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.D.2.P.4

Qualitative Narratives *(October 1, 2020 – September 30, 2021)*

Due to MDHHS by: 11/15/2021

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

Ensuring member access and engagement to a primary care provider and promoting the characteristics of patient-centered medical homes continued to be targeted priorities for Mid-State Health Network (MSHN) during FY21. 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. The table included on pages 5-10 of this report provides a summary of the efforts and achievements of each CMHSP during FY21 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

Another way MSHN and its CMHSP participants are addressing comprehensive care is through implementation of Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs provide a comprehensive array of services to expand access, stabilize people in crisis, and provide necessary treatment for those with the most serious, complex mental illnesses and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and integration of physical and behavioral health. Three CMHSPs in the MSHN region were selected for participation in the State of Michigan Center for Medicare & Medicaid Services (CMS) CCBHC Demonstration Project- CEI CMHSP, Saginaw CMH, and The Right Door (Ionia County). Additionally, LifeWays CMH received a SAMHSA planning grant for CCBHC expansion. During FY 2021 MSHN facilitated planning meetings with the 4 CCBHC locations in preparation for a 10/1/2021 implementation date.

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 FY21 MSHN hosted three Whole Health Action Management (WHAM) trainings with support from MDHHS Adult Mental Health Block Grant funding. WHAM is an evidence-based model that uses peer support specialists to engage persons served in chronic disease self-management and assist them with developing and achieving person-centered health goals. A total of 47 peers were trained in WHAM during FY21 and have implemented it in a variety of settings including peer support drop-in centers, CMHSPs, and co-located integrated health clinics.

- 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 21 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

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 FY21, 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 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. During FY21 MSHN partnered with Michigan Health Information Network (MiHIN) and MDHHS in a pilot project for electronic consent management and SUD data-sharing. During FY21 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.

- Care Coordination with Medicaid Health Plans- During FY21, MSHN had integrated care plans for 70 individuals in partnership with 7 Medicaid Health Plans (Blue Cross Complete, Meridian Health Plan, Molina, United Health Care, Aetna, Priority Health, and McLaren). FY21 outcomes for individuals involved in PIHP/MHP care coordination were as follows:
  - 100% of care plans were closed successfully with some goals or all goals met (excluding cases closed due to incarceration, loss of Medicaid eligibility, or due to moving outside of the PIHP region)
  - 67% 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 utilize CC360 and/or other health information technology to identify care gaps for members on their caseload and assist persons served 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

As a result of these efforts, 85% of adults and 93% of children who received CMHSP services in the MSHN region during FY21 also had at least one visit with a primary care provider.

4. Accessible Services

MSHN and its CMHSP and SUDSP networks are involved in numerous initiatives 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. MSHN engaged in the following initiatives to improve accessibility to services during FY 2021:

- Project ASSERT- Project ASSERT is a model of early intervention, screening, and referral to SUD treatment for individuals in hospital and primary care settings. MSHN-funded peer recovery coaches trained in Project ASSERT are currently located in hospital emergency departments in 13 counties in the MSHN region. Individuals who present to the hospital ED with substance-related concerns are offered the opportunity to speak with a Project ASSERT peer recovery coach who provides appropriate referrals and follow-up support.

***2,147 individuals** received screening and follow-up support from Project ASSERT coaches in response to a substance-related hospital ED visit during FY 2021*

- 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 modality for service provision throughout FY21 based on individual preference and type of service.

- Mobile Care Unit- MSHN, through partnership with SUD Provider Recovery Pathways, operates a mobile care unit (MCU) named the Action in Motion (AIM) bus 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. During FY 2021, the AIM Mobile Unit greatly expanded its route. It currently provides services in Midland, Saginaw, Arenac, Isabella, Gladwin, and Bay Counties. Additional information about AIM and the services it provides is available HERE.

5. Quality & Safety

Throughout FY 2021, 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. As a region, MSHN performed above Michigan Medicaid Health Plan (MHP) averages on 6 of 10 priority measures. Quality performance data is available to stakeholders and the public on the MSHN website: MSHN Data Dashboard.

Additionally, MSHN maintains a comprehensive Quality Assessment and Performance Improvement Program (QAPIP) which addresses a broad array of quality and safety items. Information about the MSHN QAPIP and an annual effectiveness review are available on the MSHN website: MSHN Compliance and Quality Reports.

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	Provide wellness classes run by nursing staff (currently suspended due to COVID-19) Development and implementation of Advanced Nursing/Health program for those individuals who are at a greater health risk. Deployment of strategies to ensure the diabetes and cardiovascular screenings/monitoring are occurring (i.e., the HEDIS measures)	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 Assisting with design and are waiting for the deployment of the CC360 direct interface with our EHR. Engaged with MiHIN for use of VPR through their Gateway so we can access health care records provided by local health systems for coordination of care.	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 projects involving diabetes screening and coordination with primary care physicians as well as cardiovascular screening and monitoring
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. Provisional CCBHC Certification in Michigan on October 1, 2021. On-site primary health clinic (Birch Health Center) at main CMH location. Nursing Assessments are completed for those with chronic conditions and Nurse Care Managers enhance coordination with primary care and other providers. Use of Peer Supports, Peer Recovery Coaches. Access to MAT is available	Through the CCBHC select staff are trained in wellness coaching to support individuals served. WHAM and Writers Group offered by Peer Support Specialists. A consumer newsletter is sent out monthly with agency updates and wellness resources . Consumer Advisory Council linked to Board Committee. Charter House Club House offers many opportunities for consumer centered planning and activities.	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. Continuity of Care Document is sent to primary care and other providers. Nurse Care Managers assist with care coordination Receiving ADT Alerts and now sending ADT	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 Use of blended telehealth when requested and clinically appropriate. Use of same-day access for intakes into Adult Mental Health Services.	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. Process mapping and improvements to our insurance verification practices. Development of Care Pathways for Hypertentions, Diabetes, Asthma, and Hepititis

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**
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
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. Program monitors patients using the Athelas One, an FDA-cleared platform that generates WBC & Neutrophil counts from a finger prick of blood. The Program additionally provides specialty pharmacy access to manage patient prescriptions and software 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 and clinical leaders utilize ICDP (Zenith) to monitor Care Alerts in accordance with process improvement projects such as diabetes monitoring. NCMH actively monitors the Michigan Mission Based Performance Indictor System (MMBPIS) to identify dimensions of quality through performance measures. NCMH was found to be "best practice" in: Indicator 2, Initial Assessment within 14 Days, and Indicator 3, Start of service within 14 days. Utilize health care alerts to identify individuals who have a history of high emergency room utilization. In collaboration with Spectrum Health Gerber Memorial Hospital, clinical leaders work to address barriers to high utilizers accessing primary care.

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**
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	Health Education is provided by a Health Educator as part of the PIPBHC grant. Current focus is on addressing tobacco use among adults and youth and improving lifestyle choices. Blood pressure clinics will resume in Q2 FY22 to focus on the prevalence of hypertension in both children and adults In conjunction with Great Lakes Bay Health Centers (GLBHC), regularly scheduled dental services provided on site with the GLBHC Dental Bus Telehealth is available based on consumer preference for medication reviews GLBHC offers on site/on demand immunizations including COVID 19 and influenza vaccination.	Implementation of AZARA is projected for FY22. This project will engage PIPBHC partners and GLBHC to provide encounter data and develop shared plans of care for SCCMHA consumers who have GLBHC as their primary care provider. Coordinate referrals and follow up for individuals who present in Covenant Health System ED using an "urgent psychiatric clinic" model that provides evaluation and support on an as-needed basis and ongoing treatment. SCCMHA Behavioral Health Consultants (funded through the PIPBHC SAMHSA grant) are co-located in GLBHC's primary care setting for adults and at CMU's Pediatric Clinic. SCCMHA utilizes interdisciplinary team-based care with the goal to improve the coordination of care and delivery of services.	Implemented extended services hours from 7:00am - 7:00pm (Formerly 8:00am – 5:00pm) SCCMHA offers telehealth as a service option through use of ipads which are delivered directly to consumer for limited time use with the purpose of providing access to services. SCCMHA hosts co-located Quest lab drawing services in addition to an on-site pharmacy, Genoa. Genoa offers onsite on demand influenza vaccines, curbside delivery, and prescription home delivery.	Key agency quality performance metrics reviewed bi-monthly by committee of medical and clinical leaders with focus on improving health outcomes & access to care CLIA-waived screening instruments incorporated into health assessment. HbA1c and lipids levels captured at intake & periodic biometric screening to identify need for further lab tests or health education referral Consumer Wellness Committee reconvened in FY21 with participation of consumers to develop health education initiatives using EBPs with focus on improving consumer health November 2021 implementation of multi-year NIH research project, DECIPHeR, in partnership with John's Hopkins and University of Michigan. SCCMHA providers are trained in cardiovascular risk reduction strategies with adults to address weight reduction, smoking cessation, improved cholesterol and diabetes control, and decreased blood pressure.
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: 90% of consumers will be screened for tobacco use 80% of eligible consumers will have CO levels monitored quarterly 75% of positive screens who express interest will be referred to TTS 100% of consumers will have their vital signs and BMI measured at each visit. A1c will be measured per guidelines for eligible consumers 75% of eligible participants who are interested will be referred to Solutions for Wellness

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**
The Right Door for Hope, Recovery & Wellness (TRD)	Certified Community Behavioral Health Clinic (CCBHC) offers comprehensive services for behavioral health, SUD, and primary care. Health Screens completed annually for all persons served & referral to primary or specialty care is provided by care coordinator or community clinician. Dedicated nurse as primary care liaison. Monthly primary care communication newsletter in English/Spanish Dedicated referral process for one time case consults with primary care providers.	Care Coordinators available to attend doctor appointments with persons served for advocacy, support, & to increase health literacy Electronic health record patient portal available to all individuals served Persons served have access to a variety of activities/services available to support health & wellness goals such as healthy eating prep and cooking classes Whole Health Action Management (WHAM) peer support program assists individuals with developing person-centered wellness goals	Day to day coordination with local hospital system and monthly administrative coordination CMH psychiatrist, nurses and clinical leaders provide strategic physician outreach with local primary care providers to educate, provide consultation and address high utilizing patients. (limited d/t COVID-19) Formal coordination of care agreements with most all Rural Health Clinics in Ionia County Medication reviews, evaluation notes, and lab values are sent to primary care providers for care coordination ADTs used in the medical record for follow up post hospitalization Health grant focused on connecting persons served to a primary care provider when they are without one Dedicated nurse for follow up on labs needed as well as onsite labs available	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 TRD has extended service hours from 5-7pm at night and Saturdays from 8am - 12pm.	Quarterly pharmacy audits review of samples and AIM testing on psychotropic drugs used by providers Use of nationally recognized quality health measures such as diabetes screening and monitoring Quarterly Peer reviews by nursing staff and prescribers Medical Director provides ongoing consultation for county jail and local primary care physicians to ensure safety in the prescribing and monitoring of psychotropic medications. Nurse and Director of QI utilize ICDP (Zenith) to monitor Care Alerts for process improvement projects such as diabetes monitoring, cardiovascular screening, and access to care.
Tuscola Behavioral Health Services (TBHS)	TBHS continues to provide integrated health care services through a fully operational on-site wellness primary care clinic	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 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 and use results to drive improvements HEDIS results are reviewed each month and utilized as an ongoing gauge for consumer integration purposes. Controlled medication prescribing practices of all TBHS psychiatrists are reviewed annually to ensure practices are consistent with state, federal and APA guidelines. Utilize Zenith Data Analytics for medication and diagnosis reconciliation for consumers recently discharged from a psychiatric or acute care admission.