
**Performance Bonus Incentive Program (PBIP)**
**Participation in Patient-Centered Medical Homes Narrative**

**Region 4 - Southwest Michigan Behavioral Health**

**Attention:**

**Michigan Department of Health and Human Services**

**Behavioral and Physical Health and Aging Services Administration**

(Reporting Period October 1, 2023 – September 30, 2024)

# Southwest Michigan Behavioral Health (SWMBH)

## Comprehensive Care

The overall goal of Complex Case Management (CCM) is to help members move towards optimum health, improved functional capability, and a better quality of life. A SWMBH Registered Nurse (RN) helps facilitate the identification of steps needed and the community support available to meet the patient-centered goals. CCM is available to members who have various comorbid behavioral health, physical conditions, and social determinants of health (SDOH) needs. CCM offers SWMBH members the opportunity to work with an RN for comprehensive assessment of the member's needs, establish member-centered goals to address needs, identify barriers and solutions to help achieve goals, and to identify additional available community resources. CCM aims to help organize and coordinate services for members with complex physical and behavioral health conditions. The RN works through physical and behavioral health obstacles or barriers with members on an individual basis, and helps members navigate multiple service pathways and secure physical health, behavioral health, and community services. The criteria for enrollment includes, but is not limited to, one or more severe mental illness (SMI) behavioral health diagnoses and at least one of the following criteria:

- Recent (two in the past six months) inpatient admissions (IP) to the hospital
- High Emergency Department (ED) User
- Four or more chronic medical diagnoses
- A combination of IP admissions/high ED use along with a less severe mental illness

## Patient-Centered Care

SWMBH was awarded mental health block grant funding aimed at reducing racial disparities which exist in access and engagement of behavioral health treatment. SWMBH measures racial disparities in performance bonus incentive metrics including Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence, Follow-Up After Hospitalization (FUH), and the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). As a means of reducing these disparities, SWMBH employed a Health Equity Project Coordinator to plan and develop a region-wide program increasing the access and participation of minority populations in behavioral health services. SWMBH endeavored several tasks toward understanding and reducing health disparities for persons served:

- Formed a regional Health Equity Focus Group comprised of Community Mental Health Service Program (CMHSP) representatives to identify prominent minority population needs and barriers of each county.
- Health Equity Project Coordinator participates in community events and collaborative stakeholder meetings to raise awareness of health disparities through data promotion and sharing.
- Partnered with Michigan Public Health Institute (MPHI) to conduct focus interviews with peer recovery workers at various access points to identify barriers faced by minority populations throughout the region.
- Launched "Flip the Script", an anti-stigma media campaign advertised over billboards, social media, and radio to adjust the way people view seeking help for mental health, specifically Black mental health.
- Provided a virtual health equity series addressing Stigma in Mental Health, Health Communication 101, Disparities in Behavioral Health, Bias & Community Engagement, and Disability & Health Equity as well as a full day in-person health equity symposium, Flip the Script: Creating a New Narrative.

## Coordination of Care

SWMBH has a robust Integrated Care department aimed at improving the health of members served while reducing utilization of high-cost treatment interventions and readmissions. Coordination of care initiatives are designed to enhance the quality and coordination of healthcare services. Such initiatives recognize the importance of delivering comprehensive and integrated care and include a variety of strategies to address the complex needs of populations served while striving to achieve positive health outcomes and cost-effective care. The SWMBH Integrated Care Team (ICT) positions Transition Navigators to track FUH monitoring for members in the region not already connected to or engaged in treatment with a local Certified Community Behavioral Health Clinics (CCBHC) or CMHSP. Transition Navigators provide member outreach encouraging participation in aftercare and assist in coordinating resources to reduce barriers to the member accessing services.

SWMBH's ICT facilitates monthly meetings including staff from SWMBH, Medicaid Health Plan (MHP), CMHSP and primary care physician (PCP) staff participating in care coordination with a shared goal of person-centered planning toward improved health outcomes. A SWMBH Integrated Care Specialist runs the risk stratification list for each MHP two weeks prior to the ICT meeting date. Targeted outcomes are reduction of chronic conditions and reduction of ED visits. Members are prioritized based on high ED use and high IP admissions, non-emergent ED use, SMI diagnoses, and recent behavioral health and physical health claims. Meeting facilitation identifies members' needs, any barriers to meeting those needs, and potential action items to address barriers. Participating stakeholders collaborate to provide behavioral health and medical updates. Identified members are tracked in ICT meetings until they are stable for 3 months (e.g., no chronic ED or IP visits), are active and/or stable with behavioral care, or are discharged from behavioral health treatment.

SWMBH staff have access to the SWMBH Medical Director, Dr. Michael Redinger, a psychiatrist for member-specific consultation via phone and ad hoc meetings at any time. Members brought for discussion with Dr. Redinger are typically diagnosed with SMI and multiple chronic physical health conditions and usually have a recent history of inpatient psychiatric admission with very difficult to treat symptomology. After reviewing diagnoses, presenting behaviors, and treatment history, Dr. Redinger can provide consultation on viable next steps for the member's treatment regimen. Difficult cases or members with complex needs are brought to Dr. Redinger for consultation.

## Accessibility of Services

SWMBH has two CMHSPs, (Integrated Services of Kalamazoo and Pivotal) who have been participating in the CCBHC Demonstration since 2021. In October 2023, four additional CMHSPs (Summit Pointe, Barry, Woodlands, and Pines) joined the demonstration. An additional CMHSP (Van Buren) was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Expansion grant in 2023 and was accepted to the demonstration beginning October 2024. CCBHCs are required to provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder diagnosis regardless of ability to pay, thus exponentially expanding accessibility to services. CCBHCs engage in formal coordination agreements with primary care and other health entities such as Integrated Care Organizations (ICOs) and MHPs providing intensive care management to all enrollees who need it.

During FY24, The Opioid Health Home (OHH) program was operating at four different provider locations throughout the region. The OHH provider network consists of three out-patient treatment providers (OTPs): Victory Clinical Services Kalamazoo, Victory Clinical Services Battle Creek, Harbortown, and one CMHSP: Summit Pointe. Each OHH has an integrated care team consisting of a Nurse Care Manager, Peer Recovery Coached, Behavioral Health Specialist, and Community Health Workers (CHWs) who work together with the member to identify areas of need and create a care plan for their services. The care team works within the OHH model framework focusing on six core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referrals to community and social support services. SWMBH's current OHHs have built relationships with community resources to refer members to additional supports to meet their social determinants of health needs that aid in their recovery. This includes food resources, clothing needs, housing supports, legal concerns, and employment. A large focus of the program is on expanding member's access physical healthcare, including dental care, and the promotion on preventative care to reduce overutilization of the ED. In FY24, the four OHHs enrolled a total of 704 members and provided over 11,500 services.

## Quality and Safety

SWMBH utilizes Relias's Population Performance platform to monitor behavioral and physical health status of members served, using Care Connect360 Medicaid service data. Population Performance contains reports measuring inpatient and emergency department utilization, medication adherence, prescribing trends, and Healthcare Effectiveness Data and Information Set (HEDIS) metrics. SWMBH has developed algorithms to identify individuals with a wide range of chronic health conditions and behavioral health diagnoses, along with their IP and ED utilization, and demographics. SWMBH is currently exploring how to best use this information to monitor and improve population health and have published a population health report. Relias Population Health can also identify individuals at risk for high inpatient and ED utilization, based on service history and chronic conditions. SWMBH

has added HEDIS metrics related to the Michigan CCBHC demonstration, and is developing care manager caseload monitoring capacities, so that care managers can view the comprehensive health status of their member population and identify individuals in need of individual outreach or support. CCBHCs can use Population Performance to monitor their CCBHC-enrolled populations and to track trends on CCBHC quality bonus metrics. SWMBH and CMHSP leadership can use Population Performance to identify regional and local population health trends, and drive decision-making for regional clinical initiatives.

## Barry County Community Mental Health Authority (BCCMHA)

### Comprehensive Care

BCCMHA maintains their certification as a CCBHC Demonstration site and is currently in the second year of a four-year SAMHSA CCBHC Improvement and Advancement grant. Efforts to integrate comprehensive health measures continue to grow, including daily interdisciplinary huddles, expanded group services focused on whole health, and screenings to address SDOH. Key health indicators are assessed during intake and throughout treatment as appropriate. Areas of focus for screening and monitoring include adult and youth body mass index (BMI), diabetes, tobacco use, and alcohol use. BCCMHA has developed targeted reporting based on the SDOH screener to identify high-priority needs, which are incorporated into the agency's strategic plan. BCCMHA has been selected to participate in a Rural Communities CCBHC workgroup, sponsored by the National Council for Mental Wellbeing, aimed at identifying and addressing barriers to providing comprehensive care in rural communities.

### Patient-Centered Care

BCCMHA's care coordinators initiate the person-centered planning process following intake, ensuring that individuals are empowered to direct their own treatment. SDOH screenings are integrated into this process, with the support of CHWs who assist with system navigation, connecting individuals to resources, and helping them achieve their personal health goals. BCCMHA offers a variety of health-focused groups addressing all aspects of wellness, including the 8 Dimensions of Wellness, Smoking Cessation, and Illness Management and Recovery. All BCCMHA's members are assigned a care coordinator who monitors risks, needs, and referrals throughout the course of care. Care coordinators also facilitate daily interdisciplinary huddles to foster collaboration among internal providers. Primary care screenings are conducted minimally, at intake and annually, serving as a safeguard given the scarcity of physicians in the community. BCCMHA monitors psychiatric members for metabolic syndrome and conducts on-site A1C testing to address low compliance with ordered lab work.

### Coordination of Care

BCCMHA coordinates care across health and supportive services through formal agreements with healthcare providers, local courts, the county jail, social service agencies, schools, and the Veteran's Administration. Daily rounds with the local ED address behavioral health cases, and additional information is shared as needed. Weekly meetings with the local Federally Qualified Health Center (FQHC) discuss mutual members and barriers to care, while nurse care managers receive alerts when active members are discharged from the ED to ensure follow-up and coordination of care. Monthly meetings with SWMBH and MHPs further support collaborative care. BCCMHA also uses an Electronic Health Record (EHR) tracking system to monitor and follow up on internal and external referrals, with care coordinators overseeing completion.

### Accessibility of Services

As a CCBHC Demonstration site, BCCMHA provides services to all individuals, regardless of diagnosis, insurance, or location, offering same-day and scheduled intake assessments through both in-person and telehealth options. Crisis services are accessible during business hours on a walk-in basis, after-hours through on-call crisis therapists, and 24/7 via a mobile crisis team. To reduce barriers to service, BCCMHA employs an Outreach Specialist and a Veterans Navigator. The Outreach Specialist has fostered connections with local physicians, churches, and social service agencies and has participated in community events like Wellness Fairs and Gender-Sexuality Alliance (GSA) groups. The Veterans Navigator engages in groups like Walking with Warriors, Veterans Community Action Team (VCAT), and Woman Veteran Strong, and collaborates with the Battle Creek Veterans Affairs (VA) Medical Center. Additionally, the Veterans Navigator has organized two Promise to Address Comprehensive Toxics (PACT) Act events and Barry County's first Military Ball to raise awareness of available services.

### Quality and Safety

As part of its Disparity Impact Statement for the SAMHSA CCBHC- Improvement and Advancement (IA) grant, BCCMHA has established reporting to analyze service utilization and community referrals by LGBTQIA+ versus non-LGBTQIA+ members, using this data to guide outreach, training, and service decisions. BCCMHA also maintains an agency-wide alert system for potential threats and conducts regular lockdown drills. A High-Risk Care Pathway has been implemented for members at higher suicide risk, featuring frequent check-ins, service adjustments, and interdisciplinary review. The Quality Improvement (QI) Committee tracks performance data on quality, safety, suicides, inpatient readmissions, sentinel events, unbilled services, and improvement outcomes, while the Sustainability Committee addresses inefficiencies related to unbilled services and missed opportunities.

## Berrien County (Riverwood Center)

### Comprehensive Care

Riverwood Center applied for and was awarded the SAMHSA CCBHC-IA grant which began in April of 2024. Riverwood Center also applied for and was awarded the CCBHC Demonstration Site Designation grant which began on 10/01/2023. Through the Demonstration Site Riverwood Center served 4,853 members FY24.

### Patient-Centered Care

Riverwood Center is committed to patient-centered care for all individuals. Riverwood Center assists members that do not have a PCP to find a provider or medical home. Riverwood Center meets with members in the most convenient manner possible by offering “remote” or telehealth visits for members that want to meet in this manner. Telehealth provides the individual with more options and flexibility in the way that services are provided to meet their individual needs and preferences.

### Coordination of Care

The coordination and integration of care is a fundamental goal of Riverwood Center for FY24. Riverwood Center has developed a Health Information Exchange (HIE) with Michigan Health Information Network (MiHIN) and with Corewell Health System, FQHC InterCare, and other providers in Berrien County to better coordinate care between providers, with the goal being to better share patient information to improve care coordination and outcomes. Riverwood Center’s Care Coordinators help to facilitate coordinated care with PCPs, community providers, and other agencies to address SDOH and other basic needs and resource access. Riverwood Center continues to employ a co-located Department of Social Services (DSS) enrollment/eligibility worker to help members enroll and maintain Medicaid, Healthy Michigan, and other DSS Services.

### Accessibility of Services

Riverwood Center continues to meet the Michigan Mission Based Performance Indicator Standards (MMBPIS) for access to services and works proactively to assure that members can see behavioral providers and psychiatric team in the most timely and convenient appointment and manner available. Riverwood Center is continually monitoring access by evaluating availability of the workforce to provide timely services, and to staff programs appropriately.

### Quality and Safety

Riverwood Center presently monitors the CCBHC quality metrics, adult and children satisfaction through satisfaction surveys, and MMBPIS indicators. Riverwood Center continues to emphasize safety by providing quarterly Tabletop exercises which include situational awareness, medical emergencies, bomb threats, and severe weather drills. Riverwood Center is a Carver Model of Governance and thus uses “Ends” or Goals proof of organizational success to their Board of Directors. The Current Board Ends of the priority populations (individuals with Intellectual and Developmental Disabilities (IDD), SMI, Severe Emotional Disturbance (SED), Substance Use Disorder (SUD), and Prevention) uses the 4 Domains of Healthcare Quality – Accessibility, Person and Family Centered, Safety and Effectiveness. That is a 12-month process which includes input from staff and board members to make the Ends more meaningful, purposeful, and well-defined.

## Branch County (Pines Behavioral Health)

### Comprehensive Care

Pines Behavioral Health assesses the person relative to their physical needs, behavioral health concerns, and their SDOH and services are available and provided according to various intensity, frequency, duration, and locations. Pines Behavioral Health works with several community agencies and significant effort has been made to provide outreach and awareness in the form of suicide prevention, risk screening and monitoring, and providing Adult and Youth Mental Health First Aid. As part of the CCBHC Demonstration, Pines Behavioral Health has added mobile services to provide 24/7 mobile services for both adults and youth and veterans navigation which has aided in the identification of unmet needs.

### Patient-Centered Care

Pines Behavioral Health begins the person-centered care process from the moment of first contact whether that is a person seeking services, or a referral to respond to a person's crisis in the community. Pines Behavioral Health's Care Connector is a peer support that is involved in the first engagement experience and continues to connect with the member throughout the treatment episode. During the clinical processes the individual is recognized as the expert of what they want their services to entail, and develops the goals they would like to achieve, and decides how they prefer those service to be delivered. As the individual experiences their recovery journey at Pines Behavioral Health, an emphasis is placed on continuity and transition which involves re-assessment, feedback, and an evaluation of satisfaction throughout service delivery. Risk identification and health monitoring at the point of regular service points, especially related to metabolic syndrome risk identification and treatment, provide the care coordination team the opportunity to identify and address risks factors early and often.

### Coordination of Care

Pines Behavioral Health provides or contracts for the entire array of Medicaid supports and services for behavioral health services, including SUD. Pines Behavioral Health works closely with law enforcement, corrections and the court through its jail diversion program, provides jail-based therapy services, mobile crisis, and provides social work within the community's Free Health Clinic to address the needs for the uninsured. An RN Care Coordinator is also central to providing transitional care before and after an IP admission, sending and receiving Admission, Discharge, and Transfer (ADT) notifications. Pines Behavioral Health works closely with the three ProMedica rural health clinics in the county to address the comprehensive physical and behavioral health needs of those mutually served. Medically complex individuals often receive nursing and other specialized healthcare that is linked with the person's PCP, in addition to over twenty coordinating care agreements with community members. Pines Behavioral Health is a member of the Child Advocacy Center for children of trauma, sits on the boards of the Housing Authority, the Branch Area Transit Authority, Medical Control Board, and on the steering committee of the District Rotary International Steering Committee addressing mental health awareness and the call to action.

### Accessibility of Services

Pines Behavioral Health values the importance of assuring that services are accessible to those most at need in ways that best accommodate individual choice. Pines Behavioral Health has implemented Same Day Access (SDA) for intake, eliminating the wait for an assessment. Psychiatric services are available during the day, evening, and on weekends for adults and children. Urgent Care Walk-Ins are available during daytime business hours, as well as Tuesday evenings. Throughout the fiscal year, Pines Behavioral Health has increased its access to Medication-Assisted Treatment (MAT) services and provides continuous outreach and awareness to assure that all individuals in the community know how to access procedures whether routine or urgent.

### Quality & Safety

The purpose of Pines Behavioral Health's QI Program is to ensure that services provided have the capacity to result in positive member outcomes and member satisfaction through a well-designed service delivery program. The scope of the QI program is comprehensive and encompasses all service programs, direct and contracted, and includes all populations. The identification of, and subsequent reduction of sentinel events and risk incidents are critical to a quality-based program. High risk incident reports are reviewed and analyzed for performance improvement opportunities. Outlier incidents are reviewed by the QI Specialist and if necessary are referred to the Recipient Rights Officer. Members participate on the Safety Committee and the Member Advisory Council, and in FY24, Pines Behavioral Health received high remarks relative to quality and safety as it achieved its 10$^{th}$ consecutive 3 Year Full Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation.

## Calhoun County (Summit Pointe)

### Comprehensive Care/Coordination of Care/Patient-Centered Care

In FY24, Summit Pointe began its first year as a fully certified CCBHC site, which led to the ability to serve 7,603 CCBHC eligible members, which is 724 additional persons served from FY23. On August 27, 2024, Summit Pointe received ongoing CCBHC certification through 2027. Summit Pointe's EHR participates in Continuity of Care Document (CCD) exchange with Bronson Healthcare. This exchange provides clinicians with a comprehensive representation of a member's medical information. During FY24, Summit Pointe was able to fetch 3,510 CCDs from Bronson, representing 3,050 unique members. Summit Pointe continued their work with Grace Health (Calhoun County FQHC). Construction of a Grace Health pharmacy (with rooms for members to see a physician) attached to Summit Pointe's medication clinic building began in September of 2023 and is in the final stages of completion, with a plan to open by the end of 2024. Since January 2023, there has been a Grace Health pharmacist on site at Summit Pointe to assist members and staff in this partnership. Summit Pointe provided OHH services to 70 members. Summit Pointe continues to provide Calhoun County police, ambulance, and dispatch staff on Crisis Intervention Teams (CIT) training. In FY24, 12 staff completed CIT training. In FY24 Summit Pointe's Suicide Prevention Specialist provided 54 Question, Persuade, Refer (QPR) trainings to Calhoun County residents and Summit Pointe staff. Summit Pointe's Veteran Navigator provided training to 79 staff and 28 community members in FY24.

### Accessibility of Services

March of 2024 marked three years since the opening of First Step, Summit Pointe's psychiatric urgent care. There was a reduction in local ED visits for psychiatric care from 3.2% to 2.4% (Calhoun County average). During FY24, First Step served 2,840 distinct members. Increased focus was placed on shortening wait times to see a provider. A four-day Kaizen event was held to review the access process and identify improvement strategies and because of that work, MMBPIS indicator 2a saw a 14% increase, and indicator 3 increased by 35% in the fourth quarter of FY24.

### Quality and Safety

In FY24 Summit Pointe implemented the Summit Pointe Management System (SPMS), which is based on lean management principles. Through the SPMS, all teams review their relevant performance indicators daily. These meetings have helped to identify areas for improvement, which are factored into organizational goals for FY25. Summit Pointe is expanding their Quality Assurance oversight by adding a robust monitoring program for internal clinical review on the authority of state and federal guidelines. In FY24, Summit Pointe received its annual conformance to standards acknowledgement from CARF and will go through their next survey in 2025. In addition, Summit Pointe continually evaluates and updates policies and procedures to ensure compliance with Michigan Department of Health and Human Services (MDHHS), CARF, and SWMBH standards. Summit Pointe's Risk Review Committee (RRC) was recently formed and the RRC is tasked with review of incident reporting trends, reviewing safety policy/procedure, and ensuring that drills are completed. Assailant training was planned and rolled out for all staff at the end of the last quarter of FY24. There will be ongoing trainings that continue in FY25.

## Cass County (Woodlands Behavioral Healthcare Network)

### Comprehensive Care

Woodlands Behavioral Health Network (WBHN) continually works to improve the behavioral health of members and their families. WBHN partners with children, families, and adults in their journey toward recovering from mental health and substance use challenges and helps individuals with intellectual disabilities succeed in community living. WBHN seeks to achieve improvement in both clinical and non-clinical services. WBHN strives to be an innovative leader in behavioral healthcare programs for residents of the community while partnering with local agencies and providing a wide array of services. The efforts of these improvements are expected to affect member health status, quality of life, and satisfaction.

### Patient Centered Care

WBHN is committed to patient-centered care for all that enter its doors, by providing impactful behavioral healthcare services utilizing a respectful, inclusive, and positive approach. Additionally, WBHN integrates the health of all persons served, taking a whole-person approach to comprehensive, coordinated, person-centered, community-based, and recovery-oriented care and services. WBHN works to coordinate services and link members with a regular provider to provide well-rounded care.

### Coordination of Care

WBHN assists persons served in linking/coordinating services with a PCP and a MHP, and encouraging regular routine checkups. During this coordination, WBHN's medication management clinic and Case Managers provide health education, as well as work with residential care providers to ensure members are adequately following physician orders and addressing health care needs. Furthermore, persons discharged from an IP stay are scheduled within 30 days of discharge with a psychiatrist. Any no shows or cancellations to the post-discharge follow up appointment receive calls to encourage engagement and stress the importance of follow-through. Nurses and other staff also provide education on the importance of this lab testing. Lab work is coordinated and shared with PCPs as appropriate through a coordination of care document.

### Accessibility of Services

WBHN continues to improve the technological abilities and will soon be able to provide the most convenient and helpful member platform available to members in the comfort of their home. WBHN's services can be accessed by walk-in, by appointment, by referral, as well as through 24/7 mobile crisis services during and after business hours. Crisis services are offered at WBHN locations throughout the county, as well as at both hospital EDs and the local jail. WBHN also serves as a referral center for individuals experiencing non-acute behavioral health issues (mild to moderate mental health concerns).

### Quality & Safety

WBHN's QI Plan is employed in accordance with the mission, vision, and values as established by the WBHN Board of Directors and Leadership. WBHN is committed to the development, implementation, and continuous quality improvement activities of an established internal QI network of work groups and committees with priority given to those areas that impact the immediate needs of members and their families. Furthermore, the Safety Committee is responsible for monitoring staff, member, and stakeholder safety when accessing WBHN's physical locations and WBHN services. Safety practices are built into policies and procedures and improving and maintaining safety are incorporated into member assessments and treatment planning. WBHN monitors and reports Sentinel Events, Critical Incidents, and other Risk events. Those events are addressed and reviewed by the Recipient Rights Officer to ensure that the member's rights were not violated. Any sentinel events are investigated, and the Medical Director and selected staff members conduct a root cause analysis. Sentinel events and Critical events, as defined by MDHHS, are reported as required and are monitored internally through Recipient Rights and the Safety Committee to identify opportunities for improvement.

## Kalamazoo County (Integrated Services of Kalamazoo)

### Comprehensive Care

Integrated Services of Kalamazoo (ISK) Care Coordinators and CHWs coordinate services with primary care and community providers, including the county jail, to address SDOH, other basic needs, and provide resources. CHWs are trained to screen for suicide risk and coordinate with primary clinicians or emergency mental health clinicians for follow up care as needed. ISK continues care coordination between the FQHC and its MAT program.

Key health indicator screenings are completed at intake and monitored ongoing according to need. Some screenings for key indicators are completed at each psychiatric appointment including BMI screening, weight assessment, tobacco use, and blood pressure level. Testing for additional key health conditions is ordered by psychiatric providers as needed or staff coordinated with PCPs to ensure screenings occur.

### Patient-Centered Care

ISK is committed to person-centered and individualized care with all persons served. The option of telehealth provides choice and flexibility to meet needs and preferences. Although face to face contacts are the primary mode of service delivery, telehealth when it's clinically indicated and allowable, provides opportunities for engagement, access, and continuity of care. ISK values the voice of the persons served in the design and implementation of services. Individuals are invited to and involved in program planning for person-centered and integrated care.

### Coordination of Care

ISK has care coordination agreements with over fifty community partners including healthcare, education, and criminal justice/law enforcement.

ISK's Behavioral Health Consultant engages with twenty-three primary care and OB/GYN practices to link and coordinate care. In addition, Care Coordinators assist primary care offices in outreach to at-risk families to engage them in health/behavioral health services.

Care Coordinators work with contract providers to ensure engagement in services, monitor health and wellness indicators and assist in coordinating healthcare needs. They provide follow-up within 24 hours of a hospital and/or ED discharge. This allows for individuals to receive coordination and support upon their discharge. Care Coordinators for youth and families participate in system of care meetings for youth with complex needs and multisystem involvement to facilitate community supports, treatment and placement options.

### Accessibility of Services

ISK's SDA model reduces the time for accessing services and increases engagement in treatment. SDA hours were expanded to 8:00am to 8:00pm Monday-Friday and 9:00am to 2:00pm on Saturdays. SDA encourages in-person assessments while continuing to offer telehealth services as needed, allowing for quick and easy access to services. CHWs are integrated into Access Center to offer early engagement and outreach during the time of initiating services. ISK's Urgent Care and Access Center is open 24 hours a day, 7 days a week.

### Quality & Safety

Utilization of services and supporting the sustainability of providers are monitored to ensure that individuals continue to receive quality care. ISK performs comprehensive oversight activities which monitors the safety of individuals served and the quality of services provided.

ISK clinical programs utilize care pathways to assist in the identification of needs, necessary clinical care, and collection of valuable information to assess and meet the needs of those served. These efforts provide comprehensive data to support continued growth and understanding of system needs. ISK Data Analyst manages population health reports to look at risk factors including depression, suicide risk, follow up care, antipsychotics adherence, and health disparities. These reports allow ISK to identify and address gaps in service and make data-based decisions regarding treatment options and system improvements.

## St. Joe County (Pivotal)

### Comprehensive Care

Since becoming a CCBHC demonstration site on October 1, 2021, Pivotal has significantly expanded its staff and programs. Pivotal has contracted with a dietitian for consultations, an occupational therapist for Omnibus Budget Reconciliation Act (OBRA) assessments, and are actively seeking a physical therapist. Pivotal's MAT program, under the Medical Director's guidance, can prescribe Suboxone to up to 30 individuals struggling with opioid addiction.

To provide immediate mental health support, Pivotal has placed clinicians in all major city police departments, including the sheriff's office. This proactive approach has statistically reduced hospitalizations and improved access to care. Pivotal has also opened a behavioral health urgent care (Turning Point) and has a 24-hour mobile crisis unit.

### Patient Centered Care

Pivotal collaborates closely with Covered Bridge Healthcare, a local FQHC, to provide comprehensive mental and physical health services. Pivotal has begun sharing a psychiatric nurse practitioner (NP) and sending a nurse and NP to specialized residential homes in the county for more effective care and an improved understanding of member needs.

### Coordination of Care

As a CCBHC, Pivotal bridges the gap between mental and physical healthcare. Pivotal staff uses Care Connect360 to view members and populations across programs comprehensively. Two RN Care Managers engage with high ED usage members and links them to services. Pivotal has Memorandums of Understanding (MOU) with Covered Bridge Healthcare and local hospitals for primary care referrals and collaborations.

### Accessibility of Services

Pivotal continues to expand telehealth services and has leased satellite offices in Sturgis and Three Rivers. Pivotal also hired a full-time request-for-service clinician, four intake workers, a full-time and part-time nurse practitioner, and two full-time psychiatrists (one dual-certified for adults and children). Pivotal's med clinic offers after-hours appointments, and Pivotal has contracted with QLER for telehealth psychiatry services in the behavioral health urgent care. Pivotal also continually monitors caseloads to ensure adequate staffing.

### Quality and Safety

Pivotal is CARF reaccredited and has implemented strategies to reduce no-shows, such as phone and text reminders. Pivotal has made physical improvements to their facilities for better sanitation and privacy and upgraded their security system.

## Van Buren County (Van Buren Community Mental Health)

### Comprehensive Care

Van Buren Community Mental Health (VBCMH) works with many community agencies to provide comprehensive care, and many collaborations are long standing partnerships. Examples of the collaborations include wraparound services provided in partnership with the local Department of Health and Human Services (DHHS) and juvenile court. Some of those partnerships include blended and braided funding pools including the treatment services partner in four specialty treatment courts, a school-based health center sponsored by VBCMH, employment services, senior outreach services, and as a partner in the MC3 project providing education and linkage to consultation for PCPs in a multicounty region. Additionally, work as a partner in Project AWARE (Advancing Wellness and Resiliency in Education) has strengthened mental health services at VBCMH and schools through joint training and enhanced referral processes. VBCMH was awarded a four-year CCBHC grant beginning 09/30/24, was certified as a CCBHC, and will enter the state demonstration project in FY25. The grant allowed for implementation of several positions focusing on supporting integrative efforts and outreach to underserved populations including a peer specialist, Veteran Navigator, and a RN Care Manager. The grant also allowed for an additional mobile crisis clinician to expand that service's ability to serve both youth and adults and providing MAT service. Additionally, VBCMH began partnering with WSU to improve the county system in serving and administering comprehensive care for persons on assisted outpatient treatment.

## Patient Centered Care

VBCMH access staff, clinical leadership, and medical staff work with Bronson Health System to ensure effective connections. VBCMH participates in the Bronson Community needs assessment to evaluate the needs in Van Buren County. VBCMH tracks and monitors physical health according to CCBHC standards in their EHR, reports ADTs to MiHIN, and reviews other health care ADTs that are loaded into the system.

## Coordination of Care

VBCMH continues to provide wraparound services, psychiatric consultation to county primary care practices who are treating adults with behavioral health conditions, Parent Advocacy services in partnership with local courts, regularly scheduled QPR and suicide gatekeeper trainings to the community, educating hundreds on preventing suicide. VBCMJ also has hospital liaison services to ensure ongoing high rates of follow up care upon discharge from IP hospitalizations. Care coordination occurs regularly on individual members with the local FQHC.

## Accessibility of Services

VBCMH staff worked with numerous members to solve issues related to challenges to accessing services and provide solutions such as telehealth, or in person access at alternate sites, and assisting with transportation issues. The CCBHC grant has allowed for increased outreach to underserved populations including veterans, Hispanic and LGBTQIA+ members through participation in numerous county committees and through community events, including bilingual staff at the events.

## Quality & Safety

Safety planning education and consultation continued in FY24. VBCMH increased trauma informed training for staff and the community. Initiatives that were new this year included increasing screenings for members related to health risks and risk of suicide, implementing several new tools within the EHR to collect information and data, and completing 3 MiFAST reviews. Additionally, training in Evidence-Based Practices (EBPs) has been increased and enhanced through the CCBHC grant.