POPULATION HEALTH AND INTEGRATED CARE PLAN 2024-2025

Mid-State Health Network, Clinical Leadership Committee Approved: 3/28/2024
Mid-State Health Network, Operations Council Approved: 4/15/2024
Mid-State Health Network, Medical Directors Approval: 3/15/2024
Mid-State Health Network, Regional Equity Advisory Committee for Health: 3/25/2024

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I. Overview/Mission Statement

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Community Health as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, The Right Door (formerly Ionia County CMH), Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness and Tuscola Behavioral Health Systems. As of October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

The mission of Mid-State Health Network is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.

II. Scope of Plan

As an organization, Mid-State Health Network (MSHN) is committed to increasing its understanding of the 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 equity by utilizing informed population health and integrated care strategies. The purpose of the MSHN Population Health and Integrated Care plan is to establish regional guidance and best practices in these areas as well as describe specific population health and integrated care initiatives currently underway in the MSHN region. The Population Health and Integrated Care Plan is intended to support and advance the goals and priorities outlined in the MSHN Strategic Plan. The plan will:

- Identify the population served by MSHN and explore key population health needs
- Identify chronic co-morbid physical health conditions that contribute to poor health and drive health costs for individuals with behavioral health disorders
- Describe the concepts of population health, social determinants of health, health disparities, health equity, and identify specific factors that impact the population in the MSHN region
- Examine key foundational areas necessary to support population health programs and evaluate MSHN's stage of readiness for each area
- Describe current population health and integrated care initiatives underway by MSHN and its CMHSP partner organizations.

The summary section of the plan incorporates all the above and recommends priority steps to drive population health and integrated care efforts across the region. These include:

- Identify and address current integrated health program gap areas, if applicable.
- Advance strategic priorities for 2024-2025 related to improving health outcomes and reducing health disparities.
- Determine resource and budget requirements for effective population health and integrated care initiatives.
- Identify the role of regional Council(s) and Committee(s) relative to strategic planning, monitoring and oversight of integrated care and population health activities.
- Measure the value and effectiveness of regional population health and integrated care initiatives through quality, costs, outcomes.

III. Definitions

1. **Behavioral Health:** refers to care provided to individuals with a Mental Health, Intellectual Developmental Disability, Substance Use Disorder Provider and/or children with Serious Emotional Disturbances.

2. **Behavioral Health Home (BHH):** a healthcare service delivery model focused on the integration of primary care, mental health services, and social services and supports for adults and children diagnosed with mental illness. The BHH model of care uses a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals.

3. **Care Management:** programs that apply systems, science, incentives, and information/data, ideally for implementation across all settings and levels, to improve health care practice and assist consumers and their support systems to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively.

4. **Care Coordination**: services which are primarily implemented at the practice level (with support from the care management level) that help to execute and support the plan of care.

5. **Certified Community Behavioral Health Clinic (CCBHC):** a specially designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth.

6. **CMHSP:** Community Mental Health Service Program

7. **Comorbid Conditions/Comorbidity**: The presence of more than one disease or disorder. This may include physical health conditions and behavioral health conditions.

8. **Customers/Consumers:** Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.

9. **Epidemiology**: The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.

10. **FQHC (Federally-Qualified Health Center):** Community-based health care providers that receive funds from the federal Health Resources & Services Administration to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.

11. **Health Disparity:** Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

12. **Health Equity**: Occurs when nobody is denied the opportunity to be healthy even if they belong to a socially disadvantaged group.

13. **HEDIS (Healthcare Effectiveness Data and Information Set):** The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care.

14. **High Risk:** Consumers identified as having 1 or more emergency department visits, no primary care visit within the previous 12 months, 2 or more chronic conditions, psychiatric or physical hospitalization within the previous 12 months.

15. **Managed Care Entity/Managed Care Organization:** A type of health insurance plan that maintains contracts with health care providers and medical facilities to provide care for its members.

16. **MCIS:** Managed Care Information System

17. **MDHHS:** Michigan Department of Health and Human Services

18. **MiHIN:** Michigan Health Information Network

19. **MHP:** Medicaid Health Plan; a managed care organization responsible for administering physical health insurance benefits to Michigan Medicaid enrollees

20. **NCQA:** The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality by evaluating and reporting on the quality of managed care and other health care organizations in the United States. NCQA provides accreditation to health plans using rigorous standards that are regarded as national best practices.

21. **Opioid Health Home:** an OHH provides comprehensive care management and coordination of services to Medicaid/Healthy Michigan Plan beneficiaries with opioid use disorder. The OHH functions as the central point of contact for direction patient-centered care across the broader health care system.

22. **PIHP**: Prepaid Inpatient Health Plan; a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders.

23. **PHI:** Protected Health Information

24. **Population Health:** the health outcomes of a group of individuals; an approach to healthcare that aims to improve the health of an entire group of people

25. **Social Determinants of Health (SDH):** conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks

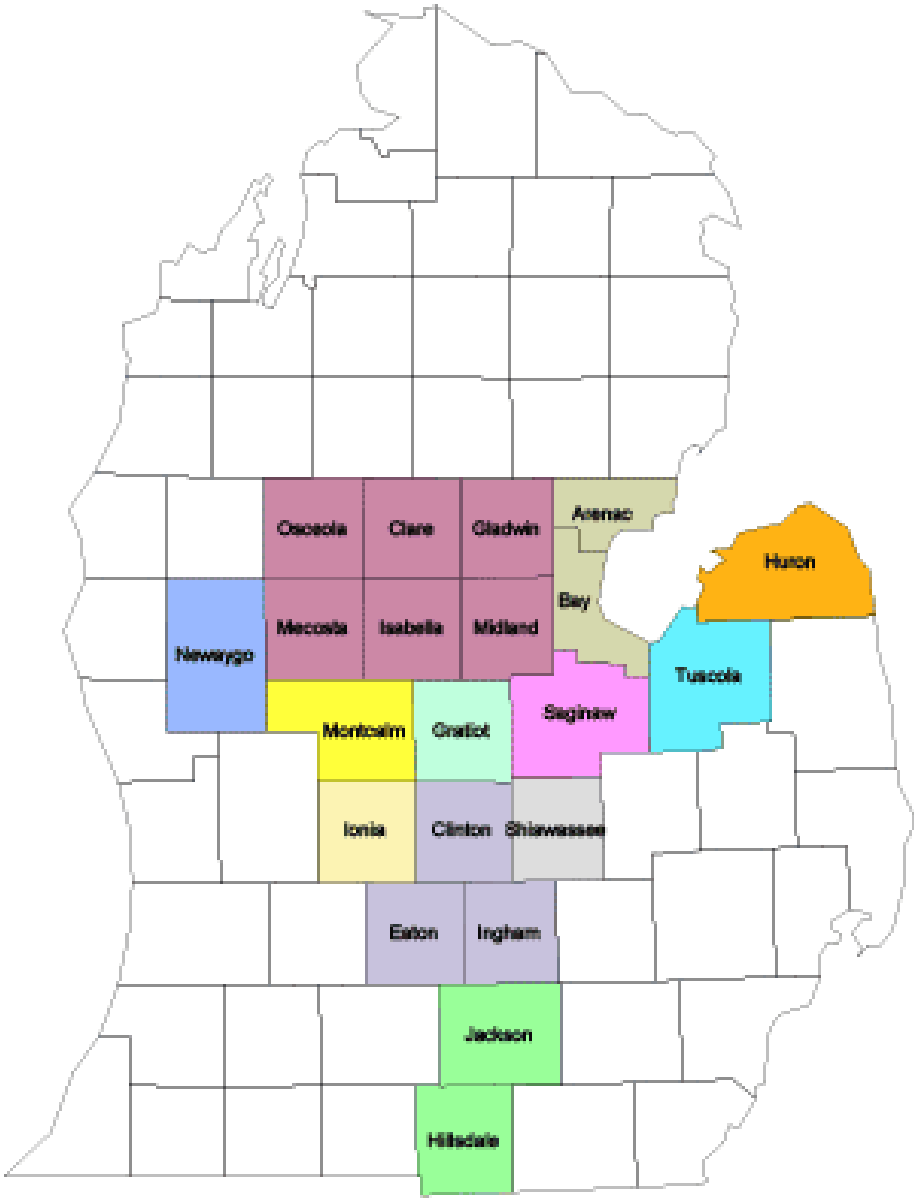
26. **SSO:** Single Sign On, uses uniquely identified credentials to gain access to approved systems and datasets secured by the State of Michigan.

27. **CareConnect360 (CC360):** Software tool developed by Optum for the State of Michigan to query and report healthcare data from encounters submitted by fee for service providers, MHPs and PIHPs. Common tool used by MHPs, PIHPs and State of Michigan employees and contractors.

28. **SUD:** Substance Use Disorder

IV. Mid-State Health Network Population Analysis

Description & Demographics



Mid-State Health Network is the Pre-Paid Inpatient Health Plan (PIHP) for behavioral health services for Region 5 in Michigan, covering a 21-county service area. The composition of MSHN's 21-county service region is diverse, ranging from urban to very rural areas with a total population of 1,632,554 (US Census Bureau, 2022). According to U.S. Census Bureau 2022 population estimates, Region 5 is 82.75% Non-Hispanic White, 6.96% Black/African American, 5.66% Hispanic/Latino, 2.77% self-identifies as "Two or more races," 0.77% American Indian/Alaska Native, and Pacific Islander/Native Hawaiians make up <0.1% (U.S. Census Bureau, 2022).

There is considerable variation among the racial/ethnic composition of individual counties, however. Ten of MSHN's 21 counties have populations that are ≥ 90% Non-Hispanic White, while two of MSHN's 21 counties have non-white populations that exceed the Michigan average of 25.1%: Six of MSHN's 21 counties have populations that range from nearly 15% to over 30% people of color. Saginaw (31.5%) and Ingham (31.2%) counties have the highest non-white populations followed by Eaton (18.5%), Jackson (16.2%) and Isabella (15.4%). Saginaw county has the highest concentration of Black/African Americans (19.2%) and Hispanic/Latinos (9.3%), while Ingham county had the largest population of Asians at 6.6% and "Two or more races" at 4.6%. The highest concentration of American Indian/Native Alaskans was found in Isabella county (3.9%) (U.S. Census Bureau, 2022).

Given disparities in health outcomes among people of color, MSHN recognizes the importance of attention to these populations' needs.

The percentage of individuals living in poverty in the MSHN region range from 8.90% to 20.4% by county and 18 of the 21 counties have poverty rates that surpass the national average poverty rate of 11.5% (U.S. Census Bureau, 2022). Data from the 2022 U.S. Census Bureau's *American Community Survey 5-year Estimates* show the median household income in Region 5 was $59,065. Household income varies widely among counties where the range was from $47,816 in Clare County to a high of $82,594 in Clinton County. Only four counties (Clinton, Eaton, Midland, and Ionia) in the MSHN region exceeded the state median household income of $68,505. Additional population data, poverty information and health ranking status for each of MSHN's 21 counties is available in Appendix A.

MSHN partners with 12 local Community Mental Health Service Program (CMHSP) participants throughout its 21 counties to deliver specialty behavioral health services to eligible Medicaid and Healthy Michigan Plan beneficiaries. MSHN provides direct oversight of the region's substance use disorder (SUD) treatment and prevention services through contracts with over 75 SUD prevention, treatment, and recovery agencies in over 140 provider sites in and outside of the region.

Figure 1: MSHN CMHSP Member Organizations and Counties Served

CMHSP	Counties Served
Bay-Arenac Behavioral Health	Arenac, Bay
CMH for Clinton, Eaton, Ingham Counties	Clinton, Eaton, Ingham
CMH for Central Michigan	Osceola, Clare, Gladwin, Mecosta, Isabella, Midland
Gratiot Integrated Health Network	Gratiot
Huron Behavioral Health	Huron
The Right Door for Hope, Recovery & Wellness	Ionia
LifeWays CMH	Jackson, Hillsdale
Montcalm Care Network	Montcalm
Newaygo CMH	Newaygo
Saginaw County CMH Authority	Saginaw
Shiawassee Health and Wellness	Shiawassee
Tuscola Behavioral Health System	Tuscola

Medicaid Behavioral Health & Physical Health Dual-Service Population

The physical health benefits for Medicaid and Healthy Michigan Plan beneficiaries are managed by eleven (11) Medicaid Health Plan (MHP) managed care organizations throughout the State. Of the 11 MHPs in the State of Michigan, eight (8) of those MHPs provide service coverage to individuals within the 21 counties in the MSHN region.

In October 2023 the Michigan Department of Health and Human Servies (MDHHS) announced a competitive procurement process for Michigan's Medicaid Health Plans. Through this process, MDHHS will select eligible MHP contractors to provide comprehensive health care services to Michigan Medicaid beneficiaries in future contract years. Contract awards are expected to be announced in 2024, which could result in changes to the number of MHPs as well as the counties that each MHP operates in. Figure 2 below shows the current configuration of MHPs operating in the MSHN region and the counties covered by each.

Figure 2: Medicaid Health Plans and Counties Covered by Each in MSHN Region

Health Plan	Counties Covered
Aetna	Jackson, Hillsdale, Clinton, Eaton, Ingham
Blue Cross Complete	Jackson, Hillsdale, Shiawassee, Tuscola, Huron, Osceola, Mecosta, Newaygo, Ionia, Montcalm, Gratiot, Saginaw, Midland, Bay, Clare, Gladwin, Arenac, Isabella
HAP CareSource	Shiawassee, Tuscola, Huron, Jackson, Hillsdale, Clinton, Eaton, Ingham
McLaren	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Meridian	Jackson, Hillsdale, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Molina	Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Priority Health	Osceola, Mecosta, Newaygo, Ionia, Montcalm
United Healthcare	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Osceola, Mecosta, Newaygo, Ionia, Montcalm

The Medicaid Health Plans also manage the mild to moderate behavioral health benefits for Medicaid and Healthy Michigan beneficiaries. MSHN manages the behavioral health services for beneficiaries with severe and persistent mental illness (SPMI).

Physical Health **Behavioral Health**

Includes Mild to Moderate Behavioral Health

SPMI, Specialty Benefit, IDD and SUD

Dual-service Medicaid enrollees are those individuals who are receiving services for both physical health needs through a Medicaid Health Plan (MHP) and behavioral health needs through MSHN or one of its CMHSP participants. In calendar year 2023, dual-service enrollees totaled 45,640 enrollees of the individuals served by the MHPs in the MSHN Region. Among the dual-service Medicaid enrollees that MSHN serves, over 90% of those individuals have a developmental disability (DD) and/or mental illness (MI).[1]

Figure 3: Displays the 45,640 Dual-Service Medicaid enrollees from FY2023 and their distribution among the Medicaid Health Plans. *Note: Unknown MHP are those individuals who have not selected a Medicaid Health Plan and/or are part of the MDHHS Fee for Service population.*

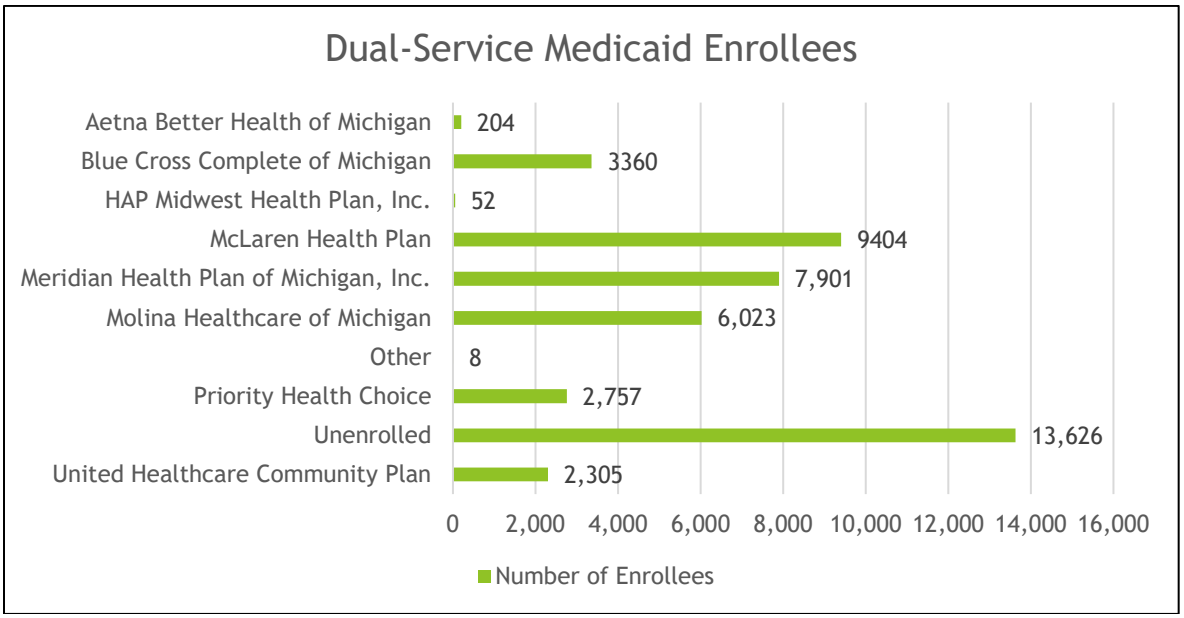
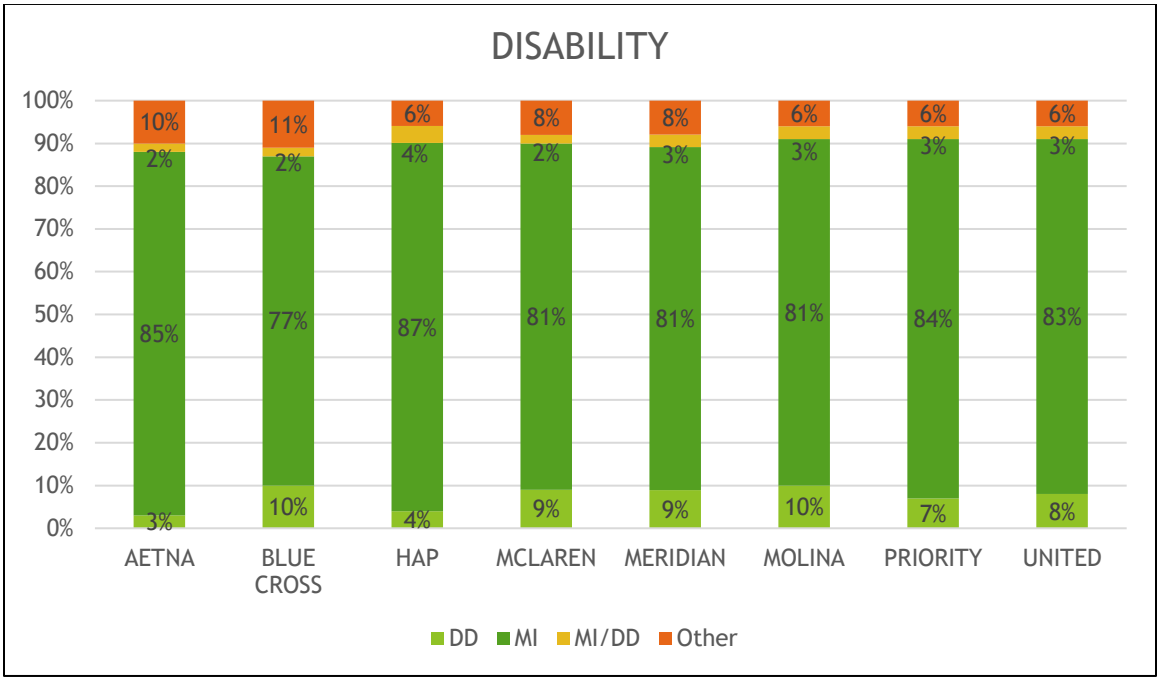


Figure 4: Behavioral Health Disability Designations by Medicaid Health Plan

[1] The designations are based upon the diagnoses attached to Medicaid claims in the past 12 months for all individuals included. If there is an attached I/DD, MI or combination of diagnoses it makes up the first three categories. If there is no I/DD or MI diagnosis in the timeframe attached to a Medicaid claim, the individual is listed as other.



Epidemiology & Preventable Morbidity

The 2023 *America's Health Ranking* report rated the State of Michigan's overall health at 26th, in the bottom 50% of the country. Factors that had the most significant impact on the rating included:

- Adult obesity rate of 34.5%
- 9.2% low birthweight (defined as under 5lbs)
- 13.0% of adults with multiple chronic conditions

The County Health Rankings data produced in collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute measure a number of health risk factors and health outcome factors to determine overall health of a county**. Length of life** (premature death) and **quality of life** (health status, percent of low birthweight of newborns) are also measured for each county.

MSHN counties that ranked in the ***10 most healthy Michigan counties*** are:

- Clinton #2
- Midland #7

MSHN counties ranked in the ***10 least healthy Michigan counties*** are:

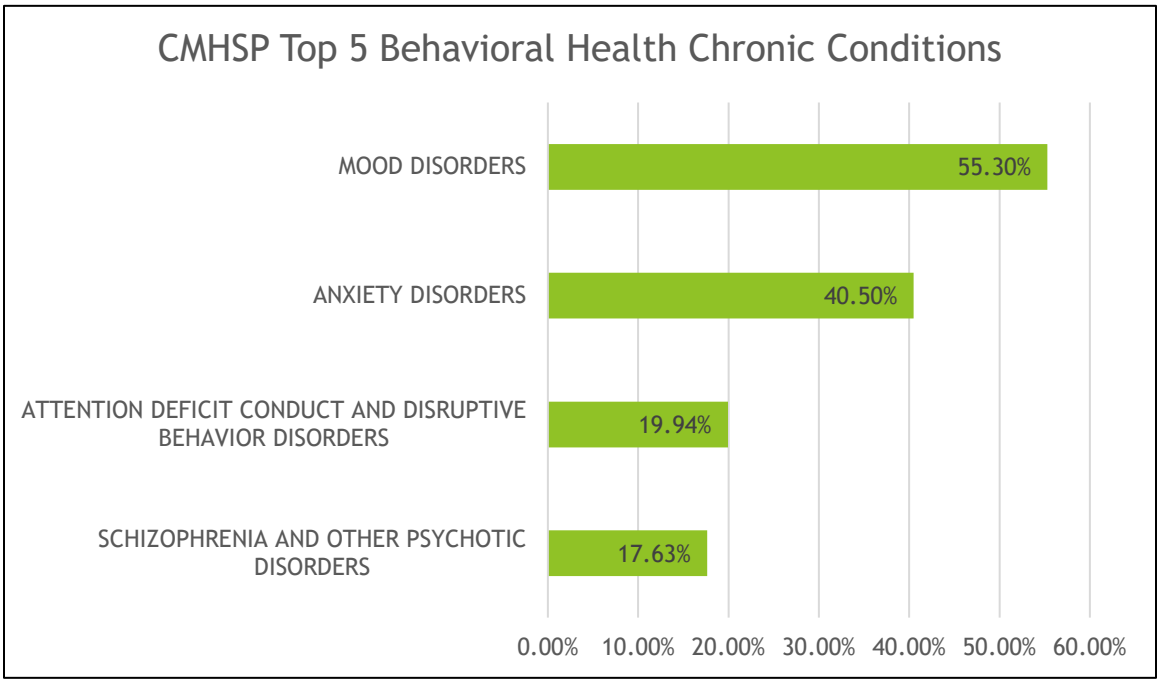
- Saginaw #76
- Gladwin #77
- Clare #78

According to the World Health Organization, people with severe mental health disorders have a higher prevalence of many serious chronic diseases and are at a higher risk for premature death as a result of

those diseases than the general population. Current data suggests that adults in the U.S. living with serious mental illness die on average 10 to 20 years earlier than the general population. The premature mortality rate among people with behavioral health problems is largely explained by the high prevalence of preventable illnesses[2] such as cardiovascular, respiratory, and metabolic diseases. (In this context, the term metabolic disease is a collective term referring to diabetes, hypertension, and weight gain).

Research consistently shows individuals suffering from chronic psychiatric disorders and concurrent chronic lifestyle related physical illnesses consume exponentially more health resources while experiencing significantly diminished health outcomes. By addressing behavioral and physical conditions, behavioral health symptoms associated with impaired compliance or self-care may be better addressed. This may lead to improved management or treatment of the preventable conditions.

Figure 5: Displays the top 5 Behavioral Health Chronic Conditions by the percentage of Medicaid individuals served by CMHSPs within the MSHN region in the past 12 months. (Population: 45,640)



[2] Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). Morbidity and mortality in people with serious mental illness. *Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council*, *25*(4), 1-87.

Figure 6: Displays the top 5 Behavioral Health Chronic Conditions by the percentage of Medicaid individuals served by SUD providers within the MSHN region in the past 12 months. (Population: 6,572)

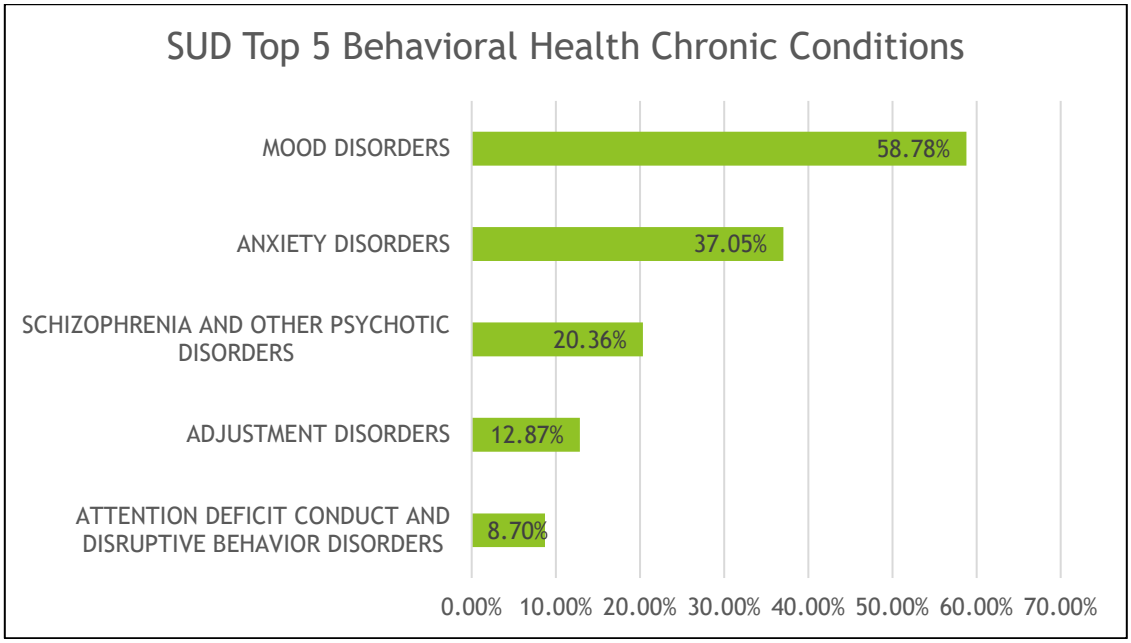


Figure 7: Displays the top 5 Physical Health Chronic Conditions by the percentage of Medicaid individuals served by CMHSPs within the MSHN region in the past 12 months. (Population: 45,640)

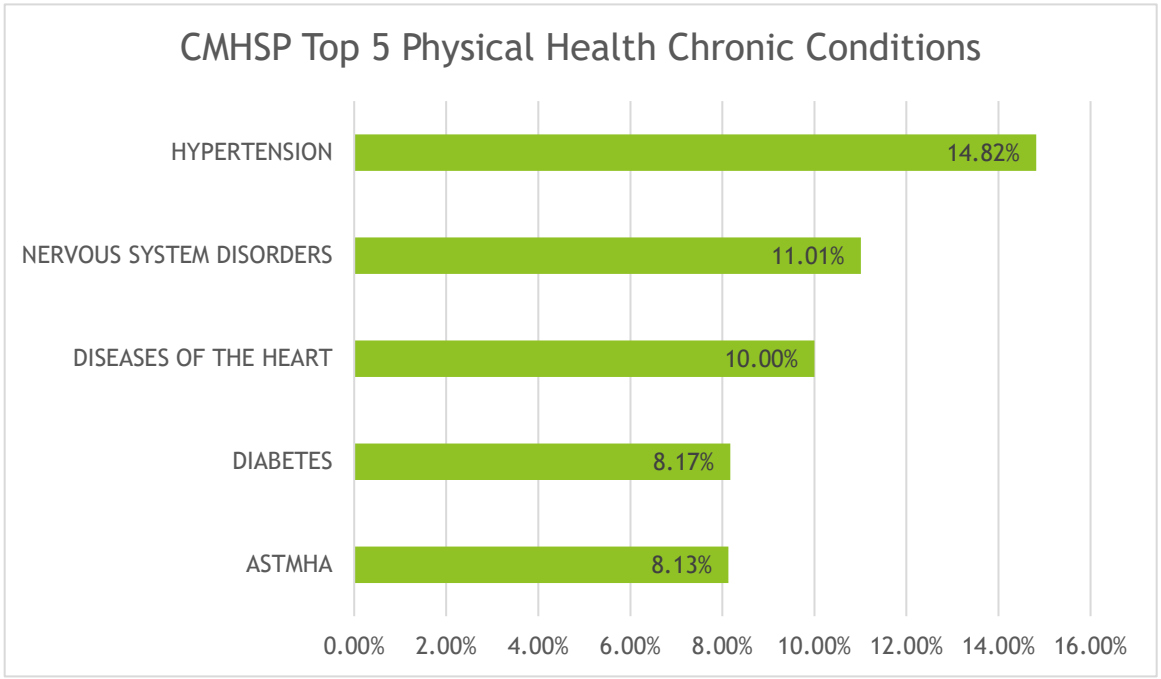
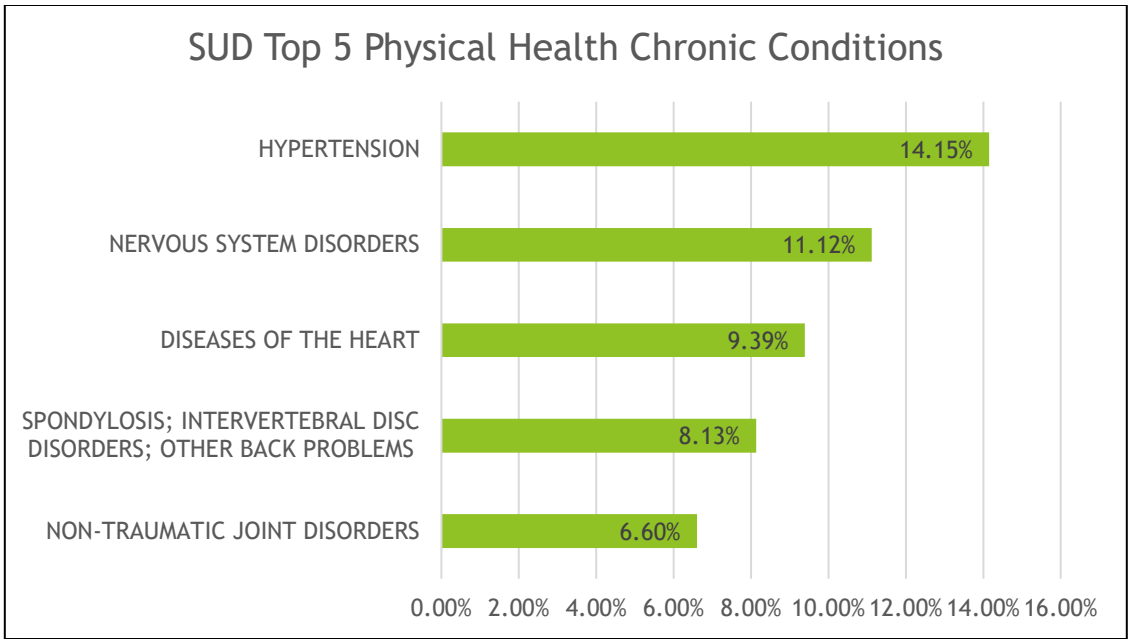
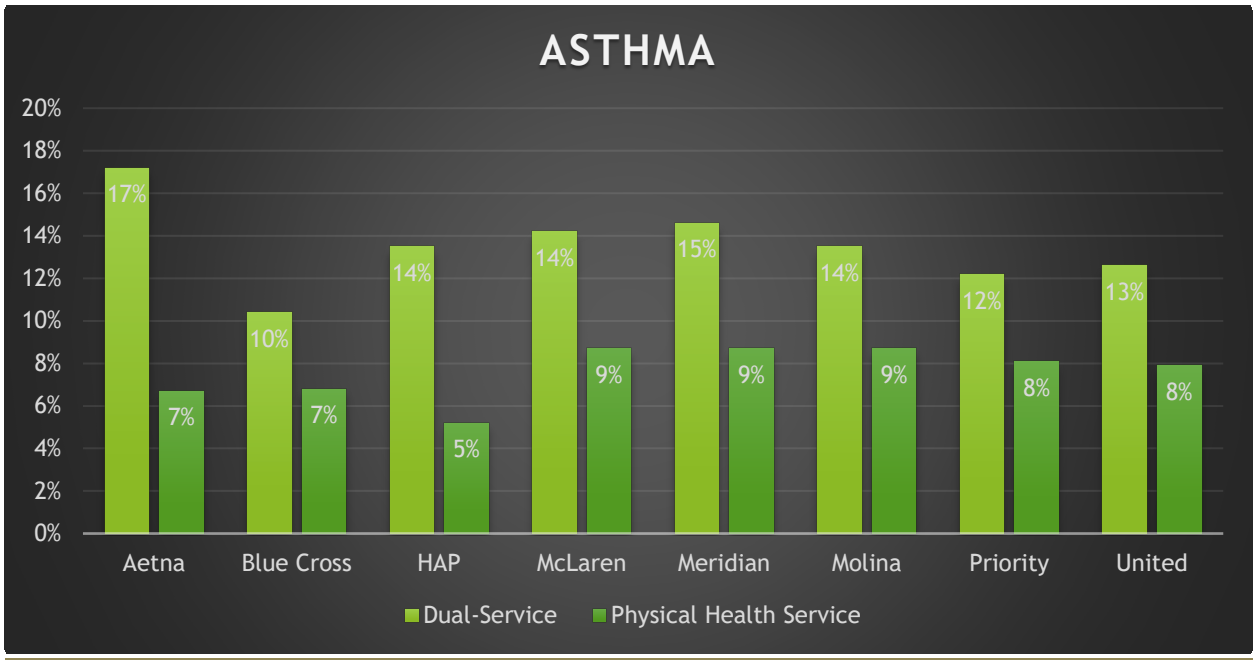
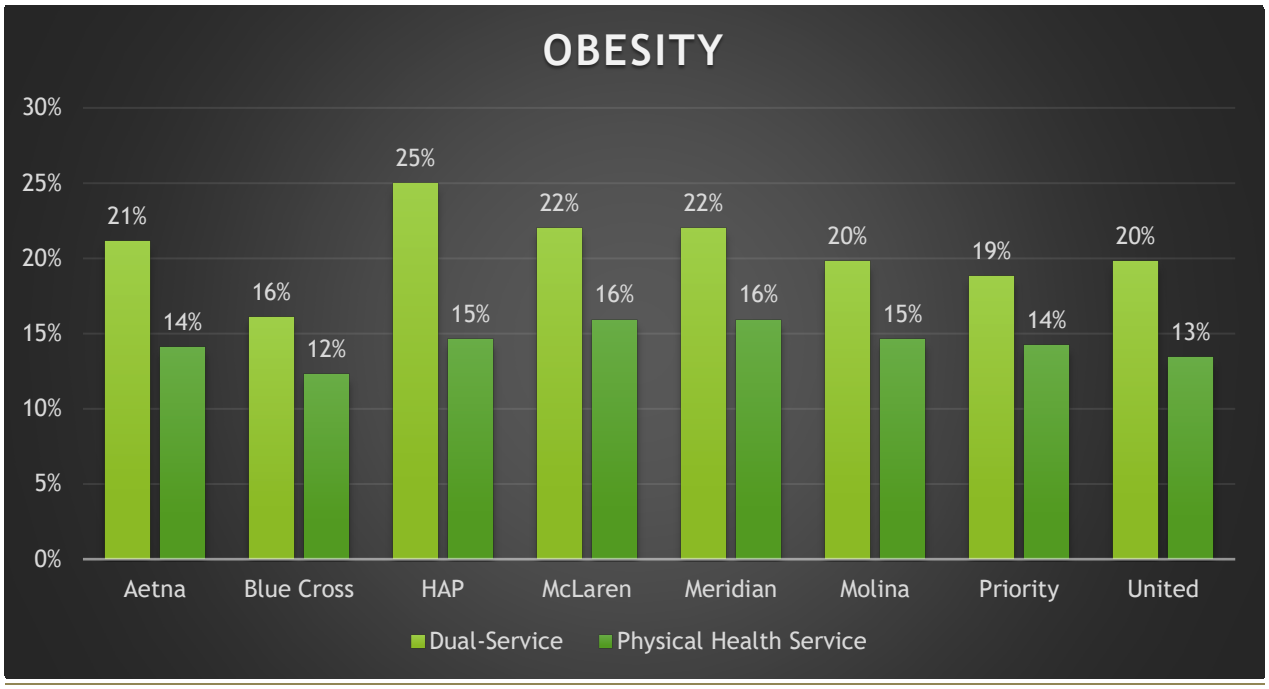


Figure 8: Displays the top 5 Physical Health Chronic Conditions by the percentage of Medicaid individuals served by SUD providers within the MSHN region in the past 12 months. (Population: 9,283)



Figures 9-14: Depict the rates of specific chronic diseases in the physical-health Medicaid enrollee population in the MSHN region (n = 511,674) compared to the dual-service Medicaid enrollee population in the MSHN region (n =45,640).

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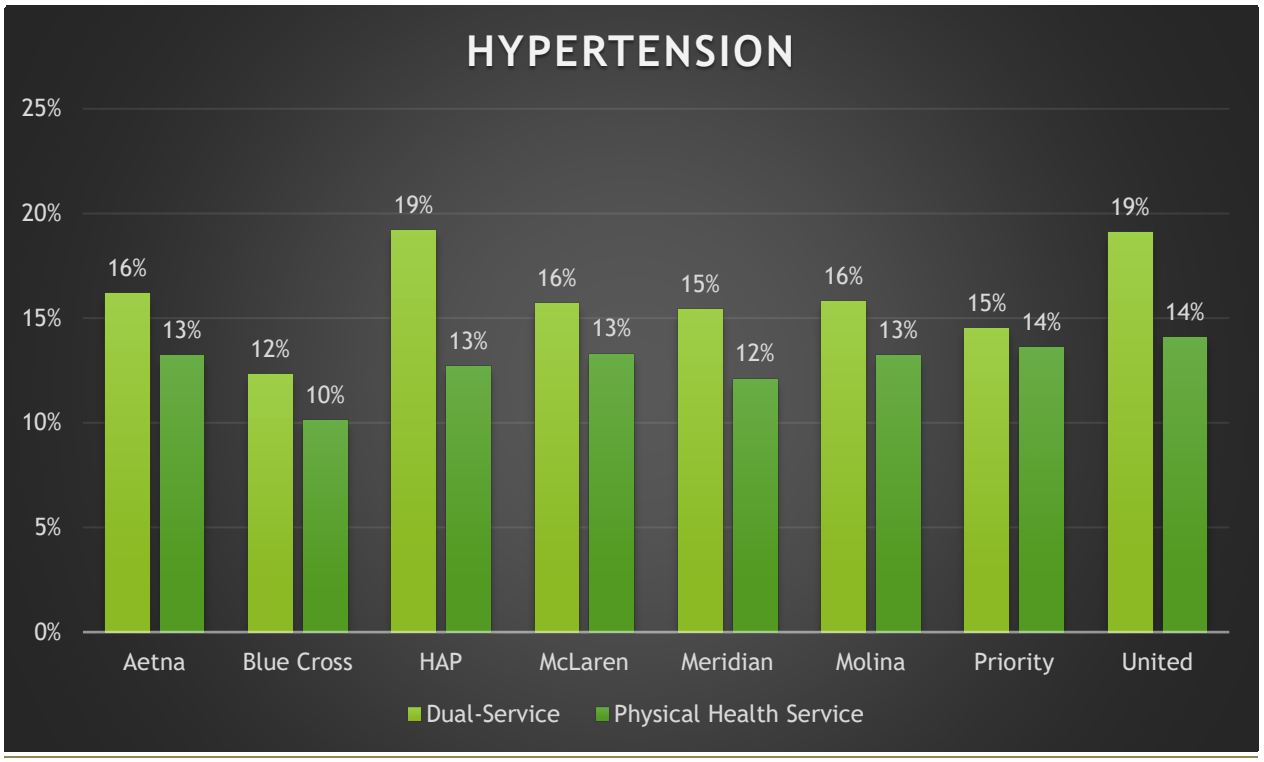
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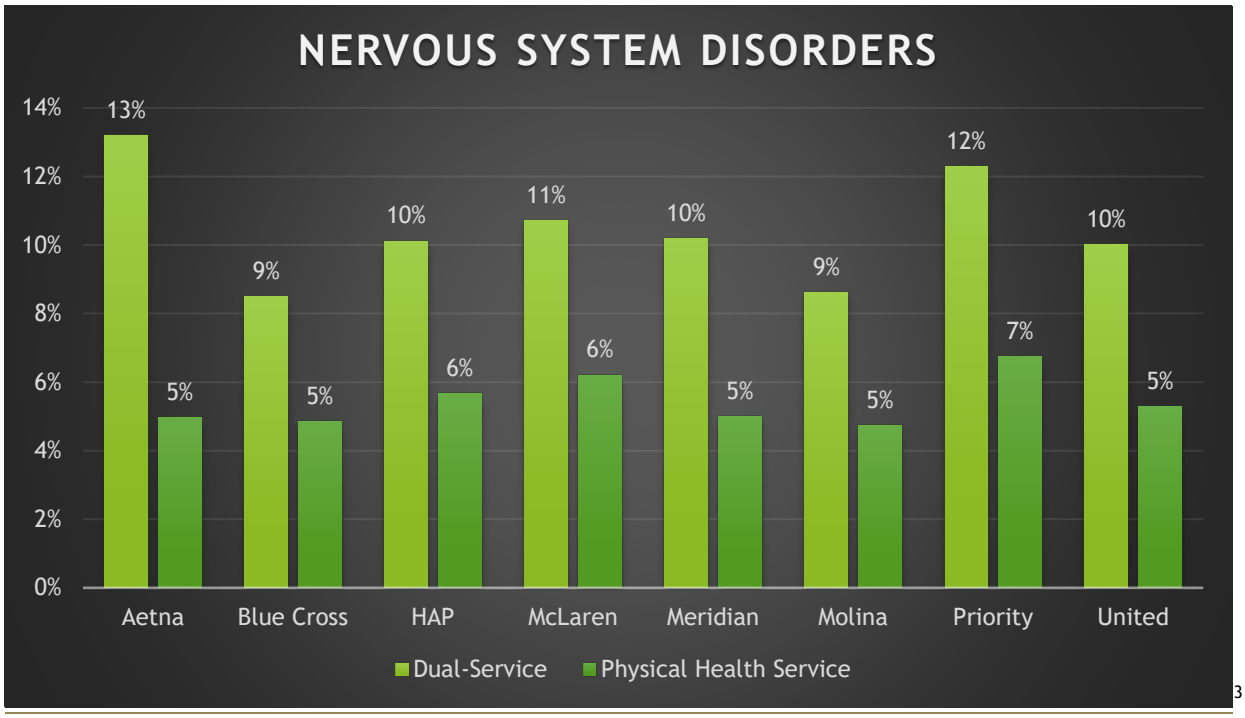
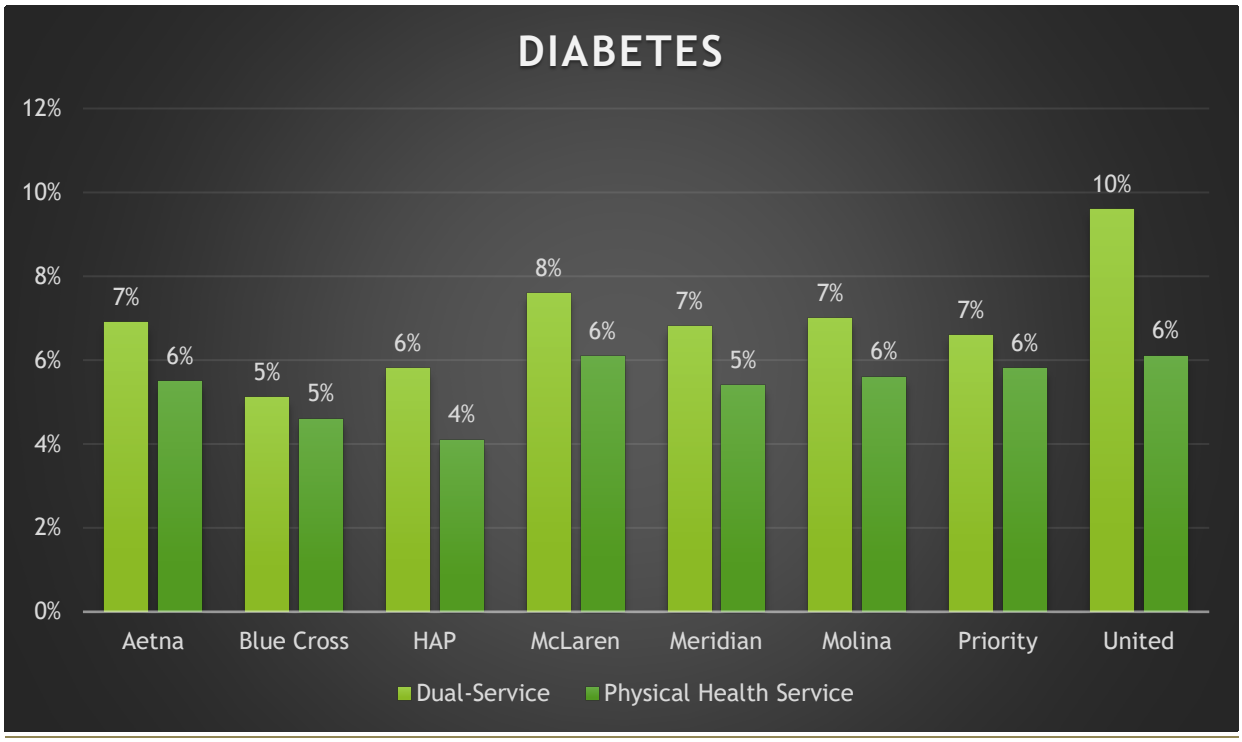
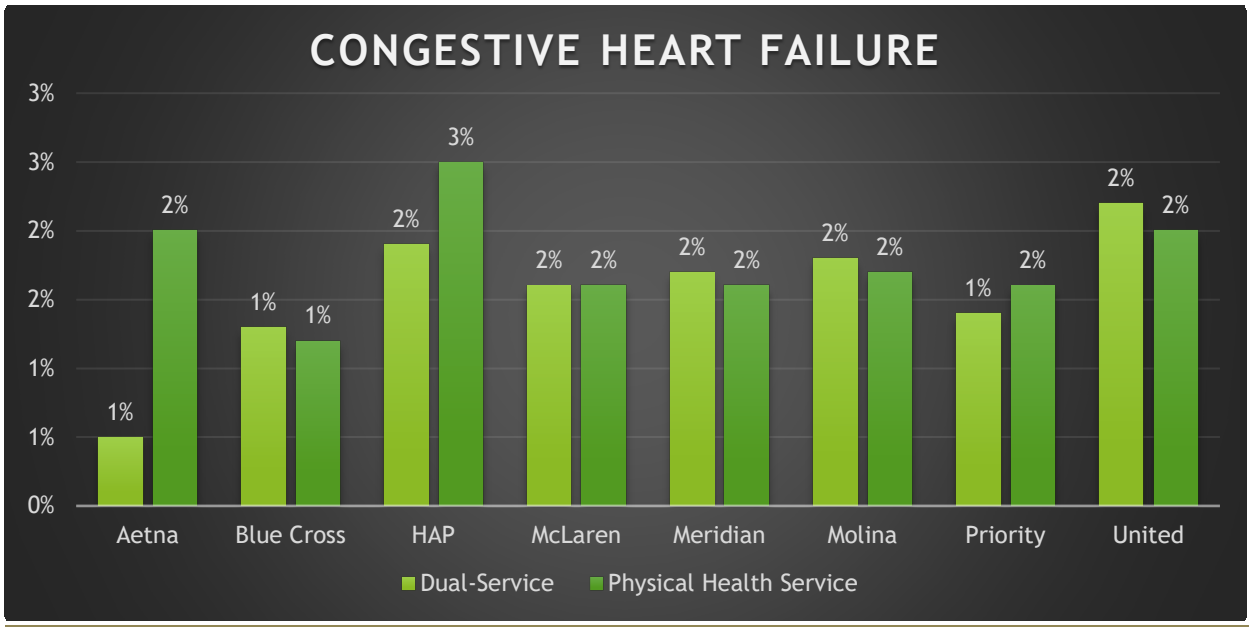


[3]



[3] Refer to Appendix B for full Nervous System Disorders Code Set



Given that individuals with severe mental illness and intellectual and developmental disorders experience higher than average rates of chronic health conditions it is important for MSHN to examine population health strategies, social determinants of health, and opportunities for integrated health service delivery. Improved care management with the Medicaid Health Plans is also vital in order to decrease inappropriate and disjointed care for dual-service members who often experience multiple chronic physical and behavioral health conditions.

V. Population Health and Health Equity

In the United States, health has long been looked at from an individual level and addressed by traditional sectors – governmental public health agencies and the health care delivery system. While that may be beneficial for the problem at hand, treating the sick individual, it does little to address the reasons why a person may fall ill in the first place. A different approach, population health, involves a more holistic, preventative look at health and includes sectors that may not have been traditionally involved to improve health outcomes of the communities these sectors serve. This broader perspective allows for a more conclusive look at the many reasons why specific groups have poorer health outcomes than others. Collectively, these reasons are called the social determinants of health (SDOH).

According to the Centers for Disease Control and Prevention (CDC), social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants of health include things such as: the availability of resources to meet basic needs (e.g. safe housing and food); access to healthcare service; level of education; employment; transportation; social support; language and literacy; and economical and financial resources. SDOH are not generally included in the traditional health care service delivery system, yet they strongly influence the overall health outcomes of individuals or populations.

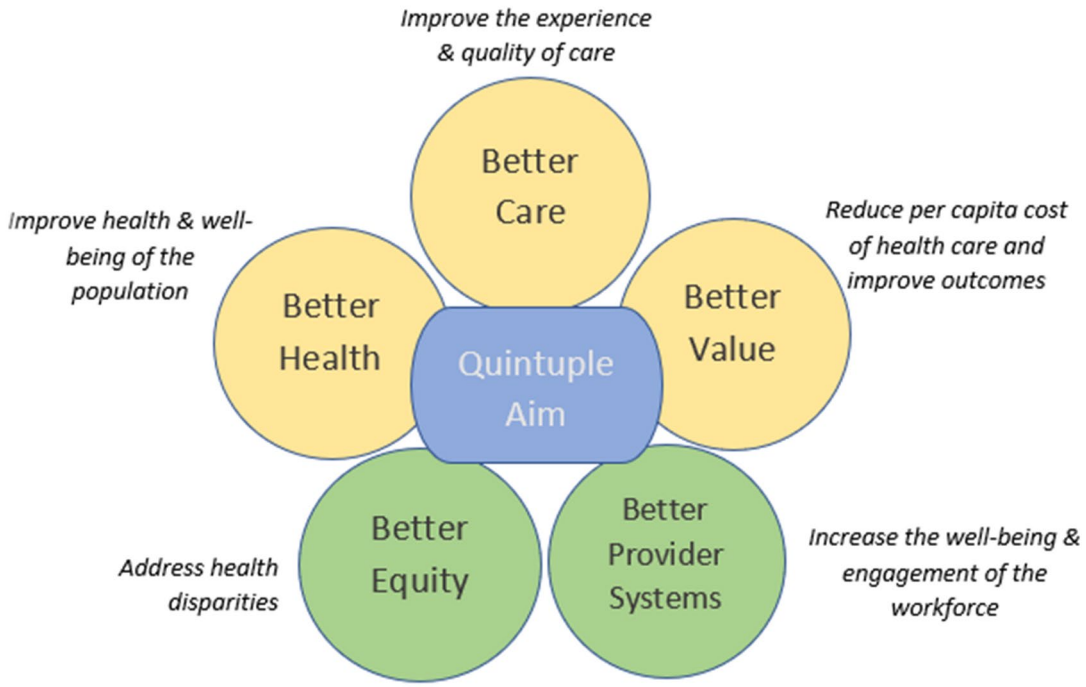
SDOH also contribute to health inequities. Health inequities are the "unfair and avoidable differences in health status seen within and between communities" (WHO). Health equity occurs when nobody is denied the opportunity to be healthy even if they belong to a socially disadvantaged group. The achievement of health equity can be measured by the presence or absence of health disparities. The CDC describes health disparities as "preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities." Fewer health disparities represent a movement toward health equity.

In general, the availability of and access to high-quality education, nutritious food, decent and safe housing, affordable and reliable public transportation, health insurance, and clean water and air all influence a person's health. In addition, race, socioeconomic status, literacy levels, and discrimination all play significant roles in a person's or population's opportunities to be healthy. Creating solutions to these differences will lead to a healthier overall population.

Addressing population health is the key to reducing health disparities and achieving health equity. By studying the overall health of a specific group, MSHN and its CMHSP and SUD provider partners can work on reducing the impacts that race, home environment, income, and education have on a person's health. Therefore, implementing effective population health strategies can specifically impact individuals' health and lead to overall better health outcomes regardless of one's social standing. This conceptualization of total person well-being for all individuals regardless of race, income, social standing, gender, sexual orientation, or other factors is the foundation for the MSHN vision statement:

The vision of Mid-State Health Network is to continually improve the health of our communities through the provision of premier behavioral healthcare and leadership. Mid-State Health Network organizes and empowers a network of publicly-funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region.

MSHN has developed and implemented a regional strategic plan using the model of the Healthcare Quintuple Aim:



The successful achievement of the Quintuple Aim requires highly effective healthcare organizations to implement population health and integrated care systems. The backbone of any effective healthcare system is an engaged and productive workforce/provider network that finds joy and meaning in their work. The Quintuple Aim adds a focus on achieving health equity by addressing health disparities.

MSHN is committed to identifying and addressing health disparities where they exist in the region and ensuring all individuals have the resources and opportunities needed to be healthy, especially those belonging to socially disadvantaged and historically marginalized groups. MSHN has taken a number of steps in recent years to promote and elevate diversity, equity, and inclusion (DEI) in its internal operations as well as external operations, including:

- Established the Regional Equity Advisory Committee for Health (REACH), comprised of individuals who represent diverse communities and at-risk groups to provide guidance to MSHN on DEI matters.
- Developed a board-approved DEI Statement including values and commitments. The full statement is available on the MSHN website: MSHN_Official_DEI_Statement_Approved.pdf (midstatehealthnetwork.org).
- Hosted an innovative Equity Lecture Series & Learning Collaborative. The lecture series featured national experts who shared different perspectives on the landscape of SUD health disparities as well as why disparities exist (systemic racism, implicit bias, access issues, mistrust of the medical system, cultural issues specific to communities of color, etc.). Following the lecture series, MSHN launched a pilot Learning Collaborative of SUD providers who will be working together to

translate knowledge into action to improve access and quality of care for all populations and to reduce disparities in SUD health outcomes. Recordings of all of the Equity Upstream Lecture Series are available on the MSHN website: Equity Upstream - Mid-State Health Network (midstatehealthnetwork.org).

- Formed the internal Inclusion, Diversity, Equity, and Accessibility (IDEA) workgroup comprised of volunteer MSHN employees to make organizational recommendations for MSHN based on ethical DEI principles.
- Partnered with the Michigan Department of Civil Rights to complete an internal DEI organizational assessment. Results of the assessment were then used to develop a workplan to address and strengthen identified areas where MSHN could improve its DEI policies, procedures, and practices.
- Each CMHSP in the region is engaged in local efforts to promote the practices and principles of DEI. CMHSPs shared their respective DEI plans with MSHN which will be used to inform the development of a comprehensive MSHN regional DEI plan in FY24.
- MSHN continues to engage in quality improvement efforts in collaboration with Medicaid Health Plan partners to reduce racial and ethnic disparities on specific integrated health performance measures. More detailed information is found later in this plan (Section VII - MDHHS Integrated Health Performance Requirements).
- MSHN and its regional partners are currently engaged in a three (3) year MDHHS-approved Performance Improvement Project (PIP) aimed at reducing or eliminating racial and ethnic disparities in access to PIHP managed services between Black/African American Medicaid beneficiaries and White Medicaid beneficiaries. More detailed project information and status updates about the PIP are available on the MSHN website: Compliance and Quality Reports - Mid-State Health Network (midstatehealthnetwork.org)

VI. Foundational Components of Effective Population Health

MSHN identified three core elements of an effective Population Health Plan:

- Systematic effort to improve health outcomes in sub-populations that share multiple clinical and social attributes
- Reflects the interdependence of biology, behaviors, social, cultural, economic, and environmental factors that impact well-being
- Compels healthcare and social service providers and the insurer to envision and develop organized and integrated delivery systems capable of achieving the Quintuple Aim.

Below are core foundational components that enable organizations to be successful in population health and care management**,** as well as a brief description of MSHN's efforts and activities in each foundational area. (Note: These foundations were presented at the American CMH Association Symposium for Behavioral Health and Primary Care in Washington, DC on January 20,2016. They have been modified here to illustrate MSHN's organizational readiness and current efforts in the areas of population health and integrated care).

Figure 15: Summary of MSHN Activity in Core Areas of Population Health

FOUNDATIONAL AREA	MSHN READINESS
Data Informed Strategy	• MSHN utilizes multiple data sources and risk-stratification models to identify target sub-populations and understand issues impacting health outcomes. • Comprehensive data-informed Population Health and Integrated Care Plan to articulate strategy toward managing population health concerns. • Research and develop a predictive modeling approach to population health.
Compensation/Reimbursement and incentives (to move from Volume to Value)	• Current value-based purchasing pilots with select SUD service providers. • CMHSP sub-capitation supports value-based managed care efforts by giving CMHSP participants the flexibility to engage in VBP arrangements with their provider networks.
Information Technology	• Utilize Integrated Care Delivery Platform (ICDP) and Admission/Discharge/Transfer (ADT) feeds from participating hospitals to obtain alerts and notifications. • Participate in Health Information Exchanges (HIE) such as VIPR and MiHIN • All CMHSPs in the MSHN region submit behavioral health ADT feeds to MiHIN.
Identification and management of high-risk and at-risk members	• MSHN utilizes CC360 for identification and care management of shared high-risk members with Medicaid Health Plans. • Employs utilization management practices to identify under and over-utilization in the population.
Development of Person-Centered Plan, health goals.	• Person-Centered Planning occurs at the local level with CMHSP and SUD service providers within the MSHN region. • Additional individual care planning for highest-risk members occurs on a monthly ongoing basis in collaboration with MHP partners. • Implementation of Behavioral Health Homes and Opioid Health Homes in the region to function as the central point of contact for patient-centered care across the broader health care system.
Care coordination; community support referrals and connections.	• Policies and procedures ensure care coordination and community referrals happen consistently throughout the region. • Community resources available on website; linking occurring with MHPs, CMHSPs, SUD Providers. • Memorandums of understanding with all Medicaid Health Plans in region.
Follow disease management protocols, clinical pathways, and evidence-based clinical practices/guidelines.	• Identified specific disease management performance metrics (HEDIS measures) and developed corresponding clinical protocols. • Coordination with MHPs to develop protocols for hospital readmissions and transitions of care.
Clinical Monitoring and Interventions	• Clinical monitoring and interventions occur at local level through partner CMHSP participants and SUD providers. • All CMHSPs and SUDSPs ensure coordination with primary care physicians for persons served; encourage annual wellness exams for all individuals and provide health screenings. • CMHSPs utilize ICDP for care alert monitoring and interventions.

FOUNDATIONAL AREA	MSHN READINESS
Self-management including prevention and wellness.	• CMHSPs & SUD providers support health education and communication to beneficiaries. • Required annual testing and follow up if not present by primary care physician. Monitoring for testing through ICDP. • CMHSPs offer Whole Health Action Management (WHAM) an evidence-based model that uses peer workforce to engage persons served in chronic disease self-management.
Multi-Media Support for Patient Care – Information Therapy	• Use of telehealth services in all CMHSP and SUDSP organizations. • Use of automated call reminders through EHR vendor in CMHSP participant organizations. • Web-based provider directory available for all CMHSP and SUDSP services.
Focus on health determinants	• Health determinants routinely screened by CMHSPs and SUDSPs (such as smoking, high-risk factors for communicable diseases). • Members with identified health determinants are offered supportive wellness services and/or referrals as part of the person-centered planning process. • Risk stratification models include health determinants such as homelessness and involvement in foster care.
Team-based care; integrated care	• CMHSPs participate in a variety of local-level integrated care activities including patient-centered health home practices. Described in further detail later in this plan. • Increased engagement of SUD service providers in integrated care strategies for co-morbid physical, behavioral health and substance use disorder concerns.
Relationships and Partnerships	• Strong collaborative relationships with all 8 MHPs that serve the 21-county MSHN region. • CMHSP participants have local partnerships with community health centers, hospitals, and primary care practices. • Increased care management and care coordination between MHPs, CMHSPs and SUD providers. • MSHN actively participates in community prevention coalitions in all 21 counties in the region.
Transitional Care	• CMHSP and SUD providers coordination of care between levels of care. • Enhanced follow-up protocols and data sharing between MSHN and MHPs for individuals when they are discharged from hospital.
Complex case (Care) Management Programs	• Local-level complex case management occurs within CMHSP participants and SUDSPs. • Participates in plan-to-plan level care management with MHPs for highest-risk shared members; develop coordination goals and share with CMHSP and SUD providers. • CMHSPs utilize ICDP to monitor health conditions and use to educate and follow up on alerts. • Protocols used to implement clinical best practices for high-risk individuals (i.e.: diabetes screening protocols).

FOUNDATIONAL AREA	MSHN READINESS
Quality: Evaluation; Performance metrics.	• Measurement portfolio includes performance metrics related to population health and integrated care. • Performance metrics reviewed by MSHN leadership councils and committees; provide change strategy recommendations for improvement.

VII. MDHHS Integrated Health Performance Requirements

The Michigan Department of Health and Human Services (MDHHS) operates a Performance Bonus Incentive Program (PBIP) which includes PIHP-only performance measures and PIHP/MHP joint performance measures. The intent of the PBIP is to incentivize Medicaid payers to improve health outcomes for the beneficiaries they serve through coordinated quality improvement efforts and the integration of behavioral health and physical health services.

The following is a summary of the FY24 PBIP measures and MSHN activities and initiatives to support each measure. PBIP requirements and specifications are subject to change from year to year. A full description and technical specifications for each year's PBIP measures is maintained on the MDHHS reporting website: Reporting Requirements (michigan.gov)

FY24 PIHP-Only Performance Measures:
P.1. Implement data driven outcomes measurement to address social determinants of health
P.2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)
P.3. Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment (IET)
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes

FY24 PIHP/MHP Joint Performance Measures:
J.1. Implementation of Joint Care Management processes
J.2. Follow-Up After Hospitalization for Mental Illness within 30 days (FUH)
J.3. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Implement Data Driven Outcomes Measurement to Address Social Determinants of Health

MSHN will conduct data analysis of BH TEDS records to establish baseline data about housing status and employment rates of persons served. This data will be shared with regional CMHSP and SUDSP partners to develop a comprehensive regional strategy for increasing housing and employments outcomes for persons served.

Additionally, MSHN will explore a regionwide approach to collecting SDOH data through the use of Z-Codes. This is already a requirement for CCBHCs and health homes, but having a standard method of collecting and reporting SDOH data will enhance MSHN's knowledge of the needs of the population and inform new programming and interventions.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

MSHN will conduct data analysis to establish baseline data about persons served. This data will be shared with regional CMHSP and SUDSP partners to develop a comprehensive regional strategy for increasing antipsychotic medication adherence for individuals with Schizophrenia. MSHN will work closely with its Regional Medical Directors' Committee to develop clinical interventions and care pathways specific to condition.

Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment (IET)

During FY23 MSHN participated in a data validation project with MDHHS to ensure PIHP data aligned with MDHHS data for the measure. Efforts during FY24-FY25 will focus on reducing racial/ethnic health disparities between the white population and minority populations served.

MSHN began publishing provider specific IET performance metrics on the MSHN website as of April 2023 for the purpose of improved transparency and accountability in the SUD service delivery system. Current IET data can be found here: AOD Initiation and Engagement - Mid-State Health Network (midstatehealthnetwork.org).

MSHN also began holding a quarterly SUD data workgroup to discuss SUD-specific performance metrics, including IET, as well as improvement strategies. Participation in the data workgroup is optional for SUD providers.

Increased Participation in Patient-Centered Medical Homes

MSHN submits an annual report to MDHHS summarizing regional efforts, initiatives, and achievements in the five (5) key areas of patient-centered medical homes. The FY23 report is available on the MSHN website: MSHN_Region_5_FY23_PBIP_Narrative_Report_Final.pdf (midstatehealthnetwork.org).

Implementation of Joint Care Management Process

The Medicaid Health Plan (MHP) and Pre-Paid Inpatient Health Plan (PIHP) Integrated Health Workgroup identified and agreed to the inclusion of the following stratified risk criteria for the selection of persons requiring the most thoughtful and well-coordinated care between the MHPs and PIHPs:

- Number of emergency department visits in previous 12 months
- No visits to a primary care physician within the last year
- Number of chronic conditions (physical health and behavioral health)
- Number of psychiatric/physical health hospitalizations within the last 12 months
- Social Determinant of Health (SDOH) factors such as homelessness

MSHN participates in monthly care management meetings with each of the 8 MHPs in the region for coordinated service planning and care management activities for shared members who meet established risk criteria.

The risk criteria are retrievable through Care Connect 360 (CC360) which results in a list of consumers whose interface (or lack thereof) with the healthcare system as well as the presence of chronic health conditions amounts to ongoing issues related to social determinants of health/wellness, poor access to care, increased risk of utilization of higher cost services, and increased chances of a general worsening of overall physical and psychological well-being.

New for FY24, PIHPs and MHPs will be required to develop and implement a process for identifying minors with appropriate severity and risk factors and provide care coordination to the population. MSHN is chairing a focused workgroup comprised of representatives from MHPs and PIHPs to develop risk criteria and care coordination processes for children and youth, including those involved with the foster care system. Additional information and updates will be shared in quarterly MSHN Integrated Health Department reports as this work progresses throughout FY24-25.

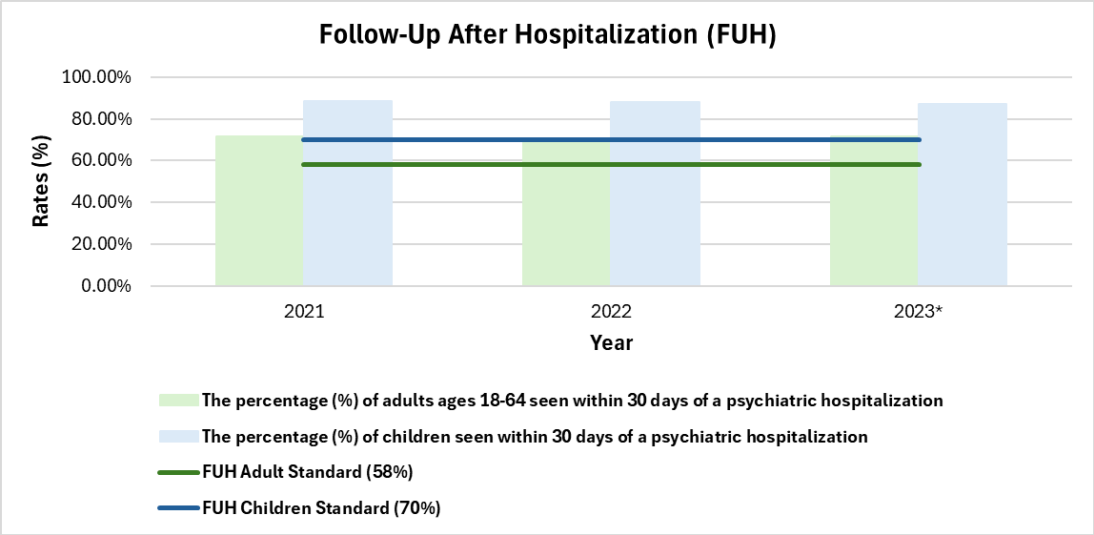
MSHN tracks and monitors the following outcome measures related to care management for high-risk shared members.

- Reduction in number of visits to ER
- Reduction in hospital admissions for psychiatric/physical health reasons
- Percent of consumers who have had a PCP visit in the last twelve months
- Reason for closure of care management case
- Amount of time (in days) spent in a care management plan arrangement

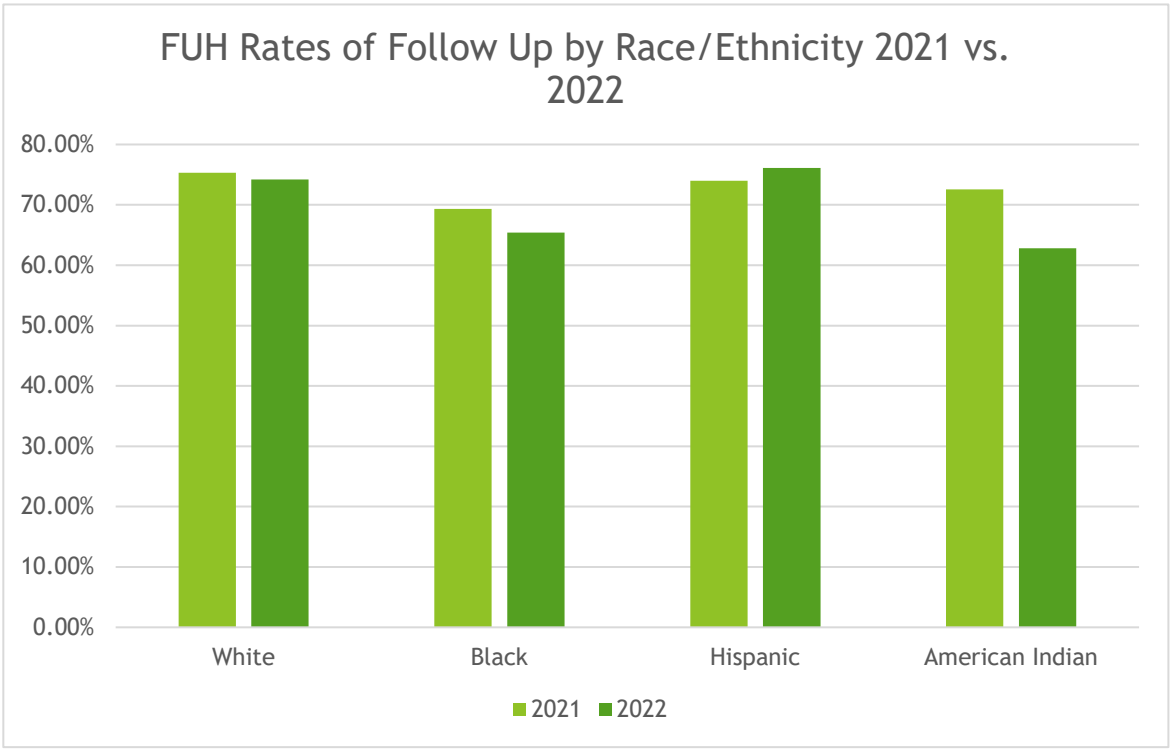
Follow-Up After Hospitalization for Mental Illness

In addition to the monthly care coordination meetings for shared high-risk members, MSHN also participates in ongoing targeted care coordination efforts with its MHP partners to provide comprehensive follow-up care for shared members after an inpatient psychiatric hospitalization when people are often most vulnerable. In partnership with local CMHSP's, MSHN provides inpatient admission notification for shared members to each of its 8 MHP partners within 5 business days. MSHN and the MHP care managers coordinate to determine which plan will be responsible for providing follow-up care within designated timeframes. The MSHN Quality Improvement Council monitors this metric on a quarterly basis and participates in quality improvement activities when adverse trends are identified. Historically, MSHN as a region has always exceeded the benchmark rates for both adults and children on this measure.

Figure 16: MSHN Historical Performance on FUH Metric



In addition to meeting established benchmark rates for adults and children, PIHPs must reduce or eliminate racial and ethnic disparities in the rates of follow up between minority groups and the White population. There was a statistically significant disparity in the MSHN region in the rates of follow-up after hospitalization between the Black/African American population and White population in 2021 and 2022. Final data for 2023 is not available as of the writing of this plan, however early projections indicate the disparity is likely to persist.



Follow-Up After Emergency Department Visit for Alcohol or Other Drugs (FUA)

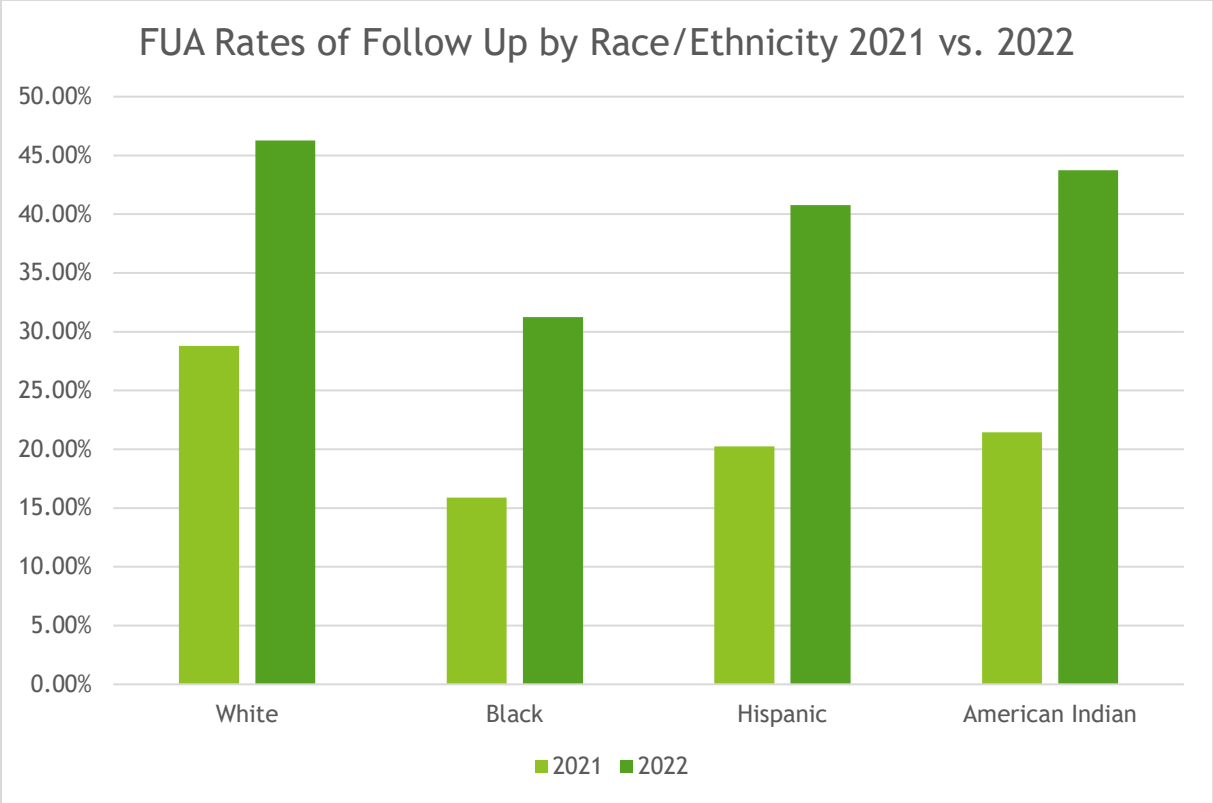
According to Michigan Medicaid claims data there were 22,341 emergency room visits related to a primary substance use disorder reason by Medicaid beneficiaries statewide during 2022. Only 9,465 of these visits (42.37%) resulted in a follow-up service to address the substance use concern within 30 days

following the ER visit. Additionally, there is a significant racial disparity when looking at the rates of follow-up between African-American/Black individuals (32.50%) and White individuals (46.85%) statewide. The rates of follow-up for Medicaid beneficiaries in the MSHN region during this same time period was nearly the same as the statewide data with an overall follow-up rate of 43.25%, follow-up rate for African-American/Black individuals of 31.25%, and follow-up rate for White individuals of 46.28%.

MSHN is committed to ensuring that Medicaid-eligible individuals in its service region who may be experiencing, or at-risk of, a substance use disorder are identified earlier and provided with appropriate options for treatment and recovery resources. One of the ways MSHN is working to accomplish this is through the use of Project ASSERT (Alcohol & Substance Abuse Services Education Referral Treatment) interventions in hospital emergency rooms in its 21 counties. The Project ASSERT model utilizes peer recovery coaches with lived experience to intervene with at-risk individuals prior to discharge from the ER and provide them with brief education, referrals to treatment (if applicable), and other community resources to support the individual. Demographic data and contact information are also gathered in order to perform outreach and follow up.

MSHN launched a value-based purchasing (VBP) pilot project with Project ASSERT providers with goals of increasing both the total number of Project ASSERT encounters that occur in hospital ERs and the overall rate of follow-up contacts. Please refer to Section VIII of the plan for more detailed information about SUD Value-Based Purchasing Pilot Projects, including Project ASSERT.

Rates of FUA improved dramatically from 2021 to 2022, thanks to the efforts of Project ASSERT coaches in the region. Although rates of follow up improved overall, there remains a disparity in the rate of follow up between the Black/African American population and White population.



VIII. Other Population Health & Integrated Care Initiatives

Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics (CCBHCs) are designed to provide a broad array of mental health and substance use disorder services to persons of all ages, regardless of ability to pay, including those who are underserved, have low incomes, have Medicaid, are privately insured or uninsured, and are active-duty military or veterans. The CCBHC model requires access to 24/7/365 crisis response services, along with other critical elements including strong financial and quality metric reporting; formal coordination with primary and other care settings to provide intensive care management and transitions of care; linkage to social services, criminal justice/law enforcement, and educational systems.

The CCBHC demonstration pilot launched in Michigan on October 1, 2021, and is anticipated to run for six (6) years. Three CMHSPs in the MSHN region began participating in the demonstration at the initial outset: CEI CMH, Saginaw CMH, and The Right Door. LifeWays became the fourth CMHSP in the MSHN region to join the CCBHC demonstration with implementation on October 1, 2023. Over 15,000 individuals were served by CCBHCs in the MSHN region within the first two (2) years of the demonstration (FY22-FY23).

MDHHS is responsible for certification, monitoring, and program evaluation of the CCBHC demonstration in Michigan. As the PIHP, MSHN is responsible for providing technical assistance and support to CCBHCs in the region to ensure they meet all required standards to maintain CCBHC certification. Additionally, MSHN is responsible for distributing payment, facilitating beneficiary enrollment to the CCBHC demonstration, and monitoring and reporting on CCBHC quality performance measures. More information about the CCBHC demonstration and requirements is available on the MDHHS website: Certified Community Behavioral Health Clinics (CCBHC) Demonstration Program (michigan.gov).

One of MSHN's strategic objectives for 2024-2026 is to expand availability of behavioral health services and supports to residents of the MSHN region by increasing the number of Certified Community Behavioral Health Centers (CCBHC).

Behavioral Health Homes

Behavioral Health Homes (BHH) are an innovative Medicaid service delivery model that provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this attends to a beneficiary's complete health and social needs.

When someone enrolls in the BHH program, they work closely with a multi-disciplinary Care Team designed to help individuals better understand and manage their conditions under one roof, with the goal of simplifying where services are delivered. The Care Team works with the person served to create a care plan which will address physical, mental health, substance use, recovery, and social service needs.

The BHH initiative launched in the MSHN region beginning on May 1, 2023. Five CMHSPs in the MSHN region launched BHH programs during the initial FY23 implementation: Saginaw CMH, Newaygo CMH, Montcalm Care Network, Shiawassee Health & Wellness, and CMH for Central Michigan. Gratiot Integrated Health Network will launch its BHH beginning in FY24. CMHSPs in the MSHN region may choose to join the BHH initiative at any time. Over 500 Medicaid beneficiaries were served by BHH programs in the MSHN region during FY23.

As the PIHP, MSHN is responsible for certification, monitoring, program evaluation, providing technical assistance and support to BHHs in the region to ensure they meet all required standards of the BHH program. Additionally, MSHN is responsible for distributing payment, facilitating beneficiary enrollment to the BHH, and monitoring and reporting on BHH quality performance measures. More information

about the BHH program and requirements is available on the MDHHS website: Behavioral Health Home (michigan.gov).

MSHN strives to improve the overall wellness of individuals struggling with comorbid chronic conditions by providing comprehensive care management and integrated services to address social, behavioral, and physical health needs through health home programs. One of MSHN's strategic objectives for 2024-2026 is to expand availability of health home services and support to residents of the MSHN region by increasing the number of Behavioral Health Homes.

Opioid Health Homes & SUD Health Homes

Opioid Health Homes (OHH) are an innovative Medicaid service delivery model that provide comprehensive care management and coordination services to Medicaid beneficiaries with a diagnosis of Opioid Use Disorder. For enrolled beneficiaries, the OHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this attends to a beneficiary's complete health and social needs.

When someone enrolls in the OHH program, they work closely with a multi-disciplinary Care Team designed to help individuals better understand and manage their conditions under one roof, with the goal of simplifying where services are delivered. The Care Team works with the person served to create a care plan which will address physical, mental health, substance use, recovery, and social service needs.

The OHH initiative launched in the MSHN region beginning on October 1, 2022, with Victory Clinical Services in Saginaw as the first OHH in the MSHN region during the initial year of the program. Over 175 Medicaid beneficiaries were served by the OHH program in the MSHN region during the first year of implementation. MSHN is working on implementation planning with a cohort of providers to launch additional new OHH clinic locations during FY24:

- Victory Clinical Services in Jackson and Ingham Counties
- Recovery Pathways in Bay County and Shiawassee Counties
- Isabella Citizens for Health in Isabella County
- MidMichigan Community Health Center serving Clare, Gladwin, Osceola, and Mecosta Counties

As the PIHP, MSHN is responsible for certification, monitoring, program evaluation, providing technical assistance and support to OHHs in the region to ensure they meet all required standards of the OHH program. Additionally, MSHN is responsible for distributing payment, facilitating beneficiary enrollment to the OHH, and monitoring and reporting on OHH quality performance measures. More information about the OHH program and requirements is available on the MDHHS website: Opioid Health Home (michigan.gov).

MSHN strives to improve the overall wellness of individuals struggling with comorbid chronic conditions by providing comprehensive care management and integrated services to address social, behavioral, and physical health needs through health home programs. One of MSHN's strategic objectives for 2024-2026 is to expand availability of health home services and support to residents of the MSHN region by increasing the number of Opioid Health Homes.

At the time of the writing of this plan, MDHHS has indicated a plan to expand the eligibility of Opioid Health Home services beginning in FY25 to individuals with Stimulant Use Disorder and Alcohol Use Disorder diagnoses in addition to Opioid Use Disorder under the umbrella of Substance Use Disorder (SUD) Health Homes. If final approval is granted by the Centers for Medicare and Medicaid and legislative funding support is obtained, MSHN will seek to implement and expand SUD Health Homes in the region.

Population Health & Integrated Care Measurement Portfolio

With input from its regional councils and committees, MSHN developed a priority measure portfolio based on national healthcare industry standards. MSHN utilizes data analytics software to monitor and track these measures regionally as well as by individual performance of each CMHSP. CMHSPs and other stakeholders can view regional performance and CMHSP-specific data on the MSHN website: Priority Measures - Mid-State Health Network (midstatehealthnetwork.org). Metrics are reviewed quarterly, if not more frequently, by regional MSHN councils and committees for ongoing input into performance improvement strategies.

Value-Based Purchasing Pilot Projects for Substance Use Disorder Services

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "Value-based payment (VBP) models pay health care providers based on the value rather than the volume of services. Use of these models has been concentrated in physical health services. However, due to the magnitude of substance use disorders (SUDs) in the United States, there has been a growing movement toward using VBP for SUD treatment and recovery services. VBP models have the potential to improve delivery of the integrated and coordinated care necessary for the complex and continuing needs of individuals with SUDs."[4]

MSHN is currently engaged in a SUD VBP pilot project to improve outcomes for individuals following a hospital emergency department visit for a reason related to alcohol or other substance use. Research shows that individuals with mental health and substance use conditions have more hospital emergency department (ED) reoccurring visits in comparison to those who visit the ED for a physical health ailment. In particular, high ED use for individuals with alcohol or other drug (AOD) use may signal lack of access to care or issues with continuity of care.[5] Timely follow-up care for individuals with AOD who were seen

[4] Center for Financing Reform and Innovation (2023). *Exploring Value-Based Payment for Substance Use Disorder Services in the United States.* Substance Abuse Mental Health Services Administration. HHS Publication No. PEP23-06-07-001.

[5] New England Healthcare Institute (2010) A Matter of Urgency: Reducing Emergency Department Overuse, A NEHI Research Brief. http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf

in the ED is associated with a reduction in substance use, future ED use, hospital admissions and bed days.[6] [7] [8]

A national and state performance measure titled Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA) tracks the percentage of individuals who receive a follow-up visit within 30 days after going to the ED for alcohol or other drugs. Please refer to Section VII of this plan for more detailed information about MSHN regional performance on the FUA performance measure.

One of the primary interventions MSHN has implemented to improve follow up care for individuals after they visit the ED for alcohol or substance-related issues is Project ASSERT. Project ASSERT is a model of early intervention, screening, and referral to 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 offers appropriate referrals and follow-up support. The Project ASSERT provider then submits an encounter to MSHN to capture the activity being performed.

MSHN seeks to increase both the total number of Project ASSERT encounters that occur in hospital EDs and the overall rate of follow-up contacts with individuals following the ED visit. The current VBP pilot will use innovative payment strategies that incentivize Project ASSERT providers to increase the rate of follow-up care for individuals who have experienced an ED visit for alcohol or other drugs.

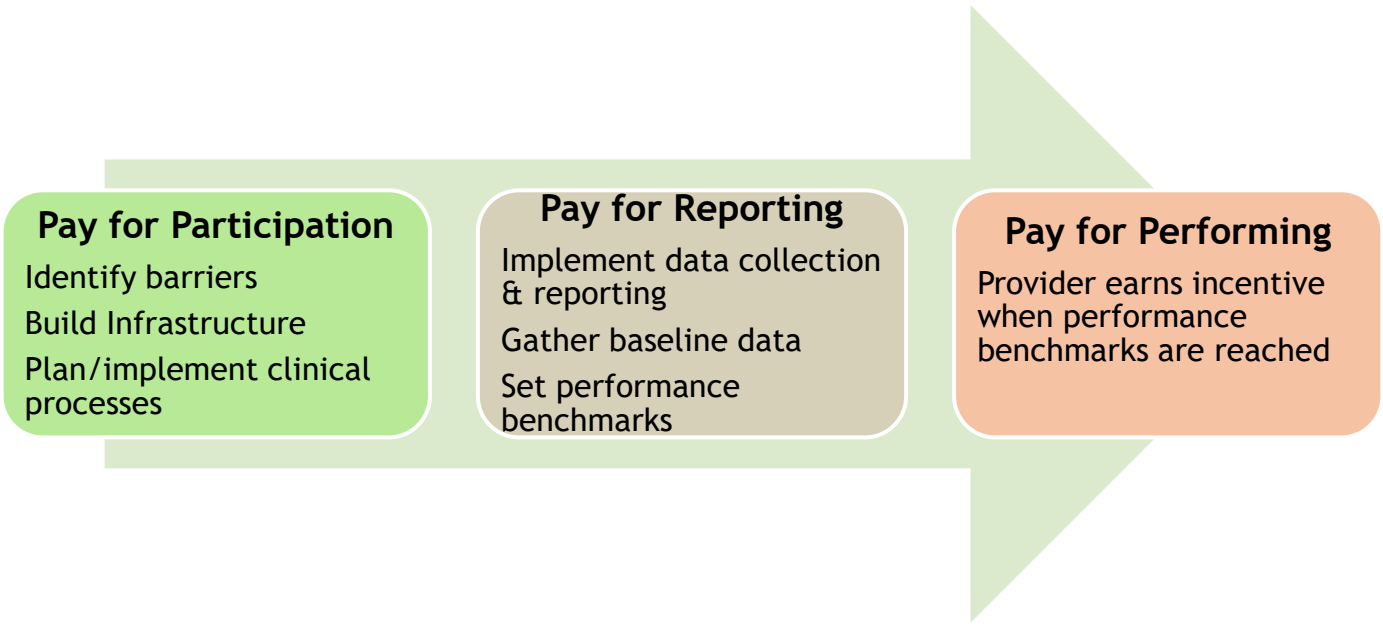
The pilot will follow three phases of implementation as depicted below. Provider participation will be incentivized at each phase, with financial incentives evolving from planning, infrastructure development and information gathering, to full implementation of the clinical model. MSHN and Project ASSERT providers engaged in the Pay for Participation and Pay for Reporting phases of the pilot in FY23. Implementation of the final Pay for Performing phase is scheduled to occur during FY24.

MSHN is also using a data-informed approach to evaluate other areas where there may be gaps in care or opportunities to improve outcomes for persons served. MSHN intends to take experiences and lessons learned from the Project ASSERT VBP to inform development of future VBP models across other provider types and levels of care in the SUD service delivery system.

[6] Kunz, F. M., Jr, French, M. T., & Bazargan-Hejazi, S. (2004). Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner-city hospital emergency department. *Journal of studies on alcohol*, *65*(3), 363–370. https://doi.org/10.15288/jsa.2004.65.363

[7] Mancuso, D., Nordlund, D.J., & Felver, B. (2004). Reducing emergency room visits through chemical dependency treatment: focus on frequent emergency room visitors. Olympia, Wash: Washington State Department of Social and Health Services, Research and Data Analysis Division.

[8] Parthasarathy, S., Weisner, C., Hu, T. W., & Moore, C. (2001). Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. *Journal of studies on alcohol*, *62*(1), 89–97. https://doi.org/10.15288/jsa.2001.62.89



Regional Substance Use Disorder Strategic Plan

MSHN prevention and community SUD recovery services operate from the guiding principle to serve individuals and communities wherever they are across the entire spectrum of preventative care/services. To that end, the MSHN FY24-26 SUD Strategic Plan is comprised of a focused set of goals to support expansion and enhancement of an array of services within the recovery-oriented system of care. These goals will also have an alternative purpose to reduce the health disparities among high-risk populations receiving, prevention, treatment, harm reduction, and recovery services. The full MSHN SUD strategic plan is available on the MSHN website: Substance Use Disorder - Mid-State Health Network (midstatehealthnetwork.org).

CMHSP Integrated Health Initiatives

There is a large variance across the CMHSPs in the MSHN region regarding size, resources, and number of persons served. Some CMHSPs have the ability to participate in a large number of activities to affect population health while others have fewer resources. The following regional best practices are the minimal integrated health activities each CMHSP is engaged in:

- Verify consumer self-reported health conditions either through ICDP, CC360 or direct contact with primary care[9]
- Inform every consumer that the CMHSP is required to coordinate care with their primary care physician.[10]
- Meet the measurements identified through Meaningful Use for patient portals.

[9] MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program - 8.4.2 Contract Withholds

[10] MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program - 7.4 Integrated Physical and Mental Health Care; 19.5 Primary Care Coordination.

- Each CMHSP will identify its high-risk utilizers and develop a plan for stratification as locally determined and defined. MSHN monitors and defines its risk stratification as defined in this plan as high-risk. *(Consumers identified as having 1 or more emergency department visits, no primary care visit within the previous 12 months, 2 or more chronic conditions, psychiatric or physical hospitalization within the previous 12 months).*

- Care Coordination occurs with primary care and behavioral health care.

- At least once annually (typically during the pre-planning for person centered planning), staff will utilize electronic data feeds to determine the last time the individual had contact with their primary care physician.

- Each CMHSP will work with its medical directors to review and discuss MSHN priority measures that are measured and tracked as a region.

- Each CMHSPs Information Technology Directors and EMR vendors will work together to embed ICDP/CC360 into the electronic medical record to facilitate easier access to integrated health data for practitioners.

In addition to the regional integrated health best practices, many CMSHPs participate in extensive additional population health and integrated care activities in their local communities, as resources allow. Annually, MSHN compiles a narrative report for submission to MDHHS summarizing the broad-level population health activities performed by the PIHP as well as the extensive integrated health efforts and achievements of MSHN's member CMHSP organizations. The annual reports can be accessed on the MSHN Website- Population Health & Integrated Care.

IX. Summary & Recommendations

MSHN is a leader among Michigan PIHPs in the areas of Population Health and Integrated Care. The region collectively and all 12 CMHSP participants individually have consistently met and exceeded many nationally normed health quality metrics since 2016. MSHN's Population Health program utilizes advanced healthcare data technology to better understand the healthcare needs of the region's population, identify gaps in care, and inform strategies to improve services. MSHN together with its CMHSP participants and provider networks remain committed to the goals of providing quality supports and services that help individuals achieve whole-person wellness, reducing health disparities for marginalized and vulnerable populations, and continuous improvement in health equity.

In furtherance of these goals, recommendations for FY24-25 include the following:

- **Continue to explore technology platforms that leverage the use of data for predictive modeling of health outcomes.**

- **Fully implement the use of ADTs and other CareConnect360 data with MSHN's SUDSP network.**

- Develop clinical protocols around the use of ADTs and expectations of providers relating to care coordination with physical healthcare providers.

- **Continue to gather and analyze regional data on health disparities.**
  - Gather stakeholder input about factors that contribute to health disparities in their communities through use of focus groups.

- **Expand existing SUD Value Based Purchasing arrangements; consider use of performance metrics with all SUD providers to incentivize quality outcomes.**

- **Consider regional training support for CMHSP and SUDSP workforce in care management, transitions of care, and effective coordination with MHPS and physical healthcare systems.**

- **Develop and implement a comprehensive MSHN regional DEI Plan which also includes strategies to reduce and eliminate health disparities and promote health equity in all aspects of operations and service delivery.**

- **Expand availability of behavioral health services and support to residents of the MSHN region by increasing the number of Certified Community Behavioral Health Centers.**

- **Expand availability of health home services and support to residents of the MSHN region by increasing the number of Behavioral Health Homes, Opioid Health Homes, and SUD Health Homes.**

- **Develop risk stratification for Complex Care Management systems in-region to improve overall population health (e.g. unenrolled, high cost, complex physical and BH).**

- **Develop system to monitor and support Children in Foster Care/Welfare System with joint care planning.**

- **Research and develop reporting system on Social Determinates of Health for individuals served, focusing on employment and housing for FY24-25.**

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Appendix A: MSHN Population Data, Per County

County	2022 Population Census	Percent Persons in Poverty	County Health Ranking	5 Year Change (County Health Ranking)
Bay	102,821	14.30%	34	↓2
Huron	31,248	12.00%	51	↑7
Tuscola	52,945	12.30%	40	↑11
Arenac	15,089	13.60	80	↑18
Saginaw	188,330	18.10%	74	↓3
Gladwin	25,728	13.90%	66	↑1
Midland	83,674	8.90%	7	↓1
Clare	31,352	17.20%	72	↓3
Isabella	64,447	19.40%	50	↓4
Gratiot	41,100	12.30%	38	↑8
Osceola	23,274	15.70%	35	↓22
Mecosta	40,720	20.40%	57	↑33
Montcalm	67,433	14.80%	32	↓10
Newaygo	50,886	13.30%	47	↑9
Ionia	66,809	12.10%	19	↑1
Clinton	79,748	9.10%	2	↓1
Shiawassee	68,022	12.10%	30	↓11
Eaton	108,992	9.00%	16	↑2
Ingham	284,108	16.30%	56	↓3
Jackson	160,066	13.00%	55	↓9
Hillsdale	45,762	13.90%	27	↓1
TOTAL	**1,632,554**	Compared to National Poverty Level of 11.5% (2022)	N/A	N/A

US Census Bureau Quick Facts, www.census.gov/quickfacts

County Health Rankings: http://www.countyhealthrankings.org/app/michigan/2017/overview

Appendix B: Nervous System Disorders Code Set

The following were the top 10 frequently occurring ICD-10 diagnostic codes classified as "Nervous System Disorders" as represented in the table on page 15 of this plan:

ICD Code	Name
G43909	MIGRAINE, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS MIGRAINOSUS
G40909	EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS
H2513	AGE-RELATED NUCLEAR CATARACT, BILATERAL
G894	CHRONIC PAIN SYNDROME
H903	SENSORINEURAL HEARING LOSS, BILATERAL
G43009	MIGRAINE WITHOUT AURA, NOT INTRACTABLE, WITHOUT STATUS MIGRAINOSUS
G5601	CARPAL TUNNEL SYNDROME, RIGHT UPPER LIMB
G35	MULTIPLE SCLEROSIS
G809	CEREBRAL PALSY, UNSPECIFIED
G629	POLYNEUROPATHY, UNSPECIFIED