

NorthCare Network

2016 Fiscal Year

Annual Performance Report



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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.



NorthCare Network

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From the Chief Executive Officer William Slavin, NorthCare Network

Friends of NorthCare Network,

We are again pleased to share with you our annual performance report, this time for Fiscal Year 2016. This report reflects the diligent efforts of both Board and staff at NorthCare as we strive to improve our performance on the metrics by which we are measured and evaluated. As a Specialty Services Health Plan (Prepaid Inpatient Health Plan), one of ten in Michigan, we are evaluated through a variety of measures in our contract with the Michigan Department of Health and Human Services, by standardized measures of performance monitored by the Health Services Advisory Group, the External Quality Review Organization under contract with the MDHHS, and by URAC, a national accrediting body for Health Plans. More importantly we are evaluated by the persons we serve, our consumers and communities.

Our performance and success is tied directly to the success and performance of our affiliates and providers who deliver the services and supports. Our success is also tied to the support of our community and the NorthCare Board members who represent our community and give unselfishly their time, guidance and expertise. ***“People before profits,”*** means any savings accrued during the year in the public system are reinvested into programs and services.

We hope you find this report interesting and informative and, as always, we welcome your comments. Thank you for your continued interest and support.

Sincerely,



William Slavin, CEO

Our 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's Values

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery and a culture of gentleness.
- We also endorse effective, efficient community based systems of care based on the ready availability of a competent workforce and evidence based practices.
- We believe in services that are accessible, accountable, value-based and trauma-informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, at the right time, for the right cost, and with the right outcome.

NorthCare Network Governing Board Membership

Copper Country:

Michael Koskinen

Patrick Rozich (Chairperson)*

James Tervo

Gogebic:

Margaret Rayner

Stephen Thomas*

David McRae (Oct.)

Joe Bonovetz (Nov. – Oct.)

Dan Siirila (alternate)

Hiawatha:

Kathy Cairns

George Ecclesine

Dr. John Shoberg

Bob Barr (alternate)

Northpointe:

Mari Negro

John Nelson*

Dr. Michael Zevitz (Oct. – May)

Joan Luhtanen (June – Oct.)

*CMHSP Board Chairperson

Pathways:

George Botbyl (Secretary)

William Davie (Vice-Chair)

Rudy Kempainen (Oct. – Mar.)

Pat Bureau (April – Oct.)

GOVERNING BOARD PAST CHAIRPERSONS

- Rudy Kempainen

- Karen Raether

- Dan LaFoilie

NorthCare Network Substance Use Disorder Policy Board Membership

Catherine Pullen, Alger County

Michael Koskinen, Baraga County

James Moore (Board Chair), Chippewa County

David Rivard, Delta County

John Degenaar, Jr. (Vice Chair),
Dickinson County

LeRoy Kangas, Gogebic County

Tim Palosaari, Houghton County

Rosalie King, Iron County (Oct. – July)

James Brennan III, Iron County (Aug. – Oct.)

Randy Eckloff, Keweenaw County

Nancy Morrison, Luce County

Jim Hill, Mackinac County

Pat Bureau, Marquette County

John Nelson, Menominee County

John Pelkola, Ontonagon County

Craig Reiter, Schoolcraft County



Performance Report Card

NorthCare Network continues to be monitored for performance in a variety of ways, one of which is through an independent review organization. The Health Service Advisory Group (HSAG) is the External Quality Review Organization (EQRO) contracted by the Michigan Department of Health and Human Services (MDHHS) to conduct a three part survey of all Prepaid Inpatient Health Plans (PIHPs) in Michigan. This external review is mandated by the Balanced Budget Act of 1997 (BBA) and is conducted in accordance with the Centers for Medicare and Medicaid Services EQR (External Quality Review) guidelines. This three-part review consists of:

1. **Compliance Monitoring** which is an assessment of NorthCare's compliance with applicable BBA and MDHHS contract requirements. In July 2016, HSAG conducted a follow-up review where they assessed compliance with standards not fully met in the previous year. NorthCare had three areas needing follow-up review. These address access to services, consumer appeals, and collecting Disclosure of Ownership, Control, and Criminal Convictions from providers.

Areas Reviewed for Compliance Monitoring Review (NA indicates standards not evaluated for that year.)	FY12	FY13	FY14	FY15	FY16
Quality Assessment & Performance Improvement Plan & Structure	NA	100%	NA	100%	NA
Performance Measures	100%	NA	NA	100%	NA
Practice Guidelines	100%	NA	NA	100%	NA
Staff Qualifications	NA	100%	NA	100%	NA
Utilization Management	NA	96%	100%	100%	NA
Customer Services	100%	NA	NA	100%	NA
Enrollee Grievance Process	NA	100%	NA	100%	NA
Enrollee Rights & Protections	98%	NA	100%	100%	NA
Subcontracts & Delegation	100%	NA	NA	100%	NA
Provider Network	100%	NA	NA	100%	NA
Credentialing	99%	NA	100%	100%	NA
Access & Availability	NA	97%	NA	94%	100%
Coordination of Care	100%	NA	NA	100%	NA
Appeals	NA	100%	NA	89%	100%
Disclosure of Ownership, Control, & Criminal Convictions	NA	NA	NA	72%	100%
Overall	99%	99%	100%	98%	100%

2. **Performance Measure Validation (PMV)** is a comprehensive review of our state mandated performance measure, encounter and demographic data. HSAG looks at how the data is collected, calculated, and reported and then evaluates the accuracy, completeness, and timeliness of our data. They found our data integration, data controls, and performance indicator documentation to be acceptable.

The chart on the following page represents a 5-year comparison of indicators that measure timeliness of service delivery. We received a "fully complaint" rating on all performance measures reviewed and show significant improvement in four of the five indicators noted below.

Performance Report Card (cont.)

Performance Measures	2012	2013	2014	2015	2016
Percentage of new persons receiving an assessment w/in 14 days of request for non-emergency service.	99%	99%	98%	98%	97%
Percentage of new persons starting on-going services w/in 14 days of non-emergent assessment.	99%	99%	96%	97%	99%
Percentage of discharges from psychiatric inpatient unit who are seen for follow-up care w/in 7 days of discharge.	97%	95%	98%	89%	97%
Percentage of adults served who are employed competitively.	8.5%	3.5%	4.4%	5.2%	12.3%
Percentage of adults served who earn minimum wage or more from any employment activities.	52%	52%	37%	40%	64.4%

3. **Performance Improvement Project (PIP) Validation** is the evaluation of the PIP required by the MDHHS. HSAG's validation review is to determine if the PIP is written and conducted in a way that can assure valid and reliable outcomes and that the outcomes show statistically significant improvement that is sustained over time. The topic for this study, which started in FY14, is to increase the percentage of adults with mental illness who indicate a medical diagnosis of obesity in the self-reported health measures and receive a medical nutritional therapy services from a primary care provider. This project is designed to increase proper referrals and follow-up for these individuals.

Some interesting facts and reasons why this study topic was chosen is because it has the potential to improve beneficiary health and co-morbidity as well as reducing costs for health care services related to obesity. Risk factors such as poor dietary habits, obesity, and a sedentary lifestyle play a significant role in the physical health needs of adults with serious mental illness. These risk factors can be improved with proper care and management.

Michigan has the 10th highest prevalence of obesity in the United States. In 2009, three out of every ten adults in Michigan were obese, while approximately 35% of adults were overweight for the general population. In 2018, Michigan is expected to spend \$12.5 billion on obesity related health care costs if rates continue to increase at their current levels.

The increased rate of morbidity and mortality among adults with serious mental illness (for example, schizophrenia and bipolar disorder) constitutes a public health crisis. Individuals with serious mental illness die on average 25 years before persons in the general population, because of co-morbid medical conditions such as cardiovascular factors and diabetes. A significant difference for individuals living with serious mental illness may be the presence of a metabolic syndrome, which is a key component of excessive weight gain for many of these individuals. Metabolic syndrome is the medical term used to describe the medication side effects, such as secondary weight gain and metabolic alterations linked to the use of second-generation antipsychotic agents which contribute to the high prevalence of medical co-morbidities and poor health outcomes for this population. Further, these physical health needs of persons with serious mental illness can be exacerbated by a lack of access, due to various reasons, to high-quality medical care.

Performance Report Card (cont.)

HSAG's Validation Reports stated, "The PIP validation evaluated the technical methods of the PIP (i.e., the study design). Based on its technical review, HSAG determined the overall methodological validity of the PIP." All elements reviewed were met at 100%. In Fiscal Year 2016, NorthCare Network achieved a statistically significant improvement over baseline with a total of 42 individuals, or 3.8%, receiving a medical nutritional therapy service from a primary care provider. This is 1.4 percentage points over our goal of 2.4%.

Additional Performance Improvement Projects — 2016

Children's Health and Safety Quality Improvement Project

At the end of FY16, NorthCare completed a three year clinical PIP focused on the health and safety of the children in CMHSP services. Four rounds of clinical chart reviews were conducted – one baseline data from FY13 chart reviews and three intervention years of data. Two Clinicians with extensive experience with children reviewed 143 charts over the course of the PIP.

The study population includes all children who:

- are covered by Medicaid and MICHild; **Note:** as of FY15, MICHILD was rolled into the Medicaid funding received by the PIHP
- are under 18 years of age any time during the reporting period;
- have a primary disability designation of SED or DD or SED/DD;
- are currently open;
- have one or more of the following checked under the Medical Section and/or Safety Section in the BPS:
 - Need or Concern
 - Concern or Risk

An individual review sheet was returned to the primary clinician with explicit feedback on the 11 different standards being reviewed through the PIP.

The primary study indicators were:

1. The percent of children in study population who have health concerns identified in the BPS have those concerns appropriately addressed in the Individual Plan of Service. **Target is 95%.**
2. The percent of children in study population who have safety concerns identified in the BPS have those concerns appropriately addressed in the Individual Plan of Service. **Target is 95%.**

NorthCare completed the PIP in December 2016 and the overall goals of the project were attained. NorthCare utilized a system of documentation developed by David Lloyd called the Golden Thread that directs clinicians to trace the golden thread from assessment through treatment planning and on through the progress being made in services.

Children’s Health and Safety Quality Improvement Project (cont.)

The supervisor and each clinician had a map of the issues each case had with connecting the golden thread. A key finding across the years was the need to retrain staff bi-annually on this system of charting to keep the focus on measurements that are critical to coordination of care. The full results of the study are available by calling NorthCare and requesting a copy of the completed project. The structure of this PIP lends itself to other study questions and we anticipate using a similar model for a PIP to determine the availability and successful use of vocational services across our region.

Community Mental Health Providers Performance Improvement Project—2016

NorthCare has been involved with a Performance Improvement Project (PIP) which measures engagement for those consumers approved for CMHSP specialty services. By engaging consumers at the CMHSP it is hoped that those consumers would receive needed services and in turn have a better quality of life. Engagement can increase treatment compliance which could reduce psychiatric symptoms, prevent complications and reduce use of inpatient hospitalizations. By having consumers engaged in receiving services there would be less missed appointments at the CMHSP which would in turn increase staff productivity as time associated with missed appointments would be reduced. Also lack of engagement can increase the use of inpatient psychiatric hospitalizations.

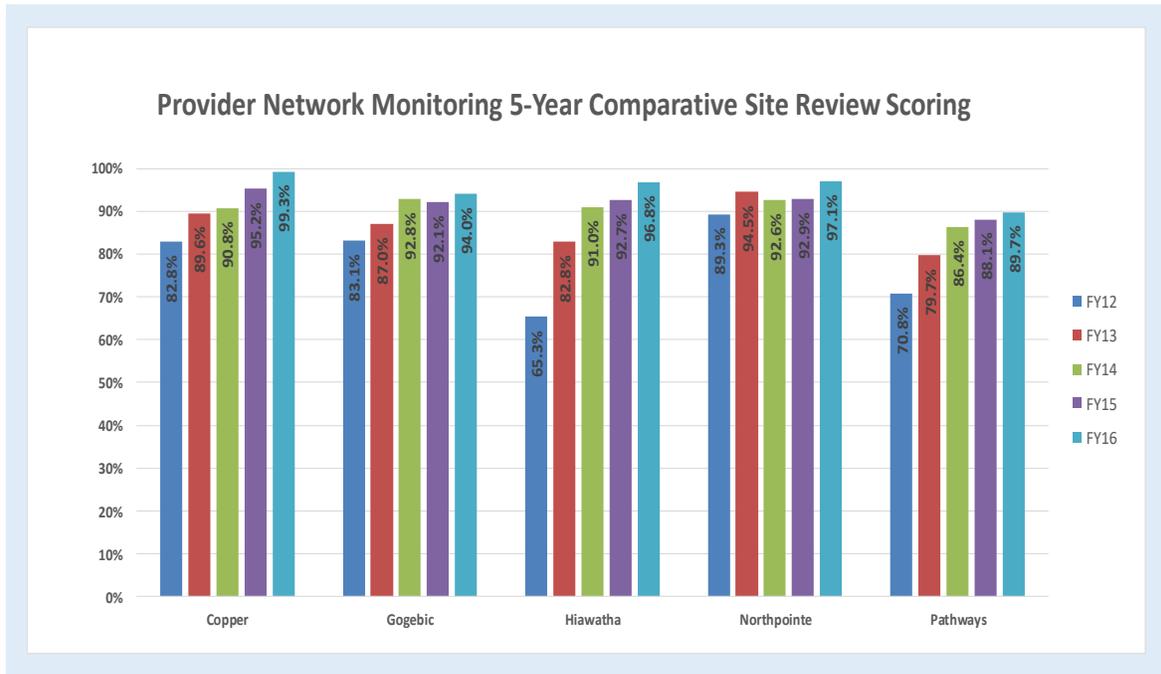
NorthCare has been tracking consumers who were determined to be eligible for CMHSP specialty services and were discharged within 90 days as a way to measure engagement. The data collection tools have had to be refined to ensure accurate data is collected. The number of consumers who are discharged within 90 days has been averaging 10 % across the region during the baseline phase of data collection. Barriers to engagement include: lack of transportation, appointments being forgotten or cancelled, inconvenient appointment times, and poor rapport with the clinician.

Length of Stay - Comparison of Approved Intakes with Discharges Between 0 - 90 Days (FY16)			
COPPER COUNTRY CMH			NORTHPOINTE BHS
FY15-Q4 & FY16 Admissions	243		FY15-Q4 & FY16 Admissions
FY16 Discharges 0 - 90 days	24		FY16 Discharge 0 - 90 days
Percent discharged in 90 days or less	9.88%		Percent discharged in 90 days or less
GOGEBIC CMH			PATHWAYS CMH
FY15-Q4 & FY16 Admissions	119		FY15-Q4 & FY16 Admissions
FY16 Discharges 0 - 90 days	7		FY16 Discharges 0 - 90 days
Percent discharged in 90 days or less	5.88%		Percent discharged in 90 days or less
HIAWATHA BH			NorthCare
FY15-Q4 & FY16 Admissions	327		FY15-Q4 & FY16 Admissions
FY16 Discharges 0 - 90 days	48		FY16 Discharges 0 - 90 days
Percent discharged in 90 days or less	14.68%		Percent discharged in 90 days or less

Discharges Between 0-90 Days by Reason (FY16)								
	Death	Dropped out of treatment	incarcerated	Other	Terminated by facility	Transferred	Treatment completed	NorthCare
CCCMH	0	14	0	6	0	4	0	24
GCCMH	0	5	0	0	0	2	0	7
HBH	0	19	2	9	4	9	5	48
NPBHS	1	52	2	5	1	7	3	71
PWCMH	0	41	4	0	2	10	1	58
NorthCare	1	131	8	20	7	32	9	208

62% of consumers who were discharged within 90 days dropped out of treatment. NorthCare is working with the regional UM committee to implement strategies to increase engagement across the region.

Site Review 5-Year Scoring Comparison



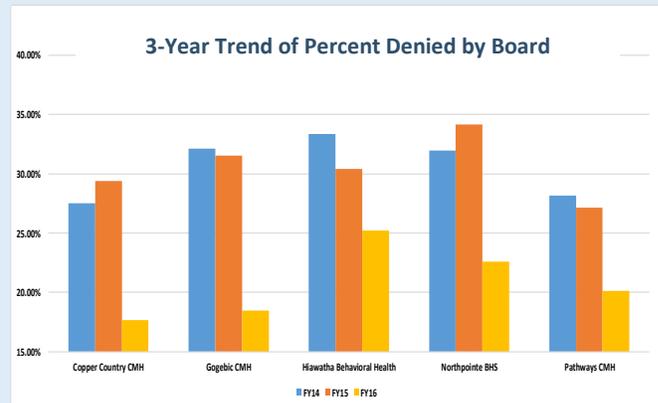
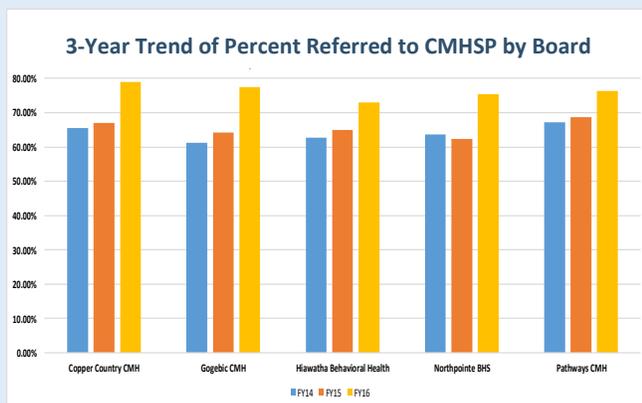
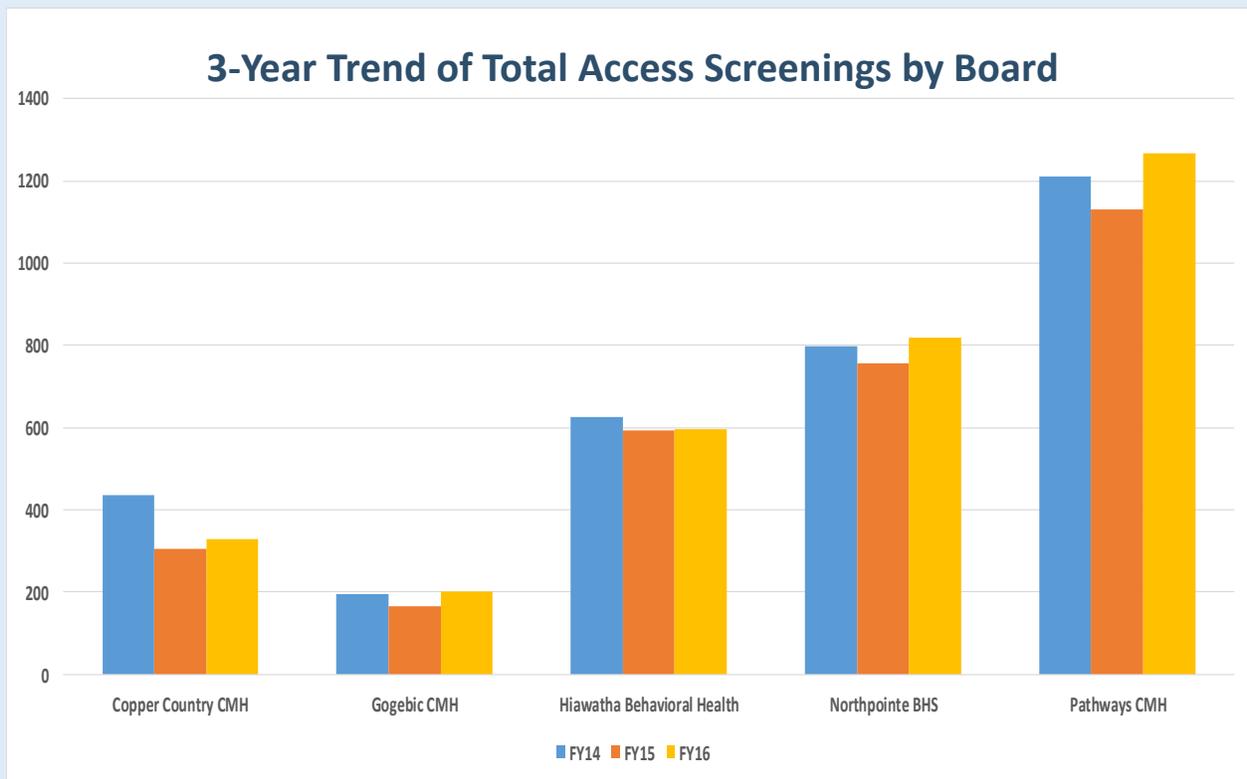
MI Mission-Based Performance Indicator System 2016

NorthCare Network Performance Measure Scores for FY16-Michigan Mission-Based Performance Indicator System															
	(1) Timeliness - Inpatient Screening		(2) Timeliness - Face to Face Assessment						(3) Timeliness - First Service						
	Children	Adults	MI-Children	MI-Adults	DD-Children	DD-Adults	Medicaid SA	Total	MI-Children	MI-Adults	DD-Children	DD-Adults	Medicaid SA	Total	
NorthCare	100%	100%	100%	99%	100%	99%	98%		99%	98%	93%	97%	99%		
Statewide Rate	98.91	98.76	98.73	99.12	98.95	99.34	98.91	98.95	97.22	97.57	98.45	97.88	99.45	98.27	
MDHHS Standard	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	
	(4) Continuity of Care			(5)	(6)	(8) Competitive Employment			(9) Minimum Wage			(10) Inpatient Recidivism		(13/14) Private Residence	
	Follow-up Care-Children	Follow-up Care-Adults	Follow-up Care-Detox	Penetration Rate	HSW Rate	MI-Adults	DD-Adults	MI/DD Adults	MI-Adults	DD-Adults	MI/DD Adults	Children	Adults	DD-Adults	MI-Adults
NorthCare	98%	99%	95%									5%	10%		
Statewide Rate	98.34	97.77	92.69	7.47	97.89	9.56	7.63	7.6	75.48	32.99	36.3	8.59	13.49	18.72	37.94
MDHHS Standard	>=95%	>=95%	>=95%	NA	NA	NA	NA	NA	NA	NA	NA	<=15%	<=15%	NA	NA

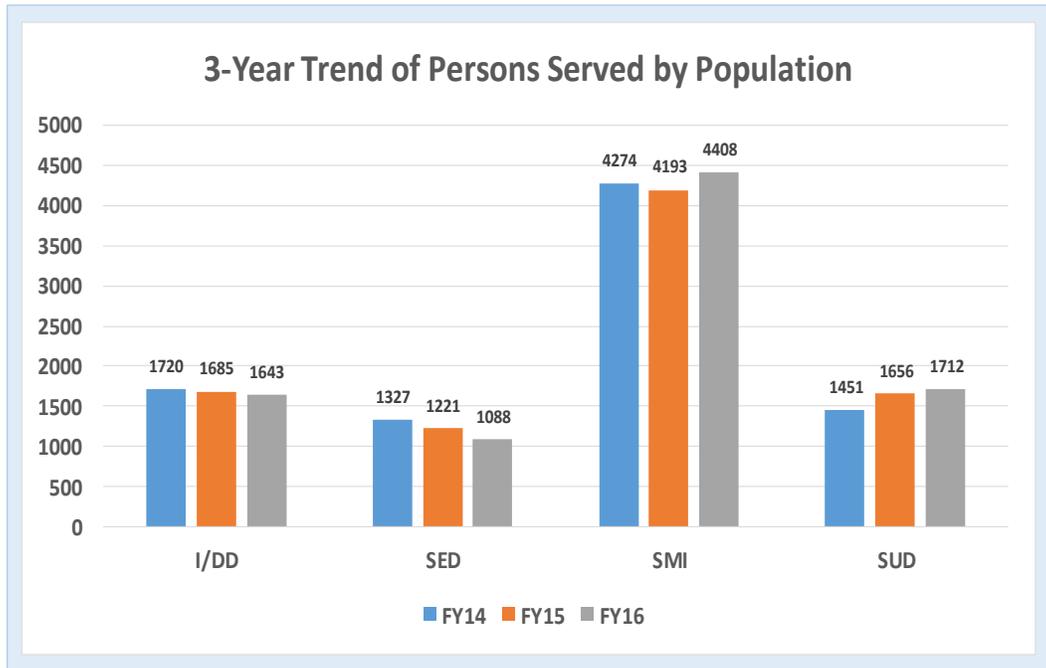
The Michigan Mission Based Performance Indicator System is part of the quality measurement system from MDHHS for state-wide data reports on the accountability for the public mental health system. The measures cover the domains of Access, Efficiency and Outcomes.

Access Screenings for Mental Health Services

There has been an overall increase in the total amount of access screenings over the last three years (FY14 – Y16). This is represented in the graphs below. Of those total access screenings there has been, on average, an increase in the percent of consumers referred to the Community Mental Health Service Programs (CMHSP) for mental health services.



Persons Served by Population: 3-Year Trend



Public Act 107-Performance Bonus

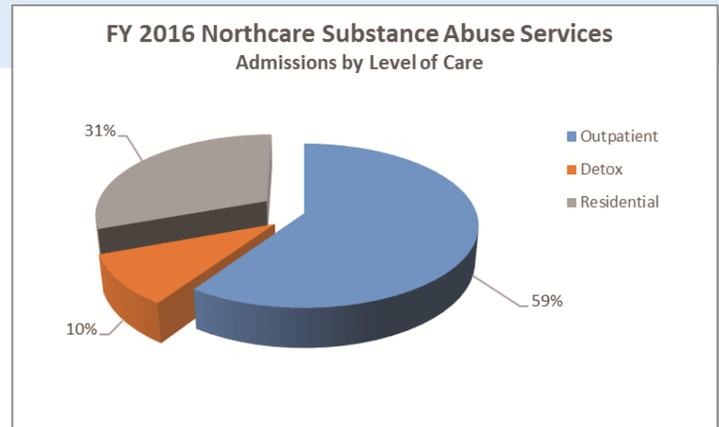
In accordance with section 105d of Public Act 107 of 2013, the Michigan Department of Health and Human Services (MDHHS) requires performance metrics. Those metrics include partnering with other contracted health plans to reduce non-emergent emergency department utilization, increase participation in patient-centered medical homes, increase use of electronic health records and data sharing with other providers, and identify enrollees who may be eligible for services through the veterans' administration.

NorthCare was in compliance with these performance expectations by:

1. Working in collaboration with the Medicaid Health Plan to develop a total of 18 care coordination plans for individuals diagnosed with a mental illness and physical co-morbidities.
2. Working with the UPHP to reduce non-emergent emergency department utilization for individuals jointly served.
3. Exceeding the state standard for ensuring individuals receive a follow-up appointment after discharge from psychiatric inpatient care.
4. Supporting member CMHSPs (Community Mental Health Service Programs) in various initiatives to increase participation in patient-centered medical homes; to co-locate primary care providers at the CMHSP facility, etc.
5. Met with Major Brian Webb (MDHHS Veterans Liaison) regarding a new state-wide Veterans Liaison program. Major Webb also presented to the NorthCare Governing Board. NorthCare has identified 239 individuals with a Veteran status per the BH-TEDS data and will be working with Major Webb during the three-year phase in planning for this program.

Substance Use Disorder Treatment Services Statistics

This graph breaks up the total Substance Use Disorder (SUD) admissions by level of care for FY16. The charts below compare SUD statistics from FY15 and FY16.



SUD Admissions by Primary Substance at Admission

Primary Substance of Abuse at Admission	# of Admissions FY15	# of Admissions FY16	% of Admissions FY 15	% of Admissions FY 16
Alcohol	886	952	40.48%	41.59%
Other Opiates / Synthetics	911	903	41.62%	39.45%
Heroin	72	84	3.29%	3.67%
Marijuana / Hashish	216	197	9.87%	8.61%
Methamphetamine / Speed	51	79	2.33%	3.45%
All Other Drugs	53	74	2.42%	3.23%
Total Admissions:	2189	2289	100%	100%

Total CDR Screenings for SUD Residential	
Medicaid	
FY 14	376
FY 15	632
FY 16	639
Non-Medicaid	
FY 14	278
FY 15	234
FY 16	327
Total	
FY 14	654
FY 15	866
FY 16	966

SUD Admissions by Age Group

Age (Years) at Admission	# of Admissions FY15	# of Admissions FY16	% of Admissions FY15	% of Admissions FY16
Less than 18	111	54	5.07%	2.36%
18-25	517	499	23.62%	21.80%
26-39	1118	1242	51.07%	54.26%
40-49	288	301	13.16%	13.15%
50-64	155	191	7.08%	8.34%
65 or over	*	2	*	0.09%
Total Admissions:	2189	2289	100%	100%

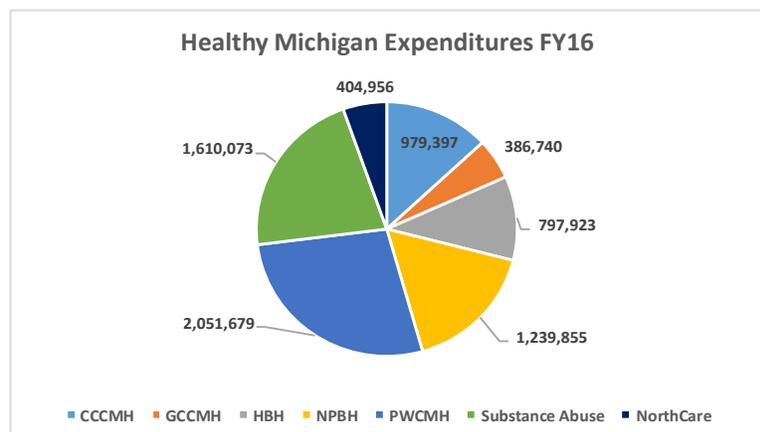
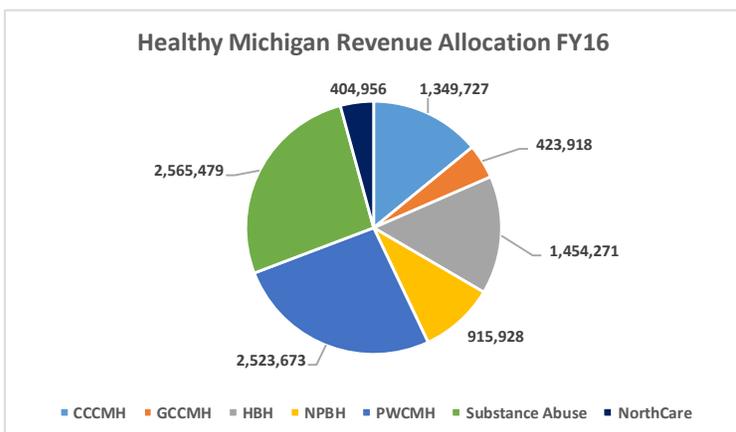
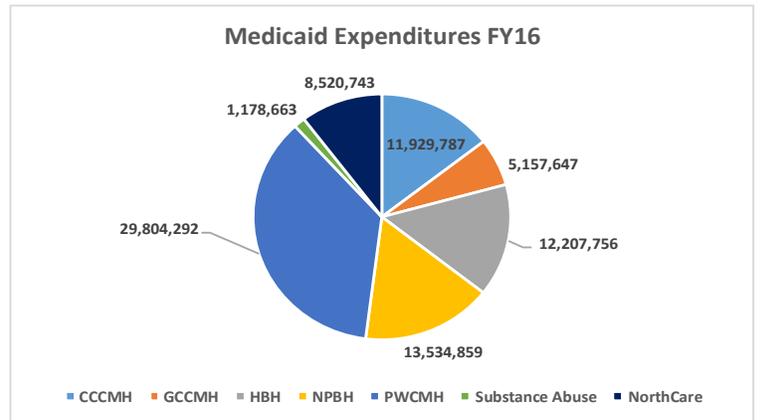
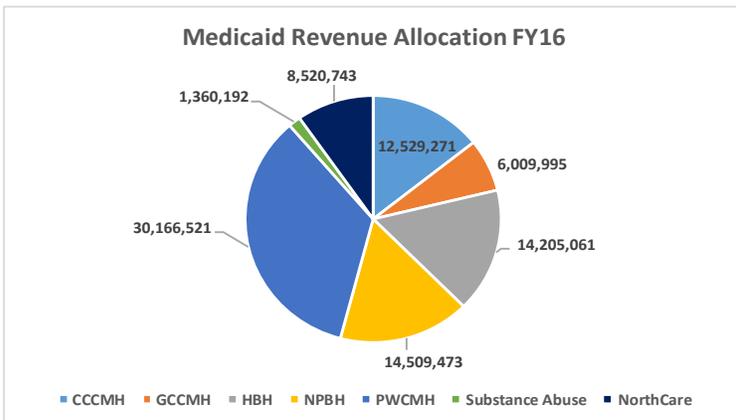
* Data not available for FY 15

NorthCare's total screening for residential treatment have continued to rise since 2014.

NorthCare Finances

NorthCare Network is responsible for the management of the Medicaid Managed Specialty Supports and Services concurrent 1915 (b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs under contract with the Michigan Department of Health and Human Services (MDHHS). NorthCare provides a comprehensive array of specialty mental health and substance abuse services and supports for adults with serious mental illnesses, children and adolescents with serious emotional disturbances, persons with intellectual/developmental disabilities, and persons with substance abuse disorders across the 15 counties in the Upper Peninsula of Michigan.

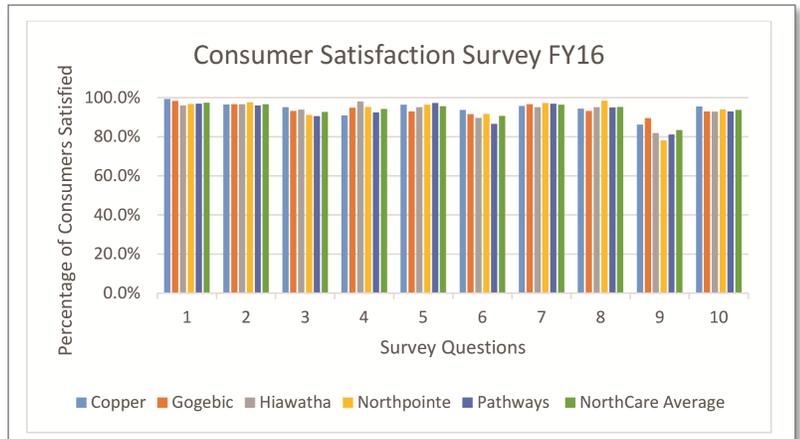
NorthCare is allowed to carry unspent funds forward in one of two ways. First, money can be transferred into an Internal Service Fund to protect the region if Medicaid or Healthy Michigan is overspent in a future year. Second, money can be directed toward improvements in clinical services or creating administrative efficiencies to reduce future expenditures. NorthCare Network’s Internal Service Fund is currently fully funded and continues to assess areas of improvement to streamline functions and accessibility to care. Regional savings for Fiscal Year 2016 were: \$3,544,420 and \$2,362,946 for Healthy Michigan and Medicaid, respectively.



Consumer Satisfaction

NorthCare conducts a number of surveys annually to ensure our consumers are satisfied with the care they are receiving. One of these surveys is the Consumer Satisfaction Survey. **Consumers were surveyed on the following questions:**

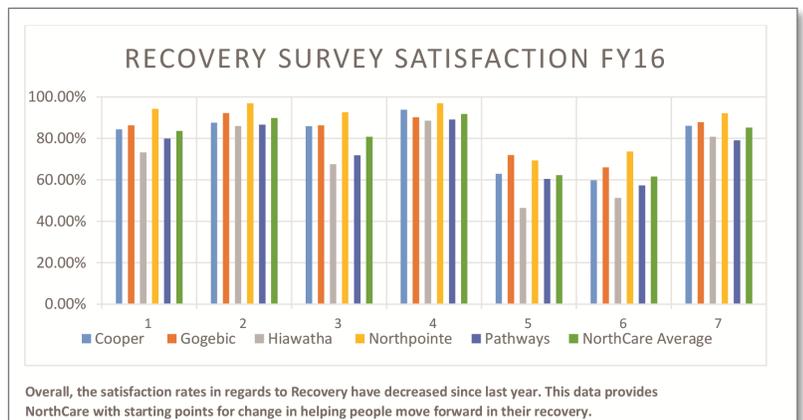
1. Appointments are scheduled at times that work best for me.
2. I am informed of my rights.
3. I feel better because of the service received.
4. I know what to do if I have a concern or complaint.
5. Staff are sensitive to my cultural/ethnic background.
6. I was able to get the type of service I needed.
7. My wishes about who is and who is not given information about my treatment are respected.
8. My wishes about who is and who is not involved in my treatment are respected.
9. I am satisfied with the telephone crisis service when calling the crisis line after 5 pm on weekdays and/or on weekends.
10. I would recommend these services to a friend or relative.



The data in the graph (upper right) represents overall consumer satisfaction rates throughout all five CMHSP in regards to the questions above.

Consumers are also asked to share their opinion in regards to their recovery. The questions are:

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. Coping with my mental illness is no longer the main focus of my life.
6. My symptoms interfere less and less with my life.
7. My services and supports from CMHSP are helping me in my recovery.



The results for the listed questions are represented in the graph to the right.

Annually, NorthCare also conducts a telephone survey of persons who contact the Access Center seeking access to or information about mental health services. Among persons who were screened and scheduled for an assessment at one of the five regional CMHSPs (n=25)*, 96% stated that their initial request was answered by a live person, 100% felt Access staff were welcoming, 92% reported that if they were put on hold their hold time was less than 3 minutes, 100% felt they were given adequate time to explain their reason for calling and 100% felt that staff was helpful with their request. Among persons who contacted the Access Center and were not scheduled for an assessment at one of the five regional CMHSPs but referred to other community providers (n=15)*, 100% stated their initial request for services was handled by a live person, 100% felt Access staff were welcoming, 100% stated that if they were put on hold their hold time was less than 3 minutes, 100% felt they were given adequate time to explain their reason for calling, 87% felt staff was helpful with their request and 93% stated they were notified of their right to a second opinion.

*(n = the total amount of persons surveyed)

Integrated Health Care

Across Michigan and the United States, the shift to integrated care has demonstrated that it saves a substantial amount of public health care dollars and improves the quality of life for some of the most at-risk members of our communities. Without such interventions, individuals with behavioral health needs die an average of 25 years earlier from the same primary, preventable causes than those without mental illness (Parks, et. al.). The goal of integrated care is to improve individual quality of life and member satisfaction in their overall health care delivery by linking individuals to providers for unmet needs. Cost savings are realized by eliminating overlap and duplication of services and directing individuals away from high-cost crisis care to lower cost preventative care. An integrated care team may consist of an individual's primary physician, mental health service provider(s), medical specialists, community and social supports, at the direction of the consumer through person-centered planning.

NorthCare Network facilitates integrated physical and behavioral health care through multiple Medicaid funded programs. Our Integrated Care pilot program is made possible through Block Grant Funding for Integrated Care initially awarded to NorthCare in 2014 and again renewed for FY16. The overarching goal of NorthCare's Integrated Care projects in 2016 was to expand integrated care services to adult members with a severe mental illness diagnosis that are mutually served by UPHP and NorthCare. Including individuals receiving CMHSP case management expanded the eligibility pool of shared members by approximately 3,000 people to a total of 4,529 unduplicated shared members. NorthCare Network also participates in the MI Health Link demonstration project (MHL). MHL is designed to join Medicare and Medicaid physical and behavioral health benefits into one coordinated delivery system for individuals with a mild to moderate behavioral health diagnosis. Northcare Network currently serves 987 of the 4,016 Upper Peninsula residents enrolled in the MI Health Link Program and receiving services through a CMHSP or NorthCare Network Provider.



In June, NorthCare began facilitating monthly targeted care coordination meetings with UPHP and the CMHSP case managers. Four individuals were initially identified as meeting criteria for targeted care coordination in June due to high emergency department utilization and a diagnostic billing code related to behavioral health through Michigan's Care Connect 360 database. High emergency department utilization is defined by the State of Michigan as more than 6 visits in the prior 12 months. By December, 10 individuals were receiving targeted care coordination under expanded criteria from the State of Michigan to include persons with a high amount of service utilization and two or more co-morbid physical health conditions with a behavioral diagnosis.

Through the integrated care grant, the 5 CMHSP boards have access to NorthCare Network's ProAct analytics system, a health care tool populated by Medicaid claims data for physical and behavioral health services. ProAct has been linked to the

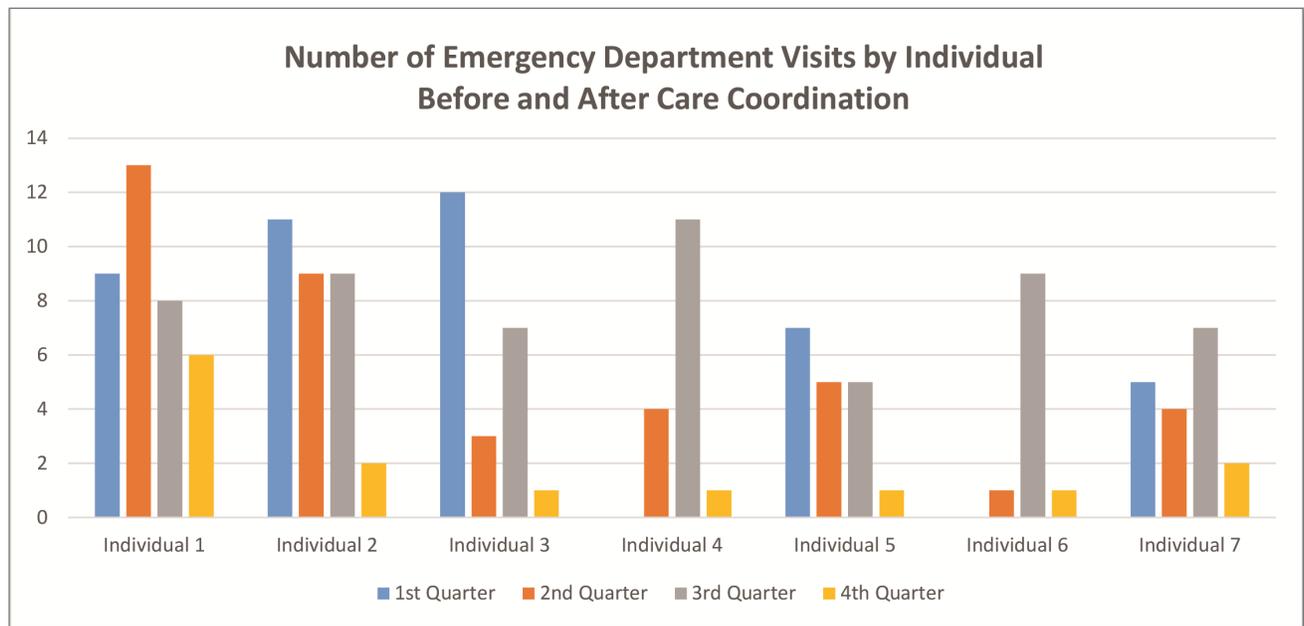
Integrated Health Care (Cont.)

electronic medical record system, ELMER, used by NorthCare Network providers. Information linked between ProAct and ELMER allows for best practice guidelines and individual health care gap alerts to be instantly relayed to their mental health practitioner. For analytics, NorthCare Network utilizes ProAct to provide reports to CMHSP staff on consumer medical usage. These reports help practitioners identify if an individual has been receiving regular preventative care through their primary care physician, labs and diagnostic tests, emergency department utilization, and hospitalization data. Information supplied into the ProAct system by the Michigan Department of Health and Human Services does not contain cost data. Therefore, NorthCare Network and UPHP also use the Symmetry Program to compile cost and insurance risk data into a Tableau desktop. The combination of these tools allows NorthCare Network to identify individuals in need of integrated care, and analyze the effectiveness of our interventions.

The Integrated Care Grant also includes funding for consumer educational fliers to approximately 1,200 individuals across the Upper Peninsula. Topics covered in these materials included an introduction to care coordination and the importance of integrating care.

The following chart depicts the emergency utilization of seven of these individuals before and after targeted care coordination, which began in the third quarter. For the 7 individuals, each bar represents their emergency department utilization by quarter.

We are excited to continue improving the quality of services through integrating care for individuals across the Upper Peninsula throughout 2017.



Works cited: Parks, J., Svendsen, D., Singer, P. Foti, M. E. (October 2006). Morbidity and mortality in people with serious mental illness. Thirteenth in a series of technical reports. National Association of State Mental Health Program Directors (NASMHPD) Medical Director’s Council. Retrieved from: <http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf>

Technology Advances to Improve Care at NorthCare Network

During FY16, NorthCare Network implemented two projects utilizing Michigan information exchange MiHIN. On a daily basis, ADT (Admission, Discharge and Transfer) records from many Michigan hospitals are available for the primary clinicians at the five Community Mental Health Service Programs (CMHSPs). This data alerts the clinical staff of other primary health services that the consumers are receiving and assists the clinical staff with integrated care delivery. The second project involves exchanging a CCDA (Consolidated Clinical Document Architecture) document with Upper Peninsula Health Plan (UPHP) which also flows through MiHIN. The CCDA is the referral notice to NorthCare of a MI Health Link consumer needing a Level II assessment.



NorthCare is utilizing a population management analytic software to assist with the delivery of integrated care to the consumers which are indicating the highest risk of continued high emergency department utilization and high-cost of care. This tool is being used by staff across the five CMHSPs and at NorthCare Network. The alerts from this tool are available in the EMR (Electronic Medical Record) dashboard for quick reference for the clinical staff.



BH-TEDS (Behavioral Health Treatment Episode Data) data collection started in October 2015 as a method for MDHHS to gather better demographic data on consumers served for outcomes reporting. TEDS was originated with SAMHSA as a national data set for the substance use population. This data set allows comparison of admission and discharge data at a national level.

2016 was the first year that the ELMER (Electronic Medical Record) system was used by the SUD providers and NorthCare for Admission, Discharge, Authorizations, Claims and Data system. This allows NorthCare to have one master patient index and to manage one central data system for all consumers served.

Highlights of Evidence-Based Practices

Autism Expansion — *Now serving youth up to the age of 20*

Since January of 2016, services to youth with autism more than doubled with 26 children under 6 and 29 additional youth from 6 years up to 20 years. This growth is inline with other PIHPs in the state who have seen an average increase of 50% in children served. We are proud of our clinical teams across the Upper Peninsula who have undergone extensive training and supervision to provide this benefit.

Competitive Employment

Due to the introduction of national reporting standards (BH-TEDS) in FY16 and updated in FY17, we do not have comparable data to report for competitive employment at this time. In FY16, significant QI efforts began to increase the percentages of individuals who are in or are seeking competitive employment. In FY17, we will provide a comparison between competitive employment and other forms of vocational support to use as a benchmark moving forward.

Family Psychoeducation

Family Psychoeducation (FPE) is an effective model of multiple family group sessions with a high degree of staff and consumer satisfaction. Over the past three years, there has been a downward trend for participation in FPE. To address that trend, 7 new clinicians were trained in the FPE model in FY16 and a local booster training was held in the summer of 2016 to update the skills of current FPE staff. A Pathways clinician who is a certified trainer and supervisor is conducting the monthly coaching calls to the clinicians in trainings so they may be certified as independent FPE Facilitators. We anticipate their certification in early FY17.

FPE Groups in the Upper Peninsula

	FY14	FY15	FY16
Number of Boards with FPE Groups	5	5	5
Number of Consumers being served	70	51	40
Number of Services Provided	819	724	343

Assertive Community Treatment /Intensive Dual Diagnosis Treatment Teams

A key fidelity measure for ACT/IDDT teams is providing services in the community where the multiple needs of the consumers on the team will be addressed in vivo. The IDDT aspect of the team addresses the need for intensive services focused on substance use disorder treatment when it is co-morbid with serious mental illness. The “Gold Standard” for out of office services is 80% and four of our regional teams met or went above that standard.

Program	Community Contacts	Total Contacts	% Contacts in Community
Chippewa - ACT	5,548	6,578	84.34%
Copper Country-ACT	4,716	5,371	87.80%
Dickinson - ACT	1,858	2,544	73.03%
Esanaba - ACT	4,020	4,981	80.71%
Gogebic - ACT	1,191	2,093	56.90%
Marquette - ACT	6,170	7,057	87.43%

Affiliate Name	FY2016			FY2015			FY2014		
	Totals	Medicaid-N	Medicaid-Y	Totals	Medicaid-N	Medicaid-Y	Totals	Medicaid-N	Medicaid-Y
	# clients								
Totals	220	11	209	233	27	206	229	17	212
Copper Country CMH	30	2	28	36	4	32	35	2	33
Gogebic CMH	36	1	35	32	4	28	30	0	30
Hiawatha	49	5	44	49	9	40	42	6	36
Northpointe	27	3	24	26	4	22	27	4	23
Pathways	78	0	78	90	6	84	96	5	91

Communities That Care

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), effective coalitions must have membership capacity to do the work, have a clear understanding of prevention planning, a common vision, high quality communication, targeted outcomes and solid relationships internally and externally. In addition, coalitions must work to engage the community sectors that are not typically sought out for prevention work. Sectors needed are; youth, parents, business, media, schools, youth-serving organizations, law enforcement, religious/fraternal organizations, civic/volunteer groups, healthcare professionals, state/local/tribal government agencies and other agencies with substance abuse

prevention/treatment experience.

In 2012, NorthCare Network received a SAMHSA/State of Michigan grant called Partnership for Success. A major component of this

funding was to build a coalition in Luce County which the state identified as underserved, using a coalition model called Communities That Care (CTC). This model includes all of the components of effective coalition work and training/technical assistance to help communities move through the work required for outcome based planning.

By the end of 2016, nine Upper Peninsula coalitions were using the CTC model and several more communities were looking to implement it. Each coalition collects local data, analyzes it, then through community partnerships built an action plan. This model works at the grassroots level. One thing is certain, this model needs dedicated volunteers to be successful.

Local FY16 CTC Information

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Coalition Spotlight

AC³ sounds like a chemical formula. But not to the residents of Alger County. AC³ is the Alger County Community Collaborative that just a few short years ago began using the Communities That Care coalition model to turn their collaborative into an action oriented group.

The coordinator describes CTC as a vehicle that is moving our coalition forward by guiding us through the data collection, decision making, and implementation process. AC³ has developed truly amazing partnerships with local organizations and businesses for youth and parents.

In mid-September, the partners really showed how dedicated to the community they are. AC³ held their first *All In The Barn* fundraiser. Set in the beautiful MSU barn in Alger County, the event included a farm-to-table meal, auction items, and music for dancing. It was a family friendly affair. Over 80 individuals and local businesses worked tirelessly to hold this event.

The coalition event was a huge success. Over 180 tickets were sold and drew people in from out of the area. Planning has already begun for the second *All In The Barn* event.



Communities That Care uses an evidence-based, prevention science process that reduces levels of youth problems including substance abuse, anxiety & depression, teen pregnancy, school dropout, delinquency & violence.