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, 2024 – September 30, 2025)*

Due to MDHHS by: 11/15/2025

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 FY25. 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 FY25 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 maintains a comprehensive 2024-2025 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. Four CMHSPs in the MSHN region participated in the State of Michigan Center for Medicare & Medicaid Services (CMS) CCBHC Demonstration Project during FY25- Community Mental Health Authority of Clinton, Eaton, Ingham Counties (CMHA of CEI), Saginaw County Community Mental Health Authority,

and Ionia County Community Mental Health DBA The Right Door for Hope, Recovery and Wellness, and Jackson-Hillsdale Community Mental Health Board DBA LifeWays. ***There were 20,940 Medicaid beneficiaries and 4,374 non-Medicaid beneficiaries enrolled in CCBHC services by the end of FY25 (as of 9/30/2025).***

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. Together with its CMHSP and SUDSP networks, MSHN is committed to the goals of reducing health disparities for marginalized and vulnerable populations and continuous improvement in health equity. During FY25 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.
- Conducted 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 analytics capability into all existing population health reports in order to monitor outcomes relative to race/ethnicity.
- Shared 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 operation of the Regional Equity Advisory Committee for Health (REACH) comprised of stakeholders and community partners from historically marginalized populations.

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 FY25, 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 had five (5) BHH partners during FY25, including: Saginaw County Community Mental Health Authority, Montcalm Care Network, Shiawassee Health & Wellness, Community Mental Health for Central Michigan, and Gratiot Integrated Health Network. ***There were 344 beneficiaries enrolled in BHH by the end of FY25 (as of 9/30/2025).***
- Substance Use Disorder Health Homes (Previously titled Opioid Health Homes) provide an integrated approach to substance use treatment where health home enrollees receive comprehensive care coordination to manage their substance use, behavioral health, and physical health needs. In FY25, MSHN had ten (10) SUDHH partners, ***including the addition of four (4) new sites***: Victory Clinical Services - Saginaw, Victory Clinical Services - Jackson , Victory Clinical Services - Lansing , Recovery Pathways – Bay City, MidMichigan Community Health Services, Isabella Citizens for Health, Recovery Pathways – Corunna (new in FY25), Sacred Heart – Saginaw (new in FY25), Sacred Heart – Bay City (new

in FY25), and LifeWays (new in FY25). ***There were 526 beneficiaries enrolled in SUDHH by the end of FY25 (as of 9/30/2025).***

- 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 to target interventions for a variety of health needs such as overdue lab work, or lack of a primary care visit in more than 12 months. 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- As of 9/30/2025, MSHN had opened integrated care plans for 125 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).
    - **65% 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. During FY25 MSHN was 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. ***As a result, 968 individuals received screening and follow-up support from Project ASSERT coaches in response to a substance-related hospital ED visit during FY25, an increase of 54% over FY24.***

5. Quality & Safety

Throughout FY25, 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 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 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)	Nursing staff embedded in various services who act as liaisons to local primary care providers and manage care pathways for chronic health conditions. Ongoing partnership with the Bay and Arenac County jails and the Bay County Juvenile Detention Center 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. Dedicated Hospital Liaison to provide coordinated care for individuals transferring into community care post inpatient admission after experiencing a psychiatric crisis. Dedicated Residential Liaison to provide coordination of care and services for individuals in needs of specialty supports and service placement (specialized AFC). Dedicated Alternative Treatment Order (ATO) Coordinator to assist individuals who are on a court order for treatment with linking to treatment and community supports and resources.	Provide wellness classes run by nursing staff. Integrated health and wellness goals are included in individual plans of service as identified by the consumer. Use of strategies to ensure diabetes and cardiovascular screenings and monitoring are occurring (i.e., the HEDIS measures). Electronic health record includes a patient portal for communication between consumer and providers. Redeployed a Clinic RN to Advanced Health Services program to focus on reducing morbidity and mortality of individuals with mental illness and chronic health conditions. 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.	Interface with multiple laboratories for the ordering and receipt of tests. Integrated Admission Discharge Transfer (ADT) alerts in electronic health record. Use of Care Connect 360 (CC360) to obtain service and provider history for new individuals and individuals with significant health issues. Direct interface between CC360 and BABHA electronic health record (EHR). Engaged with MiHIN MiGateway health information exchange (HIE) so we can access health care records provided by local health systems for coordination of care. Used routinely by clinic nursing staff and community-based nurses. Utilization of Integrated Care Data Platform (ICDP) data analytics for purposes of medication reconciliation, verification of access and engagement in primary and specialty care services, provider and diagnoses reconciliation. Emergency and Access Services (EAS) staff co-located in the emergency department (ED) of McLaren Bay Region hospital. Monthly meetings with hospital ED staff to improve process and communication. Established procedures for initial and ongoing coordination of care with primary care physicians and specialty providers.	On-site laboratory testing in partnership with Quest Diagnostics. Telehealth services are available for Psychiatric and Therapy services. Partnership with local pharmacy for medication delivery services. Use of same-day access for "walk-in" (not scheduled) psychosocial intake assessments with priority on hospital discharges, via telehealth if necessary. General Fund (GF) Formulary and Pharmacy Benefit services through an agreement with a local pharmacy to provide short-term medication services without insurance. Mobile Response Team (MRT) sees all ages of individuals in crisis in the home or community and will refer for services if the person meets CMH level criteria. MRT works with Bay Arenac Intermediate School District (ISD) and local law enforcement to assist those in need of crisis intervention. Availability of free Narcan/Naloxone and test strips at the BABH Arenac Center and Bay Madison Clinic waiting room. Narcan and test strips are also available to all BABHA clinical program staff for distribution.	BABHA uses a dashboard to track data related to various performance measures and utilization, including, but not limited to HEDIS measures. BABHA has focused measures related to Diabetes Screening, Diabetes Monitoring, and Cardiovascular Monitoring HEDIS measures in our QAPIP Plan. Medication reconciliation occurs at every appointment for individuals receiving health services. Upgraded EHR to capture non-psychiatric medication information such as amount, route, and duration. BABHA reviews a sample of consumer records quarterly to determine that coordination occurred with the primary healthcare physician. Added Clozapine Monitoring module to EHR and designated a nurse to monitor Clozapine labs after the end of the Federal Drug Administration Risk Evaluation and Mitigation Strategies (REMS) program.
Community Mental Health Authority for Clinton, Eaton,	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. Health Screening questionnaire is completed on an annual basis. Nurse Care Managers enhance coordination with primary care and other community providers. Use of Peer Supports, Peer Recovery Coaches, youth peer supports, and parent support partners. Access to Medication Assisted Treatment (MAT) is available. Implementation of Care Pathways, where behavioral health staff are collecting Blood	Select CCBHC staff are trained in Wellness Coaching to support individuals served. Piloted a Financial Wellness group; assessing expansion of these services throughout the agency. Developed a standard treatment plan training for Managers to equip them to have conversations with clinicians about person-centered planning and how to incorporate the discussion of physical health goals as part of health care integration. A consumer newsletter "Voices" is sent out quarterly with agency updates and wellness resources. Consumer Advisory Council linked to Board Committee.	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 Carefree Medical, recently awarded FQHC look-alike status, and has a behavioral health consultant that works with the medical staff and provides behavioral health services. CMHA-CEI has 4 Behavioral Health Consultants (BHC) embedded in Ingham County FQHC locations and provides clinical supervision to 13 behavioral health staff employed by the FQHC. This includes BHCs at 2 Lansing High School Health Clinics and 3 additional Lansing School District buildings.	On-site laboratory testing in partnership with U-M 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. Meeting with Sparrow Emergency Department 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. Partnerships with 7 supportive housing projects.	Implementation of Care Pathways for Hypertension, Asthma, and Hepatitis C, with review of data in the Healthcare Integration Workgroup. Internal Data Group meets monthly, 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 goals and strategies for improving integration and coordination. Training for all staff on healthcare integration initiatives on an annual basis. Developing care pathways for suicide via zero suicide model. Developed and began implementing agency training plan,

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**
Ingham (CMHA-CEI)	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. Implementation of a Social Determinant of Health Screening Tool. Participating in workgroup that is developing a Recuperative Care Shelter in Ingham County.	Charter House Club House offers many opportunities for consumer centered planning and activities.	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. Developing methods to enhance outreach to primary care providers and improve efficacy of Continuity of Care Document process.	Behavioral health staff embedded at the local 911 Call Center. Use of walk-in screening for clients requesting services and same-day access for psychosocial intake assessments. CEI standard is to receive screening within 30 minutes. CEI's current average wait is less than 6 minutes.	communications plan, and other protocols for Zero Suicide Implementation.
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 metabolic parameters, 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. Availability of peer-support specialists to support consumers in meeting their integrated health goals. Case Managers have been trained as health coaches to have more awareness on health goals and incorporating them into the Person-Centered Plan. Integrated health and wellness goals are included in individual plans of service as identified by the consumer. All RN's have completed care manager training. All RN's and MA's have been trained in population health.	Participate in Michigan Health Information Network (MIHN) MiGateway 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 five 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. Charge Nurse/Health Services team attend Care Coordination meetings with local Primary Health Care Providers. Clinical leadership provides Care Coordination with Medicaid Health Plans in consultation with MSHN.	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. Attend morning meeting twice a week with local Inpatient Psychiatric unit to coordinate services between mutual consumers.	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 development of psychiatric staff. Integrated health dashboard with a focus on cardiovascular risk factors and population health data. Recognized through Joint Commission accreditation for meeting rigorous standards of quality and patient safety. Internal Behavioral Health Home (BHH) workgroup to review BHH quality measures, data requirements, and workflows.
Gratiot Integrated Health Network (GIHN)	Member of Live Well Gratiot, a county-wide health and wellness committee. Health assessment and Social Drivers of Health screening are embedded within standard clinical workflow. Host site for Medical Residents, Medical Interns, and Psychiatric Interns and RN students. Referral module added to EHR to allows for monitoring of referrals and to provide	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. DECIPHER and IDEAL goals group and individual interventions offered to adults with chronic health conditions and SMI.	Integrated ADT feeds and process for follow-up by case holders. 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. Using MiHIN for a lab interface with our EHR, so care team can track on all labs ordered and	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. School therapists are able to complete access screen and intake assessments at school to decrease barriers for	Registered Nurses provide health education to CMH staff for chronic conditions such as Hypertension, Diabetes, Cardiovascular disease, respiratory disease/COPD/Asthma, and COVID-19. Integrated health dashboard identifies individuals served with cardiovascular risk factors and other risk factors such as inpatient and ED utilization.

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**
	additional support when individuals served do not follow through on referrals.	Behavioral Health Home offered to adults with SMI and youth with SED.	received.	youth/families to enter CMH system.	
Huron Behavioral Health (HBH)	On-site primary care in partnership with local FQHC, Great Lakes Bay Health Center. Access to Medication-Assisted Treatment (MAT) for consumers with SUD concerns through on-site psychiatric clinic. 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 in CMH Psychiatry Department. Provide Master Level internship placements and on-site job shadowing in partnership with local colleges and universities to increase interest in the MH field. Partnership with community church to address food insecurity, act as a pick-up point for food boxes, voucher program to assist with laundry facilities for individuals, voucher system in place with public transportation provider to reduce barriers to treatment.	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. Availability of peer-support specialists to support consumers in meeting their integrated health goals. Expansion of "Healthy Steps" therapeutic group to support consumers with health and wellness goals. Access to the consumer-run, Flashpoint Drop-In Center which includes access to free exercise equipment and health-focused group education. Maintenance of expanded telehealth services to best support consumers in accessing medically necessary services.	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. Dedicated Hospital Liaison to provided coordinated care for individuals experiencing a psychiatric crisis. Ongoing partnership with the Thumb Opioid Response Consortium (TORC) and the Thumb Community Health Partnership (TCHP) to offer continued prevention, outreach, and training to providers and consumers alike. Jointly coordinated day long training event to bring awareness to SUD recovery.	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. Availability of free Narcan/Naloxone in Huron Behavioral Health waiting room. In progress of purchasing vending machines to provide Narcan/Naloxone in the community. Enhanced jail liaison services providing consultation, crisis service and coordination for medication management as well as to ensure access to immediate treatment and psychiatric care following release from incarceration. Designated HBH Staff provide assistance with Medicaid enrollments for those in the community with a need, regardless of status of enrollment in HBH services.	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 medications. HBH psychiatry clinic provides cardiovascular health and diabetes screening as part of ongoing performance improvement projects. Offering of RN-provided trainings on health-related topics (e.g., cardiovascular risk, metabolic impact of anti-psychotics, COPD risk and smoking cessation strategies, CPR instruction, blood borne etc.pathogens, etc.). All Clinical staff receive SUD trainings throughout the year.
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. Expanded to offer SUD services in addition to behavioral and physical health in both counties served (Hillsdale and Jackson.) LifeWays is seeking to hire a Prevention Specialist to provide prevention services in Hillsdale County. LifeWays offers MAT services in both Hillsdale and Jackson. LifeWays is 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	Two full-time health coaches provide patient education and health coaching in Jackson and Hillsdale counties. Access Clinicians complete SDoH screenings at point of intake with follow up as needed based on results. Wellness service area continues to provide exercise, nutrition, and other classes to promote consumer whole health. Peer support specialists facilitate Whole Health Action Management (WHAM) and Wellness Recovery Action Plan (WRAP) groups which include individualized goal setting. LifeWays also has a peer recovery coach working with most consumers who are being served for SUD related needs. SUD Peer Recovery Coach provides education at community events, also.	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. LifeWays has mobilized its nursing staff to increase and enhance care coordination between treatment providers in other systems. 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. LifeWays has also partnered with Jackson County's Mental Health Court which is in its initial ramp up phase. Anticipating full	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 specialty 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.	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. Establishing improved attendance and engagement expectations for consumers to ensure effective delivery of clinical services that promote recovery with specific focus on engagement in psychiatric services. This continues to be an area of focus and opportunity for improvement. Medical Director participating in several internal committees including BTC, CERT, ICSS team meetings, case consultation, diversion committee, and others to promote best practices. Ongoing monitoring processes for performance

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**
	incarcerated settings as well as improve the health and wellbeing of participants. LifeWays provides services in the Jackson County Youth Home two days per week through partnership with the local ISD. LifeWays is participating in the MSHN Recovery Incentives pilot.	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.	expansion by early calendar year 2026. 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.	LifeWays staff are being trained in several EBPs including TF-CBT, DBT-A, and DBT for adults. LifeWays has expanded its child community-based therapy team and is also establishing an ACT team internal to the organization.	indicators such as diabetes screening, monitoring, etc. to improve consumer health and safety.
Montcalm Care Network (MCN)	Successfully implemented Health360 Behavioral Health Home (BHH) to persons with SMI and Children with SED. Nursing, Peer and Medical Assistant staff are embedded in various programs, providing the six core services defined by the BHH Guidelines. Comprehensive coordination with local primary care providers, individuals, families, transitional and community supports are implemented with each consumer and team regularly. Established Care Navigation System to identify individuals with chronic health conditions. Genoa on-site pharmacy is co-located at our Stanton location, providing ongoing and comprehensive transitional care related to medication management, medication adherence and health promotion. Initial and ongoing Integrated Health Training are provided to each clinician and clinical teams.	Implemented DeCIPHeR research project to enhance interventions toward self-management of health conditions. Trained RN, Peer and Medical Assistants staff to assist the RNs in the delivery of IDEAL Goals. Peers and Medical Assistants are trained in core and custom modules, that are based on the consumers individual risk factors and preferences. Weekly groups began July 2025 and have successfully continued. MCN operates a community-based gym where InShape programming occurs and offers nutrition classes. Yoga is also offered for children and adults. Adoption of the Accountable Health Communities, Health Related Social Needs screener has been embedded in our intake and annual health screening processes.	MCN uses the Longitudinal Record provided by the Michigan Health Information Network Shared Services. This allows for real time data to be reviewed by our Nursing, Peer and Medical Assistant staff to provide Comprehensive Care Coordination. . Conduct daily virtual huddles with Corewell Health System United Campus to collaborate on whole-health between mental health care and emergency care. Continued 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. Implemented a Nurse Navigator model to improve care coordination.	MCN continues to offer telehealth services or in person services, per consumer preference with Psychiatric medication reviews. Onsite pharmacy and onsite lab services. Promotion of COVID and flu vaccination annually as well as encouragement around other vaccines for vaccine preventable disease. Medication Assisted Treatment provided in conjuction with IDDT Program. Initiated a Nurse Practitioner preceptor program to address workforce needs. Promote MC3 psychiatric consultation services through U of M to assist local primary care providers in gaining additional supports.	Track HEDIS quality measures and have a published dashboard for stakeholders that highlights a variety of health outcome measures. Medication Reconciliation protocols. Completed Quality improvement project targeting Social Determinants of Health, continued monitoring for efficiency and effectiveness Utilize ADTs embedded in the EHR with response protocols. H360 staff continue to work with consumers and Pharmacy staff regarding medication adherence.
Newaygo Community Mental Health (NCMH)	Use of Peer Supports, Peer Recovery Coaches. Nursing students from Muskegon Community College complete a mental health rotation at NCMH. Genoa Pharmacy embedded a Client Medication Coordinator in our building. 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.	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. Availability of Peer-support specialists to support clients in meeting their integrated health goals. 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	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	NCMH has continued to provide/offer telehealth services to clients as clinically appropriate along with face-to-face services. NCMH provides on-site integrated substance use treatment services including Medications for Opioid Use Disorder (MOUD). 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. NCMH has expanded ABA programming sites and now has two office-based	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. 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**
	Health history/assessment embedded within standard clinical workflow/initial and annual intake assessments. Ongoing community partnership with the Newaygo County Sheriff's Department and County jail with expanded services to provide crisis intervention and counseling services for inmates as well as assistance with coordination of services upon release with the goal of reducing recidivism to incarcerated settings as well as improve the health and wellbeing of participants.	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. Electronic health record patient portal available to all individuals served. Telehealth is available based on persons served preference for medication reviews and when clinically appropriate.	office and supervisors specific to CPS and foster care case coordination and services. NCMH Leadership Team meets regularly with Probate Court Judge regarding joint clients/families served and more specifically involved in the AOT and guardianship evaluation processes. Review process efficiencies and areas that need improvement or procedural change to better serve the client and meet requirements of the law. Partnership between NCMH, Newaygo County Court and other community partners to establish the first Drug Treatment Court in Newaygo County slated to begin Fall 2025.	locations within the county as well as continues to offer in-home ABA programming to clients/families as well. NCMH has a social worker embedded with the Newaygo County Sherriff's Office for early intervention and referral/linking to appropriate community services. Genoa Pharmacy embedded a Client Medication Coordinator in NCMH building who works jointly with nurses, medical assistants and case managers on medication related issues for clients served. Genoa also offers medication delivery to homes of NCMH clients.	Prescribers complete peer reviews and provide feedback to one another. Client, family and community partner feedback is collected ongoing through satisfaction surveys (Experience of care, residential, family/guardian, referral source & NCI) to ensure there is an assessment of the quality of services delivered.
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 persons served have identified GLBHC as their primary care provider. 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 person served connectivity with a primary care provider with services focused on providing complex care management, care coordination, health promotion, transition of care, person served 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 implemented DECIPHeR (Disparities Elimination through Coordinated Interventions to Prevent and Control Heart Disease Risk) education sessions. 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 persons served preference for medication reviews and when clinically appropriate. Health promotion is occurring primarily in the medication clinic with a focus on addressing tobacco use and hemoglobin A1c among adults and youth and improving lifestyle choices. Continued use of, and training of clinical staff in Teach Back to promote improved engagement and health literacy among persons served.	SCCMHA coordinates referrals and follow up services for individuals who present in the Covenant Health System ED and My Michigan – St. Mary's, delivered through an "urgent psychiatric clinic" model that provides evaluation, support, and follow up for ongoing treatment on an as-needed basis. SCCMHA provides a Behavioral Health Consultant, co-located in GLBHC's primary care setting for adults. Internal SCCMHA programs use interdisciplinary team-based care model to improve the coordination of care and delivery of services. Behavioral Health Home serves as a hub for comprehensive care management, ensuring patients receive coordinated and patient-centered services across healthcare systems. SCCMHA Clinical leadership continues to meet quarterly with the clinical leadership of Health Source our local hospital for psychiatric and SUD admissions along with clinical leadership of the Emergency Care Center at Covenant Hospital to coordinate issues such as medical clearance, hospital admissions, utilization management and discharge planning. SCCMHA Clinical staff meets regularly with the Saginaw Family Court and their Detention Center staff on a variety of topics including the heath care needs of jointly served youth.	SCCMHA Mobile Response and Stabilization Services serving both children and adults are available to Saginaw County 24 hours a day seven days a week. SCCMHA continues to offer telehealth services providing iPads that can be delivered to persons served for limited time use. SCCMHA also offers video conferencing platform and room for persons served who are in need for probate court hearings. SCCMHA hosts comprehensive SUD services (ASAM Level 1, WM-1) on site, at the Hancock building, and in the provider network. Genoa Pharmacy is located inside the SCCMHA Hancock building, the site of our Psychiatric Clinic, and works jointly with prescribers and nurses on medication related issues. Genoa also provides Saginaw group homes pharmacy services including special compounding and packaging. Genoa also operates a program called Med Drop that delivers medications to the homes of persons served, coaches medication adherence and reconciles medications from both behavioral and physical health care prescribers. This pharmacy also provides easy access for COVID boosters as well as seasonal Flu vaccines to persons served and staff alike.	Key agency quality performance metrics reviewed bi-monthly by committee of medical and clinical leaders with focus on improving health outcomes & access to care. Persons served Wellness Committee meets bi-monthly with participation of persons served. The committee focuses on improving overall health by developing health education initiatives with a focus on EBPs that support persons served health.

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 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. SHW is increasing marketing and advertising with the Great Lakes Bay Health Center Clinic that is located within SHW. Shiawassee Health and Wellness was certified as a Behavioral Health Home beginning 10/1/23. SHW Psychiatrists provide 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. RN's provide medical/health recommendations in the initial and annual biopsychosocial assessments prior to goal setting.	SHW Peer Support Specialists are 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 cessation. SHW Behavioral Health Specialist for the BHH provided nutritional education and physical activities at the agency drop-in center as well as the Wellness Connection to interested and enrolled consumers. This has continued with the addition of a community health worker and certified peer support specialist in the BHH Wellness Connection. The BHH and Drop in Center work closely together to increase community involvement and health activities. SHW updated the initial biopsychosocial and annual assessment to include thorough medical history and imbedding nursing recommendations prior to the person-centered planning meeting for the IPOS. Care plans are created for individuals enrolled in BHH that are patient centered on health and wellness goals.	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. The BHH has increased coordination of care with local primary care offices, pharmacy, psychiatry and hospital through the 6 core BHH services. Transfer/upload capabilities for all laboratory and test results is currently in place with Quest Labs. SHW and GLBHC are collaborating to share access to one another's EHR'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.	Quest lab is co-located at SHW a partial day each week. GLBHC is co-located at SHW 1 day per week. Most of the medical services are now delivered in person by GLBHC and SHW. SHW Psychiatrists are fully staffed and continue to provide telehealth 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. Transportation barriers are assessed and resolved through collaboration with primary service provider and BHH, if enrolled.	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. 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. Quarterly 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.	Community Health Worker 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 systems and quarterly administrative coordination with various local health systems CMH psychiatrist, nurses and clinical leaders provide strategic physician outreach with local primary care providers to educate, provide consultation and address high utilizing patients. 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. Care Coordination letters sent to primary care providers at the initiation of services, and then annually.	TRD has capacity to do some lab tests on-site, including lab work related to Clozaril (WBC and ANC), A1c and lipids. TRD also has capacity to do a drug screen at provider discretion. TRD implemented Spravato clinic to assist with treatment resistant depression. TRD provides telehealth services in addition to face-to-face services. TRD has extended service hours from 5-7pm at night with a nurse on site for health screens and a NP available in the evenings. 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. Annual 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. .

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			ADTs used in the medical record for follow up post hospitalization.		
Tuscola Behavioral Health Services (TBHS)	TBHS continues to provide a full array of primary health care services through an onsite wellness clinic. Ongoing partnership local primary care physician for primary care health services through the Wellness Clinic. Completion of annual healthcare assessments, health history questionnaires, health and other conditions assessment, and basic health screening measures. Dedicated certified peer support specialist 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 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. 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. Medication education groups, and other person-centered recovery, offered at local drop-in center. The TBHS Navigator continues to assist individuals with applications for: Medicaid, Medicaid appeals, Medicaid renewals, MI Bridges, Marketplace, State Emergency Relief (SER), and SNAP. Outreach efforts continue attendance at Medicare Made Easy Event this past quarter with ongoing outreach to physician and pharmacy offices for targeted educational purposes. The TBHS CFO, Navigator and Health Operations Supervisor review the list of individuals effected by the loss of Medicaid coverage on a monthly basis. Ongoing outreach, appropriate interventions, and re-application occurs with individuals whom demographic data is available and remains an ongoing priority.	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, including inpatient hospitalization. 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 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. Monthly review of No PCP report in EHR with ongoing engagement with individuals to support choosing a PCP. Initiated and completed implementation of MI-SMART Psychiatric Clearance Form at McLaren Caro Emergency Department.	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. 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 and Tempus genetic testing available. Peer Wellness Coach participation on Community and Residents Empowered Connect Task Force led to first SDOH hub for Tuscola County.	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. 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. Prescriber peer review process through non-bias external provider.