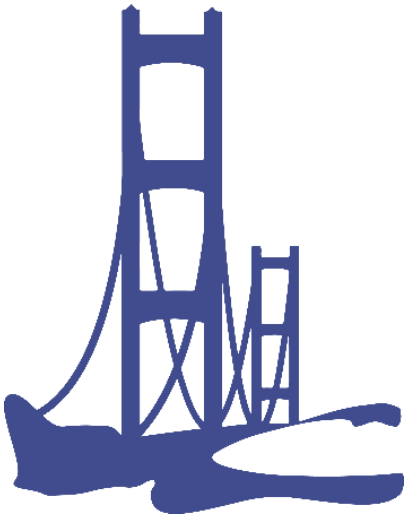
NorthCare Network

Demand and Capacity Report

FY19 Review and Analysis



June 1, 2020

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Introduction: NorthCare Network

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, or substance use services, and to provide services and support for persons with intellectual/developmental disabilities, 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. From the Healthy Michigan Amendment: In addition, CMS has approved an 1115 Demonstration project titled the Healthy Michigan Plan which provides health care coverage for adults who become eligible for Medicaid under section 1902(2) (10) (A)(i) (VIII) of the Social Security Act. Such arrangements have been designated as Concurrent 1915(b)/(c) Programs by CMS. In Michigan, the Concurrent 1915 (b)/(c) Programs and the Healthy Michigan Plan are managed on a shared risk basis by specialty Prepaid Inpatient Health Plans (PIHPs), selected through the Application for Participation (AFP) process. Further, under the approval of SAMHSA, 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 19 (October 1, 2018 through September 30, 2019)."*

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 the regions five affiliate Community Mental Health Service Programs (CMHSPs), also referred to as Community Mental Health agencies (CMH's). 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 adequate 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.

Approach

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 the 1915(b)/(c) Waiver Program Master Contract. Specialty services provided by the CMH's are directed toward the following priority populations: youth with Serious Emotional Disturbances (SED); adults 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 (SUD). In addition, NorthCare also provides screening and referral services for individuals to access SUD residential treatment. These providers are outside the CMH system.

To guarantee NorthCare's ability to serve the above individuals, there are two contract provisions regarding administrative personnel and the provider network.

- **Administrative Personnel:** The PIHP shall have adequate 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.
- **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 NorthCare's mission: *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.*

- 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 adequate administrative capabilities through internal and regional committees. Regional committees are composed of staff from the affiliate CMH's, interested consumers and stakeholders, with PIHP staff as the committee lead. The five affiliate CMH's share resources, experiences, and skills to drive performance improvement across the Region. The CMH's use a common electronic health record system and access screening center. They have consolidated certain other administrative functions such as: contracting with Gryphon, an after-hours telephone crisis response provider for all 15 counties for mental health and substance use disorder consumers, and a common software program, Great Plains, for financial management. Dial Help was previously used for crisis services for SUD providers. The Medicaid requirements are managed through contract, policy, and annual site reviews. 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 CMH's 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 and presentations as requested to the PMC. 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 consumers 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 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, and Regional Employment Leadership Team) are charged with ensuring 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. Other workgroups are developed as needed.

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. Face-to-face assessments are conducted locally at the respective affiliate CMHs. Inpatient continued-stay reviews are also conducted by NorthCare Network staff to ensure consistent application of ongoing eligibility standards as defined in the Michigan Medicaid Provider Manual.

Provider Network Management Committee ensures adequate provider capacity throughout the NorthCare Network to meet current and anticipated demands for provision of services. The committee monitors network capacity and establishes processes and practices for ensuring overall compliance of Network Providers. It 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); establishing best practices for efficient and effective management of network providers with a focus on common standards and reciprocity across providers.

Finance Committee is charged with making recommendations on regional best practices for responsible 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 Regional ELMER Management) 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 MDHHS, Health Services Advisory Group (HSAG), U.S. Department of Health and Human Services Office of Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS).

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.

Methodology

To determine the ability for NorthCare to meet the anticipated demand, NorthCare analyzes data, looks at current trends, examines U.S. Census data, and reviews the World Health Organization facts. Both Medicaid and Healthy MI consumers are considered in this reports data. Healthy MI is a version of Medicaid available to those who do not qualify for regular Medicaid but have enough financial need that they qualify for Healthy MI. MI Health Link, a combined Medicaid and Medicare program that is piloted in four areas of Michigan, will be denoted if the data is included. In addition to reviewing NorthCare data, such as the Mission-Based Performance Indicator System (MMBPIS), information is also received from the CMH's. The CMH's, comprised of:

- 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 the 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
- Waiting List
- Needs Assessment

These reports help inform NorthCare of the demand and capacity across the region. This information also provides a framework to guide future service delivery efforts within the Upper Peninsula. In FY19, the CMH's annual submission report needs assessment identified the following areas of need:

- Increased local inpatient psychiatric hospitalization options
- Additional local residential substance abuse options
- Further access to mental health services for adults and children, including early intervention
- Amplified access to outpatient psychiatric services
- Improved awareness of criteria requirements for CMHSP services
- Better awareness of the services provided by CMHSP's
- Expanded access to substance use providers
- Augmented knowledge and understanding of substance use disorders
- Enhanced school-based intervention and resources to address bullying and suicide in school aged children
- Intensified community-based services, including supported employment and volunteering
- Community resources for physical health care, especially doctors able to care for individuals with I/DD
- Facilitating a parent education and support group for parenting skills
- Development of a data-driven decision-making tool
- Maintaining a qualified workforce
- Transportation and secure housing supports

Anticipated Medicaid Enrollment

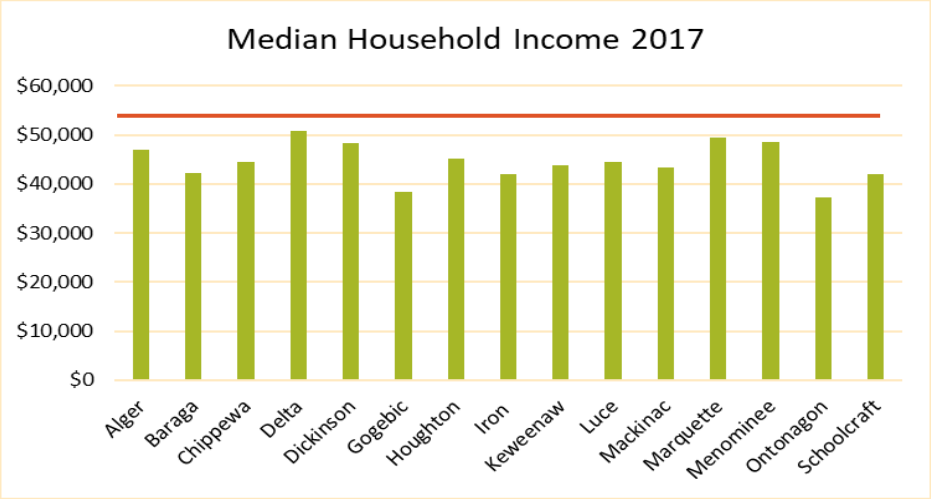
Medicaid/ Healthy Michigan

In 2019, the federal poverty income level for an individual was $12,490, a slight increase from $12,140 in 2018. The poverty income levels are used to determine Medicaid eligibility. Income below 138% of the federal poverty level would qualify an individual for Healthy MI insurance (First Quote Health).

While the 2017 median household income in the Upper Peninsula (UP) is significantly higher than the Federal Poverty Level, every UP county is below the Michigan statewide median household income of $54,840 (Kids Count).

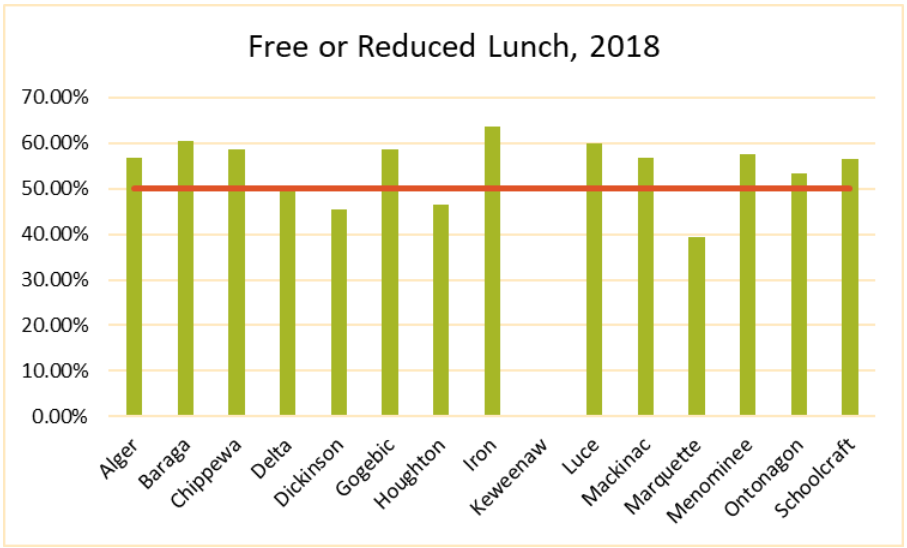
Federal Poverty Level 2019		
Household Size	100%	138%
1	$12,490	$17,236
2	$16,910	$23,336
3	$21,330	$29,435
4	$25,750	$35,535
5	$30,170	$41,635
*excluding Alaska and Hawaii		
**Source: First Quote Health		

Median Household Income 2017	
County	Amount
Michigan	$54,840
Alger	$46,991
Baraga	$42,180
Chippewa	$44,586
Delta	$50,802
Dickinson	$48,291
Gogebic	$38,343
Houghton	$45,127
Iron	$42,028
Keweenaw	$43,812
Luce	$44,479
Mackinac	$43,427
Marquette	$49,472
Menominee	$48,627
Ontonagon	$37,208
Schoolcraft	$41,973
*Source: Kids Count	



In 2018, 50% of Michigan children in the public-school system received free or reduced-price lunch (Kids Count). Free or reduced lunch is available to K-12 students from low-income families. Families below 130% of the federal poverty level are eligible for free lunch, and families with incomes between 130% and 185% of the federal poverty level are eligible for reduced-price lunch. Eleven of the 15 counties in the Upper Peninsula had over 50% of students receiving free/reduced lunch. Keweenaw County had no data available (Kids Count).

Free or Reduced Lunch, 2018		
Location	Number	Percent
Michigan	730,891	50
Alger	596	56.9
Baraga	584	60.6
Chippewa	2676	58.5
Delta	2708	50.6
Dickinson	1717	45.5
Gogebic	962	58.7
Houghton	2502	46.5
Iron	809	63.7
Keweenaw	0	*
Luce	359	59.9
Mackinac	775	56.8
Marquette	3249	39.5
Menominee	1579	57.6
Ontonagon	249	53.4
Schoolcraft	461	56.5
*Source: Kids Count		



The unemployment rate in Michigan has been declining from 2016 to 2018, with a rate of 4.10% in 2018 (Kids Count). However, the percent of Michigan residents in the labor force age 16+ is only 61.2% (U.S. Census), which is lower than the national average of 63%. Every UP county has less individuals in the labor force than the Michigan Average. Additionally, SAMHSA information from 2014 shows that among adults in the Michigan Public Mental Health System, the majority were considered to not be in the labor force. The U.S. Census defines *In the Labor Force* as consisting of people classified as employed or unemployed within certain criteria:

- Employed: meaning all civilians 16 years old and over who either (1) were "at work," that is, those who did any work at all during the reference week as paid employees, worked in their own business or profession, worked on their own farm, or worked 15 hours or more as unpaid workers on a family farm or in a family business; or (2) were "with a job but not at work," that is, those who did not work during the reference week but had jobs or businesses from which they were temporarily absent due to illness, bad weather, industrial dispute, vacation, or other personal reasons.
- Excluded from the employed are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are all institutionalized people and people on active duty in the United States Armed Forces (U.S. Census).

Individuals not considered as being *In the Labor Force* are excluded from the unemployment calculation. There are many reasons a person may not be in the labor force; including retired status, youth that are not of an age to work or who are students, homemakers, or those no longer seeking employment although they may be of a typical working age.

Unemployment In Michigan

	2016	2017	2018
Michigan	**4.90%**	**4.60%**	**4.10%**
Alger	8.00%	8.40%	7.80%
Baraga	7.90%	8.00%	6.10%
Chippewa	7.40%	7.80%	6.60%
Delta	6.30%	6.40%	5.30%
Dickinson	5.20%	4.90%	3.80%
Gogebic	6.50%	6.10%	5.10%
Houghton	5.90%	6.10%	5.10%
Iron	6.50%	6.50%	5.60%
Keweenaw	8.40%	8.70%	6.90%
Luce	6.50%	6.90%	6.20%
Mackinac	9.40%	10.20%	9.70%
Marquette	5.60%	5.70%	4.90%
Menominee	5.60%	5.00%	4.00%
Ontonagon	8.30%	9.10%	7.80%
Schoolcraft	9.10%	8.50%	7.10%

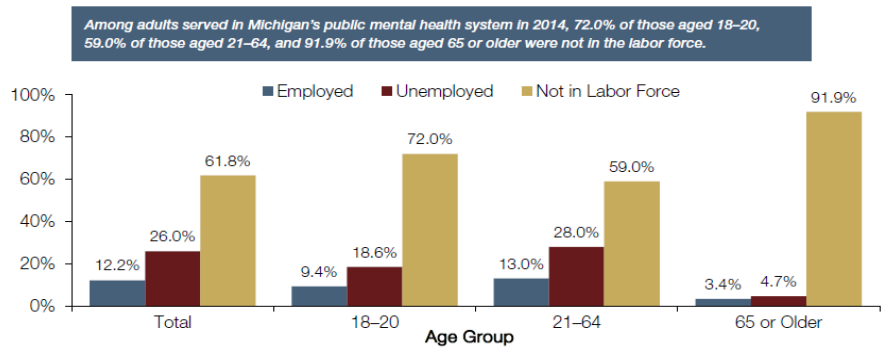
*Source: Kids Count

Percent of Individuals in the Labor Force

	% in labor force	% not in labor force
United States	**63.00**	**37.00**
Michigan	**61.20**	**38.80**
Alger	42.50	57.50
Baraga	36.60	63.40
Chippewa	51.70	48.30
Delta	56.60	43.40
Dickinson	55.80	44.20
Gogebic	47.40	52.60
Houghton	54.80	45.20
Iron	48.00	52.00
Keweenaw	50.00	50.00
Luce	42.70	57.30
Mackinac	54.80	45.20
Marquette	56.30	43.70
Menominee	58.00	42.00
Ontonagon	41.30	58.70
Schoolcraft	46.20	53.80

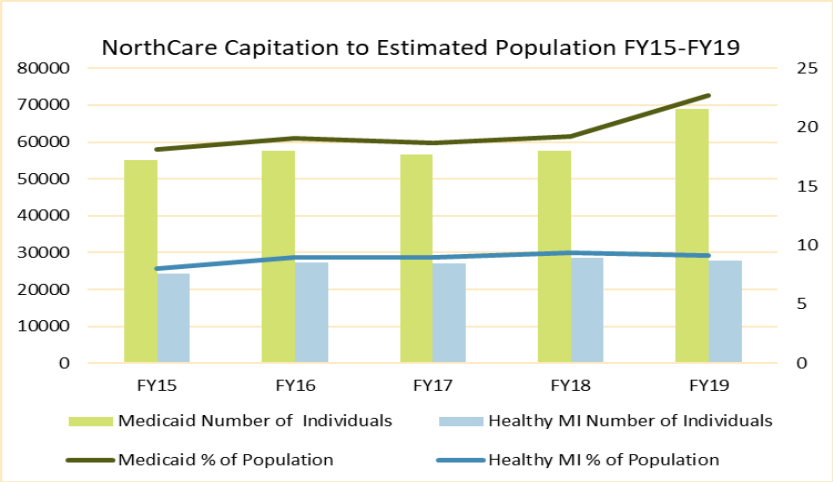
*Source: Census

Adult Mental Health Consumers Served in the Public Mental Health System in Michigan, by Age Group and Employment Status (2014)



Source: SAMHSA, Center for Mental Health Services, Uniform Reporting System, 2014.

All these factors, in addition to current Medicaid enrollment, help NorthCare anticipate future demand for services. The Median Income, Unemployment Rate, percent of kids receiving free or reduced-price lunch, and the percent of individuals in the labor force have remained consistent in the recent years. Similarly, the anticipated Medicaid and Healthy MI enrollment in the Upper Peninsula has been consistent over the past 5 years.



MI Health Link

In FY15, MI Health Link (MHL) was started as a pilot project in 4 of the 10 PIHP regions. This insurance program is for adults who have Medicare and Medicaid insurances. MHL combines the Medicare and Medicaid insurances so individuals have one insurance card. The goal of the program is to improve the quality of care for those individuals by having one plan and one card for primary health care, behavioral health care, home and community-based services, nursing home care and medications. Members have a care coordinator through Upper Peninsula Health Plan (UPHP), the Medicaid Health Plan in Region 1. The care coordinator helps to link and coordinate with providers serving the member, helps with scheduling appointments, arranges transportation, and assists in the development of the care plan. Members can enroll or disenroll at any time. Individuals who disenroll would revert to typical Medicare and Medicaid insurances. Monthly, newly eligible individuals are passively enrolled in the program by MDHHS.

Due to limited providers, individuals with MHL insurance that only have mild to moderate mental health symptoms are eligible for limited service provision though the CMH system. Services provided are based on medical necessity; and therefore, are less intense and less frequent than what would typically be provided for someone that was seriously mentally ill. Additionally, inpatient psychiatric care is managed by the PIHP for individuals with MHL insurance rather than Medicare.

The number of consumers enrolled in MHL changes month to month, as the program allows individuals to enroll and disenroll at any time. The table below shows the number of MHL enrollees and numbers served, per month, in FY19.

MI HEALTH LINK ENROLLMENT AND NUMBER SERVED												
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Enrollment	3,895	3,881	3,880	3,782	3,735	3,734	3,980	3,897	3,949	4,004	4,023	4,010
Total Served	1,088	1,116	1,104	1,092	1,106	1,087	1,117	1,108	1,130	1,137	1,167	1,197
NOTE: State conducted a passive enrollment in June 2019.												

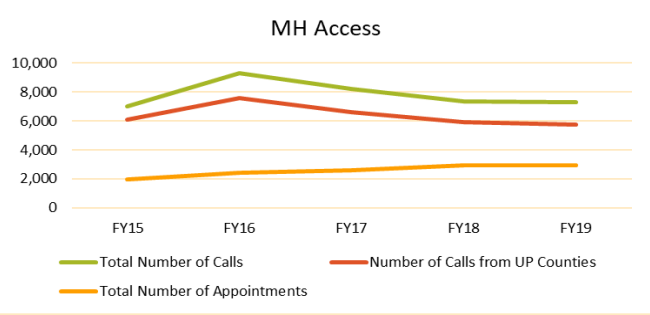
Risk Reserve

NorthCare manages a risk reserve in efforts to mitigate risks with affiliate CMH's within the region and as the entity solely responsible for Medicaid supports and services. The risk reserve is funded at approximately 92%. It has been used to cover deficits caused by the underfunding of the Healthy MI Internal Service Fund, which was fully utilized and still maintained a deficit. NorthCare monitors activity to identify cost overruns or surpluses and to ensure financial ability to serve eligible recipients.

Expected Utilization of Services

Mental Health Access of Services

In addition to the expected Medicaid enrollment, past utilization of services helps NorthCare plan for future utilization. Utilization is considered from first contact through discharge. Individuals may initiate CMHSP services in a variety of ways. The primary way to access services is by calling the centralized NorthCare Access Department for a mental health screening for services. This screening, which takes 20-30 minutes, gathers basic data about the presenting problem to help determine if an individual may be eligible for further assessment. In FY19 Access took a total of 7,270 calls, 5,742 of which were from the Upper Peninsula. Seven Hundred One of the calls were informational, such as a caller wondering about psychiatrists in the area, or crisis in nature. Callers that were in crisis were triaged to the CMH when possible. One Hundred Eighty-Five screenings were for individuals with MHL insurance. A total of 2,957 appointments were scheduled.



Mental Health Access Screenings			
Year	Total Number of Calls	Number of Calls from UP Counties	Total Number of Appointments
FY15	7,021	6,115	1,981
FY16	9,284	7,577	2,432
FY17	8,190	6,614	2,587
FY18	7,360	5,915	2,936
FY19	7,270	5,742	2,957

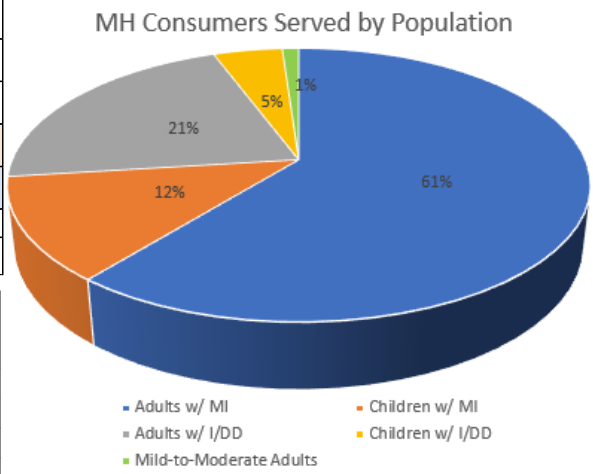
CMH Intake Data FY19					
	CMH	I/DD	SMI	SED	TOTAL
Number of people scheduled for assessment	Copper	39	235	84	358
	Gogebic	22	123	54	199
	Hiawatha	45	278	203	526
	Northpointe	61	450	213	724
	Pathways	100	678	371	1149
Number of people scheduled for assessment that did not show	Copper	0	33	6	39
	Gogebic	5	40	12	57
	Hiawatha	2	57	27	86
	Northpointe	2	119	23	144
	Pathways	2	4	9	15
Number of people who attended their assessment but did not meet criteria for CMHSP services	Copper	0	3	5	8
	Gogebic	0	1	1	2
	Hiawatha	5	22	8	35
	Northpointe	1	63	35	99
	Pathways	1	12	3	16
Number of people who attended their assessment and met criteria for CMHSP services	Copper	39	199	73	311
	Gogebic	12	75	36	123
	Hiawatha	38	199	168	405
	Northpointe	8	268	155	481
	Pathways	52	326	263	641
Number of people meeting criteria for CMHSP services placed on a waiting list for all services	Copper	2	19	1	22
	Gogebic	0	0	0	0
	Hiawatha	0	0	0	0
	Northpointe	0	0	0	0
	Pathways	0	0	0	0

*Source: PPG Data

Once approved by NorthCare Network Access Department, individuals are assessed face to face at the CMH to further determine eligibility for specialty mental health services. CMH's report, via the Annual Submission Report, the number of individuals found eligible for ongoing CMHSP services by eligibility category. Regionally, approximately 6% of individuals scheduled for an intake assessment did not meet criteria for ongoing CMHSP services.

Categorically, service provision is broken down by population type and by age. While each consumer is different and may have a different level of care or different services authorized, generally each person fits into an overall grouping. Individuals may be classified as adults with serious mental illness, children with serious emotional disturbance, adults with intellectual and/or developmental disability, and children with intellectual and/or developmental disability. Also, any of those categories may also be co-occurring with substance use disorders or have medical conditions that may factor into the illness. For those that have the MI Health Link insurance program, there is also the mild-to-moderate adult category. The following tables and charts show the utilization of each category in FY19. Northcare served more Adults with SMI, Adults with I/DD, and Children with I/DD in FY19, but less Children with SED. There was 1 more MHL Adult with Mild/Moderate services in FY19 than FY18.

Consumers Served by Age							
Population	Age 3 & Under	4-5 Years of Age	6-17 Years of Age	18-21 Years of Age	22-64 Years of Age	65+ Years of Age	Total Consumers
I/DD	22	40	250	144	974	155	1585
MI	41	75	1061	397	3288	226	5088
MMD	0	0	0	0	31	10	41
MH Totals	63	115	1311	541	4293	391	6714
SUD Totals	0	0	26	81	1535	3	1645
CMH Source: Diver / FY18 Service Model / Medicaid = Y / Service Rpeortable = Y / Population							
SUD: Source: SQL Query - Consumers with a NC SUD Encounter any time in the FY who were also Medicaid eligible any time during the FY							



Consumers Served by Population	Adults w/ MI	Children w/ MI	Adults w/ I/DD	Children w/ I/DD	Mild-to-Moderate Adults
Copper Country	559	112	196	42	10
Gogebic	272	74	98	30	0
Hiawatha	651	236	224	55	7
Northpointe	859	309	267	93	5
Pathways	1570	446	488	92	19
NorthCare (unduplicated)	3911	1177	1273	312	41
Diver / FY19 Service Model / Medicaid = 'Y' / Service Reportable = 'Y' / Population (group by broad level) / AffiliateName					
(MMD defined as consumer who had a Level of Care of Mild to Moderate at the end of the Fiscal Year, had Medicaid any time during the fiscal year, and had a reportable service any time during the fiscal year					

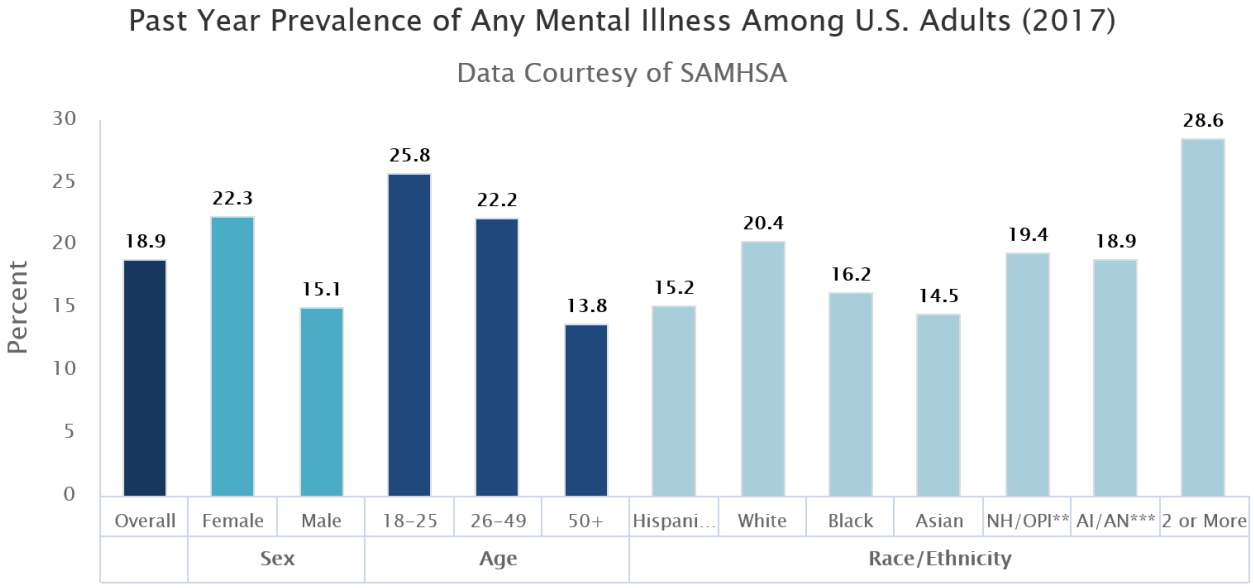
In addition to the individuals served above, CMH's also manage a waiting list for non-Medicaid consumers. CMH's provide information regarding the number of consumers on waiting lists in the annual submission report. While Medicaid consumers cannot be placed on waiting lists, non-Medicaid individuals who qualify for services can be placed on waiting lists. Copper Country had a waiting list for all services and Pathways had a waiting list for specific residential living services, highlighting that demand exceeds capacity for certain services in certain areas.

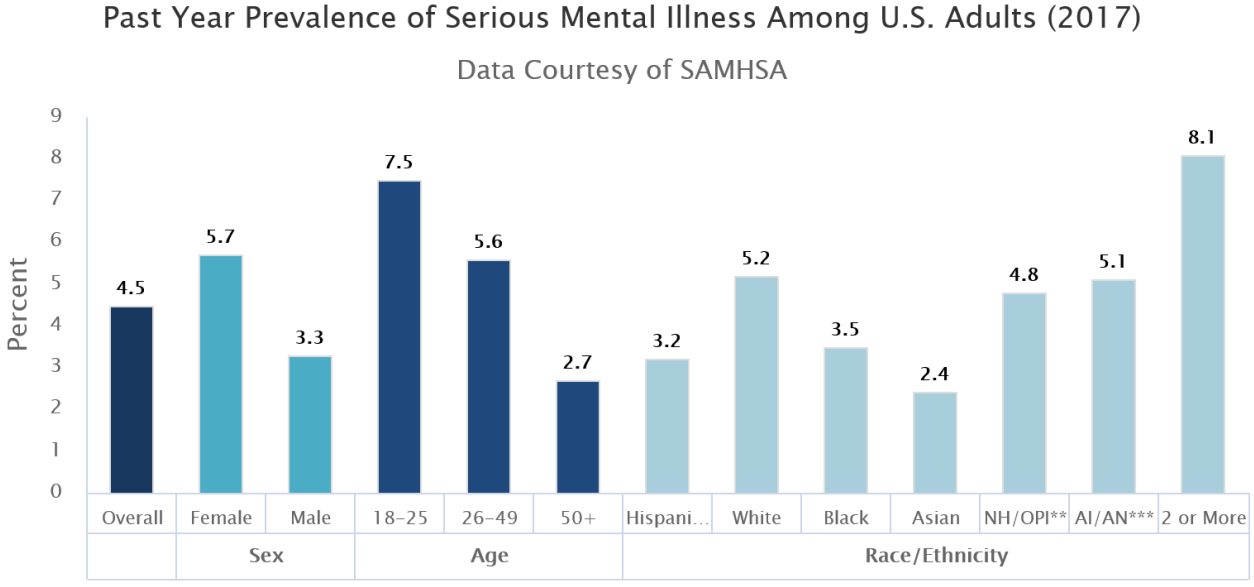
For consumers entering services, CMH's are held to Performance Indicator timeliness standards. The standard to ensure a face to face assessment within 14 days of request for service was met at 100% across all CMH's, all quarters, all populations, in FY19. The standard to ensure the start of ongoing services within 14 days of the assessment was met within the standard of 95% in all but 2 instances (denoted in red).

Start of ongoing service w/in 14 days of non-emergent face-to-face assessment w/a professional																								
State Standard is 95%.																								
	Quarter 1						Quarter 2						Quarter 3						Quarter 4					
FY19	NC	CC	GO	HBH	NP	PW	NC	CC	GO	HBH	NP	PW	NC	CC	GO	HBH	NP	PW	NC	CC	GO	HBH	NP	PW
MI - Children																								
# New Starting FTF Srv	135	14	12	22	38	49	133	5	9	29	29	61	146	19	7	28	34	58	96	6	4	29	24	33
# New Exceptions	24	1	1	5	6	11	30	2	3	10	6	9	32	5	0	9	6	12	26	2	1	10	6	7
# Starting Srv w/in 14 days	109	13	11	17	31	37	103	3	6	19	23	52	112	14	7	19	27	45	69	4	3	19	17	26
% Starting srv w/in 14 days	98%	100%	100%	100%	97%	97%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	96%	98%	99%	100%	100%	100%	94%	100%
MI - Adult																								
# New Starting FTF Srv	229	35	17	37	53	87	195	30	21	36	34	74	177	34	8	25	46	64	226	33	15	32	54	92
# New Exceptions	53	10	2	12	11	18	54	15	3	6	12	18	31	5	1	3	15	7	48	17	3	6	9	13
# Starting Srv w/in 14 days	174	25	15	25	41	68	139	15	17	29	22	56	145	28	7	22	31	57	176	16	12	26	44	78
% Starting srv w/in 14 days	99%	100%	100%	100%	98%	99%	99%	100%	94%	97%	100%	100%	99%	97%	100%	100%	100%	100%	99%	100%	100%	100%	98%	99%
DD - Children																								
# New Starting FTF Srv	13	0	2	4	4	3	9	0	3	0	3	3	17	0	1	3	5	8	16	0	2	1	7	6
# New Exceptions	6	0	1	2	2	1	2	0	0	0	1	1	5	0	0	1	3	1	7	0	1	0	4	2
# Starting Srv w/in 14 days	7	0	1	2	2	2	7	0	3	0	2	2	12	0	1	2	2	7	9	0	1	1	3	4
% Starting srv w/in 14 days	100%	#DIV/0!	100%	100%	100%	100%	100%	#DIV/0!	100%	#DIV/0!	100%	100%	100%	#DIV/0!	100%	100%	100%	100%	100%	#DIV/0!	100%	100%	100%	100%
DD - Adult																								
# New Starting FTF Srv	14	1	1	5	1	6	20	3	0	4	5	8	24	3	1	2	9	9	19	3	1	3	4	8
# New Exceptions	3	0	0	1	0	2	5	1	0	0	3	1	4	0	0	0	4	0	4	1	0	1	2	0
# Starting Srv w/in 14 days	11	1	1	4	1	4	15	2	0	4	2	7	20	3	1	2	5	9	15	2	1	2	2	8
% Starting srv w/in 14 days	100%	100%	100%	100%	100%	100%	100%	100%	#DIV/0!	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Prevalence

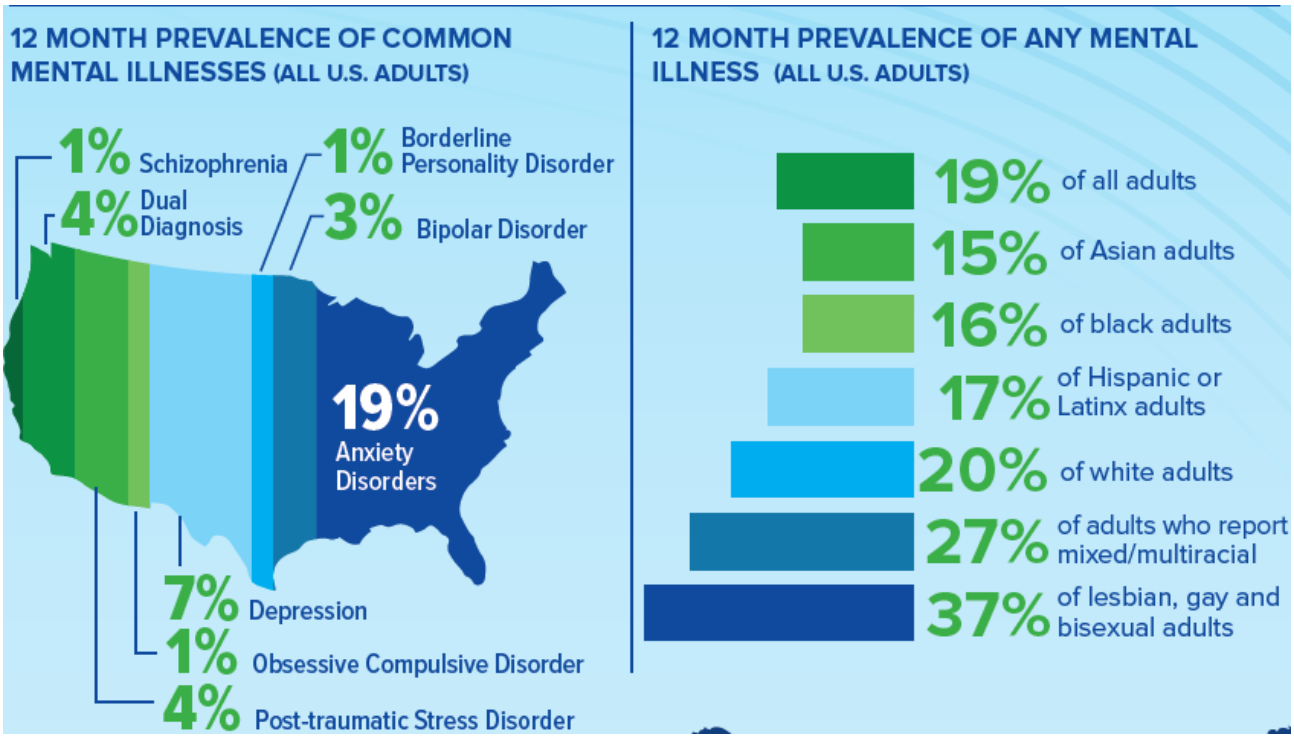
According to the National Institute of Mental Health (NIMH) and SAMHSA data, nearly 1 in 5 adults live with a mental illness (2017). To be considered in this data, the diagnosis was current or made within the past year and met the Diagnostic and Statistical Manual (DSM) criteria. Data was broken into two categories; Any mental illness, including mild, moderate, or severe, and Serious Mental Illness (SMI) defined as serious functional impairment interfering or limiting one or more major life activities. According to the data in 2017, 18.9% of adults in the United States had any mental illness. Four and a half percent of United States adults had a serious mental illness.



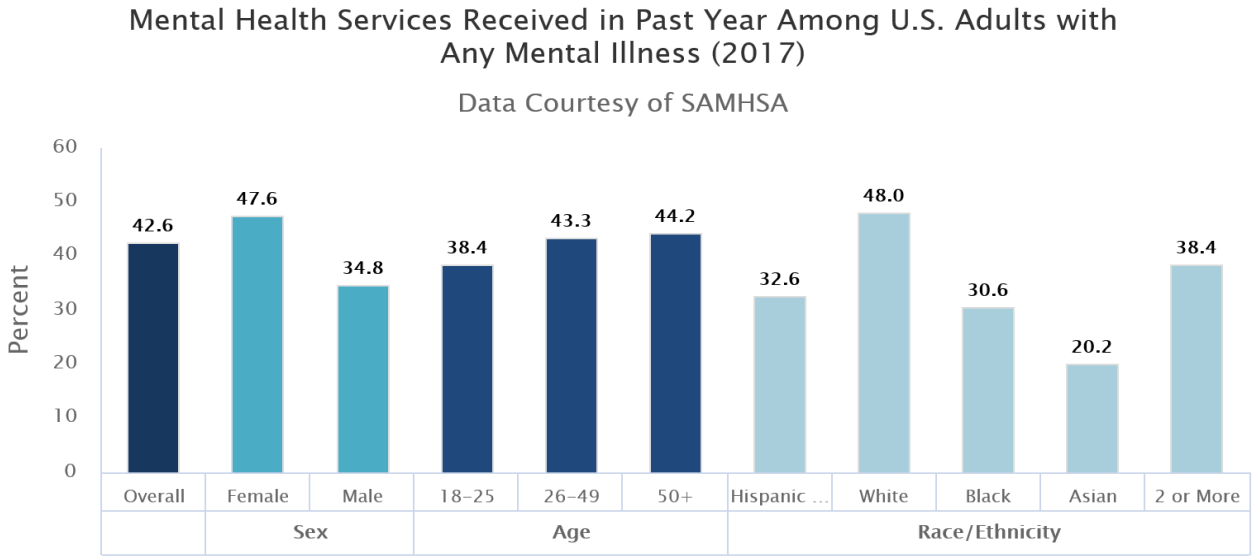


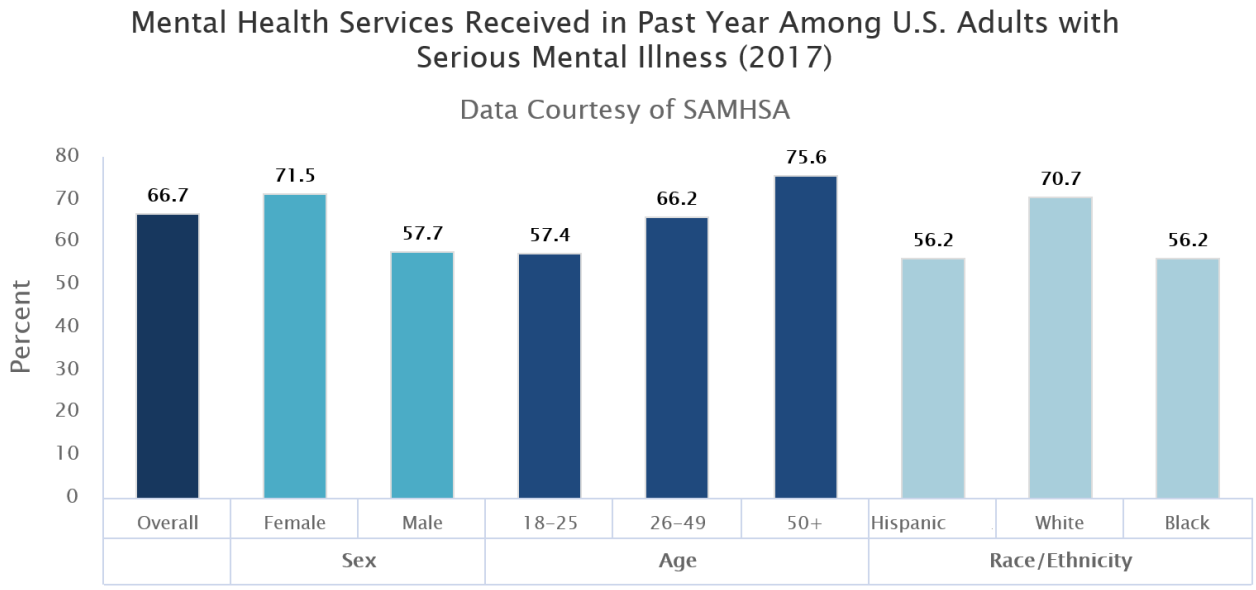
In both categories' females had a higher prevalence of mental illness than males, and young adults (age 18-25) had a higher prevalence of mental illness than older adults (NIMH). The most common category of mental illness in adults is anxiety disorders according to the National Alliance on Mental Illness (NAMI), although depression is the leading

cause of disability worldwide (WHO). Globally, depression and anxiety disorders cost $1 trillion dollars each year in lost productivity (NAMI). Prevalence also increases for in multiracial groups and for those that are LGBTQ (NAMI). NAMI reports higher prevalence rates of mental illness in the United States (40%) than SAMHSA.



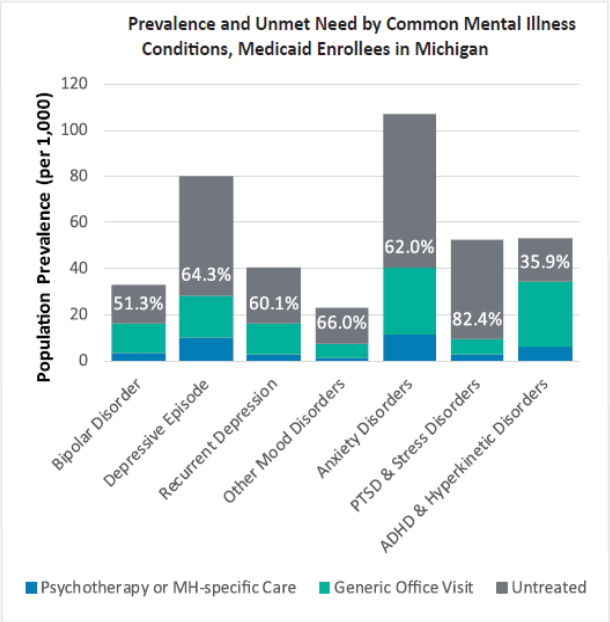
Treatment rates, however, do not correspond with prevalence rates. Young adults with SMI received treatment at a lower rate than older SMI adults (NIMH). NAMI reports that, on average, there is an 11-year delay between symptom onset and treatment. This delay could result in job loss, legal issues, homelessness, or other biopsychosocial concerns for individuals. NAMI's data highlights the importance of reducing stigma, informing the community about services, and reducing barriers to treatment. Rates of receiving treatment are shown in the following two graphs.





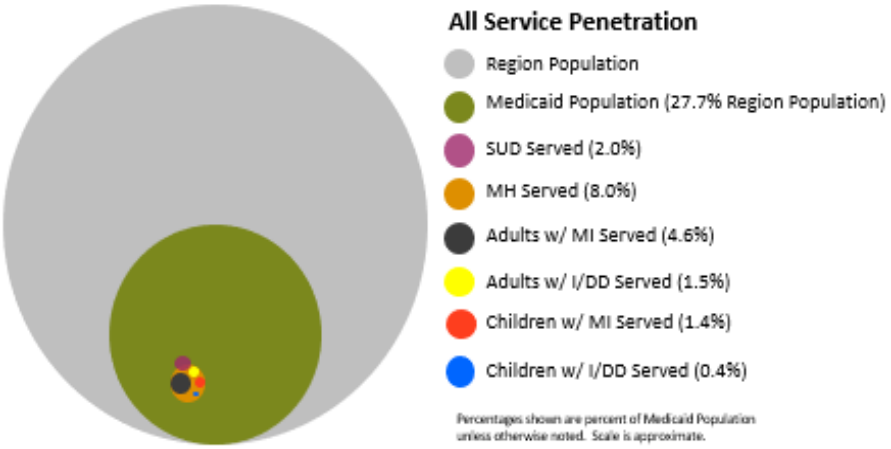
Data from the National Comorbidity Survey for adolescents estimated that 49.5% of youth age 13-18 had any mental disorder and 22.2% had a severe impairment. Similarly, NAMI estimates 17% of youth age 6-17 had a mental health disorder. This data points to the increased need for services for youth, and the likelihood that the demand for services will be increasing for the duration of this and the future generation (NIMH).

Specific to Medicaid individuals in Michigan, anxiety disorders are the most commonly treated, yet more than 60% of Medicaid enrollees with anxiety weren't treated (Altarum, 2019).



According to the U.S. Census data, there are 303,802 individuals living in the UP. NorthCare served 2.8% of the regional population of the Upper Peninsula during FY19. The Venn Diagram below shows all service penetration for the region in FY19.

Some services such as mobile intensive crisis stabilization for children and veteran services involve populations or programs of interest that may impact future demand for services and therefore are further discussed below.



Inpatient / Crisis Services

According to NAMI, 1 in 8 Emergency Room (ER) visits are related to mental health and substance use disorders. NorthCare must ensure access to crisis services for all citizens of the Upper Peninsula in accordance with the regulations outlined in the Michigan Mental Health Code. Crisis intervention services are available in each county for all individuals in that county. Screening for inpatient psychiatric hospitalization services are available for Medicaid consumers through CMH emergency services staff in each county. Admission into the psychiatric unit for Medicaid consumers is authorized by the Emergency Services (ES) staff for 24 hours. Following admission, NorthCare Utilization Management completes continuing stay reviews for verification of additional authorization. Reviews are completed for all primary Medicaid (including Healthy MI) and MI Health Link consumers.

The 2018 Michigan Certificate of Need reports the number of licensed psychiatric beds by region and lists bed days and patient days. This data is for all patients and is not restricted to patients under NorthCare's purview. It is important to note that while Upper Peninsula Health Systems- Marquette (UPHS-M) was licensed for 37 beds in 2018, low staffing did not allow for full capacity. UPHS-M has designated youth psychiatric beds, but due to not having a child psychiatrist on staff, no youth have been hospitalized there since 2016.

2018 Michigan Certificate of Need Survey Psychiatric Unit Bed Information

Hospital	Number of Licensed Beds	Number of Bed Days	Total Patient Care Days	Average Daily Census	Occupancy Rate	Average Length of Stay Days
War Memorial	20	7,300	4,548	12.5	62.30%	7.3
UPHS- Marquette	37	13,505	6,191	17	45.80%	9.9

*Source: MDHHS CON Study

The Certificate of Need report also indicates the reason for utilization of Emergency Services at acute care hospitals. For the Upper Peninsula, 6.13% of emergency services at acute care hospitals are for psychiatric reasons; which is 1.54% higher than the state average of 4.59%. Helen Newbery Joy has a statistically significant higher rate of ER use for psychiatric reasons than the other ER's in the UP. This ER utilization for psychiatric need points to the need for increased outpatient psychiatric services in the UP as well as the utilization of CMH Emergency Services staff.

2018 Michigan Certificate of Need Emergency Services Acute Care Hospital

ER	Trauma	Cardiac	Obstertic	**Psychiatric**	Asthma	Allergy	COPD	URI	Diabetes	Stroke	**All ED Visits**	**Percent Psychiatric, %**
Munising Memorial	6	107	11	**140**	75	87	65	89	45	9	1,998	**7.01**
Baraga Co. Memorial	40	340	35	**437**	101	14	240	164	319	19	3,326	**13.14**
Chippewa Co. Memorial	47	71	47	**131**	136	54	58	59	123	36	16,115	**0.81**
St. Francis OSF	0	2,004	251	**1,258**	1,063	772	1,008	561	1,210	143	16,945	**7.42**
Dickinson Co. HealthCare	87	474	367	**357**	78	279	155	294	80	98	15,654	**2.28**
Aspirus Ironwood	2,280	329	7	**271**	239	247	169	639	79	55	11,412	**2.37**
Portage Hospital	24	111	24	**259**	56	72	112	23	59	24	9,618	**2.69**
Aspirus Keweenaw	1,574	180	16	**208**	163	141	108	309	41	68	6,804	**3.06**
Aspirus Iron River	1,611	160	5	**146**	203	202	157	548	81	45	7,610	**1.92**
Helen Newberry Joy	997	172	38	**1,559**	28	26	14	139	35	19	4,280	**36.43**
Mackinac Straits	0	1,029	0	**838**	715	259	623	208	624	69	5,790	**14.47**
UPHS - Marquette	777	2,502	329	**4,104**	782	724	776	1,015	1,199	222	24,976	**16.43**
UPHS - Bell	0	158	179	**162**	202	242	182	425	42	30	8,739	**1.85**
Aspirus Ontonagon	531	91	0	**46**	63	45	48	65	28	31	2,522	**1.82**
Schoolcraft Memorial	1,017	158	52	**101**	102	119	115	156	27	21	4,812	**2.10**
Upper Peninsula Total	**8,991**	**7,886**	**1,361**	**8,617**	**4,006**	**3,283**	**3,830**	**4,694**	**3,992**	**889**	**140,601**	**6.13**
State Total	**81,802**	**190,742**	**135,119**	**212,108**	**169,833**	**127,768**	**101,616**	**205,398**	**124,539**	**33,549**	**4,618,897**	**4.59**

* Source: MDHHS CON Study

Crisis intervention notes are used for consumers who are in crisis but are not interested in, nor needing, hospitalization. There were 3513 Crisis Intervention Encounters in FY19. The ER (1611) and CMH office (1588) were the most common locations for this service. Individuals with Medicaid accounted for 1534 of the crisis intervention notes completed, Healthy MI for 962, General Fund for 838, and MI Health Link for 179. There were 2202 distinct consumers who received a crisis intervention in FY19. A total of 107 (86 distinct) co-occurring consumers had a crisis intervention note. There was a total of 13271 units of service provided across the region for crisis intervention in FY19.

The table shows the number of crisis intervention notes per CMH and the units used toward this service. It also reflects the distinct number of consumers, however as a consumer may have moved during the fiscal year the total of all the CMH's added together is higher than the total of the region. The total of the region is reflected.

Crisis Intervention Notes FY19

	Total CIN	Distinct Count CIN	Total Units
Copper Country	235	174	1341
Gogebic	244	172	890
Hiawatha	564	378	2056
Northpointe	840	559	3781
Pathways	1630	955	5203
Total	3513	2202	13271

*Source: SAL Download Report

Preadmission screenings are completed with those individuals who want, or may need, to be hospitalized on a psychiatric unit. In FY19 there were 1594 Preadmission Screenings for inpatient psychiatric hospitalization completed. This is an increase of 201 screenings from FY 18 (1393). Most of these screenings were completed in the ER, although some were completed in the medical unit of the hospital, the jail, or the CMH office. There were 58 screenings completed administratively; meaning that regional CMH staff did not see the consumer, rather CMH or hospital staff from out of the area completed the screenings and called the information in to the CMH. Most individuals screened had Medicaid (680) or Healthy MI Insurance (557). There were 249 screenings completed that fell to general fund. Individuals with MI Health Link insurance accounted for 107 screenings. There were 1065 distinct consumers who received a preadmission screening in FY19.

Not everyone who has a preadmission screening requires hospitalization. Consumers who are willing and able to safety plan to an alternative level of care are diverted from hospitalization. Others may receive multiple screenings prior to admission, due to lack of placement options. Typically, if an individual resides in the ER longer than 24 hours another screening will be completed to verify that inpatient level of care is still necessary. In FY19, 1137 screenings were found to meet criteria for admission, an admission rate of 71.33%.

FY19 Diversion Report of Preadmission Screenings

Affiliate	Disposition	Screens with this Disposition	Total Screens by Affiliate	% this Disposition
Copper Country	*Diversion	34	118	28.81%
	Hospital Admission	84		71.19%
Gogebic	*Diversion	34	112	30.36%
	Hospital Admission	78		69.64%
Hiawatha	*Diversion	87	273	31.87%
	Hospital Admission	186		68.13%
Northpointe	*Diversion	99	392	25.26%
	Hospital Admission	293		74.74%
Pathways	*Diversion	203	699	29.04%
	Hospital Admission	496		70.96%
Total	*Diversion	457	1594	28.67%
	Hospital Admission	1137		71.33%

*Diversion includes Crisis Residential **Source: ELMER Reporting Services

There were 787 distinct consumers hospitalized across 26 hospitals. Upper Peninsula Health Systems-Marquette, War Memorial, and Willow Creek Behavioral Health were the primary hospitals utilized. There were 60 preadmission screenings where the disposition was Crisis Residential in FY19.

Distinct Count of Hospitalizations FY19

Hospital Admissions FY19	Encounters
BCA Stonecrest Center	9
Bellin	15
Cedar Creek Hospital	13
Forest View	14
Harbor Oaks Hospital	10
Healthsource Saginaw (White Pine)	12
Pine Rest Christian	38
St. Mary's Hospital	35
UP Health System Marquette	303
War Memorial Hospital	158
Willow Creek Behavioral Health	152
Other Facilities	28
Total Admissions	787

Source: SQL query of Electronic Health Record Data 01

Medicaid Eligiblity was Medicaid, HMP, MHL, or MIChild at encounter

Facilties with < 5 encounters included under "Other Facilites"

Admission to State-Operated Psychiatric Hospitals excluded

In the following table, each hospital is evaluated for its average length of stay. The count of admissions is duplicated but restricted to admissions of which Medicaid is the primary payor (Medicaid, Healthy MI, MHL). Admission length of time is an important variable when determining utilization. The average length of stay is slightly longer for children (8.54 days) than adults (7.82 days). All children's admissions are out of the area, as there are no inpatient psychiatric beds for children in the UP. Also, hospitals schedule family sessions prior to discharging children to assess the interactions between the child and their family members. Both factors may contribute to the longer length of stay. There were also 4 consumers in FY19 that reported with an I/DD diagnosis while needing psychiatric hospital care.

	Hospital Total Units and Average Length of Stay FY19	Total Count of MCO ID	Sum of Total Units	Average Length of Stay
DDA	UP Health System Marquette	2	14	7.00
DDA Total		**2**	**14**	**7.00**
DDC	BCA Stonecrest Center	1	1	1.00
	University of Michigan	1	78	78.00
DDC Total		**2**	**79**	**39.50**
MIA	Alpena Regional Medical Center	1	4	4.00
	Bay Regional Medical Center dba McLaren Bay Region	3	48	16.00
	BCA Stonecrest Center	5	67	13.40
	Bellin	12	99	8.25
	Cedar Creek Hospital	3	26	8.67
	Doctors Behavioral Hospital LLC dba Doctors Neuropsychiatric	1	14	14.00
	Edward W Sparrow Hospital	1	9	9.00
	Forest View	9	113	12.56
	Harbor Oaks Hospital	5	50	10.00
	Havenwyck Hospital	1	11	11.00
	Healthsource Saginaw (White Pine)	8	92	11.50
	Hurley Medical Center	1	10	10.00
	Lakeland Hospital	2	16	8.00
	Lighthouse Behavioral Health Hospital	1	5	5.00
	Memorial Medical Center	3	17	5.67
	Mercy Health Muskegon	2	10	5.00
	MidMichigan Medical Center - Gratiot	1	14	14.00
	MidMichigan Regional Medical Center	2	6	3.00
	Munson Medical Center	1	9	9.00
	NeuroBehavioral Hospital of Northwest Indiana/Greater Chicago	2	15	7.50
	Pine Rest Christian	31	311	10.03
	RiverCrest Speciality Hospital	2	22	11.00
	St. Mary's Health Care	1	10	10.00
	St. Mary's Hospital	45	265	5.89
	University of Michigan	3	22	7.33
	UP Health System Marquette	348	2783	8.00
	War Memorial Hospital	178	1254	7.04
	Western Mental Health Institute	1	11	11.00
	Willow Creek Behavioral Health	154	1151	7.47
MIA Total		**827**	**6464**	**7.82**
MIC	BCA Stonecrest Center	3	33	11.00
	Bellin	7	41	5.86
	Cedar Creek Hospital	10	89	8.90
	Essentia Health	2	12	6.00
	Forest View	5	49	9.80
	Harbor Oaks Hospital	6	61	10.17
	Havenwyck Hospital	2	12	6.00
	Healthsource Saginaw (White Pine)	3	23	7.67
	Pine Rest Christian	8	94	11.75
	Willow Creek Behavioral Health	24	187	7.79
	Winnebago Mental Health Institute	1	5	5.00
MIC Total		**71**	**606**	**8.54**
Grand Total		**902**	**7163**	**7.94**

Two other performance indicator reports reviewed related to crisis/inpatient services include the 7-day follow up and recidivism reports. The 7-day follow up report indicates the number of consumers admitted to the inpatient psychiatric unit who are seen for follow up care within 7 days. This report excludes consumers who are not following up with the CMH. The region met the state standard of 95% all year for this measure. The Recidivism report indicates the number of consumers who are readmitted to an inpatient psychiatric unit within 30 days of discharge from a previous inpatient psychiatric admission. Each report is delineated between children and adults. If there are two quarters in a row out of compliance a corrective action plan is required. This was not the case in FY19.

The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within 7 days																								
State Standard is 95%.																								
	Quarter 1						Quarter 2						Quarter 3						Quarter 4					
FY19	**NC**	**CC**	**GO**	**HBH**	**NP**	**PW**	**NC**	**CC**	**GO**	**HBH**	**NP**	**PW**	**NC**	**CC**	**GO**	**HBH**	**NP**	**PW**	**NC**	**CC**	**GO**	**HBH**	**NP**	**PW**
Children - MH/DD																								
# Discharges	24	2	1	3	3	15	15	0	0	2	5	8	8	1	1	1	0	5	12	0	0	3	5	4
# D/C Exceptions	4	0	1	1	1	1	1	0	0	0	1	0	2	0	0	1	0	1	1	0	0	0	0	1
# D/C F/U w/in 7 days	20	2	0	2	2	14	14	0	0	2	4	8	6	1	1	0	0	4	11	0	0	3	5	3
% Seen w/in 7days	100%	100%	#DIV/0!	100%	100%	100%	100%	#DIV/0!	#DIV/0!	100%	100%	100%	100%	100%	100%	#DIV/0!	#DIV/0!	100%	100%	#DIV/0!	#DIV/0!	100%	100%	100%
Adults - MH/DD																								
# Discharges	99	14	3	22	23	37	101	9	13	17	25	37	107	12	1	9	37	48	106	13	3	19	28	43
# D/C Exceptions	16	3	0	1	6	6	18	1	3	4	3	7	26	5	0	2	5	14	16	2	0	2	6	6
# D/C F/U w/in 7 days	83	11	3	21	17	31	83	8	10	13	22	30	80	7	1	7	32	33	90	11	3	17	22	37
% Seen w/in 7days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%

The percent of children and adults readmitted to an inpatient psychiatric unit w/in 30 days of discharge																								
Standard is 15% or less w/in 30 days																								
FY19	Quarter 1						Quarter 2						Quarter 3						Quarter 4					
	NC	**CC**	**GO**	**HBH**	**NP**	**PW**	**NC**	**CC**	**GO**	**HBH**	**NP**	**PW**	**NC**	**CC**	**GO**	**HBH**	**NP**	**PW**	**NC**	**CC**	**GO**	**HBH**	**NP**	**PW**
Children																								
# of Discharges	24	2	1	3	3	15	16	0	0	2	5	9	8	1	1	1	0	5	12	0	0	2	5	5
# of D/C Exceptions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
# readmitted w/in 30days	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
% readmitted w/in 30days	4%	0%	0%	0%	33%	0%	0%	#DIV/0!	#DIV/0!	0%	0%	0%	0%	0%	0%	0%	#DIV/0!	0%	8%	#DIV/0!	#DIV/0!	0%	20%	0%
Adults																								
# of Discharges	99	14	3	22	23	37	102	9	13	17	26	37	105	10	1	10	36	48	105	11	3	18	29	44
# of D/C Exceptions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
# readmitted w/in 30days	10	1	0	3	2	4	14	2	3	2	3	4	10	1	0	3	5	1	10	0	0	1	3	6
% readmitted w/in 30days	10%	7%	0%	14%	9%	11%	14%	22%	23%	12%	12%	11%	10%	10%	0%	30%	14%	2%	10%	0%	0%	6%	10%	14%

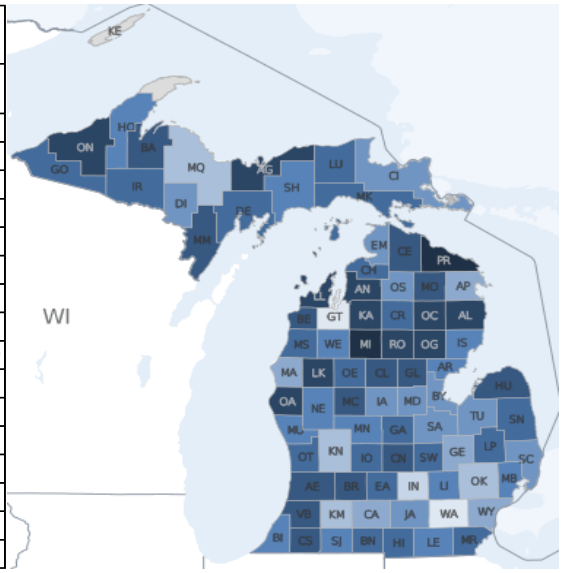
Mental Health and Psychiatric Outpatient Services

Some services are lacking across the state. A ratio of 47 child psychiatrists to 100,000 population is considered adequate. Michigan has 11 per 100,000 (Altarum). Other services are especially lacking in the Upper Peninsula. Ontonagon County only has 2 mental health professionals listed according to the 2019 County Health Rankings, which uses data from 2018. Alger County is also seriously lacking mental health providers and Keweenaw County is not calculated due to low numbers. The darker the blue on the map below indicates the greater number of individuals per mental health provider in that county, with specific numbers highlighted in the table. The UP is also lacking in dental and primary care provider services.

The Michigan state average ratio of individuals to mental health providers is 400:1; dentists 1,360:1; primary care providers 1,260:1. Only a few UP counties are exceeding the MI average for any of the services. Twelve of the 15 UP counties are understaffed for mental health providers, 14 are understaffed for dentists, and 7 are understaffed for primary care doctors. Ontonagon county is significantly lacking primary care doctors; with a ratio of 5,910 individuals per primary care provider. This is the total population of Ontonagon County for 1 provider. Only Marquette County has an adequate ratio of individuals to providers across the three provider types.

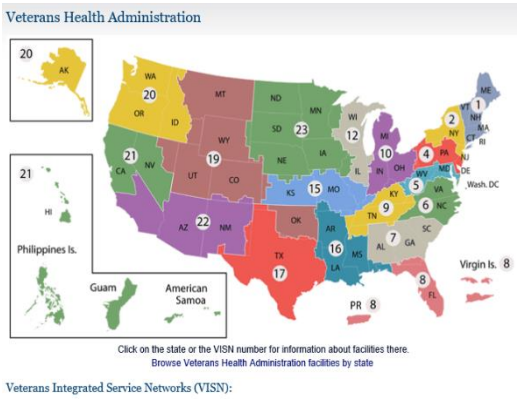
	Ratio of Individuals to Mental Health Providers		Ratio of Individuals to Dentists		Ratio of Individuals to Primary Care Providers	
County	Number of Providers	Ratio	Number of Providers	Ratio	Number of Providers	Ratio
Alger	6	1,520:1	4	2,280:1	6	1,540:1
Baraga	9	940: 1	5	1,690:1	9	940:1
Chippewa	94	400:1	25	1,510:1	24	1,570:1
Delta	58	620:1	25	1,440:1	25	1,440:1
Dickinson	56	450:1	25	1,020:1	25	1,020:1
Gogebic	25	610:1	7	2,190:1	15	1,020:1
Houghton	66	550:1	23	1,580:1	25	1,460:1
Iron	15	740:1	5	2,220:1	8	1,400:1
Keweenaw	*	*	0	2,110:0	*	*
Luce	9	710:1	3	2,120:1	8	790:1
Mackinac	15	710:1	9	1,190:1	10	1,080:1
Marquette	214	310:1	56	1,190:1	71	940:1
Menominee	23	1,000:1	14	1,650:1	9	2,590:1
Ontonagon	2	2,940:1	3	1,960:1	1	5,910:1
Schoolcraft	17	470:1	4	2,010:1	7	1,140:1

*Source: County Health Rankings. Mental Health Data from 2018, Dentist data from 2017, Primary Health data from 2016



Veteran Services

The Upper Peninsula is part of the Veteran Health Administration's Region 12 Veteran Integrated Service Network (VISN), which is connected to WI and part of Illinois. This means that VA-eligible veterans in the UP are "in network" when they receive inpatient/residential mental health and substance use disorder services in WI. These services and facilities do not currently exist within the UP. Fortunately, VA hospital staff can also refer veterans downstate if there are hospital beds there.



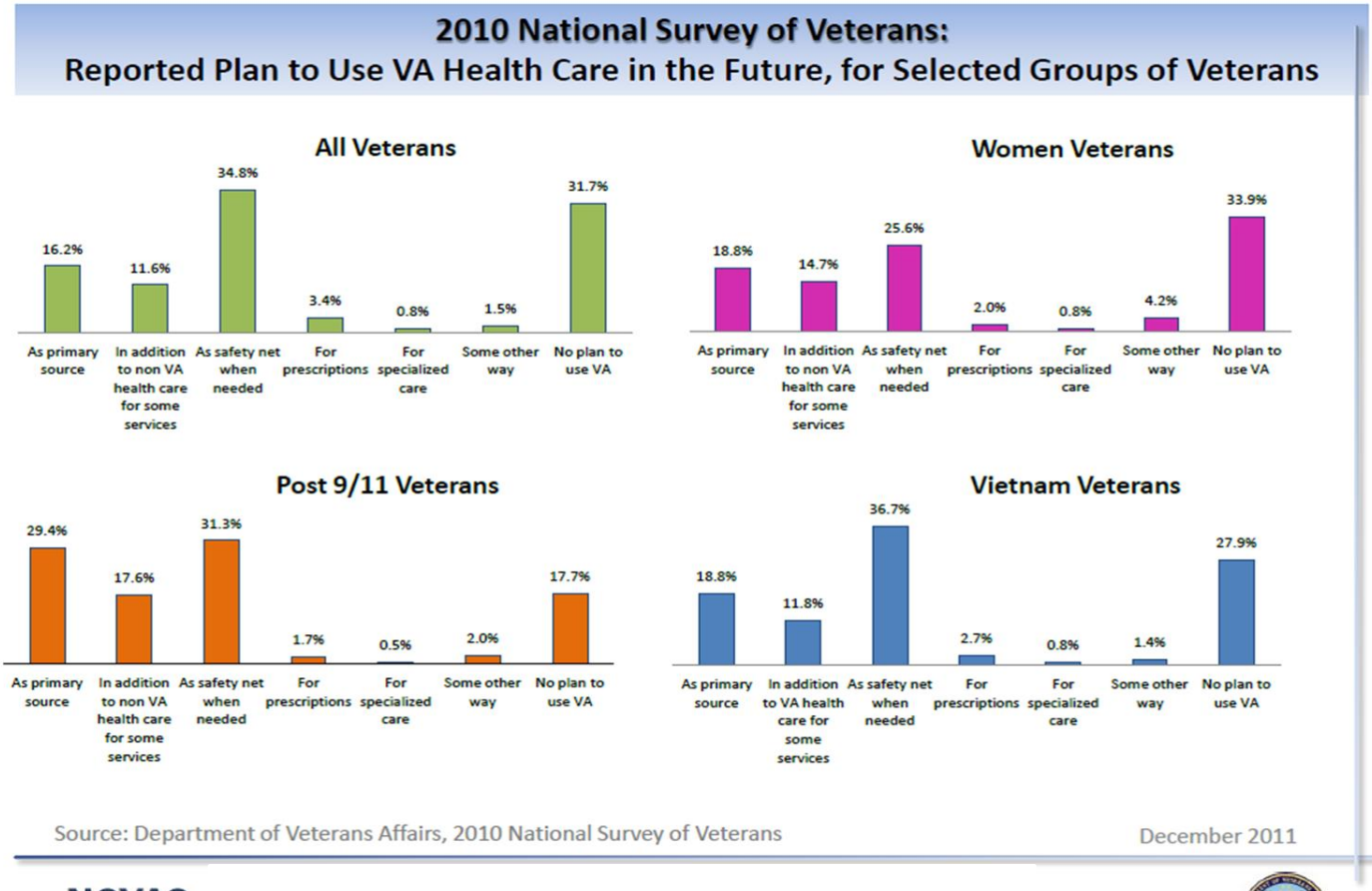
As the VA typically only pays for inpatient psychiatric care in their own facilities, Veterans either have a great distance to travel to receive inpatient psychiatric care, or, if hospitalized locally, Medicaid dollars are used for the inpatient stay if the veteran also has Medicaid.

In a 2010 study (below) by the National Center for Veteran Administration Services, almost 32% of veterans reported no plan to utilize VA healthcare (VA). The reported or suspected reasons for this percentage are not indicated in the report, however the difficulty in navigating services and the limited availability of services may have had an impact on veterans' decisions. It is estimated that 27,308 (4.9%) of Michigan's 552,412 veterans live in the Upper Peninsula although the UP only has 3.1% of the total population. Additionally, 8.9% of the UP population are veterans.

NorthCare has had a Veteran Navigator since September 13, 2017. Veteran Navigators meet monthly with the State and are developing more consistent relationships with providers, including those in the VA system, to assist Veterans and their families in accessing services. During FY19, NorthCare's Veteran Navigator contacted 43 new Veterans, 86% of whom were male and either retired or completed their term of service in the armed forces. Approximately 46.5% of Veterans seeking services were younger than age 50. A total of 32 referrals were made for mental health and SUD services to agencies such as CMH, SUD providers, hospital/medical providers, and the Veteran's Health Administration. Additional referrals for an array of ongoing community supports were made to the regional Veteran's Community Action Team (VCAT), county Veteran Service Officers (VSO) and other community resources. Referrals have increased 26.5% throughout FY19 for Veterans, Service members, and their families seeking services.

Veteran Population Estimation	
Alger	875
Baraga	721
Chippewa	3,112
Delta	3,635
Dickinson	2,456
Gogebic	1,464
Houghton	2,523
Iron	1,265
Keweenaw	274
Luce	486
Mackinac	960
Marquette	5,952
Menominee	2,072
Ontonagon	815
Schoolcraft	699
Total	27,308

*Source: Veterans Administration



NCVAS

Legal Services

According to NAMI, 37% of people incarcerated in state and federal prison have a diagnosed mental health condition and 70% of youth in the Juvenile Justice system have a mental health condition. The Michigan Incident Crime Reporting - 2018 Arrests by County data table shows the number of arrests in each county, by each agency, for each type of crime. Factoring 37% of the 2018 total arrests, indicates that there are 2,863 individuals currently in the legal system that have a mental health diagnosis and may be eligible for CMH services.

The tables below represent the number of jail diversions in FY19. Jail diversion staff work with area law enforcement to better serve individuals with a mental health need and provide them appropriate care, sometimes in lieu of legal ramification. Some ways that jail diversion staff do this is through training with local law enforcement and presentations and trainings offered to community members. In the past years it had been identified that sometimes jail diversion activity was occurring; however, not being accurately recorded. NorthCare added the ability to indicate when an activity is jail diversion related on the crisis intervention note and progress note. This allowed for more accurate reflection of pre-booking jail diversion contacts and is included in the second table. With the previous method of reporting, only 40 jail diversion activities would have been counted; however, with the new tracking mechanism 107 jail diversion activities were recorded. In FY18, there were 32 jail diversion's reported.

Arrests by County - All Agencies				
County	**2015**	**2016**	**2017**	**2018**
Alger	237	254	218	254
Baraga	183	184	137	173
Chippewa	974	1,052	843	939
Delta	1,288	1,392	1,287	1,213
Dickinson	266	263	355	338
Gogebic	326	337	373	321
Houghton	664	532	532	416
Iron	331	293	309	290
Keweenaw	21	20	22	12
Luce	144	167	166	213
Mackinac	464	434	410	323
Marquette	1,906	1,989	2,143	2,125
Menominee	852	774	895	845
Ontonagon	167	81	110	58
Schoolcraft	270	240	243	218
Total	**8,093**	**8,012**	**8,043**	**7,738**

*Source: Michigan Incident Crime Reporting

CMHSPs	Jail Diversion FY19 *Old 10/01/18 to 9/30/19										
	Number of times people diverted Pre-Booking					Number of times people diverted Post-Booking					Total Pre & Post Booking
	Adults w MI	Adults w COD	Adults w/DD	Adults w DD & COD	Sub Total Pre-Booking	Adults w MI	Adults w COD	Adults w/DD	Adults w DD & COD	Sub Total Post-Booking	
Copper Country	1	2			**3**	3	1			**4**	**7**
Gogebic						2				**2**	**2**
Hiawatha		2			**2**		6			**6**	**8**
Northpointe	3	2			**5**	4	1			**5**	**10**
Pathways	1	1	1		**3**	5	3	1	1	**10**	**13**
GRAND TOTAL	**5**	**7**	**1**		**13**	**14**	**11**	**1**	**1**	**27**	**40**

CMHSPs	Jail Diversion FY19 *New 10/01/18 to 9/30/19										
	Number of times people diverted Pre-Booking					Number of times people diverted Post-Booking					Total Pre & Post Booking
	Adults w MI	Adults w COD	Adults w/DD	Adults w DD & COD	Sub Total Pre-	Adults w MI	Adults w COD	Adults w/DD	Adults w DD & COD	Sub Total Post-	
Copper Country	2	4	2		**8**	3	1			**4**	**12**
Gogebic						3				**3**	**3**
Hiawatha		3			**3**	1	12			**13**	**16**
Northpointe	5	4	2		**11**	14	26	1		**41**	**52**
Pathways	3	4	1	1	**9**	7	6	1	1	**15**	**24**
GRAND TOTAL	10	15	5	1	**31**	28	45	2	1	**76**	**107**

Trauma

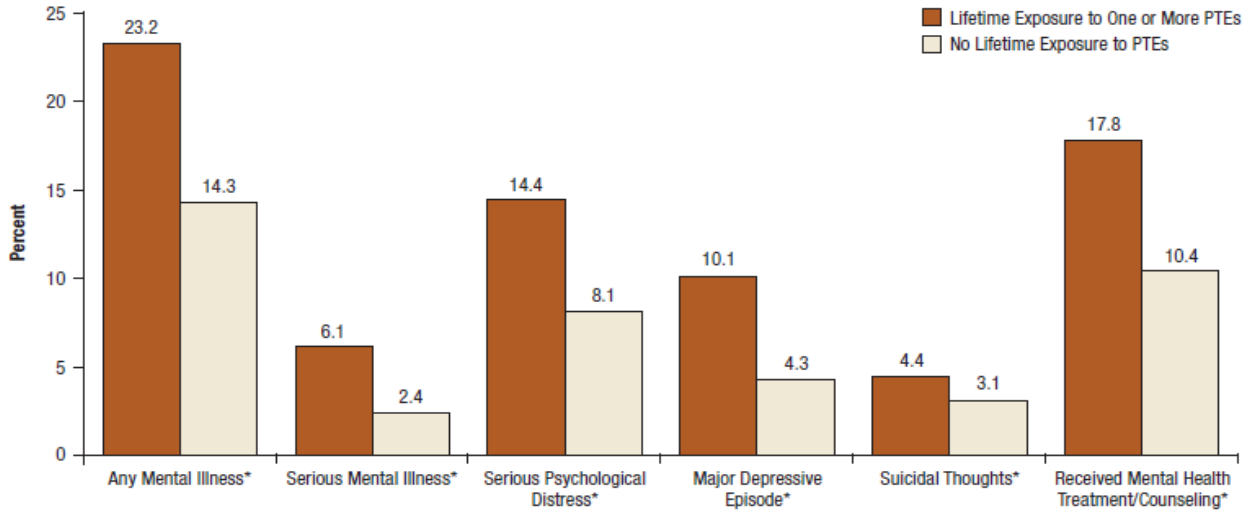
SAMHSA defines trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Trauma can take multiple forms and can happen to anyone. It is estimated that approximately 70% of people experience a traumatic event in their lifetime. One source of trauma is abuse and violence against a person. Abuse can be emotional/psychological, physical, or sexual. Specific to sexual violence, the National Intimate Partner and Sexual Violence Survey (NISVS, 2012) found that 1 in 3 women and 1 in 6 men reported some form of contact sexual violence in their lifetime. Twenty-Seven percent of women, and 11% of men experienced a form of sexual or physical violence or stalking their lifetime. Individuals with disabilities are at greater risk of experiencing trauma. NISVS survey data estimates that 39% of women and 24% of men who experienced sexual violence had a disability. For youth, 8% of girls had experienced rape or attempted rape. For boys, 0.7% experienced rape or attempted rape and 2% were made to penetrate someone or there was an attempt to make them do so (NISVS). The study also found that 35% of women who were raped as minors were also raped as an adult; compared to 10% of women who were not raped as a child.

In a 2016 survey of Michigan adults, 1.3 million (13%) Michigan residents reported experiencing 4 or more traumatic childhood events. The same survey found that adults who experienced that 4+ traumatic events as children were almost 4 times more likely to be diagnosed with depression, and two times as likely to be diagnosed with asthma, as those adults who had no traumatic events as children (Roelofs, 2019). Sadly, according to a 2018 survey of physicians in one Michigan county, only 4% indicated completing trauma assessments and only 20% indicated they even knew trauma assessments existed (Roelofs, 2019). This further points to the need for community outreach with doctors and increased coordination of care efforts.

Experiencing trauma increases the likelihood of being diagnosed with a mental illness and substance use disorder. The Mental Health Surveillance Study (2012) data shown below indicates that 23.3% of adults who experienced one or more potentially traumatic events were diagnosed with a mental illness, compared to 14.3% of adults who hadn't experienced a potentially traumatic event (Forman-Hoffman et al. 2016).

Mental Health Indicators among Adults Aged 18 or Older, by Lifetime Exposure to One or More PTEs: MHSS Clinical Study, 2008-2012 (n = 5,653)



MHSS = Mental Health Surveillance Study; PTE = potentially traumatic event.
* Differences between the lifetime exposure to one or more PTEs and no lifetime exposure to PTEs groups were significant at the $p < .05$ level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH Main Study and Clinical Sample, 2008-2012.

Peer Services

Peer Services are an important component to the service array. Peer Support Specialists have lived experience and therefore can provide a unique perspective to the treatment team and can bridge the barrier between consumers and professional staff. There are 5 types of peers.

- Youth Peer Supports are young adults age 18-26 who support youth with SED.
- Parent Support Partners are parents of children with SED or I/DD who assist other parents.
- Peer Mentors are individuals with I/DD who support others with I/DD.
- Peer Support Specialists are adults with SMI who assist others with SMI.
- Peer Recovery Coaches are adults with SUD who assist others with SUD.

Peer Services					
CMH Mental Health Peer Specialist Services	Distinct Served	Youth Peer Support Specialist Services	Distinct Served	Parent Support Partner Services	Distinct Served
Copper Country	43	Copper Country	6	Copper Country	8
Gogebic	31	Gogebic	7	Gogebic	21
Hiawatha	70	Hiawatha	0	Hiawatha	19
Northpointe	128	Northpointe	0	Northpointe	15
Pathways	55	Pathways	0	Pathways	12
Grand Total	**328**	**Grand Total**	**14**	**Grand Total**	**76**

Drop-In Centers are peer run facilities designed to provide an informal environment to assist those with mental illness in bolstering coping skills and self-esteem and encouraging an active role in their treatment. Another service, Clubhouse, is a community-based program for Medicaid adults with serious mental illness. Clubhouse, by definition, is choice based. Members and staff work side by side to make daily decisions and in governance. The Clubhouse model includes working on employment services, educational services, and community, social, and wellness supports in the community setting. In FY19 the Clubhouses also had a grant to serve eligible individuals who had a Medicaid deductible (spenddown). There were 4 individuals served in Clubhouse through this grant.

Drop In Center Utilization	Distinct Served
Brantley Drop In Center	14
Get Away Drop-In Center	16
Gogebic - Serenity Center	30
Our Place Community Center	3
Rainbow's End Drop-In Center	17
Grand Total	**80**

*Source: SAL Report

Clubhouse Utilization	Distinct Served
Copper - Northern Lights	40
Hiawatha - Waters Edge	19
Northpointe - House of Dreams	20
Pathways - South Shore Place	36
Grand Total	**115**

*Source: SAL Report

Employment Services

CMH and sub-contract providers offer employment services to those interested in working. According to the *Employment First in Michigan - November 2019* report, the National Core Indicators show that 53% of individuals with disabilities want a community job, but only 22% are employed in a community job. Employment services statewide have reduced the number of persons with a disability working under minimum wage from 68% to 35% in 2017. NorthCare in FY17 had 6% of adults with I/DD competitively employed (full and part time), and 10% of individuals with I/DD not competitively employed. This category includes sheltered workshops, enclaves, and self-employment. Eighty-four percent were unemployed. The statewide average in FY17 for percentage of individuals competitively employed was 8.8%. In FY19, the number of I/DD consumers in competitive employment went up to about 9%. Approximately 17% of SMI adults and 9% of adults that are both SMI and I/DD were competitively employed. The region continues to work on increasing the number of individuals in competitive employment.

Employment Status, Adults with I/DD, FY17

PIHP	% Competitively Employed	% Not Competitively Employed	% Not Employed
Statewide	**8.8**	**16.8**	**74.4**
NorthCare	**6**	**10**	**84**
Northern Michigan	13	16	71
LakeShore	12	5	83
Southwest	9	13	78
Mid-State	9	11	80
Southeast	9	14	77
Detroit Wayne	8	29	63
Oakland	11	10	79
Macomb	6	28	66
Region 10	6	16	78

*Source: Employment First in MI, MIDDI 2019 Report

Employment Status, Adults with I/DD, FY17

CMH	N	% Competitively Employed	% Not Competitively Employed	% Not Employed
NorthCare	**1239**	**6**	**10**	**84**
Copper	201	5	7	88
Gogebic	96	10	7	83
Hiawatha	209	9	6	85
Northpointe	262	6	9	85
Pathways	521	4	13	73

*Source: Employment First in MI, MIDDI 2019 Report

Competitive Employment by Population

	MIA Competitively Emp	MIA Consumers Served	Percent	DDA Competitively Emp	DDA Consumers Served	Percent	DD and MI Competitively Emp	DD and MI Consumers Served	Percent
NorthCare	575	3265	17.61	67	750	8.93	46	505	9.11
Copper Country CMH	90	522	17.24	7	100	7.00	12	96	12.50
Gogebic CMH	33	219	15.07	8	46	17.39	6	49	12.24
Hiawatha Behavioral	90	537	16.76	14	143	9.79	8	78	10.26
Northpointe BHS	166	848	19.58	11	124	8.87	11	145	7.59
Pathways CMH	202	1186	17.03	27	340	7.94	9	140	6.43

Residential Services

The Centers for Disease Control (CDC) indicates recent estimates show that 1 in 6 (17%) of children in the U.S. aged 3-17 have a developmental disability. While not all will require Adult Foster Care type housing once they become an adult, some may. According to the Annual Submission Report, there are 1,529 licensed Adult Foster Care (AFC) beds in the Upper Peninsula. Homes may be operated by the CMH or a private provider that the CMH may contract with. Homes may accept individuals from the UP or other areas. There are also UP consumers placed in homes downstate. In FY 19, there were 743 consumers living in residential settings, including children.

On March 17, 2014 the Centers for Medicare and Medicaid (CMS) published a new set of rules for delivery of Home and Community Based Services (HCBS). An HCBS chapter was added to the Medicaid Provider Manual on January 1, 2018. Through these rules, CMS aims to improve the experience of individuals in these programs by enhancing access to the community, promoting the delivery of services in more integrated settings, and expanding the use of person-centered planning.

In FY19, statewide work on CAPs for B3 consumers began. MDHHS purposes to complete full compliance with these new regulations by March 17, 2022. As of December 2019, NorthCare Network has completed 96% of the required B3 CAPS. The graph below represents statewide completion, delineated by region, as of February 2020. Throughout FY19, MDHHS has worked with providers who were on heightened scrutiny to obtain compliance. MDHHS maintains the responsibility to review and monitor those providers who are on heightened scrutiny. Some cases are being 'de-escalated' from heightened scrutiny status based on survey responses. Those cases will be given to the PIHP for continued monitoring and review in FY20. While the goal of HCBS is to improve the quality of care for consumers, there is a very real and negative potential effect of the HCBS transition plan. For homes that cannot come into compliance with the rules of HCBS, Medicaid dollars will not be able to be used in those homes for that individual. This could result in a consumer having to move or find alternative funding for their personal care and community living support services.

1915i (B3W) CAP Completion (Not Including De-Escalations)						
Month	Region	# CAPs required	# CAPs not started	# CAPs in progress	# CAPs completed	% CAPs completed this month
February, 2020	1	47	0	2	45	96%
	2	151	0	69	82	54%
	3	413	8	245	159	38%
	4	222	0	6	216	97%
	5	339	17	259	63	19%
	6	144	0	0	144	100%
	7	913	426	24	463	51%
	8	515	19	392	104	20%
	9	272	272	0	0	0%
	10	172	2	15	155	90%
	Statewide	3188	744	1012	1431	**45%**

Two services frequently used by those in residential care are Personal Care and Community Living Supports. The Community Living Support code of H2016 is a per diem code for individuals in specialized living arrangements. Across the region, approximately 7% of all consumers are receiving this service.

Per Diem Personal Care: T1020 Service Utilization FY19					
	Total Consumers	Units	# Consumers with T1020	% of All Consumers	Units/Consumer Receiving PC
Totals	7,591	168,974	544	7.17%	310.61
Copper Country	1,020	25,908	91	8.92%	284.70
Gogebic	562	8,892	28	4.98%	317.57
Hiawatha	1,357	31,295	99	7.30%	316.11
Northpointe	1,966	29,072	92	4.68%	316.00
Pathways	2,867	73,807	234	8.16%	315.41
*Source: Diver					

Per Diem CLS: H2016 Service Utilization FY19					
	Total Consumers	Units	# Consumers with H2016	% of all consumers	Units/Consumer Receiving CLS
Totals	7,591	173,251	557	7.34%	311.04
Copper Country	1,020	27,765	98	9.61%	283.32
Gogebic	562	9,039	28	4.98%	322.82
Hiawatha	1,357	31,591	98	7.22%	322.36
Northpointe	1,966	29,263	95	4.83%	308.03
Pathways	2,867	75,593	238	8.30%	317.62
*Source: Diver					

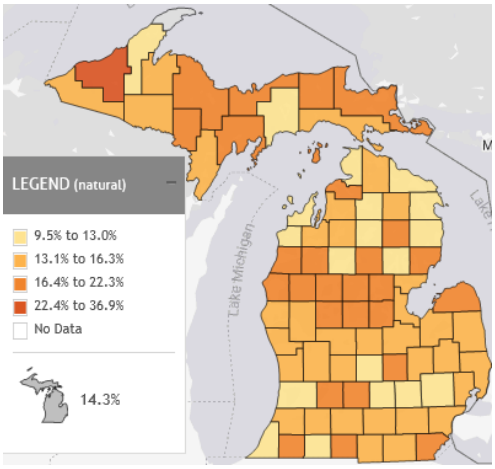
Respite services are available to caregivers on a short-term, intermittent, basis to relieve the caregiver from the stress and demands of caring for the consumer. Respite services can be provided to adults and children. Approximately 2% of the total adult population and 6% of the total youth population received respite in FY19. The following tables represent all respite service codes across all populations and living environments.

Youth (<18) Receiving Respite					
Affiliate Name	Total Consumers	Units	# Consumers with Respite	% of Youth Receiving Respite	Units/ Consumer
Totals	1,810	127,315	107	5.91%	1,189.86
Copper Country	200	4,200	7	3.50%	600.00
Gogebic	120	8,858	12	10.00%	738.17
Hiawatha	363	2,009	7	1.93%	287.00
Northpointe	508	95,580	61	12.01%	1,566.89
Pathways	637	16,668	20	3.14%	833.40
*Source: Diver					

Adults Receiving Respite					
Affiliate Name	Total Consumers	Units	# Consumers with Respite	% of Adults Receiving Respite	Units/ Consumer
Totals	5,781	100,673	122	2.11%	825.19
Copper Country	820	6,637	14	1.71%	474.07
Gogebic	442	5,868	11	2.49%	533.45
Hiawatha	994	5,444	11	1.11%	494.91
Northpointe	1,458	47,649	36	2.47%	1,323.58
Pathways	2,230	35,075	50	2.24%	701.50
*Source: Diver					

Children's Services

Statewide there were 1,568,658 children enrolled in school during the 2018-2019 school year, 208,543 (13.3%) were enrolled in special education (MI School Data). This is a slight increase from last year; in which 13.1% of children were enrolled in special education. Data from Kids Count (2018) reports a 14.3% special education enrollment rate for children age 0-26, and reports Ontonagon County has the highest rate of children enrolled in special education in the state (see map).



The Intermediary School Districts list enrollment by various disability. Speech and Language Impairments as well as specific learning disabilities are the most prevalent need across the UP (MI School Data). Per the Annual Submission Report, Copper Country CMH had 3 students "age out" or graduate from special education services. Gogebic CMH had 12, Hiawatha Behavioral Health had 29, Northpointe Behavioral Health and Pathways CMH data is unavailable.

2018-2019 Special Education Data Portrait: Disability Snapshot

	Total Special Ed Count	Autism	Cognitive Impairment	Deaf/Blind	Early Childhood Developmental Delay	Emotional Impairment	Hearing Impairment	Physical Impairment	Severe Multiple Impairments	Specific Learning Disability	Speech and Language Impairment	TBI	Visual Impairment	Other Health Impairment
Copper Country ISD	786	44	48	<10	45	29	<10	<10	<10	246	207	<10	<10	151
Delta-Schoolcraft ISD	1,014	65	54	<10	28	23	<10	<10	24	237	392	<10	<10	169
Dickinson-Iron ISD	872	68	57	<10	25	35	<10	<10	18	357	209	<10	<10	85
Eastern Upper Peninsula ISD	1,039	113	98	<10	30	49	<10	<10	16	216	318	<10	<10	186
Gogebic-Ontonagon ISD	426	33	31	<10	40	19	<10	<10	<10	138	80	<10	<10	71
Marquette-Alger RESA	1,645	111	62	<10	117	44	16	<10	21	488	580	<10	<10	201
Menominee ISD	334	23	23	<10	14	25	<10	<10	<10	96	85	<10	<10	57

*Source: MI School Data

The CDC estimates that 1 in 59 children are diagnosed on the autism spectrum. NorthCare served 120 consumers with Autism in FY19. Of those consumers, 82 remain open in FY20. The others may have disenrolled for a variety of reasons including voluntary disenrollment/declining services, relocation, and no longer meeting medical necessity criteria.

Speech therapists evaluate and treat communication disorders and often work with individuals with Autism Spectrum Disorders. In FY19, there were 47 consumers who had speech and language services.

On 9/1/17, MDHHS required the implementation of intensive crisis stabilization services for children, also known as mobile crisis services. This service is for children receiving CMH services when there is a crisis requiring staff support but not requiring immediate inpatient psychiatric hospitalization. Staff would identify if a child seemed appropriate for this service when the guardian called for support. Two staff would then respond to the crisis at the child's home. During FY18 the program progressed from development to implementation stage, with the first service being provided in July 2018. FY19 was the first year of full utilization, although the number of encounters did not increase much from FY18.

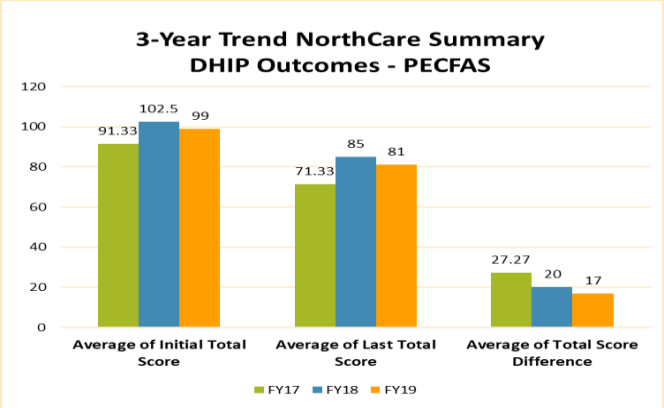
Autism Closures	
Closing Reason	Total
Approved - Declined Services	4
Met all treatment plan goals	8
Moved out of State	4
No Longer Eligible for Medicaid	2
Not Interested	1
Other	6
Re-Evaluation did not meet medical necessity	4
Voluntarily Disenrolled from Services	9
Total	**38**

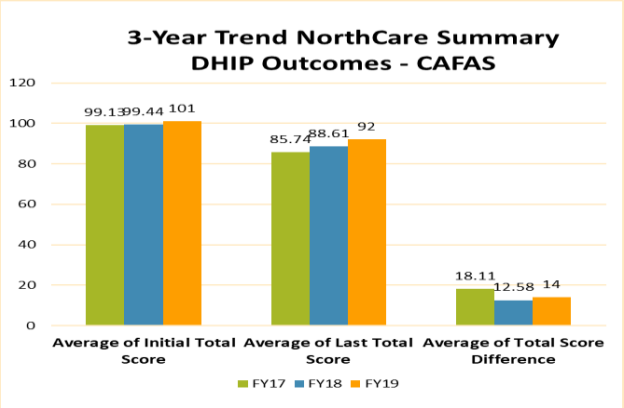
*Source: WSA All Data Report

Mobile Crisis Utilization FY19		
	Number of Encounters	Number of Distinct Consumers
Copper Country	7	6
Gogebic	0	0
Hiawatha	2	1
Northpointe	2	2
Pathways	7	7
Grand Total	18	15

*Source SAL Report

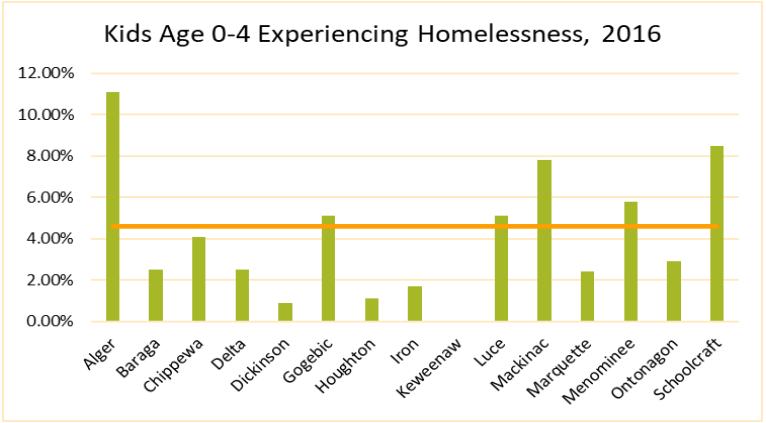
The local CMHs receive MDHHS Incentive Payments (DHIP) for children and youth that are served in the Michigan Foster Care or Child Protective Services system. The average initial Child and Adolescent Functional Assessment Scale (CAFAS) and preschool version (PECFAS) scores of the children and youth for which the incentive payment was received were compared to the average of the last CAFAS/PECFAS scores during the past 3 years. The graphs below depict the comparison between the initial and last scores. Below you will see that the last CAFAS/PECFAS scores trended lower than the initial score, representing overall improvement in the children/youth's behavioral health in each year. Also, interesting to note is that for CAFAS, the initial scores are averaging slightly higher in FY19 than in previous years.





Additionally, Infant Mental Health (IMH) Services are available for children age 0-3. IMH services provide parent-infant support and intervention when the parents condition and life circumstances threaten the attachment between the infant and parent. One such life circumstance would be homelessness. In Michigan, 4.6% of children age 0-4 experienced homelessness in 2016 (Kids Count). The UP average is below the state average, at 4.39%, however some UP counties, especially Alger County, were significantly higher than the state average for kids experiencing homelessness.

Kids 0-4 Experiencing Homelessness	
Location	2016
Michigan	**4.60%**
Alger	11.10%
Baraga	2.50%
Chippewa	4.10%
Delta	2.50%
Dickinson	0.90%
Gogebic	5.10%
Houghton	1.10%
Iron	1.70%
Keweenaw	*
Luce	5.10%
Mackinac	7.80%
Marquette	2.40%
Menominee	5.80%
Ontonagon	2.90%
Schoolcraft	8.50%
*Source: Kids Count	



Homelessness		
	Biennial Count	Served by CMH
Copper	109	NA
Gogebic	186	3
Hiawatha	NA	13
Northpointe	349	19
Pathways	NA	101
*Source: PPG Data		

NAMI indicates that 20% of people experiencing homelessness also have a serious mental illness. According to PPG data, there are hundreds of individuals homeless in the Upper Peninsula, a few of which we serve. In 2019, NorthCare, Pathways CMH, and Upper Peninsula Health Plan (UPHP) targeted homelessness, or individuals at risk for homelessness, as part of the integrated care team meetings through grant funding UPHP received. NorthCare reviewed 21 individuals flagged as being homeless and having had contact with Pathways CMH within the 3 months prior to August 2019. Five of those individuals were already receiving integrated care services through UPHP and Pathways. Outreach efforts with 6 of the remaining 19 were successful in engaging the consumer into either a health home with a primary care physician, or with Pathways CMH. The other 13 individuals were unable to be reached/located or refused integrated care services.

Integrated Care Services

Integrated care is a systemic change to current methods of treatment; to integrate the behavioral health and physical health needs of a person. Integration is important between all providers as people with serious mental illnesses have an increased risk for chronic diseases such as diabetes and cancer and their cardiometabolic disease rate is twice that of an adult without a serious mental illness (NAMI). Behavioral Health issues are also impacting care on the physical health side. Poor physical health from mental health and substance use disorders increased 11% between 1990 and 2016 in the United States (IMHE).

To increase integration, NorthCare staff and CMH staff met with staff from UPHP to discuss the treatment of shared consumers who are high utilizers of services. In FY19, the team served 49 distinct consumers, 11 of whom were receiving treatment for co-occurring mental health and substance use disorders. The team works together to improve outcomes for consumers. One way to improve overall outcomes is to ensure that any consumer who is willing to have a primary care doctor has one. Regionally, 92% of consumers have a primary care doctor, and 63.7% saw their doctor for an office visit in the prior 12 months (Relias).

Percent of Consumers with a PCP	
Copper	91%
Gogebic	90%
Hiawatha	93%
Northpointe	96%
Pathways	92%

*Source: PPG Data

Other ways that the integrated care team impacts overall consumer health is by analyzing population health metrics built from Medicaid claims and encounter data. Quality measures in medication adherence, hospital admissions, emergency department utilization, and identification of co-morbid conditions and gaps in recommended care often identify individuals who can benefit from an integrated care team approach. NorthCare ensures that all individuals on psychotropic medications have regular metabolic and vital sign monitoring. Early detection of metabolic changes affords an opportunity to reduce the risk of chronic diseases and their impacts on individuals with serious mental illness. In the table below, the chronic co-morbidity rates are depicted.

RELIAS

NorthCare Chronic Co-morbidity Hospitalization Risk

Report Period: October 1, 2018 through September 30, 2019

Top 10 Chronic Co-Morbidities	N	% of Total	N Hosp. Visits per 100 Pts	Relative Risk of Hosp.
No Chronic Co-Morbidity	2,834	66.9%	10	1.29
Any Chronic Co-Morbidity	1,403	33.1%	35	4.48
Chronic Pain and Hypertension	142	3.4%	76	9.64
Asthma and Hypertension	196	4.6%	68	8.67
Asthma and Diabetes	128	3.0%	68	8.62
Diabetes and Hypertension	209	4.9%	67	8.49
Asthma and Past Tobacco Use	111	2.6%	63	8
Neurological Disorders and Any Other Chronic Condition	596	14.1%	61	7.68
Asthma and Chronic Pain	154	3.6%	55	6.92
CAD / Hyperlipidemia / MI and Any Other Chronic Condition	644	15.2%	51	6.51
Diabetes and Dyslipidemia	205	4.8%	48	6.06
Asthma and Dyslipidemia	173	4.1%	46	5.86

Co-Occurring Services

Co-Occurring treatment implies treatment of mental health and substance abuse needs that are present at the same time. A person with a mental illness is more likely to have a substance use disorder, and a person with a substance use disorder is more likely to have a mental illness. According to the National Institute on Drug Abuse, common genetic or environmental risk factors can contribute to mental health and substance use. Also, some individuals may self-medicate to reduce the symptoms of their mental health, and others may have physical brain changes from their substance use, increasing their likelihood of developing a mental illness (NIDA). There were 140 substance abuse assessments completed by the CMH's in FY19. Additionally, 630 unduplicated clients were provided co-occurring services, at a rate of 9.65% across the region.

Affiliate Name	# clients with HH service	# of Clients Served	% w/ Co-occuring Services
Copper Country	151	909	16.61%
Gogebic	10	474	2.11%
Hiawatha	183	1166	15.69%
Northpointe	83	1528	5.43%
Pathways	203	2596	7.82%
NorthCare (unduplicated)	**628**	**6508**	**9.65%**

Diver/FY19 Service Model:Medicaid=Y/Service Reportable = Y/ Encounter code: Find all HH, group / AffiliateName Consumer is considered Medicaid if they were eligible at any time during the fiscal year. Services are encounters with HH modifier signifying Co-Occuring treatment.

Substance Use Disorder Access to Services

Addiction, as defined by the American Society of Addiction Medicine (ASAM) "is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. It is a primary chronic disease of brain reward, motivation, memory and related circuitry."

It is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission.

Substance Use Disorder (SUD) Medicaid services include assessment, individual and group therapy, intensive outpatient therapy, residential services, subacute and social detox services. Through Block Grant funding, additional specialty services are available and include case management, women and children's services, recovery housing and peer recovery services, and room and board for residential placement.

The American Society of Addiction Medicine (ASAM) separates Substance Use Disorder treatment into different levels of care ranging from *Early Intervention* for those at risk of use to *Medically Managed* services for individuals at risk of detox. The various levels provide a continuum of care allowing for consumers to move up and down the continuum as medically necessary.

ASAM Levels of Care	
Level .5 Early Intervention	Service for individuals at risk of developing a SUD
Level 1 Outpatient Services	Typically less than 9 hours a week for adults or 6 hours a week for adolescents of therapy
Level 2.1 Intensive Outpatient	More than 9 hours a week for adults and 6 hours a week for adolescents of therapy and encompassing services that are capable of meeting complex needs
Level 2.5 Partial Hospitalization	20 or more hours of service a week but not requiring 24 hour care
Level 3.1 Clinically Managed Low-Intensity Residential Services	24 hour living support with trained personnel and offers 5 hours of clinical services a week
Level 3.3 Clinically Managed Population-Specific High Intensity Residential Services	Adult only 24 hour care with trained counselors and capable of assisting those with cognitive or other impairments
Level 3.5 Clinically Managed Medium-Intensity Residential Services	24 hour care with trained counselors with the goal of outpatient treatment and utilizing the full milieu and therapeutic communities
Level 3.7 Medically Monitored High-Intensity Inpatient Services	24 hour nursing care with a physician available and counseling 16 hours a day
Level 4 Medically Managed Intensive Inpatient Services	24 hour nursing care and daily physician care and available counseling
Source: ASAM Continuum	

Prevalence

According to the 2018 National Survey of Substance Abuse Treatment Services (N-SSATS) conducted by SAMHSA, which surveyed 465 providers, 88% provided outpatient treatment, 19% provided residential treatment, and 3% provided hospital inpatient treatment. Some providers provided multiple levels of care. Almost all the providers took cash payment however only 69.7% took Medicaid (SAMHSA). Only 2.5% of facilities offered opioid treatment programs.

Type of care, by number and percent

	Facilities	
	No.	%
Outpatient	409	88.0
Regular	396	85.2
Intensive	165	35.5
Day treatment/partial hospitalization	36	7.7
Detoxification	45	9.7
Methadone/buprenorphine maintenance or naltrexone treatment	91	19.6
Residential (non-hospital)	89	19.1
Short term (≤ 30 days)	71	15.3
Long term (> 30 days)	68	14.6
Detoxification	42	9.0
Hospital inpatient	14	3.0
Treatment	9	1.9
Detoxification	12	2.6
Total	465	

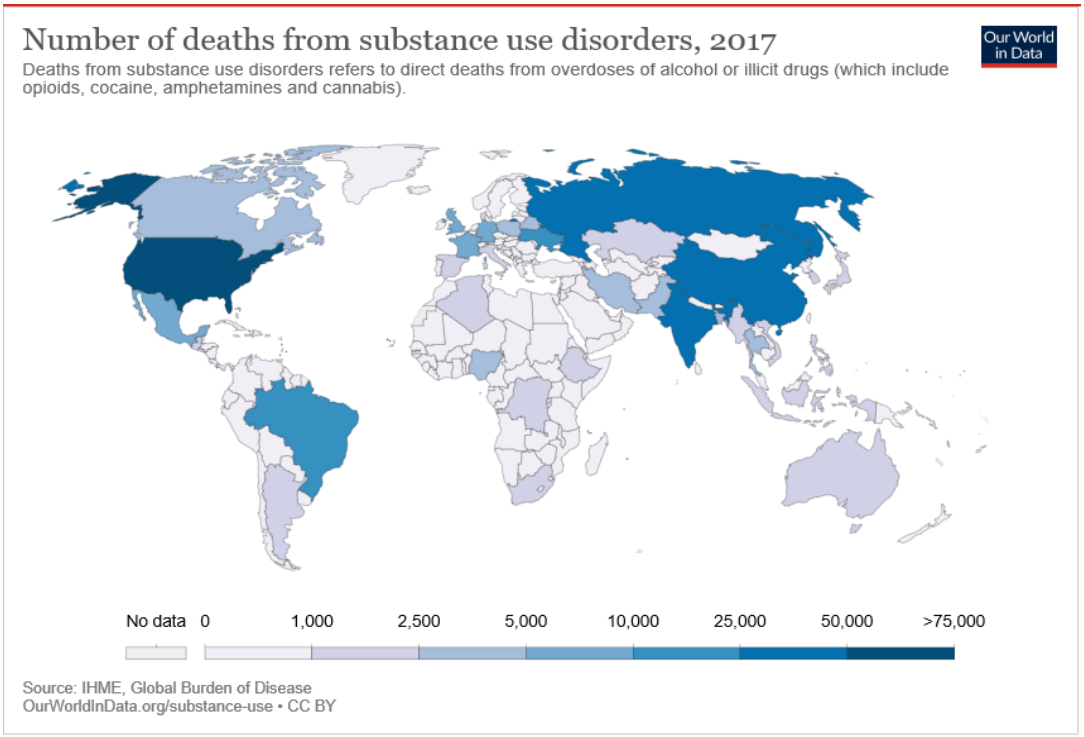
Note: Facilities may provide more than one type of care.

Facility payment options, by number and percent

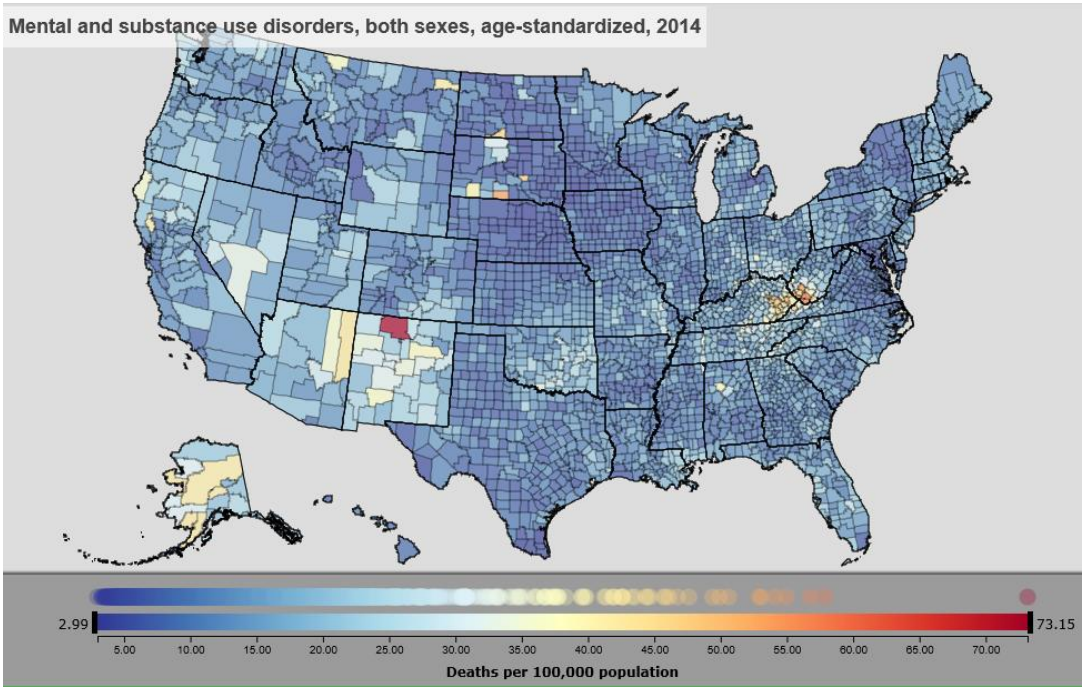
	No.	%
Cash or self-payment	427	91.8
Private health insurance	373	80.2
Medicare	273	58.7
Medicaid	324	69.7
State-financed health insurance	258	55.5
Federal military insurance	194	41.7
No payment accepted (free treatment for all clients)	4	0.9
IHS/Tribal/Urban (ITU) funds	41	8.8
Other payments	1	0.2
Sliding fee scale	262	56.3
Treatment at no charge or minimal payment for clients who can't pay	170	36.6

Note: Facilities may accept more than one type of payment.

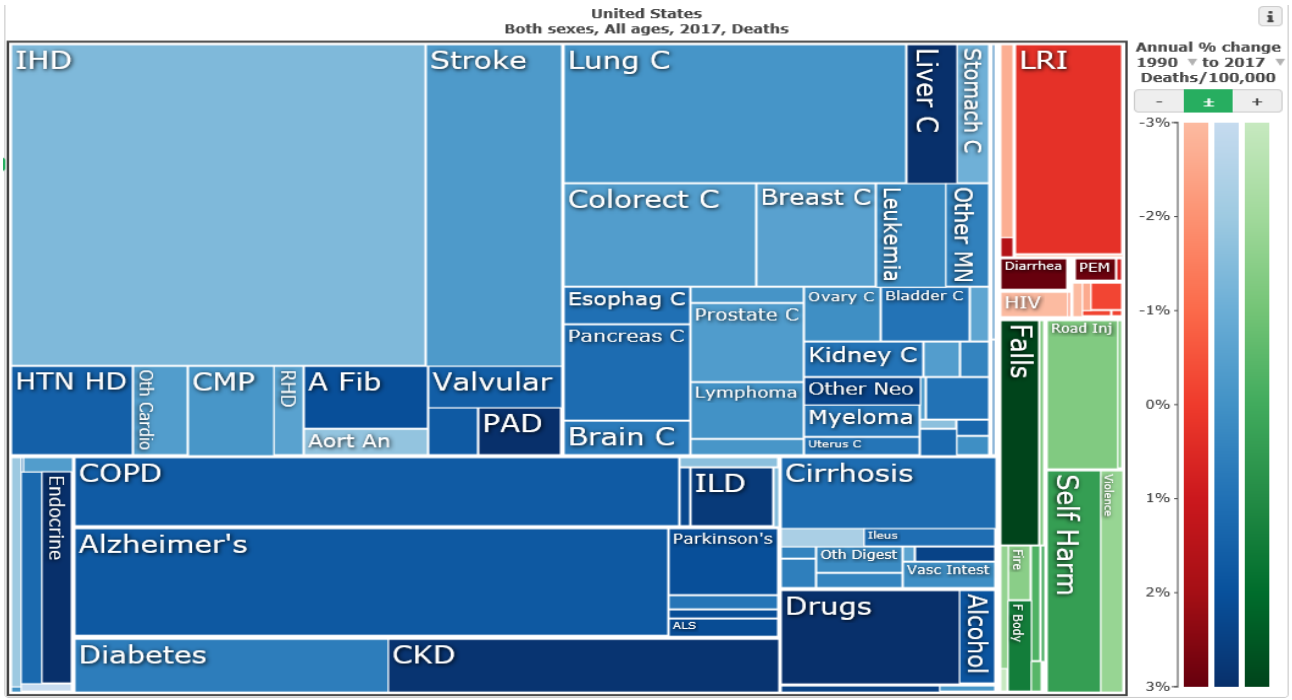
According to the Institute for Health Metrics and Evaluation (IHME), as reported in *Our World In Data*, Alcohol was the primary substance that directly caused death from overdose globally in 2017. Alcohol accounted for almost 185,000 deaths globally that year. Alarmingly, of the countries with data, the U.S. has the highest rate of deaths from substance use disorders in 2017. Alcohol is the primary substance use disorder among the Medicaid population in Michigan according to Altarum (2019).



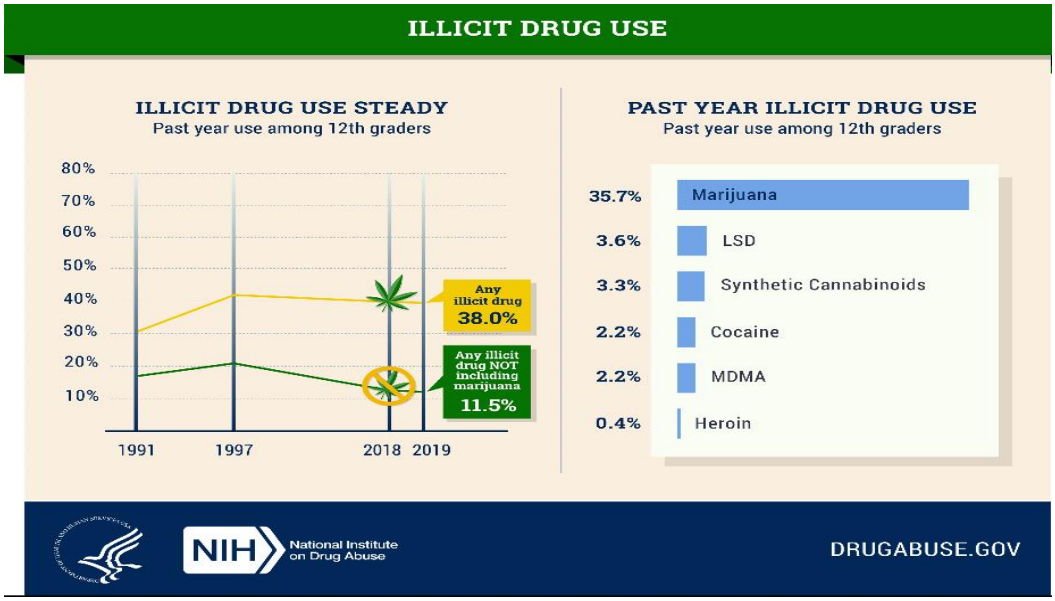
Across the United States, in 2014 there were 13.39 deaths per 100,000 population related to mental health and/or substance use disorders in 2014 (IMHE). In Michigan, that same year, there were 15.6deaths per 100,000 (IMHE). Chippewa Co. had the highest rate in the UP at 15.78 deaths per 100,000.



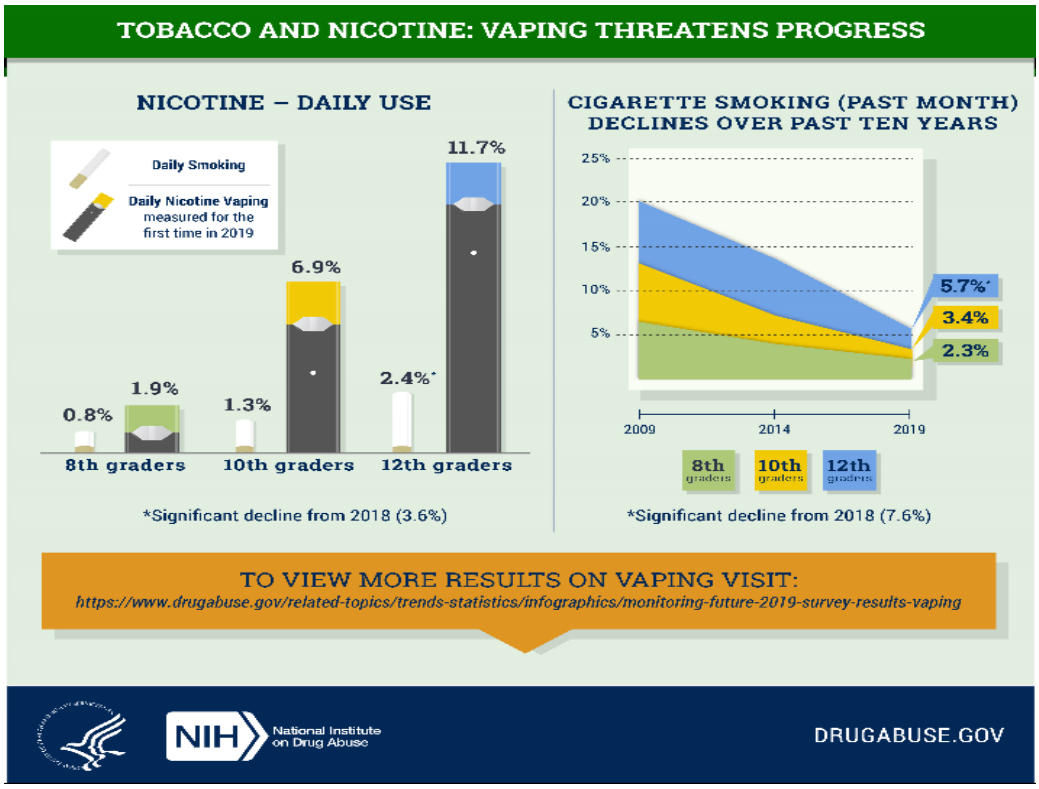
The deaths from substance use are increasing. The chart below from the Institute for Health Metrics and Evaluation (IMHE), shows that the major causes of death in the U.S. include Ischemic Heart Disease, Alzheimer's, and various cancers. However, drugs, alcohol, and self-harm also make an appearance. Each cause of death also shows the percent change from 1990 to 2017 on the side color bars; a richer color indicating a greater increase in percentage of deaths due to this cause. Red indicates communicable, maternal, neonatal and nutritional deaths, blue represents non-communicable deaths, and green represents deaths due to injury. Deaths from self-harm nationally increased by 0.4% between 1990-2017; alcohol by 1.89%, and drugs by 8.07% (IMHE). Michigan had a greater rate of change than nationally with the death from self-harm increasing by .82%, alcohol by 2.53%, and drugs by 8.97% (IMHE).



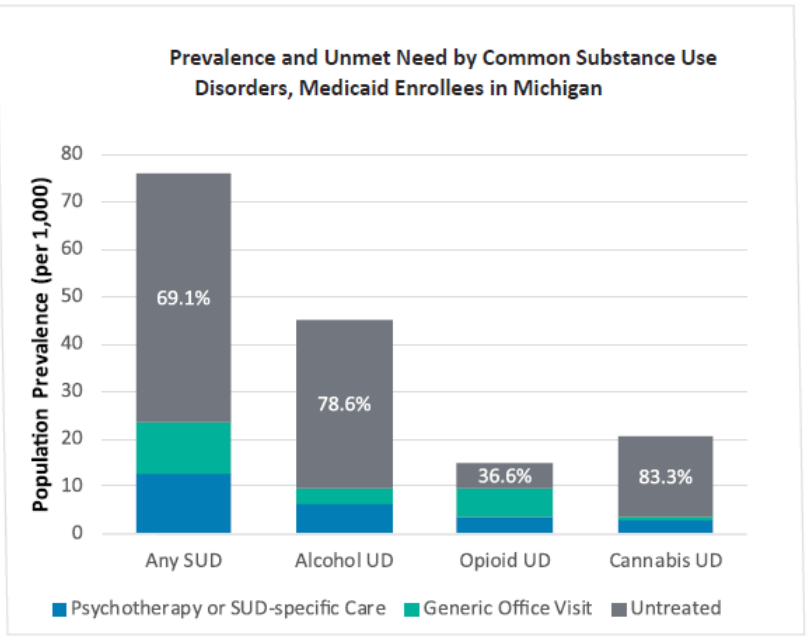
With deaths due to drug use increasing, is it important to look at what drugs youth are using. A 2019 survey of 42,531 students of the 8th, 10th, and 12th grades across 396 schools sponsored by NIH found that marijuana is the primary substance of abuse for 12th graders. The use of prescription drugs, specifically Vicodin, Oxycontin, and Adderall has declined since 2014.



Of new concern in 2019, and newly surveyed in 2019, is vaping. Vaping is the inhalation of vapor produced by a vaporizer or e-cigarette. Vaping is a new common way to consume nicotine. While cigarette smoking is decreasing, vaping may be replacing it; and vaping has its own health effects. Nationwide 2,500 lung illnesses and 54 deaths were confirmed due to vaping as of December 2019 (O'Donnell, USA Today). Teens can vape nicotine as well as marijuana. Health officials have linked vitamin E acetate, an additive used as a thickening agent or to dilute THC oil, as a primary suspect in the illnesses (O'Donnell, USA Today).

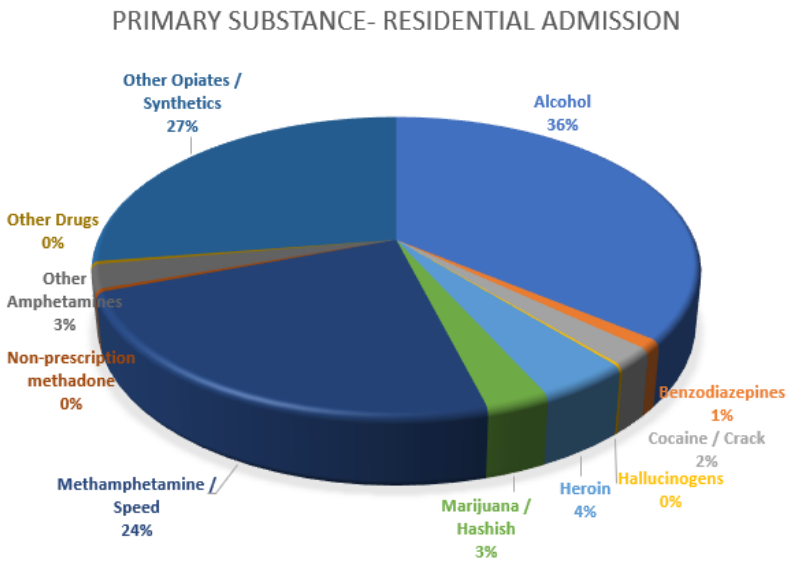


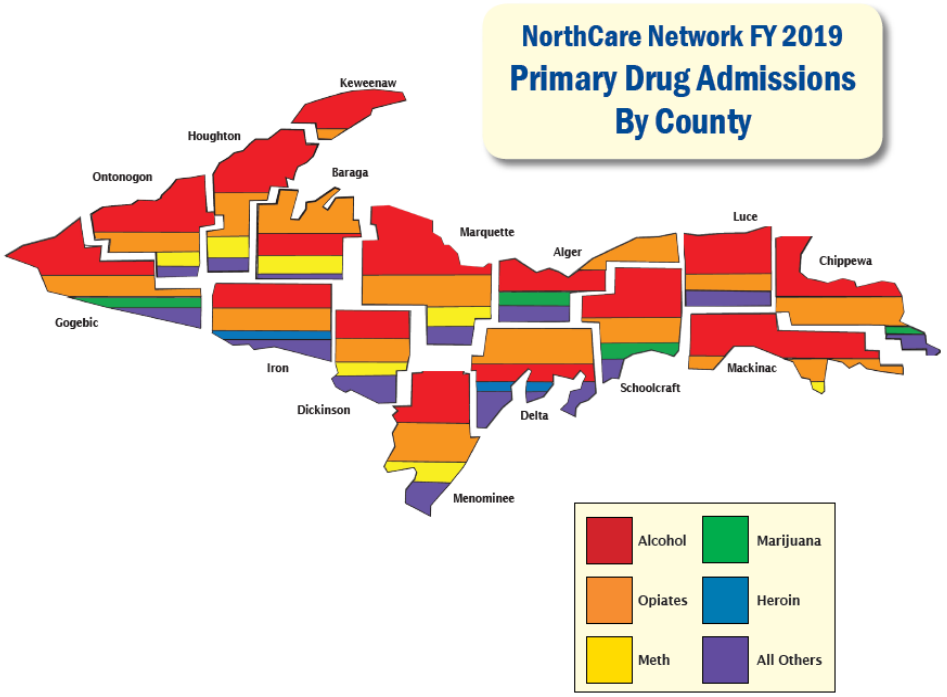
In a study by Altarum of all Medicaid consumers in Michigan, it was found that most consumers are seeking treatment for Alcohol, opioids, and cannabis. Many Medicaid individuals receiving treatment for substance use disorders are receiving treatment through a specialty provider. However, still a vast majority are having their needs unmet. Opioid disorders have the lowest unmet need, likely in response to the increased efforts on providers and governments behalf to address the recent opioid crisis.



Residential Treatment

In FY19 NorthCare Network Substance Use Access Department completed a total of 1765 pre-screenings for all insurance types. After the pre-screening, a screening was completed to determine what level of care an individual may need. Of the 1187 completed screenings, 1149 resulted in a referral to residential treatment, 40 to social detox, 9 to intensive outpatient, and 19 to outpatient. All 40 social detox referrals were also referred to residential treatment. Of those referrals there were 779 admissions to SUD residential treatment. Alcohol and Opiates remain the primary reasons for admission to treatment. Methamphetamines are an increasing reason for seeking treatment in certain counties.





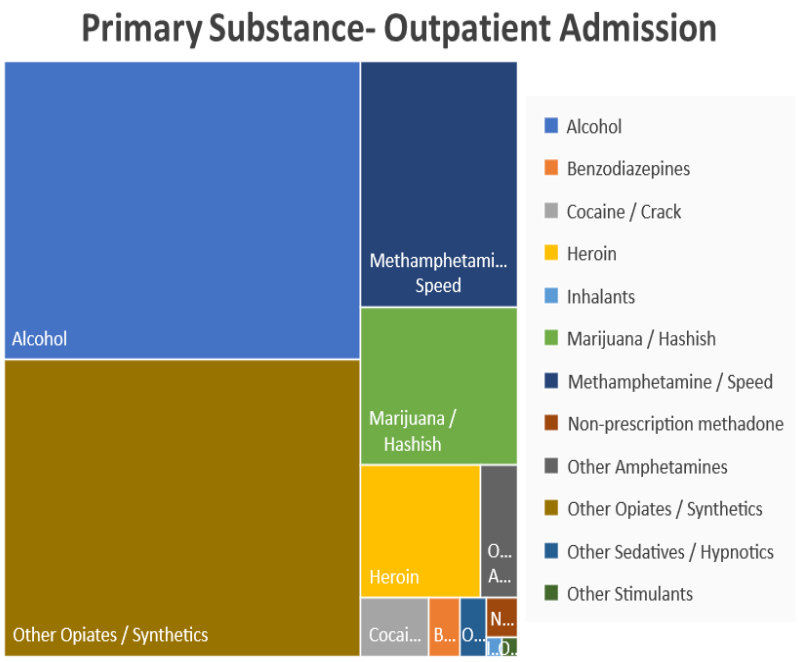
Outpatient Treatment

There were 999 outpatient treatment admissions in FY19. Like residential treatment, Alcohol and Opiates are the primary substances at time of admission for outpatient treatment as well. Marijuana and heroin only accounted for 7% of admissions to residential treatment, but they account for 13% of outpatient admissions; with marijuana a more prevalent primary substance at time of admission in outpatient treatment.

SUD Outpatient Admissions - Primary Substance At Admission													
	Alcohol	Benzodiazepines	Cocaine / Crack	Heroin	Inhalants	Marijuana / Hashish	Methamphetamine / Speed	Non-prescription methadone	Other Amphetamines	Other Opiates / Synthetics	Other Sedatives / Hypnotics	Other Stimulants	Grand Total
Total	348	6	13	52	1	81	126	4	16	346	5	1	**999**

Social detox is another level of care a consumer may access. Social detox does not have medical staff but can be a valuable resource for those struggling with addiction. There were 233 admissions to social detox in FY19. For social detox, opiates are the primary substance at time of admission, with alcohol a close second. For the other levels of care alcohol has been primary with opiates as a close second.

SUD Detox Admission - Primary Substance at Admission							
	Alcohol	Cocaine / Crack	Heroin	Methamphetamine / Speed	Non-prescription methadone	Other Opiates / Synthetics	Grand Total
Total	98	2	17	8	1	107	**233**

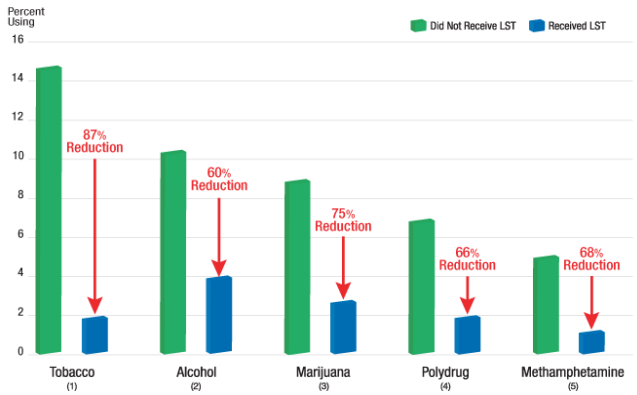


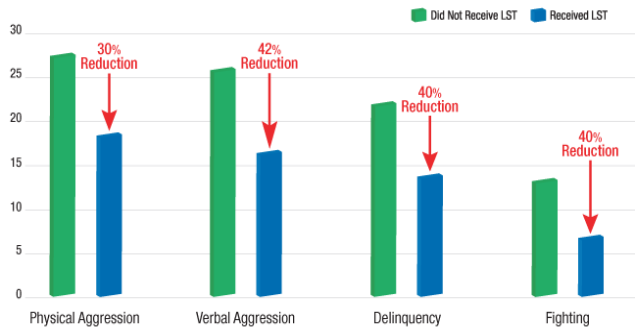
Providers have Performance Indicator standards regarding timely access to services. One of the performance indicators measures the percent of consumers discharged from a social detox unit that are seen for follow-up care within 7 days. This was met at 100% in FY19.

Prevention Programming

Prevention services are a vital component to reduce future demand and NorthCare provides a solid base of primary prevention services across the region. There are 14 substance use prevention coalitions that cover all 15 counties in the Upper Peninsula. Each coalition has one coordinator and many community volunteers who utilize an evidence-based coalition model, *Communities that Care*. These coalitions help identify the risk and protective factors that are affecting the community's youth.

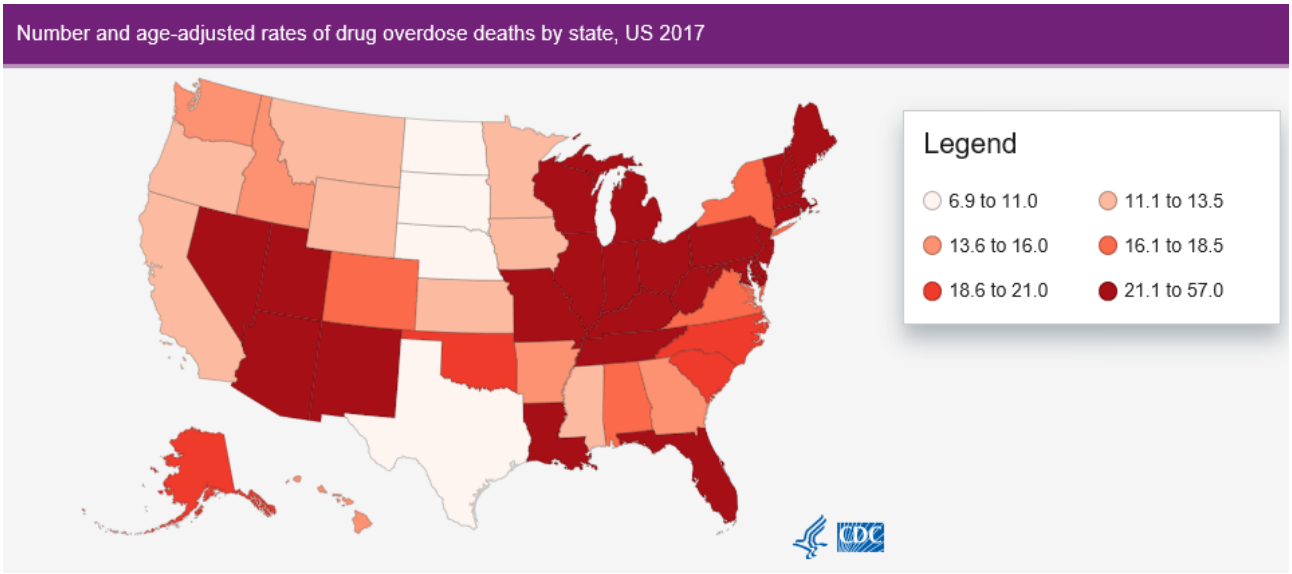
In FY19, 57% of UP middle school youth in grades 6, 7, and 8 received the Botvin's LifeSkills training. Nationally, students receiving Botvin's LifeSkills training have significantly lower substance use as well as aggression rates compared to children who didn't receive the course. According to their website, their training data shows a reduction in tobacco use by 87%, alcohol use by 60%, marijuana use by 75%, and methamphetamine use by 68%. Further, it has shown positive effects even 12 years later (National Health Promotion Associates).





Medication Assisted Treatment

Findings from the Global Burden of Disease Study found that the number of deaths from opioid use skyrocketed in 2016 from 3,333 deaths in 1990 to 18,238 deaths in 2016 (IMHE). From 2000 to 2017, 399,000 Americans have died from an opioid overdose (including prescription and illicit Opioids). In 2017, 70,237 people died from drug overdoses in the United States and 47,600 overdose deaths were from opioids. Drugs are now the leading cause of injury-related death in the United States (CDC). Since 2012 in Michigan, opioid overdose deaths from Heroin, Synthetic Opioids (Fentanyl, Oxycodone, Hydrocodone), and prescription Opioids have steadily increased. Fentanyl is often mixed with Heroin, Cocaine or pressed into pills. Fentanyl is very potent, and it takes a very small amount for it to be lethal.



There are approximately 63,000 people diagnosed with Opioid Use Disorder in Michigan. There are approximately 83 board certified addiction specialists in Michigan to treat the population, for a ratio of 800 patients per addiction specialist. Due to the increased risk of death from opioids, it is important to bolster the number of area providers.

Although Medication Assisted Treatment (MAT) is evidenced based and the recommended course of treatment by numerous organizations; including, the American Academy of Addiction Psychiatry, AMA, National Institute on Drug Abuse, SAMHSA, National Institute on Alcohol Abuse and Alcoholism, and the CDC, only 10% of the addicted population has access to treatment for a disease that has roughly the same incident rate as diabetes. This is partially due to lack of providers waivered to provide suboxone treatment and the stigma regarding the use of medication to treat Opioid Use Disorder. MAT helps to normalize brain chemistry, block euphoric effects, relieve cravings, and is tailored to meet each consumer's needs (SAMHSA). MAT aims to improve patient survival, increase retention in treatment, and decrease illicit use. It requires coordinated counseling as part of the treatment program. Medications for Opioid Use Disorder reduce mortality by 50%, reduce risk of HIV transmission by 50% and help people decrease use of other substances by 30-50% per toxicology screens.

NorthCare is involved in the Michigan Opioid Collaborative. NorthCare has contacted providers who are waivered to provide MAT to offer technical assistance to remove any barriers to providing treatment. Additionally, NorthCare has worked to identify any doctor who is willing to obtain the waiver to provide MAT. NorthCare has provided access to doctors who are seeking referral or resource information, consultation, and trainings. NorthCare has 16 providers for MAT, 9 of which are in the UP.

Numbers and Types of Providers

Mental Health

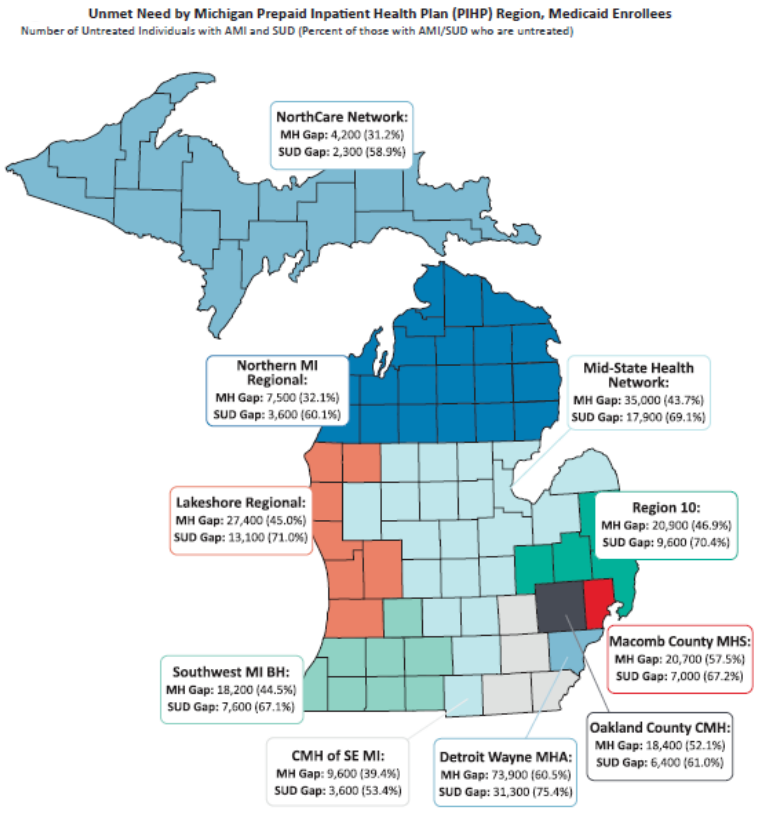
The following table reflects the license types, and numbers of providers in that license type, at each CMH and NorthCare SUD; which is a combination of all the SUD providers. NorthCare Dual represents the community providers that have been authorized by NorthCare for providing MHL services.

Affiliate	ACSW-Lic Master's Social Worker	BCaBA	BCBA-D	Board Cert Behavior Analyst	CAADC	CADC	CADC-M	Cert. Peer Support Specialist	Clin-Lic Mstr Soc Wkr	Controlled Substance - Federal	Dietitian	Lic. Bachelor's Social Worker	Lic. Marriage & Family Therapist	Licensed Behavior Analyst	Licensed Master's Social Worker	Licensed Practical Nurse	Licensed Professional Counselor	Licensed Psychologist	Limited license Psychologist	Ltd. Lic. Bachelor's Social Wkr	Ltd. Lic. Master's Social Worker	Ltd. Lic. Professional Counselor	Macro-Lic Mstr Soc Wkr	Nurse Practitioner	Occupational Therapy Assistant	Physician Medical	Physician's Assistant	Reg. Occupational Ther. - State	Reg. Social Service Technician	Registered Physical Therapist	Registered Professional Nurse	Speech Language Pathologist	**Grand Total**
Copper Country			1			1	1			10		11			11	1	3	1	3	3	3			1	1	6	1	1	1		14		**74**
Gogebic								1	10	9		11		1	12		2	1	3	4	4	1	2			10		2	1		7		**81**
Hiawatha		1		5	2			4	1	5		9			17		6		2	5	7	2				8		4	1	1	9	5	**94**
NorthCare Dual															41			21						11		38	6						**117**
NorthCare SUD	7					1						1	1		17	3	12	2	4	2	15	10		1		3	1				2		**82**
Northpointe								1			1	18			15		1		3	11	11			3		2		1	3		22		**92**
Pathways		2		4	3			1	1	7	1	14		1	33	2	1	1	5	17	16	1	8	3		6		4		1	16	2	**150**
Grand Total	**7**	**3**	**1**	**9**	**5**	**2**	**1**	**7**	**12**	**31**	**2**	**64**	**1**	**2**	**146**	**6**	**25**	**26**	**20**	**42**	**56**	**14**	**10**	**19**	**1**	**73**	**8**	**12**	**6**	**2**	**70**	**7**	**690**

As mentioned previously, the UP is lacking mental health providers, dentists, and primary care providers as well as providers offering MAT. Altarum highlights the variance in geographic location across Michigan, indicating that if all areas in Michigan could achieve the rates of care as seen in the areas with the best access, 57,000 more people with mental health needs and 27,000 more people with substance use needs would receive care across the state (2019). Within the CMH system, there are 117 providers serving adults with I/DD, 71 providers serving children with I/DD, 206 providers serving adults with SMI, and 127 providers serving children with SED. Providers who serve multiple populations are counted in multiple categories. When reviewing the ratio of consumers to providers, it is important to note that because staff may serve multiple populations or have multiple other duties, they may not be serving 1 FTE for a population.

Ratio of Consumers to Providers	
Adult with I/DD	10.4 : 1
Child with I/DD	4.3 : 1
Adult with SMI	13.5 : 1
Child with SED	7.8 : 1
* Source: Diver	

While resources are often scarce in the UP, some areas are resource rich, and the region is providing care. In a study by Altarum, it was found that the percentage of Medicaid enrollees with any mental illness *not* receiving care ranges from a low of 31.2% in the Upper Peninsula to a high of 58.8% in the Detroit Metro area. SUD treatment ranges from a rate of 55% to 72.4% of Medicaid individuals *not* receiving care.



Reasons for not receiving care according to Altarum included transportation issues and lack of information about where to go for treatment/how to get treatment. This highlights the continued need for community integration, interaction, and engagement. It also highlights the importance of telehealth services.

Self-Reported Reasons for Not Receiving Behavioral Health Care

TOP REASONS FOR NOT RECEIVING TREATMENT	% Citing Each Reason, AMI Care	% Citing Each Reason, SUD Care
Couldn't Afford Costs	29%	27%
Didn't Know Where to Go	23%	19%
Thought Could Handle/Not Ready to Get Treatment	18%	38%
Didn't Have Time	14%	5%
Concerned Might Get Committed/Have to Take Meds	16%	-
No Transportation/Too Far	11%	9%

Source: 2016 National Survey on Drug Use and Health. Respondents could select multiple answers. For AMI care, respondents are those covered under Medicaid. For SUD care, payer-type specific results were not available.

Technology is changing the way we think about providing services. Telehealth is becoming more prevalent to accommodate the growing need in areas with few providers. There were many encounters of telehealth in FY19, as shown in the table. Also, mobile technology, such as *my*Strength, is providing people a way to access evidence-based information and self-help from anywhere they have an internet connection. *my*Strength is available to anyone though NorthCare's Community Login.

Telehealth Utilization FY19

CPT Code	Descriptor	Total Units	# Distinct Clients
90791	Psychiatric Diagnostic Evaluation (no medical services)	29	29
90792	Psychiatric Diagnostic Evaluation (with medical services)	184	182
90832	Individual Therapy Adult or Child or TFCBT Therapy 16-37 minutes	1782	804
90834	Individual Therapy Adult or Child or TFCBT Therapy 38-52 minutes	4343	1231
90837	Individual Therapy Adult or Child or TFCBT Therapy 53 + minutes	7354	1444
99201	New patient office or outpatient (Certification exam)	2	2
99203	Office/outpatiet/New; 3 key components 30 minutes face to face	1	1
99205	Office/outpatient/new; 3 key components, face to face 60 minutes	10	10
99212	Office/outpatient/established; 10 minutes(Certification exam)	58	27
99215	Office/outpatient/established; 2 of 3 key components; 40 minutes	64	56
0368TU5	Adaptive behavior treatment with protocol modification and clinical observation & direction administered by qualified professional first 30 minutes	215	46
0369TU5	Adaptive behavior treatment with protocol modification and clinical observation & direction administered qualified professional each additional 30 minutes	329	40
Q3014GT	Telehealth Originating Site Fee	6801	1840

*Source: Diver

Substance Use Disorder

There were 9 Substance Use Disorder provider agencies in network in FY19 located in 25 sites across the UP and two additional sites downstate. There were 6 outpatient providers with numerous offices, 7 residential providers including 1 youth residential provider, and 4 providers for residential detox services. Provider sites are denoted on the map on page 38.

MI Health Link

NorthCare has numerous outpatient providers/agencies paneled to provide MI Health Link mild/moderate services to MHL consumers. Upper Peninsula Health Plan (UPHP), the health plan in the region, continues to not recognize 6 CMH psychiatrists who are not board-certified. While it is not a federal or state requirement to be board-certified to practice psychiatry, UPHP refuses to panel or pay for services rendered to an MHL individual by a non-board-certified psychiatrist. This has restricted the options for MHL consumers in an area that already lacks resources.

Providers Not Accepting New Patients

Waiting List

While Medicaid consumers cannot be placed on a waiting list for services in general, there were waiting lists for select services in Copper Country CMH and Pathways CMH area. Copper Country CMH had waiting lists for Case Management, Clinic Services and Community Living Supports. Pathways had a waiting list for Residential Services. The other CMH's did not report a waiting list for services in FY19.

Directory

In FY18, Health Services Advisory Group, Inc. (HSAG), a quality improvement organization did an external quality review and indicated that NorthCare and each CMH needed to update current directories to specify who was accepting new patients. This was completed in FY19 and can be found on the NorthCare website.

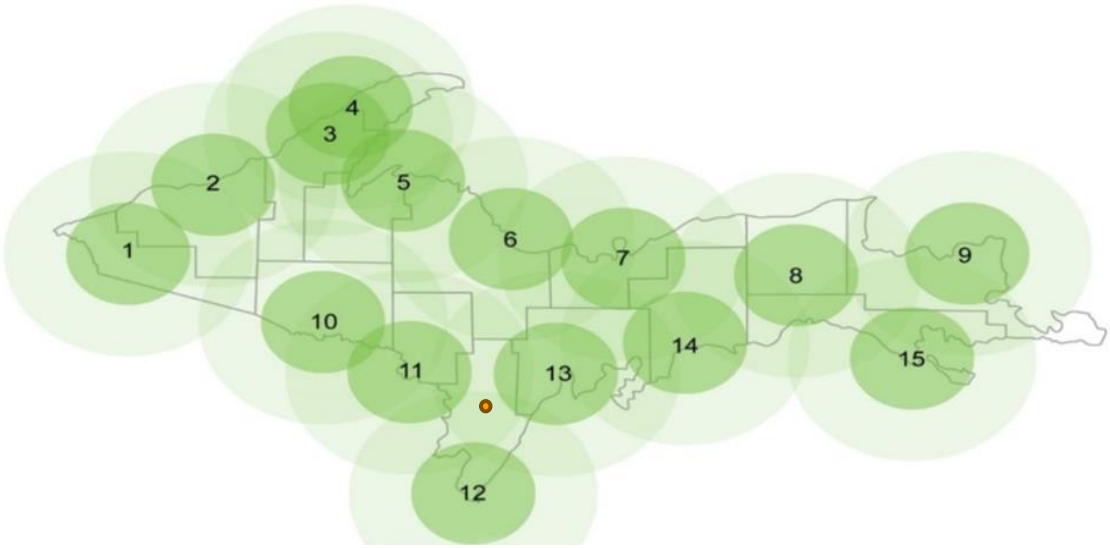
DAB Migration

In FY18, it was discovered that some consumers who previously had Medicaid suddenly had Healthy Michigan benefit coverage. While this provides the same service coverage for the individual, Healthy MI pays providers at a lesser rate than Medicaid. Seventy consumers with a I/DD diagnosis that should have been considered Medicaid since they had a disability were impacted in FY18. One Hundred Six consumers were impacted in FY19; 3 of which were Habilitative Support Waiver Consumers and 11 that lived in dependent residential settings. The estimated impact of this is $415,800 in FY19. It is unknown how much revenue was lost on SMI consumers.

While this loss does not directly impact the consumer, it does result in lost revenue for the system which could indirectly impact staffing and wages- thus creating workforce shortage and having an impact on the consumer. NorthCare hired a part time staff member who will be tasked with identifying and fixing insurance issues.

Geographic Location of Providers

To best provide services, NorthCare strives to ensure providers are available in an individual's area. NorthCare is held to the 60-minute/60-mile rule. The CMH's are located to accommodate this rule. The provider directory, available at www.northcarenetwork.org lists all the CMH providers and links to specific office information such as contact names and address. Directories are updated as needed to assure members have current information about available resources. The dark green area in the map below represents the Urban rule of 30-min/30-miles from each CMH office. The light Green area represents the 60-min/ 60-mile radius from each CMH office. To note, Menominee county has two offices, one located by #12 on the map and another in Powers MI, indicated by the small orange circle. The office in Powers is run part time to better accommodate those who live in that area. Because it is only open a few days a week it has not been added permanently to the map. The second map indicates all the UP SUD providers by county.



Copper Country CMH
5 Baraga County
3 Houghton County
4 Keweenaw County
2 Ontonagon County

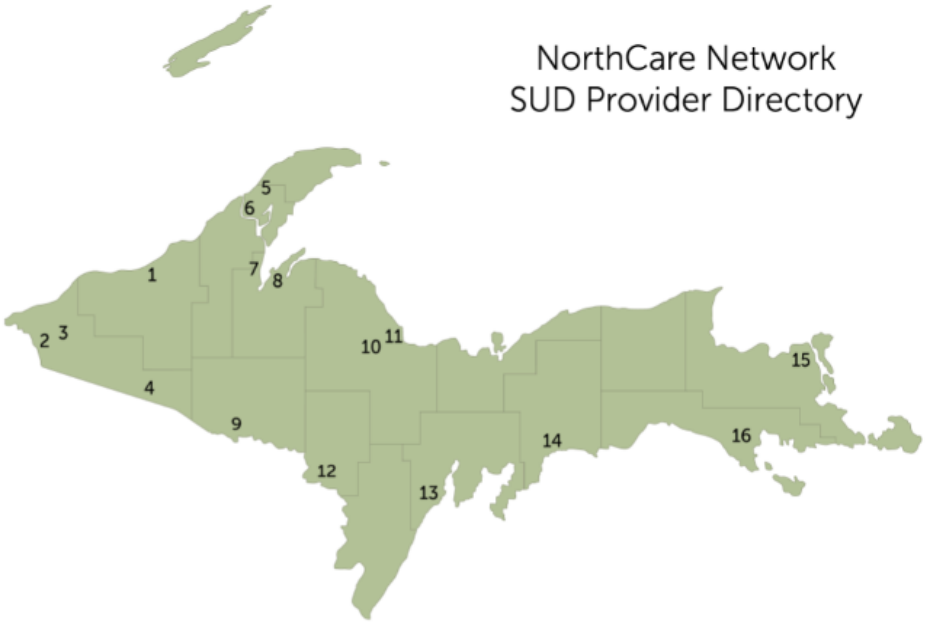
Gogebic Co. CMH
1 Gogebic County

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

Northpointe Behavioral Health
11 Dickinson County
10 Iron County
12 Menominee County

Pathways CMH
7 Alger County
13 Delta County
8 Luce County
6 Marquette County

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 Lac Vieux Desert BHS Outpatient
E23970 Pow Wow Trail Road, Watersmeet

5 Phoenix House Residential & Outpatient
57467 Watersworks Street, Calumet

6 Phoenix House Outpatient
801 North Lincoln Drive, Hancock

Great Lakes Recovery Outpatient
920 Water Street #6, Hancock

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

8 New Day Treatment Center
16025 Brewery, L'Anse

9 Great Lakes Recovery Outpatient
305 W. Genesee St. Suite 3
Iron River, MI 49935

10 Great Lakes Recovery Outpatient
97 South Fourth Street, Ishpeming

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

11 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

Marquette General Behavioral Health Services
580 West College, Marquette

12 Great Lakes Recovery
427 South Stephenson Avenue, Iron Mountain

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

13 Catholic Social Services
1100 Ludington Street #401, Escanaba

Great Lakes Recovery
1401 North 26th #109, Escanaba

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

15 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

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

Revised 8/2018

Conclusion

Since the inception of Prepaid Inpatient Health plans in 2002, NorthCare has been striving to provide efficient and effective treatment to eligible consumers within the Upper Peninsula through effective utilization management. Services are provided through contracted providers including the CMHSP's, SUD providers, inpatient psychiatric hospital units, Gryphon after hours crisis center, and community MI Health Link providers. Oversight of these services is provided through a variety of committees.

The number of consumers approved for services by NorthCare Access has continued to increase again this year although the overall population in the UP has remained stable. Of the consumers approved for an intake for CMHSP services, approximately 94% met criteria for ongoing treatment. Services are provided according to the timeframes indicated in the Mission Based Performance Indicator Standards.

Prevalence rates of youth with mental illness are estimated to be higher than current prevalence rates of adults with mental illness, indicating an increasing need for services in this and the next generation. Due to prevalence rates of trauma and opioid use, the UP needs more providers that are specifically trained in trauma and medication assisted therapy. Similarly, the community lacks inpatient psychiatric resources, dentists, primary care doctors, outpatient psychiatrists, and services for individuals who are homeless. While it is beyond the scope of NorthCare to increase the number of community providers, NorthCare and its affiliated CMH and SUD providers continue to integrate and coordinate care to ensure efficient services are provided to consumers. Coordination efforts with UPHP continues to grow. NorthCare aids the community through the MC3 consultation service, myStrength availability, the Veteran Navigator and the Michigan Opioid Collaborative staff. The Veteran Navigator is working to reduce barriers for veterans to get services and the Opioid Collaborative staff is outreaching to community providers to increase the number of doctors willing to prescribe Medication Assisted Treatment for Opioid Disorders.

SUD prevention collations work with the middle schools to provide education to youth. In FY20 it is expected that over 70% of youth will have received skills training. CMH staff work with area businesses through skill building and supported employment programs to increase the number of consumers competitively employed. Individuals on Medicaid can be employed and make up to a certain amount of money whilst maintaining their Medicaid health insurance benefit.

There continues to be concern regarding the misplacement of consumers off Medicaid and onto Healthy MI Insurance. While this has no impact on the consumers services through CMH or SUD providers, it does result in less revenue for the PIHP which, in turn, means less revenue for the providers to deliver the full scope of services to consumers. There is also concern related to the Home and Community Based Services rule, which is expanding to all B3 services in FY20, and the impact this service may have on residential providers and the consumers who live in them.

Emergency Services utilization increased in FY19. The increasing demand for emergency services continues to be reviewed by regional committees. NorthCare has sought for the approval of crisis intervention via telehealth from MDHHS, however this was not approved.

NorthCare expects a continued trend of increased prevalence of mental illness and substance use disorders in the immediate future and will continue with its mission to ensure that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsibility management of regional resources. NorthCare will continue to provide services consistent with the MDHHS/PIHP contract, the Medicaid Provider Manual, the MI Mental Health Code, and the Code of Federal Regulations.

NorthCare will continue to track utilization and demographic trends and report process and concerns in the annual newsletter, performance report, and on the website in addition to this annual report. Data will be reviewed in various committees and training needs will be identified and addressed as applicable.

Please contact NorthCare Network Customer Service at **888-333-8030** with concerns.

References

CMHSP Annual Submission Report

CMT Reporting

DIVER Reporting

ELMER Reporting

Michigan Mission-Based Performance Indicator System

U.S. Census Data

Access to Behavioral Health Care in Michigan, Results for the Medicaid-Enrolled Population | Altarum (2019). Retrieved 6 April 2020, from https://altarum.org/sites/default/files/uploaded-publication-files/Altarum_Behavioral-Health-Access_Brief-Medicaid.pdf

Autism Spectrum Disorder Data and Statistics on Autism Spectrum Disorder | Centers for Disease Control and Prevention. (April 5, 2019). Retrieved 10 January 2020, from https://www.cdc.gov/ncbddd/autism/data.html

CDC's Response to the Opioid Overdose Epidemic | Centers for Disease Control and Prevention. (November 29,2019). Retrieved 24 February 2020, from https://www.cdc.gov/opioids/.

CDC's Work on Developmental Disabilities | Centers for Disease Control and Prevention. (25 September 2019). Retrieved 10 January 2020, from https://www.cdc.gov/ncbddd/developmentaldisabilities/about.html

Certificate of Need. (2020). Retrieved 10 January 2020, from https://www.michigan.gov/documents/mdhhs/Report_040_Psychiatric_Services_658542_7.pdf

Certificate of Need. (2020). Retrieved 10 January 2020, from https://www.michigan.gov/documents/mdhhs/Report_112_Emergency_Roo_Services_658582_7.pdf

Employment First in Michigan. (November 2019). Michigan Developmental Disabilities Council, Michigan Developmental Disabilities Institute- Wayne State University, Michigan Protection and Advocacy Service, Inc.

Federal Poverty Level (FPL) | Income Guidelines For 2019. (2020). Retrieved 10 January 2020, from https://www.firstquotehealth.com/health-insurance-news/federal-poverty-level-fpl-guidelines

Forman-Hoffman, Valerie; Bose, Jonaki; Batts, Kateryn; Glasheen, Cristie; Hirsch, Erica; Karg, Rhonda; Huang, Larke; Hedden, Sarra. (April 2016). Correlates of Lifetime Exposure to One or More Potentially Traumatic Events and Subsequent Posttraumatic Stress among Adults in the United States: Results from the Mental Health Surveillance Study, 2008-2012. Substance Abuse and Mental Health Services Administration. CBHSQ Data Review. Retrieved 10 January 2020, from https://www.samhsa.gov/data/sites/default/files/CBHSQ-DR-PTSDtrauma-2016/CBHSQ-DR-PTSDtrauma-2016.pdf

Hannah Ritchie and Max Roser (2020) - "Drug Use". *Published online at OurWorldInData.org.* Retrieved 10 January 2020 from https://ourworldindata.org/drug-use#deaths-from-substance-use-disorders

Median Household Income- SAIPE in Michigan | KIDS COUNT Data Center. (2020). Retrieved 10 January 2020, from https://datacenter.kidscount.org/data/tables/1767-median-household-income--saipe?loc=24&loct=5#detailed/5/3745,3750,3760,3764-3765,3770,3774,3779,3785,3791-3792,3795,3798,3809,3820/true/871,870,573,869,36,868,867,133,38,35/any/3741

Medication and Counseling Treatment | SAMHSA. (2020). Retrieved 6 April 2020, from https://www.samhsa.gov/medication-assisted-treatment/treatment

Mental Health Care Matters | National Alliance on Mental Illness. (2020). Retrieved 10 January 2020, from https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-Mental-Health-Care-Matters-FINAL.pdf

Mental Health Providers | County Health Rankings. (2020). Retrieved 10 January 2020, from https://www.countyhealthrankings.org/app/michigan/2019/measure/factors/62/data?sort=sc-3

Michigan Crime Incident Reporting, 2018 Arrests by County Statistics. Retrieved 1 May 2020, from https://www.michigan.gov/msp/0,4643,7-123-1586_3501_4621---,00.html

National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, 2010 National Survey of Veterans. (December 2011). Retrieved 10 January 2020, from https://www.va.gov/vetdata/docs/QuickFacts/2010NSV_Quick_Fact_Final.PDF

National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, Veteran Population. (November 8, 2019). Retrieved 10 January 2020, from https://www.va.gov/vetdata/Veteran_Population.asp

National Health Promotion Associates. Botvin LifeSkills Training. (2006). Retrieved 12 February 2020, from https://www.lifeskillstraining.com/fact-sheet/

NIDA. (2018, August 1). Comorbidity: Substance Use Disorders and Other Mental Illnesses. Retrieved 10 January 2020 from https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

NIMH. Mental Illness. (2020). Retrieved 10 January 2020, from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

O'Donnell, Jayne. (29 December 2019). USA Today. Five myths and misconceptions about the nation's 2019 vaping illness crisis. Retrieved 10 January 2020, from https://www.msn.com/en-us/news/us/five-myths-and-misconceptions-about-the-nations-2019-vaping-illness-crisis/ar-BBYonAC

Roelofs, Ted. (13 December 2019). Bridge. Childhood trauma is tied to health risks, but Michigan doctors don't ask. Retrieved 6 March 2020, from https://www.bridgemi.com/michigan-health-watch/childhood-trauma-tied-health-risks-michigan-doctors-dont-ask

Sexual Violence and Intimate Partner Violence Among People with Disabilities | Centers for Disease Control and Prevention. (24 October 2018). Retrieved 10 January 2020, from https://www.cdc.gov/violenceprevention/datasources/nisvs/svandipv.html

Sexual Violence in Youth | Centers for Disease Control and Prevention National Center for Injury Prevention and Control. (2012). Retrieved 10 January 2020, from https://www.cdc.gov/violenceprevention/pdf/2012FindingsonSVinYouth-508.pdf

Special Education Ages 0-26 in Michigan | KIDS COUNT Data Center. (2020). Retrieved 10 January 2020, from https://datacenter.kidscount.org/data/map/1714-special-education-ages-0-26?loc=24&loct=2#5/any/true/false/37/any/13112/Orange/

Special Education Data Portraits: Disability | MI School Data. (2020). Retrieved 10 January 2020, from https://www.mischooldata.org/SpecialEducationEarlyOn2/DataPortraits/DataPortraitsDisability.aspx

Students Receiving Free or Reduced Price Lunch | KIDS COUNT Data Center. (2020). Retrieved 10 January 2020, from https://datacenter.kidscount.org/data/tables/1672-students-receiving-free-or-reduced-priced-lunch?loc=24&loct=5#detailed/5/any/true/37,871,870,573,869,36,868,867,133,38/any/3551,13159

Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Michigan, 2015*. HHS Publication No. SMA–16–Baro–2015–MI. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Retrieved 10 January 2020, from https://www.samhsa.gov/data/sites/default/files/2015_Michigan_BHBarometer.pdf

Substance Abuse and Mental Health Services Administration. National Survey of Substance Abuse Treatment Services (N-SSATS) 2018 State Profile.

The Ripple Effect of Mental Illness | National Alliance on Mental Illness. (2020). Retrieved 10 January 2020, from https://nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-Impact-Ripple-Effect-FINAL.pdf

Trauma and Violence | Substance Abuse and Mental Health Services Administration. (2 August 2019). Retrieved 10 January 2020, from https://www.samhsa.gov/trauma-violence

U.S. Census Bureau QuickFacts: Michigan. (2020). Retrieved 10 January 2020, from https://www.census.gov/quickfacts/MI

Unemployment in Michigan | KIDS COUNT Data Center. (2020). Retrieved 10 January 2020, from https://datacenter.kidscount.org/data/tables/1718-unemployment?loc=24&loct=5#detailed/5/3745,3750,3760,3764-3765,3770,3774,3779,3785,3791-3792,3795,3798,3809,3820/true/37,871,870/any/13133

University of Washington. Institute for Health Metrics and Evaluation (2020). US Health Map | Viz Hub. All Causes, Both Sexes, Age-Standardized,2014. Retrieved 10 January 2020, from https://vizhub.healthdata.org/subnational/usa

University of Washington. Institute for Health Metrics and Evaluation (2020). GBD Compare | Viz Hub. Global, Both Sexes, All Ages, 2017, DALYs. Retrieved 10 January 2020, from https://vizhub.healthdata.org/gbd-compare/

What Are the ASAM Levels of Care? | American Society of Addiction Medicine. (13 May 2015). Retrieved 10 January 2020, from https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

You are Not Alone | National Alliance on Mental Illness. (2020). Retrieved 10 January 2020, from https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-You-Are-Not-Alone-FINAL.pdf