NorthCare Network
Demand and Capacity Report

FY15 Review and Analysis
September 2016

Customer Service: 888-333-8030 or (906) 225-7254
Admin. Fax (906) 225-5149 Clinical Fax: (906) 225-7352 SUD Fax: (248) 406-1286
www.northcare-up.org
To Request Behavioral Health Services Call: 888-906-9060

Table of Contents

Introduction NorthCare Network

Program Description

The Michigan Department of Health and Human Services (MDHHS) awarded NorthCare Network (NorthCare) the contract to serve as the Prepaid Health Plan for all Upper Peninsula Medicaid recipients requiring specialty mental health services, substance use services, and support services for persons with developmental disabilities. The contract became effective October 1, 2002. The contract is updated and renewed annually. Specifically:

The Michigan Department of Community Health (MDCH) hereby enters into a contract with the specialty Prepaid Inpatient Health Plan (PIHP) identified on the signature page of this contract. Under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDCH operates a Section 1915(b) Medicaid Managed Specialty Services and Support Program Waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been "carved out" (removed) from Medicaid primary physical health care plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for persons with developmental disabilities. From the Healthy Michigan Amendment: In addition, CMS has approved an 1115 Demonstration project titled the Healthy Michigan Plan which provides health care coverage for adults who become eligible for Medicaid under section 1902(2) (10)(A)(i)(VIII) of the Social Security Act. Such arrangements have been designated as "Concurrent 1915(b)/(c)" Programs by CMS. In Michigan, the Concurrent 1915(b)/(c) Programs and the Healthy Michigan Plan are managed on a shared risk basis by specialty Prepaid Inpatient Health Plans (PIHPs), selected through the Application for Participation (AFP) process. Further, under the approval of SAMHSA, MDCH operates a SUD prevention and treatment program under the SUD Community Grant. The purpose of this contract is to obtain the services of the selected PIHP to manage the Concurrent 1915(b)/(c) Programs, the Healthy Michigan Plan and SUD Community Grant Programs, and relevant I Waivers in a designated services area and to provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in this contract.

On January 1, 2014, NorthCare Network Prepaid Inpatient Health Plan completely separated from Pathways DBA NorthCare. Region 1 NorthCare Network PIHP was reconfigured as an independent regional entity under Section 1204(b) of the Michigan Mental Health Code and is governed by a board of directors with representation from five member Community Mental Health Authorities. NorthCare Network holds a contract with the Michigan Department of Health and Human Services for the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program, Healthy Michigan Plan (HMP) and under the approval of SAMHSA, NorthCare operates a SUD prevention and treatment program under the SUD Community Grant.

NorthCare is responsible to assure a network of providers sufficient to provide access to all medically necessary services covered under the contract between MDHHS and the PIHP (the Specialty Services and Supports Contract). To maintain adequate capacity, NorthCare considers the following:

- The anticipated Medicaid enrollment.
- The expected utilization for services, considering Medicaid enrollee characteristics and health care needs.
- The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services.
- The number of network providers who are not accepting new patients. (That number is zero for the five Affiliate Boards. Nor are they allowed to keep a waiting list for Medicaid consumers for entry to care.)
- The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for persons with disabilities. The Upper Peninsula is held to the 60 minute/ 60 mile rural rule for service availability.

To make the determination as to our effectiveness in addressing the factors above, current utilization (Table 1-next page) is evaluated in relation to the Michigan Mission-Based Performance Indicator System (MMBPIS). The NorthCare Performance Indicator Report _FY15[1] measures a variety of clinical markers for access to care. NorthCare met the standards of timeliness for individuals in crisis to receive an emergency assessment and decision as to treatment response within three hours above the 95% standard with the exception of Quarter 3FY15 when the score was 94.4 % for children. In terms of access to services, all individuals who are eligible for services receive an initial assessment within

[1] NorthCare Performance Report _FY15 is available by calling 888-333-8030 and requesting an electronic or paper version

the 14 day standard. The compliance rate was above 95% for the entire region for all four quarters. Individuals receive an ongoing service within 14 days above the 95% standard. One measure below the allowable 95% score for two quarters in FY15 was the same in FY12, FY13, & FY15. The performance measure below standard requires that a child be seen for a follow-up appointment within seven days after discharge from an inpatient unit and must meet 95%compliance. Audits of the outliers does not indicate a shortage of practitioners and suggests there are challenges in coordination of care with the local CMHSP and the schedules of the families. Efforts to address this through required corrective action plans was not sufficient to effect a change. What compounds the resolution of this measure is the lack of trending at any particular CMHSP. It does seem to be driven by consumer/ family schedules and an occasional inability of the local CMHSP to meet their scheduling needs. This will remain a focus of the Emergency Services Workgroup in FY16. This review demonstrates NorthCare Network has sufficient capacity to meet the needs of the Medicaid consumers who are eligible for behavioral health services provided by the public community mental health system. In FY15, the trend noted in previous Demand and Capacity Reports of declining population in the UP continues in 14 of the 15 counties.

Table 1 Snapshot of regional CMHSP and US census populations by county
Source:Diver/Medicaid:Y/ServiceReportable:Y/AffiliateName/SubElementPop/Age;
https://www.census.gov/quickfacts/table/PST045215/00

	FY15 Services		Coverage US Census		
CMHSP Board	FTE-Licensed Professionals	Consumers	County	Population	Change in population % 2014 to 2015
Copper Country	**Serving MIA** 40 **Serving MIC** 26 **Serving DDA** 37 **Serving DDC** 27 Total Clinical Professionals 59	**MIA** 356 **MIC** 88 **DDA** 203 **DDC** 34	Baraga Houghton Keweenaw Ontonagon	8575 36380 2168 6007	-0.92 -0.32 -2.26 -2.75
Gogebic	**Serving MIA** 14.57 **Serving MIC** 11.92 **Serving DDA** 17.35 **Serving DDC** 12.92 Total Clinical Professionals 26	**MIA** 153 **MIC** 45 **DDA** 88 **DDC** 27	Gogebic	15431	-1.98
Hiawatha	**Serving MIA** 43 **Serving MIC** 32 **Serving DDA** 43 **Serving DDC** 37 Total Clinical Professionals 52	**MIA** 467 **MIC** 209 **DDA** 205 **DDC** 75	Chippewa Mackinac Schoolcraft	38033 10890 8173	-0.76 -1.4 0.02
Northpointe	**Serving MIA 56** **Serving MIC** 53 **Serving DDA** 57 **Serving DDC** 54 Total Clinical Professionals 58	**MIA** 517 **MIC** 271 **DDA** 277 **DDC** 83	Dickinson Iron Menominee	25788 11348 23548	-0.66 -0.34 -0.70

Pathways	**Serving MIA** 75 **Serving MIC** 52 **Serving DDA** 62 **Serving DDC** 41 Total Clinical Professionals 93	**MIA** 1012 **MIC** 508 **DDA** 511 **DDC** 132	Alger Delta Luce Marquette	9383 36377 6415 67215	-0.81 -0.50 -0.17 -0.69

Development Approach

Specifically in relation to demand and capacity, NorthCare must meet two contract provisions:

6.2 Administrative Personnel
The PIHP shall have sufficient administrative staff and organizational components to comply with the responsibilities reflected in this contract. The PIHP shall ensure that all staff has training, education, experience, licensing, or certification appropriate to their position and responsibilities.

7.0 Provider Network Services
The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract. The PIHP remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to the NorthCare Provider Network.

Seven essential administrative functions facilitate meeting our mission:

- Customer Services
- Provider Network Management
- Management Information Systems
- Financial Management
- Quality Assessment & Performance Improvement
- Service & Utilization Management
- Regulatory Management

NorthCare achieves these contract requirements and sufficient administrative capabilities through regional committees with PIHP staff identified as the committee lead. The committees are composed of staff from the Affiliate CMHSPs, interested consumers and stakeholders. The five Affiliate CMHSPs work effectively by sharing resources and skills. All Affiliate CMHSPs use a common electronic health record system, a common access screening center and have consolidated certain other administrative functions such contracting with many inpatient providers; an after-hours telephone crisis response provider for all fifteen counties and a common software program, Great Plains, for financial management. The regional committees provide the opportunity to continually explore further administrative efficiencies and review demand and capacity:

Performance Management Committee (PMC) is configured with CEO representation from each Member CMHSPs and the PIHP. This committee ensures the representation of local needs and focuses on performance improvement, compliance, service availability and accessibility and consumer and stakeholder satisfaction. Each of the NorthCare Network Committees provides a monthly report to the PMC on their work plans and special presentations are scheduled as needed. The PMC and Governance Board are instrumental in the pursuit of consolidation of authority and core PIHP functions while also promoting local service responsiveness.

NorthCare Network Leadership Team provides oversight to NorthCare Network Committees and ensures that tasks delegated to them are being completed in a manner consistent with the contract and regional state and federal mandates.

Quality Oversight Committee is charged to engage the individuals we serve and staff in an accurate, data-driven region-wide process, resulting in quality and performance improvement, the achievement of standards, and the establishment of new standards. Its primary charge is to implement the Quality Assurance Performance Improvement Program (QAPIP) while working to establish a culture based on the continuous quality improvement model as a means to develop and implement improvement processes and monitor their ongoing success. Data driven reporting is used to ensure progress toward quality improvement and compliance. The committee recommends processes and practices for ensuring overall regulatory compliance and focuses on compliance in a pro-active, preventative manner. The committee identifies, monitors, and controls risks associated with complex duties, obligations, rules, regulations, and requirements and refer identified compliance issues to the NorthCare Network Leadership and/or Compliance Team as appropriate.

Clinical Quality Improvement Committee and its subcommittees and workgroups (Jail Diversion, Autism workgroup, Regional Employment Leadership Team & Behavior Treatment) are charged with assuring the services are delivered by qualified providers according to effective best practices. The Committee moves forward through data driven efforts to improve clinical services as new trends and needs emerge among the populations we serve.

Utilization Management Committee and its workgroups, Regional Emergency Services and Inpatient Quality Improvement, are charged with the monitoring of clinical resources and providing supports that ensure services are used only for authorized purposes, uniformly available to eligible persons, and are provided in an effective and efficient manner. Additionally, NorthCare operates a centralized screening and access center to ensure uniform application of eligibility criteria while avoiding potential conflicts of interest in the determination of eligibility. Inpatient continued stay reviews are also conducted by NorthCare staff to ensure consistent application of ongoing eligibility standards. Face to face assessments are conducted locally at the respective Member CMHSPs.

Provider Network Management Committees and workgroups (Credentialing Committee, Sub-Contract Provider Management, NorthCare Network Site Review, NorthCare Documentation Review-Service Verification – Mental Health, NorthCare Network Site Review Documentation/Service Review – Substance Abuse) working in conjunction with the Clinical Quality Improvement Committee are charged to establish processes and practices for ensuring overall regulatory compliance across the region with specific regard to the MDHHS Specialty Services and Supports Contract, the Health Insurance Portability and Accountability Act (HIPAA) and the Balanced Budget Act (BBA), Enrollee Rights and Protections, Quality Assessments and Performance Improvement, Grievance System, and Certifications and Program Integrity Provisions and URAC accreditation standards. NorthCare prepares the Demand and Capacity Report to help plan for network provider adequacy and conducts annual site reviews of Member CMHSPs and contracted providers to ensure compliance with appropriate contract requirements and regulations.

The Finance Committee and Billing workgroup are charged with making recommendations on regional best practices for Financial Management that demonstrates our fiduciary responsibility as a “value purchaser”.

The Health Information Technology Committee and its workgroups (Data and Analytics, Help Desk, Security Officers, and Records Managers) are charged to acquire and support systems which provide essential tools and data support to employees and to ensure compliance with oversight agency requirements including HSAG, MDHHS and CMS/OCR.

The Customer Services Committee and the Consumer Conference Planning Workgroup are charged with oversight of regional consumer involvement activities, ensuring Customer Service functions delegated to affiliates are completed in a manner consistent with contract, regional, state and federal mandates, and serves as a consumer advisory committee to the Quality Improvement Committee and Governance Board. This group reviews and provides input into applicable policies, printed materials, reports, performance indicators and the consumer satisfaction survey process and results. In 2014, the customer satisfaction survey was enhanced with a section focused on recovery.

NorthCare Network’s Compliance and Risk Management Committee is charged to establish standards and sanctions, review risk assessments and prioritize risk areas, commit resources to remedy deficiencies, recommend remedial action, and review critical clinical and business information including, but not limited to, penetration rates, performance data, compliance data, critical incidents, deaths and complaints. NorthCare Network has also contracted for the services of a Compliance Helpline to provide an avenue for anonymous reporting.

The Affiliate CMHSPs, Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health Services and Pathways Community Mental Health, have a significant role in assuring the capacity of the provider network by annually assessing emerging needs in the counties they serve. Each year, they are required to submit to MDHHS an “Annual Submission Report”. There are five requirements for the submission:

- Estimated Full Time Equivalents (FTEs)
- Request for Service and Disposition of Requests
- Summary of Current Contracts for Mental Health Service Delivery (2 Forms)
- Waiting List
- Needs Assessment

NorthCare receives a copy of the full report from each Affiliate CMHSP. The data in the reports and particularly in the specific community needs narrative are utilized to develop this demand and capacity report. In FY15, the Affiliates followed up on the needs assessment and action plans developed based on the FY14 surveys. The five Boards shared the concern regarding the need for greater psychiatric services; drug use and the need for more substance used disorder treatment services for all individuals and specifically youth services. There are other sources used by NorthCare to assess capacity but the local needs assessments allow NorthCare and the CMHSPs to respond to county specific needs.

Capacity

FY15 Consumer Base & Service Delivery

- **Crisis Services:** NorthCare Network must provide crisis services to all the citizens in the Upper Peninsula according to the regulations outlined in the Michigan Mental Health Code. Crisis intervention services and screening for inpatient psychiatric hospitalization are available through emergency services at each county. The NorthCare Customer Services Handbook has a complete listing of CMHSP emergency numbers and all the county hospitals that serve as emergency evaluation sites. The handbook is available at the NorthCare website: www.northcare-up.org . A standard emergency assessment in the electronic health record (EHR) is utilized by all Affiliate CMHSP to improve coordination of care between Network providers and the psychiatric inpatient units. A specific emergency jail diversion screening form is used when law enforcement requests an assessment for diversion services at pre- booking or post- booking. The form and process it initiates allows timely coordination for decision making by law enforcement.

- **Priority Population for Specialty Mental Health and Support Network services:** The populations eligible to receive ongoing Medicaid services are defined by the Michigan Mental Health Code, the Michigan State Medicaid Provider Manual, and the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Master Contract. Specialty services provided by the CMHSP are directed toward our priority populations: youth with serious emotional disturbances (SED); individuals who have a serious mental illness (SMI); individuals with intellectual /developmental disabilities (I/DD); and those individuals who experience co-occurring disorders involving any of the above with substance abuse disorders. **The Appendices** at the end of this document provide the data as to who has been served by the PIHP and NorthCare SUD providers and the actual services provided**. Appendices 1-5** present the data for individuals being served by the CMHSPs. **Appendix 1** provides the geographic access and demonstrates the 60 mile rural rule is met for all individuals seeking mental health services in the UP. **Appendices 2, 3 &4** offer different presentations of the priority populations served. **Appendix 5** enumerates the specific services received by individuals at the CMHSPs in FY15. NorthCare & the five CMHSPs managed services for 5097 Medicaid consumers in FY15. Of these, 1610 (32 %) were individuals with a primary diagnosis of intellectual/developmental disability and 3487(68%) were adults and children with mental health disorders. Of the 5097 individuals served, 861 = 16.89% were individuals with a co-occurring Substance Use Disorder (SUD) indicated in partial or full remission.

Table 2 FY 15 NorthCare Consumers Served by population and age

Source: Diver FY15 Service Model, Medicaid = Y, Service Reportable = Y, SubElement Pop.

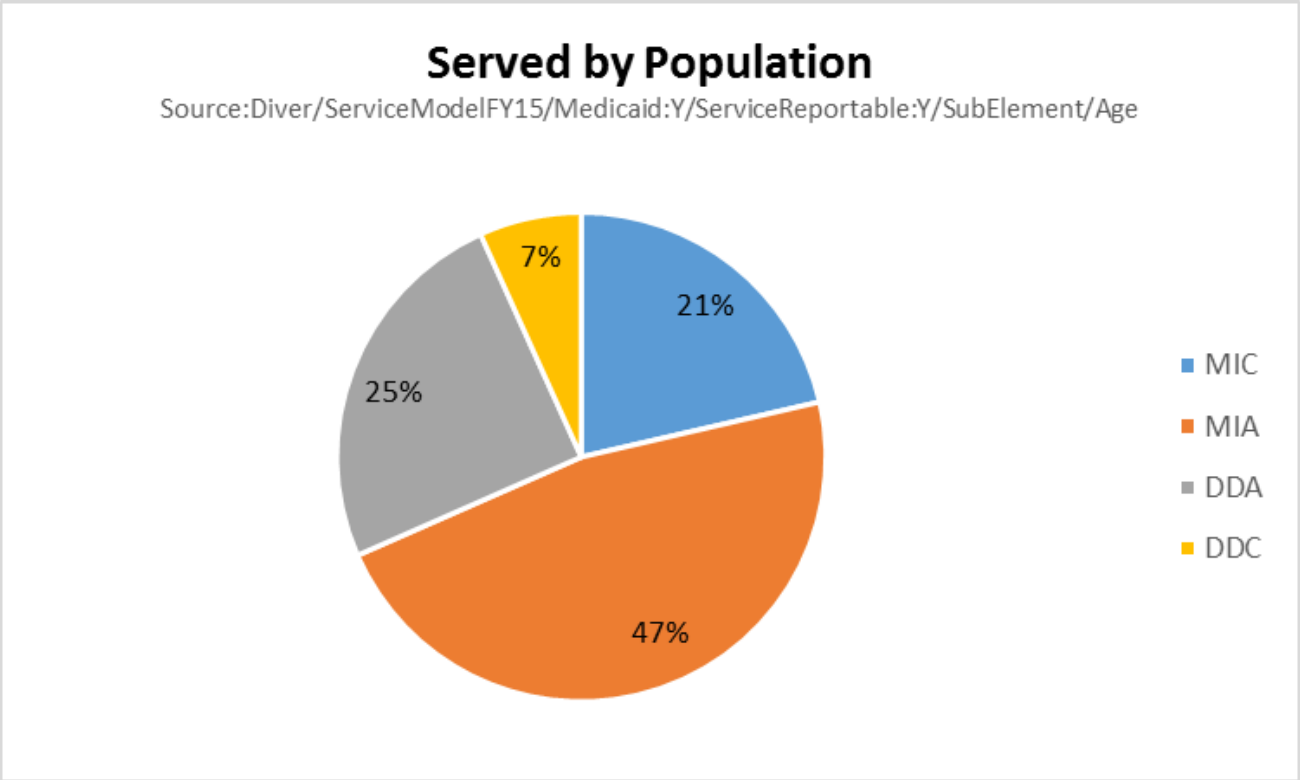
Population	Age 5 & Under**	Under 5 Years of Age*	6 to 17 Years of Age	18 to 64 Years of Age	65+ Years of Age	Total Consumers
DD	41	25	304	1135	130	1610
MI	108	68	956	2252	171	3487
Unknown	0	0	0	0	0	0
Totals	**149**	**93**	**1260**	**3387**	**301**	**5097**

* "Under 5 Years of Age" is a subset of "Age 5 & Under"

* "Under 5 Years of Age" corresponds to US Census Category

**"Age 5 & Under" corresponds to ages of autism benefit

Pie Graph representing population without consideration of specific age groups



Level of Care: Appendix 2 provides an overview of the NorthCare Level of Care Model. The NorthCare Network benefit guideline is utilized by the five CMHSP Boards when a consumer has been fully assessed and assigned a level of care. The level of care categories provide a general description of symptom severity, functional capacity measured by an evidence based tool, risk potential and typical support needs associated with each level of care. They are only intended to serve as a guideline for level of care placement decisions. Medical necessity of the consumer's health and welfare needs will determine services and intensity. The benefit plan is a guide for initiating the planning process and the clinician is able to offer services from another level of care if the service is medically necessary. The benefit plan allows regional monitoring of eligibility determinations and over and underutilization of services. The table below provides an example of the levels of care; the number of individuals receiving services according to level of care who were also identified as having a co-occurring substance use disorder (SUD). The table illustrates that individuals with an SUD disorder are provided services within their primary eligibility group across all levels of care.

Table 3 NorthCare Individuals with Co-Occurring Disorders FY15

Source: Diver FY15 Service Model, Medicaid = Y, Service Reportable = Y, SUD Value Partial or Full Remission, Level of Care.

Level of Care	Total Consumers
No Level of Care Indicated	40
DDA 1 Limited Services-Basic Support	5
DDA 2 Enhanced Support Services	8
DDA 3 Habilitation/Supports Waiver (HSW) enrollee Services	2
DDA 4 Specialized Residential and Support Services	4
DDA PWYS	0
MIA 1A Brief Intervention & Supports Maintenance	49
MIA 1B Community Support Services-Limited/Low intensity Supports/Case management	58
MIA 2A Community Support Services-Moderate intensity Supports/Case Management	304
MIA 2B Community Support Services-High intensity Supports/Case Management	169
MIA 2C Assertive Community Treatment-ACT	91
MIA 3A Therapeutic foster care	19
MIA 3B Specialized Residential/Special Contract AFC Services	7
MIA 3C Community Support Services-Moderate intensity Supports/Case Management	0
MIA 4A Inpatient Care	16
MIA 5	24
MIA 6	1
MIA Pathways General Fund	15
MIC 1A Brief Outpatient Therapy	1
MIC 1B: Supports Coordination/Therapeutic Stabilization & Support	1
MIC 2A Supports Coordination/Community Supports	5

MIC 2B Intensive Case Management/ Supports Coordination/Community Supports	10
MIC 2C Home-Based Services	28
MIC 3A Therapeutic Foster Care (SED)	2
MIC 3B Specialized Residential Contract	1
MIC 3C Treatment Group Home	0
MIC 4	1
MIC_PWYS	0
Total Number of Individuals with Co-occurring Disorders	**861 = 16.89% of total served**

- **Substance Abuse Services:** The NorthCare Substance Use Services manages the care for Medicaid and Healthy Michigan enrollees seeking treatment for substance abuse or substance dependency disorders throughout the 15 counties in the Upper Peninsula. **Appendix 6** Lists the SUD providers and the geographic access of substance use providers. **Appendix** 7 summarizes the primary diagnoses of Medicaid clients receiving substance abuse services. The treatment service array includes; Assessment, Individual and Group Therapy, Intensive Outpatient, Residential, and Sub-acute detox services. Individuals receiving services have a treatment plan that routinely includes relapse prevention. Additional specialty services funded by block grant include: Case Management, Women & Children and Room & Board for residential placement. Peer Recovery Coaches play an important role for many consumers. NorthCare Network provides funding for prevention services in the Upper Peninsula. These services are primarily evidence based with the majority focused on both communities and youth. Substance use prevention coalitions including several “Communities That Care” coalitions as well as programs such as All Stars, Botvin’s Life Skills, Big Brothers Big Sisters mentoring, Prime for Life, Children in the Middle and Strengthening Families 10 – 14 were among those funded in FY15.

- **Integrated Healthcare Services:** In FY11, MDHHS established health proxy measures to be obtained by the provider when an initial assessment is done as well as to revisit the measures during clinical reviews that occur at a minimum annually. In FY15, NorthCare remains above the MDHHS standard of 95% completion of the Health Proxy measures required. The questions about the ten health conditions focus on the individual’s health in the past twelve months and the conditions are reviewed annually. Their presence within the behavioral assessment allows the clinicians to properly coordinate care with physical health providers so better informed decisions about care can be made. To determine where to focus change initiatives, the CMHSPs documented in their Annual Submissions the prevalence of five medical conditions and the two most significant conditions noted on AXIS III were diabetes and obesity. These remained a primary focus in FY15. As part of the integrated healthcare workgroups convened at each CMHSP, education groups and Whole Health Action Management groups continue to be implemented to support behavioral health changes with those two conditions.

Table 4 NorthCare Medicaid Consumers with Reported Encounter (other than H2011 or T1023 or Hospitalization) for 10/01/14 to 9/30/2015 (FY15)

Source: FY15 Diver Demographic Model, Medicaid Yes, Affiliate, Name, Missing Health conditions NOT INCLUDING NORTHCARE DUAL 39 2						
	NorthCare	Pathways	Northpointe	Hiawatha	Gogebic	Copper
Total Medicaid Consumers with Reported Encounter 10/1/14 - 9/30/15	5369	2166	1191	984	314	714
Consumers with Every Health Conditions Field Complete	5268	2094	1189	964	314	707
% Consumers with Complete Health Conditions	**98.12%**	**96.68%**	**99.83%**	**97.97%**	**100.00%**	**99.02%**

In FY15, meeting the challenge of creating responsive data systems continued so the PIHP and MHP could coordinate care for the adults living with serious mental illness. A new collaboration project was added to improve the care of individuals who are dual eligible. The MI Health Link Program was initiated by the state to join Medicare and Medicaid benefits, rules and payments into one coordinated delivery system. Members have one plan and one card for primary health care, behavioral health care, home and community-based services, nursing home care and medications. Members have one Integrated Care Coordinator through Upper Peninsula Health Plan who will help coordinate services by linking and coordinating with all providers serving the same member. NorthCare has a Integrated Care Coordinator working on the Behavioral Health side to coordinate consents and services on the mental health side. The member's Integrated Care Coordinator may answer questions, help get appointments, assist in the development of an integrated care plan, arrange transportation, etc. In FY15, enrollment began in the second quarter. The significant increase in members in Q3 and Q4 was the state plan to proceed with passive enrollment of members after March and April active enrollment.

Table 5 MI Health Link Participants Source:SQL/MiHealthLinkLOC/Modified with BETWEEN

	FY15					
	Q2		**Q3**		**Q4**	
Affiliate	**DDA/SMI**	**M/M**	**DDA/SMI**	**M/M**	**DDA/SMI**	**M/M**
Copper MI Health Link	0	0	172	1	173	1
Gogebic MI Health Link	0	0	52	0	52	0
Hiawatha MI Health Link	1	0	99	2	96	2
Northpointe MI Health Link	2	0	155	4	155	4
Pathways MI Health Link	3	0	230	8	232	7
Community Providers	0	0	11	37	15	39
Totals	**6**	**0**	**719**	**52**	**723**	**53**

In a third initiative, NorthCare continues evaluating clinicians follow through during the treatment planning process to assure health and safety concerns are being addressed. Follow through on medical care is being reviewed as part of the performance improvement project for children that NorthCare is conducting for three years-FY13, 14 &15. In FY15, the second year of measurement, 43 charts were reviewed to measure the two goals of the project:

1. 95% of all health concerns will be addressed in the treatment planning and delivery process
2. 95% of all safety concerns will be addressed in the treatment planning and delivery process

Goal one was met at 100% and goal 2 at 97.7%. Another review will be done in FY16 to assure the focus on healthcare is sustained.

CMHSP Provider Network

NorthCare Network contracts with organizational providers: five Affiliate CMHSP and Gryphon, the agency providing regional after hour's crisis phone service, SUD providers and hospitals providing psychiatric inpatient care. In FY15, the MI Health Link Program began with CMHSPs providing care for the members with serious mental illness and developmental disabilities and NorthCare initiating contracts with a number of organizations to provide outpatient care for individuals with mild to moderate needs. NorthCare has contracts for inpatient services with two hospitals located in the Upper Peninsula. Duke LifePoint/ Marquette General Hospital, the regional hospital in Marquette has 26 beds/adults and 6 beds/youth and War Memorial Hospital in Kincheloe with 20 beds/adults. There are regional contracts with two hospitals in Grand Rapids: Pine Rest who has beds for children and adolescents as well as adults and St Mary's who serves adults. Pathways and Northpointe have a contract with Bellin Psychiatric Hospital in Green Bay, WI with 10 beds/ children, 14 beds/adolescents & 22 beds/adults. If the need arises, NorthCare develops a single case agreement with other inpatient providers. NorthCare monitors the oversight of the contracts for the above listed organizational providers. The CMHSP are responsible for all other service provider contracts. Copper, Gogebic, Northpointe and Pathways have a contract with the Ministry St Mary's in Rhinelander WI with 10 beds/adults.

NorthCare directs the mandatory requirements for Medicaid compliance through contract, policy, and regional plans, and annual site reviews. According to these documents, providers (other than inpatient hospitals) must be available within a sixty (60) mile radius from the consumer's home; a provider must be available with physical access for enrollees with disabilities; and the provider has a responsibility to assist with transportation needs through coordination of services with the Upper Peninsula Medical Health Plan and the Department of Human Services. **Appendix 1** illustrates the geographic access requirements are met. The organizational providers must be able to demonstrate that the sub-contract providers they contract with meet the standards established in the NorthCare Network Policies and relevant state and federal standards.

Three provider tiers meet the outpatient and residential service demands of a Medicaid PIHP.

- **Tier 1 – Licensed Clinical Providers**: Located at the CMHSP and SUD Providers, these professionals are responsible for providing the services at the core of our mission. A complete list of the professional providers is available to consumers and information as to their credentials and the populations they serve at the CMHSP websites where they serve and the Substance Treatment Providers are listed in **Appendix 6** as well as in NorthCare Provider Directory.[2]

- **Tier 2 – Paraprofessionals:** Provide support services to consumers. The richness of the first tier of providers is necessary to provide adequate supervision to the second tier. Aides must be properly trained and supervised on the services in the treatment plan for the individuals they are going to serve. The training requirements for aides working with children with Autism were increased in FY15 to assure that the Applied Behavioral Analysis (ABA) services delivered by this group were delivered according to the treatment plan and that the aides are supervised in situ at least one hour in every 10 hours of service provided. Peer Support Specialists are members of this Tier and they are certified by MDHHS. In FY15, 24 certified PSS worked across the region. Exciting new developments are occurring in the use of Parent Support Partners, a peer model to support parents with youth with mental health or intellectual/ developmental disabilities and Recovery Coaches, a peer model to support individuals with co-occurring SUD. In FY15, five (5) Parent Support Partners and five (5) Peer Recovery Coaches were employed in the region.

- **Tier 3 – Residential Service Staff**: Residential homes may be operated by the CMHSP or subcontracted to a private provider. Staff provide daily personal care and community living supports for 734 consumers residing in residential placements other than skilled nursing care or undefined licensed facilities. One of the critical issues highlighted in Pie Graph on page 9 is the fact that while the population of individuals with intellectual/ developmental disabilities is significantly smaller (32%) in number than individuals with serious mental health illness (68%), the expense of residential is significantly higher for those individuals (70% to 30 % respectively) As these can be seen a fixed costs in as chronic population that is growing, this is an area where costs are not easily limited or cut. However, there is increasing interest in alternative housing options and how treatment options may help lower the number of individuals requiring secure residential care. The requirements of training of staff is also increasing as

[2] NorthCare Provider Directory is available at www.northcare-up.org

consumers have more and more co-morbid physical conditions Training for staff must be conducted by the specialty service providers.

Table 6 NorthCare Medicaid Consumers Served with Residential living arrangement FY15

Source: Diver FY15 Service Model, Living arrangement qry_LivArr.sql

Population	Crisis Residential	Foster Home/Foster Care	General Residential Home	Specialized Residential Home	Grand Total	Total Population	% of population with residential living arrangement
A-DD-18-64		7	68	337	412	1135	36%
A-DD-65+			28	71	99	130	76%
A-MI-18-64	2	8	48	61	119	2252	5%
A-MI-65+		3	20	17	40	171	23%
C-DD		2		3	5	345	1%
C-SED		48	2	9	59	1064	5%
Grand Total	**2**	**68**	**166**	**498**	**734**	**5097**	**14%**

Substance Abuse

With treatment providers located across the region, the role of the NorthCare SUD Services is to plan, coordinate and oversee the delivery of substance use disorder treatment outpatient and residential services within the 15 counties. Dial Help is the SUD after hours call center for crisis calls and information and referral. **Appendix 6** lists the providers of SUD services and illustrates the 60 mile /60 minute service delivery requirement is met. There are challenges to be met regionally to meet the anticipated demand in several areas: the rising number of individuals addicted to opiates; prescription drug abuse and the horrible consequence of these increases on the infants being born prematurely and addicted to substances that require ICU care at birth. Over the next few years, the network will have to expand to address these needs.

Community (Acute) Inpatient Psychiatric Service Providers

These providers work with both NorthCare Network and the CMHSPs for authorization and continuing stay reviews. The CMHSPs authorize the initial 24 hours of inpatient care. NorthCare is responsible for ongoing authorization of payment for inpatient authorizations. NorthCare employs a clinical reviewer for ongoing authorizations for all CMHSP admissions to Duke LifePoint/Marquette General Hospital and War Memorial Hospital to ensure medical necessity criteria are met. Quality Improvement meetings are held regularly with the Director of MGH Inpatient Services and with the staff at War Memorial Hospital Inpatient Unit. At other inpatient units, ongoing clinical reviews are conducted either by NorthCare staff or staff at the admitting CMHSP. A standard annual review form is used for all inpatient contracts to assure they are in compliance with federal, state and NorthCare standards. In FY15, NorthCare continued to experience a reduction in the use of the Duke LifePoint /MGH Inpatient unit and an increase in the use of War Memorial plus a 55% increase in other hospitals. This shift is indicative of staff challenges at Duke LifePoint as well as their increasing use of denying

placement based on an individual not be suited for the “milieu”. NorthCare plans to participate in the statewide review of inpatient beds and refusals to accept consumers for care as other PIHPs are experiencing similar challenges. The Upper Peninsula is unique however in the significant distances and expenses and delays in treatment that are caused by the lack of available beds and transportation costs in our region.

Table 7 Episodes of Care and Inpatient Days Authorized by NorthCare in FY15

Hospitals	# of Episodes of Care	% of Episodes of Care	# of Days of Care	% of Days
DLP/Marquette General Hospital	483	66.5%	3440	65.5%
War Memorial Hospital	130	17.9%	883	16.8%
Other	113	15.6%	932	17.7%
Total	726	100%	5252	100%

Out of Network Providers

These providers are located outside our geographic area. Each CMSHP has the authority to contract for any services needed authorized on a case by case basis. Consumers using a self-determination model for their treatment plan may access out of network providers of their choice. Payment for the services would be negotiated on the individual budget developed as part of the individual plan of service.

Analysis of Future Network Needs

Approach

Our analysis of future needs considers the probable impact of the following factors on the public mental health service system:

Medicaid Expansion

Demographic Changes--Broad effects of demographic changes on behavioral service needs in the Upper Peninsula.

Prevalence rates-- 1) increasing incidence of Autism Spectrum Disorders (ASD) in the country and status in the Upper Peninsula 2) ongoing health concerns about the use of Antipsychotic Polypharmacy 3) increased suicide rates 4) Ongoing implementation of Integrated Healthcare models to address multiple aspects of Co-morbidity and outcome studies to determine the effectiveness of treatment.

Medicaid Expansion

The behavioral health needs of Medicaid consumers in the Upper Peninsula are met by two systems**.** Medicaid consumers with mild to moderate disorders are served by the Upper Peninsula Health Plan. During FY15, the average monthly enrollment for the UPHP was 42,286 Medicaid members per month inclusive of the three Medicaid Plans: UPHP Medicaid, UPHP Healthy Michigan, and UPHP Children's State Health Care Services. This increase of 8.3% over FY14 is primarily due to the increase in Healthy Michigan members. In FY 15, 11.5 % of UPHP members accessed mental health benefits under the twenty visits per year benefit. In Q2, Q3 & Q4 of 2015, 53 individuals were served through NorthCare community contractors to receive mild to moderate outpatient services through the MI Health Link (MHL) Program. NorthCare anticipates greater use of this benefit in FY16 when it is operating for a full year. There were 723 Medicaid recipients served by the CMHSPs who were identified as members of the MHL program. The value in this new program will be evaluated over the next two years and the expectation is there will be an increase in coordination of care and member satisfaction and a reduction in expense.

In their report, Mental Illness Surveillance among Adults, 2011 estimates (as of FY15 these are the most current estimates available) are provided of incidents of depression, anxiety, visits to health care providers with a complaint of a mental condition. The data for each disorder varies but all the data hovers between (9) % and 20 % prevalence. Therefore, NorthCare and the Upper Peninsula Health Plan need to be prepared to work within that framework. Our penetration rates in FY15 (see Table 7 below for NorthCare penetration rates) suggest we are slightly below current national epidemiological estimates for behavioral health services.

Table 8 Percentage (%) of Medicaid eligible consumers who were served by NorthCare in FY15.
Source: DiverServiceModelFY15/Medicaid:Y/ServiceReportable:Y/FiscalQuarter

NorthCare Medicaid Penetration Rate by Quarter - all services				
Based on Encounters		**10/1/2014 thru**		**9/30/2015**
Fiscal Year	**QTR**	**Consumers Served**	**Consumers Eligible**	**Penetration Rate (Percent)**
2015	1	3850	58988	6.53%
2015	2	3749	61272	6.12%
2015	3	3732	62137	6.01%
2015	4	3650	62276	5.86%

Medicaid Penetration Rate by Quarter - (Same as above except excludes crisis) Source:DiverServiceModelFY15/Medicaid:Y/ServiceReportable:Y/FiscalQuarter/Crisis/AsmtOnly:No				
Based on Encounters		10/1/2014 thru		9/30/2015
Fiscal Year	QTR	Consumers Served	Consumers Eligible	Penetration Rate (Percent)
2015	1	3562	58988	6.04%
2015	2	3503	61272	5.72%
2015	3	3467	62137	5.58%
2015	4	3369	62276	5.41%

To plan services in the future, knowing the current number of consumers in specific age groups who accessed services in FY15 is critical. These figures are examined in light of trending of recent census data and expected disease prevalence for future planning. The table outlines the percent of Medicaid eligible in four age groups. Table 8 includes the category of number of individuals with unknown ages.

Table 9 NorthCare Medicaid Eligibles by Quarter, Age Group,
Source: in_Consultation_Draft_Medicaid_Eligibles_DCRptNew

Age Group	Q1		Q2		Q3		Q4	
Unknown	1676	2.84%	1704	2.78%	1720	2.77%	1729	2.78%
5 and under	6929	11.75%	6744	11.01%	6767	10.89%	6757	10.85%
6 to 17	15122	25.64%	14846	24.23%	14884	23.95%	15014	24.11%
18 to 64	30767	52.16%	33536	54.73%	34358	55.29%	34448	55.32%
65+	4494	7.62%	4442	7.25%	4408	7.09%	4328	6.95%
Totals	58988		61272		62137		62276	
	Medicaid Eligible Consumers FY15	Medicaid Eligible This Quarter FY15						

Demographic Changes

A review of the figures in the Demand and Capacity Report in FY14 demonstrates this year's figures continue the negative trend of the general population of the UP declining with the specific age group of youth up to 18 declining and the population of elderly increasing. The census data for FY15 is captured in the two tables below. Table 10 presents each county's age breakdown which is critical for the local providers to accommodate local variances in the need for services and providers. Table 10 presents the change in population for each county from 2014 to 2015 per age group.

Table 10: Upper Peninsula Population Comparison by Age, by County. *Note- table does not included the percentage for ages 18-64 as they are not relevant to our trending for the elder population and youth*

County	Persons under 5 years (Percent 2015 * 2015 Population Estimate)	Persons under 18 (Percent 2015 * 2015 Population Estimate)	Persons 65 years and over(Percent 2015 * 2015 Population Estimate)	2015 Total Population Estimate
CC - Baraga	386	1586	1689	8575
CC - Houghton	1892	7349	6039	36380
CC - Keweenaw	76	338	728	2168
CC - Ontonagon	138	781	2012	6007
Copper Country Total	**2492**	**10054**	**10469**	**53130**
GG - Gogebic	**586**	**2407**	**3642**	**15431**
HW - Chippewa	1826	7112	6313	38033
HW - Mackinac	436	1819	2875	10890
HW - Schoolcraft	360	1438	2035	8173
Hiawatha Total	**2621**	**10369**	**11224**	**57096**
NP - Dickinson	1315	5183	5338	25788
NP - Iron	465	1850	3280	11348
NP - Menominee	1060	4498	5204	23548
Northpointe Total	**2840**	**11531**	**13822**	**60684**
PW - Alger	338	1436	2289	9383
PW - Delta	1819	7385	8003	36377
PW - Luce	244	1033	1309	6415
PW - Marquette	3226	12031	11561	67215
Pathways Total	**5627**	**21884**	**23162**	**119390**
NorthCare Total	**14166**	**56246**	**62318**	**305731**

Table 11 NorthCare Population Percentages by Age, County *Note- table does not included the percentage for ages 18-64 as they are not relevant to our trending for the elder population and youth*

Source: https://www.census.gov/quickfacts/table/PST045215/00

County	Persons under 5 years (2015)	Persons under 18 years (2015)	Persons 65 years and over (2015)	2015 Population Estimate	% Total Population Change from 2014 to 2015
CC - Baraga	4.5%	18.5%	19.7%	8575	-0.92%
CC - Houghton	5.2%	20.2%	16.6%	36380	-0.32%
CC - Keweenaw	3.5%	15.6%	33.6%	2168	-2.26%
CC - Ontonagon	2.3%	13.0%	33.5%	6007	-2.75%
Copper Country Total	**4.7%**	**18.9%**	**19.7%**	**53130**	**-0.77%**
GG - Gogebic	**3.8%**	**15.6%**	**23.6%**	**15431**	**-1.98%**
HW - Chippewa	4.8%	18.7%	16.6%	38033	-0.76%
HW - Mackinac	4.0%	16.7%	26.4%	10890	-1.4%
HW - Schoolcraft	4.4%	17.6%	24.9%	8173	.02%
Hiawatha Total	**4.6%**	**18.2%**	**19.7%**	**57096**	**-0.77%**
NP - Dickinson	5.1%	20.1%	20.7%	25788	-0.66%
NP - Iron	4.1%	16.3%	28.9%	11348	-0.34%
NP - Menominee	4.5%	19.1%	22.1%	23548	-0.70%
Northpointe Total	**4.7%**	**19.0%**	**22.8%**	**60684**	**-0.62%**
PW - Alger	3.6%	15.3%	24.4%	9383	-0.81%
PW - Delta	5.0%	20.3%	22.0%	36377	-0.50%
PW - Luce	3.8%	16.1%	20.4%	6415	-.17%
PW - Marquette	4.8%	17.9%	17.2%	67215	-.69%
Pathways Total	**4.7%**	**18.3%**	**19.4%**	**119390**	**-0.61%**
NorthCare Total	**4.6%**	**14.2%**	**20.4%**	**305731**	**-0.74%**
Michigan	**5.8%**	**22.2%**	**15.8%**		

Our Regional Population

The most current census data from 2015 continues dominant trends in Michigan for the past 15 years. There is ongoing flight by younger people and families out of the Upper Peninsula as the UP still experiences relatively high unemployment. The UP continues to be an aging region without the influx of new families to mitigate the effect of this demographic. The comparison population change from 2014 to 2015 indicates a decline in 14 of the 15 counties. Within these declining populations, a significant demographic shift is still occurring as our number of youth continues to decline and our elder population increases. While these trends are generally apparent across Michigan, they are more pronounced in the UP where our percentage of older adult's is 4.6% higher than the state average and our percentage of youth under 18 is 8% lower than the state average.

Table 12 2015 NorthCare Census Demographic Information

Source: https://www.census.gov/quickfacts/table/PST045215/00

County	% White Persons 2015	Persons in Poverty, Percent 2014	% Native American 2015
CC - Baraga	73.5%	15.8%	13.9%
CC - Houghton	93.4%	18.7%	0.7%
CC - Keweenaw	98.3%	12.7%	0.2%
CC - Ontonagon	96.5%	17.8%	1.3%
Copper Country	90.7%	17.9%	2.9%
GG - Gogebic	90.7%	20.9%	2.8%
HW - Chippewa	71.4%	19.9%	15.7%
HW - Mackinac	75.3%	15.4%	17.1%
HW - Schoolcraft	86.6%	17.6%	9.2%
Hiawatha	74.3%	18.7%	15.0%
NP - Dickinson	96.7%	14.4%	0.7%
NP - Iron	96.5%	17.3%	1.3%
NP - Menominee	94.6%	14.5%	2.9%
Northpointe	95.8%	15.0%	1.7%
PW - Alger	85.1%	15.5%	4.2%

PW - Delta	94.4%	14.8%	2.5%
PW - Luce	79.9%	20.6%	4.9%
PW - Marquette	93.6%	15.4%	1.9%
Pathways	92.4%	15.5%	2.4%
Michigan	**79..7%**	**16.2%**	**0.70%**

Impact of Census Data

Older Adults-The number of older adults eligible for services can be expected to increase and the needs of the aging population with developmental disorders and the high incidence of co-morbidity with medical disorders will increase the demand for a wider array of services. This will be analyzed further under the section on integrated healthcare and co-morbidity**.**

Youth-Persons under 18 are a declining population in the UP. However, there are areas where increased numbers of youth impacting the mental health system may occur. While there are fewer youth in the UP, the rise of autism rates, suicide rates and substance use are discussed below in the section on the prevalence of disorders which complicate the lives of our youth. There is no indication that the youth inpatient unit at Duke LifePoint/ Marquette General Hospital will close its six bed unit and has the capacity to increase beds if needed. In FY15, NorthCare SUD Services applied for grant funding for region wide suicide prevention activities for multiple years to sustain prevention activities for youth with substance use and mental health disorders.

Ethnic groups

Caucasian- The Upper Peninsula has a predominately Caucasian culture. The lowest percentage of Caucasians is in Chippewa County with 71.4% and the highest percentage is in Keweenaw County with 98.3%. Significantly, 7 of the 15 counties have a population of Caucasians greater than 90% with 4 of those 7 counties greater than 95%. This homogeneity has ramifications on the provision of healthcare services as there is a Northern European culture that supports self- sufficiency and taking care of one's extended family.

Native American- The Native American population is the largest ethnic group after Caucasian in the UP. Three counties have a Native population greater than 13% and only two counties are below the Michigan average of 0.70%. Studies by SAHMSA and Center for Health Equity Research and Promotion indicate Native Americans score significantly higher in substance abuse disorders and higher reports of frequent mental distress among adults than other ethnic groups in the United States. The presence of Native Americans across the Upper Peninsula suggests the importance of sustaining efforts to collaborate on prevention and educational programs that have been effective with this group. NorthCare requires annual cultural diversity training for staff which may include training on various aspects of Native American Culture. NorthCare recognizes the need for culturally specific services for the Native American population. The added element of culturally diverse training at the provider level enhances the potential for improved outcomes. NorthCare works to identify and create regional and local training opportunities. To facilitate this, the NorthCare Prevention Coordinator has been trained to provide SAMHSA's Substance Abuse Prevention Skills Training (SAPST) adapted for Native American populations.

Poverty: The Upper Peninsula unemployment rates have followed the national trend of decreasing in 2015. The average unemployment rate varying form 7% to 8% in 6 counties and 6% to 4% in the remaining 9 counties compared to the Michigan average of 5.4 %. It is important to note that these averages mask the high unemployment of youth and young adults between 16 and 24 years of age. Their Michigan unemployment rates vary from 8.8% (women 20 to 24 years of age) and 17.6% (male youth between 16 to 19 years of age). This is a critical concern for future impact on services as high unemployment is correlated with increased depression rates and increased suicide risk.

Prevalence Rates

In FY12, we noted our intention to continue to monitor three areas of concern over the next five years.

- The increasing rate of diagnosis of Autism Spectrum Disorders (ASD).
- Antipsychotic Polypharmacy and increasing metabolic syndrome.
- The increasing suicide rates affecting our youth.

And in FY14, NorthCare added to that focus:

- Results from the *Center of Disease Control Behavioral Risk Factor Surveys* that are conducted annually at the state level. We trend the Upper Peninsula in relation to state averages on key areas surveyed related to suicide, depression, and co-occurring substance use disorders among the general adult population responding to the survey. The survey contains questions related to primary healthcare and we may examine those responses in light of the efforts of the behavioral health provider network partnering with medical providers to increase integration of care.

Autism Spectrum Disorders

In FY14 across the NorthCare Network, forty (40) children under six years old were diagnosed with Autism Spectrum Disorders. During that fiscal year, eight (8) of those children qualified for the state benefit for Autism Disorder. In FY15, an additional 12 children under 5 years of age were assessed; 9 were found eligible by MDHHS for the benefit and 6 of the 9 started services. Two key observations about our relatively low numbers in two years of implementation are the continued declining population in the defined age group and the homogeneity of the region over 90 % Northern European. This second factor may contribute to the lack of early identification of cases of Autism. At this time, there is still a culture of infants and toddlers being raised in their family homes and not necessarily coming to the attention of professionals until school age. In the summer of 2015, the regional Autism Workgroup began a study of youth who would become eligible for autism services under the expansion expected to begin in January 2016. A significant increase in demand for services is anticipated as up to 220 youth may be eligible for the benefit when the age of eligibility expands through 20 years of age.

There are no new national prevalence figures since the 2010 report from the US Center for Disease Control for Autism Disorders in the United States cited in our 2012 report. The highlights from the report are:

1. About 1 in 68 children (or 14.7 per 1,000 8 year olds) were identified with ASD. It is important to remember that this estimate is based on 8-year-old children living in 11 communities. It does not represent the entire population of children in the United States.
2. This new estimate is roughly 30% higher than the estimate for 2008 (1 in 88), roughly 60% higher than the estimate for 2006 (1 in 110), and roughly 120% higher than the estimates for 2002 and 2000 (1 in 150). We don't know what is causing this increase. Some of it may be due to the way children are identified, diagnosed, and served in their local communities, but exactly how much is unknown.
3. The number of children identified with ASD varied widely by community, from 1 in 175 children in areas of Alabama to 1 in 45 children in areas of New Jersey.
4. Almost half (46%) of children identified with ASD had average or above average intellectual ability (IQ greater than 85).
5. Boys were almost 5 times more likely to be identified with ASD than girls. About 1 in 42 boys and 1 in 189 girls were identified with ASD.
6. White children were more likely to be identified with ASD than black or Hispanic children. About 1 in 63 white children, 1 in 81 black children, and 1 in 93 Hispanic children were identified with ASD.
7. Less than half (44%) of children identified with ASD were evaluated for developmental concerns by the time they were 3 years old.
8. Most children identified with ASD were not diagnosed until after age 4, even though children can be diagnosed as early as age 2.
9. Black and Hispanic children identified with ASD were more likely than white children to have intellectual disability. A previous study has shown that children identified with ASD and intellectual disability have a greater number of ASD symptoms and a younger age at first diagnosis. Despite the greater burden of co-occurring intellectual disability among black and Hispanic children with ASD, these new data show that there was no difference among racial and ethnic groups in the age at which children were first diagnosed.
10. About 80% of children identified with ASD either received special education services for autism at school or had an ASD diagnosis from a clinician. This means that the remaining 20% of children identified with ASD had symptoms of ASD documented in their records, but had not yet been classified as having ASD by a community professional in a school or clinic.

Antipsychotic Polypharmacy and Metabolic Syndrome

In FY12, NorthCare noted "The need for integrated healthcare for medical and behavioral services is critical in this area." A primary goal of coordination of care is the careful assessment of an individual's entire prescription list for all the medical and behavioral health disorders. Michigan has taken action to require behavioral health providers to assess medical and safety issues for each person they serve and incorporate any key findings into the treatment plan for that individual receiving services at the CMHSP. NorthCare initiated a three year quality improvement project in FY13 to assure children served were assessed for health and safety needs. And also that the treatment plan identified services for health and safety needs where the family required assistance. In FY15, the second year of this project, the five CMHSPs met all the two key goals of the project. In FY16, the final study will be conducted to measure our success in sustaining the focus on medical and safety issues.

Medical providers need access to behavioral health information –particularly related to diagnoses and medication. The probability of a serious prescription cascade is increased when antipsychotic polypharmacy is combined with the medications used for the common co- morbid disorders of diabetes, cardiovascular diseases and obesity. In FY15, NorthCare began the use of two software programs to assist in identifying the individuals who could be at risk of such cascading of medications and could benefit integrated coordination of care. One program assists UPHP and NorthCare to identify those individuals who are high users of both medical and behavioral health services and actively coordinate care across the two systems. A second program meets the mandate from MDHHS to examine trends across the clinical populations served by the PIHP. NorthCare, with the assistance of grant funding from MDHHS, purchased an analytic program from Care Management Technologies. Data from all Medicaid sources—pharmacy, medical health care, behavioral health care and all emergency room visits and hospitalizations can be viewed at a population level and at an individual level. The product, called "ProAct" identifies a number of QI indicators and provides clinical algorithms to remediate a clinical situation that may be increasing risk for the individual being served. It is exciting to consider the ability to share pharmacy information between physical and behavioral health physicians (and Physician Assistants and Nurse Practitioners) as well as provide clinical algorithms to assist in insuring best practices in the use of multiple antipsychotics across specialists. Purchase and initial implementation began in FY15 and clinical staff involvement is expected to start in FY16.

Youth & Suicide Rates and Co-occurring Substance Use Disorders

The current benefit plan is designed to serve the Seriously Emotionally Disturbed youth in our region. Although the youth population is expected to decline across the next 13 years, epidemiology for severe mental illness and co-occurring disorders suggests we will need to continue to focus resources on this population. Collaboration with the school systems in prevention and early intervention programs dealing with substance abuse, teen suicide and violence is essential. Planning for local SUD Prevention services relies on epidemiologic data. Historically, prevention services have been focused on two priorities: reducing or eliminating childhood and underage drinking; and reducing prescription and over-the-counter drug abuse/misuse.

While both of these priorities will continue to be addressed, data indicates that the risk of suicide increases in youth who also report binge drinking. The Michigan Youth Risk Behavior Survey shows that in 2009, attempted suicide by non-drinkers was 6.4% while for binge drinkers the rate was 11.7%. The significant difference clearly identifies that a reduction in underage binge drinking may reduce the number of suicide attempts for this population. There are many shared risk and protective factors for substance use and mental health disorders including many that are addressed with our substance use prevention efforts.
http://www.michigan.gov/documents/MDHHS/Risk_and_Protective_Factors_revised_02_25_14_459423_7.pdf

NorthCare actively supported Mental Health First Aid (MHFA) across our region as a proactive step to encourage the average citizen to become a first responder in behavioral health crisis including suicidal thinking and planning. Each Board has responded to the need for outreach and education in their community working with local partners to determine their specific needs. There is a specific modification of MHFA for youth and we have a group of 8 trainers who work to address outreach to that group. Each of the CMHSPs has a website that highlights their activities in these areas and their websites can be accessed through www.northcare-up.org. An example of the work by one of our boards indicates the breadth of the audience that can be reached and the impact for the different population groups served by NorthCare. The Trainer at Northpointe Behavioral Health is representative of the work going on across the region:

Mental Health First Aid Training Group	Date of Training	Number of Participants	Location
MHFA Adult	10/17/2014	21 people	Wakefield, MI
MHFA Adult	11/10/2014	10 people	Kingsford, MI
MHFA Youth	12/8/2014	9 people	Menominee, MI
MHFA Adult	2/23/2015	8 people	Kingsford ,MI
MHFA Adult	3/17/2015	14 people	Wakefield MI
MHFA Adult	3/23/2015	12 people	Iron River, MI
MHFA Adult	4/14/2015	8 people	Ironwood, MI
MHFA Adult	4/21/2015	5 people	Menominee, MI
MHFA Adult	6/24/2015	10 people	Kingsford, MI
MHFA Youth	6/29/2015	9 people	Kingsford MI
MHFA Adult	7/22/2015	10 people	Kingsford, MI
MHFA Youth	8/27/2015	8 people	Menominee, MI
MHFA Adult	9/24/2015	16 people	Kingsford, MI
		Total Trained =140	
Denotes this training was MHFA Youth with a primary focus of helping youth in crisis.			
Denotes this training was MHFA Adult Higher Education with a primary focus is staff working with college students.			

Michigan Behavioral Risk Factor Surveys

Note--The FY15 data for the MBRF Surveys is not available at the time of this report. NorthCare intends to continue to analyze the critical areas outlined below and assess the need to change the direction of programming and services based on the findings. The results from review in FY14 have been kept in this version of the Demand and Capacity report until it is possible to revise by including the FY15 data.

The federal government through the Center of Disease Control & Prevention has developed a survey that addresses between 34 to 35 behavioral risk factors to support their goal of gathering information to help focus efforts to improve the health of US citizens.[3] The annual surveys are conducted at a state level and as of 2012 a format was standardized so the scores could be compared across years and regions in the state. The Upper Peninsula is a distinct region and the UP data can be compared to the state averages and it is possible to trend the results where there are variances between the state and where we are in line with state trends. For the purpose of this report, NorthCare has selected 15 questions that were asked adults in Michigan during phone surveys in 2012, 2013 & 2014. These topics were selected based on issues presented earlier in this report or have relevance as we move forward with integrated health care.

[3] The Annual Reports are available at MDHHS, search Michigan BRFS Annual Reports

Table 13 NorthCare Analysis Selected Fields of MBR Survey 2012, 2013, 2014 selected fields

Table Name & #	Year 2012 *Michigan*/*UP*	Year2013 Michigan/UP	Year 2014 *Michigan*/*UP*	Comments
Table 2-Poor Mental Health # of days within past 30	13% / 5.6%	12% / 10.5% significant increase over 2012	12.9% / 14.6%	In the UP, significant increase from 2012 to 2013 in reporting poor mental health. In 2014 not significant but continues trend to be higher than state average
Table 3-Mean # of days of poor mental health	4.1 days/2.4 days	3.9 days/ 3.5 days	4.1 days /4.2 days	Increase in poor mental health days in UP but not significant. Maybe better screening?
Table 15 -No routine Checkup in past yr	33.5% / 35.9%	30.1% / 31.0%	28.2% / 27.7% significant decrease statewide between 2012 and 2014	Would we expect increase in depression and heart disease due to increased / earlier identification?
Table 5 - Weight status--obese	31.1% / 27.3%	31.5% / 32.9%	30.7% / 28.8%	No significant differences from state averages all three years
Table 5- Weight status--overweight	36.4% / 36.2%	34.7% / 34.9%	34.9% / 33.6%	No significant differences from state averages all three years
Table 5--Weight Status-Normal weight	32.8% / 33.3%	32.5% / 30.9%	32.5% / 36.1%	No significant differences from state averages all three years

Table 31 -- Diabetes: ever told they have diabetes	10.5% / 12.6%	10.4% / 9.9%	10.4% / 11.8%	no sig difference in state or region in three years
Table 29-- Ever told they had any cardiovascular disease	9.9% / 10.2%	10.1% / 11.9%	10.0% / 12.2%	no sig dif although UP appears to be higher in HA and told has coronary heart disease in all three years-- possibly this reflects genetic homogeneity of UP.
Table 33-Doctor told them they had Depressive disorder	20.6% / 15.5%	21.3% / 21.2%	20.5% / 27.0	no sig difference but appears to be trending higher. Better awareness of SAD and depression. This could be the result of better screening due to more primary care visits. Probably related to Table 2 and table 15
Table 11-Heavy Drinking	6.1% / 8.7%	6.2% / 9.6%	6.8% / 7.4%	One yr sig dif from state % --adults who reported more than 2 drinks per day for men; 1 drink for women
Table 12-Binge drinking	19.2% / 21.5%	18.9% / 22.4%	18.9% / 19.4%	No sig difference in 3yrs from state--men who reported at least 5 drinks at one time within the past 30 days(women--4 drinks)
Table 8 -Current smoking	23.3% / 21.7%	21.4% / 19.8%	21.2% / 22.2%	no significant differences

Table 8 Former smoking	25.8% / 30.5%	27.0% / 32.6%	26.7% / 30.6%	no sig differences except within the 2013 yr between state and region
Table 8 --never smoked	50.9% / 47.8%	51.6% / 47.5%	52.1% / 47.3%	no sig dif over three years but consistently our region is below the state average
Table 10 --current smokers who have attempted to quit one day or longer in past yr.	64.3% / 64.4%	62.7% / 52.3%	61.5% / NA	NA=suppressed due to a denominator <50 and or a relative standard error>30%+E1A18:E21

A review of the fields selected from the MBRF Survey shows that the general population of the Upper Peninsula does not vary significantly from the state average in most dimensions. The residents of the Upper Peninsula are struggling with obesity and challenges of smoking in the same proportion as others in the state. There are three areas worth noting for future planning of services. The State of Michigan significantly lowered the responses to Table 15 for not receiving routine health care in the past 12 months from 2012 to 2014. This coincides with the Medicaid expansion program, Healthy Michigan. It seems plausible that the increase in reports of depression and heart attacks, though not significantly different from the state could be the result of increased contact with medical providers and better screening. This could lead to an increase in services needed to treat identified depression (see section below on depression) and to explore the behavioral health diagnoses co-morbidity with heart issues more closely. The second area of concern is the high reporting of alcohol consumption and concern about binge drinking. There is only one year with a significant difference between the UP and the state average on Table 11 Heavy Drinking and no significant difference across the three years on Table 12 Binge Drinking. However, a review shows on all six fields in the two tables, the UP reports higher incidents of use. The third area of risk is the high use of tobacco and the clear desire by more than half of current smokers to quit smoking. Since the co-morbid rates of smoking with Mental illness are even higher than the general population (upwards to 75%) this is an area where offering evidence based treatments for smoking cessation should be the rule for behavioral centers not the exception.

Topics that cross over youth and the aging population are depression, substance abuse and suicide. For both populations the trio of disorders frequently link together. The World Health Organization (WHO) provides the following key facts and depression:

- Depression is a common mental disorder. Globally, an estimated 350 million people of all ages suffer from depression.
- Depression is the leading cause of disability worldwide, and is a major contributor to the overall global burden of disease.
- More women are affected by depression than men.
- At its worst, depression can lead to suicide. Suicide is the second leading cause of death in 15-29-year-olds.
- There are effective treatments for depression.

Further facts from WHO about our elders are:

- Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders).
- 6.6% of all disability (disability adjusted life years-DALYs) among over 60s is attributed to neurological and mental disorders. These disorders in the elderly population account for 17.4% of Years Lived with Disability (YLDs). The most common neuropsychiatric disorders in this age group are dementia and depression.

- Anxiety disorders affect 3.8% of the elderly population.
- Substance use problems affect almost 1% - Substance abuse problems among the elderly are often overlooked or misdiagnosed.
- Around a quarter of deaths from self-harm are among those aged 60 or above.

WHO's Mental Health Action Plan 2013-2020, endorsed by the World Health Assembly in 2013, recognizes the essential role of mental health in achieving health for all people. The plan includes 4 major objectives:

- More effective leadership and governance for mental health;
- The provision of comprehensive, integrated mental health and social care services in community-based settings;
- The implementation of strategies for promotion and prevention;
- Strengthened information systems, evidence and research.

NorthCare Network continues to view these objectives as a concise roadmap for moving forward in improving behavioral health services.

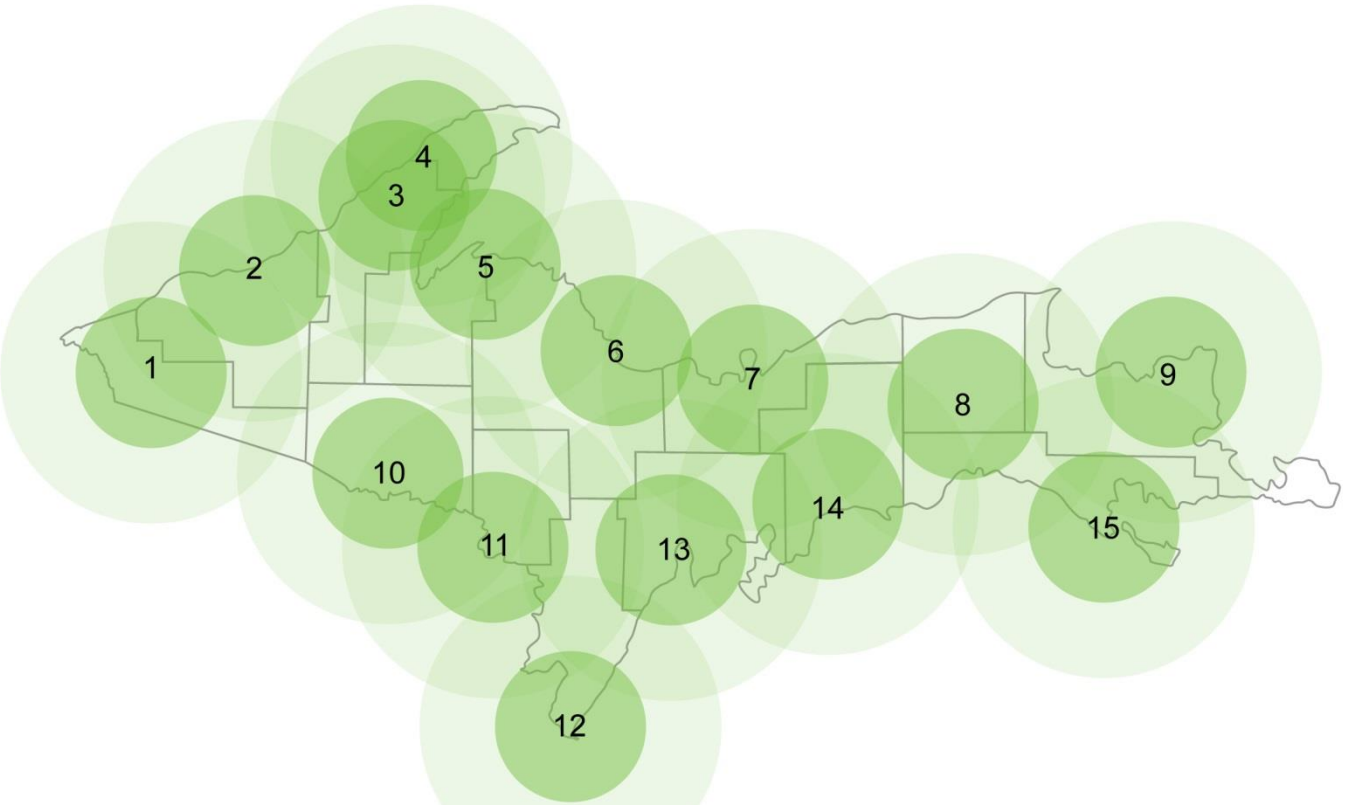
Conclusions

On May 25, 2012, WHO issued a *Call to Global Action* regarding mental health disorders based on the fact that the "treatment gap for mental disorders is large all over the world, that between 76%and 85% of people with severe mental disorders in low and middle income countries receive no treatment for their mental health conditions and that the corresponding figures for high income countries are also high-between 35 % 50 %."[4] In the state of Michigan, the public community mental health system has sought to improve access to care for those individuals with serious mental illness and individuals with serious functional limitations due to intellectual/developmental disabilities. The PIHPs have been charged since their creation in 2002 to provide evidence based practices to treat the individuals they serve. We have been able to work steadily for 14 years to make inroads in maximizing access to care and providing treatment based on effective, researched methods. At the end of FY15, NorthCare met the new demand of the Michigan Health Link Program and existing service demands for individuals served by the CMHSPs and SUD providers. New software systems are in place to allow real time coordination of care for the adults with serious mental illness and their physical health care providers. A complete record of all pharmacy, medical services and behavioral health services is available in the ProAct program which also provides specific QI indicator information regarding trends in health provision such as poly-pharmacy practices with possible negative interactions. We anticipate increased joint efforts with the Upper Peninsula Health Plan to improve the overall health of shared Medicaid members in FY16. There is much to be done moving forward and NorthCare will continue to report our progress in a variety of ways: annual newsletter; annual performance report; website; and this report. We rely on feedback from our partners to tell us where we have fallen short and to how to maximize our successes. Please contact NorthCare Network at any time through our customer service line at 888-333-8030.

[4] World Health Organization WHA65.4 Agenda Item 13.2

Appendices

Appendix 1 FY15 Geographic Access for Mental Health Services



Dark Green – Urban Rule: 30 mile radius from each CMH Office in NorthCare Region

Light Green – Rural Rule: 60 Mile radius from each CMH Office in NorthCare Region

Copper Country Community Mental Health
- 5 Baraga County
- 3 Houghton County
- 4 Keweenaw County
- 2 Ontonagon County

Goegebic Community Mental Health
- 1 Gogebic County

Hiawatha Behavioral Health
- 9 Chippewa County
- 15 Mackinac County
- 14 Schoolcraft County

Northpointe Community Mental Health
- 11 Dickinson County
- 10 Iron County
- 12 Menominee county

Pathways Community Mental Health
- 7 Alger County
- 13 Delta County
- 8 Luce County
- 6 Marquette County

The Current NorthCare Provider Directory is available on our website: www.northcare-up.org. It contains a list of the Organizational Providers that NorthCare contracts with to provide the full array of Medicaid services.

The NorthCare website has links to each of the CMHSPs where a current CMHSP Provider Directory can be obtained. The CMHSP Directory includes the location, the names, credentials and the populations the providers are serving at the time of publication. The Provider Directory is updated when staff are credentialed or re-credentialed, or if they begin a new assignment with a program or population that requires specific credentialing or training that has been obtained. NorthCare and the Affiliate CMHSPs update their directories as needed to assure members have current information about available providers.

Appendix 2 FY15 NorthCare Network Level of Care Placement Protocols

Reminder-The level of care categories provide a general description of symptom severity, functional capacity, risk potential and typical support needs associated with each level of care. They are only intended to serve as a guideline for level of care placement decisions. Medical necessity of the consumer's health and welfare needs will determine services and intensity.

Level of Care and Utilization System (LOCUS) for MI Adults

Level of Care LOCUS Score

Level I Brief or Limited Outpatient Services 10-16

MH1A: Brief Outpatient Therapy

MH1B: Supports Coordination/Therapeutic Stabilization & Support

Level II Intensive Outpatient Services 17-22

MH2A: Supports Coordination/Community Supports

MH2B: Intensive Case Management/ Supports Coordination/Community Supports

MH2C: Assertive Community Treatment/ Home-Based Services

Level III Residential Treatment Services 23-27

MH3A: Therapeutic Foster Care (SED)

MH3B: Specialized Residential Contract

MH3C: Treatment Group Home

Level IV Inpatient Care 28 and above

MH4A: Inpatient Psychiatric Care (includes Crisis Stabilization or Crisis Residential)

MH4B: State Hospital Inpatient Care

NorthCare DD Functional Assessment – DDA and DDC

Level of Care NorthCare DD Functional Assessment Range

DD Level I - Basic Support Services 0 to 15

DD Level II - Enhanced Support Services 12 – 20

DD Level III - Specialized Support Services 17 - 40

DD Level IV - Intensive Residential and Support Services 37 - 96

Child and Adolescent Functional Assessment (CAFAS) Scale – SED (Youth ages 7-17)

Two or more elevated scores rated at 20 or 30 AND total impairment score of 50 or greater on the 8 clinical subscales: School/Work, Home, Community Behavior towards Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking

Preschool and Early Childhood Functional Assessment Scale – SED (Youth ages 4-6)

Total score of 60 or greater

Infant Mental Health (IMH) (infants and children under 4)

Current functional impairment criteria are met according to IMH assessment

Appendix 3 FY14 Consumer Base Overview by Diagnostic Category

AXIS 1 Diagnosis Category	Age 5 & under	Age 6-17	Age 18-64	Age 65+	Total Consumers
Adjustment Disorders	8	34	35	1	78
Anxiety Disorders	13	180	269	9	471
Attention Deficit Disorders	9	248	39		296
Autistic Spectrum Disorders-incl Pervasive DD	30	151	155	1	337
Behavior Disorders	19	153	44	1	217
Bipolar Disorders		33	419	33	485
Dementia			5		5
Diagnosis deferred		4	67	1	72
Disorders due to General Medical Condition			4		4
Eating, Sleeping, Movement and Elimination Disorders	2	1	2		5
Learning Disorders	6	19	8	2	35
MISC Affective Disorders	1	114	199	12	326
Major Depressive Disorders		55	355	26	436
Misc. Childhood Disorders	31	23	2		56
No diagnosis noted	25	155	377	32	589
Psychotic Disorder		1	36	6	43
Schizophrenia		5	627	83	715
Substance Abuse Disorders		4	60	1	65
Substance Induced Disorders			4	1	5
V codes	9	7	2		18
Totals	**153**	**1187**	**2709**	**209**	**4258**

AXIS 2 Diagnostic Category	Age 5 & under	Age 6-17	Age 18-64	Age 65+	Total Consumers
Diagnosis deferred	1	8	4	0	13
Mental Retardation	5	80	666	92	843
Personality Disorder		2	39		41
Cognitive Disorder			5		5
Totals	**6**	**90**	**714**	**92**	**902**

Source: Diver FY15 DiagCat Model, Medicaid Yes, Axis1Primary, Axis II Primary and DSM5 Primary, consumer counts are un-duplicated

Appendix 4 FY15 Consumer Base Consumers by Primary Eligibility and Level of Service

Source: Diver/service model FY15/Medicaid=Y/Service Reportable=Y/LOC

Level of Care	Total Consumers
No Level of Care Indicated	713
DDA 1 Limited Services-Basic Support	242
DDA 2 Enhanced Support Services	441
DDA 3 Habilitation/Supports Waiver (HSW) enrollee Services	354
DDA 4 Specialized Residential and Support Services	126
DDA_PWGF	9
DDC 1 Limited Services-Basic Support	73
DDC 2 Enhanced Support Services	169
DDC 3 Habilitation/Supports Waiver (HSW) enrollee Services	42
DDC 4 Specialized Residential and Support Services	14
DDC_PWGF	1
MIA 1A Brief Intervention & Supports Maintenance	119
MIA 1B Community Support Services-Limited/Low intensity Supports/Case management	193
MIA 2A Community Support Services-Moderate intensity Supports/Case Management	812
MIA 2B Community Support Services-High intensity Supports/Case Management	362
MIA 2C Assertive Community Treatment-ACT	152
MIA 3A Therapeutic foster care	85
MIA 3B Specialized Residential/Special Contract AFC Services	39

MIA 3C Community Support Services-Moderate intensity Supports/Case Management	0
MIA 4A Inpatient Care	42
MIA 5	44
MIA 6	12
MIA_PWGF	36
MIC 1A Brief Outpatient Therapy	70
MIC 1B: Supports Coordination/Therapeutic Stabilization & Support	110
MIC 2A Supports Coordination/Community Supports	327
MIC 2B Intensive Case Management/ Supports Coordination/Community Supports	199
MIC 2C Home-Based Services	232
MIC 3A Therapeutic Foster Care (SED)	21
MIC 3B Specialized Residential Contract	6
MIC 3C Treatment Group Home	7
MIC 4B Inpatient Care	0
MIC_PWGF	0
MIC 4A	45
Total	**5097**

Appendix 5 FY15 CMHSP Services Provided to Medicaid Consumers

Source: Diver FY15/ Medicaid = Y/ Service Reportable = Y / State Service Description

State Service Description	Total Consumers
Totals	5097
Assertive community treatment face-to-face per 15 minutes	203
Assessment - Developmental Testing	5
Assessment by Non-Physician; use ST for trauma assessment	1269
Autism home care training monitoring	18
Behavioral Health Screening by non-physician	74
Behavioral Health; Short-Term Residential; non hospital resident treatment	65
Brief Office Visit to Monitor RX	86
CLS - Comprehensive Community Support Services p/15 minutes	1010
CLS Per Day - Comprehensive community supports services p/diem in specialized residential and other settings	543
CLS/Supported Housing p/diem; non licensed independent settings or own home per day	70
Children of adults with mental illness	1
Community Transition, Per Service	1
Community-based Wrap-Around services, per diem (SEDW only)	4
Comprehensive Multidisciplinary Evaluation; does not require face to face with beneficiary	94
Crisis Intervention Services p/15 minutes	1160
Dialectical Behavioral Therapy (DBT)	69
Domiciliary/rest home, est pt. 2 of 3 key components, typically 25 min	43
Domiciliary/rest home, est pt. 2 of 3 key components; typically 40 min	1
Domiciliary/rest home; est pt. 2 of 3 key components, typically 15 min	20
Domiciliary/rest home; new pt. 3 of 3 key components, typically 45 min	1
Drop-In center attendance; encounter	71
Durable medical equipment, miscellaneous	16
ECT	3
Evaluation of speech fluency, eg. stuttering, cluttering	1
Evaluation of speech sound production expanded	48

Evlauation of speech sound production	1
Family Psycho-education Skills Workshop	14
Family Psycho-education: family educational groups (either single or multi-family)	29
Family Psychoeducation Joining	19
Family Training & Family Parent Training as TFCBT	136
Family therapy with consumer present and with consumer as TFCBT	159
Family therapy without consumer present; choose ST for TFCBT	140
Foster care, therapeutic, child, per diem (use for CCI) Licensed settings only. Report only for per diem bundled rate that does not include Medicaid-funded personal care and/or community living supports	9
Group therapy adult or child (other than of a multiple-family group)	175
Home Based Services or Home Based Trauma Focused TFCBT; Community psychiatric supportive treatment, face-to-face with child or family; p/15 minutes	348
Home Care Training, Non-Family (Children's Waiver Service Only)	12
Home Modifications, Per Service.	10
Home visit, est pt. 2 of 3 key components, typically 15 min	9
Home visit, est pt. 2 of 3 key components, typically 25 min	6
INDIRECT psychological services and documentation	6
Individual Therapy Adult or Child & Individual Therapy as TFCBT 16-37 minutes	488
Individual Therapy Adult or Child & Individual Therapy as TFCBT 53 + minutes	881
Individual Therapy Adult or Child & Individual Therapy as TFCBT 38-52 minutes	649
Infant Mental Health; Aproved MDCH models only	5
Injection, Fluphenazine Decanoeate, Up To 25 mg	11
Injection, Haloperidol Decanoeate, Per 50 mg	28
Injection, Risperidone, Long Acting, 0.5mg	25
Injection, aripiprazole, extended release, 1 mg	5
Injection, paliperidone palmitate, extended release, 1 mg	38

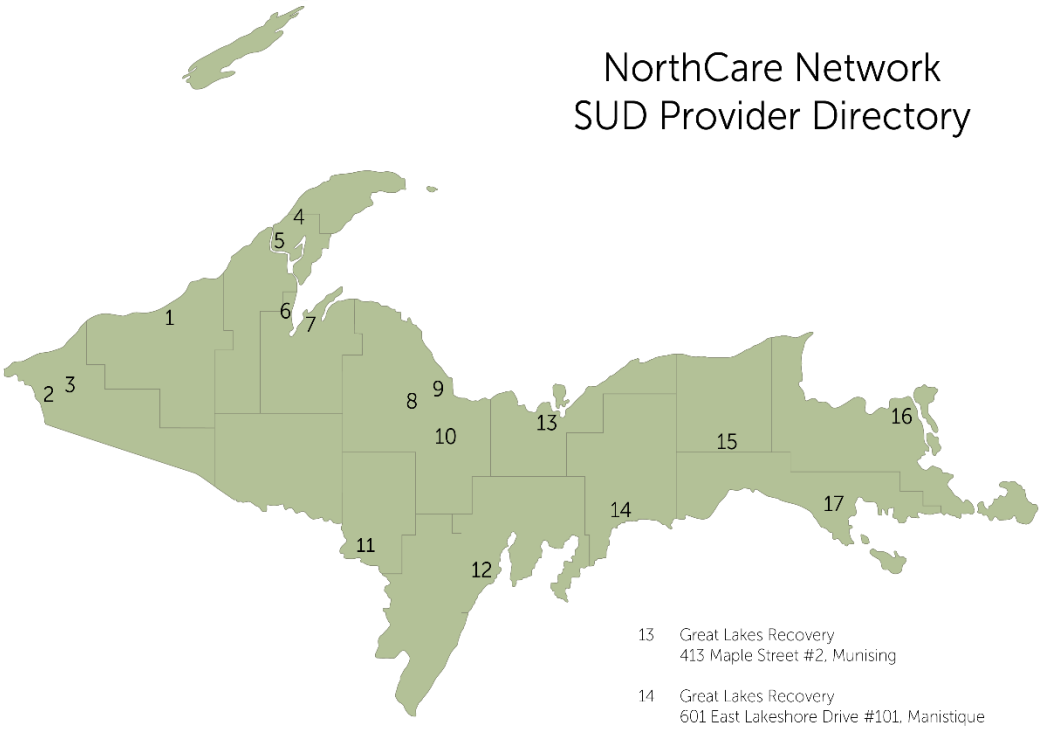
Inpatient Hospitalization - All Inclusive Room & Board Plus Ancillaries	391
Intensive Crisis Stabilization Team Service	1
Interactive Complexity Add on Code	14
Interpretation or explanation of results of Psychiatric tests to consumer,family and courts. TS is used for recertications	1
Medical nutrition therapy reassessment & intervention, individual, face-to-face with patient 15 minutes	37
Medical nutrition therapy, initial assessment & intervention, individual face-to-face with the patient	53
Medication Administration by injection	250
Medication training and support p/15 minutes	22
Memo to Chart	14
Mental Health Clubhouse Services	51
Mental health service plan development by non-physician	1669
Miscellaneous Therapeutic Items & Supplies, NOC	132
Multiple-family psychotherapy	2
Neuro-psychological testing p/hr	1
New patient office or outpatient (Certification exam)	3
Non emergency transportation services; ancillary; parking fees, tolls, other	1
Non-Emergency Transportation; Patient Attendant/Escort	1
Nursing Assessment	146
Nutritional Counseling, Dietician Visit	17
OT Indirect Acivity consult/paperwork	12
OT/PT Aquatic therapy individual per 15 minutes	2
OT/PT Gait training(includes stair climbing)individual p/15 minutes	3
OT/PT Individual Sensory Integrative Techniques	9
OT/PT Individual Therapeutic Activities p/15 minutes	23
OT/PT Manual Therapy Individual	4
OT/PT Neuromuscular reeducation individual p/15 minutes	6
OT/PT Orthotic(s) management and training; individual p/15 minutes	1
OT/PT Self care home management training; individual p/15 minutes	4

OT/PT Strength ROM - Individual	8
OT/PT Wheelchair Management/Propulsion Training	2
OT/PT physical or maniupulative therapy performed for maintenance rather than restoration	4
Occupational Therapy Evaluation	227
Occupational Therapy Re-Evaluation	19
Office outpatient/new; 3 key components face to face; 45 minutes	15
Office/outpatient/established; 10 minutes(Certification exam)	107
Office/outpatient/established; 2 of 3 key components; 25 minutes	1416
Office/outpatient/established; 2 of 3 key components; 40 minutes	246
Office/outpatient/established; 5 minutes	93
Office/outpatient/estb; 2 of 3 key components; 15 minutes	1636
Office/outpatient/new; 3 key components, face to face 60 minutes	158
Office/outpatiet/New; 3 key components 30 minutes face to face	3
Out of Home Pre-Vocational (HSW Only)	10
PERS Maintenance	5
PT Indirect, consult/paperwork	1
Parent Education	6
Patient Education, NOC, Non-Physician, Group	47
Patient Education, NOC, Non-Physician, Individual	3
Peer specialist services provided by certified per specialist; p/15 minutes	190
Personal Care Per Diem	529
Personal care item, NOS	25
Phyical Therapy Evaluation	13
Physical Therapy Re-evaluation	1
Physician services provided in inpatient hospital care. Initial p/30 minutes	2
Physician services provided in inpatient hospital care. Initial p/50 minutes	12
Physician services provided in inpatient hospital care. Subsequent care p/15 minutes	8
Physician services provided in inpatient hospital care. Subsequent care p/25 minutes	13
Physician services provided in inpatient hospital care. Subsequent care p/35 minutes	3

Private Duty Nursing, habilitation supports waiver(individual nurse only) 21 years and over ONLY (LPN)	2
Psychiatric Diagnostic Evaluation (no medical services)	72
Psychiatric Diagnostic Evaluation (with medical services)	236
Psychological Testing by psychologist or physician p/hr	67
Psychotherapy for crisis 1st 60 minutes	1
RN services, up to 15 minutes	303
Recoding SALs of INACTIVE staff	1
Respite Care Day, In home	5
Respite Care Services, day in an out of home setting	52
Respite care p/15 minute	303
Screening to Determine Appropriateness of Inpatient Hospitalization	600
Skill Building & Training / Out-of-Home Non-Vocational Habilitation (HAB);use TT modifier when multiple consumers are served	780
Specialized Medical Equipment, NOS	10
Specialized Supply, NOS	24
Specialized Wraparound Facilitation	37
Speech Indirect/Documentation	2
Speech and Language Evaluation of oral & pharyngeal swallowing function	2
Speech and language therapy, individual	38
Staff Meeting	1
Supported Employment	249
Supports Coordination	2475
Targeted Case Management	678
Targeted Case Management Services - Child Waiver only.	18
Telehealth Originating Site Fee	620
Therapeutic Camping, Day	6
Therapeutic Camping, Overnight	19
Vehicle Modifications	1
Waiver Service NOS	110

Appendix 6 FY15 SUD Provider List and Geographic Access

NorthCare Network
SUD Provider Directory



1 Phoenix House Outpatient
902 River Street, Ontonagon

2 Great Lakes Recovery Outpatient
113 South Curry, Ironwood

3 Phoenix House Outpatient
101 East Mart Street #3, Bessmer

4 Phoenix House Residential & Outpatient
57467 Watersworks Street, Calument

5 Phoenix House Outpatient
801 North Lincoln Drive, Hancock

Great Lakes Recovery Outpatient
920 Water Street #6, Hancock

6 Keweenaw Bay Indian Community Outpatient
16429 Bear Town Road, Baraga

7 New Day Treatment Center
16025 Brewery, L'Anse

8 Great Lakes Recovery Outpatient
97 South Fourth Street, Ishpeming

Great Lakes Recovery Youth Residential & Outpatient
104 Malton Road, Negaunee

9 Great Lakes Recovery Outpatient
1009 West Ridge Street #C, Marquette

Great Lakes Recovery Residential
241 Wright Street, Marquette

Catholic Social Services Outpatient
347 Wright Street, Marquette

Upper Peninsula Health Systems Behavioral Health Services
580 West College, Marquette

10 Catholic Social Services Outpatient
328 Fortress, Gwinn

11 Great Lakes Recovery
427 South Stephenson Avenue, Iron Mountain

Catholic Social Services Outpatient
427 South Stephenson Avenue #215, Iron Mountian

12 Catholic Social Services
1100 Ludington Street #401, Escanaba

Great Lakes Recovery
1401 North 26th #109, Escanaba

13 Great Lakes Recovery
413 Maple Street #2, Munising

14 Great Lakes Recovery
601 East Lakeshore Drive #101, Manistique

15 Great Lakes Recovery
405 Newberry Avenue #2, Newberry

16 Great Lakes Recovery New Hope Outpatient
2655 Ashmun, Sault Ste. Marie

Great Lakes Recovery Women's New Hope House
2655 Ashmun, Sault Ste. Marie

Great Lakes Recovery Men's New Hope House
301 East Spruce Street, Sault Ste. Marie

17 Great Lakes Recovery Outpatient
799 Hambach Street, St. Ignace

Appendix 7 FY15 Diagnosis of Clients with SUD

Medicaid SUD Admissions by Primary Diagnosis, FY15

Primary Dx	Dx Description	# of Adm	% of Adm
305.00	Alcohol abuse	112	7.56%
303.90	Alcohol dependence	393	26.52%
305.70	Amphetamine or similarly acting sympathomimetic abuse/intoxication	4	0.27%
304.40	Amphetamine or similarly acting sympathomimetic dependence	37	2.50%
305.20	Cannabis abuse/intoxication	55	3.71%
304.30	Cannabis dependence	92	6.21%
304.20	Cocaine dependence	11	0.74%
304.50	Ecstasy /Ketamine dependence	1	0.07%
304.50	Hallucinogen dependence	1	0.07%
304.60	Inhalant dependence	5	0.34%
305.50	Opioid abuse/intoxication	14	0.94%
304.00	Opioid dependence	730	49.26%
305.90	Other or unspecified psychoactive substance abuse/intoxication	2	0.13%
304.80	Polysubstance dependence	5	0.34%
305.40	Sedative, hypnotic, or anxiolytic abuse/intoxication	3	0.20%
304.10	Sedative, hypnotic, or anxiolytic dependence	17	1.15%
	Total Medicaid Admissions:	**1482**	*** 100.01%**

* Note: Due to rounding, percentages may not = 100%