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

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Qualitative Narratives *(October 1, 2022 – September 30, 2023)*

Due to MDHHS by: 11/15/2023

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 FY23. 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 at the end of this report provides a summary of the efforts and achievements of each CMHSP during FY23 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 which was developed with input from the region's medical directors, councils and committees, and approved by the MSHN board of directors. 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 related to improving health outcomes and reducing health disparities
   - Recommendations for strategic planning, monitoring and oversight of integrated care and population health activities

   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 any individuals with a behavioral health or substance use disorder, regardless of insurance type or ability to pay. 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 participated in the State of Michigan Center for Medicare & Medicaid Services (CMS) CCBHC Demonstration Project during FY23- CEI CMHSP, Saginaw CMH, and The Right Door (Ionia County). Additionally, LifeWays CMH was approved to join the Demonstration Project

beginning in FY24. ***13,501 Medicaid beneficiaries and 1,656 non-Medicaid beneficiaries received CCBHC services in the MSHN region during FY23.***

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. 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 23 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 group.
- 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.
- Continued implementation of the Regional Equity Advisory Committee for Health (REACH) comprised of stakeholders and community partners from historically marginalized populations.
- Developed and hosted the Equity Upstream Virtual Lecture Series & Learning Collaborative to reduce racial & ethnic disparities in opioid overdose deaths with national experts to illuminate different perspectives on the landscape of SUD health disparities with an overview of epidemiological trends in the overdose epidemic, as well as what's known about why disparities exist (systemic racism, implicit bias, access issues, mistrust of the medical system, cultural issues specific to communities of color, etc.).

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 FY23, MSHN engaged in the following activities and initiatives related to coordinated systems of care:

- Behavioral Health Homes (BHH) provide an integrated approach to treatment where health home enrollees receive comprehensive care coordination to manage all of their behavioral health and physical health needs. MSHN launched the BHH initiative on 5/1/2023 with 5 health home partners: Saginaw CMH, CMH for Central MI, Montcalm Care Network, Newaygo Community Mental Health, and Shiawassee Health & Wellness. ***MSHN and its regional partners launched the BHH initiative on 5/1/2023 and served 336 individuals during the first 6 months of the initiative.***
- Opioid Health Homes (OHH) provide an integrated approach to substance use treatment where health home enrollees receive comprehensive care coordination to manage all of their substance use,

behavioral health, and physical health needs. ***MSHN launched the OHH initiative with Victory Clinical Services on 10/1/2022 and served 234 individuals during the first year of the initiative.***

- 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). ICDP users receive 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. ***As a result of these efforts, 89% of adults and 96% of children who received CMHSP services in the MSHN region during FY23 also had at least one visit with a primary care provider.*** Additionally, all 12 CMHSPs in the MSHN region send behavioral health Admission, Discharge, Transfer (ADT) messages to Michigan Health Information Network (MiHIN). MSHN is also participating in a pilot project with MiHIN and MDHHS for electronic consent management and SUD data-sharing to enhance care coordination for individuals receiving substance use treatment.
- Care Coordination with Medicaid Health Plans- During FY23, MSHN had integrated care plans for 50 individuals in partnership with 8 Medicaid Health Plans (Blue Cross Complete, Meridian Health Plan, Molina, United Health Care, Aetna, Priority Health, HAP Empowered, and McLaren). ***75% of individuals experienced a reduction in Emergency Department (ED) utilization as compared to the 12-month period prior to being opened for care coordination.***

4. Accessible Services

MSHN and its CMHSP and SUDSP networks are committed to 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.

Additionally, MSHN-funded peer recovery coaches trained in Project ASSERT are embedded in hospital emergency departments in 13 counties in the region. Project ASSERT is a model of early intervention, screening, and referral to SUD treatment for individuals in hospital and primary care settings. 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. ***728 individuals received screening and follow-up support from Project ASSERT coaches in response to a substance-related hospital ED visit during FY 2023.*** MSHN is currently engaged in a value-based purchasing (VBP) pilot project with Project ASSERT providers to increase the overall number of Project ASSERT screenings as well as the rate of individuals who receive a follow-up visit within 30 days of an ED visit for substance-related concerns.

5. Quality & Safety

Throughout FY23, MSHN continued to monitor and perform quality improvement activities for a portfolio of HEDIS quality measures related to access/availability of care, effectiveness of care, and chronic disease management. As a region, MSHN performed above State and/or National performance benchmarks on 8 of 11 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 is 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. 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 and 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.
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 (Birch Health Center-FQHC) 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. 447 referrals for services came from primary care physicians in the past year. Use of Peer Supports, Peer Recovery Coaches. Access to MAT is available. Implementation of Care Pathways, where behavioral health staff are collecting Blood Pressure reading and engaging in health education conversations with clients. Providing on-site housing support via Mental health workers and Peer Support Specialists, who are wellness coaches.	Through the CCBHC select staff are trained in Wellness Coaching to support individuals served. Currently developing a standard treatment plan training that can be implemented in every clinical program to ensure all clinicians are trained in person-centered planning and incorporate physical health goals as part of health care integration. 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. Over 300 local providers are enrolled into MC3. CMHA-CEI and Ingham Community Health Centers (ICHC) implemented Primary Care Behavioral Health model at all ICHC locations. CMHA-CEI also has a partnership with Care Free Medical and have a full time BHC that works with the medical staff and provides behavioral health services. CMHA-CEI has 8 Behavioral Health Consultants (BHC) embedded in Ingham County FQHC locations and provides clinical supervision to 12 behavioral health staff employed by the FQHC. This includes BHCs at 2 Lansing High Schools and 3 additional Lansing School District buildings. Participate in electronic health information exchange (HIE) with other local health systems to improve care coordination for shared patients. Continuity of Care Document is sent to primary care and other providers.	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. Provides flu and Covid vaccination clinics. Use of blended telehealth when requested and clinically appropriate. Use of same-day access for psychosocial intake assessments into Adult Mental Health Services and Youth SED. Meeting with Sparrow Emergency Department and medical units three times a week to improve process and communication with connecting to needed services. AFC and Housing Specialists on site with local homeless shelters. Chair of Coordinated Entry System Committee to access housing resources. Utilization of HIMS.	Implementation of Care Pathways for Hypertension, Asthma, and Hepatitis C, with review of data in the Healthcare Integration Workgroup. Development of an internal Data Group, which is utilized to review CCBHC quality measures and other CCBHC data requirements and then formulates suggestions for Quality Improvement that is brought to CCBHC Leadership. Healthcare Integration Workgroup meets monthly to review ongoing strategies for improving integration and coordination. Developing care pathways for suicide via zero suicide model.

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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 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. Clinical service delivery with Team Based Care model to increase collaborative care efforts.	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. All Case Managers have been trained as health coaches to have more awareness on health goals and incorporating them into the Person-Centered Plan.	Participate in Great Lakes Health Connect HIE. Labs ordered by non-CMH healthcare providers are directly fed into CMH health record. RNs review ADTs daily and provide each team with updates and input on necessary actions. Behavior Health Home offered in two counties which includes close monitoring of physical and mental health conditions and close coordination of care with community providers. Psychiatric staff all assigned to and participate in team-based care for close coordination with case holders.	Open, same-day access for services available. Provide multiple options for reducing barriers to obtaining medication such as pharmacy delivery service. On-site primary care services in partnership with FQHC. Expansion of telehealth services available in all six counties. Increase in medical assistant (MA) support to give RN ability to complete comprehensive RN assessment, education, and collaboration. Crisis/hospital diversion clinic for consumers not yet in health services through CMHCM.	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 "lunch & learn" educational opportunities to promote health and medical training and knowledge for all CMH staff. Psychiatric residents program offered to enhance training and promotion of development of psychiatric staff. RN present Integrated health dashboard with a focus on cardiovascular risk factors and population health data.
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 electronic health record for case holders to share with 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. Weekly care coordination hour for all staff to allow time for coordination for individuals with complex health needs, those on the Zero Suicide Care Pathway, etc.	Eight Dimensions of Wellness Peer Led group provided twice annually. On-site integrated substance use treatment services including Medication Assisted Treatment (MAT) and SMART Recovery Group. SMART Recovery Group is also offered on site at local Homeless Shelter.	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. Approximate 25% increase in consumer utilization during FY23. Access to Medication-Assisted Treatment (MAT) for consumers with SUD concerns through on-site psychiatric clinic.	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 the consumer. Expansion of "Healthy Steps" therapeutic group to support consumers with health	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.	Maintenance of expanded telehealth services to best support consumers in accessing medically necessary services. 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	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 to ensure safety in the prescribing and monitoring of psychotropic

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CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
	Collaboration with Thumb Community Health Partnership (TCHP). Emphasizes county-wide health initiatives to address comorbid physical and mental health conditions. Expansion of Nurse Practitioner and Physician Assistant internships slots in CMH Psychiatry Department.	and wellness goals.	Initiative with McLaren Thumb Region hospital to share telepsychiatry services for individuals in crisis. Dedicated Hospital Liaison to provided coordinated care for individuals experiencing a psychiatric crisis.	medications even in the absence of reliable transportation.	medications. HBH psychiatry clinic provides cardiovascular health and diabetes screening as part of ongoing performance improvement projects.
LifeWays Community Mental Health	Ongoing partnership with Center for Family Health (FQHC) to provide on-site primary care services. Medical/primary care services are fully embedded at CMH main site location. Expanding to offer SUD services in addition to behavioral and physical health in both counties served (Hillsdale and Jackson.) LifeWays has an SUD Prevention Specialist working with schools and providers in the Hillsdale community. The Hillsdale building now has a NARCAN vending machine and will soon have a fentanyl testing strip option. Exploring MAT service expansion. LifeWays is now a CCBHC Demonstration site in the State of Michigan. Ongoing partnership with Jackson and Hillsdale County jails with expanded services to provide pre- and post-release services with the goal of reducing recidivism to incarcerated settings as well as improve the health and wellbeing of participants.	Two full-time heath coaches provide patient education and health coaching in Jackson and Hillsdale counties. Community Health Workers (CHW) complete SDoH screenings at point of intake to ensure referral and connection to community resources. Wellness service area remodeled and includes exercise equipment and a teachable kitchen. Partnership with MSU Extension and qualified staff to provide nutritional programs including cooking demonstrations. Peer support specialists facilitate Whole Health Action Management (WHAM) and Wellness Recovery Action Plan (WRAP) groups which include individualized goal setting. Electronic health record includes a patient portal for communication between consumer and providers. Veteran-focused groups and coordination of care efforts by a Veteran Clinician and Veteran Peer Support Specialist.	LifeWays is a member of the Jackson Health Network and participates in MiHIN. Exploring options to increase active participation in the Jackson Health Network. Continuity of Care Document (CCD) electronic exchange with Henry Ford Health Systems which allows for better communication between providers. Six Community Health Workers hired to service Jackson and Hillsdale. This includes a variety of duties including care coordination with MH and healthcare providers. Partnership between Hillsdale County's Drug Treatment Court, Family Treatment Court, and (new) Domestic Violence Treatment Court to offer medically necessary services and enhance partnership between legal system and CCBHC.	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 in collaboration with Athelas. Program monitors patients using an FDA-cleared platform that generates WBC & Neutrophil counts from a finger prick of blood. Program uses pecialty pharmacy access to manage patient prescriptions and software to document the Clozapine REMS patient registry with test results. Embedded CHWs into Access department to improve connection of individuals to SDoH resources. Engagement team comprised of clinicians and peer supports actively seek out individuals who are struggling to engage with specific emphasis on those coming in for intake assessments and/or post-hospital appointments.	Upgraded EMR to capture non-psychiatric medication information such as amount, route, and duration. Integrated the National Outcome Measurement System (NOMS) into EMR. Quality Improvement team has developed and continues to develop risk stratification dashboards and reports for analysis of high needs cases for intervention. Working to implement a psychiatric medical chart enhancement to improve the user experience and improve completion of required activities.

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**
Montcalm Care Network (MCN)	Launched Health360 Behavioral Health Home targeting individuals with SMI and chronic health conditions. Nursing staff embedded in various services who act as liaisons to local primary care providers and manage care pathways for chronic health conditions. Established Integrated Health Stratification System to identify persons with chronic health conditions. Genoa on-site pharmacy at our Stanton location.	Use of Patient Activation System (PAM) and Coaching for Activation (CFA) 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. Yoga is also offered for children and adults. Embedded Social Determinants of Health screening in initial and annual intake processes.	MCN uses VIPR a health information exchange (HIE) and ADTs are embedded in the electronic health record. Conduct daily on-line huddles with Spectrum Health to collaborate on the overlap between mental health care and emergency care. Established care coordination communication mechanisms with local primary care physicians. Participation in Healthy Montcalm community wide needs assessment in partnership with local Health Department and hospital systems.	Provide telehealth services. Onsite pharmacy. Onsite COVID testing, COVID and flu vaccination. Onsite HIV and Hep Testing with treatment referral protocols. Onsite lab services. Medication Assisted Treatment provided.	Track HEDIS quality measures and have a published dashboard for stakeholders that highlights a variety of health outcome measures. Medication Reconciliation protocols. Quality improvement project targeting Social Determinants of Health. Utilize ADTs embedded in the EHR with response protocols.
Newaygo Community Mental Health (NCMH)	2 Behavioral Health Clinicians embedeed in primary physicians' offices through a contract with the local hospital. Provide direct treatment and referrals for primary health care patients. Use of Peer Supports, Peer Recovery Coaches. NCMH is a host site for medical residents, medical Interns, psychiatric Interns and RN students through Central Michigan University. NCMH nursing staff act as liaisons to local primary care providers, specialty doctors and help manage care pathways for chronic health conditions. Member of North Central MiThrive Committee and workgroups which focus on (countywide and beyond) health and wellness, accessibility of health care and mental health services. Health history/assessment embedded within standard clinical workflow/initial and annual intake assessments.	NCMH assists individuals with addressing SDOH needs such as resources and transportation. Integrated health and wellness goals are included in individual plans of service as identified by clients. NCMH provides health education to all persons served about the importance of primary and preventive care. Consumer Advisory Council is linked to The NCMH Board Committee. NCMH staff have written many articles on various mental health topics for a local community online news source/resource called Near North Now, which covers the greater Newaygo County area. NCMH case managers/Care Coordinators are available to attend doctor appointments with persons served for assistance with advocacy, support and to help increase health literacy.	Each inpatient pre-screen, psychiatric review, and/or medication review documentation is sent to the client's identified primary care provider, specialty provider and/or patient centered medical home. NCMH staff participate in on-site care coordination with local FQHC including information exchange and referrals. NCMH conducts regular meetings with local hospital staff (administrators, nursing supervisors, social work staff, etc.) to collaborate on the overlap between mental health care and emergency care. NCMH youth services team meets regularly with juvenile court judge and probation officers regarding joint clients/families served; The same process occurs with the local DHHS office and supervisors specific to CPS and foster care case coordination and services.	NCMH has continued to provide/offer telehealth services to clients as clinically appropriate along with face-to-face services following the COVID pandemic. NCMH has an agreement/contract with NCRESA/school districts within the county to provide therapist staff time/counseling services to students in the school setting who may not otherwise meet CMH criteria for services based on symptom severity and/or insurance coverage. Individual and group counseling services have been offered and provided. NCMH provides on-site integrated substance use treatment services including Medication Assisted Treatment (MAT). Ongoing community education and distribution of Narcan. NCMH offers outpatient counseling services in three locations within the county (White Cloud, Newaygo and Fremont offices) for easier access to clients who may live closer to one location over the other. NCMH offers extended service hours on Thursdays from 8 a.m.-7 p.m.	NCMH is implementing processes for monitoring Behavioral Health Home measures incorporating performance, quality and outcome data of those served. Utilize Integrated Care Delivery Platform (ICDP) to monitor Care Alerts in accordance with regional and local process improvement projects for priority measures such as Follow-up after hospitalization, Access to primary care, Plan all-cause readmission, Diabetes screening, Diabetes monitoring, Cardiovascular screening, and others. Active monitoring and oversight to ensure Individual plans of service address health and safety, including coordination with primary care providers. NCMH actively monitors the Michigan Mission Based Performance Indicator System (MMBPIS) and implements quality improvement efforts as needed for indicators that fall below the standard.

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 SCCMHA psychiatric services clinic, onsite physical health care. Over 1,000 consumers have identified GLBHC as their primary care provider. PIPBHC (Promotion of Integration of Primary and Behavioral Health Care) grant prioritized reductions in high morbidity/mortality rates for adult SMI population. PIPBHC focused on improving primary care participation and improving screening and obesity rates for children with SED. Grant ended 10/31/2023. Certified Community Behavioral Health Clinic (CCBHC) offering comprehensive services for behavioral health, substance use disorders, and primary health care. SCCMHA identified as a Behavioral Health Home in 4/2023. This service emphasizes consumer connectivity with a primary care provider with services focused on providing complex care management, care coordination, health promotion, transition of care, consumer and family inclusion in planning, and referral to community supports.	Health promotion is occurring primarily in the adult medication review clinics with focus on addressing tobacco use among adults and youth and improving lifestyle choices. In conjunction with Great Lakes Bay Health Centers (GLBHC), regularly scheduled dental services are provided on site with the GLBHC Dental Bus. SCCMHA has been named a study and implementation site for DECIPHeR (Disparities Elimination through Coordinated Interventions to Prevent and Control Heart Disease Risk). This multi-year longitudinal study, supported by the University of Michigan, focuses on adult SMI at risk for cardiac metabolic syndrome. The study includes the application of two evidence-based practices: Life Goals and IDEAL goals. Telehealth is available based on consumer preference for medication reviews.	Continued implementation of joint project with GLBHC to create a platform where SCCMHA and GLBHC will update shared plans of care for SCCMHA consumers who have GLBHC as their primary care provider. This platform will advance care coordination for consumers that are patients of GLBHC. SCCMHA works to coordinate referrals and follow up services for individuals who present in the Covenant Health System ED, delivered through an "urgent psychiatric clinic" model that provides evaluation and support on an as-needed basis with follow up for ongoing treatment. SCCMHA provides Behavioral Health Consultants, co-located in GLBHC's primary care setting for adults and another Consultant located at CMU's Pediatric Clinic. Internal SCCHMA programs use interdisciplinary team-based care model to improve the coordination of care and delivery of services. Implementation and planning for the Behavioral Health Home will emphasize the establishment of consumer-specific treatment teams that will support improved health outcomes captured in the IPOS.	SCCMHA Mobile Response and Stabilization Services serving both children and adults are available to Saginaw County from 8:00am – 10:00pm, five days a week and 24 hours on Friday and Saturday SCCMHA continues to offer telehealth services providing iPads that can be delivered to consumers for limited time use. SCCMHA also offers video conferencing platform and room for consumers who are in need for probate court hearings. SCCMHA hosts co-located Quest lab drawing services in addition to an onsite pharmacy, Genoa. Genoa offers on-demand influenza and COVID 19 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. HbA1c and lipids levels captured at intake & periodic biometric screening to identify need for further lab tests or health education referral. Consumer Wellness Committee meets bi-monthly with participation of consumers. The committee focuses on improving overall health by developing health education initiatives with a focus on EBPs that support consumer health.
Shiawassee Health & Wellness (SHW)	Shiawassee Health & Wellness (SHW) has a strong partnership with 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 was a SAMSHA grantee for the Promoting Integrated Primary and Behavioral Health Care (PIPBHC) grant. This grant was successfully carried out and ended 9/30/2023.	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 Health Outcomes Specialist provided nutritional education and physical activities through the PIPBHC grant at the agency drop-in center to interested and enrolled consumers, tracking health outcomes. This is continuing	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 lab is co-located at SHW a partial day each week. GLBHC is co-located at SHW 1 day per week, exploring potential for a second day each week. During COVID -19 response operations, GLBHC provided tele-health services to the vast majority of patients served. Majority of the services are now delivered in person. SHW Psychiatrists are fully staffed and continue to provide telehealth	SHW tracks HEDIS measures. Registered Nurses provide education on chronic health conditions to individuals served, as well as clinicians. RN's review health screenings through biopsychosocial assessments to capture individuals who may need further education or assistance with locating a primary care provider. Prescribers complete peer reviews and reviews together during their prescribers' meetings.

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**
	SHW Psychiatrists provide ongoing psychiatric consultation with GLBHC (patient-centered medical home). SHW has been certified as a BHH and launched The Wellness Connection Behavioral Health Home in FY23. Medical Assistant or nurse performs a brief assessment (including vitals) for all newly enrolled consumers and those coming in for medication reviews.	with the addition of a community health worker through the BHH program. SHW updated the initial biopsychosocial and annual assessment to include thorough medical history and imbedding nursing recommendations prior to the person centered plan.	Quest Labs. SHW and GLBHC are collaborating to share access to one another's HER's for ongoing integrated care needs and improved communication. SHW is exploring the use of the PCE External Referrals and Follow up module to support consistent coordination of care.	appointments, encouraging individuals to participate in telehealth sessions from office and occasionally from their home to alleviate barriers. SHW Child Psychiatrist provides after work, after school appointments on Thursday evenings up to 7pm.	Improved response rate for MHSIP and YSS significantly. These surveys are completed by the individual/family served and will be utilized by the Quality team to improve programs and services provided by SHW.
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. Dedicated nurse for follow up on labs needed as well as onsite labs available.	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.	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. Health grant focused on connecting persons served to a primary care provider when they are without one.	Use of nationally recognized quality health measures such as diabetes screening and monitoring. Quarterly Peer reviews by nursing staff and prescribers. Quarterly pharmacy audits review of samples and AIM testing on psychotropic drugs used by providers. 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 a full array of primary health care services through an onsite wellness clinic. Ongoing partnership with two different primary care physician offices, allowing primary care choice in providers in wellness clinic. Completion of annual healthcare assessments, health history questionnaires, health and other conditions assessment, and basic health screening measures.	All wellness clinic individuals are offered peer wellness coaching (PWC), by peer coaches who are certified in Wellness Recovery Action Planning (WRAP). Community Electronic Health Record (CEHR) portal access for all individuals served. Purchase and distribution of at-home COVID-19 test kits for individuals served. Offer myStrength, online wellness resource for	Utilization of ICDP data analytics for purposes of medication reconciliation, verification of access and engagement in primary and specialty care services, provider and diagnoses reconciliation. Participation in the Thumb Community Health Partnership with other human service organizations for maximization of resources. Coordination of Care correspondence disseminated to primary care providers	McLaren Family Practice offers onsite laboratory services on a weekly basis. Telehealth offered for both primary and psychiatric care services. Utilization of telehealth assessment equipment (tele otoscope and stethoscope). Ongoing community education and presentations related to mental health, Narcan distribution, Mental Health First Aid.	Consumer satisfaction surveys for wellness clinic and telepsychiatry services with results to drive QI process. Review of HEDIS results monthly for all key performance indicators. Review and monitoring of all controlled prescriptive practices annually to ensure consistency with state, federal, and APA guidelines.

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**
	Dedicated nursing staff as peer wellness coach for primary care services. CMH clinicians receive training related to predominant physical health diagnoses in order to best serve individuals.	all individuals served. Individualized health and wellness goals as part of the IPOS as directed by individuals served. Survey of individuals served regarding medication literacy with targeted education provided. Survey of individuals served regarding IPOS treatment outcomes and satisfaction.	annually, at minimum. Receive and send ADT alerts through the EHR. Review and use CC360 data related to immunization status for those served. Development of service coordination agreements to address and support issues related to mutually served individuals. Utilization of ICDP data analytics for medication and diagnosis reconciliation for those recently discharged from acute or psych admission(s).	Collaboration with local pharmacies for medication delivery services, including medication management and safety dose planners. On-site COVID-19 testing for individuals residing in specialized residential settings. Point of care testing for HbA1c, glucose, cholesterol, urinalysis, hCG, drug screening, and EKG. Genesight testing.	Monitoring of no-show and recovery appointment rates for psychiatric services and wellness clinic, use of data to drive QI process. Review of report for high utilization of ED services and those served who were sent to ED for purposes of physical injury and/or medication error. Quarterly infection control and medication management committee meetings for review of infection rates and mediation errors of those served. Integration with qualified health plans regarding high utilizers of services, coordination and integration of services.