MSHN
Mid-State Health Network

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, 2021 – September 30, 2022)*

Due to MDHHS by: 11/15/2022

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 FY22. 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 FY22 related to the five Patient-Centered Medical Homes Characteristics.

1. Comprehensive Care

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

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

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

8,059 Medicaid beneficiaries and 347 non-Medicaid beneficiaries received CCBHC services in the MSHN region during FY22.

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 22 MSHN endeavored in a number of tasks toward understanding and reducing health disparities for persons served:

- Analyzed regional service penetration rate data by county and race/ethnicity to identify areas of the PIHP region where increased outreach and engagement efforts might be needed for minority groups
- Began to conduct focus groups and learn from people of color and other at-risk groups about their experiences with access to care and the healthcare system
- Built additional data analysis capability into all existing population health reports in order to monitor outcomes relative to race/ethnicity
- Began sharing health disparity data with CMH and SUD providers specific to their organizations in order to better inform patient-centered care for the individuals they serve
- Formed a Regional Equity Advisory Committee for Health (REACH) in January 2022 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 FY22, MSHN engaged in the following activities and initiatives related to coordinated systems of care:

- 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 with plans to expand to additional health home partners and counties served in FY23-24.
- 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, 86% of adults and 95% of children who received CMHSP services in the MSHN region during FY22 also had at least one visit with a primary care provider.*** Additionally, all 12 CMHSPs in the MSHN region are sending Admission, Discharge, Transfer (ADT) messages to Michigan Health Information Network (MiHIN) as of June 2022. 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 FY22, MSHN had integrated care plans for 79 individuals in partnership with 7 Medicaid Health Plans (Blue Cross Complete, Meridian Health Plan, Molina, United Health Care, Aetna, Priority Health, and McLaren). The shared member population between MSHN and HAP Empowered is very small (around 500 members) and there were no beneficiaries who met the risk criteria for care coordination during FY22. The outcomes for individuals involved in PIHP/MHP care coordination during FY22 were as follows:
  - **93% of care plans were closed successfully** with some goals or all goals met (excluding cases closed due to incarceration, loss of Medicaid eligibility, or due to moving outside of the PIHP region)
  - **78% 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. ***789 individuals received screening and follow-up support from Project ASSERT coaches in response to a substance-related hospital ED visit during FY 2022.***

5. Quality & Safety

Throughout FY22, MSHN continued to monitor and perform quality improvement activities for a portfolio of 10 HEDIS quality measures related to access/availability of care, effectiveness of care, and chronic disease management. As a region, MSHN performed above State and/or National performance benchmarks on 11 of 13 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. Use of Peer Supports, Peer Recovery Coaches. Access to MAT is available	Through the CCBHC select staff are trained in Wellness Coaching to support individuals served. WHAM and Writers Group offered by Peer Support Specialists. A consumer newsletter is sent out monthly with agency updates and wellness resources . Consumer Advisory Council linked to Board Committee. Charter House Club House offers many opportunities for consumer centered planning and activities.	CMHA-CEI with Michigan Child Collaborative Care (MC3) offers pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. 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 has 8 Behavioral Health Consultants embedded in Ingham County Federally Qualified Health Center (FQHC) locations and provides clinical supervision to 11 behavioral health staff employed by the FQHC. SUD BHC were added to address patient's substance use concerns. Medication Assisted Treatment (MAT) available for patients of ICHC and other safety net providers. Behavioral health supports in three Lansing School District buildings CMHA-CEI, Ingham County Health Center (ICHC), and Ingham County Health Department (ICHD) established electronic exchange of patient care data for shared consumers to improve care coordination. 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 clincs. Use of blended telehealth when requested and clinically appropriate. Use of same-day access for intakes into Adult Mental Health Services and Youth SED. On-site integrated substance use treatment services including contracted Medication Assisted Treatment (MAT)	Each clinical program at CMHA-CEI has selected a healthcare integration project to improve health outcomes for the population served by the program. Examples include: Providing health education and support to families of children with a diagnosis of asthma; Providing health education and support for adults with a diagnosis of hypertension CCBHC Expansion Grant has established national outcome measures (NOMS) with baseline and 6-month measurements. Process mapping and improvements to insurance verification practices. Development of Care Pathways for Hypertension, Diabetes, Asthma, and Hepatitis C

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**
			Nurse Care Managers assist with care coordination Receiving Hospital ADT Alerts into the Electronic Health Record and now sending Behavioral Health(BH) ADTs to MIHIN. Currently testing with MiHIN the ability to receive BH ADTS into the EHR. Access to the HIE record (VIPR) within the EHR.		
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 direct fed into CMH health record RNs review ADTs daily and provides each team with updates and input on necessary actions	Open access for services Provide multiple options for reducing barriers to obtaining medication such as pharmacy delivery service On-site primary care services in partnership with FQHC Expansion of telehealth services in response to COVID-19 pandemic 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 monthly "lunch & learn" educational opportunities to promote health and medical training and knowledge for all CMH 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 patient portal to individuals served	Integrated ADT feeds and process for follow-up by case holders CMH Nurse Practitioner provides physical healthcare services to consumers and general public in St. Louis satellite office Crisis therapist is co-located in emergency department of Mid-Michigan Medical Center	CMH Therapist located in St. Louis primary care clinic provides therapy to mild-to-moderate population On-site integrated substance use treatment servies including Medication Assisted Treatment (MAT)	Registered Nurses provide health education to CMH staff for chronic conditions such as Hypertension, Diabetes, Cardiovascular disease, Respiratory disease/COPD/Asthma, and COVID-19

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**
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. Procurement of ongoing grants to support evidence-based outreach approaches.	Patient portal allows individuals served to access their health data. Agency has coordinated annual initiatives to encourage consumer use of portal Integrated health and wellness goals are included in individual plans of service as identified by consumer Expansion of "Healthy Steps" therapeutic group to support consumers with health and wellness goals.	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.	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 medications even in the absence of reliable transportation	Integrated Health and Wellness Committee that meets at a minimum quarterly to explore ongoing strategies for improving integration and coordination within Huron County HBH Medical Director provides ongoing consultation for both the county jail physician and other local primary care physicians in order to ensure safety in the prescribing and monitoring of psychotropic medications HBH psychiatry clinic provides cardiovascular health and diabetes screening as part of ongoing performance improvement projects
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 substance use disorder services in additional to behavioral health and physical health in both counties served (Hillsdale and Jackson) Progress on strategic plan to become a CCBHC Finalizing nursing assessment to include more whole person care issues	Two full-time heath coaches to work with individuals who are interested in learning more about wellness. This covers Jackson and Hillsdale counties. Wellness services area is now completed with exercise equipment and a teachable kitchen. Partnership with MSU Extensions and qualified staff to provide these nutritional programs which include 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	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 Six Community Health Workers hired to service Jackson and Hillsdale. This includes a variety of duties including care coordination with MH and healthcare providers.	Two full time Consumer Medication Coordinators on-site (one in Jackson and one in Hillsdale) to assist with medication delivery, prescription questions, coordination between the client, psychiatrist, and pharmacy, and prior authorizations Partnership with the Refractory Schizophrenia Assistance Program devised by HLS Therapeutics (USA), Inc in collaboration with Athelas. Program monitors patients using the Athelas One, an FDA-cleared platform that generates WBC & Neutrophil counts from a finger prick of blood. The Program additionally provides specialty pharmacy access to manage patient prescriptions and software to facilitate the documentation of the Clozapine REMS patient registry with test results	Upgraded EMR to capture non-psychiatric medication information such as amount, route, duration Integrated the National Outcome Measurement System (NOMS) into EMR Quality Improvement team is developing risk stratification dashboards and reports for analysis of high needs cases for intervention

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CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Montcalm Care Network (MCN)	Nursing staff embedded in various services who act as liaisons to local primary care providers and manage care pathways for chronic health conditions Established Integrated Health Stratification System to identify persons with chronic health conditions Operation of a COVID Clinic through MCN including vaccinations and PCR testing 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.	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.	Provide telehealth services Onsite pharmacy Onsite COVID testing, COVID and flu vaccination Onsite HIV and Hep Testing with treatment referral protocols.	Track HEDIS quality measures and have a published dashboard for stakeholders that highlights a variety of health outcome measures Medication Reconciliation protocols
Newaygo Community Mental Health (NCMH)	Continue to provide two Master's- level behavioral health clinicians who are placed in primary physicians' offices through a contract with the local hospital. Provide direct treatment and referrals for primary health care patients. Use of Peer Supports, Peer Recovery Coaches. NCMH is a host site for medical residents, medical Interns, and psychiatric Interns and RN students. We currently have a working agreement with Central Michigan University. Nursing staff are embedded in various services (adult services team, medication clinic), who act as liaisons to local primary care providers, specialty doctors and to offer assistance to 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 provides support to individuals for addressing needs related to Social Determinants of Health such as assisting with 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 for therapy, case management and psychiatric services 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 two locations within the county (White Cloud and Fremont offices) for easier access to clients who may live closer to one location over the other. NCMH offers extended services hours on Tuesdays and Thursdays from 8 a.m.- 7 p.m.	Utilize Integrated Care Delivery Platform (ICDP) to monitor Care Alerts in accordance with process improvement projects, as needed. Regional and local priority measures that are monitored regularly include: Follow-up after hospitalization, Access to primary care, Plan all-cause readmission, Diabetes screening, Diabetes monitoring, Cardiovascular screening, Follow-up Children ADHS initiation phase, Follow-up ADHS Children Continuation & Monitoring Phase, and Use of multiple concurrent antipsychotics. Clinicians are educated in accordance with MDHHS waiver standards; The client's Individual plan of service addresses health and safety, including coordination with primary care providers. This is actively audited, including most recently in the July 2022 MDHHS Waiver Review. NCMH actively monitors the Michigan Mission Based Performance Indicator System (MMBPIS) to identify dimensions of quality through performance measures. NCMH & MSHN complete an analysis of those records that are "out of compliance", and those that are identified as "exceptions". When NCMH identifies an indicator as below standard, it is reviewed for quality improvement planning.

Increased Participation in Patient-Centered Medical Homes Characteristics Region 5 CMHSP Activities, Efforts & Achievements					
CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Saginaw County Community Mental Health Authority (SCCMHA)	Great Lakes Bay Health Centers (GLBHC) co-located within the SCCMHA psychiatric services clinic, onsite physical health care. Over 1,000 consumers have identified GLBHC as their primary care provider. PIPBHC (Promotion of Integration of Primary and Behavioral Health Care) grant participant prioritizing reductions high morbidity/mortality rates for adult SMI population. PIPBHC focuses on improving primary care participation and improving screening and obesity rates for children with SED Certified Community Behavioral Health Clinic (CCBHC) offering comprehensive services for behavioral health, substance use disorders, and primary health care SCCMHA has submitted an application to MDHHS to be 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. Current focus is 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 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 GLBHC offers on site/on demand immunizations including COVID 19 and influenza vaccination.	Implementation of AZARA continues to move forward. This project, which continues to evolve, will engage PIPBHC partners and GLBHC to provide encounter data 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 have minimal lag time for encounter data and 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 a “as needed” basis with follow up and support 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. Both positions are funded through the PIPBHC SAMHSA grant. Internal treatment teams have moved to team-based care with the goal to improve the coordination of care and delivery of services. Teams are using an interdisciplinary team model. 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, seven days a week. 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 on-site pharmacy, Genoa. Genoa offers onsite on demand influenza vaccines, curbside delivery, and prescription home delivery.	Key agency quality performance metrics reviewed bi-monthly by committee of medical and clinical leaders with focus on improving health outcomes & access to care CLIA-waived screening instruments incorporated into health assessment. HbA1c and lipids levels captured at intake & periodic biometric screening to identify need for further lab tests or health education referral Consumer Wellness Committee reconvened 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.

Increased Participation in Patient-Centered Medical Homes Characteristics Region 5 CMHSP Activities, Efforts & Achievements					
CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Shiawassee Health & Wellness (SHW)	Shiawassee Health & Wellness (SHW) has a strong partnership Great Lakes Bay Health Center (GLBHC), a patient-centered medical home, who is co-located at the SHW building and provides primary care on-site to shared patients. Shiawassee Health and Wellness is a SAMSHA grantee for the Promoting Integrated Primary and Behavioral Health Care (PIPBHC) grant. SHW 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.	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 is providing nutritional education and physical activities through the PIPBHC grant at the agency drop-in center to interested and enrolled consumers; tracking health outcomes. SHW is currently working with PCE to improve the initial biopsychosocial assessment to include thorough medical history and imbedding nursing recommendations prior to the person centered plan.	SHW and GLBHC share information regularly about shared patient enrollment and coordinate care needs. SHW reviews and implements an active follow up process for all ADTs received from local health care offices and the hospital SHW has been selected as the pilot site to use Azara for population health management. Transfer/upload capabilities for all laboratory and test results is currently in place with Quest Labs. SHW and GLBHC are collaborating to share access to one another's HER's for ongoing integrated care needs and improved communication.	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 after the start of 2023. 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 continue to provide telehealth appointments, offering choice 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.	Quality performance measures for consumers enrolled in integrated care model: 90% of consumers will be screened for tobacco use 75% of positive screens who express interest will be referred to TTS 100% of consumers will have their vital signs and BMI measured at intake and follow visits. A1c will be measured per guidelines for eligible consumers. 75% of eligible participants who are interested will be referred to Solutions for Wellness.
The Right Door for Hope, Recovery & Wellness (TRD)	Certified Community Behavioral Health Clinic (CCBHC) offers comprehensive services for behavioral health, SUD, and primary care. Health Screens completed annually for all persons served & referral to primary or specialty care is provided by care coordinator or community clinician. Dedicated nurse as primary care liaison. Monthly primary care communication newsletter in English/Spanish Dedicated referral process for one time case consults with primary care providers.	Care Coordinators available to attend doctor appointments with persons served for advocacy, support, & to increase health literacy Electronic health record patient portal available to all individuals served Persons served have access to a variety of activities/services available to support health & wellness goals such as healthy eating prep and cooking classes Whole Health Action Management (WHAM) peer support program assists individuals with developing person-centered wellness goals	Day to day coordination with local hospital system and monthly administrative coordination CMH psychiatrist, nurses and clinical leaders provide strategic physician outreach with local primary care providers to educate, provide consultation and address high utilizing patients. (limited d/t COVID-19) Formal coordination of care agreements with most all Rural Health Clinics in Ionia County Medication reviews, evaluation notes, and lab values are sent to primary care providers for care coordination ADTs used in the medical record for follow up post hospitalization Health grant focused on connecting persons served to a primary care provider when they are without one Dedicated nurse for follow up on labs needed as well as onsite labs available	TRD has capacity to do some lab tests on-site, including lab work related to Clozaril (WBC and ANC), A1c and lipids. TRD will be co-locating with Sparrow Medical Group in Portland during FY21. TRD provides telehealth services in addition to face-to-face services TRD has extended service hours from 5-7pm at night and Saturdays from 8am - 12pm.	Quarterly pharmacy audits review of samples and AIM testing on psychotropic drugs used by providers Use of nationally recognized quality health measures such as diabetes screening and monitoring Quarterly Peer reviews by nursing staff and prescribers Medical Director provides ongoing consultation for county jail and local primary care physicians to ensure safety in the prescribing and monitoring of psychotropic medications. Nurse and Director of QI utilize ICDP (Zenith) to monitor Care Alerts for process improvement projects such as diabetes monitoring, cardiovascular screening, and access to care.

Increased Participation in Patient-Centered Medical Homes Characteristics Region 5 CMHSP Activities, Efforts & Achievements					
CMHSP	**Comprehensive Care**	**Patient Centered**	**Coordinated Care**	**Accessible Services**	**Quality & Safety**
Tuscola Behavioral Health Services (TBHS)	TBHS continues to provide integrated health care services through a fully operational on-site wellness primary care clinic in order to provide a full array of primary health care services. 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. Dedicated nursing staff as wellness clinic liaison for primary care services.	All wellness clinic individuals are offered peer wellness coaching (PWC), by a certified PWC. PWC 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 all individuals served Individualized health and wellness goals as part of the IPOS as directed by individuals served Community activities offered, directly and indirectly, to promote mental health, wellness, and community integration Survey of individuals served regarding medication literacy with targeted education provided	Utilization of Zenith 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 Continued partnership with the Tuscola County Health Department through the PHE Development of Coordination of Care correspondence for annual dissemination to primary care providers Receiving and sending ADT alerts through the EHR Use and daily review of MIHIN alerts for COVID-19 results for those served Review and use of CC360 data related to immunization status for those served	McLaren Family Practice offers onsite laboratory services on a weekly basis Telehealth offered for both primary and psychiatric care services Purchase and use of telehealth assessment equipment (tele otoscope and stethoscope) Ongoing community education and presentations related to mental health, Narcan distribution Collaboration with local pharmacies for medication delivery services, including medication management and safety dose planners On-site influenza and COVID-19 vaccine clinics 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	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 Utilization of Zenith data analytics for medication and diagnosis reconciliation for those recently discharged from acute or psych admission(s) 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 Relias training for clinicians related to predominant physical health diagnoses 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