NorthCare Network
2022 Fiscal Year
Annual Performance Report

Mission Statement

NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources.

Inside this issue

NorthCare Network, 1230 Wilson Street, Marquette, MI 49855 **Phone:** 1-888-333-8030 **www.northcarentwork.org**

A Message From the Interim Chief Executive Officer
Megan Rooney, NorthCare Network

NorthCare Network is excited to share our annual performance report with you. This report reflects the hard work of our entire provider network and staff as they continue to serve our consumers across the Upper Peninsula.

NorthCare Network is the Prepaid Inpatient Health Plan (PIHP) for the U.P. contracted through the Michigan Department of Health and Human Services (MDHHS) to manage and provide a comprehensive array of specialty mental health and substance use services and supports to Medicaid and Healthy Michigan Plan beneficiaries. Our performance is measured by metrics, compliance monitoring, financial audits, and site reviews to name a few. We are monitored by MDHHS, Health Services Advisory Group (HSAG), our Governing Board, and consumers. Each year we strive to improve our performance.

As the public health emergency continued through 2022, the hard work and dedication of our providers and staff was evident throughout our entire region. Front line staff continued to engage in face-to-face contact with consumers to meet their needs despite the risk that COVID-19 still presented. We were able to continue to offer telehealth services to our consumers.

There remains a staff shortage which has put a strain on all of our providers and the behavioral health system statewide. As a region, we are working together to develop creative ways to recruit and retain staff. Several CMHs teamed up to share coverage of after-hours crisis services for their areas. NorthCare Network will continue to utilize its resources to invest in future generations and to strengthen the public behavioral health system in the U.P.

Our Behavioral Health Home (BHH) and Opioid Health Home (OHH) Partners worked hard this past year to increase enrollment in each of the home models. As more community outreach events resumed throughout the U.P., our Veteran Navigator was able to interact more with veterans, service members and their families.

Thank you to our Governing Board Members, SUD Policy Board Members, CMHSPs, SUD Providers, Provider Network, Staff, Consumers, and the U.P. Communities and their County Board of Commissioners for continuing to support the public behavioral health system. We have an amazing team throughout the U.P. who are committed to serving our consumers.

Sincerely,

Megan Rooney, Interim CEO

NorthCare Vision

NorthCare Network envisions a full range of accessible, efficient, effective, and integrated quality behavioral health services and community based supports for residents of Michigan's Upper Peninsula.

NorthCare Network FY22 Governing Board Members

NorthCare Network's Governing Board is made up of 15 members with representation from each of the 5 CMHSPs in the region. Each CMHSP appoints three delegates from their respective CMH boards to serve as a board member on the Governing Board. CMHSPs may also appoint an official alternate to serve in the place of their appointed board members in the event a board member is unable to attend a meeting.

Executive Officers

Chairperson: George Botbyl, Pathways
Vice-Chair: Margaret Rayner, Pathways
Secretary: Pat Rozich, Copper Country

Joe Bonovetz, Gogebic
Carrie Braspenick, Gogebic
George Ecclesine, Hiawatha
Mike Koskinen, Copper Country
Bill Malloy, Gogebic
Ann Martin, Northpointe
Jim Moore, Hiawatha
Mari Negro, Northpointe
Kevin Pirlot, Northpointe
Dr. John Shoberg, Hiawatha
Jim Tervo, Copper Country
Glenn Wing, Pathways

Board Alternates:
Richard Herrala, Copper Country
Colleen Kichak, Gogebic
Patricia Philips, Northpointe

Thank you to our outgoing board members for serving on the Governing Board:

Bill Davie, Pathways
George Beninghaus, Gogebic
Steve Thomas, Gogebic
Tom Korpi, Northpointe Alternate

Remembering

Gerald McCole passed away on July 14, 2022. Gerald served on NorthCare's Governing Board as a Northpointe board member from 2017-2019.

Governing Board Past Chairpersons:

Rudy Kemppainen
Karen Raether
Dan LaFoille
Pat Rozich

Substance Use Disorder Policy FY22 Board Members

The SUD Policy Board is a designated committee of the NorthCare Network Governing Board. The SUD Policy Board is made up of 15 members with representation from each of the 15 Upper Peninsula counties. Each County Board of Commissioners appoints one member to serve as their counties representative on the SUD Policy Board

Alger County	Cathy Pullen	**Mackinac County**	Jim Hill
Baraga County	Mike Koskinen	**Marquette County**	Stephen Adamini
Chippewa County	Jim Moore, ***Chair***	**Menominee County**	Steve Gromala
Delta County	Bob Barron	**Ontonagon County**	Robert Nousiainen
Dickinson County	Ann Martin	**Schoolcraft County**	Craig Reiter, ***Vice-Chair***
Gogebic County	Joe Bonovetz		
Houghton County	Roy Britz		
Iron County	Patti Peretto		
Keweenaw County	Randy Eckloff		
Luce County	Nancy Morrison		

THANK YOU

to our outgoing board member

for serving on the SUD Policy Board.

Tim Aho *(Iron County)*

Veteran Navigator

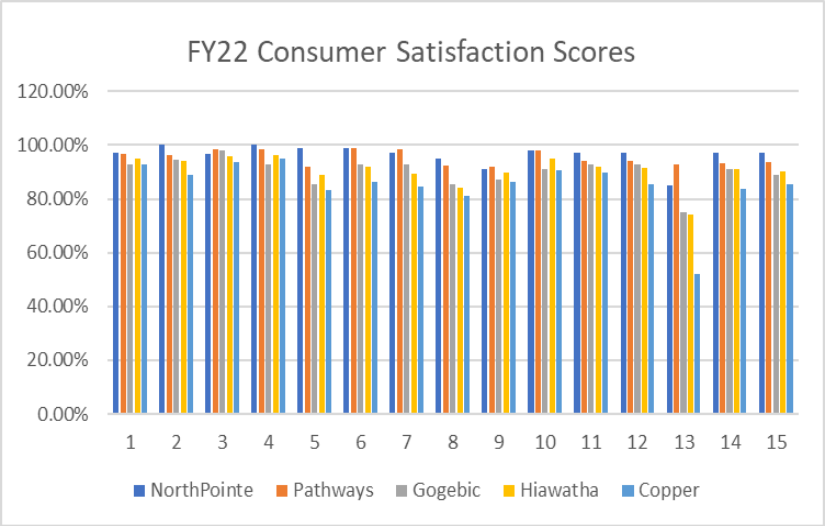
During FY22, the Veteran Navigator assisted 61 Veterans with 46 being new contacts. Of those contacts, 91% were male and had either retired or completed their term of service in the Armed Forces. Approximately 64% of Veterans seeking services were under the age of 55, which was a 17% decrease from the previous fiscal year. A total of 30 referrals were made for mental health and SUD services to agencies such as Community Mental Health Service Programs (CMHSP), SUD providers, hospital/medical providers, and the Veteran's Health Administration. Additionally, another 62% of all referrals made were for ongoing community supports such as county and coalition Veteran Service Officers (VSO), housing agencies, transportation, employment, and other community resources. Referrals increased slightly during FY22 for Veterans, Service members, and their families seeking services in large part due to resumption of services post-COVID. More community outreach events occurred allowing for increased interactions. In the upcoming fiscal year we will be adding a Veteran Peer Support Specialist to the team, hope to start a Women Veterans chapter in the Upper Peninsula, and increase engagement in outdoor recreational opportunities promoting healthy habits and well being.

Consumer Satisfaction 2022

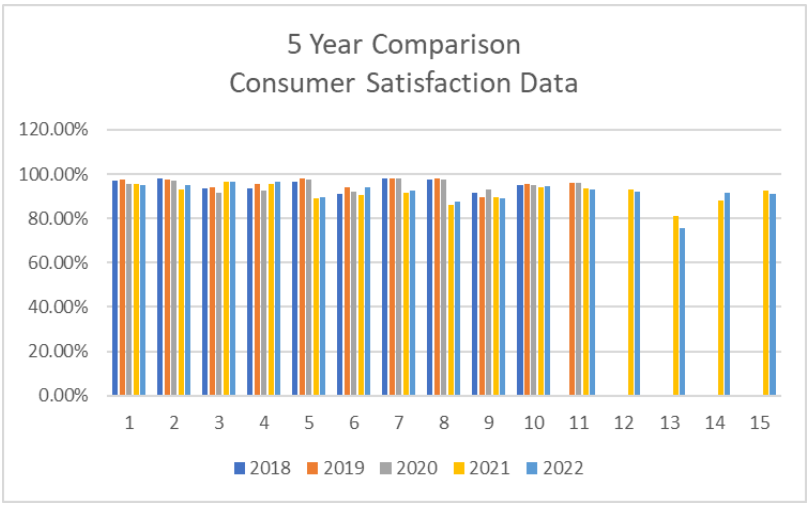
NorthCare Network conducts a regional satisfaction survey , the results are tabulated annually. Overall the region scored well in FY22.

Part A– Consumers were surveyed on the following questions:

1. Appointments are scheduled at time that work best for me.
2. I am informed of my rights as a CMH/ SUD service recipient.
3. I feel welcomed and comfortable where I receive services.
4. Staff speak in ways I can understand easily.
5. I know what to do if I have a concern or complaint.
6. Staff are sensitive to my cultural/ ethnic and spiritual background.
7. Staff are sensitive when I am discussing my past.
8. I am aware of the types of services available.
9. I was able to get the type of services I feel I needed.
10. My wishes about who is given information about my treatment are respected.
11. I feel involved in my care and included in the decision-making process regarding my services.
12. I feel staff see me as a whole person and address all my needs.
13. I am satisfied with the telephone crisis service, when calling the crisis line after 5pm on weekdays or on weekends.
14. I am able to communicate with my CMH/ SUD provider easily.
15. I would recommend these services to a friend or relative.



The graph above represents the percentage of consumers that reported overall satisfaction with their CMH. Questions one, three, four, and ten all scored above 90%. Questions two, five, six, seven, eight, nine, eleven, twelve, fourteen, and fifteen all scored above 80%. Question thirteen had scores lower than 80%.

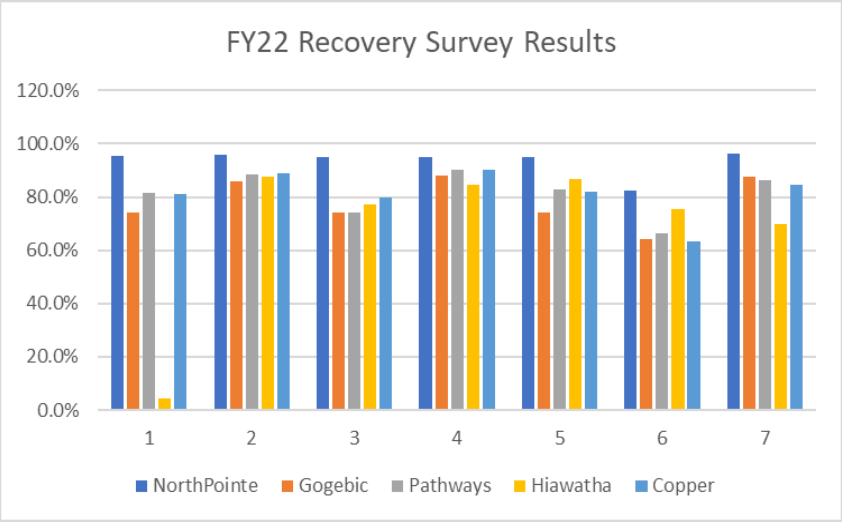


The graph above shows a comparison of consumer satisfaction data for the region over the past five (5) years. Questions twelve through fifteen were added in 2021. Overall satisfaction for every question from 2021 to 2022 have increased except for question number thirteen.

2022 Recovery Survey

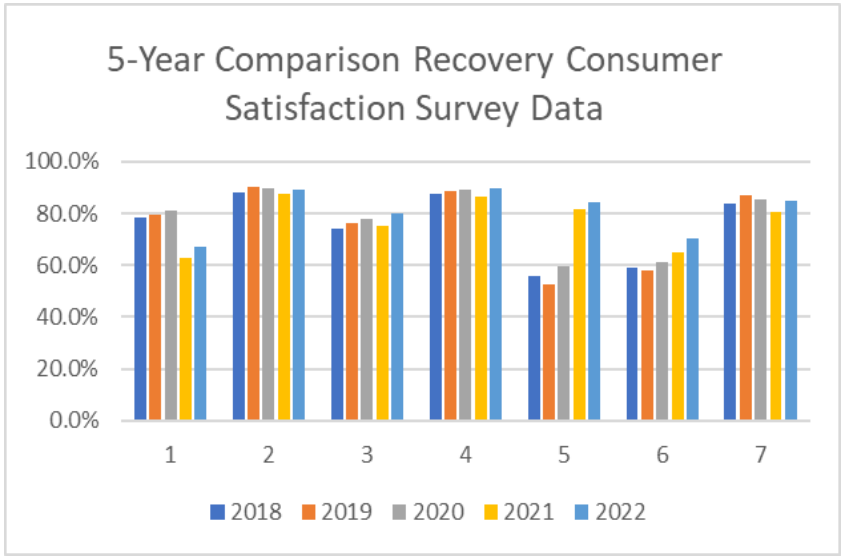
Part B– Recovery Questions

1. I am hopeful about my future.
2. I am willing to ask for help.
3. I believe that I can meet my current personal goals.
4. I have people I can count on.
5. I feel coping with my mental illness is easier to do now, than it was when I began services.
6. My symptoms interfere less and less with my life.
7. My services and supports from my CMH/SUD provider are helping me in my recovery.



The graph to the left is from Part B of the 2022 Consumer Satisfaction Survey.

This graph represents the percentage of consumers who overall agreed to the recovery questions, indicating that they feel supported in their recovery and hopeful about their future.



The graph to the left is a comparison of Recovery Question data over the past five years.

There has been an increase in overall satisfaction for every question from 2021 to 2022. Overall rates of satisfaction remained steady.

Behavioral Health Home

The Behavioral Health Home (BHH) is a comprehensive care management program that focuses on ensuring coordinated whole-person health care is delivered to adults experiencing mental illness and children living with emotional disturbance. As of 12/9/22, there are 1,956 people enrolled in BHH services across the state. In FY2022 there were 82 beneficiaries residing in the Upper Peninsula enrolled, with 487 unites of BHH service.

BHH Utilization FY22		
	Units	Enrollees
Copper	70	18
Gogebic	50	7
Hiawatha	66	12
Northpointe	276	41
Pathways	25	4

Population– Integrated Health

During FY22, NorthCare continued efforts with the Upper Peninsula Health Plan (UPHP) to coordinate and integrate services. There were 6,010 unduplicated individuals served in joint population health measures. Continued meetings and data sharing promotes improvement in these measures, including:

- antipsychotic medication adherence
- anti-depressant medication adherence
- hepatitis C testing and treatment
- spirometry testing for newly diagnosed COPD
- breast and colorectal cancer screenings
- reducing physical health related hospitalizations/re-hospitalizations
- follow-up after hospitalization for mental illness
- follow-up after an emergency room visit for alcohol or other drugs or mental illness
- annual dental screenings, and
- on multiple measures related to preventative or monitoring screenings for metabolic syndrome

In FY2022, 52 individuals were served by the high-utilization Integrated Care Team program jointly managed by NorthCare and UPHP.

NorthCare also began a grant funded project for community health worker supports with Superior Housing Solutions, a recovery organization supporting individuals with co-occurring substance use disorders and mental illness. Ninety unduplicated individuals who are not traditionally reached by the CMHSP system received community based outreach. Supports include assisting people with getting medical care through a primary care physician, following through on physician recommendations, supports to obtain permanent housing, and linking to mental health and substance use disorder providers.

Opioid Health Home

An Integrative and Evidence-Based Solution to the Opioid Crisis

The Opioid Health Home (OHH) is an optional Medicaid benefit that provides comprehensive care management and coordination of services to Medicaid beneficiaries with an Opioid Use Disorder (OUD). In FY22, NorthCare Network served as the lead entity for the OHH program and collaborated with two designated Health Home Partners (HHPs) that included Great Lakes Recovery Centers, Inc. and Upper Great Lakes Family Health Center.

There are three primary goals for the OHH program:

1. Improve care management of beneficiaries with OUD, including Medication Assisted Treatment (MAT).
2. Improve care coordination between physical and behavioral healthcare services.
3. Improve care transitions between primary, specialty, and inpatient settings of care.

Enrollment into OHH ensures that beneficiaries have access to an interdisciplinary care team that can address behavioral and physical healthcare needs. For enrolled beneficiaries, the OHH functions as the central point of contact for directing patient centered care across the broader healthcare system. OHH services provide integrated, person-centered, and all-inclusive care to eligible beneficiaries to address the complexity of OUD, physical, and behavioral health comorbidities.

The OHH model of care elevates the role of importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, it will more fully attend to a beneficiary's needs in all aspects of their health.

The HHPs provide six federally required core health home services and coordinate with the other community-based providers to manage the full breadth of beneficiary needs. These services include:

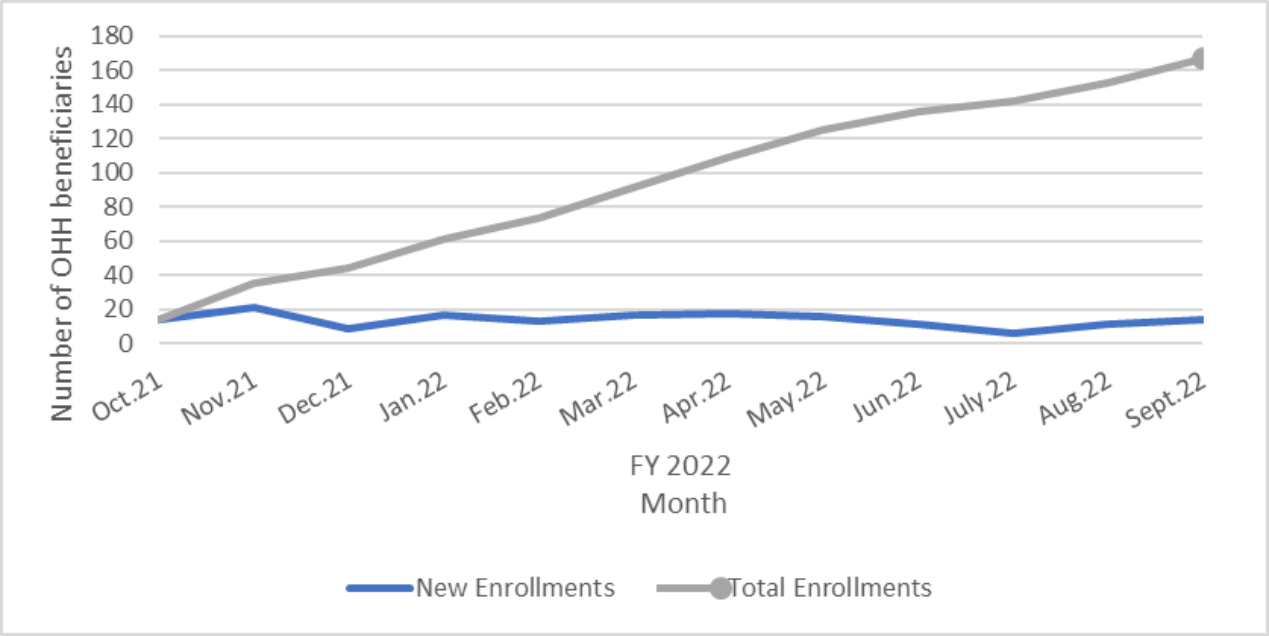
1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Supports
6. Referral to Community and Social Support Services

The OHH program has continued to develop across the Upper Peninsula throughout FY22 despite difficulties in filling OHH staff position vacancies at the Health Home Providers. Consequently, this has resulted in lower program enrollments and active participation of OHH beneficiaries.

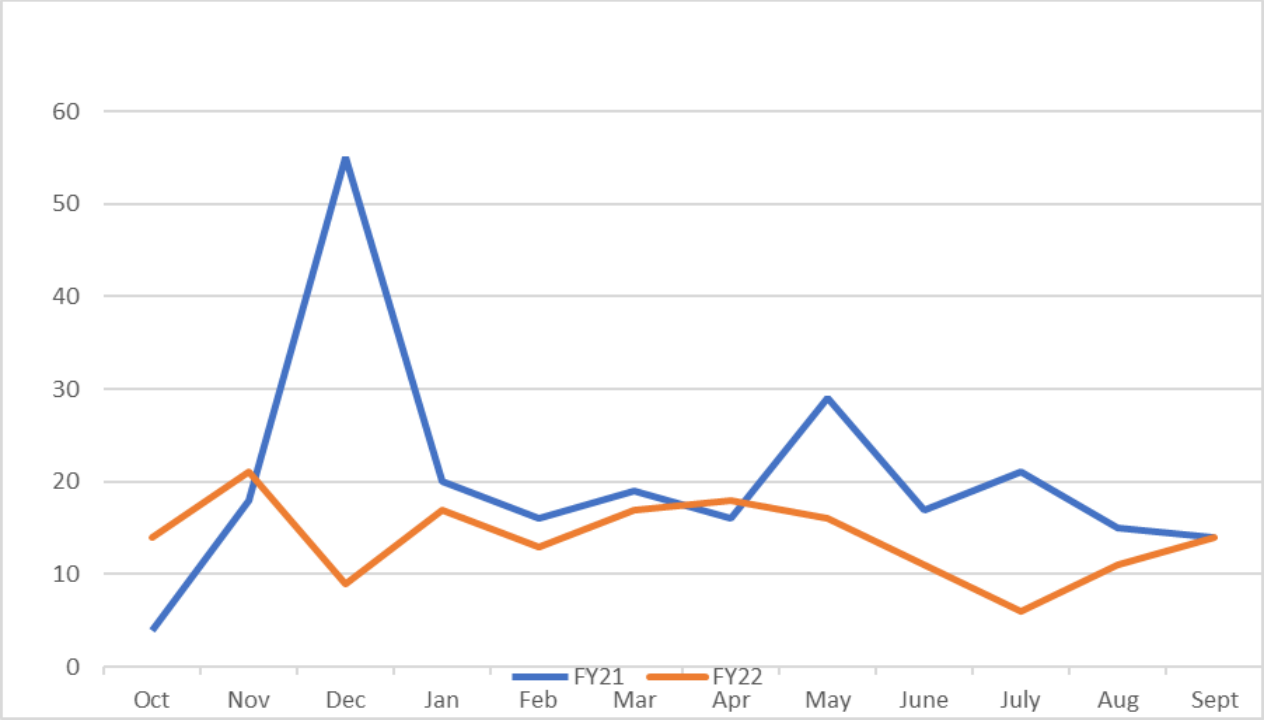
Together with Great Lakes Recover Centers, Inc. and Upper Great Lakes Family Health Center, NorthCare Network enrolled a total of 167 new beneficiaries into the Opioid Health Home program in FY22 and a total of 411 individuals since the program launched in the Upper Peninsula in October of 2020.

OHH Continued

FY 2022 OHH beneficiary enrollments by month



New enrollments by month comparison FY2021 & FY2022



NorthCare Network CY2020 IET Evaluation

Description: Percentage of Medicaid beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit. See here for full details: Measure Details (cms.gov)

Evaluation: The file MDHHS sent to us had 365 Indexed Episodes. In this, there were 142 (39%) that met the measure, and 223 (61%) that did not meet the measure. Matching the Beneficiary ID with the Medicaid ID in our records using a mix of a SQL report for claims and the SUD Admissions report, our data was compared with what is in the data warehouse. NorthCare had a Denominator of 329 Indexed Episodes. In this, there were 152 (46%) that met the measure, and 177 (54%) that did not meet the measure. Below is the charting of the analysis.

MDHHS Analysis		
Denom	**Yes**	**No**
365	142	223
%	39%	61%

NorthCare Analysis		
Denom	**Yes**	**No**
329	152	177
%	46%	54%

The Denominator was less for NorthCare because 36 of the Indexed Episodes were found to not have AOD and/or an admission or known to NorthCare, so that was noted back to MDHHS by marking D4 or D5. There were more "Yes's" because some of the ones marked "No" by MDHHS were found to have the AOD treatments before 14 days as well as 2 more within 34 days of initiation. There was a total of 18, and were all marked as N2, which means Numerator: Change result flag to 'yes' based on procedure, revenue, or other billing codes.

D4	33
D5	3
N2	18

URAC Accreditation

NorthCare Network's URAC Accreditation will expire March 1, 2023. After 8 years of accreditation, NorthCare has made the decision not to renew accreditation at this time due to the redundancy in compliance reviews conducted by MDHHS and HSAG as well as the human and financial resources necessary to ensure a full accreditation status.

Crisis in the World of Crisis

Inpatient Psychiatric Hospitalization

Inpatient psychiatric services have historically been difficult to access at both the acute and state level of care. On 6/30/22, the chances of accessing state hospitalization were reduced even further. Dr. Mellos and administration announced that Hawthorn and the other state hospitals reduced their bed capacity due to staffing shortages. Caro was short 6 staff, Center for Forensic Psychiatry was short 50 staff, Hawthorne was short 28 staff, Kalamazoo Psychiatric Hospital was short 36 staff, and Walter Ruther was short 19 staff as of that time. Ultimately, the state psychiatric bed capacity was reduced by approximately 100 beds.

Compounding the bed availability for state psychiatric admission issue are 2 other issues, namely forensic population priority and discharge options. “Forensic beds” compete with “probate beds,” meaning that individuals waiting for forensic assessment are admitted to state psychiatric hospitals after determination by a judge. These individuals take precedence for open beds. This has unfortunately resulted in a situation where the best way for an individual to get the treatment they need, is to go to jail.

Discharge options also compound the bed availability issue. Per Dr. Mellos, on any given month, of the population of approximately 600-700 state psychiatric hospital admissions, approximately 40% are ready for discharge. However, there is limited residential options for these individuals. There are not enough AFC homes to take the influx of adults, many of whom have lived in the state facility for years. Nor are there enough placements for children. If the individuals want to leave the hospital and they are ready for discharge, the state facility cannot hold them against their will. However, discharge with inappropriate supports and to inappropriate levels of care increases the burden on other systems such as homeless shelters, jails, acute hospitals, substance use providers, etc. It also significantly increases the burden on the CMH system, creating an influx in the most severely ill individuals when resources are already stretched thin. Add to that the CMH’s own staffing issues and the entire system is pressured to the disaster point.

Given the reduction in state psychiatric beds, there could be a case made for increasing the number of acute psychiatric inpatient beds. The Certificate of Need (CON) calculation requires proving need before a new hospital/unit can be established. This creates a delay in access to care between the time the need is proven and the time the hospital unit is built/established. Not all states have CON laws, but Michigan does. As of 2017 and updated in 2022, the Michigan CON psychiatric bed need for the Upper Peninsula was identified as 75 beds but there are only 51 adult beds in the Upper Peninsula (MDHHS). Six of the UP Health System beds are for children.

HSA 8 - ALGER, BARAGA, CHIPPEWA, DELTA, DICKINSON, GOGEBIC, HOUGHTON, IRON, KEWEENAW, LUCE, MACKINAC, MARQUETTE, MENOMINEE, ONTONAGON, SCHOOLCRAFT

FACILITY NAME	CITY	FACILITY NUMBER	ADULT LICENSED BEDS	ADULT DEPT INV*
Chippewa County War Memorial Hosptial - Psych	Kincheloe	17-2601	20	20
UP Health System -Marquette	Marquette	52-0050	37	37
PLANNING AREA TOTAL			57	57
AREA BED NEED				75

While there are 57 beds distributed across War Memorial and Upper Peninsula Health System, there is not staffing capacity for 57 individuals to be psychiatrically hospitalized in the U.P. Upper Peninsula Health System- Marquette (UPHS-M) typically caps their bed availability at 20 adult beds. War Memorial Hospital (WMH) typically caps their bed availability around 12-14 adult beds. There are no adolescent beds in the Upper Peninsula, although UPHS-M is licensed for 6 beds, they do not have a child psychiatrist to provide youth inpatient services.

Staffing issues have impacted crisis services locally as well. In FY22, Northpointe Behavioral Health and Gogebic CMH joined forces. A contract agency provides after hours crisis services to all four counties. The Gogebic and Northpointe supervisors' alternate supervisor coverage. Additionally, in FY22, Pathways CMH contracted for their after-hours crisis services. In FY23, Copper Country and Pathways teamed up like Northpointe and Gogebic to share coverage of supervisory duties. Currently, after-hours crisis services are managed by contract for all but Hiawatha Behavioral Health. Screenings are typically completed remotely via telehealth.

There were 1,843 preadmission screenings (PAS) completed in FY22 (an 22% increase from 1,506 in FY21) across 1,146 distinct consumers. Of these, 1,041 were for Medicaid individuals and sent as an encounter. Seventy-two screenings were administrative. Administrative Preadmission Screenings are completed based on paperwork from another CMH agency outside the area when they complete the screening of the individual. These are not reported as encounters. Northpointe and Gogebic have many Administrative Preadmission Screenings because people cross the border, are assessed in Wisconsin ERs and then the WI ER or inpatient psychiatric hospital requests authorization for the admission.

There were 125 staff across the region who completed preadmission screenings in FY22 (down from 153 last year), comprising of 99 distinct staff across the region. There was a median of 4 PAS per person, although many staff only completed 1 PAS during the year, and one staff completed 76 screenings during the year. The average PAS took approximately 54 minutes to complete. Preadmission screenings are reported as encounters. Most screenings completed were Medicaid eligible, as Preadmission Screenings are not required on individuals who are not accessing public funds, as we cannot authorize use of private insurances, however there were some screenings completed on non-Medicaid individuals.

The 5 NorthCare Dual screenings are entered by PIHP staff. These screenings were for MHL individuals who were hospitalized outside the area, typically out of the state, and no CMH involvement occurred prior to or during the hospitalization.

Utilization of Preadmission Screenings (T1023)

		Contacts (all insurance, all status)			Encounters (sent)		Medicaid Encounters (sent)	
	Number of Staff who Billed T1023	Count of Services	Distinct Count of Consumers	Average of Elapsed Minutes	Count of Services	Distinct Count of Consumers	Count of Services	Distinct Count of Consumers
Copper	22	180	104	106.8	173	99	159	89
Gogebic	11	98	71	60.2	50	39	42	32
Hiawatha	26	397	288	40.5	372	278	290	222
NorthCare Dual	0	5	5	18	0	0	0	0
Northpointe	15	296	183	45.1	278	171	261	155
Pathways	26	867	524	51.6	306	233	289	218
Grand Total	**99**	**1,843**	**1,146**	**53.9**	**1,179**	**808**	**1,041**	**704**

* SAL Download report by CPT code. Total Contacts reviews the count of MCOs and Distinct Count of MCO's by Affiliate and Provider. Encounters limits this to face to face services (encounter status sent), reviewing the same values. Medicaid Encounters looks at face to face encounters that were Medicaid Eligible (fund source). Staff billed reflects those who billed Medicaid.

Just over 45% of preadmission screenings resulted in a diversion from hospitalization. This is a significant increase from last year at 30%. At times, individuals were diverted to the ER for further monitoring while CMHSP staff continued to seek inpatient hospitalization beds for consumers. This likely accounts for much of the increase in diversions. In FY22 there was not a way to track the number of diversions that are diverted back to the ER, but in FY23 the Electronic Medical Record was adjusted to allow for this delineation. The diversion numbers, listed below, do not include the 5 PAS's added by NorthCare Network staff. Those 5 screenings were retrospective administrative PAS's for individuals with MHL who were hospitalized out of the area and did not have CMH involvement in their admission.

Diversion by CMHSP in FY22

Affiliate	Disposition	Screens with this Disposition	Total Screens by Affiliate	% of Affiliate's Screens with this Disposition
Copper	*Diversion	91	**180**	50.56%
	Hospital Admission	89		49.44%
Gogebic	*Diversion	36	**98**	36.73%
	Hospital Admission	62		63.27%
Hiawatha	*Diversion	137	**397**	34.51%
	Hospital Admission	260		65.49%
Northpointe	*Diversion	107	**296**	36.15%
	Hospital Admission	189		63.85%
Pathways	*Diversion	458	**867**	52.83%
	Hospital Admission	409		47.17%
Total	***Diversion**	**829**	**1,838**	**45.10%**
	Hospital Admission	**1,009**		**54.90%**

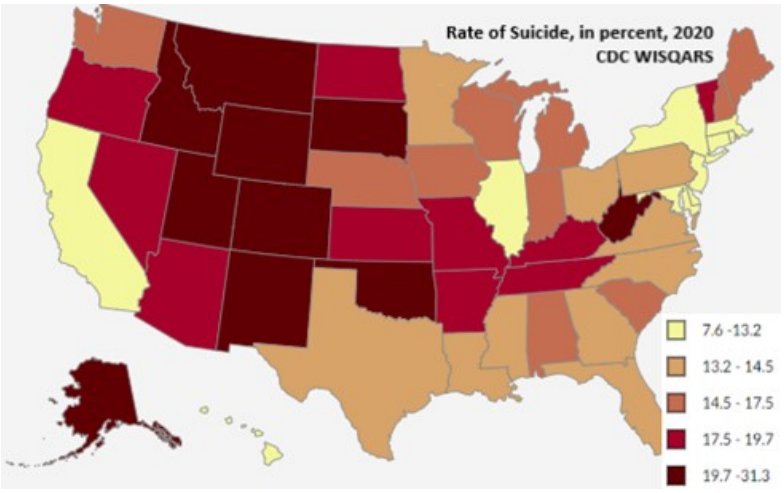
*Diversion includes Crisis Residential. Preadmission Screening SQL report, excludes MHL admissions completed by NorthCare under the NorthCare Dual provider.

Suicidal ideation is often a cause for inpatient admission. In FY22, 409 of the preadmission screenings indicated that suicidal ideation was present. This continues to decrease from a high in FY19. Pathways had a significant decrease, which may be a difference in documenting vs. actual decrease in suicidal ideation in the area. In Michigan, there were 14 deaths by suicide per 100,000 people. This ranged from 9 to 40 deaths by suicide per 100,000 people across counties in the state. The 2022 County Health Rankings used data from 2016-2020 for this measure.

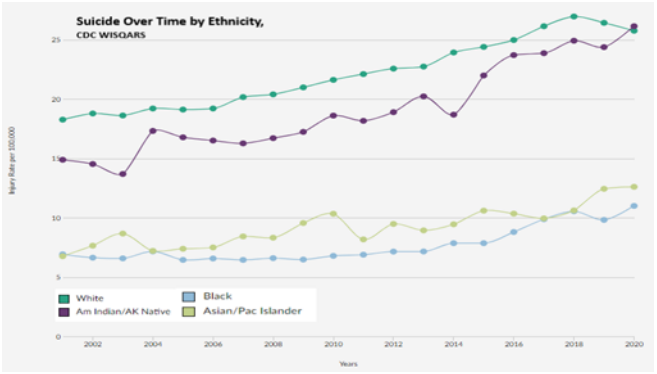
Suicidal Behaviors in PAS Trend

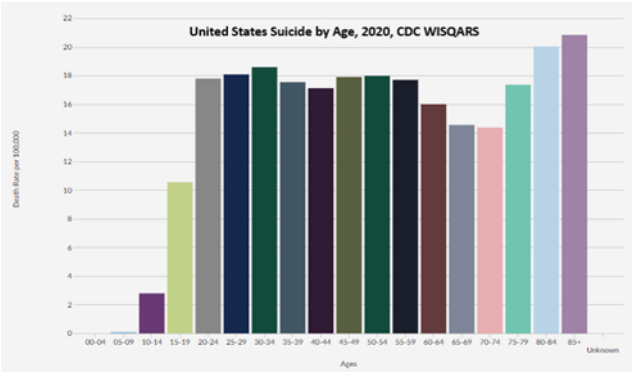
	FY17	FY18	FY19	FY20	FY21	FY22
Copper	60	59	46	46	56	54
Gogebic	26	39	32	40	13	13
Hiawatha	106	130	107	102	126	128
Northpointe	69	80	133	76	95	116
Pathways	317	331	339	272	230	98
Grand Total	**578**	**639**	**657**	**536**	**520**	**409**

Source: SQL Query of PAS within 10/1/16 to 9/30/22



In 2020, there were 45,979 deaths by suicide; a crude rate of 13.96% and an estimated 942,431 years of potential life lost (*CDC WISQARS, 2020*). In Michigan that same year, the crude rate was 14.49%. Nationally, males completed suicide 4 times more often than females. The risk of suicide completion increases significantly with adulthood and remains stable until retirement. Retirement age individuals show a decrease in suicide completion; however, this again increases to the highest level of suicide completion in the elderly. There are numerous potential reasons for the increase in suicide rates among the elderly, but they likely include loneliness and health issues. Rates of suicide are highest among Caucasian (15.05%) and American Indian/Alaskan Native (14.53%) individuals, whereas Black (7.40%) and Asian (6.79%) individuals have a much lower rate of suicide. Overall rates of suicide have been climbing with a downward trend in 2020 for Caucasians.

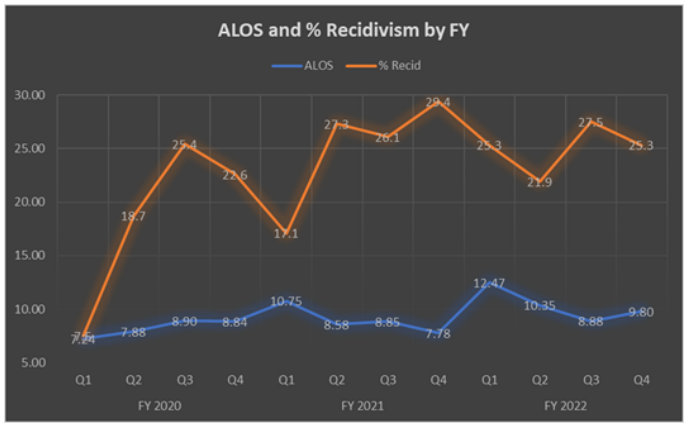




Average Length of Stay

The average length of hospital stay for individuals increased to 10.32 days in FY22. The Average Length of Stay (ALOS) by CMH and by provider is listed below. Historically, NorthCare's average length of stay has ranged between 6 and 9 days. MHL individuals, listed as NorthCare Dual, tend to have longer lengths of stay. Typically, individuals in this category have comorbid medical conditions that may require slower medication titration or complicate treatment in other ways.

Average Length of Stay	
Copper	11.38
Gogebic	7.31
Hiawatha	9.26
NorthCare Dual	8.36
Northpointe	10.59
Pathways	11.01
Grand Total	**10.32**



A longer length of stay doesn't directly correlate with recidivism. As shown on the next page, the ALOS is steadily climbing, and recidivism is also on an upward trend. Individuals appear to be recovering slower. This may be due to lack of care during COVID-19, increased use of new and often untestable illicit substances, or more physiological needs such as food and housing not being met.

Recidivism

Recidivism measures re-hospitalization of individuals within 30 days of discharge. There were 132 hospitalizations (counting the initial and any subsequent hospitalization(s) within 30 days) across 56 distinct individuals in FY22.

Recidivism FY22		
	Hospitalizations	Distinct Consumers
Copper	7	3
Gogebic	6	3
Hiawatha	33	11
Northpointe	37	18
Pathways	49	21
Grand Total	132	56

Recidivism is reviewed in the following table by quarter per CMH and is compared to the state average. The goal is to have less than 15% of individuals readmitted in a given quarter. An individual can be considered "new" to a CMH and not be "new" to the PIHP if they were seen at a different CMH within the past 90 days; therefore, the percentages cannot be added and averaged.

Performance Indicator by CMH Compared to State Average - Recidivism								
	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Adults	Children	Adults	Children	Adults	Children	Adults	Children
Copper	5.6%	0%	0%	0%	25%	0%	0%	33.3%
Gogebic	0%	0%	0%	NA	25%	0%	0%	0%
Hiawatha	15.8%	50%	23.5%	0%	8.7%	0%	19.2%	25%
Northpointe	11.1%	18.2%	0%	33.3%	10%	11.1%	19.0%	0%
Pathways	3.3%	0%	17.5%	3.0%	11.9%	0%	6.3%	16.7%
NorthCare	10.20%	20.80%	12.36%	10.00%	11.38%	4.35%	12.5%	15.0%
Statewide	11.37%	7.41%	11.35%	7.06%	11.67%	5.88%	12.73%	8.93%

*Performance Indicator Report. Excludes those following up with other providers only, autism, OBRA, dual eligible, care/caid, transfers. Number of days calculated at 30 or less the event is considered a readmission.

7-day follow up

After hospitalization, individuals are expected to have an appointment within 7 days at a CMH or another provider. Performance Indicators measure the percent of discharged individuals who are following up with the CMH providers who have their appointment within 7 days. The regional performance, by CMH and compared to the state average, is shown in the table below. This specifically measures those that are following up at CMH. Individuals following up at a community provider and not interacting with CMH are not included in this data. An individual can be considered "new" to a CMH and not be "new" to the PIHP if they were seen at a different CMH within the past 90 days; therefore, the percentages cannot be added and averaged. The standard is 95% or better.

Performance Indicator by CMH Compared to State Average - 7 Day Follow Up								
	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Adults	Children	Adults	Children	Adults	Children	Adults	Children
Copper	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	33.3%
Gogebic	100.0%	100.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%
Hiawatha	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Northpointe	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%
Pathways	100.0%	75.0%	96.7%	100.0%	100.0%	100.0%	96.6%	100.0%
NorthCare	97.30%	95.70%	98.53%	100.0%	97.59%	100%	94.9%	90.0%
Statewide	92.01%	92.34%	88.93%	90.31%	89.86%	90.11%	91.10%	90.89%

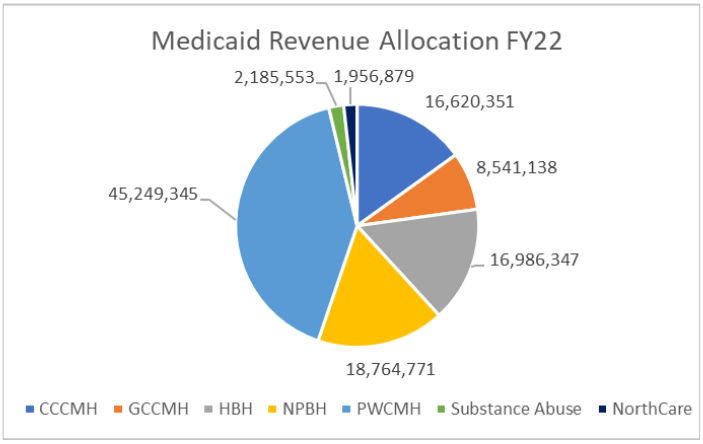
*Performance Indicator Report. Excludes those following up with other providers only, autism, OBRA, dual eligible, care/caid, transfers. Exceptions include those refusing appointment within 7 days or those who had an appointment scheduled but then no-show or cancel.

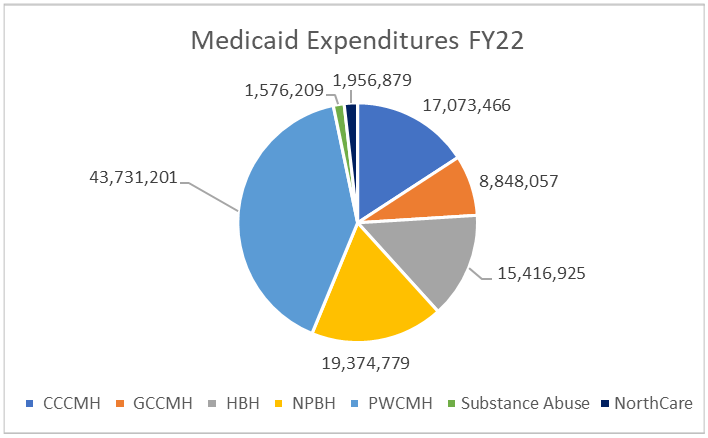
Overall, crisis services in the U.P. are doing more with less. Providers are seeing people within 7 days of discharge to provide better care, and hospitals are keeping individuals longer, yet recidivism isn't going down. There is going to be continued need for hospital beds, including state hospital beds, in the future.

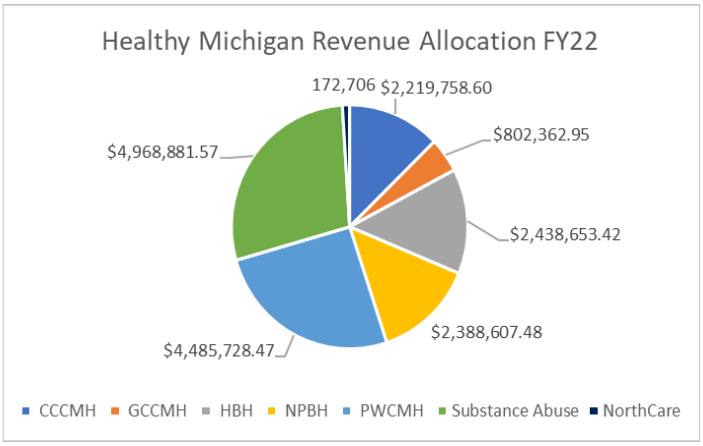
Finance

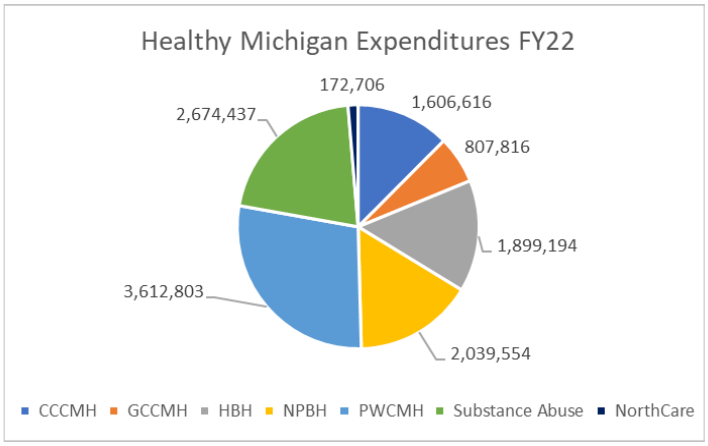
NorthCare Network is responsible for the management of Medicaid and other Block Grant funds to provide services to beneficiaries with mental illnesses, intellectual/developmental disabilities, and substance use disorders across the 15 counties in the Upper Peninsula of Michigan. NorthCare Network receives the Medicaid funds and then advances these funds per the MDHHS/PIHP contract to the five CMHSPs as well as other Providers.

NorthCare Network can utilize Medicaid carryforward funds to mitigate risk through the Internal Service Fund and Medicaid savings. The Internal Service Fund provides some protection if the region is overspent in a future year. Medicaid savings must be expended in the year following when it was earned and must be spent on specific criteria outlined by the MDHHS/PIHP contract. NorthCare Network's Internal Service Fund is currently funded at $9,067,590 and NorthCare Network continues to assess areas of improvement to streamline both administrative and clinical functions and accessibility to care. Regional savings for Fiscal Year 2022 totaled $2,972,486 for Medicaid and $5,604,544 for Healthy Michigan which will be utilized to support FY23 services.









CCCMH - Copper County Community Mental Health

GCCMH - Gogebic County Community Mental Health

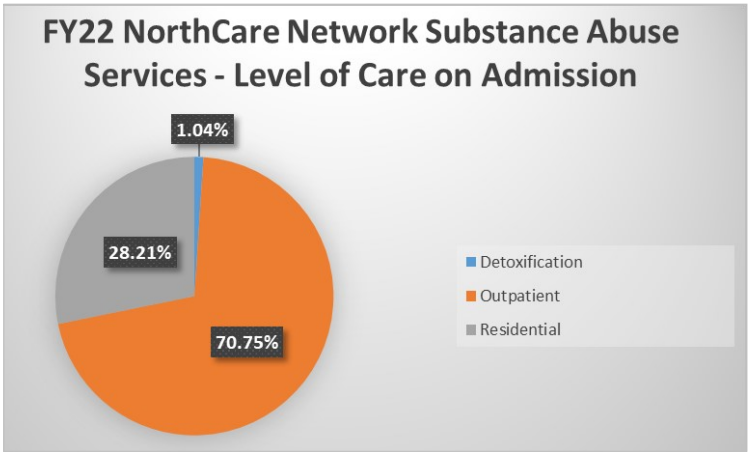
HBH - Hiawatha Behavioral Health

NBHS - Northpointe Behavioral Health Systems

PWCMH - Pathways Community Mental Health

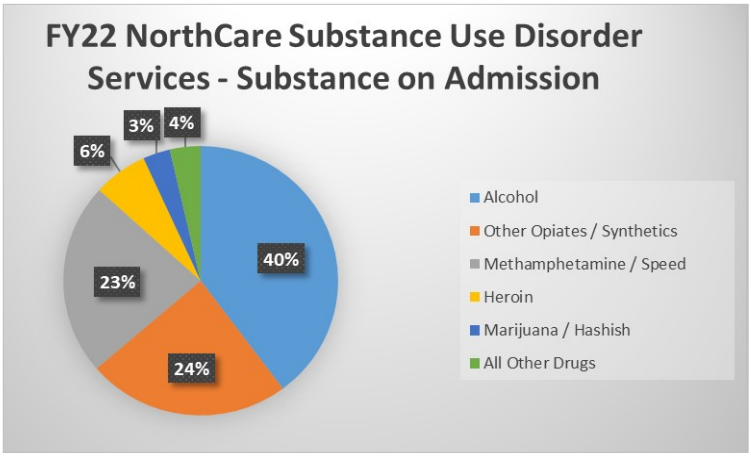
SUD Admissions FY22

SUD Admissions by Level of Care



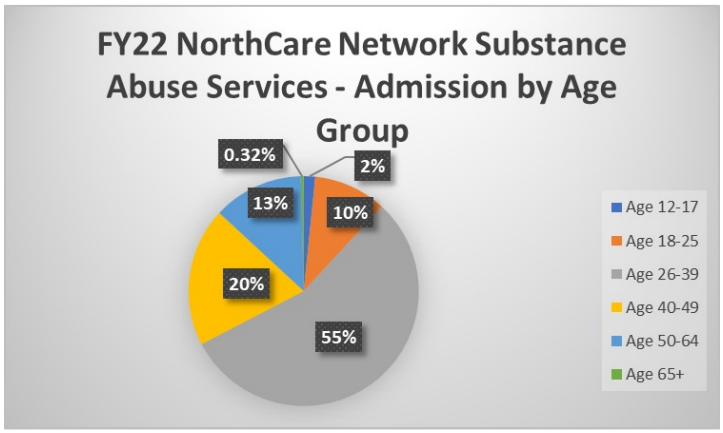
Level of Care	# of Admissions	% of Admissions
Detoxification	33	1.04%
Outpatient	2247	70.75%
Residential	896	28.21%
Grand Total	**3176**	**100.00%**

SUD Admissions by Primary Substance



Primary Substance at Admission	# of Admissions	% of Admissions
Alcohol	1264	39.80%
Other Opiates / Synthetics	759	23.90%
Methamphetamine / Speed	733	23.08%
Heroin	203	6.39%
Marijuana / Hashish	102	3.21%
All Other Drugs	115	3.62%
Total Admissions	**3176**	**100%**

SUD Admissions by Age Group



Age Group at Admission	# of Admissions	% of Admissions
Age 12-17	51	1.61%
Age 18-25	326	10.26%
Age 26-39	1762	55.48%
Age 40-49	621	19.55%
Age 50-64	403	12.69%
Age 65+	13	0.41%
Total	3176	100%

Source: SUD Admissions PCE Standard Report in ELMER. These reports summarizes all SUD admissions where the admission date was between 10/1/22 through 9/30/22.