NorthCare Network
Demand and Capacity Report

FY16 Review and Analysis
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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 Inpatient Health Plan (PIHP) for all Upper Peninsula Medicaid recipients requiring specialty mental health services, substance use services, and provide services and support for persons with intellectual/developmental disabilities. The contract became effective October 1, 2002. The contract is updated and renewed annually. Specifically:

> *"The Michigan Department of Health & Human Services (MDHHS) hereby enters into a contract with the specialty Prepaid Inpatient Health Plan (PIHP)…. Under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDHHS 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. Such arrangements have been designated as "Concurrent 1915(b)/(c)" Programs by CMS. 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 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, MDHHS operates 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." Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 16 (October 1,2015 through September 30, 2016)."*

On January 1, 2014, NorthCare Network PIHP was reconfigured as an independent regional entity under Section 1204(b) of the Michigan Mental Health Code. NorthCare is governed by a Board of Directors with representation from Region 1's five affiliate Community Mental Health Service Programs (CMHSPs) and is no longer a DBA of Pathways Community Mental Health. In 2014 NorthCare Network earned URAC Health Plan Accreditation, demonstrating our commitment to quality performance in the management of specialty mental health services in all 15 counties of Michigan's Upper Peninsula.

NorthCare Network is responsible to assure a network of providers sufficient to provide access to all medically necessary services covered under the Specialty Services and Supports Contract between MDHHS and the PIHP. 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.
- 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-mile rural rule for service availability.

To make the determination as to our effectiveness in addressing the factors above, current utilization is evaluated in relation to the Michigan Mission-Based Performance Indicator System (MMBPIS) and the population demands. The NorthCare Performance Indicator Report FY16[1] measures a variety of clinical markers for access to care. Service provision is evaluated using the 60-minute/60-mile rural standard. NorthCare meets or exceeds the 95% standard of timeliness for individuals in crisis to receive an emergency assessment and decision as to treatment response within three hours. In terms of access to services, all individuals who are eligible for specialty mental health services received an initial

[1] NorthCare Performance Report _FY16 is available by calling 888-333-8030 and requesting an electronic or paper version.

assessment within the 14-day standard above the 95% standard, except in one quarter where one consumer did not complete an assessment within 14 days of their eligibility determination. In FY16 NorthCare was below the allowable 95% performance measure standard for a follow-up to inpatient hospitalization for mental illness for a child (ages 6 – 20) in one quarter. This measure was below 95% during one quarter in each FY12, FY13, and FY15. Audits of the outliers do not indicate a shortage of practitioners. Instead, a review suggests there are challenges in coordination of care with the local CMHSP (Community Mental Health Service Programs) and the schedules of the families. The resolution of this measure is compounded by the lack of trending at a specific CMHSP. Improving this measure remained a focus of the Emergency Services Workgroup throughout FY16. The same indicator of a follow-up appointment for adults after hospitalization was met at 95% for the year.

In FY16 the trend noted in previous demand and capacity reports of declining population in the UP continues in 13 of the 15 counties (**Table 1**). The continued decline in population and the CMHSPs' performance on access measures 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.

Table 1. Snapshot of Regional CMHSP and U.S. Census Populations by County

Source: Diver/FY16 Service Model/Medicaid: Y/ServiceReportable:Y/AffiliateName/SubElementPop/Age; https://www.census.gov/data/tables/2016/demo/popest/counties-total.html

CMHSP Board	FY16 Services		Coverage US Census		
	FTE-Licensed Professionals	Consumers	County	Estimated Population 2016	Change in population % 2015 to 2016
Copper Country	**Serving MIA 45** **Serving MIC 22** **Serving DDA 45** **Serving DDC 22** Total Clinical Professionals 47	**MIA 494** **MIC 112** **DDA 209** **DDC 26**	Baraga Houghton Keweenaw Ontonagon	8503 36555 2199 5911	-0.50% 0.48% 1.06% -1.61%
Gogebic	**Serving MIA 15** **Serving MIC 7** **Serving DDA 13** **Serving DDC 8** Total Clinical Professionals 21	**MIA 211** **MIC 47** **DDA 98** **DDC 27**	Gogebic	15243	-1.30%
Hiawatha	**Serving MIA 35** **Serving MIC 26** **Serving DDA 35** **Serving DDC** 31 Total Clinical Professionals 43	**MIA 662** **MIC 180** **DDA 217** **DDC 82**	Chippewa Mackinac Schoolcraft	37724 10820 8001	-0.73% -0.71% -1.91%
Northpointe	**Serving MIA 54** **Serving MIC** 49 **Serving DDA 54** **Serving DDC** 49 Total Clinical Professionals 54	**MIA 783** **MIC 313** **DDA 271** **DDC 78**	Dickinson Iron Menominee	25535 11195 23281	-0.80% -1.30% -0.99%
Pathways	**Serving MIA** 74 **Serving MIC** 49 **Serving DDA** 60 **Serving DDC** 32 Total Clinical Professionals 87	**MIA 1425** **MIC 468** **DDA 503** **DDC 104**	Alger Delta Luce Marquette	9219 36202 6358 66435	-1.37% -0.56% -1.24% -1.29%

MIA – Mentally Ill-Adult
MIC – Mentally Ill-Child
DDA- Developmentally Disabled Adult
DDC- Developmentally Disabled Child

Development Approach

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 its provider networks.

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 internal and regional committees. Regional committees are composed of staff from the affiliate CMHSPs, interested consumers and stakeholders, with PIHP staff as the committee lead. The five affiliate CMHSPs share resources, experiences, and skills to drive performance improvement across Region 1. The CMHSPs use a common electronic health record system and access screening center. They have consolidated certain other administrative functions such as: contracting with inpatient providers, an after-hours telephone crisis response provider for all 15 counties, and a common software program, Great Plains, for financial management. The regional committees noted below provide the opportunity to continually explore further administrative efficiencies and review demand and capacity:

Performance Management Committee (PMC) is configured with CEO representation from the 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 administrative areas provides a monthly report to the PMC on work plans. 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.

Quality Improvement Committee is charged to engage 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 Assessment and Performance Improvement Plan(QAPIP). The committee works 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 proactive, preventative manner. The committee identifies, monitors, and controls risks associated with complex duties, obligations, rules, regulations, and requirements. The Quality Improvement Committee refers identified compliance issues to the NorthCare Network Leadership and/or Compliance Team as appropriate.

Clinical Practices Quality Improvement Committee and its subcommittees and workgroups (Jail Diversion, Autism Workgroup, Regional Employment Leadership Team & Behavior Treatment) are charged with assuring the full array of services are provided according to best clinical practices by a qualified workforce that supports the recovery of the individuals and families served in accordance with the Michigan Mental Health Code, Michigan Medicaid Provider Manual and MDHHS Technical Requirements attached to the MDHHS/PIHP contract. 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 monitoring utilization of clinical resources and providing supports that ensure services are used only for authorized purposes, are uniformly available to eligible persons, and are provided in an

effective and efficient manner. NorthCare Network 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 Network staff to ensure consistent application of ongoing eligibility standards. Face-to-face assessments are conducted locally at the respective affiliate CMHSPs.

Provider Network Management Committee ensures adequate provider capacity throughout the NorthCare Network to meet current and anticipated demands for provision of services. Monitors network capacity and establishes processes and practices for ensuring overall compliance of Network Providers. Provides final review and approval for network provider performance reviews and makes recommendation to the credentialing committee and Quality Oversight and Monitoring Committee as appropriate. This includes assisting the CFO in the development of RFI/RFPs as requested; credentialing of organizational providers in collaboration with HR, credentialing committee, and site review team(s); establish best practices for efficient and effective management of network providers with a focus on common standards and reciprocity. Assist with the annual Demand and Capacity Report.

Finance Committee is charged with making recommendations on regional best practices for financial management that demonstrates our fiduciary responsibility as a "value purchaser".

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

Customer Services Committee and the Recovery Conference Workgroup are charged with oversight of regional consumer involvement activities. The committee ensures customer service functions delegated to affiliates are completed in a manner consistent with contract, regional, state, and federal mandates. This group reviews and provides input into applicable policies, printed materials, reports, performance indicators, and the consumer satisfaction survey process and results. It serves as a consumer advisory committee to the Quality Improvement Committee and Governance Board.

The 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 Annual Submission Report from each affiliate CMHSP, one of the sources used in the PIHP Demand and Capacity Report. Specific information related to the affiliates' local needs assessment provides a framework to guide future service delivery efforts. All five affiliates expressed concern regarding increasing substance use across the region. The affiliate boards all shared concern related to the availability and access of psychiatric and substance use disorder services for all individuals, and emphasized the need for more youth services in both areas. NorthCare began a review of the services provided by the CMHSPs for co-occurring disorders during FY16. The review concluded that there was a trend of fewer co-occurring disorder (COD) services being provided by affiliate CMHSPs. This trend coincided with a significant exodus of experienced staff departing the CMHSPs, leaving consumers with fewer providers trained in COD. Based on the feedback in CMHSPs' annual reports and corresponding encounter data, NorthCare initiated plans to increase COD services being provided at the CMHSPs and to improve referrals to SUD providers when clinically appropriate. In FY17 there will be several interventions to improve the skills of the CMHSP clinicians to better engage consumers with co-occurring behavioral health and substance use disorder needs.

Capacity

FY16 Consumer Base and Service Delivery

Crisis Services: NorthCare Network must ensure the provision of crisis services to all the citizens in the Upper Peninsula in accordance with regulations outlined in the Michigan Mental Health Code. Crisis intervention services and screening for inpatient psychiatric hospitalization are available through CMHSP emergency services in each county. The NorthCare Customer Services Handbook has a complete listing of CMHSP emergency numbers and all hospitals that serve as emergency evaluation sites in Region 1. The handbook is available at the NorthCare website: www.northcarenetwork.org . A standard emergency assessment in the electronic health record (EHR) is utilized by all affiliate CMHSPs to improve coordination of care between network providers and 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. Utilizing a standard practice for jail diversion allows for timely coordination for decisions made 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, the Medicaid Managed Specialty Supports and Services Contract, and 1915(b)/(c) Waiver Program Master Contract. Specialty services provided by the CMHSPs are directed toward the following 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 (COD) involving any of the above with a substance use disorder. Detailed data regarding individuals served by NorthCare Network PIHP and SUD providers, and the services received by those individuals, is provided in the attached appendices:

- **Appendices 1-5** CMHSP Specific
  - **Appendix 1** – Geographic Access for Mental Health Service
  - **Appendices 2, 3, and 4** – Level of Care Services and Priority Populations Served
  - **Appendix 5** – Services Provided to Medicaid Consumers

NorthCare and the five affiliate CMHSPs managed services for 6,137 Medicaid consumers in FY16. Of these, 1,597 (26%) were individuals with a primary diagnosis of intellectual/developmental disability and 4,540 (74%) were adults and children with mental health disorders. Of the 6,137 individuals served, 963 (15.69%) were individuals with a co-occurring Substance Use Disorder (SUD).

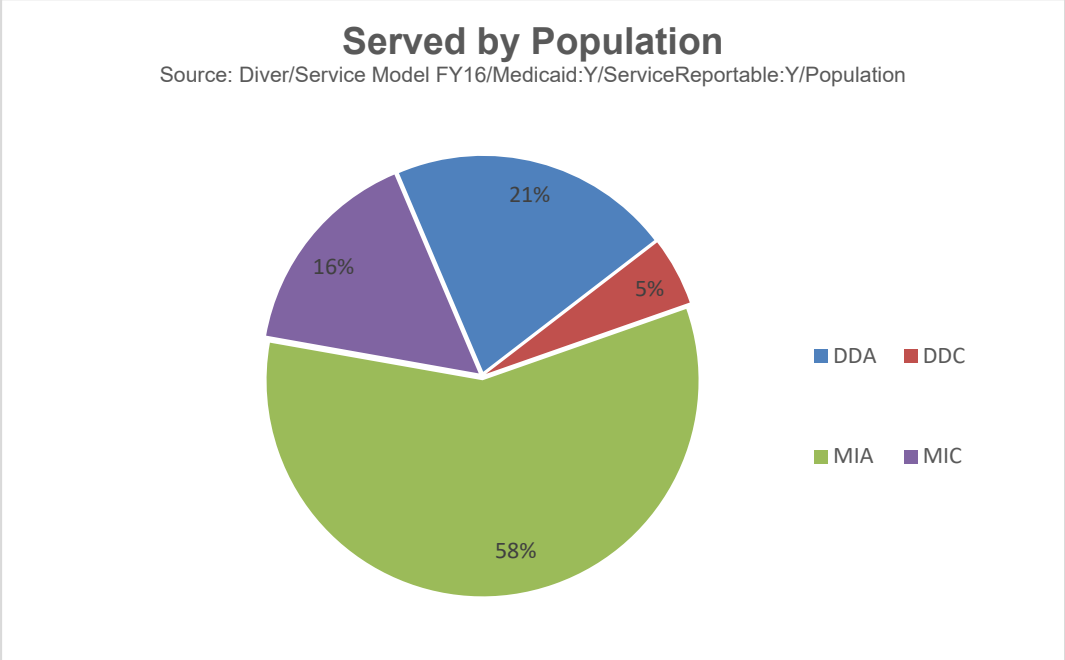
Table 2. NorthCare Consumers Served by Population and Age – FY16

Source: Diver FY16 Service Model, Medicaid = Y, Service Reportable = Y, Sub Element Pop

Population	Age 5 & Under	6 to 17 Years of Age	18 to 64 Years of Age	65+ Years of Age	Total Consumers
DD	47	264	1133	153	1597
MI	87	884	3364	205	4540
Totals	**134**	**1148**	**4497**	**358**	**6137**

DD-Developmentally Disabled MI-Mental Illness

FY16 - Pie Graph Representing Population Without Consideration of Age



DDA- Developmentally Disabled Adult
MIA – Mental Ill Adult

DDC-Developmentally Disabled Child
MIC - Mental Ill Child

Appendix 2 – Level of Care provides an overview of the NorthCare Level of Care (LOC) Model. 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 under-utilization of services. Table 3 demonstrates LOC for individuals with co-occurring disorders.

Table 3. NorthCare Individuals with Co-occurring Disorders – FY16

Source: Diver FY16 Service Model, Medicaid = Y, Service Reportable = Y, SUD Value Partial or Full Remission, Level of Care.

Level of Care	Total COD Consumers
No Level of Care Indicated	66
DDA 1 Limited Services-Basic Support	5
DDA 2 Enhanced Support Services	10
DDA 3 Habilitation/Supports Waiver (HSW) Enrollee Services	2
DDA 4 Specialized Residential and Support Services	3
DDA PWYS	0
MIA 1A Brief Intervention & Supports Maintenance	61
MIA 1B Community Support Services-Limited/Low intensity Supports/Case Management	42
MIA 2A Community Support Services-Moderate Intensity Supports/Case Management	376
MIA 2B Community Support Services-High Intensity Supports/Case Management	125
MIA 2C Assertive Community Treatment-ACT	40
MIA 3A Therapeutic Foster Care	79
MIA 3B Specialized Residential/Special Contract AFC Services	4
MIA 3C Community Support Services-Moderate Intensity Supports/Case Management	0
MIA 4A Inpatient Care	17
MIA 5	71
MIA 6	5
MIA Pathways General Fund	20
MIC 1A Brief Outpatient Therapy	1
MIC 1B: Supports Coordination/Therapeutic Stabilization & Support	0
MIC 2A Supports Coordination/Community Supports	6
MIC 2B Intensive Case Management/ Supports Coordination/Community Supports	7
MIC 2C Home-Based Services	7
MIC 3A Therapeutic Foster Care (SED)	1
MIC 3B Specialized Residential Contract	1
MIC 3C Treatment Group Home	0
MIC 4	14
MIC_PWYS	0
Total Number of Individuals with Co-occurring Disorders	**963 = 15.69% of total served**

DDA- Developmentally Disabled Adult MIA – Mental Ill Adult MIC - Mental Ill Child

Substance Abuse Services: NorthCare Network Substance Use Disorder Services assures the care for Medicaid and Healthy Michigan enrollees utilizing a provider network throughout the 15 counties in the Upper Peninsula. The SUD treatment service array includes; Assessment, Individual and Group Therapy, Intensive Outpatient Therapy, Inpatient Residential, Sub-acute Detox Services, and Recovery Housing. Individuals receiving SUD services have a treatment plan that routinely includes relapse prevention. Additional specialty services funded by the SUD block grant include: Case Management, Women and Children Services, and Room and Board for residential placement. Peer Recovery Coaches have an important role in SUD recovery of consumers. In FY16, the number of Peer Recovery Coaches in NorthCare Network increased to six, who are available in five counties. Active recruitment and training of Peer Recovery Coaches will continue in FY17. NorthCare Network provides funding for community and youth specific evidence-based SUD prevention services in the Upper Peninsula. Examples of these include several *Communities That Care* coalitions and additional programs such as *Community All Stars*, *Botvin's Life Skills*, *Big Brothers Big Sisters* mentoring, *Prime for Life*, *Children in the Middle*, *Strengthening Families: parents and youth 10 – 14*, and *Guiding Good Choices* were among those funded in FY16.

- **Appendices Specific to SUD**
  - **Appendix 6** –SUD Provider List and Geographic Access
  - **Appendix 7** – Diagnoses of Clients with SUD

Integrated Health-care Services: NorthCare remained above the 95% completion standard for the 10 MDHHS standard health proxy measures required throughout 2016 (see **Table 4** below). At initial assessment, and annually thereafter, consumers are questioned about these encounters, and additional physical health conditions with a 12-month review. The integration of this health care data within the behavioral assessment allows the CMHSPs and network clinicians to coordinate care with physical health providers to better treat the individual's holistic health needs. To determine where to focus change initiatives, the CMHSPs documented in their Annual Submission Reports the prevalence of five medical conditions. The two most significant conditions noted on AXIS III were diabetes and obesity. The importance of supporting individuals who are obese to find methods to change their lifestyle has been the focus of a multi-year Performance Improvement Project (PIP) across all five CMHSPs. The goal of the PIP study is to increase the percentage of adults with mental illness who self-report a diagnosis of obesity and receive primary health services to address this condition. Adults with mental illness frequently have risk factors that can result in obesity, which can be alleviated with proper care and management. Forty-two adults (or 3.9% (0.0389) from our denominator of 1,079 had a Medical Nutritional Therapy service from a primary care provider in FY16. This increase is statistically significant over baseline of 1.07% with 2.83 percentage points over baseline and 1.5 percentage points over the project goal of 2.4% (0.0240). NorthCare can comfortably state that the interventions implemented during this project have resulted in statistically significant improvement in population health.

Table 4. NorthCare Medicaid Consumers with Reported Encounter for FY16

(excluding crisis, assessment, hospitalization, or respite-only services)

Source: FY16 Diver Demographic Model / Medicaid=Y / Crisis or Assessment Only=N / Health Conditions Measure Missing (excludes NorthCare Dual)

	NorthCare	Copper Country	Gogebic	Hiawatha	Northpointe	Pathways
Total Medicaid Consumers with Reported Encounter 10/1/15 - 9/30/16	**4788**	685	281	821	1152	1849
Consumers with Every Health Conditions Field Complete	**4616**	650	277	781	1142	1766
% Consumers with Complete Health Conditions Reported	**96.41%**	**94.89%**	**98.58%**	**95.13%**	**99.13%**	**95.51%**

In FY15 MI Health Link, a new collaboration project, was added to improve the care of individuals who have dual insurance with Medicare and Medicaid benefits. The MI Health Link Program was initiated by the state of Michigan 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 (UPHP), the Upper Peninsula's only Medicaid Health Plan (MHP), who coordinates services by linking and coordinating with all providers serving the same member. The member's integrated care coordinator may answer questions, help set appointments, assist in the development of an integrated care plan, arrange transportation, and aid with other Medicaid covered services.

Table 5. FY16 Region 1 MI Health Link Participants

Source: NC MI Health Link Report; Aggregated by Quarter based on enrollment data & LOC at assigned location.

	Q1		Q2		Q3		Q4	
Affiliate	**DDA/SMI**	**M/M**	**DDA/SMI**	**M/M**	**DDA/SMI**	**M/M**	**DDA/SMI**	**M/M**
Copper MI Health Link	190	0	185	2	187	4	187	4
Gogebic MI Health Link	57	0	55	0	59	0	61	0
Hiawatha MI Health Link	108	8	109	11	117	8	118	4
Northpointe MI Health Link	174	4	175	3	179	6	174	6
Pathways MI Health Link	266	12	263	11	278	13	281	12
Community Providers	13	32	20	48	24	38	32	52
TOTALS:	**808**	**56**	**807**	**75**	**844**	**69**	**853**	**78**

DDA- Developmentally Disabled Adult SMI-Serious Mental Illness M/M- Mild to Moderate

FY16 Provider Overview

Provider Network: NorthCare Network contracts with organizational providers: five CMHSPs; Gryphon, the agency providing regional after-hours crisis phone service; Dial Help, who provides after-hours crisis service for SUD consumers; SUD providers; and hospitals providing psychiatric inpatient care. In FY16 the MI Health Link Program was expanded as NorthCare continued developing contracts with more organizations to provide outpatient care for individuals with mild to moderate behavioral health needs. NorthCare has contracts for inpatient services with two hospitals located in the Upper Peninsula. Duke LifePoint's UP Health System Marquette, 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, adolescents, and 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, and 22 beds/adults. Copper, Gogebic, Northpointe, and Pathways have a contract with the Ministry St Mary's in Rhinelander, WI, with 10 beds/adults. In FY16 NorthCare developed 72 single-case agreements with other inpatient providers. NorthCare monitors and provides oversight of the contracts for the above listed organizational providers. The CMHSPs are responsible for all other service provider contracts.

NorthCare Network mandates the requirements for Medicaid compliance through contract, policy, regional plans, and annual site reviews. According to these documents, providers (other than inpatient hospitals) must be available within a 60-mile radius from the consumer's home (see **Appendix 1**). 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 UPHP and MDHHS. In FY16 NorthCare piloted a grant to address the impact of the reduction of the CMHSPs' ability to provide critical transportation due to reduced General Funds. While the grant was only in effect for four full months in FY16, it was approved for a full year in FY17. NorthCare Network aims to blend funding streams for routine and crisis care through this regional grant.

The organizational providers must be able to demonstrate that their sub-contract providers 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 CMHSPs and SUD service providers, these professionals are responsible for providing the services at the core of our mission. A complete list of the professional providers, their credentials, and populations served, is available to consumers through the CMHSPs' websites. The SUD providers are listed in **Appendix 6** and in the NorthCare Provider Directory.[2]

- **Tier 2 – Paraprofessionals:** These professionals 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 serve. The training requirements for aides working with children with autism were increased in FY14 to assure that the applied behavioral analysis (ABA) services delivered by this group were delivered according to the treatment plan and that aides are supervised in situ at least one hour for every 10 hours of service provided. Peer Support Specialists (PSS) are members of this tier certified by MDHHS. In FY16, 24 PSSs worked across the region. Exciting new developments are occurring in the use of peer models which include trained Parent Support Partners (PSP), to support parents of youth with mental health needs or intellectual/developmental disabilities, and Recovery Coaches to support individuals with co-occurring SUD. In FY16, five PSPs and six Peer Recovery Coaches were employed in Region 1.

- **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 721 consumers residing in residential placements other than skilled nursing care or undefined licensed facilities. The CMHSPs have developed and monitored placements for individuals who have resided in lower Michigan in FY16 (some for many years). Individuals live in placements in lower Michigan for a variety of reasons: challenging behaviors, training programs not available in the Upper Peninsula, insufficient bed capacity in the Upper Peninsula, and self-determined choice by the individual in placement. A regional residential workgroup continues to focus on strategies to return individuals to their home communities as appropriate. As noted in the pie graph on page 9, the population of individuals with intellectual/developmental disabilities is significantly smaller (31%) in number than individuals with serious mental health illness (69%). However, the expense of residential care is significantly higher for the I/DD individuals (60% to 40% respectively). Residential costs are not easily limited or cut, and NorthCare anticipates that costs will continue to remain high in this growing, chronic population. There is increasing interest in alternative housing and treatment options which may help lower the number of individuals requiring secure residential care. The requirements for training staff are increasing as consumers have an increasing incidence of co-morbid physical conditions. Staff training on specialty services must be conducted by the specialty service providers.

Substance Use Disorder Treatment Providers: With treatment providers located across the region, the role of the NorthCare coordinating agency is to plan, coordinate, and oversee the delivery of outpatient and residential SUD treatment services within Region 1. **Appendix 6** lists the providers of SUD services while **Appendix 1** illustrates the 60-mile service delivery requirement is met.

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 payment for the initial 24 hours of inpatient care. NorthCare is responsible for ongoing authorization of payment for inpatient admissions. NorthCare employs a clinical reviewer for ongoing authorizations for all CMHSP admissions to Duke LifePoint/UP Health System Marquette (UPHSM) and War Memorial Hospital to ensure medical necessity criteria are met. Quality improvement meetings are held regularly with the Director of UPHSM Inpatient Services as UPHSM is the primary provider in Region 1. At other inpatient units, ongoing clinical reviews are conducted by staff at the admitting CMHSP or the NorthCare clinical reviewer. A standard annual review form is used for all inpatient contracts to assure compliance with federal, state, and NorthCare standards. In FY16, NorthCare continued to experience a reduction in the use of the UPHSM inpatient unit and an increase in the use of War Memorial Hospital, plus a 55% increase in other hospitals. This shift is indicative of staff challenges at UPHSM and an increase in placement denials based on and individual not "suited for the milieu." NorthCare participates in the statewide PIHP review of inpatient beds and refusals to accept consumers for care. However, the

[2] NorthCare Provider Directory is available at www.northcarenetwork.org.

Upper Peninsula is unique in the significant distances and expenses and delays in treatment that are caused by the lack of beds in Region 1.

Table 6. Episodes of Care and Inpatient Days Authorized by NorthCare – FY16

Hospitals	# of Episodes of Care	% of Episodes of Care	# of Days of Care	% of Days
DLP/Marquette General Hospital	321	51.8%	2705	52.8%
War Memorial Hospital	158	25.5%	1135	22.2%
Other	141	22.7%	1283	25%
Total	**620**	**100%**	**5123**	**100%**

Out-of-Network Providers: These providers are located outside our geographic area. Each CMSHP may subcontract 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 during the budgeting process that is part of the individual plan of service.

Analysis of Network Needs

Approach

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

- Demographic changes: Broad effects of demographic changes on behavioral service needs in the Upper Peninsula.
- Prevalence rates:
  - Increasing incidences of Autism Spectrum Disorders (ASD) in the country and status in the Upper Peninsula
  - Increasing drug addiction in the youth and older adult population and serious concerns about neonatal addiction
  - Increasing suicide rates
- Integrated care: Ongoing implementation of integrated health care models to address multiple aspects of co-morbidity and outcome studies to determine the effectiveness of treatment.

NorthCare reviews the number of consumers in specific age groups who accessed services in relation to census data and expected disease prevalence to plan for future services. On the following page, **Table 7** provides the penetration rates of Medicaid, Healthy Michigan, and MI Health Link consumers and **Table 8** provides penetration rates by age group.

Table 7. Consumers Served by NorthCare Quarterly in FY16 by Coverage Funding

Source: Eligibility based on 820 payment files, service based on type of eligibility in 837 enrollment files and receipt of reportable services within the given quarter. Minus crisis values exclude consumers receiving only H2011, T1023, and H0031 services. Methodology mirror's MDHHS's PI-5 method of calculation.

	Fiscal Year	2016			
	Quarter	1	2	3	4
Medicaid & Medicaid HMO	Consumers Eligible	47044	48231	48148	48193
	Consumers Served	3709	3784	3830	3765
	Penetration Rate	7.88%	7.85%	7.95%	7.81%
	Consumers Served (Minus Crisis)	3518	3612	3641	3566
	Penetration Rate (Minus Crisis)	7.48%	7.49%	7.56%	7.40%
Healthy Michigan	Consumers Eligible	19782	20305	19854	19674
	Consumers Served	869	918	927	966
	Penetration Rate	4.39%	4.52%	4.67%	4.91%
	Consumers Served (Minus Crisis)	753	796	834	837
	Penetration Rate (Minus Crisis)	3.81%	3.92%	4.20%	4.25%
MI Health Link	Consumers Eligible	4021	3855	4152	4087
	Consumers Served	830	810	852	856
	Penetration Rate	20.64%	21.01%	20.52%	20.94%
	Consumers Served (Minus Crisis)	821	798	834	836
	Penetration Rate (Minus Crisis)	20.42%	20.70%	20.09%	20.46%

Table 8. NorthCare Medicaid Eligible by Quarter, by Age Group in FY16

Source: Eligibility determined by those included in the catchment area for Medicaid capitation funding in the payment file.

	Q1		Q2		Q3		Q4	
Age Group	Eligible	Percent of Total	Eligible	Percent of Total	Eligible	Percent of Total	Eligible	Percent of Total
Unknown	1794	2.72%	1801	2.66%	1746	2.60%	1785	2.67%
5 and under	7016	10.64%	7418	10.96%	7326	10.93%	7241	10.83%
6 to 17	15446	23.41%	16233	23.98%	16125	24.05%	16043	24.00%
18 to 64	37186	56.37%	37740	55.74%	37302	55.63%	37191	55.63%
65+	4527	6.86%	4513	6.67%	4556	6.79%	4590	6.87%
Totals	**65969**		**67705**		**67055**		**66850**	

Demographic Changes

A review of the figures in the Demand and Capacity Report in FY14 with the figures available in FY16 demonstrates the continuing trend of declining general population in the UP. Overall, the specific age group of youth up to 18 is declining and the population of older adults is increasing. Current census data does not delineate if there is an increase in the number of older adults within Region 1, or an increase in the percentage of older adults based on declining population among other age groups. NorthCare will continue to review census data in FY17, as available, in an effort to answer this question. Available data continues to reflect the dominant trends in Michigan for the past 15 years. There is ongoing flight by young adults and families out of the Upper Peninsula. The Upper Peninsula still experiences relatively high unemployment in comparison to other regions. Region 1 continues to be an aging region without the influx of new families to mitigate the effect of this demographic shift. The comparison population change from 2014 to 2015 indicates a decline in 14 of the 15 Upper Peninsula counties. Within these declining populations, a significant demographic shift is still occurring as our number of youth continues to decline while our older population increases. While these trends are generally apparent across Michigan, they are more pronounced in Region 1 where our percentage of older adults is 4.6% higher than the state average and our percentage of youth under 18 is 8% lower than the state average (**Table 9-11**).

Table 9. Upper Peninsula Population Comparison by Age, by County

Note: table does not include the percentage for ages 18-64 as they are not relevant to our trending for the older adult 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 10. NorthCare Population Percentages by Age, by County

Note: table does not include 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%**		

Table 11. 2015 NorthCare Census Demographic Information

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

County	% White Persons 2015	Persons in Poverty, Percent 2015	% Native American 2015
CC - Baraga	73.5%	17.3%	13.9%
CC - Houghton	93.4%	17.4%	0.7%
CC - Keweenaw	98.3%	13.4%	0.2%
CC - Ontonagon	96.5%	14.6%	1.3%
Copper Country	90.7%	16.9%	2.9%
GG - Gogebic	90.7%	18.6%	2.8%
HW - Chippewa	71.4%	19.7%	15.7%
HW - Mackinac	75.3%	16.1%	17.1%
HW - Schoolcraft	86.6%	15.9%	9.2%
Hiawatha	74.3%	18.5%	15.0%
NP - Dickinson	96.7%	12.3%	0.7%
NP - Iron	96.5%	14.6%	1.3%
NP - Menominee	94.6%	16.9%	2.9%
Northpointe	95.8%	14.5%	1.7%
PW - Alger	85.1%	14.6%	4.2%
PW - Delta	94.4%	14.8%	2.5%
PW - Luce	79.9%	19.6%	4.9%
PW - Marquette	93.6%	15.0%	1.9%
Pathways	92.4%	15.2%	2.4%
Michigan	**79.7%**	**15.8%**	**0.70%**

Impact of Census Data

Age Groups

Older Adults: The number of older adults eligible for services continues 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 health care and co-morbidity.

Youth: Persons under 18 years are a declining population in the Upper Peninsula. Despite fewer youth in Region 1, rates of autism disorder diagnoses, suicide, and substance use are increasing. Further discussion regarding the prevalence of disorders which complicate the lives of our youth is provided in the Prevalence Rate section of this report. There is no indication that the youth inpatient unit at Duke LifePoint/UPHSM will close its 6-bed unit; however, they have not accepted any inpatient youth since July 2016, and the future of this unit is unclear at this time. In FY16 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 population. The lowest percentage of Caucasians is in Chippewa County with 71.4% and the highest percentage is in Keweenaw County with 98.3%. Significantly, seven of the 15 counties have a population of Caucasians greater than 90% with four of those seven counties greater than 95%. This homogeneity has ramifications on the provision of health care services due in part to the 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 population. 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. The diversity training at the provider level enhances the potential for improved outcomes. NorthCare recognizes the need for culturally specific services for the Native American population. 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

Unemployment rates in the Upper Peninsula have followed the national trend of decreasing in 2016. The average unemployment rate varyies from 7% to 8% in six counties and 6% to 4% in the remaining nine counties compared to the Michigan average of 5.4 %. 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 the future impact on services as high unemployment is correlated with increased depression rates and suicide risk.

Prevalence Rates/ Future Capacity – FY16 focus on prevalence rates:

- Autism Spectrum Disorders;
- Integrated health care to address co-morbidity with medical conditions and reduce polypharmacy;
- Increasing mental health disorders among youth and older adults
- Diagnostic category trending

Prevalence data sources are the World Health Organization, the Center of Disease Control Behavioral Risk Factor Surveys for Michigan in 2015, the Michigan Department of Health and Human Services, and NorthCare Diagnostic Data (**Appendices 3 and 7**). The Upper Peninsula survey data trends in relation to state averages on key areas related to suicide, depression, and co-occurring substance use disorders, and medical co-morbidities among the general adult population responding to the survey. The survey contains questions related to primary healthcare and we may consider those responses in determining future integrated care projects with the Medicaid health plan.

Autism Spectrum Disorders

Key facts- Source: World Health Organization

- Globally, 1 in 160 children has an Autism Spectrum Disorder (ASD). In the US,1 in 68 children has an ASD.
- ASDs begin in childhood and tend to persist into adolescence and adulthood.
- While some people with ASD can live independently, others have severe disabilities and require life-long care and support.
- Evidence-based psychosocial interventions, such as behavioral treatment and parent skills training programs, can reduce difficulties in communication and social behavior. These practices have a positive impact on well-being and quality of life for persons with ASD and their caregivers.
- Interventions for people with ASD need to be accompanied by broader actions for making physical, social, and attitudinal environments more accessible, inclusive, and supportive.
- Worldwide, people with ASD are often subject to stigma, discrimination, and human rights violations. Globally, access to services and support for people with ASD is inadequate.
- In January 2016, MDHHS expanded the autism benefit through the age of twenty. The expansion significantly increased NorthCare's enrolled consumers and created an environment conducive to expand the number of

providers in Region 1. The tables below summarize the regional implementation of the benefit in relation to statewide implementation. Region 1 is in line with the percentages of penetration rates for the other nine PIHP regions in the state **(Table 13)**. With the expansion of autism services, NorthCare Network anticipates a higher penetration rate in FY17.

Table 12. Consumers Enrolled in Autism Benefit by County of Residence and Age Group – FY16

	Q1		Q2		Q3		Q4	
County of Residence	**0 to 5 years old**	**Age 6 to 20**	**0 to 5 years old**	**Age 6 to 20**	**0 to 5 years old**	**Age 6 to 20**	**0 to 5 years old**	**Age 6 to 20**
Alger	0	0	0	0	0	0	0	0
Baraga	0	0	0	0	0	0	0	0
Chippewa	0	2	0	1	1	2	1	2
Delta	2	1	3	1	4	1	5	1
Dickinson	0	0	0	1	0	4	0	6
Gogebic	1	0	1	0	2	3	2	5
Houghton	3	0	4	1	6	1	6	3
Iron	1	0	1	0	1	1	1	1
Keweenaw	0	0	0	0	0	0	0	0
Luce	1	0	1	0	1	0	2	0
Mackinac	1	1	1	1	1	1	1	1
Marquette	1	4	1	3	1	3	1	6
Menominee	0	1	1	1	1	3	2	4
Ontonagon	0	0	0	0	0	0	0	0
Schoolcraft	0	0	1	0	1	0	1	0
TOTALS:	**10**	**9**	**14**	**9**	**19**	**19**	**22**	**29**

Table 13. Comparison PIHPs for Penetration Rate of Youth Enrolled in ABA per 1,000 Medicaid Youth
Source: WSA Autism Enrollment & ELMER Demographics Information for County of Residence

MI Medicaid Ratio of ASD Youth Receiving Applied Behavior Analysis Service by PIHP (Sept. 2016)			
PIHP Region	**Total Medicaid Youth Enrolled**	**Medicaid Youth w/ ASD Receiving ABA**	**Ratio**
Region 1 NorthCare	24,418	49	2.0 per 1000
Region 2 Northern MI	45,893	203	4.4 per 1000
Region 3 Lakeshore	118,873	587	4.9 per 1000
Region 4 Southwest	87,948	195	2.2 per 1000
Region 5 Mid State	152,829	679	4.4 per 1000
Region 6 Southeast	47,190	149	3.2 per 1000
Region 7 Detroit Wayne	258,592	662	2.6 per 1000
Region 8 Oakland	67,759	197	2.9 per 1000
Region 9 Macomb	70,400	300	4.3 per 1000
Region 10 PIHP	78,332	210	2.7 per 1000
Total	**952,234**	**3,231**	**3.4 per 1000**

Integrated Health Care

Michigan requires 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 a CMHSP. 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. NorthCare Network continues work integrating consumer health data with the Medicaid Health Plan serving Region 1.

With support from the Care Connect 360 tool, NorthCare Network began holding integrated care team meetings with the Medicaid Health Plan and CMHSPs to address “super-utilizers” within the member networks. In partnership, individuals in need of high level care coordination were identified to target unmet physical and behavioral health needs which caused these individuals to seek care in emergency department/crisis settings. To ensure that lessons learned from serving this group were applied across the region, NorthCare Network, the CMHSPs, and Medicaid Health Plan Integrated Care Workgroup developed workflows for front-line staff at both the CMHSPs and the Medicaid Health Plan. The flowcharts illustrate the sharing of information, with member consent, across both networks. These workflows have resulted in reduction of duplicative processes between behavioral health and physical health providers within NorthCare and the Medicaid Health Plan’s providers. NorthCare also continued the integration of the care management technologies with the ProAct tool into the electronic health record (EHR) system for clinician utilization. Information available to clinicians through the EHR dashboards includes health alerts for those with complex co-morbid conditions. Quality measures within ProAct identify potential risk situations with multiple anti-psychotics being prescribed particularly when medications are prescribed by more than one provider. ProAct also provides information on all prescriptions being filled and who is prescribing the medications. This allows true integration of pharmacological treatment by the doctors and nurses working with a specific consumer regardless of the physician specialty. Quarterly reports populated through Medicaid claims data were supplied to ProAct on hospitalizations and relative risk scores were available to each CMHSP board for Utilization Management and Clinical Reviews throughout FY16.

Youth and Older Adults - Shared Challenges

Global Trends

Topics that cross over youth and the aging populations are depression, substance abuse, and suicide. Data collected by the World Health Organization (WHO) provides the following key facts about depression and suicide and issues confronting adolescents and older adults

- Key Facts - Depression
  - Depression is a common mental disorder. Globally, more than 300 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.
  - There are effective treatments for depression.
- Key Facts - Suicide
  - Close to 800,000 people die due to suicide every year.
  - For every suicide, there are many more people who attempt suicide every year. A prior suicide attempt is the single most important risk factor for suicide in the general population.
  - Suicide is the second leading cause of death among 15- to 29-year-olds.
  - 78% of global suicides occur in low- and middle-income countries.
  - Ingestion of pesticide, hanging, and firearms are among the most common methods of suicide globally.
- Key Facts - Adolescents
  - An estimated 1.2 million adolescents died in 2015, over 3,000 every day, mostly from preventable or treatable causes.
  - Road traffic injuries were the leading cause of death in 2015. Other major causes of adolescent deaths include lower respiratory infections, suicide, diarrheal diseases, and drowning.
  - Globally, there are 44 births per 1,000 to girls aged 15 to 19 per year.
  - Half of all mental health disorders in adulthood start by age 14, but most cases are undetected and untreated.
- Key Facts - Older Adults
  - Globally, the population is aging rapidly. Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double, from 12% to 22%.
  - Mental health and emotional well-being are as important in older age as at any other time of life.
  - Neuropsychiatric disorders among the older adults account for 6.6% of the total disability (disability adjusted life years-DALYs) for this age group.
  - Approximately 15% of adults aged 60 and over suffer from a mental disorder.
- Further facts from WHO about our elders:
  - Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders).
  - 6.6% of all disability (DALYs) among those over 60 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.

State Trends: Michigan Behavioral Risk Factor Survey (MiBRFS)

The federal government, through the Center for Disease Control & Prevention, has developed a survey that addresses 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 phone surveys are conducted at a state level. Since 2012 the survey format was standardized, enabling scores to be compared across years and regions in the state. The Upper Peninsula data is analyzed as a single region and can be compared to the state averages. NorthCare focuses on measures where there are variances between the state and Upper Peninsula percentages. NorthCare has selected 15 questions that were asked of adults in Michigan during surveys in 2012, 2013, 2014 and 2015. After completing the 2015 surveys, MDHHS decided to combine the data

[3] The Annual Reports are available at MDHHS: www.michigan.gov/mdhhs Search Michigan BRFS Annual Reports

for 2013, 2014, and 2015. The analysis is then based on a larger sample and there is greater confidence about the results. The items in the table below were selected based on the shortened life expectancy for individuals living with chronic mental illness due to a higher incidence of addictions and other chronic health issues. The MiBRFS participants are members of the general public, and these risk factors are shared by the individuals served by community mental health agencies. The surveys can indicate the health disparities most critical to focus on in quality improvement projects.

Table 13. NorthCare Analysis Selected Fields of MBR Survey 2012, 2013, and 2014 and Most Current BRFSS Analysis Combing 2013, 2014 and 2015 Data for a Larger Sample Size.

Note: the national survey process and analysis results in data analysis one year behind.
Michigan statistics are in green. UP statistics are in Blue.
Red indicates a significant difference between survey years and may be a state or UP or both difference.

Table Name and Number	Year 2012 *Michigan/UP*	Year 2013 Michigan/UP	Year 2014 *Michigan/UP*	2013 – 2015 combined *Michigan/UP*	Comments
Table 2 - Poor mental health: number of days within past 30	13% / 5.6%	12% / 10.5%	12.9% / 14.6%	12.8% / 11.8%	In the UP, significant increase from 2012 to 2013. In combined data for 2013-2015, there is a dip below the state in reporting poor mental health.
Table 3 - Mean number of days of poor mental health	4.1 days / 2.4 days	3.9 days / 3.5 days	4.1 days /4.2 days	4.1days / 4.3 days	UP remains slightly higher during the period 2013-2015 but not a significant difference from the state.
Table 15 – No. routine checkup in past year	33.5% / 35.9%	30.1% / 31.0%	28.2% / 27.7% significant decrease statewide & UP between 2012 and 2014	28.8% / 27.3% For the combined period 2013 - 2015 numbers stay the same in terms of reduced from 2012 and slightly less each year.	Anticipate an increase in depression and heart disease due to increased/earlier identification. If the Medicaid expansion ends, will the indicators keep going up?
Table 5 - Weight status-obese	31.1% / 27.3%	31.5% / 32.9%	30.7% / 28.8%	31.1% / 31.2%	No significant differences from state averages all period measured.
Table 5 - Weight status-overweight	36.4% / 36.2%	34.7% / 34.9%	34.9% / 33.6%	34.9% / 33.3%	No significant differences from state averages all periods measured.
Table 5 - Weight status-Normal weight	32.8% / 33.3%	32.5% / 30.9%	32.5% / 36.1%	32.4% / 33.9%	No significant differences from state averages all periods measured.
Table 31 - Diabetes: ever told they have diabetes	10.5% / 12.6%	10.4% / 9.9%	10.4% / 11.8%	10.5% / 11.7%	No significant difference in state or region during periods measured.

Table 29 - Ever told they had any cardiovascular disease	9.9% / 10.2%	10.1% / 11.9%	10.0% / 12.2%	9.7% / 11.4%	No significant difference.
Table 33 - Doctor told them they had depressive disorder	20.6% / 15.5%	21.3% / 21.2%	20.5% / 27.0	20.5% /23.0%	No significant difference during periods measured but appears to be trending higher. Better public awareness of Seasonal Affective Disorder and depression and better screening due to more primary care visits. May be related to table 2 and table 15.
Table 11 - Heavy drinking	6.1% / 8.7%	6.2% / 9.6%	6.8% / 7.4%	6.5% / 7.5%	One year significant difference UP 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%	18.8% / 19.5%	No significant difference during all periods measured 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%	21.1% / 20.4%	No significant differences.
Table 8 - former smoking	25.8% / 30.5%	27.0% / 32.6% Significant difference between state and region 1	26.7% / 30.6%	26.7% / 30.9% Significant difference between state and region 1	Trend appears to be holding that more individuals in the UP are now former smokers than in the rest of the state.
Table 8 - never smoked	50.9% / 47.8%	51.6% / 47.5%	52.1% / 47.3%	52.2% / 48.8%	no significant difference over periods measured but consistently our region is below the state average.
Table 10 - current smokers who have attempted to quit one day or longer in past year	64.3% / 64.4%	62.7% / 52.3%	61.5% / NA	62.3/55.1	NA=suppressed due to a denominator <50 and or a relative standard error.

A review of the fields selected from the MiBRFS 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 tobacco use 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 through 2015. 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 binge drinking. There is only one year with a significant difference between the UP and the state average on **Table 11**: Heavy Drinking. No significant difference was noted across the years analyzed on **Table 12**: Binge Drinking. However, a review shows the UP reports higher incidents of use on all fields in the two tables. 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 by individuals with mental illness are even higher than the general population (upwards of 75%), this is an area where offering evidence-based treatments for smoking cessation could bring about significant change. In 2017 the five CMHSP Boards will be asked to provide tobacco cessation support at all major sites and provide electronic and phone support through helplines as minimum treatment.

Evidence-based treatments need to be utilized not only in the treatment of tobacco addiction but to address the serious opioid epidemic in the UP. This will be further discussed under the following section on diagnostic categories. For youth, prevention services focus on the need to reduce or eliminate childhood and underage drinking, and reduce prescription and over-the-counter drug abuse/misuse. Self-reports by youth in the most recent Youth Risk Behavior Surveys indicate 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%. This trend continues and suggests that a reduction in underage binge drinking may reduce the number of suicide attempts for this population. NorthCare actively supports 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 crises including suicidal thinking and planning. In FY16 one of our network providers, Great Lakes Recovery Center, received grant funding to conduct MHFA across the UP. Each affiliate CMHSP has responded to the need for outreach and education in their community with local partners to determine their specific needs. There is a specific modification of MHFA for youth and NorthCare has a group of eight trainers who work to address outreach to that group. Collaboration with the school systems and the community in prevention and early intervention programs dealing with substance abuse, youth suicide, and violence is essential. Each CMHSP is charged with having an active role in the prevention activities and providing ongoing support to increase awareness of issues specific to their community. Specific county information can be found on the CMHSP websites.[4]

Diagnostic Categories FY16

- **Appendix 3** summarizes the diagnostic categories of the individuals who were served by the CMHSPs.
- **Appendix 7** summarizes the diagnostic categories of the individuals who sought treatment from a provider who specializes in the treatment of Substance Use Disorders (SUD).
- The summaries allow NorthCare to ask critical questions about whether there are providers with training in evidence-based practices needed to address the treatment needs for all our consumers. A critical area of focus is identified in the parallels between Appendix 3 and Appendix 7. The top three diagnostic categories for substance use disorders are the same whether the consumer is only receiving SUD treatment at a SUD treatment provider or if they are receiving COD treatment at a CMHSP. The two provider systems do not capture data in an identical way, but the data is comparable. The top three diagnoses were: alcohol dependence, opioid dependence, and cannabis dependence.

SUD Treatment Admissions:

- Opioid dependence, uncomplicated, accounted for 853 consumer admissions
- Alcohol dependence, uncomplicated, accounted for 584 consumer admissions
- Cannabis dependence, uncomplicated, accounted for 96 consumer admissions

CMHSP Admissions with SUD diagnoses:

- Alcohol substance-related disorders accounted for 103 consumer diagnoses
- Opioid substance-related disorders accounted for 43 consumer diagnoses
- Cannabis substance-related disorders accounted for 22 consumer diagnoses

[4] The CMHSP websites may be accessed through the NorthCare website www.northcarenetwork.org.

Public awareness of the rising opioid addiction crisis in the United States is increasing. Action is being taken on federal, state, and regional levels. Unborn children are often the innocent victims harmed in the opioid crisis when born to an addicted parent. Diversion and treatment court strategies provide opportunities to the mothers and families of unborn children, but this must be coordinated with medication-assisted treatment for both the mother and the newborn infant upon arrival. It is critical to keep our attention on the harm to unborn children whose mother's alcohol use could result in Fetal Alcohol Disorder (FAD) and Fetal Alcohol Spectrum Disorders (FASD). Current estimates of this lifelong disorder for a child born with FAD or FASD are between 2% to 5% per 1,000 births. This translates to 1 in 50 births, or 1 in 20 births. This is a significantly higher incidence rate of FAD and FASD than autism spectrum disorders and higher than neonatal drug addiction. NorthCare needs to assure prevention, evidence-based treatment, and care coordination with community partners for these rising disabilities among our parents and children.

Conclusions

In the state of Michigan, the public 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 15 years to make inroads in maximizing access to care and providing treatment based on effective, researched methods. In FY16 NorthCare continued to meet the demand of the MI Health Link Program and existing service demands for individuals served by the CMHSPs and SUD providers.

Multi-year grant funding has allowed for shared software systems to be put in place between NorthCare Network Providers and the Medicaid Health Plan. Information is better utilized to allow real-time coordination of care for the individuals with serious mental illness with their physical health care providers. A complete record of all pharmacy, medical and behavioral health services is available through the ELMER Patient Portal for all NorthCare consumers. The ProAct analytics software program also provides specific QI indicator information regarding trends in health provision such as poly-pharmacy practices with possible negative interactions to the ELMER clinician and patient portals. We anticipate increasing joint efforts with the Upper Peninsula Health Plan to improve the overall health of shared Medicaid members in FY17.

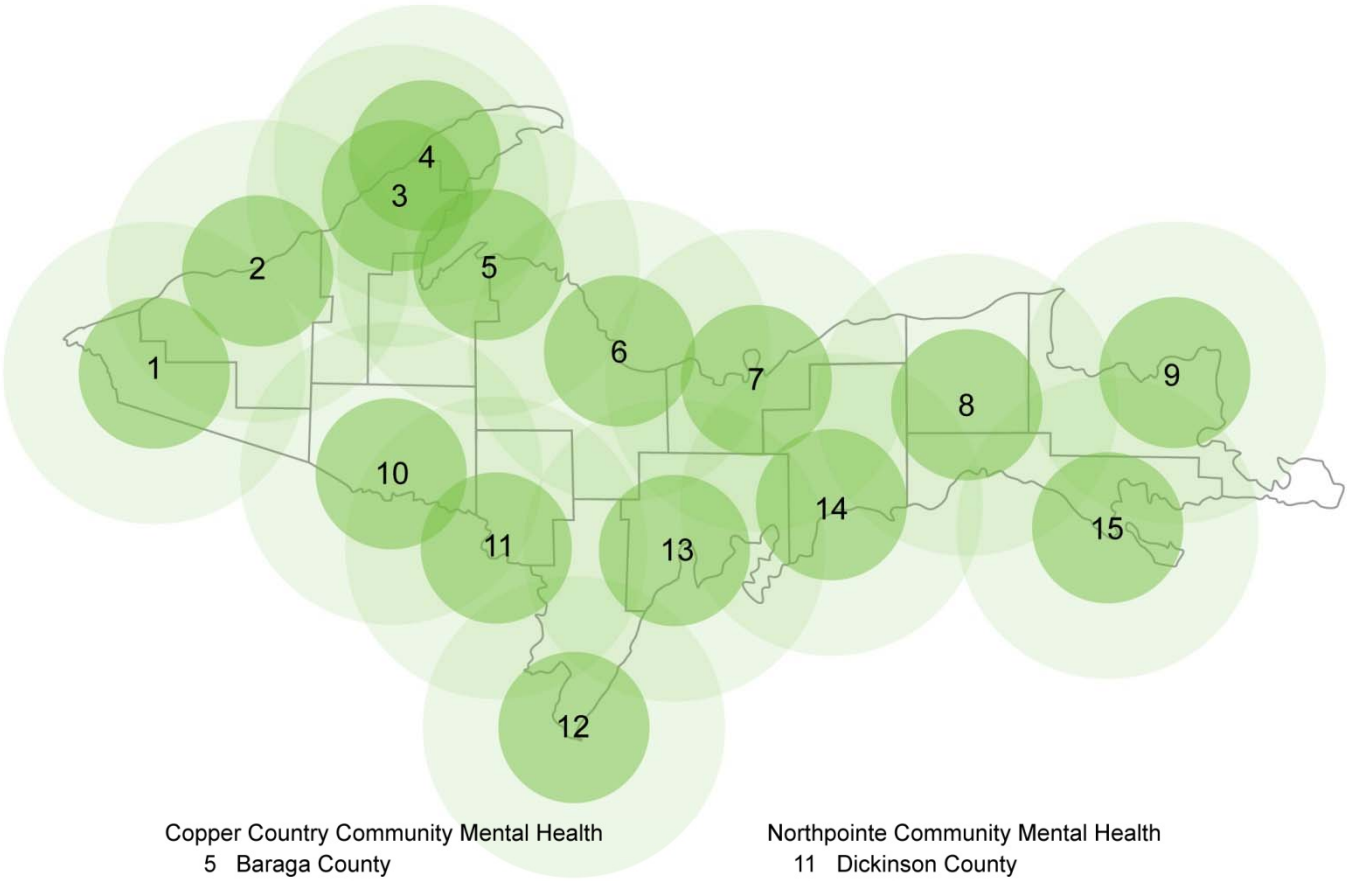
The lack of available, affordable public transportation was identified as a key barrier to routine behavioral health services. This lack of transportation accessibility could contribute to an escalation in behavioral health symptoms requiring acute treatment. In 2016 MDHHS funded a second grant to address the need to provide safe transportation for adults with serious mental illness, substance use disorders, and other co-morbid conditions. The grant was initiated in the four months of the 2016 fiscal year and implementation was underway by the end of September 2016. Full year reporting of the Safe Systems Transport Grant will be available for the FY17 Demand and Capacity Report.

Reviewing the SUD diagnostic information and the map of the network of SUD providers, NorthCare recognizes the need to build service capacity in multiple ways: joint training with SUD and CMHSP professional staff, co-location of SUD and CMHSP staff; and expanding coordination of care for co-morbid consumers who need a higher level of care from either provider. The need for coordination with law enforcement is highlighted by the high incidence of substance use disorders reported above. Consumers with substance use disorders are frequently involved in the legal system. There is a strong history of effective jail diversion in Region 1 and all county mental health agencies are able to assess any person for pre-booking or post-booking jail diversion. In FY16 there were 22 individuals with mental health diagnoses that were diverted from jail. Interventions beyond diversion that need further development and support are treatment courts, drug courts, and ongoing training of law enforcement in Mental Health First Aid and Crisis Intervention Training (CIT). MDHHS provided grant funding to Pathways CMH to offer CIT training and additional training to clinicians in Moral Recognition Therapy to treat individuals who are released through the drug and treatments courts. Lessons learned are being shared through the Jail Diversion Committee and ongoing coordination throughout the Region 1.

In an effort to monitor the needs of our community, we will continue to track utilization and demographic trends. NorthCare will continue to report our progress in a variety of ways: our annual newsletter; our annual performance report; our website-www.northcarenetwork.org; and this report. We rely on feedback from our partners to tell us where we have fallen short and how to maximize our successes. Please contact NorthCare Network Customer Service at 888-333-8030.

Appendices

Appendix 1: Geographic Access for Mental Health Services – FY16



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.northcarenetwork.org. It contains a complete listing of the clinical professional staff who provide peer monitoring of our provider network as well as a list of the organizational providers that NorthCare contracts to provide the full array of Medicaid services.

The NorthCare website links to each of the CMHSP websites where current provider directories are available. The CMHSP directory includes the location, contact 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. NorthCare and the affiliate CMHSPs update their directories as needed to assure members have current information about available providers.

Appendix 2: NorthCare Network Functional Assessments Level of Care Protocols – FY16

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.

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

Level I: Brief or Limited Outpatient Services - LOCUS 10-16

MH1A: Brief Outpatient Therapy

MH1B: Supports Coordination/Therapeutic Stabilization & Support

Level II: Intensive Outpatient Services - LOCUS 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 - LOCUS 23-27

MH3A: Therapeutic Foster Care (SED)

MH3B: Specialized Residential Contract

MH3C: Treatment Group Home

Level IV: Inpatient Care - LOCUS 28 and above

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

MH4B: State Hospital Inpatient Care

II. Level of Care NorthCare Developmentally Disabled (DD) Functional Assessment for Developmentally Disabled Adults (DDA) and Developmentally Disabled Child (DDC)

DD Level I - Basic Support Services **- score 0 to 15**

DD Level II - Enhanced Support Services **- score 12 – 20**

DD Level III - Specialized Support Services **- score 17 - 40**

DD Level IV **-** Intensive Residential and Support Services **- score 37 - 96**[5]

III. Level of Care Functional Assessments for Serious Emotional Disturbance (SED) Youth

A. Infant Mental Health (IMH) (infants and children under 4)
Current functional impairment criteria are met according to IMH assessment

B. Preschool and Early Childhood Functional Assessment (PECFAS) Scale – SED (Youth ages 4-6)
Total score of 60 or greater

C. Children 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**

[5] NC regional Utilization Management Committee completed revisions to the level of care models late in FY16. The revisions will be reported in the FY17 Demand and Capacity Report

Appendix 3: CMHSP Consumer Base Overview by Diagnostic Category - FY16

Source: FY16 Consolidated Service Model, Reportable Service = Y, Medicaid = Y; merged with current diagnosis and category data.

Diagnostic Category	Age 5 & Under	Age 6-17	Age 18-64	Age 65+	Total Medicaid Consumers
Anxiety Disorders	21	90	218	7	336
Attention Deficit/Hyperactivity Disorder	5	289	65		359
Autism Spectrum Disorder	38	148	243	5	434
Bipolar and Related Disorders		24	694	42	760
Communication Disorders	3	5	6	2	16
Depressive Disorders	1	174	1086	53	1314
Diagnosis Deferred			6	1	7
Disruptive, Impulse-Control, and Conduct Disorders	8	156	77	1	242
Dissociative Disorders			3		3
Elimination Disorders		2			2
Feeding and Eating Disorders	2	2	5	1	10
Intellectual Disabilities	5	58	501	90	654
Major or Mild Vascular Neurocognitive Disorder			2		2
Motor Disorder		1			1
Neurocognitive Disorders			6	7	13
Neurodevelopmental Disorders			1		1
No Diagnosis			2		2
Obsessive-Compulsive & Related Disorders		11	55	12	78
Other	17	23	81	10	131
Other Mental Disorders	1	2	4		7
Paraphilic Disorders			1	1	2
Personality Disorder, Cluster A			1	1	2
Personality Disorder, Cluster B		1	110		111
Personality Disorder, Other			11		11
Personality Disorders, Cluster C			3		3
Schizophrenia Spectrum & Other Psychotic Disorders		6	751	111	868
Sleep-Wake Disorder	1		3		4
Somatic Symptom and Related Disorders			6		6
Specific Learning Disorder	1	1	3		5
Substance-Related & Addictive Disorders, Alcohol			103	4	107
Substance-Related & Addictive Disorders, Amphetamine			3		3
Substance-Related & Addictive Disorders, Cannabis		1	21		22
Substance-Related & Addictive Disorders, Hallucinogen			1		1
Substance-Related & Addictive Disorders, Inhalant			2		2
Substance-Related & Addictive Disorders, Opioid			42	1	43
Substance-Related & Addictive Disorders, Other or Unknown			34		34
Substance-Related & Addictive Disorders, Sedative/Hypnotic/Anxiolytic			2		2
Trauma- and Stressor- Related Disorders	31	154	345	9	539
Totals	**134**	**1148**	**4497**	**358**	**6137**

Appendix 4: Consumer Base Consumers by Primary Eligibility and Level of Service – FY16

Source: Diver/service model FY16/Medicaid=Y/Service Reportable=Y/LOC

Level of Care	Total Consumers
No Level of Care Indicated	1083
DDA 1 Limited Services-Basic Support	239
DDA 2 Enhanced Support Services	448
DDA 3 Habilitation/Supports Waiver (HSW) enrollee Services	353
DDA 4 Specialized Residential and Support Services	126
DDA_PWGF	7
DDC 1 Limited Services-Basic Support	63
DDC 2 Enhanced Support Services	162
DDC 3 Habilitation/Supports Waiver (HSW) enrollee Services	50
DDC 4 Specialized Residential and Support Services	14
DDC_PWGF	1
MIA 1A Brief Intervention & Supports Maintenance	202
MIA 1B Community Support Services-Limited/Low intensity Supports/Case management	133
MIA 2A Community Support Services-Moderate intensity Supports/Case Management	1277
MIA 2B Community Support Services-High intensity Supports/Case Management	243
MIA 2C Assertive Community Treatment-ACT	68
MIA 3A Therapeutic foster care	293
MIA 3B Specialized Residential/Special Contract AFC Services	24
MIA 3C Community Support Services-Moderate intensity Supports/Case Management	0
MIA 4A Inpatient Care	70
MIA 5	130
MIA 6	27
MIA_PWGF	43
MIC 1A Brief Outpatient Therapy	176
MIC 1B: Supports Coordination/Therapeutic Stabilization & Support	36
MIC 2A Supports Coordination/Community Supports	440
MIC 2B Intensive Case Management/ Supports Coordination/Community Supports	97
MIC 2C Home-Based Services	72
MIC 3A Therapeutic Foster Care (SED)	44
MIC 3B Specialized Residential Contract	4
MIC 3C Treatment Group Home	1
MIC 4B Inpatient Care	0
MIC_PWGF	3
MIC 4A	211
Total	**6137**

Appendix 5: CMHSP Services Provided to Medicaid Consumers – FY16

Source: Diver FY16/ Medicaid = Y/ Service Reportable = Y / State Service Description

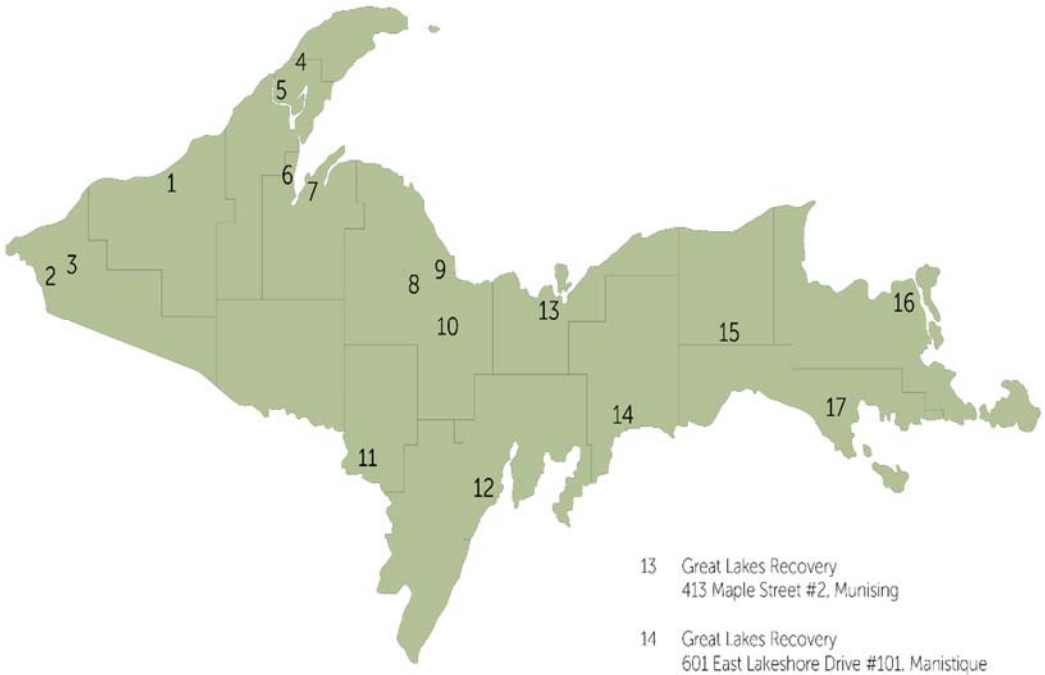
State Service Description	Total Consumers
Totals	6137
Assertive community treatment face-to-face per 15 minutes	205
Assessment - Developmental Testing	1
Assessment by Non-Physician; use ST for trauma assessment	1604
Autism home care training monitoring	35
Behavioral Health Screening by non- physician	97
Behavioral Health; Short-Term Residential; non- hospital resident treatment	57
Child Waiver - Activity therapy per session of 45 minutes or more.	1
CLS - Comprehensive Community Support Services p/15 minutes	985
CLS Per Day - Comprehensive community supports services p/diem in specialized residential and other settings	545
CLS/Supported Housing p/diem; non- licensed independent settings or own home per day	65
Community-based Wrap-Around services, per diem (SEDW only)	7
Comprehensive Multidisciplinary Evaluation; does not require face to face with beneficiary	78
Crisis Intervention Services p/15 minutes	1695
Dialectical Behavioral Therapy (DBT)	106
Domiciliary/rest home, est pt. 2 of 3 key components, typically 25 min	30
Domiciliary/rest home, est pt. 2 of 3 key components; typically 40 min	2
Domiciliary/rest home, new pt. 3 of 3 key components, typically 60 min	5
Domiciliary/rest home; est pt. 2 of 3 key components, typically 15 min	19
Domiciliary/rest home; new pt. 3 of 3 key components, typically 45 min	3
Domiciliary/rest home; new pt. 3 of 3 key components, typically 75 min	1
Drop-In center attendance; encounter	70
Durable medical equipment, miscellaneous	12
ECT	2
Evaluation of speech sound production	9
Evaluation of speech sound production expanded	44
Family or TFCBT therapy with consumer present	195
Family or TFCBT therapy without consumer present	140
Family Psychoeducation Joining	10
Family Psycho-education: family educational groups (either single or multi-family)	27
Family Training & Family Parent Training as TFCBT	128
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	4
Group therapy adult or child (other than of a multiple-family group)	213
Home Based Services or Home Based Trauma Focused TFCBT; Community psychiatric supportive treatment, face-to-face with child or family; p/15 minutes	350
Home Care Training, Non-Family (Children's Waiver Service Only)	13
Home Modifications, Per Service.	3
Home visit, est pt. 2 of 3 key components, typically 15 min	15
Home visit, est pt. 2 of 3 key components, typically 25 min	6

Individual Therapy Adult or Child or TFCBT Therapy 16-37 minutes	725
Individual Therapy Adult or Child or TFCBT Therapy 38-52 minutes	953
Individual Therapy Adult or Child or TFCBT Therapy 53 + minutes	1141
Infant Mental Health; Aproved MDCH models only	11
Injection, aripiprazole, extended release, 1 mg	2
Injection, Fluphenazine Decanoeate, Up To 25 mg	2
Injection, Haloperidol Decanoeate, Per 50 mg	6
Injection, paliperidone palmitate, extended release, 1 mg	2
Inpatient Hospitalization - All Inclusive Room & Board Plus Ancillaries	485
Interactive Complexity Add on Code	1
Interpretation or explanation of results of Psychiatric tests to consumer, family and courts. TS is used for re-certifications	4
Medical nutrition therapy reassessment & intervention, individual, face-to-face with patient 15 minutes	43
Medical nutrition therapy, initial assessment & intervention, individual face-to-face with the patient	66
Medication Administration by injection	298
Medication training and support p/15 minutes	28
Memo to Chart	12
Mental Health Clubhouse Services	49
Mental health service plan development by non-physician	2291
Miscellaneous Therapeutic Items & Supplies, NOC	136
Neuro-psychological testing p/hr	1
New patient office or outpatient (Certification exam)	5
Non-emergency transportation services; ancillary; parking fees, tolls, other	1
Non-Emergency Transportation; Patient Attendant/Escort	1
Nursing Assessment	145
Nutritional Counseling, Dietician Visit	14
Occupational Therapy Evaluation	238
Occupational Therapy Re-Evaluation	21
Office outpatient/new; 3 key components face to face; 45 minutes	29
Office/outpatient/established; 10 minutes (Certification exam)	114
Office/outpatient/established; 2 of 3 key components; 25 minutes	1697
Office/outpatient/established; 2 of 3 key components; 40 minutes	303
Office/outpatient/established; 5 minutes	115
Office/outpatient/estb; 2 of 3 key components; 15 minutes	1909
Office/outpatient/new; 3 key components, face to face 60 minutes	168
Office/outpatient/New; 3 key components 30 minutes face to face	4
OT/PT Aquatic therapy individual per 15 minutes	2
OT/PT Gait training (includes stair climbing) individual p/15 minutes	2
OT/PT Individual Sensory Integrative Techniques	9
OT/PT Individual Therapeutic Activities p/15 minutes	17
OT/PT Manual Therapy Individual	4
OT/PT physical or manipulative therapy performed for maintenance rather than restoration	4
OT/PT Self-care home management training; individual p/15 minutes	5
OT/PT Strength ROM - Individual	11

OT/PT Wheelchair Management/Propulsion Training	3
Out of Home Pre-Vocational (HSW Only)	14
Parent Education	7
Patient Education, NOC, Non-Physician, Group	47
Patient Education, NOC, Non-Physician, Individual	2
Peer specialist services provided by certified per specialist; p/15 minutes	256
PERS Maintenance	3
Personal care item, NOS	12
Personal Care Per Diem	538
Physical Therapy Evaluation	11
Physician services provided in inpatient hospital care. Initial p/30 minutes	9
Physician services provided in inpatient hospital care. Initial p/50 minutes	22
Physician services provided in inpatient hospital care. Subsequent care p/15 minutes	14
Physician services provided in inpatient hospital care. Subsequent care p/25 minutes	22
Physician services provided in inpatient hospital care. Subsequent care p/35 minutes	8
Private Duty Nursing, habilitation supports waiver (individual nurse only) 21 years and over ONLY (LPN)	3
Psychiatric Diagnostic Evaluation (no medical services)	226
Psychiatric Diagnostic Evaluation (with medical services)	354
Psychological Testing by psychologist or physician p/hr	73
Psychotherapy for crisis 1st 60 minutes	4
Respite Care Day, In home	1
Respite care p/15 minute	279
Respite Care Services, day in an out of home setting	58
RN services, up to 15 minutes	287
Screening to Determine Appropriateness of Inpatient Hospitalization	776
Skill Building Assistance; use TT modifier when multiple consumers are served	672
Specialized Medical Equipment, NOS	6
Specialized Supply, NOS	42
Specialized Wraparound Facilitation	50
Speech and Language Evaluation of oral & pharyngeal swallowing function	7
Speech and language therapy, individual	31
Supplies, NOS Goods and Services	1
Supported Employment	246
Supports Coordination	2634
Targeted Case Management	806
Targeted Case Management Services - Child Waiver only.	18
Telehealth Originating Site Fee	997
Therapeutic Camping, Day	4
Therapeutic Camping, Overnight	19
Vehicle Modifications	2
Waiver Service NOS	105

Appendix 6: SUD Provider List and Geographic Access – FY16

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, Calumet

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: Diagnosis of Clients with SUD – FY16

Source: FY16 Consolidated Service Model, Reportable Service = Y, Medicaid=Y; merged with current diagnosis and category data.

Primary Dx	Diagnosis Description	# of Admissions	% of Admissions
F10.10	Alcohol abuse, uncomplicated	111	5.89%
F10.12	Alcohol abuse with intoxication, uncomplicated	3	0.16%
F10.20	Alcohol dependence, uncomplicated	584	31.01%
F10.21	Alcohol dependence, in remission	1	0.05%
F10.22	Alcohol dependence with intoxication, uncomplicated	2	0.11%
F11.10	Opioid abuse, uncomplicated	13	0.69%
F11.12	Opioid abuse with intoxication delirium	1	0.05%
F11.20	Opioid dependence, uncomplicated	853	45.30%
F11.21	Opioid dependence, in remission	1	0.05%
F11.22	Opioid dependence with intoxication, uncomplicated	5	0.27%
F11.23	Opioid dependence with withdrawal	1	0.05%
F11.28	Opioid dependence with opioid-induced sexual dysfunction	1	0.05%
F11.29	Opioid dependence with unspecified opioid-induced disorder	2	0.11%
F12.10	Cannabis abuse, uncomplicated	39	2.07%
F12.20	Cannabis dependence, uncomplicated	96	5.10%
F12.21	Cannabis dependence, in remission	1	0.05%
F12.22	Cannabis dependence with intoxication, uncomplicated	2	0.11%
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	3	0.16%
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	11	0.58%
F13.23	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated	3	0.16%
F14.20	Cocaine dependence, uncomplicated	15	0.80%
F15.10	Other stimulant abuse, uncomplicated	8	0.42%
F15.20	Other stimulant dependence, uncomplicated	78	4.14%
F15.24	Other stimulant dependence with stimulant-induced mood disorder	1	0.05%
F19.20	Other psychoactive substance dependence, uncomplicated	6	0.32%
R69.	Illness, unspecified	1	0.05%
T40.0X	Adverse effect of opium, initial encounter	1	0.05%
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out	35	1.86%
Z04.8	Encounter for examination and observation for other specified reasons	4	0.21%
Z71.1	Person with feared health complaint in whom no diagnosis is made	1	0.05%
Grand Total		**1883**	**100.00%**