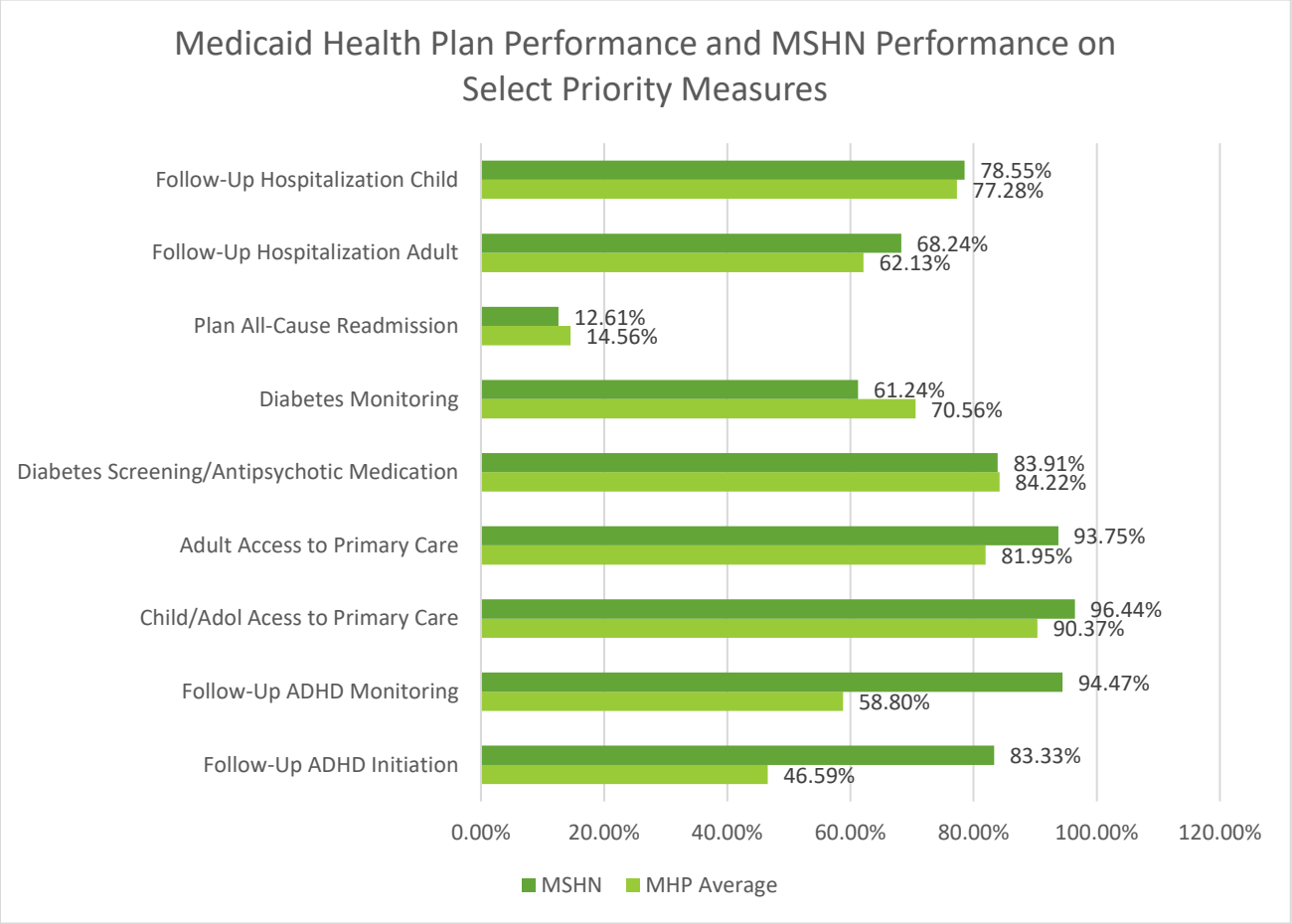
- Project ASSERT- MSHN, in partnership with several SUDSP organizations, has co-located peer recovery coaches in hospital emergency departments (ED) to provide screening, brief interventions, and referral to treatment for individuals who present to the ED for reasons related to alcohol and/or drug use. During FY20 Project ASSERT recovery coaches were located in hospitals in 13 counties in the MSHN region- Midland, Gratiot, Osceola, Isabella, Clare, Gladwin, Mecosta, Saginaw, Bay, Ingham, Hillsdale, Montcalm, and Eaton

- Telehealth- With the onset of the COVID-19 pandemic in March 2020, MSHN and its CMHSP and SUDSP networks implemented telehealth service delivery immediately for all services which did not require in-person interaction. Telehealth continued to be a primary modality for service provision throughout the remainder of FY20.

- Mobile Care Unit- In October 2019, MSHN deployed a mobile care unit (MCU) named the Action in Motion (AIM) bus which was designed to expand access to substance use and opioid disorder treatment services (including medication-assisted treatment) in MSHN's rural counties where there are few providers and transportation creates barriers to treatment. MSHN contracted with Recovery Pathways, a provider of MAT, counseling, case management, and peer support services. Initially the MCU was deployed in November 2019 to Charlotte in Eaton County. It was on-site from November 2019 until early March 2020 when the COVID-19 lock-down precluded continuity of services under safe conditions, although it continued to provide services via telemedicine with existing Eaton County clients. Additionally, MSHN collaborated with MDHHS and county health departments to use the MCU to expand COVID-19 testing for a particularly vulnerable population, opioid-dependent individuals, especially those with intravenous drug use. During FY20 Q4, the MCU was deployed to Saginaw, Bay, and Ingham counties to provide testing for up to 1,500 individuals receiving MSHN-funded opioid treatment services.

5. Quality & Safety

Throughout FY20, MSHN continued to monitor and perform quality improvement activities for a portfolio of 10 HEDIS quality measures related to access/availability of care, effectiveness of care, and chronic disease management. *MSHN regional performance through FY 20 exceeded State and National benchmarks on 7 out of 10 measures*. The graph below compares Michigan Medicaid Health Plan average performance with MSHN regional performance on select HEDIS quality measures during 2019:



**MHP performance data obtained from 2019 HEDIS Aggregate Report for Michigan Medicaid*

Additionally, MSHN completed enhancements to its website during FY20 to offer a wide range of quality and performance data to stakeholders and the public. (Link: MSHN Data Dashboards)

Increased Participation in Patient-Centered Medical Homes Characteristics
Region 5 CMHSP Activities, Efforts & Achievements

CMHSP	Comprehensive Care	Patient Centered	Coordinated Care	Accessible Services	Quality & Safety
Bay-Arenac Behavioral Health Authority (BABHA)	•Clinical behavioral health assessment contains questions about typical chronic co-morbid conditions to identify individuals for referral to nursing staff for health assessment and enhanced coordination of care with primary care providers	•Conduct a Patient Portal incentive program to inspire individuals served to access/use their patient portal •Provide wellness classes run by nursing staff (currently suspended due to COVID-19)	•Interface with multiple laboratories for the ordering and receipt of tests •Integrated ADT alerts in electronic health record •Use of CC360 to obtain service and provider history for new individuals and individuals with significant health issues	•On-site laboratory testing in partnership with Quest Diagnostics •Telehealth services for all primary care services •Partnership with local pharmacy for medication delivery services	•Integrated Health Competency Checklist included in annual staff performance evaluation process with baseline competency requirements related to integrated health standards of care •Participating in a performance improvement project involving diabetes screening and coordination with primary care physicians
Community Mental Health Authority for Clinton, Eaton, Ingham (CMHA-CEI)	•Certified Community Behavioral Health Clinic (CCBHC) offering comprehensive services for behavioral health, substance use disorders, and primary health care •On-site primary health clinic (Birth Clinic) at main CMH location	•Through the CCBHC select staff are trained in wellness coaching to support individuals served •A consumer newsletter is sent out monthly with agency updates and wellness resources	•CMHA-CEI with Michigan Child Collaborative Care (MC3) offers pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. Currently, over 300 local providers have been enrolled into MC3. •CMHA-CEI and Ingham Community Health Centers (ICHC) implemented Primary Care Behavioral Health model at all ICHC locations •CMHA-CEI has 6 Behavioral Health Consultants embedded in 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	•On-site laboratory testing in partnership with Sparrow Health System •On-site pharmacy at main CMH location; pharmacy also delivers medications to CMH residential facilities and Adult Foster Care homes	•Each clinical program at CEI CMH has selected a healthcare integration project to improve health outcomes for the population served by the program. Examples include: Providing health education and support to families of children with a diagnosis of asthma; Providing health education and support for adults with a diagnosis of hypertension; Increase the number of individuals who receive supportive behavioral health services in community-based primary care settings •CCBHC Expansion Grant has established national outcome measures (NOMS) with baseline and 6 month measurements.
Community Mental Health for Central MI (CMHCM)	•On-site Federally Qualified Health Center (FQHC) and Medication-Assisted Treatment (MAT) for substance use disorders •Electronic health record (EHR) includes an integrated health dashboard containing health information for each person served such as BMI, tobacco use status, blood pressure, and alerts for emergency visits and hospital admissions •Multi-disciplinary Clinical Review and Consultation Team provides comprehensive treatment planning and interventions for high-risk individuals with chronic medical conditions	•Electronic health record patient portal available to all individuals served •Persons served have access to a variety of activities/services to support their health & wellness goals such as healthy eating prep and cooking classes and exercise opportunities •Whole Health Action Management (WHAM) peer support program assists individuals with developing person-centered wellness goals	•Participate in Great Lakes Health Connect HIE •Labs ordered by non-CMH healthcare providers are direct fed into CMH health record	•Open access for services •Provide multiple options for reducing barriers to obtaining medication such as pharmacy delivery service •On-site primary care services in partnership with FQHC	•Use of nationally recognized quality health measures such as diabetes screening and monitoring •Medication reconciliation occurs at every appointment for individuals receiving health services •Psychiatric providers offer monthly “lunch & learn” educational opportunities to promote health and medical training and knowledge for all CMH staff

Increased Participation in Patient-Centered Medical Homes Characteristics Region 5 CMHSP Activities, Efforts & Achievements					
CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Gratiot Integrated Health Network (GIHN)	•Member of Live Well Gratiot, a county-wide health and wellness committee •Health assessment embedded within standard clinical workflow •CMH is host site for Medical Residents, Medical Interns, and Psychiatric Interns and RN students	•Nurse case manager attends medical appointments with consumers with high physical health needs •Health specific information is available in patient portal to individuals served	•Integrated ADT feeds and process for follow-up by case holders •CMH Nurse Practitioner provides physical healthcare services to consumers and general public in St. Louis satellite office •Crisis therapist is co-located in emergency department of Mid-Michigan Medical Center	•CMH Therapist located in St. Louis primary care clinic provides therapy to mild-to-moderate population •On-site integrated substance use treatment servies including Medication Assisted Treatment (MAT)	•Registered Nurses provide health education to CMH staff for chronic conditions such as Hypertension, Diabetes, Cardiovascular disease, Respiratory disease/COPD/Asthma, and COVID-19
Huron Behavioral Health (HBH)	•On-site primary care in partnership with local FQHC, Great Lakes Bay Health Center	•Patient portal allows individuals served to access their health data. Agency has coordinated annual initiatives to encourage consumer use of portal •Integrated health and wellness goals are included in individual plans of service as identified by consumer	•Integrated electronic health record with FQHC for ease of information sharing and coordination of care •Integrated ADT feeds and process for follow-up and documentation by case holders •Well established procedures for initial and ongoing coordination of care with primary care physicians and specialty providers •Initiative with McLaren Thumb Region hospital to share telepsychiatry services for individuals in crisis	•Expansion of telehealth services in response to COVID-19 pandemic •Innovative technology support project provides mobile hotspots to individuals without internet access to facilitate participation in telehealth services •Medication delivery services ensure individuals have access to needed medications even in the absence of reliable transportation	•Integrated Health and Wellness Committee that meets at a minimum quarterly to explore ongoing strategies for improving integration and coordination within Huron County •HBH Medical Director provides ongoing consultation for both the county jail physician and other local primary care physicians in order to ensure safety in the prescribing and monitoring of psychotropic medications •HBH psychiatry clinic provides cardiovascular health and diabetes screening as part of ongoing performance improvement projects

Increased Participation in Patient-Centered Medical Homes Characteristics
Region 5 CMHSP Activities, Efforts & Achievements

CMHSP	Comprehensive Care	Patient Centered	Coordinated Care	Accessible Services	Quality & Safety
LifeWays Community Mental Health	•Ongoing partnership with Center for Family Health (FQHC) to provide on-site primary care services. During FY20 a remodel project was completed so that medical/primary care services are fully embedded at CMH main site location •Expanding to offer substance use disorder services in additional to behavioral health and physical health •Progress on strategic plan to become a CCBHC •Finalizing nursing assessment to include more whole person care issues	•Full-time heath coach works with individuals who are interested in learning more about wellness •Wellness services area is now completed with exercise equipment and a teachable kitchen. Wellness coach is developing more extensive program offerings •Electronic health record includes a patient portal for communication between consumer and providers	•LifeWays is a member of the Jackson Health Network and participates in MiHIN •Continuity of Care Document (CCD) electronic exchange with Henry Ford Health Systems which allows for better communication between providers	•Two full time Consumer Medication Coordinators on-site (one in Jackson and one in Hillsdale) to assist with medication delivery, prescription questions, coordination between the client, psychiatrist, and pharmacy, and prior authorizations •Partnership with the Refractory Schizophrenia Assistance Program devised by HLS Therapeutics (USA), Inc in collaboration with Athelas. This Program provides the ability to monitor patients using the Athelas One, an FDA-cleared platform that generates WBC & Neutrophil counts from a finger prick of blood. The Program additionally provides optional access to a specialty pharmacy connection to assist in managing patient prescriptions along with a software tool to facilitate the documentation of the Clozapine REMS patient registry with test results	•Upgraded EMR to capture non-psychiatric medication information such as amount, route, duration •Integrated the National Outcome Measurement System into EMR •Quality Improvement team is developing risk stratification dashboards and reports for analysis of high needs cases for intervention
Montcalm Care Network (MCN)	•Nursing staff embedded in various services who act as liaisons to local primary care providers and manage care pathways for chronic health conditions •Collaborate with Spectrum Health on various health initiatives such as offering flu clinic on site at MCN and providing COVID testing for asymptomatic persons in AFC homes after known exposure	•In FY21 MCN will be launching the utilization of an evidence-based platform- Patient Activation System (PAM) to enhance interventions toward self-management of health conditions •Peers are trained in models of health coaching and facilitate groups like WRAP and smoking cessation •MCN operates a community-based gym where InShape programming occurs and offers nutrition classes in partnership with MSU Extension. Yoga is also offered for children and adults	•MCN uses VIPR a health information exchange (HIE) and ADTs are embedded in the electronic health record •Conduct regular meetings with local hospitals to collaborate on the overlap between mental health care and emergency care	•Provide telehealth services •Direct arrangements with a pharmacy when individuals need medication package in daily dispenses •Onsite flu clinics	•Track HEDIS quality measures and have a published dashboard for stakeholders that highlights a variety of health outcome measures

Increased Participation in Patient-Centered Medical Homes Characteristics Region 5 CMHSP Activities, Efforts & Achievements					
CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Newaygo Community Mental Health (NCMH)	•Provided two behavioral health clinicians who are placed in primary physicians' offices through a contract with the local hospital. Provide direct treatment and referrals for primary health care patients	•NCMH provides support to individuals for addressing needs related to Social Determinants of Health •NCMH provides health education to all persons served 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	•Each inpatient prescreen, psychiatric reviews, and/or medication review documentation is sent to the client's identified primary care provider and/or patient centered medical home •NCMH staff participate in on-site care coordination with local FQHC including information exchange and referrals	•NCMH has provided telehealth services prior to, and amid the COVID-19 pandemic •Two clinicians co-located in primary physicians' offices through a contract with the local hospital. They provide direct treatment and referrals for primary health care patients	•QI/Corporate Compliance Director (in coordination with NCMH clinical leaders) utilized ICDP (Zenith) to monitor Care Alerts issued by the system in accordance to process improvement projects such as diabetes monitoring. •NCMH actively monitored the Michigan Mission Based Performance Indictor System (MMBPIS) to clearly monitor the dimensions of quality through performance measures. oNCMH was found to be "best practice" in: Indicator 2, Initial Assessment within 14 Days, and Indicator 3, Start of service within 14 days. •Utilized health care alerts to identify individuals who have a history of high emergency room utilization. In collaboration with Spectrum Health Gerber Memorial Hospital, worked with clinical leaders to address barriers to high utilizers accessing primary care.
Saginaw County Community Mental Health Authority (SCCMHA)	•Great Lakes Bay Health Centers (GLBHC) co-located within the SCCMHA psychiatric services clinic, onsite physical health care for over 500 SCCMHA adult consumers •PIPBHC (Promotion of Integration of Primary and Behavioral Health Care) grant participant prioritizing reductions high morbidity/mortality rates for adult SMI population. PIPBHC focuses on improving primary care participation and improving screening and obesity rates for children with SED •Certified Community Behavioral Health Clinic (CCBHC) offering comprehensive services for behavioral health, substance use disorders, and primary health care	•SCCMHA continues to promote the use of the patient portal for improved consumer communication and the promotion of consumer health and wellness	•Participating in MDHHS and Michigan Primary Care Association pilot project for the care coordination platform AZARA. The project allows the PIPBHC partners and GLBHC to use shared encounter data to develop and update shared plans of care for SCCMHA consumers who have GLBHC as their primary care provider •SCCMHA utilizes the ZENITH/ICDP platform to support a "huddle" document that combines EHR daily scheduled consumer appointments, CC360 encounters, hospital and ED encounters along with identifying the need for lab testing and other physical health care metrics to inform clinical decision making on the day of a consumer appointment	•Provision of telehealth has been fully implemented for consumer access. SCCMHA continues to promote its use and helps consumers access resources for reduced or free data to participate in telehealth •Onsite laboratory draw services, onsite pharmacy •GLBHC provides monthly onsite dental services at main SCCMHA building through mobile dental unit •SCCMHA contracts with GENOA pharmacy to provide in home medication delivery services •SCCMHA provides community wide access to myStrength mobile app, a platform that promotes wellness, recovery and self-management support for mental health	•SCCMHA regularly reviews performance metrics and initiatives at a bi-monthly meeting facilitated by the SCCMHA medical director, the primary care health care provider from GLBHC, a GENOA pharmacist and SCCMHA clinical directors. The committee focuses upon improved consumer health outcomes, access to care and monitoring the performance of the agency in key health and quality metrics.

Increased Participation in Patient-Centered Medical Homes Characteristics Region 5 CMHSP Activities, Efforts & Achievements					
CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Shiawassee Health & Wellness (SHW)	•Shiawassee Health & Wellness (SHW) has a strong partnership Great Lakes Bay Health Center (GLBHC), a patient-centered medical home, who is co-located at the SHW building and provides primary care on-site to shared patients •Shiawassee Health and Wellness is a SAMSHA grantee for the Promoting Integrated Primary and Behavioral Health Care (PIPBHC) grant. •SHW Medical Director provides ongoing psychiatric consultation with GLBHC (patient-centered medical home). •Medical Assistant or nurse performs a brief assessment (including vitals) for all newly enrolled consumers and those coming in for medication reviews	•SHW Peer Support Specialist is trained in solutions for wellness and has been working with interested individuals to implement strategies to improve their health outcomes. •SHW has a Tobacco Treatment Specialist that supports individuals with tobacco reduction and reduction.	•SHW and GLBHC share information regularly about shared patient enrollment and coordinate care needs •SHW reviews and implements an active follow up process for all ADTs received from local health care offices and the hospital •SHW has been selected as the pilot site to use Azara for population health management. •Transfer/upload capabilities for all laboratory and test results is currently in place with Quest Labs	•Quest lab is co-located at SHW a partial day each week. •GLBHC is co-located at SHW 1 day per week •During COVID -19 response operations, GLBHC provided tele-health services to the vast majority of patients served. •Exploring partnership with Genoa Pharmacy to have onsite pharmacy technician 3 days per week. This would open opportunities for medication deliveries	•Quality performance measures for consumers enrolled in integrated care model: o90% of consumers will be screened for tobacco use o80% of eligible consumers will have CO levels monitored quarterly o75% of positive screens who express interest will be referred to TTS o100% of consumers will have their vital signs and BMI measured at each visit oA1c will be measured per guidelines for eligible consumers o75% of eligible participants who are interested will be referred to Solutions for Wellness
The Right Door for Hope, Recovery & Wellness (TRD)	•TRD collaborates with local primary care physicians to provide whole person care	•TRD will be supporting the training of multiple peer/recovery coaches as health coaches in the coming year •TRD's patient portal is in the development stage •Nurses/Case Managers/Peers attend doctor appointments with consumers when consumer struggles with knowledge of their medical condition and would like support	•TRD coordinates with the local hospital system multiple times per month administratively in addition to the day-to-day interface •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. (limited d/t COVID-19) •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 •In addition to sending medication reviews and evaluation notes, also share lab values with primary care providers to coordinate care	•TRD has capacity to do some lab tests on-site, including lab work related to Clozaril (WBC and ANC), A1c and lipids. •TRD will be co-locating with Sparrow Medical Group in Portland during FY21. •TRD provides telehealth services in addition to face-to-face services	•Quarterly pharmacy audits-review of samples and AIM testing on psychotropic drugs used by providers •Quarterly Peer reviews by nursing staff and prescribers

Increased Participation in Patient-Centered Medical Homes Characteristics Region 5 CMHSP Activities, Efforts & Achievements					
CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Tuscola Behavioral Health Services (TBHS)	•TBHS continues to provide integrated health care services through a fully operational on-site wellness primary care clinic	•During FY20 TBHS partnered with the Michigan State University Extension office to provide Cooking Matters, Dining with Diabetes, Stress Less with Mindfulness, and Relax: Alternatives to Anger classes to consumers •TBHS has offered Wellness Workouts in partnership with State Street Fitness, as well as Walking Wednesday through the Caro District Library •Peer wellness coaching available through on-site wellness clinic	•TBHS participates in the Thumb Community Health Partnership •Utilization of the Zenith Data Analytics for purposes of medication reconciliation, verification of access and engagement in primary and specialty care services, as well as provider and diagnosis reconciliation •TBHS has continued, and strengthened, its partnership with the Tuscola County Health Department through the COVID-19 pandemic. Coordination efforts are currently underway for the Health Department to conduct influenza vaccination clinics for the consumers of TBHS	•TBHS works with two different pharmacies in the community for medication delivery services to consumers including medication management services and safety dose packaging •McLaren Family Practice offers onsite laboratory services on weekly basis •Telehealth primary care and psychiatric care services •Ongoing community education and distribution of Narcan	•Conduct consumer satisfaction surveys for wellness clinic and telepsychiatry services on a quarterly basis. Results are reviewed and utilized to make changes in service design and delivery. •HEDIS results are reviewed each month and utilized as an ongoing gauge for consumer integration purposes. •TBHS reviews the controlled prescriptive practice of all psychiatrists under contract with on an annual basis to ensure prescribing practices are consistent with state, federal and current APA guidelines/recommendations. •Utilize Zenith Data Analytics for medication and diagnosis reconciliation for consumers recently discharged from a psychiatric or acute care admission. •As part of 2019-20 TBHS Strategic Plan, TBHS successfully increased the number of consumers seen in the wellness clinic by 23%.