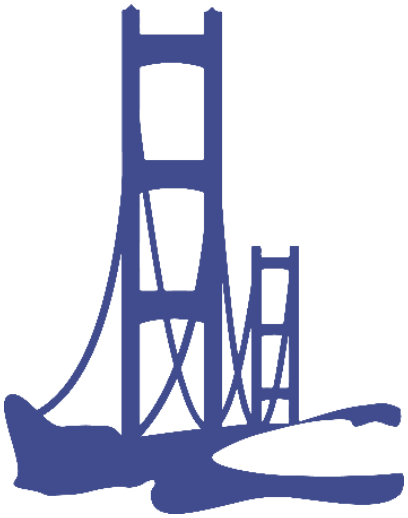
NorthCare Network

Demand and Capacity Report

FY20 Review and Analysis



June 1, 2021

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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 1115 Demonstration 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 1115 Demonstration Waiver operates in conjunction with the 1915(i) Waiver and 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 1115 Demonstration Waiver and the 1915 (i), 1915 (c) and 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 a SUD prevention and treatment program under the Substance Abuse Prevention and Treatment Block Grant.*
>
> *The purpose of this contract is to obtain the services of the selected PIHP to manage the 1115 Demonstration Waiver and 1915 (c)/(i) 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 20 (October 1, 2019 through September 30, 2020)."*

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 (CMHs). 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. Specialty services provided by the CMHs 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 CMHs, interested consumers and stakeholders, with PIHP staff as the committee lead. The five affiliate CMHs share resources, experiences, and skills to drive performance improvement across the Region. The CMHs 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 and allow for coordinated management:

Performance Management Committee (PMC) is configured with CEO representation from the CMHs 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 Governing 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.

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 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 Governing Board.

Contract Management Committee is charged with assuring contract language meets state and federal requirements; utilize and implement state reciprocity workgroup tools. The committee will collaborate regionally on common contract standards and processes. This committee also provides an avenue for regional contract managers to network and share best practices.

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 CMHs. The CMHs, 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 FY20, the CMH's annual submission report needs assessment was specific to the COVID-19 pandemic and identified the following areas of need:

- Safety During the Pandemic
    - Improved health and well-being of residents in group homes and consumers in outpatient programs
    - Staff safety, including provision of Personal Protective Equipment
    - Improved testing capabilities with quicker results
    - Assessment of long-term programming, including safe provision of face-to-face individual and group formats during and post pandemic
    - Cleaning services and protocol development
    - Education regarding the science and government mandates related to COVID-19
- Staffing
    - Increased ability for staff to complete all job duties, including provision of technology to work from home during the pandemic
    - Addressing staff shortages, which were increasingly short during COVID-19 as staff were out sick/quarantining, applicable to CMHSP staff and group home staff
- Interpersonal and Interagency Connections
    - Enhanced staff morale
    - Engaging with community partners utilizing a safe method
    - Mitigating the mental health impact of COVID-19 on consumers, staff, and community members
- Emergent Psychiatric Care
    - Assessing the appropriateness of face-to-face crisis intervention services in the Emergency Rooms
    - Increased placements for COVID-19 positive individuals requiring treatment on an inpatient psychiatric unit

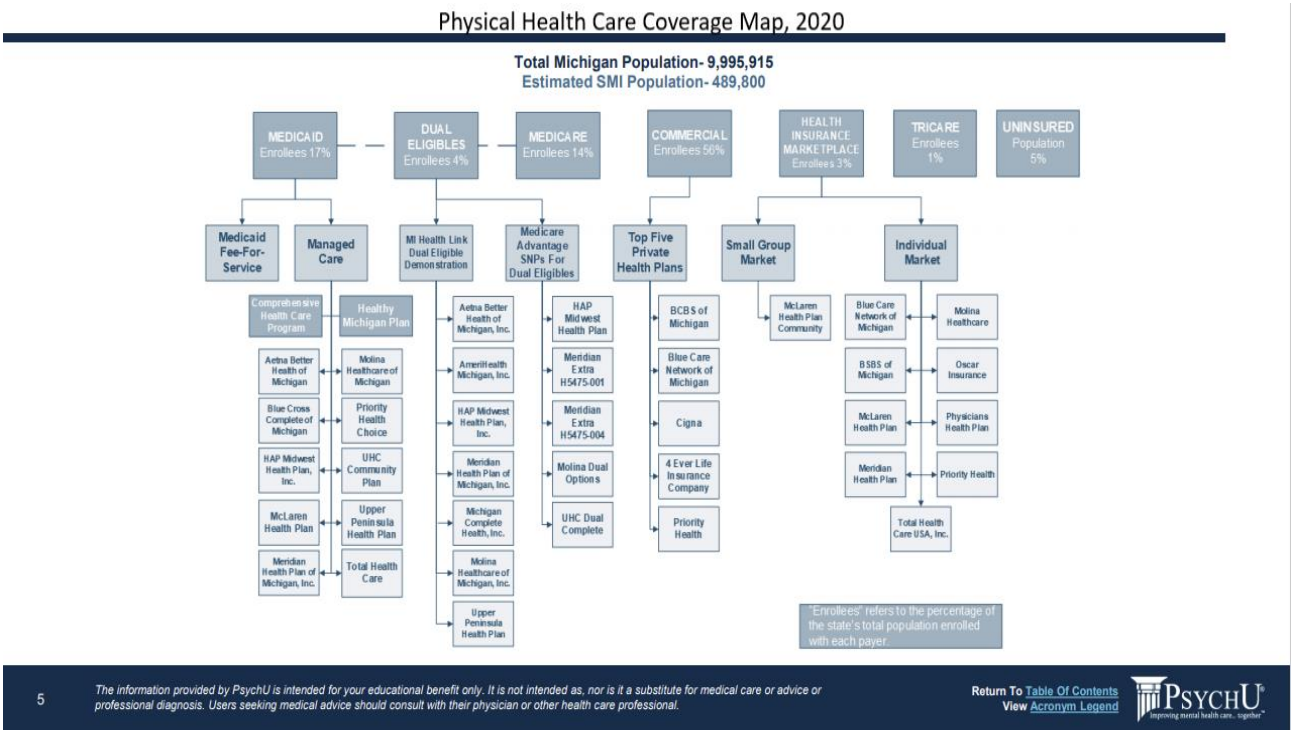
Anticipated Medicaid Enrollment

Medicaid/ Healthy Michigan

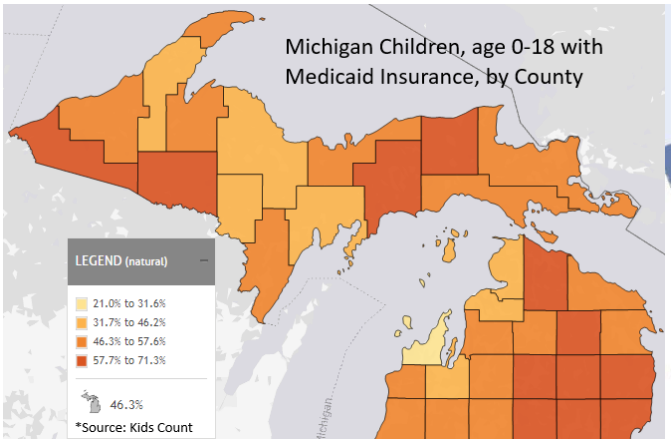
One determinate of Medicaid and Healthy Michigan enrollment is household income. The poverty guidelines are used to help determine eligibility for a variety of programs including Head Start, Supplemental Nutrition Assistance Program (SNAP), School Lunch Program, Low-Income Home Energy Assistance, and the Children's Health Insurance Program (CHIP). The cash assistance programs such as Supplemental Security Income (SSI) do not use these guidelines. The federal poverty guideline is the same for the 48 contiguous states, and in 2020 the guideline was $12,760/annual for one individual in the household (U.S. Department of Health and Human Services, 2020). Individuals earning below 138% of the federal poverty level who are between the ages of 19 and 64 are eligible for Healthy Michigan. This is based off the modified adjusted gross income for the family (US Department of Health and Human Services, 2021). In May 2020, there were 715,239 individuals enrolled in Healthy Michigan (Otsuka Pharmaceutical Development & Commercialization, Inc., 2020).

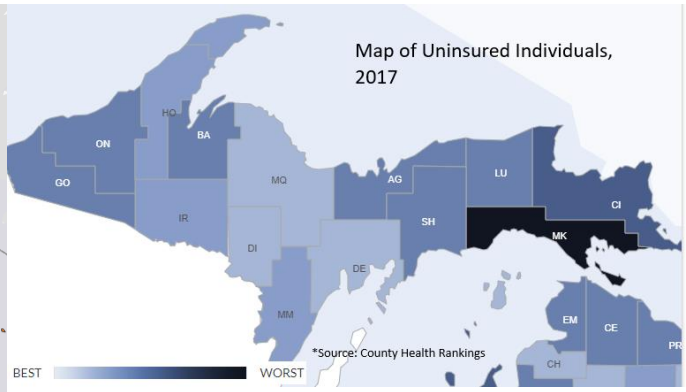
2020 Poverty Guidelines	
Family Size	Guideline
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120
For families with more than 8, add $4,480 per person	
Source: Healthcare.gov	

Michigan is the 10th most populous state in the nation; 9,995,915 individuals in 2020 and composed 3% of the United States Population. The Upper Peninsula constituted about 3% of Michigan's population. Seventeen percent of Individuals in Michigan were covered by Medicaid insurance. Additionally, 4% were enrolled in Medicare and Medicaid, 5% of the population was uninsured, and 3% were enrolled through the Health Insurance Marketplace. Additionally, 4.3% of Michigan children had private insurance that did not cover their mental or emotional health care (Mental Health America, 2020).



The following maps give a visual representation of children with Medicaid and uninsured individuals. In 2017, Mackinac County had the highest rate of uninsured individuals under the age of 65 in the state; 11% (University of Wisconsin Population Health Institute, 2020). Depending on the financial stability of those who are uninsured and purchasing insurance, and the benefit coverage of the purchased insurance, it could be anticipated that anywhere from 17% to 29% of Michigan's population could meet enrollment requirements for Medicaid.





While the U.S. had a median income of $61,937, Michigan had a median income of $56,697 in 2020. Local county numbers for 2019 are noted in the table and reflect that every county in the U.P. is below the state median income by anywhere from $3,000 to $18,000. This may contribute to the fact that while nationally only 2% of individuals are considered uninsured, in Michigan 5% are uninsured (Otsuka Pharmaceutical Development & Commercialization, Inc., 2020).

Employment is another important factor to consider when discussing anticipated Medicaid enrollment. COVID-19 impacted unemployment rates significantly in FY20 and beyond. Numerous businesses shut down, resulting in previously employed individuals to suddenly find themselves unemployed. The uncertain health risk of COVID-19 initially scared a lot of individuals into not wanting to seek employment elsewhere. As the pandemic continued, some individuals did begin seeking employment, but many continued to be unemployed out of concerns for their health, needing to care for children who did not return to school, or a multitude of other reasons. Two financial assistance methods occurred in Michigan during the COVID-19 pandemic. Unemployment benefits increased and stimulus checks were provided. These combined financial payments were designed to ensure individuals could maintain their housing, afford groceries, etc. The impact of COVID-19 significantly skewed any data related to employment. The unemployment rate in Michigan went from 3.7% in March 2020 to 23.60% in April 2020 and as of September 2020 was still 8.2% (Bureau of Labor and Statistics, 2021).

Median Income by Michigan County (2019)	
Michigan	$57,144
Alger	$45,570
Baraga	$46,065
Chippewa	$46,486
Delta	$47,434
Dickinson	$51,645
Gogebic	$38,839
Houghton	$43,183
Iron	$41,599
Keweenaw	$50,292
Luce	$45,469
Mackinac	$47,938
Marquette	$53,970
Menominee	$46,828
Ontonagon	$41,546
Schoolcraft	$45,500

** Source: Census*

Unemployment Rate, Pre-COVID-19 and During COVID-19			
Date	National Unemployment Rate	Michigan Unemployment Rate	Michigan Unemployed
Feb-21	6.20%	—	—
Jan-21	6.30%	5.70%	270,791
Dec-20	6.70%	8.20%	400,370
Nov-20	6.70%	8.20%	396,682
Oct-20	6.90%	8.10%	392,843
Sep-20	7.80%	8.20%	398,010
Aug-20	8.40%	8.50%	412,633
Jul-20	10.20%	9.00%	435,896
Jun-20	11.10%	14.10%	695,082
May-20	13.30%	20.80%	976,829
Apr-20	14.80%	23.60%	1,084,356
Mar-20	4.40%	3.70%	182,929

**Source: Department of Numbers*

January 2021 Unemployment by County				
Area	Labor Force	Employed	Unemployed	Rate
Michigan	4,713,000	4,424,000	289,000	6.1
Alger	3,037	2,690	347	11.4
Baraga	3,120	2,822	298	9.6
Chippewa	15,889	14,448	1,441	9.1
Delta	17,098	15,793	1,305	7.6
Dickinson	12,239	11,508	731	6
Gogebic	5,909	5,534	375	6.3
Houghton	15,700	14,764	936	6
Iron	4,878	4,497	381	7.8
Keweenaw	875	797	78	8.9
Luce	2,163	1,976	187	8.6
Mackinac	4,054	3,265	789	19.5
Marquette	31,977	29,830	2,147	6.7
Menominee	10,651	10,113	538	5.1
Ontonagon	2,012	1,838	174	8.6
Schoolcraft	3,213	2,885	328	10.2

Source: Michigan DTMB, Bureau of Labor Market Information and Strategic Initiatives, Local Area Unemployment Statistics (LAUS). Data not seasonally adjusted.

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 CMHSP 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.

Four percent of Michigan's population of 9,995,915 were considered 'dual eligible' in 2020, meaning they were enrolled in both Medicare and Medicaid, although not necessarily in MHL (Otsuka Pharmaceutical Development & Commercialization, Inc., 2020). 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 FY20.

MI Health Link Enrollment by Month												
	2019			2020								
	October	November	December	January	February	March	April	May	June	July	August	September
Enrollment	4,004	4,023	4,010	4,017	3,994	4,044	4,015	4,065	4,081	4,083	4,130	4,185
Total Served	1,137	1,167	1,197	1,200	1,211	1,232	1,162	1,151	1,111	1,167	1,177	1,191

Risk Reserve

NorthCare manages a risk reserve in efforts to mitigate risks with affiliate CMHSPs 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 to Services

COVID-19

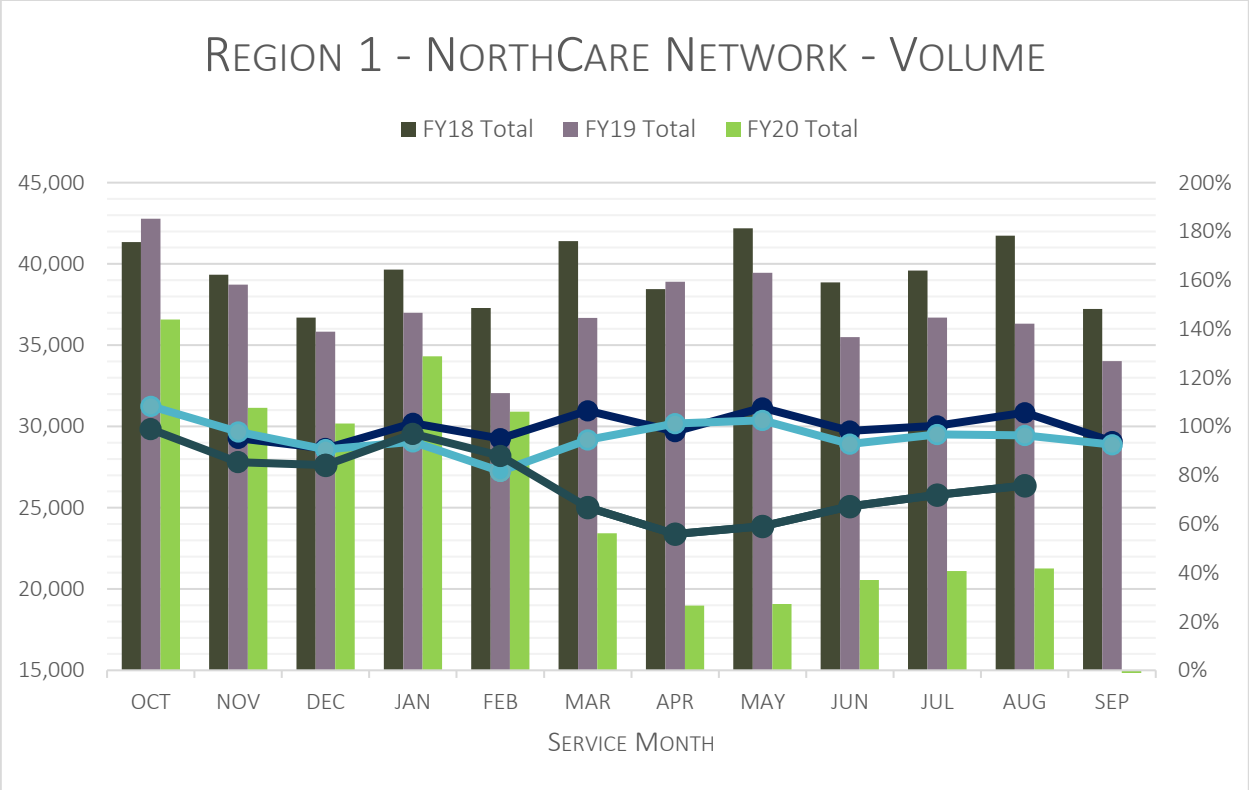
Traditionally, past utilization of services also assists in planning for future utilization. However, FY20 threw the world a curve ball no one had the ability to anticipate or predict. NorthCare's priority from the start of the pandemic was to ensure behavioral health services continued to be provided while protecting the health and safety of consumers and staff. Changes implemented included having staff work remotely where possible, purchasing and distributing Personal Protective Equipment (PPE) to the entire provider network, and expanding telehealth services. During FY20, and continuing into FY21, PPE was shipped or delivered to providers across the region, including residential facilities and adult foster care homes, weekly. Michigan's Department of Health and Human Services (MDHHS) expansion of services allowable through telehealth technology, which was passed through Michigan State Legislature, allowed providers to deliver a broader array of services on a platform previously disallowed by Medicaid.

Prior to the pandemic, NorthCare and our providers had been using technologies like Zoom and LifeSize. This allowed our region to adapt quickly to this necessary change. Telehealth continues to be instrumental in helping providers and consumers connect for services in a manner which provides the consumer with choices that work best for them. The utilization of secure internet and cloud-based technologies offered the flexibility for work-from-home scenarios, allowing staff to seamlessly provide services and supports from their location. The use of teleconferencing technology, while already regularly utilized, expanded greatly during COVID-19 to allow staff to communicate and collaborate quickly and effectively through audio, video, and chat. The transition to remote operations has not been without its problems; work-from-home scenarios, coupled with virtual learning and a generally increased use of information technology to stay in touch has placed unprecedented stress on Internet infrastructure. Working closely with technology partners throughout the region has allowed us to swiftly manage bandwidth and logistics concerns and keep productivity maximized.

Our provider network found additional ways to stay connected with their consumers by loaning iPads to some consumers who did not have computers to assist with telehealth appointments, picking up groceries for consumers who were not able to leave their homes, and worked to accommodate other consumer requests and potential needs throughout this pandemic.

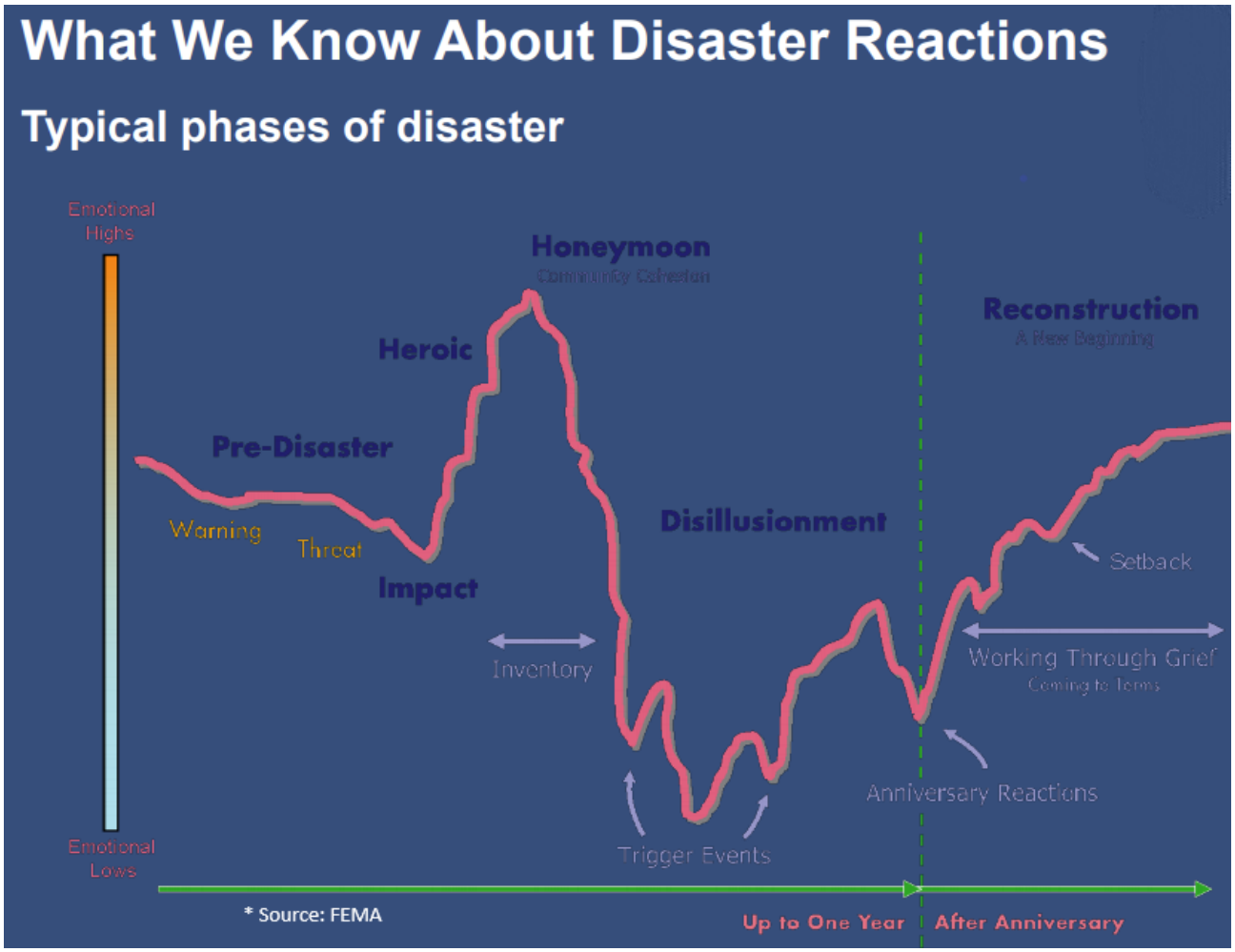
NorthCare has provided financial support to our providers through advances, expanding the premium pay, and covering additional payroll costs incurred in Adult Foster Care homes serving COVID positive consumers. NorthCare collaborated with U.P. Health Departments and MDHHS to get additional COVID-19 testing supplies sent to our region and created a region wide testing strategy. SUD Providers and CMHSPs were given guidance and testing kits for residential facilities across the Upper Peninsula. NorthCare is grateful and thankful to all our partners, consumers, and families for working together in keeping each other safe.

Below is a graph showing the changes in the volume of services provided by NorthCare Network CMHSPs and SUD providers since the start of the pandemic in mid-March 2020. Regional encounter volume dropped for services provided in March, April and May 2020 with encounters moving back up through June, July, and August. Regarding timeliness, NorthCare's results have been consistently at or near 100% for the last two fiscal years.



Statewide, COVID-19 intensified the lack of services available and intensified the mental health concerns of individuals (Michigan Department of Health and Human Services, 2021). The Center for Disease Control (CDC) found an increase in mental health related Emergency Room Visits for children between 2019 and 2020, with a 24% increase in ER visits for children ages 5-11 and a 31% increase for children ages 12-17 (Michigan Department of Health and Human Services, 2021). Parents have reported seeing a decline in their child's mental health since the onset of COVID-19. Additionally, a CDC study of 5,000 individuals across the U.S. found 41% of people reported a mental health concern due to COVID-19, including anxiety, depression, and substance use (Michigan Department of Health and Human Services, 2021).

Typically, disasters strike a particular group or geographical area, but COVID-19 had a global impact. According to the Federal Emergency Management Agency (FEMA), generally individuals react to disasters in a predictable way, including a honeymoon period of emotional highs and a time of emotional lows before beginning to come to terms with the grief they suffered (Ligenza et al, 2010). Following a disaster there is an opportunity for Post Traumatic Growth, where individuals can use the negative experience or adversity they went through to rise to a higher level of functioning and a psychological shift in their way of thinking about and relating to the world.



While COVID-19 continues to be a world-wide concern at the time of this report, hope is on the horizon. While most individuals will naturally recover from their disaster response, and some will experience Post Traumatic Growth, others may have serious ongoing reactions and behavioral health consequences from the pandemic. Predicting the increase on demand this will have is unprecedented, but it is expected that there will be an increase in demand in FY21 and for months post-COVID-19 as individuals experience anniversary reactions and work through their grief.

NorthCare Access

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 and functional deficits to help determine if an individual may be eligible for further assessment. In FY20, there were 2883 Access Screenings completed with 2501 resulting in appointments for further assessment at the CMHSP.

Consumers are surveyed annually via phone call to determine their satisfaction with the Access experience. In FY20, 100% of contacted consumers indicated that they found access staff helpful.

CMHSP Access

Once approved by NorthCare Network Access Department, individuals are assessed face to face (or via telehealth during COVID-19) at the CMHSP to further determine eligibility for specialty mental health services. CMHSP's report, via the Annual Submission Report, the number of individuals found eligible for ongoing CMHSP services by eligibility category. Those in the *unknown* category may have come from the waiting list or may be individuals with multiple needs and further assessment is required to better determine their primary designation. Regionally, approximately 76% of individuals scheduled for an intake assessment met criteria for ongoing CMHSP services.

Categorically, service provision is broken down by population type and by age. 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 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 FY20.

Request for Services and Disposition of Requests					
	I/DD	SMI	SED	Unk	Total
Number of People that Called or Walked In					
Copper	18	250	109	803	1180
Gogebic	6	133	55	441	635
Hiawatha	23	307	182	623	1135
Northpointe	42	444	182	846	1514
Pathways	64	752	313	1789	2918
Number of People Requesting CMHSP Services					
Copper	18	250	109	0	377
Gogebic	6	133	55	0	194
Hiawatha	23	307	182	0	512
Northpointe	42	444	182	0	668
Pathways	64	752	313	0	1129
Number of People Scheduled for Assessment					
Copper	18	208	97	0	323
Gogebic	6	108	52	0	166
Hiawatha	20	252	171	0	443
Northpointe	42	354	172	0	568
Pathways	63	638	297	0	998
Number of People Meeting CMHSP Eligibility					
Copper	14	160	82	0	256
Gogebic	6	80	42	0	128
Hiawatha	19	184	143	0	346
Northpointe	42	327	147	0	516
Pathways	48	386	231	9	674

*Source: CMHSP PPG Data

Consumers Served by Population					
	Adults w/ MI	Children w/ MI	Adults w/ I/DD	Children w/ I/DD	Mild-to-Moderate Adults
Copper Country	553	142	189	34	7
Gogebic	280	74	95	26	2
Hiawatha	653	235	212	45	3
Northpointe	841	287	270	72	10
Pathways	1536	446	490	92	23
NorthCare (unduplicated)	3863	1184	1256	269	45

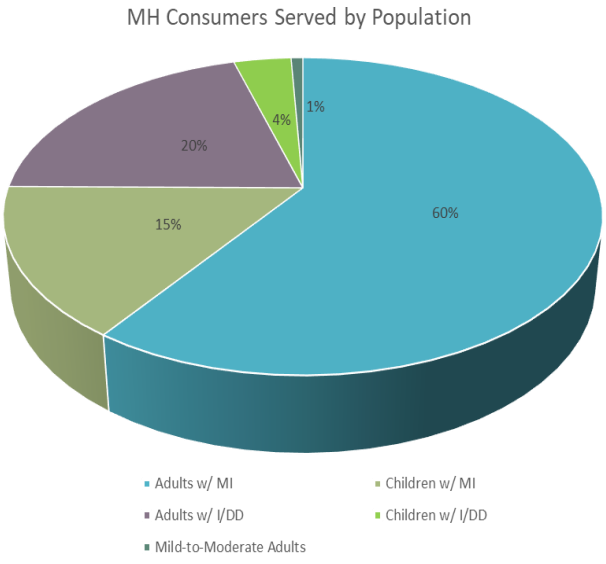
Source: Diver / FY20 Service Model / Medicaid = 'Y' / Service Reportable = 'Y' / Population (group by broad level) / AffiliateName

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

Consumers Served by Age							
Population	Age 3 & Under	4-5 Years of Age	6-17 Years of Age	18-21 Years of	22-64 Years of	65+ Years of	Total Consumer
I/DD	8	43	217	132	965	145	1510
MI	29	73	1028	357	3177	208	4872
MMD	0	0	0	0	36	9	45
MH Totals	37	116	1245	489	4178	362	6427
SUD Totals	0	0	24	57	1452	4	1537

CMH Source: Diver / FY20 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



In addition to the individuals served above, CMHSP's also manage a waiting list for non-Medicaid consumers. CMHSPs 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 may qualify for services can be placed on waiting lists. Waiting lists are broken into different service categories. The following categories had some individuals on a waiting list at the end of FY20. Individuals who were added to the waiting list and removed from the waiting list within the fiscal year are not reflected in this table.

Number of Individuals on a Waiting List at the End of FY20 by Services and Population												
	Supports for Residential Living				Clinical Services				Case Management/Supports Coordination			
	MIA	IDD	SED	Total	MIA	IDD	SED	Total	MIA	IDD	SED	Total
Copper	0	0	0	0	3	0	0	3	1	3	0	4
Gogebic	0	0	0	0	0	0	0	0	0	0	0	0
Hiawatha	0	0	0	0	0	0	0	0	0	0	0	0
Northpointe	0	0	0	0	0	0	0	0	0	0	0	0
Pathways	4	17	1	22	0	0	0	0	0	0	0	0
*Source: CMH PPG Data												

Accessing services in a timely manner is important for the consumers we serve and is a performance indicator measurement for MDHHS. The table below shows NorthCare's statistics regarding CMHSP access to services as compared to the state average for FY20Q4. While some indicators are above state average, and some below, all leave room for improvement. Biopsychosocial assessments take approximately two hours to complete. Ensuring there are enough staff to schedule consumers timely, and that consumers attend these appointments will improve overall efficiency. The BPS attendance table below suggests that staffing levels are lacking for some populations, or possibly reflects the need for increased engagement efforts to ensure an individual attends their appointment.

FY20Q4 Statewide Performance Indicator Data		
Indicator	NorthCare Average	Statewide Average
The Percent of New Persons During the Quarter (FY20Q4) Receiving a Completed BPS within 14 Calendar Days of a Non-Emergency Request for Services	65.69%	68.54%
Children (SED)	70.23%	70.31%
Adults (SMI)	62.94%	66.47%
Children (IDD)	83.33%	78.24%
Adults (IDD)	68.18%	71.18%
The Percent of New Persons During the Quarter (FY20Q4) Starting any Medically Necessary Ongoing Covered Service within 14 days of Completing a BPS	78.31%	81.62%
Children (SED)	81.44%	80.71%
Adults (SMI)	75.97%	81.36%
Children (IDD)	81.82%	85.33%
Adults (IDD)	92.86%	83.92%
Source: MDHHS		

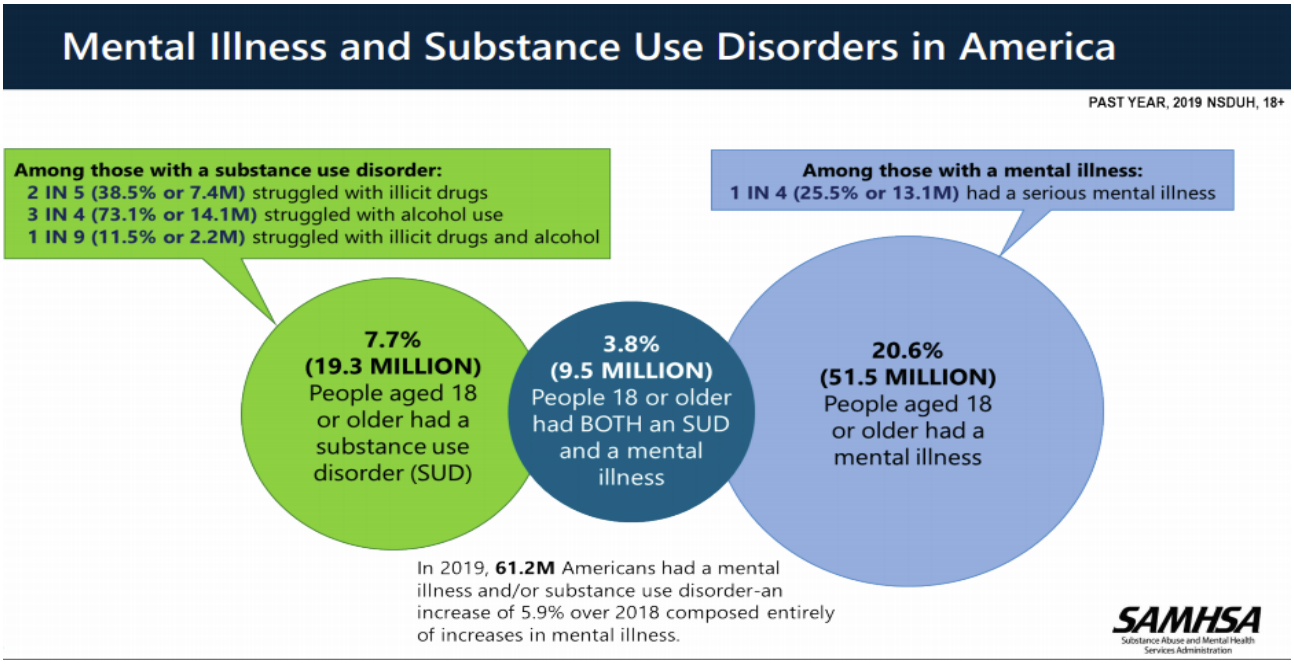
Additionally, once an individual has their BPS, if approved, the first appointment is also expected to happen within 14 days. Effective engagement in ongoing service is vital early in the process. The National Alliance on Mental Illness (NAMI) reports that 70% of individuals seeking mental health services drop out within the first two visits (NAMI, 2016). The annual satisfaction survey question *appointments are schedules at times that work best for me* scored an average of 95%.

NorthCare had an Engagement Performance Improvement Project (PIP) in FY20 to increase the number of individuals who receive services for at least 90 days after initial assessment determined eligibility for services. The goal is to ensure consumers are engaged beyond their initial appointment. As a result of the engagement efforts of the CMHSPs, the percent of individuals not engaged decreased from a baseline of 16.31% in FY18 to 13.86% in FY20.

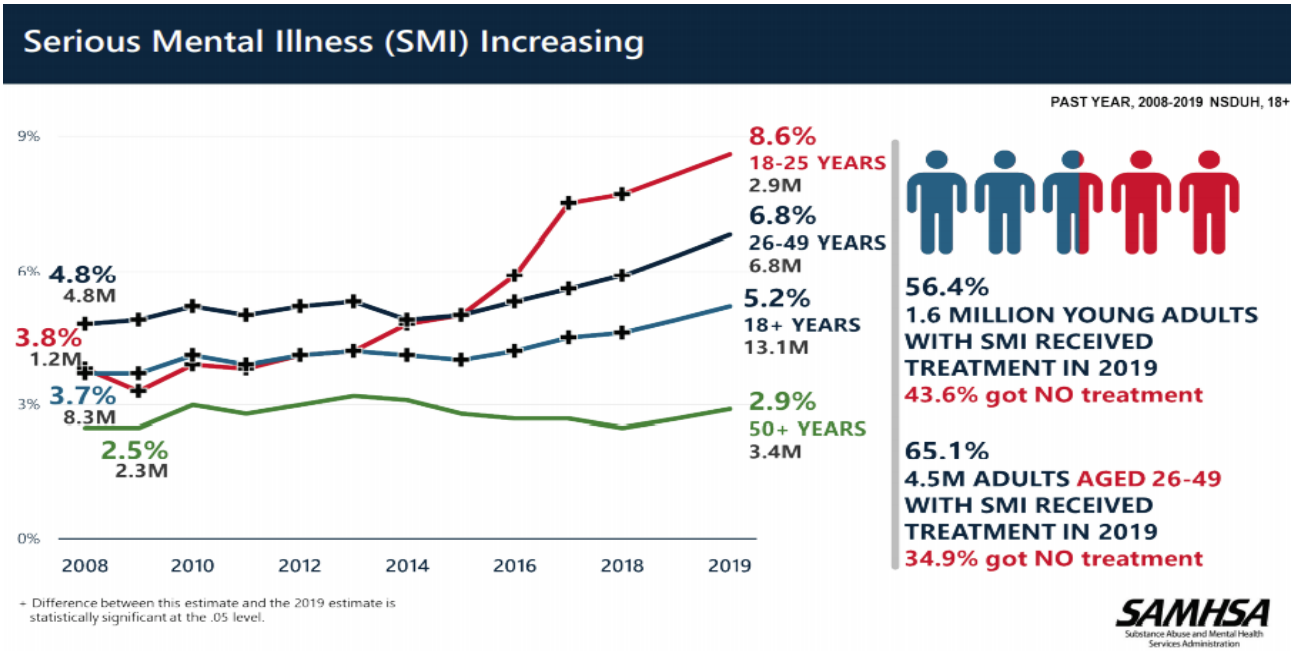
Engagement Performance Improvement Project				
Measurement Period	Numerator	Denominator	% NOT Engaged	Goal
10.1.17 - 9.30.18	307	1882	16.31%	Baseline
10.1.18 - 9.30.19	225	1592	14.13%	<16.31%
10.1.19 - 9.30.20	216	1559	13.86%	<14.13%
10.1.20 - 9.30.21				<13.86%

Prevalence Rates

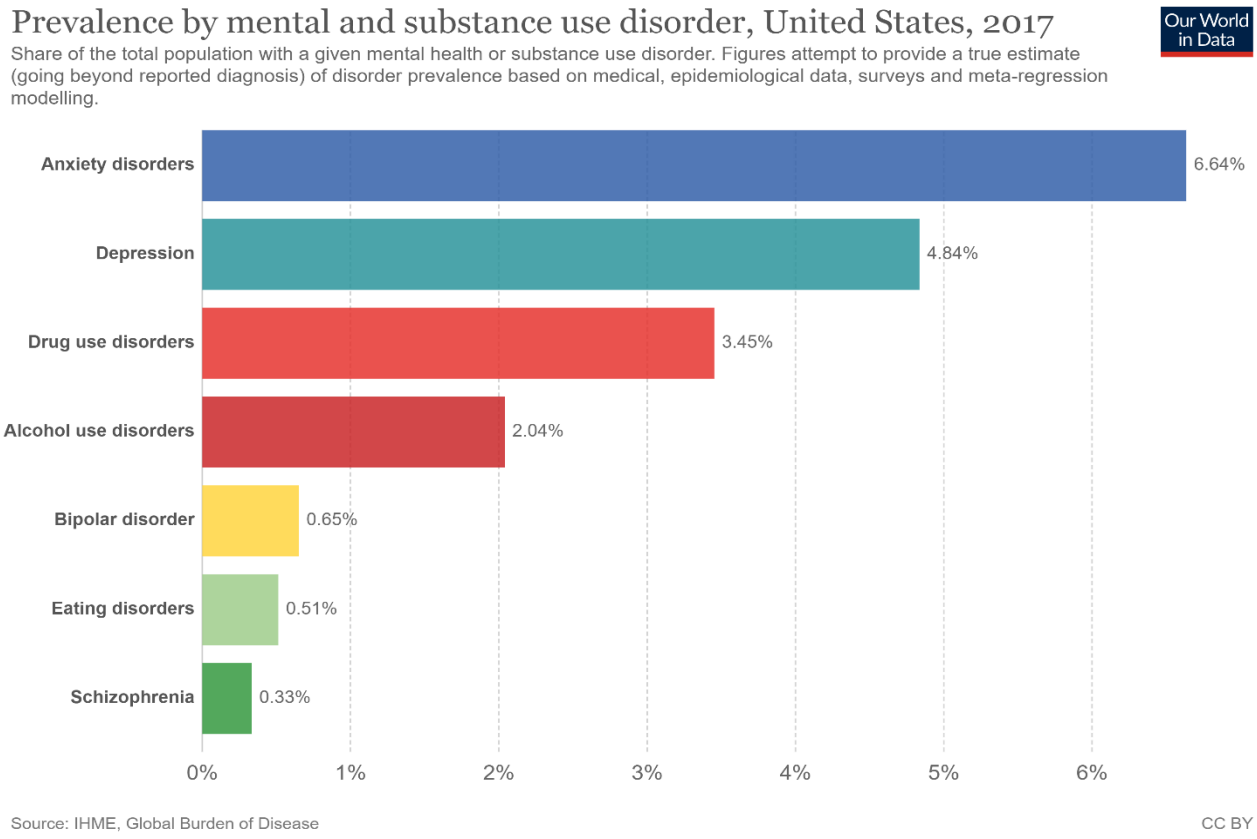
SAMHSA reported that in 2019, 19.3 million adults in the U.S. had a substance use disorder, 51.5 million had a mental illness, and 9.5 million had a co-occurring mental health and substance use disorder. This is an increase of 5.9% from 2018, comprised entirely of increases in mental illness and is illustrated in the chart below (SAMHSA, 2020). It is important to note that this data from 2018-2019 is pre-COVID-19. Therefore, demand for mental health services was increasing even prior to COVID-19. COVID-19 is expected to increase demand even more.



While demand is increasing, utilization and capacity is not necessarily following suit. Mental Health America reports nationally 57.2% of adults with any mental illness did not get any treatment in 2020. In Michigan 51.1% went without treatment. For those that did get treatment, 22.3% of adults nationally (22.0% Michigan) indicated they still had an unmet need (Mental Health America, 2020). SAMHSA reports similar numbers for individuals with Serious Mental Illness with approximately 35 to 44% not receiving treatment (SAMHSA 2020).

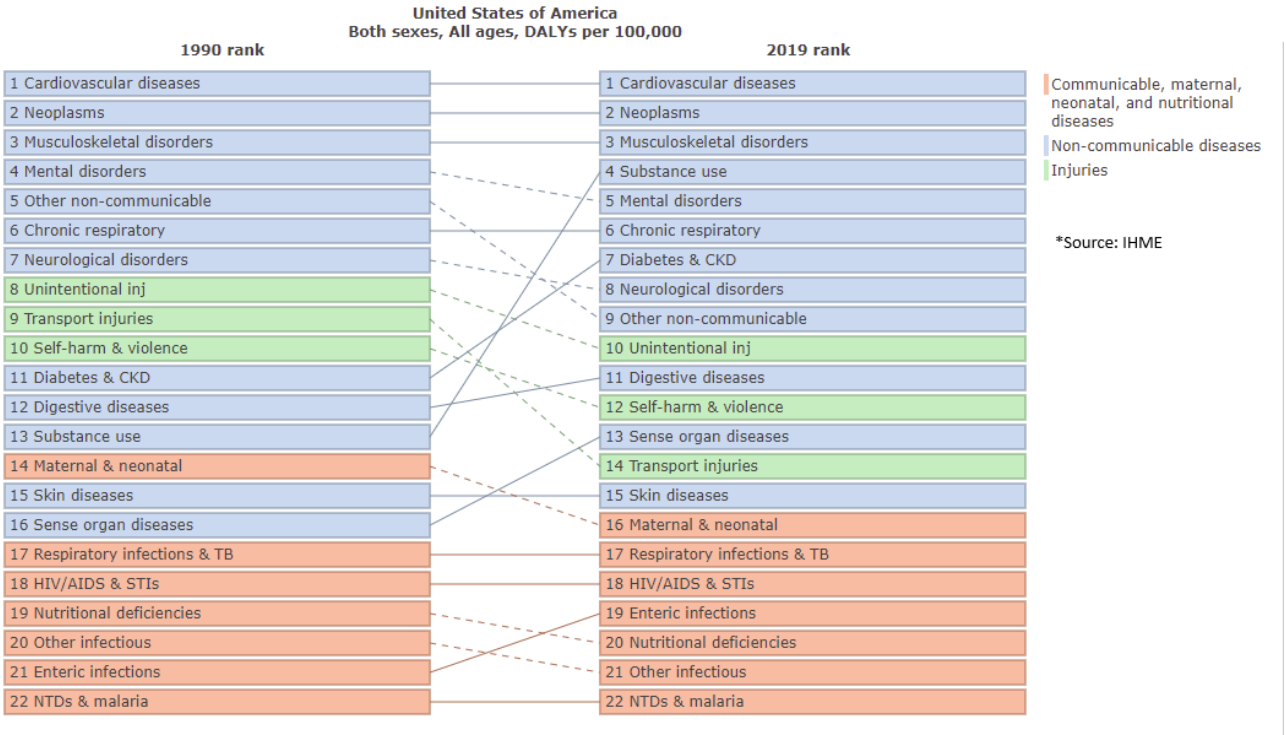


According to Psych U, in 2020, an estimated 489,800 Michigan individuals were considered Seriously Mentally Ill (Otsuka Pharmaceutical Development & Commercialization, Inc., 2020). The U.S. primarily struggles with anxiety and depressive disorders, followed by drug and alcohol use disorders, according to 2017 data from Institute for Health Metrics and Evaluation (IMHE) as reported by Our World in Data. While anxiety is the most prevalent disorder in the U.S. and worldwide, worldwide it accounts for 3.76% of the total population with the given diagnosis (Our World in Data, 2017).

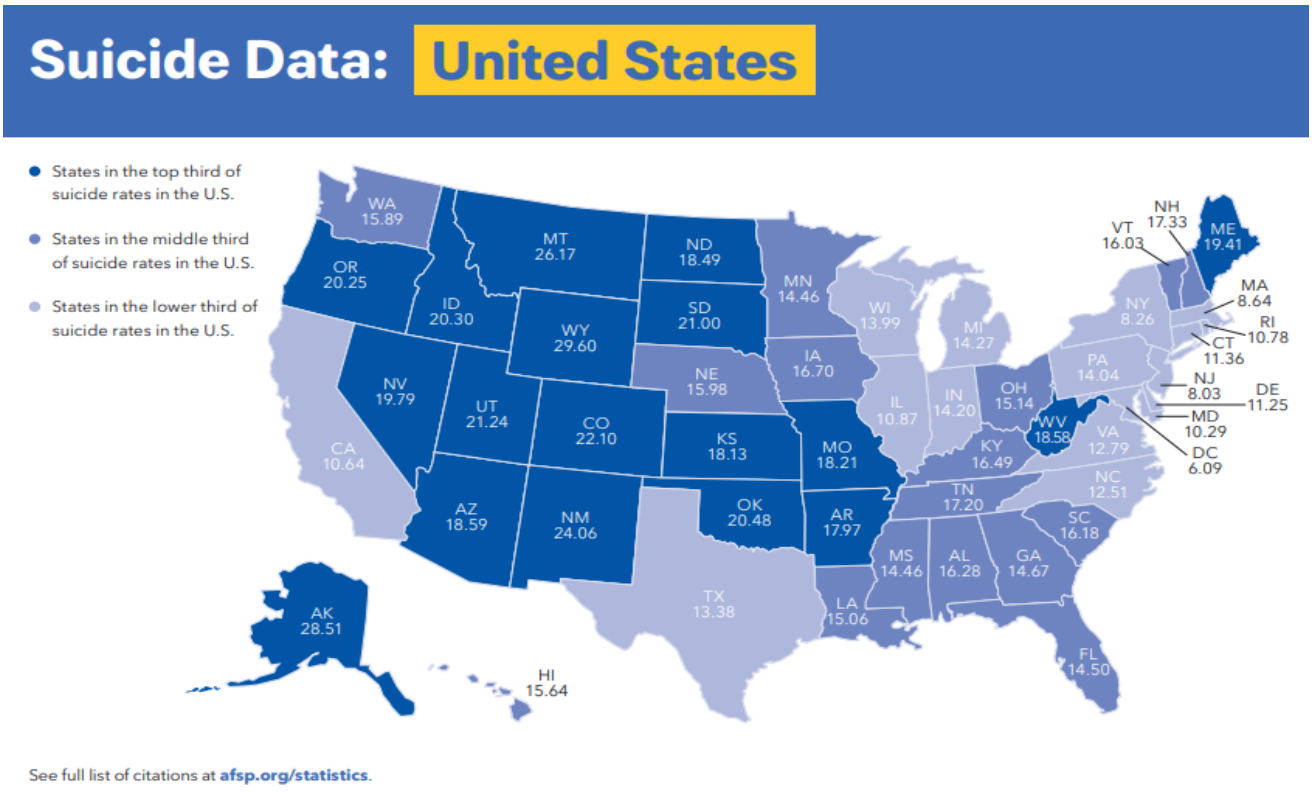


To improve care, MDHHS is creating Behavioral Health Homes (BHH) in FY21. The purpose of BHH is to provide comprehensive care management and coordination services to Medicaid Beneficiaries with a serious mental illness or children with a serious emotional disturbance. This will be open to individuals with Medicaid and functions as the primary contact point for patient-centered care. This team-based model focuses on holistic care and emphasizes the role of the Peer Support Specialist to improve overall wellness. Diagnoses for this service include Attention-Deficit Hyperactivity Disorder (ADHD) for children, Bipolar Disorder, Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Schizoaffective Disorders, Adjustment Disorders, and Other Mental Disorders due to Physiological Condition (MDHHS). NorthCare will participate in this initiative in FY21.

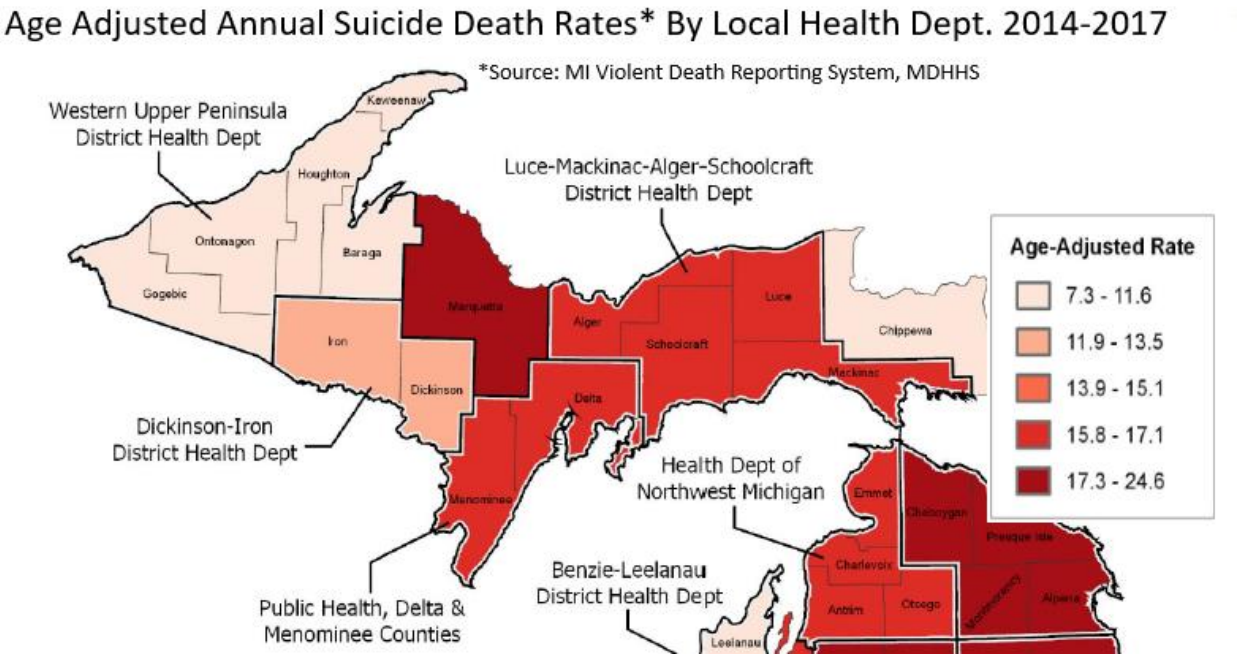
In 1990, self-harm and violence was the 8th ranked cause of death for all ages in the U.S. In 2019 this dropped to the 11th ranked cause. However, substance abuse increased from 14th ranked to 8th ranked. Mental health disorders remained at the 21st ranking both years, according to IHME. But when looking at the disability adjusted life years, the measure of the disability burden on a population, substance use jumps to 4th ranked in 2019 and mental health is 5th. Finally, when comparing years lived with the disability, mental health and substance use are ranked 2nd and 3rd. While individuals may not need treatment during the entire time of their disability, it does indicate the longevity of the potential need for treatment and suggests that demand for services is unlikely to decrease. On the next page, the disability adjusted life years are represented, suggesting a significant increase of substance use between 1990 and 2019 (Institute of Health Metrics and Evaluation, 2019).



The 2017 National Violent Death Reporting System data for Michigan indicates that 22.6% of individuals who died via suicide or an undetermined cause were treated at some point in their lives for a mental health problem while only 16.8% had current treatment at the time of their death. Nearly forty-one percent had a known mental health problem at the time of their death (Centers for Disease Control and Prevention, 2017).

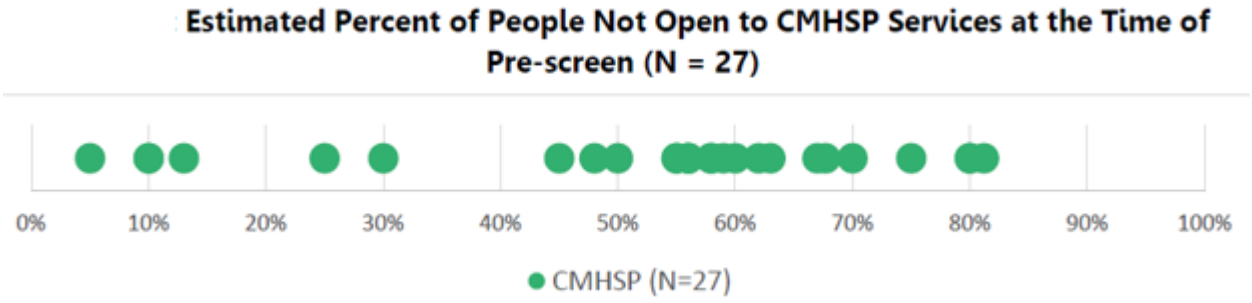


As shown in the map on page 16, Michigan had a 14.27% suicide rate according to most recent 2019 data (Centers for Disease Control and Prevention, 2021). Slightly older data from the Michigan Violent Death Reporting System, below, has a breakdown by county, showing some counties in the Upper Peninsula had some of the lowest occurrence of death by suicide. However, the Native American population had the highest rate of death by suicide at 24.8% between 2014-2017, almost double the state average of 13% (Michigan Department of Health and Human Services, 2017).



Inpatient/ Crisis Services

Based on a survey of CMHSP providers across the state, it is estimated that Michigan has a crisis line call volume of approximately 400,000 calls a year (Michigan Public Health Institute, 2021). Crisis is often the first time the CMHSP becomes involved with an individual. According to the Crisis Survey Report, of the 27 CMHSPs who responded to this question, more than half reported that most individuals they screen for hospitalization are not open to CMHSP services at the time of the screening.



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. Screening for inpatient psychiatric hospitalization services is 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 2019 Michigan Certificate of Need survey for the U.P. Emergency Departments indicates that 7,245 visits were related to psychiatric needs. This is down from 8,617 visits in 2018.

2019 Michigan Certificate of Need Annual Survey; Emergency Services for Acute Care Hospitals by Type of Service (Common Types Listed)												
Facility Name	Trauma	Cardiac	Obstetric	**Psychiatric**	Asthma	Allergy	COPD	URI	Diabetes	Stroke	All ED Visits	**% Psychiatric**
Baraga Co. Memorial	32	137	68	**258**	21	133	69	125	99	16	3,474	**7.43%**
Chippewa Co. Memorial	44	83	265	**59**	170	37	55	56	138	36	15,227	**0.39%**
St. Francis OSF	10	1,432	248	**1,042**	682	550	668	625	959	156	15,397	**6.77%**
Dickinson Co. HealthCare	79	501	320	**415**	81	220	182	275	99	124	15,652	**2.65%**
Aspirus Ironwood	2,120	292	12	**216**	266	257	291	510	82	65	10,464	**2.06%**
Portage Hospital	21	180	83	**242**	55	60	47	421	47	16	8,493	**2.85%**
Aspirus Keweenaw	1,512	171	21	**163**	172	132	149	293	26	46	6,440	**2.53%**
Aspirus Iron River	1,640	179	5	**168**	201	166	183	597	73	51	7,923	**2.12%**
Helen Newberry Joy	918	105	28	**89**	27	44	22	96	21	38	4,024	**2.21%**
Mackinac Straits	41	1,029	5	**458**	473	235	413	205	448	50	5,641	**8.12%**
UPHS - Marquette	690	1,965	283	**3,723**	861	691	643	1,084	1,107	167	24,198	**15.39%**
UPHS - Bell	0	137	147	**212**	206	168	226	439	63	29	8,935	**2.37%**
Aspirus Ontonagon	547	96	1	**45**	67	47	4	72	34	34	2,298	**1.96%**
Schoolcraft Memorial	1,038	172	33	**109**	69	96	81	189	37	38	4,567	**2.39%**
Upper Peninsula Total	8,692	6,521	1,519	**7,245**	3,397	2,858	3,046	4,992	3,244	884	134,788	**5.38%**
Michigan Total	88,707	188,801	120,076	**204,946**	166,581	120,293	99,425	202,054	123,109	34,162	4,574,824	**4.48%**
** Source: MDHHS CON Study*												

There was a decrease in crisis intervention utilization. Crisis intervention notes are used for consumers who are in crisis but are not interested in, nor needing, hospitalization. There were 2458 Crisis Intervention Encounters in FY20. Telehealth (947) and CMH office (625) were the most common locations for this service. Individuals with Medicaid accounted for 1065 of the crisis intervention notes completed, Healthy MI for 772, General Fund for 496, and MI Health Link for 125. There were 1691 distinct consumers who received a crisis intervention in FY20. A total of 83 (67 distinct) crisis intervention notes indicated the person served was co-occurring. There was a total of 8757 units of service provided across the region for crisis intervention in FY20.

Preadmission screenings are completed with those individuals who want, or may need, to be hospitalized on a psychiatric unit. In FY20Q4, NorthCare Network was the only PIHP region across the state to complete the pre-admission screening for children and adults within 3 hours 100% of the time.

Percentage of Individuals Receiving a Pre-Admission Screening within 3 hours FY20Q4			
	Percent	Referred	Completed
Children			
NorthCare	100%	23	23
State	98.85%	2,551	2,520
Adults			
NorthCare	100%	235	235
State	98.31%	12,118	11,859
**Source: MDHHS*			

In FY20 there were 1403 Preadmission Screenings for inpatient psychiatric hospitalization completed. This is a decrease of 191 screenings from FY19 (1594). While screenings typically occur in the ER, this year most of these screenings were completed via Telehealth due to the COVID-19 pandemic. There were 77 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 (642) or Healthy MI Insurance (510). There were 149 screenings completed that fell to general fund. Individuals with MI Health Link insurance accounted for 102 screenings. There were 1003 distinct consumers who received a preadmission screening in FY20.

Diversion Report				
Affiliate	Disposition	Number of Dispositions	Total Screens	% of Screens by Disposition
Copper	*Diversion	34	125	27.20%
	Hospital Admission	91		72.80%
Gogebic	*Diversion	39	107	36.45%
	Hospital Admission	68		63.55%
Hiawatha	*Diversion	72	254	28.35%
	Hospital Admission	182		71.65%
Northpointe	*Diversion	114	272	41.91%
	Hospital Admission	158		58.09%
Pathways	*Diversion	191	638	29.94%
	Hospital Admission	447		70.06%
Total	*Diversion	450	1396	32.23%
	Hospital Admission	946		67.77%
* Diversion includes Crisis Residential Admissions				

Not everyone who has a preadmission screening requires hospitalization. Consumers who are willing and able to safely plan for 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 FY20, not including Admin NorthCare Dual screenings added by NorthCare, 946 screenings were found to meet criteria for admission, an admission rate of 67.77%.

There were 706 distinct hospital admissions in FY20 for individuals with Medicaid, Healthy Michigan, MiChild, and MI Health Link. Upper Peninsula Health Systems- Marquette, War Memorial, and Willow Creek Behavioral Health were the primary hospitals utilized. There were 36 admissions to Crisis Residential in FY20. NorthCare contracted with 1 Crisis Residential facility for adults in FY20 and none for children. There are only 3 crisis residential facilities for children in the state.

Typically, individuals in crisis who require hospitalization are hospitalized at an acute psychiatric facility. Occasionally, individuals may require longer term, more intensive treatment in an inpatient facility. These individuals may be referred to a state psychiatric facility. There are 5 state facilities in Michigan, totaling 745 beds, however accessing these beds is difficult. There are on average 125 individuals on waiting lists to get into these facilities at any given time (Otsuka Pharmaceutical Development & Commercialization, Inc., 2020).

Distinct Count FY20 Hospital Admissions

Hospitals	Admissions
UP Health System Marquette	292
War Memorial Hospital	164
Willow Creek Behavioral Health	120
Pine Rest Christian	27
Bellin	19
St. Mary's Hospital	17
Forest View	16
Havenwyck Hospital	9
Harbor Oaks Hospital	6
Healthsource Saginaw (White Pine)	6
Cedar Creek Hospital	5
Other Facilities	25
Total Admissions:	**706**

**Source: SAL download report*

Suicidal Ideation is often a cause for inpatient admission. In FY20, 536 of the completed preadmission screenings indicated that suicidal ideation was present. Interestingly, this number is down from previous years. According to the American Foundation for Suicide Prevention, suicide was the 10th leading cause of death in the U.S. in 2020, and it was the 2nd leading cause of death for individuals ages 10-34. While women are 1.4 times more likely to attempt suicide, men are 3.6 times more likely to die from suicide. Transgender adults are almost twelve times more likely to attempt suicide than the general population (Solomon, 2020). It is estimated that suicide cost $69 billion in medical costs and work-loss in 2015 (American Foundation for Suicide Prevention, 2020). In 2017, 17% of Michigan individuals who died from suicide or undetermined circumstances had a history of suicidal thoughts or plans, 15% had a history of suicide attempts, 19% disclosed intent to commit suicide, and 28% left a suicide note (Michigan Department of Health and Human Services, 2017). According to an Open Minds report, mental health follow-up within 7 days of discharge from a psychiatric facility is linked to a 44% lower suicide risk among youth during the 180 days post discharge (Open Minds, 2020). Both the Michigan Missions Based Performance Indicator System (PI) and NorthCare's Follow Up to Hospitalizations Performance Improvement Project (PIP) use 7-day follow up measures.

Suicidal Behaviors in PAS FY20

	# of Consumers
Copper	46
Gogebic	40
Hiawatha	102
Northpointe	76
Pathways	272
Total	536

**Source: SQL Query of PAS*

Suicidal Behaviors in PAS Trend

	FY17	FY18	FY19	FY20
Copper	60	59	46	46
Gogebic	26	39	32	40
Hiawatha	106	130	107	102
Northpointe	69	80	133	76
Pathways	317	331	339	272
Grand Total	578	639	657	536

Source: SQL Query of PAS within 10/1/16 to 9/30/20

PI measures the percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow up care within 7 days for individuals who are open consumers, or approved by NorthCare Access for services, at the CMHSP. It reports on Medicaid individuals and excludes individuals eligible for both Medicare and Medicaid. It also excludes consumers who are OBRA related, primarily diagnosed with autism, or refused an offered appointment within 7 days or rescheduled their appointment to outside of 7 days. There are also select service codes that are excluded from the 7-day follow up option.

FY20Q4 Statewide Performance Indicator Data		
Indicator	NorthCare Average	Statewide Average
The Percent of Individuals Discharged from a Psychiatric Inpatient Unit Who Are Seen for Follow Up Care Within 7 Days of Discharge (Standard 95%)		
Adults	91.76	94.54
Children	88.89	94.43
Source: MDHHS PIHP Consultation Draft		

NorthCare's FY20Q4 PI Data compared to the state indicates that we, and the state, are below the 95% standard to ensure adults and children are seen for a follow up appointment within 7-days of discharge. The low number of children hospitalized from the region does make meeting this indicator difficult, but improvement in this area should be an ongoing goal; and is addressed in NorthCare's Follow Up to Hospitalization Performance Improvement Project (PIP).

Follow Up to Hospitalization Performance Improvement Project			
Measurement Period	Number of Discharges	Actual Percent	Goal Percent
Combined			
1.1.18-12.1.18	421 of 686	61.37%	
1.1.19-12.1.19	385 of 622	61.89%	
1.1.20-12.1.20	499 of 796	62.68%	
Children (6-20yo)			
1.1.18-12.1.18	93 of 142	65.49%	
1.1.19-12.1.19	64 of 104	61.53%	75.28%
1.1.20-12.1.20	51 of 80	63.75%	77.80%
Adults (21+)			
1.1.18-12.1.18	328 of 544	60.29%	
1.1.19-12.1.19	321 of 518	61.96%	61.98%
1.1.20-12.1.20	448 of 716	62.56%	66.40%
* Source: Relias			

The Follow Up to Hospitalization PIP uses the Healthcare Effectiveness Data and Information Set (HEDIS) standards which measure compliance differently than PI. HEDIS counts every discharge, regardless of where the follow up appointment is scheduled. It does not exclude select populations like PI does and it has different service's that do not count for the 7-day follow up appointment. Some of the services that do not count include case management and supports coordination. This has been recognized as a barrier to increasing our performance on this PIP. Data in reported by calendar year. The percent of individuals seen within 7-days following inpatient psychiatric hospitalization is increasing slowly but remains below our goal.

FY20Q4 Statewide Performance Indicator Data		
Indicator	NorthCare Average	Statewide Average
The Percent of Individuals Readmitted to an Inpatient Psychiatric Unit within 30 Calendar Days of Discharge from a Psychiatric Inpatient Unit (standard <15%)		
Adults	15.45	12.64
Children	10	10.09
Source: MDHHS PIHP Consultation Draft		

Another PI measurement is recidivism. Recidivism measures the percent of individuals readmitted to an inpatient psychiatric unit within 30 days of discharge from an inpatient psychiatric unit. The hypothesis is that individuals who are quickly and effectively engaged in services post hospital discharge will not be readmitted to the hospital. Recidivism is another PI measurement utilized by MDHHS. In FY20Q4, the region had fewer children's readmissions than the standard (<15%) but more adult readmissions than the standard.

Mobile Intensive Crisis Stabilization Services

One service that could address children's crisis services is Mobile Intensive Crisis Stabilization Services. Intensive Crisis Stabilization Services has been a mandate for children since 2017 and can also be provided for adults. CMHSPs across the U.P. only currently provide this service for children. There were 35 episodes of this service provided in FY20 with the service lasting an average of 51 minutes. COVID-19 complicated the ability to deliver this already difficult to deliver service. MDHHS is looking closely at this service in FY21 and going forward. Per a CMHSP survey, the following barriers to delivering this service were identified by CMHSPs across the state (Michigan Public Health Institute, 2020), with the primary concern being staffing. This service model requires two staff, one with at least a master's level, to respond to the community/home where the child is located to manage the crisis.

Mobile Intensive Crisis Stabilization Services for Children	
	Encounters
Copper	4
Gogebic	12
Hiawatha	16
Northpointe	3
Pathways	0
Source: Encounter Report	

Barriers to Implementing and Sustaining Mobile Crisis Teams		
Barrier	# of CMHSP's Indicating Barrier for Children	# of CMHSP's Indicating Barrier for Adults
CMHSPs have difficulties in staffing the service like hiring qualified master's level staff, retaining staff, balancing staff workloads, and staffing after-hours. This barrier is heightened by the requirement for two staff members to be deployed.	25	24
The current reimbursement structure does not cover the cost of the service for many CMHSPs.	15	16
There is low demand and utilization of service, partially due to lack of awareness of people being served, and this impacts funding and staffing.	11	5
Some communities are resistant to the model, such as community members not wanting staff to enter their home, other community partners already providing similar service, and the preference to access care in emergency departments.	11	2
CMHSPs struggle to ensure staff safety, especially in remote locations with no cell phone service or when law enforcement is not available to accompany CMHSP staff.	2	9
CMHSPs described this model not working for rural communities. Large geographical service areas make accessing people in a timely manner difficult and options for contracting the service limited.	7	4
Hospital staff do not understand the mobile crisis services and the alternative crisis diversion options available to a person in crisis.	2	*
It is hard to obtain contracts to serve non-Medicaid children.	2	*
CMHSPs struggle to obtain parental authorization of the service, especially if child is located at school at time of crisis and parent does not agree to service.	2	*
Medication adjustment is not included in the model.	1	*
Coordinating care for children in foster care is difficult.	1	*
The ambulance is not able to transport to locations other than the ED and there is a lack of alternative transportation resources.	*	1
A CMHSP with high demand for mobile crisis service has had to prioritize certain people in need at the front end of crisis because of the lack of resources to cover everyone in need.	*	1
Source: CMHSP Responses, 43 CMHSP's responded		

Additionally, some factors contributing to success of these services were also identified. The primary factors include:

- Relying on community partner support, such as referrals from long-term collaborations (law enforcement, shelters, hospitals, schools),
- Having dedicated staff that are trained to provide this service along with the support of leadership,
- Using staff flexibly to cover this service and do other roles, and
- Educating community partners about the service and use marketing to promote the service.

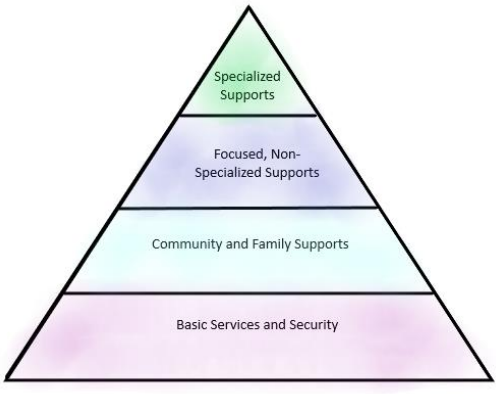
Jail Diversion Services

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. Jail diversion may result in an individual being psychiatrically hospitalized rather than jailed. Some ways that jail diversion staff increase mental health awareness is through training with local law enforcement and presentations and trainings offered to community members. The following table reflects the number of pre- and post- booking jail diversions completed by each CMHSP in FY20. Individual diversions are reflected into population categories of mental illness, MI with co-occurring SUD, I/DD, and I/DD with co-occurring disorder.

Jail Diversion FY20											
	Pre-booking					Post-booking					
	Adults with MI	Adults with COD	Adults with DD	Adults with DD and COD	Subtotal	Adults with MI	Adults with COD	Adults with DD	Adults with DD and COD	Subtotal	**Total**
Copper Country	2	2			4		1			1	**5**
Gogebic	1				1	2	4			6	**7**
Hiawatha		3			3	1	3			4	**7**
Northpointe	2	5			7	11	19	1		31	**38**
Pathways	4	8	1		13	5	3	3	1	12	**25**
Total	**9**	**18**	**1**		**28**	**19**	**30**	**4**	**1**	**54**	**82**

Mental Health and Psychiatric Outpatient Services in the Community

Lack of community providers increases the demand for services at Community Mental Health agencies. The U.P. lacks psychiatry and primary care doctors able to address mental health disorders in their patients. Additionally, some regions lack mental health providers outside of the CMHSP system. According to the County Health Rankings, the 90th percentile of top U.S. counties has a rate of 290 patients per mental health provider in 2019. Michigan has an overall rate of 370:1. Individual U.P. county data is shown in the table to the right (University of Wisconsin Population Health Institute, 2020). Bolstering community and non-specialized supports is integral to ensuring the psychological well-being of U.P. Communities (World Health Organization, 2017). NorthCare provides specialized services to individuals. Individuals who have access to adequate supports at lower tiers in the pyramid may not ever require the specialized supports NorthCare CMHSP and SUD Providers offer (*pyramid adapted from the IASC Guidelines, WHO 2017).



Mental health providers (ratio of population to provider) in Michigan		
Michigan	Number	26,794
	Rate	373 to 1
Alger	Number	6
	Rate	1,516 to 1
Baraga	Number	11
	Rate	756 to 1
Chippewa	Number	120
	Rate	313 to 1
Delta	Number	55
	Rate	652 to 1
Dickinson	Number	79
	Rate	321 to 1
Gogebic	Number	27
	Rate	559 to 1
Houghton	Number	66
	Rate	549 to 1
Iron	Number	13
	Rate	855 to 1
Keweenaw	Number	0
	Rate	NA
Luce	Number	9
	Rate	698 to 1
Mackinac	Number	19
	Rate	568 to 1
Marquette	Number	248
	Rate	268 to 1
Menominee	Number	26
	Rate	884 to 1
Ontonagon	Number	2
	Rate	2,898 to 1
Schoolcraft	Number	18
	Rate	448 to 1
*Source: MI League for Public Policy		

Veterans 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.

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. In FY20, 9 of Michigan's 10 PIHPs had a regional Veteran Navigator and 9 of the 46 CMHSPs had a Veteran Navigator (Michigan Department of Health and Human Services, 2021). Michigan-wide, outreach grew by 500 families in FY20. Locally, 66 new veterans (56 male, 10 female) accessed services, an increase of 34.8% from last year. Veterans reached are of all ages, with the majority being over age 55. There were 2305 males and 739 female veterans served across the state from all branches of military. The four largest challenges identified for veterans Michigan-wide were PTSD (475), alcohol abuse (422), depression and/or anxiety (411), and opioids (130). Locally, veterans were primarily challenged with Depression (18), PTSD (14), and Anxiety (7). Veterans Navigators assisted in making referrals to various agencies. Across the state, 45% of the referrals made were to CMHSP or SUD providers (Michigan Department of Health and Human Services, 2021), but locally most referrals were made to the VSO or the VA.

Branches of the Military Served by a Veteran Navigator		
State	Branch	Local
1657	Army	43
481	Navy	13
427	Air Force	3
448	Marines	7
31	Coast Guard	0
*Source: MDHHS Veteran Navigator Project		

Veteran Referral Locations		
State %	Location	Local #
45%	Community Mental Health/ SUD Providers	0
31%	Veterans Affairs (VHA, VBA) CBOC's, Local VA	33
15%	Housing	13
12%	Employment	5
8%	Education	0
12%	Transportation	5
28%	Veteran Service Officer	40
5%	Legal/ Veteran Court	7
*Source: MDHHS Veteran Navigator Project		

Access to services was challenging during FY20 due to COVID-19 restrictions at all levels of care. Many Veterans were resistant to telehealth services or had challenges accessing the telehealth technology. Isolation exacerbated conditions.

Employment Services

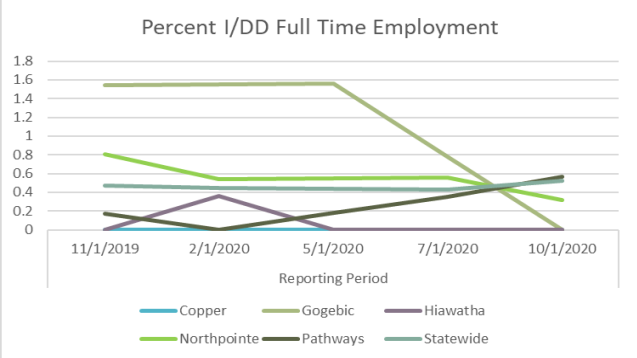
Using BH-TEDs data, the Michigan Employment Outcome Data Project identifies consumers employment status. From November 2019 to October 2020 there was a statewide increase from .47% to .52% of individuals with an intellectual / developmental disability who were employed full time in competitive, integrated employment settings. Gogebic CMH shows a much higher rate of employment in this category than the state average. It is unknown based on the data if the significant decrease for Gogebic County in October is an impact of COVID-19 or if there are data anomalies present (Institute for Community Inclusion at UMASS Boston, 2020).

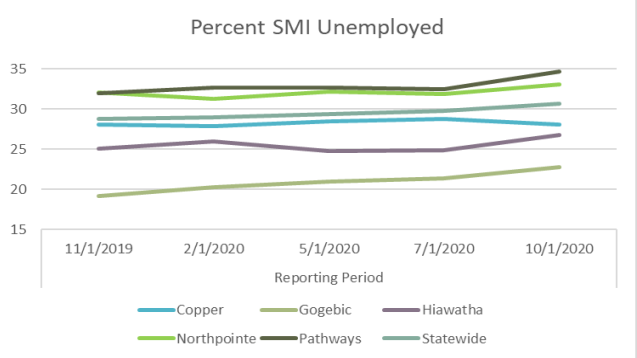
Percent of Individuals with I/DD in Full-time, Competitive, Integrated Employment					
	Reporting Period				
	11/1/2019	2/1/2020	5/1/2020	7/1/2020	10/1/2020
Copper	0	0	0	0	0
Gogebic	1.54	1.55	1.56	0.78	0
Hiawatha	0	0.36	0	0	0
Northpointe	0.81	0.54	0.55	0.56	0.32
Pathways	0.17	0	0.18	0.35	0.57
Statewide	0.47	0.45	0.44	0.43	0.52

*Source Statedata.info

Percent of Individuals with SMI Unemployed					
	Reporting Period				
	11/1/2019	2/1/2020	5/1/2020	7/1/2020	10/1/2020
Copper	28.08	27.83	28.48	28.72	28.08
Gogebic	19.19	20.23	20.92	21.32	22.78
Hiawatha	25.05	25.98	24.76	24.87	26.79
Northpointe	32.03	31.29	32.18	31.86	33.06
Pathways	31.97	32.68	32.66	32.5	34.68
Statewide	28.75	28.94	29.37	29.8	30.64

*Source: Statedata.info





Individuals with SMI have low employment rates. According to NAMI, 17.8% of individuals receiving public mental health services were employed in 2012 (Michigan Department of Health and Human Services, 2020). Individual Placement and Support (IPS) is an evidence-based employment model that has been in practice in various parts of Michigan since 2004. Yet, in April-June of 2020, the 24 sites in Michigan that utilized the IPS model had a 36.9% employment rate. Great Lakes Recovery Centers in Sault Ste Marie began implementation of the IPS model for individuals with substance use disorders. There were 19 referrals to IPS services which resulted in 5 positions in FY20. It is anticipated that numbers might have been even higher but for COVID-19. There were no CMHSPs using the IPS model in FY20.

There are two Benefits to Work coaches in the U.P., one at Copper Country CMH and the other at Northpointe Behavioral Health. These staff can assist consumers to determine how much they can work and how much money they can make while maintaining their current benefits. Many consumers and staff do not realize that consumers can work and maintain Medicaid and SSI eligibility, and possibly even some SSI dollars (World Institute on Disability, 2021). Individuals can earn more money by working and staying on SSI and Medicaid than they would on SSI alone.

Health Conditions Among the Homeless Population vs. Housed Population		
A Health Center Patient Survey, 2009		
Homeless	Condition	Housed
18%	Diabetes	9%
50%	Hypertension	29%
35%	Heart Attack	17%
20%	HIV	1%
36%	Hepatitis C	1%
49%	Depression	8%
58%	Substance Use Disorders	16%

Source: National Health Care for the Homeless Council

Housing Services

The National Health Care for the Homeless Council reported that the federal government reports 1.5 million people a year experience homelessness (2019). Being homeless can exacerbate current health concerns, create increased stress and new health concerns,

and make recovery more difficult. Homelessness also shortens the lifespan. The homeless population dies, on average, 12 years earlier than the general U.S. population.

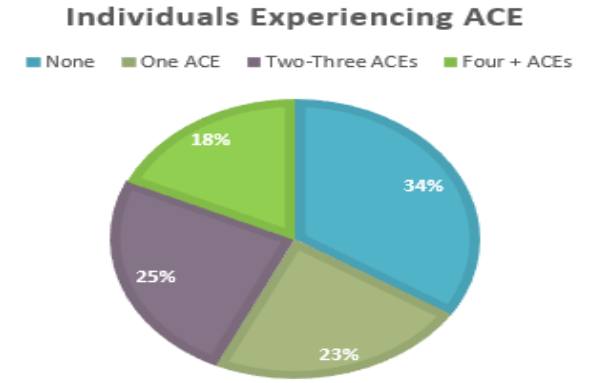
According to a 2020 article, individuals who are homeless have longer lengths of hospital stays, each admission costs about $4000 more, the inpatient readmission rate is twice as high as individuals who have housing, the number of ER visits is 3 times as high, and the readmission rate to the ER is 6 times higher than those who have housing (United Healthcare Services, Inc., 2020). Therefore, while the initial costs of supporting individuals in finding housing may seem high, there is evidence to suggest that over time there can be a cost savings.

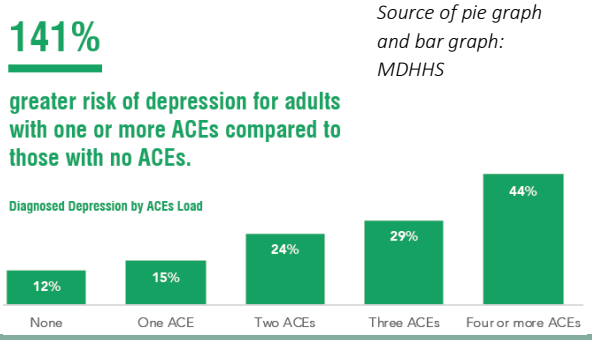
While hospitalization may stabilize an individual, often the treatment does not seem to mitigate the effects of returning to homelessness. Individuals who are homeless have much greater prevalence rates of medical and behavioral health diagnoses than individuals with housing according to the Health Center Patient Survey in 2009 (National Healthcare for the Homeless Council, 2019). There were 176 homeless individuals open to CMHSP services at some point in FY20.

Homeless Living Arrangement	
	Count
Copper	12
Gogebic	11
Hiawatha	38
Northpointe	30
Pathways	85
Total	**176**
*Source: Diver	

Trauma Services

2016 MI ACE Results		
Category	Number	Percent
Verbal Abuse as a Child	2.7 Million	39%
Sexual Abuse as a Child	1.1 Million	16%
Physical Abuse as a Child	1.3 Million	18%
Physical Violence in the Home	1.4 Million	19%
Incarcerated Household Member	0.6 Million	9%
Substance Abuse in the Home	2.1 Million	29%
Mental Illness in the Home	1.4 Million	20%
Separated/Divorced Parents	1.9 Million	27%
*Source: MDHHS ACE Infographic		





Source of pie graph and bar graph: MDHHS

Adverse Childhood Experiences (ACE) are defined by the CDC as, "all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18." In Michigan, the annual Behavioral Risk Factor Telephone Survey tracks 8 specific ACEs adults may have experienced as a child. The 8 areas include items such as verbal abuse, substance use in the household, and mental illness in the household. In 2016, 66% of Michiganders reported having 1 or more ACEs (Michigan Department of Health and Human Services, 2019). The percent of surveyed individuals experiencing each type of ACE event is detailed in the table to the left.

Traumatic experiences as a child have adverse outcomes for individuals as adults. Increasing numbers of ACEs also increase the probability of risky behaviors and poor health outcomes. Individuals with 4 or more ACEs have an increased likelihood of having been diagnosed with depression, COPD, asthma, and overall poor health. Smoking increased based on the number of ACEs a person experienced as a child. Compared to individuals who had no ACEs in childhood, individuals with 1 or more ACE in childhood had a 46% increased risk for binge drinking, 82% greater risk for poor mental health, 83% greater risk for COPD, and 141% greater risk of depression (Michigan Department of Health and Human Services, 2019). Overall risky behavior increases the more ACEs a person experience. As shown in the pie graph, in 2016, only 34% of individuals did not report experiencing any adverse childhood experiences. According to the Michigan League for Public Policy (2020) there were 27,894 children ages 0-17 who were confirmed victims of abuse and/or neglect in 2020. Preventing traumatic

Confirmed Victims of Abuse and/or Neglect, Ages 0-17 in Michigan															
Michigan	Alger	Baraga	Chippewa	Delta	Dickinson	Gogebic	Houghton	Iron	Keweenaw	Luce	Mackinac	Marquette	Menominee	Ontonagon	Schoolcraft
27,894	17	21	156	95	59	65	44	39	2	25	29	76	34	13	45
*Source: MI League for Public Policy															

experiences to children should be forefront in our efforts, but once a child has trauma the system can still support the individual and help improve their overall health. Social support has been found to buffer the negative consequences of Adverse Childhood Experiences by 7-29% (Michigan Department of Health and Human Services, 2019). NorthCare Network CMHSPs served 109 distinct individuals using the ST modifier which is limited in its use to *Home-based, mental health therapy, or trauma assessment when providing Trauma Focused-Cognitive Behavioral Therapy or Child Parent Psychotherapy or Family training using 'Caring for Children who have experienced Trauma: A Workshop for Resource Parents' Curriculum.*

Eating Disorders

Psych U Data suggests that individuals with eating disorders are at an increased risk of suicide and that approximately 20% of deaths of individuals with anorexia nervosa are from suicide (Otsuka Pharmaceutical Development & Commercialization, Inc., 2020). The National Institute of Mental Health found that most individuals with eating disorders also met criteria for other diagnoses, mainly anxiety (2017).

Lifetime Co-morbidity of Eating Disorders with Other Core Disorders Among U.S. Adults Data from National Comorbidity Survey - Replication (NCS-R)[1]			
	Anorexia Nervosa (%)	Bulimia Nervosa (%)	Binge-Eating Disorder (%)
Any Anxiety Disorder	47.9	80.6	65.1
Any Mood Disorder	42.1	70.7	46.4
Any Impulse Control Disorder	30.8	63.8	43.3
Any Substance Use Disorder	27.0	36.8	23.3
Any Disorder	56.2	94.5	78.9

Eating disorder services are not a special service coverage in the Michigan Medicaid Provider Manual. While Forestview Psychiatric Hospital specializes in eating disorders, individuals must meet inpatient psychiatric criteria to be placed on that unit, and because it is a psychiatric unit, the average length of stay is like other psychiatric units. Residential placement for eating disorders is not covered by Medicaid, nor are there any Residential placements for adults with eating disorders available in Michigan. However, as indicated in the prevalence chart on page 15, eating disorders are the 6th leading disorder in the U.S. In FY20, there were 712 individuals with an eating disorder diagnosis in ELMER served by the CMHSPs (Source: Diver).

Peer Services

Peer Supports

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 ages 18-28 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.

Copper Country had 3 peers in FY20, Gogebic 2, Hiawatha 7, Northpointe 5, Pathways 6. Numerous individuals were served at all 5 CMHSPs with peer support services. A subset of services were provided to youth by a Youth Peer Support at all CMHSPs except Northpointe.

Youth Peer Support (YPS) is a peer-delivered service for youth and young adults. On September 1, 2020, the age limits of YPS expanded to provide services to young adults up to age 26 if the individuals developmental and life stage needs were appropriate.

Peer Support Specialist Utilization		
	Number of Services	Distinct Count of Consumers
Copper	182	20
Gogebic	473	28
Hiawatha	1849	84
Northpointe	2330	88
Pathways	552	56
Grand Total	**5386**	**277**
**Source: SAL Download Report*		

Youth Peer Support Utilization		
	Number of Services	Distinct Count of Consumers
Copper	38	9
Gogebic	21	7
Hiawatha	112	8
Pathways	2	1
Grand Total	**173**	**25**

Clubhouse

Clubhouse services were provided differently in FY20 due to COVID-19. While different, the Clubhouse programs were innovative in their solutions to connect to members and provide meaningful activity and support. Pathways Clubhouse, *South Shore Place,* had 9 members obtain new jobs, 12 members assist with gardening/landscaping, and stayed connected through numerous newsletters and daily individual phone/video calls, regularly scheduled group calls, and socially distanced gatherings at community parks in 2020.

Hiawatha's Clubhouse, *Water's Edge*, had two members obtain new jobs, and connected with members with daily outreach calls, daily meetings, monthly newsletters, and care packets being delivered, as well as creating a podcast on Clubhouse for their Auspice Agency, and a bi-weekly social recreational activity with other U.P. Clubhouses. Staff and members also attended the virtual Clubhouse USA Conference.

Northpointe's Clubhouse, *House of Dreams,* also attended the Clubhouse USA Conference and stayed connected with their members through daily outreach calls, virtual zoom meetings and social activities, and bi-monthly newsletters. Staff and members created care packages, went on wellness walks, cared for the community garden, and gathered at locations that allowed for social distancing. Clubhouse members were provided community resources over the phone, and were assisted with signing up for benefits, obtaining cell phones, setting up appointments, and accessing food pantries. Four members started working and two members maintain their supported employment. One member started college.

Copper Country's Clubhouse, *Northern Lights,* had twice daily conference calls with members and staff and offered individual outreach calls. Clubhouse supported its members with housing, employment, benefits, and coordination of services via phone. Outdoor gatherings occurred as the weather permitted and members worked on the newsletter. One member who was working on transitional employment was hired part time and received a promotion. Twenty members, 72% of membership, were actively engaged during the pandemic. There was attendance at the Clubhouse USA Conference. Northern Lights also began the process of planning for moving locations. Their new location will be three times larger and boasts a commercial kitchen.

Gogebic CMH has an approved waiver from MDHHS and is not required to have a clubhouse program.

Drop-In

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. Seventy distinct consumers used the Peer Drop-In Centers in FY20 for a total of 1452 services.

Peer Drop In Utilization		
Brantley Drop In Center	355	14
Get Away Drop-In Center	427	15
Gogebic - Serenity Center	387	22
Our Place Community Center	89	3
Rainbow's End Drop-In Center	194	16
Grand Total	1452	70
**Source: SAL Download Report*		

Residential Services

According to the Annual Submission Report, there are 1,450 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 725 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. HCBS compliance date for CMS is 3/17/23 but for Michigan compliance date is 3/17/22.

Residential Consumers FY20	
	Count
Copper	106
Gogebic	42
Hiawatha	136
Northpointe	125
Pathways	316
NorthCare	725
Source: Diver FY20 Service Model	
Medicaid = Y / Service Reportable = Yes / Living Arrangement = "Foster Home / Foster Care (MH)", "General Residential Home," and "Specialized Residential Home" (Group) / AffiliateName	

Two services are frequently used by individuals in residential services: Personal Care and Community Living Supports (CLS). For those in specialized AFC homes, Personal Care and CLS are offered on a per diem. Individuals can also have CLS outside of the home. While not a residential service, respite services are designed to give caregivers a break from the demands of caring for the consumer and are available to caregivers on a short-term, intermittent, basis. Respite services can be provided to adults and children.

Intellectual and Developmental Disability Specific Services

The Supports Intensity Scale (SIS) is an assessment completed by an independent assessor every three years for individuals 16 years old and older with intellectual and/or developmental disabilities engaged in CMHSP services. The SIS assessment utilizes two respondents who know the individual receiving services well to score the support needs of the individual. Across the state, 55.5% of the eligible population had a SIS completed, as of January 13, 2021 data (TBD Solutions, 2021). NorthCare region has completed 60.6%.

Overall Percent SIS Completion as of January 2021	
CMHSP	% Complete
Gogebic	78.4%
Copper	61.1%
Hiawatha	59.8%
Northpointe	63.8%
Pathways	54.9%
NorthCare	60.6%
State	55.5%
Source: TBD Solutions	

Children's Specific Services

For the 2020-2021 schoolyear, there were 1,437,612 students enrolled in school (MI School Data 2020) and 13.47% of those children had a disability. One youth out of every six in the U.S. between the ages of 6 and 17 experience a mental health disorder each year (Solomon, 2020). Additionally, one in six children between ages 2-8 has a mental, behavioral, or developmental disorder (CDC).

2019-20 Special Education Data Portraits : Disability Snapshot Statewide: All Disabilities														
Entity	Total Special Ed Count	Autism Spectrum Disorder%	Cognitive Impairment %	Deaf-Blindness %	Early Childhood Developmental Delay%	Emotional Impairment %	Hearing Impairment %	Physical Impairment %	Severe Multiple Impairment %	Specific Learning Disability%	Speech & Language Impairment %	Traumatic Brain Injury%	Visual Impairment %	Other Health Impairment %
Statewide	210,550	10.70%	8.50%	0.00%	3.90%	5.40%	1.20%	0.80%	1.50%	27.50%	26.00%	0.20%	0.40%	13.90%
Copper Country ISD	803	5.70%	5.70%	N/A	4.40%	4.40%	N/A	N/A	N/A	31.10%	28.60%	N/A	N/A	18.20%
Delta-Schoolcraft ISD	997	7.30%	6.10%	N/A	3.40%	1.90%	N/A	N/A	2.50%	22.10%	37.20%	N/A	N/A	17.20%
Dickinson-Iron ISD	854	7.00%	5.70%	N/A	3.30%	4.70%	N/A	N/A	2.10%	40.40%	24.70%	N/A	N/A	10.40%
Eastern Upper Peninsula ISD	1,105	10.30%	10.50%	N/A	3.50%	5.00%	N/A	N/A	1.40%	18.60%	31.30%	N/A	N/A	18.30%
Gogebic-Ontonagon ISD	430	8.40%	6.50%	N/A	8.40%	3.00%	N/A	N/A	N/A	37.20%	15.30%	N/A	N/A	17.40%
Marquette-Alger RESA	1,663	7.10%	3.50%	N/A	6.40%	2.80%	0.90%	N/A	1.20%	28.70%	35.50%	N/A	N/A	13.40%
Menominee ISD	362	8.60%	7.20%	N/A	3.00%	7.20%	N/A	N/A	N/A	30.70%	24.60%	N/A	N/A	16.00%
*Source: MI School Data														

The Intermediary School Districts (ISD) 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 2020). Per the Annual Submission Report, Copper Country CMH had 34 students "age out" or graduate from special education services. Gogebic CMH had 19, Hiawatha Behavioral Health had 57, Northpointe Behavioral Health and Pathways CMH were not identified.

Prevention - Early On and Infant Mental Health

Early On is a service for children who need supports for developmental delay with various developmental milestones such as feeding, dressing, talking, and social connection. Addressing delays early can have beneficial outcomes for youth, even into adulthood. The ISDs served over 11,000 children between the ages of 0 and 2 in 2018 (Michigan League for Public Policy, 2018). Infant Mental Health services provides parent-infant support to families when the parents life circumstances, or the infants particular needs, threaten the attachment and bond between child and parent. Services are aimed at increasing healthy attachment. Within the CMHSP system, 39 children under the age of 4 received Infant Mental Health specific services. Children under the age of 4 who are in the home-based program would have their services billed under the home-based program.

Infant Mental Health Utilization (S9482)		
	Count of Services	Distinct Count of Consumers
Copper	78	6
Gogebic	76	2
Hiawatha	209	10
Northpointe	255	21
Grand Total	**618**	**39**

*Source: SAL Download Report

Children Receiving Early On Services Age 0-2																
Michigan	Alger	Baraga	Chippewa	Delta	Dickinson	Gogebic	Houghton	Iron	Keweenaw	Luce	Mackinac	Marquette	Menominee	Ontonagon	Schoolcraft
11,025	108	52	73	66	46	25	52	46	52	73	73	108	17	25	66

*Source: MI League for Public Policy

Home-Based

Home-Based services are intensive services to children and their families and offer an array of mental health services. Treatment is focused on the family unit. Clinical staff working in the home-based program have a max capacity of 12 consumers on their caseload, allowing them to dedicate more time to these children and families with intense needs.

Home-Based Utilization		
	Count of Services	Distinct Count of Consumers
Copper	741	28
Gogebic	1710	32
Hiawatha	862	16
Northpointe	5787	112
Pathways	1956	71
Grand Total	**11056**	**260**

*Source: SAL Download Report

Wraparound

Wraparound services utilize a team-based approach across multiple agencies that the child and family interact with. The wraparound plan is a collaborative effort by all the agencies involved. This service method also has a maximum capacity of 10 – 12 consumers, if 2 are in transition, allowing staff to dedicate more time to the children and families in this program.

Wraparound Utilization		
	Count of Services	Distinct Count of Consumers
Copper	9	2
Gogebic	181	4
Hiawatha	31	5
Northpointe	179	7
Pathways	209	16
Grand Total	**609**	**35**

*Source: SAL Download Report

Autism

From January 2014 to September 2018 enrollment in Michigan's Applied Behavioral Analysis (ABA) program grew from 504 children to 5,973 children and young adults under age 21 (Michigan Autism Council 2018). NorthCare's enrollment has also grown over the years. The table shows the number of new referrals by calendar year starting January 2014 through May 2021. FY20 was slow due to COVID-19, with only 14 new referrals during the year. The ages of referred children ranged from 3 to 17, with an average age of 8 years old.

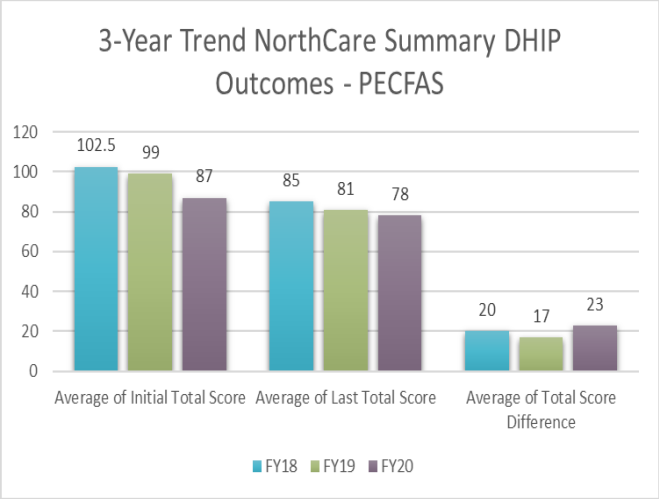
ABA Services	
Calendar Year	Number of Referrals
2014	14
2015	27
2016	69
2017	48
2018	43
2019	52
2020	9
2021	5
Grand Total	267

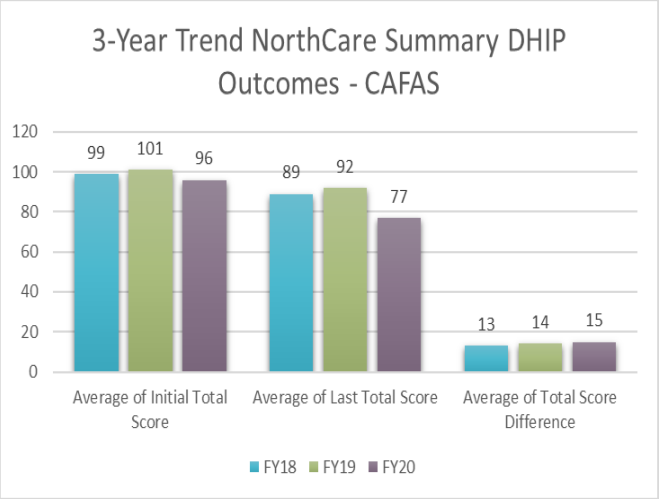
*Source: WSA

As of January 2020, there were 1,198 licensed BCBAs and 93 licensed BCaBAs in Michigan (Autism Council 2020). During the 2020 calendar year, Northern Michigan University offered a free ABA clinic to the public, providing 10 hours a week to children between age 2 and 6 (Michigan Autism Council 2020).

DHIP

The local CMHSPs 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 average of the last CAFAS/PECFAS scores trended lower than the average of the initial score for the fiscal year, representing overall improvement in the children/youth's behavioral health in each year. In FY20 there was greater change between initial scores and last scores.





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. To increase integration, NorthCare staff and CMHSP staff met with staff from UPHP to discuss the treatment of shared consumers who are high utilizers of services. In FY20, the team served 73 distinct consumers, 12 of whom were receiving treatment for co-occurring mental health and substance use disorders. The team works together to improve outcomes for consumers. Providing services in a manner that supports psychosocial well-being and ensuring availability of mental health care within general health care services are two key measures to address risks of mental health according to the World Health Organization (2017).

Individuals with high-risk pregnancy are predominately served through a NorthCare Women's and Family Program SUD/Neonatal Abstinence provider and the UPHP Maternal and Infant Health Program. Individuals with co-occurring disorders receive SUD services through other NorthCare SUD providers and/or the CMHSPs are served with care coordination through NorthCare's Integrated Care Specialist (ICS) as primary coordinator.

One way to improve overall outcomes is to ensure that any consumer who is willing to have a primary care doctor has one and attends an annual checkup. Regionally 74.38% of consumers saw their doctor for an office visit in the prior 12 months (Relias).

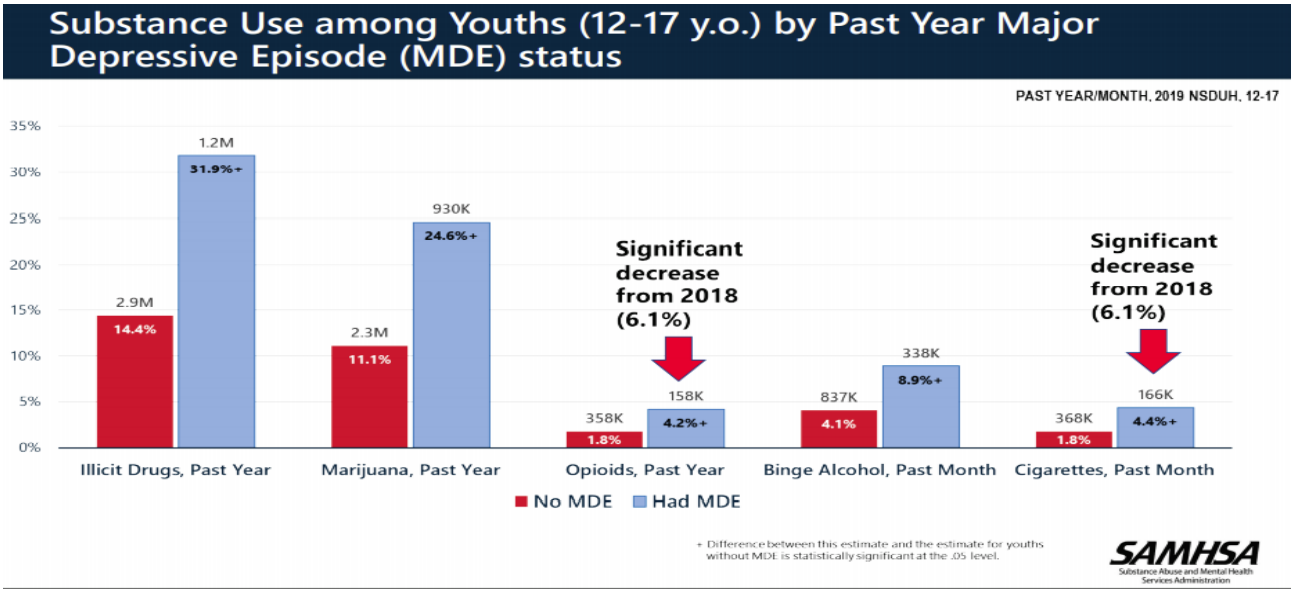
Other ways that the integrated care team impacts overall consumer health is by analyzing population health metrics built from Medicaid claims and encounter data. Quality measures in medication adherence, hospital admissions, emergency department utilization, and identification of co-morbid conditions 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 on the next page, the chronic co-morbidity rates are depicted.

Chronic Condition	Total	Pathways	Northpointe	Hiawatha	Copper	Gogebic
No Chronic Co-Morbidity	71%	69%	73%	71%	69%	75%
Any Chronic Co-Morbidity	29%	31%	27%	29%	31%	25%
Dyslipidemia and Past Tobacco Use	2%	1%	2%	2%	2%	2%
Hypertension and Past Tobacco Use	2%	2%	2%	2%	2%	4%
Asthma and Past Tobacco Use	2%	2%	3%	2%	2%	3%
Chronic Pain and Hypertension	3%	3%	3%	3%	4%	3%
Asthma and Diabetes	3%	3%	2%	3%	4%	4%
Neurological Disorders and Any Other Chronic Condition	12%	14%	12%	11%	12%	8%
Asthma and Hypertension	5%	5%	3%	5%	5%	6%
Hypertension and Morbid Obesity	2%	2%	2%	2%	1%	3%
Chronic Pain and Diabetes	2%	2%	2%	2%	2%	2%
CAD / Hyperlipidemia / MI and Any Other Chronic Condition	12%	12%	13%	13%	13%	9%
*Source Relias						

Co-Occurring Services

Co-Occuring SUD and MH Services FY20		
	Distinct Consumers Treated by Integrated Team	Distinct Consumers with Co-Occuring Not Being Treated by an Integrated Team
Copper	17	24
Hiawatha	22	17
Gogebic	0	25
NorthCare Dual	1	11
Northpointe	4	64
Pathways	25	47
Total	**69**	**188**
Source: SQL query finding consumers being treated with an integrated Tx plan by an integrated team, and those not being treated by the integrated team.		

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. The following graph shows the increased likelihood of youth with a major depressive episode trying substances (SAMHSA, 2020). The graph also shows a decrease in likelihood of youth using opioids and cigarettes from 2018, which is a positive trend. There were 69 distinct consumers treated by an integrated treatment team, and 188 consumers with co-occurring disorders not being treated by an integrated treatment team based on the co-occurring disorder designation within the BioPsychoSocial assessment indicating *Yes, client with co-occurring SU and MH problems is being treated with an integrated Tx plan by an integrated team* or *Client with co-occurring SU and MH problems is NOT currently receiving integrated treatment.*



Substance Use Disorder Access to Services

NorthCare Access

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.

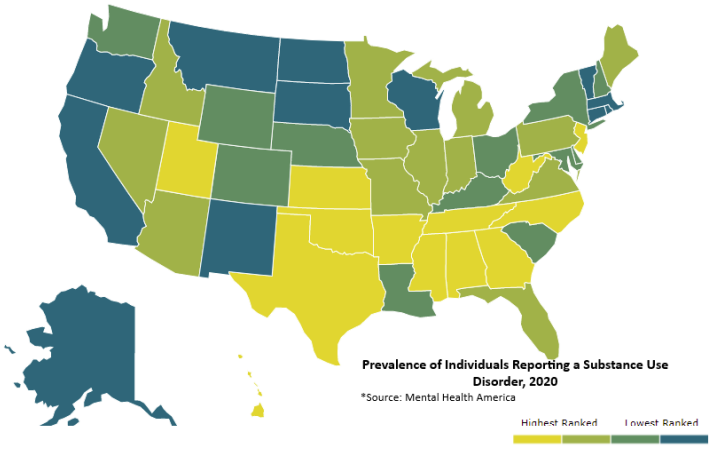
Substance Use Disorder (SUD) Medicaid services include assessment, individual and group therapy, intensive outpatient therapy, residential services, subacute and social detox services. Through Block Grant funding, additional specialty services are available and include case management, women and children's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

All treatment providers must be licensed, accredited, and designated for ASAM Level of Care for the services under their contract. There are 7 contracted treatment providers, three of which are licensed in multiple locations. Services, including medication assisted treatment at Office Based Opioid Treatment offices, outpatient, residential, and social detox are available within the region. Current programming examples include:

- Auricular Acupuncture (not Medicaid covered)
- Cognitive Behavioral Therapy
- Life Goals
- Living in Balance
- Rational Emotive Behavioral Therapy
- Seeking Safety
- Smart Recovery

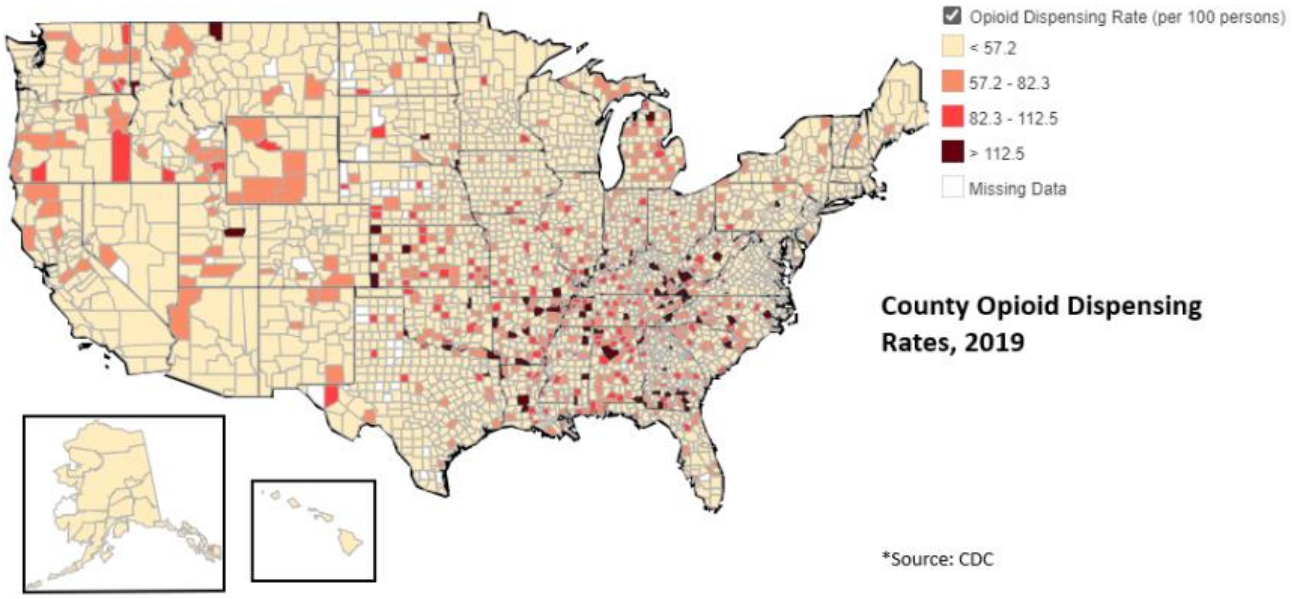


Prevalence

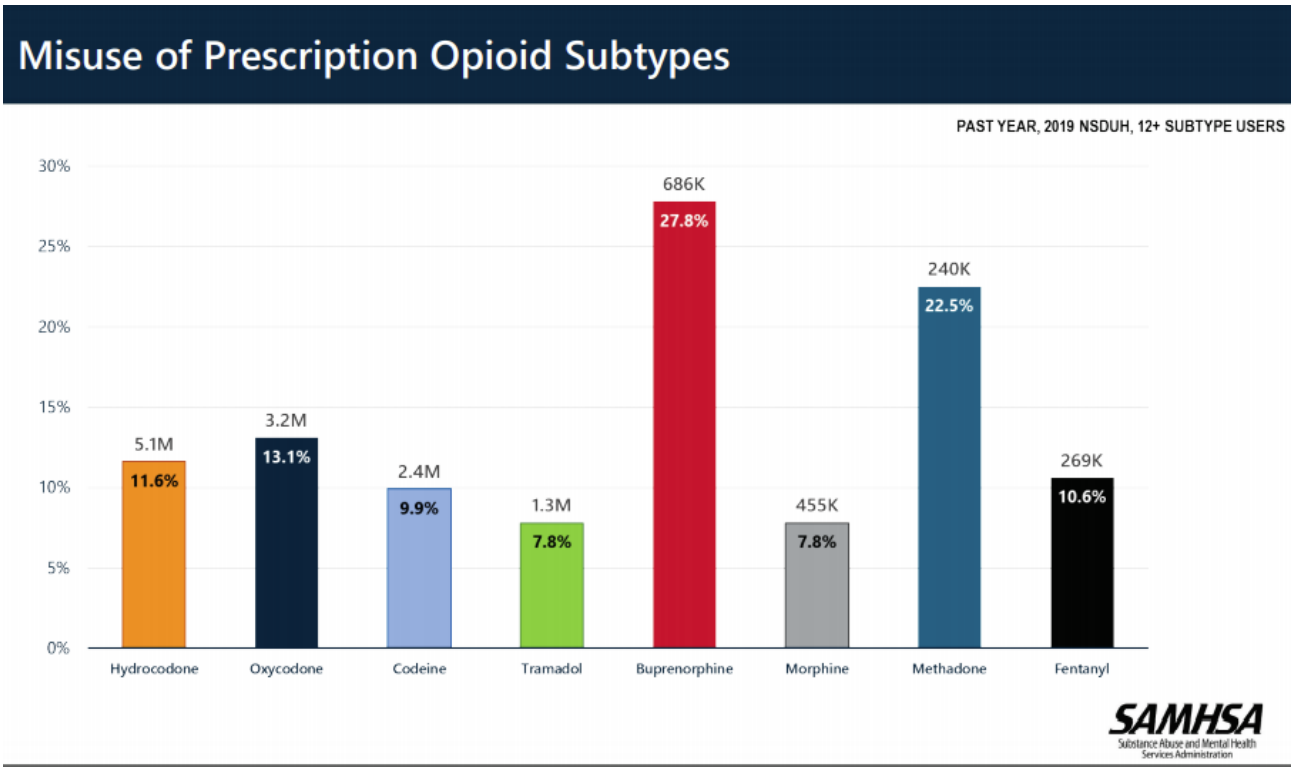
According to Mental Health America, 7.68% of adults in America reporting having a substance use disorder in the past year (2020). Almost 8% (7.93%) of Michigan individuals indicated a substance use disorder (Mental Health America, 2020).

From 1999 to 2016, overdose deaths involving opioids increased 17 times in Michigan, from 99 to 1,699 (Michigan Department of Health and Human Services). In 2015, the Michigan Automated Prescription System (MAPS) reported 11.4 million prescriptions for painkillers were written, which is 115 opioid prescriptions per 100 people. Given the Opioid Crisis, national opioid dispensing rates are decreasing from a high of over 80 prescriptions per 100 people

between 2010 and 2012 to 46.7 prescriptions per 100 people in 2019 (Centers for Disease Control and Prevention, 2019). Michigan's dispensing rate in 2019 was 58 scripts for every 100 people (CDC). The map below shows dispensing rates by county in 2019.



There is also misuse of opioid subtypes. Some of the subtypes are prescribed to try to reduce the dependence on opioids themselves; however, these are also becoming highly misused as illustrated in the SAMHSA table below (SAMHSA 2020). That said, opioid use disorder did decline in 2019 compared to 2018 (SAMHSA).



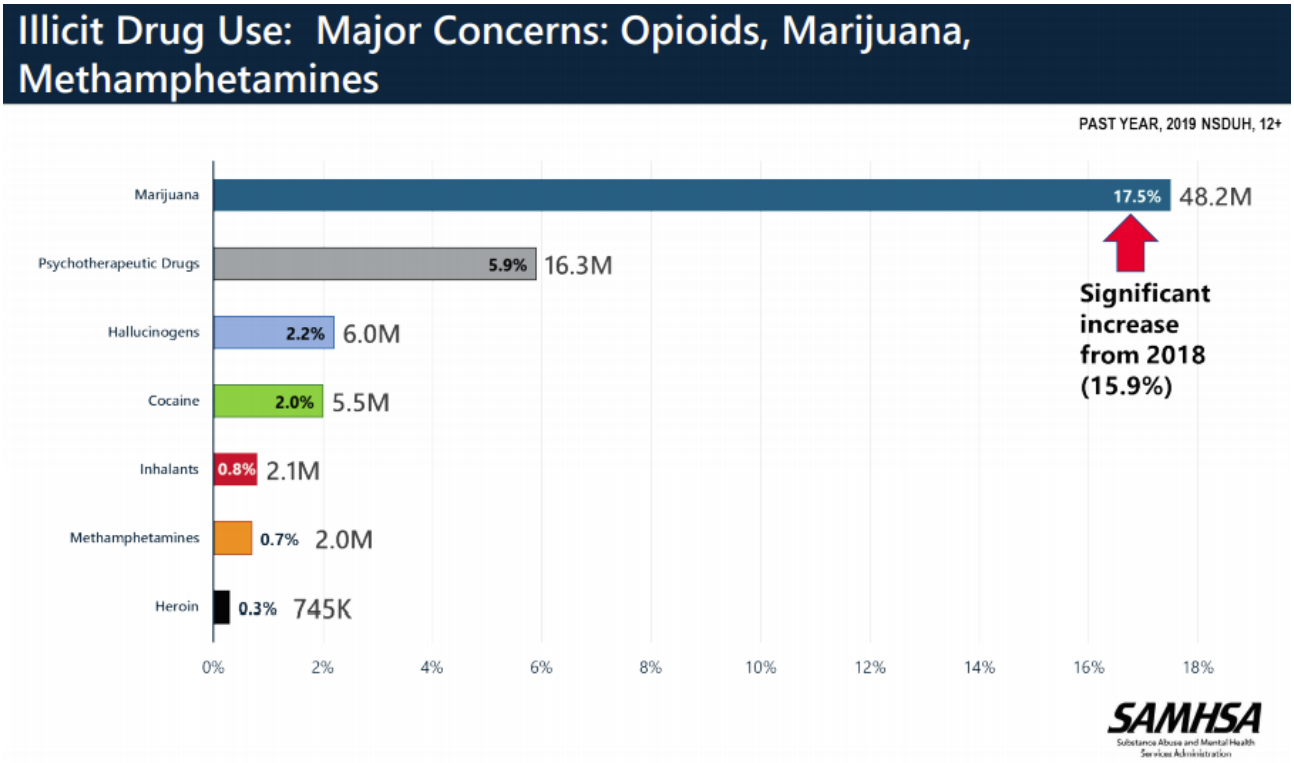
To improve care, Michigan will create Opioid Health Homes (OHH) in FY21. The purpose of the OHH is to provide comprehensive care management and coordination to Medicaid individuals with an opioid use disorder. The OHH is the primary point of contact for directing patient-centered care across agencies and systems. Peer recovery coaches are an

integral part of this model. The OHH team will work with consumers to coordinate, support, and manage recovery, health, and social needs. OHH providers will utilize health information technology to coordinate care. Anyone diagnosed with an opioid use disorder who has Medicaid can be enrolled in this voluntary program (MDHHS).

Another substance of concern is Marijuana. Michigan legalized Marijuana for recreational use in December 2019. Marijuana is the most popular illicit substance in the United States among youth while still illegal at the federal level. Young adults and adolescents are using marijuana and now may have increased access to the product. In a 2014 Monitoring the Future study of 8th, 10th, and 12th grade students from 141 schools residing in states with legalized marijuana found that while the availability of medical marijuana dispensaries was not associated with current use of marijuana there was some correlation suggesting that dispensaries within a short distance to the school (less than 5 miles) may be associated with a higher level of recent marijuana use (Shi Y, 2016). In 2016, 6.5% of the U.S. adolescent population used marijuana (Center for Behavioral Health Statistics and Quality, 2016). Addiction, psychotic symptoms, and suicide are associated with marijuana use.

It is estimated that 17% of youth using marijuana will develop a cannabis use disorder. Marijuana has also been correlated with brief psychosis from marijuana intoxication as well as increased risk of developing psychosis as an adult (Ladegard, Thurstone, and Rylander, 2020). Chronic, heavy marijuana use has also been correlated with depression and suicidal ideation. Additionally, marijuana impacts the brains development and decreases attention, concentration, and working memory (Ladegard, Thurstone, and Rylander, 2020), which impacts school performance in youth as well as driving ability of users.

SAMHSA data from 2019 shows a significant increase in marijuana use between 2018 and 2019 in the chart below (SAMHSA 2020). SAMHSA also reports 7.4% of youth, 23.0% of young adults ages 18-25, and 10.2% of adults over 25 years of age used marijuana in the past month across the U.S. (SAMHSA 2020).



SUD Access

In FY20, NorthCare Network Substance Use Access Department completed a total of 1,824 pre-screenings for all insurance types. After the pre-screening, 1,261 screenings were completed to determine which level of care the caller may find most beneficial. Of the 1,261 screenings completed, 763 resulted in a referral to residential treatment and 88

to social detox. Consumers can admit to outpatient treatment without going through an Access Screening. There were a total of 1,924 substance use disorder admissions in FY20 with Alcohol being the most frequent primary drug at time of admission.

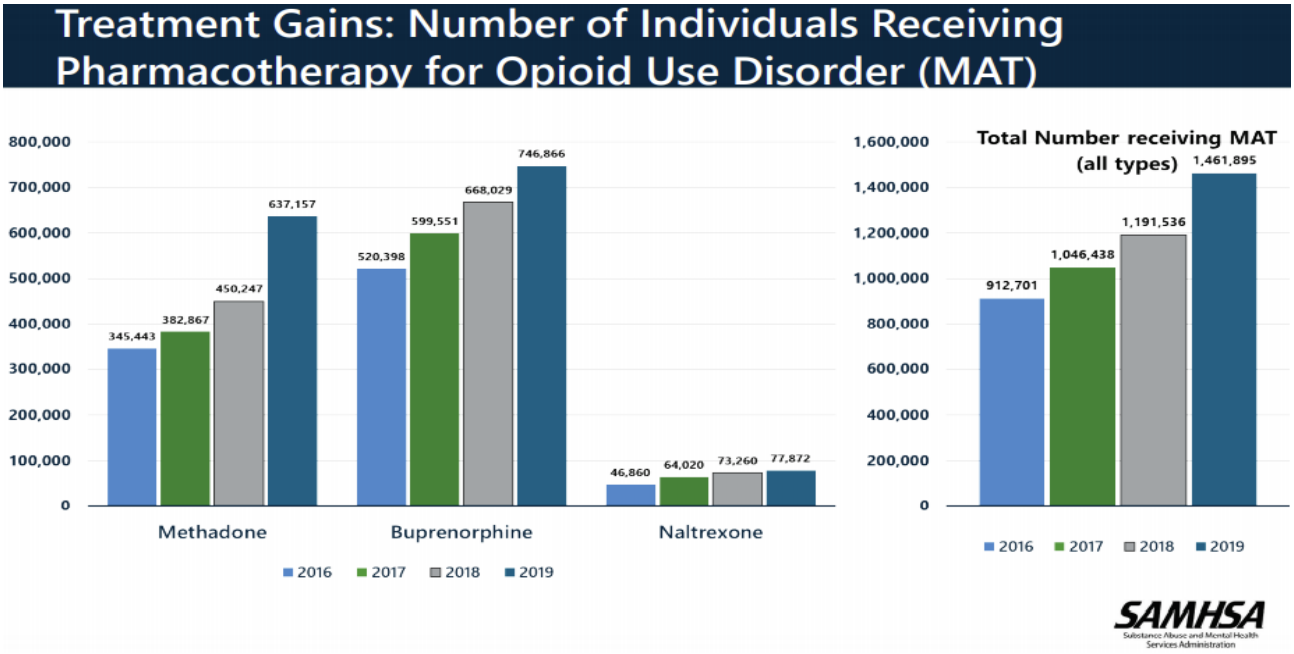
Primary Drug at Admission																	
	Alcohol	Barbiturates	Benzodiazepines	Cocaine / Crack	Hallucinogens	Heroin	Inhalants	Marijuana / Hashish	Methamphetamine / Speed	Non-prescription methadone	Other Amphetamines	Other Drugs	Other Opiates / Synthetics	Other Sedatives / Hypnotics	Other Stimulants	Over-the-Counter Medications	Grand Total
Detoxification	55		1			3			5			1	23				88
Outpatient	447	1	4	15	1	41	1	66	186	1	15	3	288	1	1	2	1073
Residential Short-Term	305		2	18	1	34		25	226		8	6	135	1		2	763
Grand Total	807	1	7	33	2	78	1	91	417	1	23	10	446	2	1	4	1924

Statewide comparison data for FY20Q4 indicates the region is struggling to ensure consumers are seen within 14 days of their request for services; 68.15% compared to the state average of 76.44%.

FY20Q4 Statewide Performance Indicator Data		
Indicator	NorthCare Average	Statewide Average
The Percent of New Persons During the Quarter (FY20Q4) Receiving a Face to Face Service for Treatment of Supports within 14 Calendar Days of a Non-Emergency Request for Services for Persons with Substance Use Disorders	68.15%	76.44%
The Number of Non-Urgent Admissions to a Licensed SUD Treatment Facility (BH-TEDS)	457	14,520
The Number of Persons Receiving a Service for Treatment of Supports within 14 Calendar Days of First Request	353	13,062
*Source: FY20Q4 PIHP Consultation Draft		

Medication Assisted Treatment Services

Use of Medication Assisted Treatment is increasing nationally. According to SAMHSA data from 2019, Buprenorphine (Suboxone) is the most prescribed pharmacotherapy for opioid use disorder (SAMHSA 2020).



NorthCare has 33 MAT provider agencies across the U.P. The Behavioral Health Consultant for the Michigan Opioid Collaborative and NorthCare Network presented 8 major presentations to over 20 individuals at a time and provided outreach via 235 consults with medical, behavioral health, SUD providers, public health workers, administrative, law enforcement, and court system staff. There were 18 new waivered providers able to prescribe Suboxone across the U.P. in FY20. Those providers attend a monthly provider group to discuss success and challenges in providing MAT in an office-based setting. This increases the ability for providers to consult with each other about general concerns they may be having. Additionally, there were 17 Michigan Opioid Collaborative patient consultations from U.P. providers; approximately 24% of the total consultations for the state. There were 266 consumers who utilized MAT services in FY20.

Prevention Services

Universal prevention has been the primary focus of prevention programming for several years. Programs funded during FY20 included:

- Botvin's Life Skills – a universal evidence-based program for middle-school students. This was also expanded to 9th graders as well. Botvin's focuses on increasing life skills and life skills development has been shown to be effective in preventing early initiation of substance use and increases emotional regulation.
- Guiding Good Choices – a universal/selected five-session program for parents of middle school students with one session that youth attends which is focused on refusal skills. This program is shown to increase positive parent-child interactions and reduce early initiation of substance use and depression.
- Prime for Life – a selected/indicated program for either youth or adults with high school or college students that have substance use issues and referred by their school.
- Communities that Care – a collation model that has been shown to effectively address youth, alcohol use, antisocial-aggressive or delinquent behavior, tobacco, and drug use.
- Social Development Strategy – an integral part of the Communities that Care model, it helps communities provide opportunities for positive interactions that teach skills needed for success and provides for consistent recognition of effort which increases bonding and emotional connection of the youth to adults.

Each county in Michigan has a Communities That Care (CTC) coalition. The UP-Coalition Network is a collaborative of the Upper Peninsula Communities That Care coalitions. CTC is a proven prevention system that guides communities through a five-phase process from getting started to evaluation. CTC offers strategy for positive youth development.

Overall, the following table reflects the number of consumers that utilized a particular SUD service in FY20.

Number of Consumers Accessing Specific Types of SUD Services, FY20		
Procedure Code	Service Description	Consumers
97810	Acupuncture 1 or more needles, no electrical stimulation initial	54
97811	Acupuncture no electrical stimulation ea. additional 15 minutes	54
H0010	AL & OR DRG SERV; SUB-ACUTE DETOXIFICATION (RAP/I)	1
H0005	AL &/OR DRG SERV; GRP COUNSELING BY A CLINICIAN	95
H0019	AL &/OR DRG SERV; LONG-TERM RESIDENTIAL	36
H0012	AL &/OR DRG SERV; SUB-ACUTE DETOX-RAP/OP	70
H0004	AL &/OR DRG SERV;INDIV CNSLG BY A CLINICIAN	366
H0001	ALCOHOL AND/OR DRUG ASSESSMENT	380
H0018	Behavioral health short term residential; non inpt tx program	227
H0050	Brief Intervention/Care Coordination	191
T2038	Community transition, waiver, per service	2
S9976	Lodging, per diem, not otherwise specified	263
T2002	Non-emergency transportation; per diem	88
90832	Psychotherapy, 30 min	5
90834	Psychotherapy, 45 min	9
90837	Psychotherapy, 60 min	45
T1012	Recovery Supports	16
Source: SQL query of SUD encounters sorted by procedure code between 10/1/19 to 9/30/20.		

Numbers and Types of Providers

Mental Health

It takes numerous staff to provide an array of services required of the PIHP, CMHSP, and SUD provider staff. Those listed as "Null" below are support staff or clinical staff that are not yet licensed. NorthCare contracted with eight inpatient psychiatric units and one Crisis Residential provider for adults in FY20. When contracted hospitals are not available to take Medicaid individuals requiring admission, NorthCare also completes single case agreements with those facilities to ensure the consumer has access to care. Unfortunately, there are no hospitals offering children's inpatient psychiatric services in the U.P. so children are admitted out of the area. There are also 3 children's crisis residential facilities in Michigan, but these are further away than the hospitals. NorthCare does not contract for this service for children, however a single case agreement would be agreed upon between NorthCare and the facility if the service is medically necessary.

Contracted Inpatient Psychiatric Hospitals and Crisis Residential Units		
Provider	Location	Population
Upper Peninsula Health Systems- Marquette	Marquette	Adults, Children*
War Memorial Hospital	Kincheloe	Adults
ForestView Hospital	Grand Rapids	Adults, Children
HealthSource Saginaw	Saginaw	Adults, Children
Pine Rest	Grand Rapids	Adults, Children
St. Mary's Rhinelander	Rhinelander, WI	Adults, Children
Stonecrest	Detroit	Adults, Children
Willow Creek	Green Bay, WI	Adults, Children
* Note: The 6 bed children's unit at UPHS-M has been unstaffed since 2017		

CMHSP staff by License Type									
Copper Country CMH	**326**	**Gogebic CMH**	**185**	**Hiawatha Behavioral Health**	**250**	**Northpointe BHS**	**400**	**Pathways CMH**	**1071**
CADC	1	Cert. Peer Support Specialist	1	Board Cert Behavior Analyst	4	Cert. Peer Support Specialist	1	BCaBA	2
CADC-M	1	Clin-Lic Mstr Soc Wkr	11	CAADC	2	Controlled Substance - Federal	1	Board Cert Behavior Analyst	2
Controlled Substance - Federal	4	Controlled Substance - Federal	5	Cert. Peer Support Specialist	3	Lic. Bachelor's Social Worker	21	CAADC	4
Controlled Substance - State	5	Lic. Bachelor's Social Worker	8	Clin-Lic Mstr Soc Wkr	1	Licensed Behavior Analyst	2	Clin-Lic Mstr Soc Wkr	1
Lic. Bachelor's Social Worker	8	Licensed Assit Behavior Analyst	1	Controlled Substance - Federal	3	Licensed Master's Social Worker	11	Controlled Substance - Federal	8
Licensed Assit Behavior Analyst	1	Licensed Behavior Analyst	4	Controlled Substance - State	1	Licensed Professional Counselor	2	Lic. Bachelor's Social Worker	12
Licensed Behavior Analyst	3	Licensed Master's Social Worker	11	Lic. Bachelor's Social Worker	7	Limited License Psychologist	3	Licensed Assit Behavior Analyst	2
Licensed Master's Social Worker	10	Licensed Professional Counselor	2	Licensed Master's Social Worker	16	Ltd. Lic. Bachelor's Social Wkr	8	Licensed Behavior Analyst	6
Licensed Practical Nurse	1	Limited License Psychologist	2	Licensed Professional Counselor	4	Ltd. Lic. Master's Social Worker	11	Licensed Master's Social Worker	31
Licensed Professional Counselor	4	Ltd. Lic. Bachelor's Social Wkr	5	Limited License Psychologist	3	NULL	310	Licensed Professional Counselor	1
Licensed Psychologist	1	Ltd. Lic. Master's Social Worker	5	Ltd. Lic. Bachelor's Social Wkr	5	Nurse Practitioner	3	Licensed Psychologist	1
Limited License Psychologist	5	Ltd. Lic. Professional Counselor	2	Ltd. Lic. Master's Social Worker	1	Physician Medical	4	Limited License Psychologist	3
Ltd. Lic. Bachelor's Social Wkr	3	Macro-Lic Mstr Soc Wkr	2	Ltd. Lic. Professional Counselor	3	Reg. Occupational Ther. - State	1	Ltd. Lic. Bachelor's Social Wkr	12
Ltd. Lic. Master's Social Worker	6	NULL	109	NULL	176	Reg. Social Service Technician	6	Ltd. Lic. Master's Social Worker	16
NULL	254	Physician Medical	8	Physician Medical	5	Registered Professional Nurse	16	Ltd. Lic. Professional Counselor	1
Nurse Practitioner	1	Reg. Occupational Ther. - State	1	Reg. Occupational Ther. - State	5			Macro-Lic Mstr Soc Wkr	8
Occupational Therapy Assistant	1	Registered Professional Nurse	8	Reg. Social Service Technician	1			NULL	927
Physician Medical	4			Registered Physical Therapist	1			Nurse Practitioner	3
Physician's Assistant	1			Registered Professional Nurse	5			Physician Medical	6
Reg. Occupational Ther. - State	1			Speech Language Pathologist	4			Reg. Occupational Ther. - State	4
Reg. Social Service Technician	1							Registered Physical Therapist	1
Registered Professional Nurse	10							Registered Professional Nurse	18
								Speech Language Pathologist	2

Substance Use

All treatment providers must be licensed, accredited, and designated for ASAM Level of Care for the services under their contract. There are 7 contracted treatment providers, three of which are licensed in multiple locations. Staff credentials within those agencies vary. Those listed as "Null" are support staff or clinical staff that are not yet licensed.

Substance Use Treatment Providers			
Provider	Counties Served	Service Type	Specialty
Catholic Social Services of the UP	Delta, Marquette	Outpatient	Medication Assisted Treatment
Great Lakes Recovery Centers	Chippewa, Delta, Dickinson, Houghton, Gogebic, Mackinac, Marquette	Outpatient	Opioid Health Home Provider
Great Lakes Recovery Centers	Chippewa, Marquette (site location)	Residential, Residential Detox	Women's Specialty
Great Lakes Recovery Centers	Marquette	Residential	Adolescent
Great Lakes Recovery Centers	Baraga, Chippewa, Marquette	Recovery Housing	
Keweenaw Bay Indian Community	Baraga	Outpatient	
Keweenaw Bay Indian Community	Baraga (site location)	Residential	Native American
Phoenix House, Inc.	Gogebic, Houghton, Keweenaw, Ontonagon	Outpatient	
Phoenix House, Inc.	Houghton (site location)	Men's Residential	
Public Counseling Services, LLC	Houghton	Outpatient	
Sacred Heart	Mackinac (site location)	Outpatient	Opioid Treatment Provider
Upper Great Lakes Family Health Centers	Gogebic, Houghton, Keweenaw, Marquette, Menominee, Ontonagon	Outpatient	Opioid Health Home Provider

Providers by License Type	
NorthCare SUD	**181**
ACSW-Lic Master's Social Worker	5
Lic. Bachelor's Social Worker	2
Licensed Master's Social Worker	10
Licensed Practical Nurse	4
Licensed Professional Counselor	3
Licensed Psychologist	1
Ltd. Lic. Master's Social Worker	11
Ltd. Lic. Professional Counselor	1
NULL	137
Nurse Practitioner	1
Physician Medical	3
Registered Professional Nurse	3

Substance Use Recovery Providers	
Provider	Counties Served
Child and Family Services of the UP	Alger, Delta, Dickinson, Marquette, Menominee
Dial Help, Inc.	Baraga, Gogebic, Houghton, Keweenaw, Ontonagon
Great Lakes Recovery Centers	Chippewa, Marquette
Phoenix House, Inc.	Gogebic, Houghton, Keweenaw, Ontonagon
Superior Recovery Housing 906	Dickinson, Marquette

Recovery supports and providers are available across the U.P. Superior Recovery Housing opened in fall 2020.

Prevention Providers in the Upper Peninsula	
Provider	Counties Served
Bay Mills Boys and Girls Club	Chippewa
Big Brothers Big Sisters	Alger, Marquette
Chippewa Co. Health Dept.	Chippewa
Copper Country Mental Health	Baraga, Gogebic, Houghton, Keweenaw, Ontonagon
Dial Help	Baraga, Gogebic, Houghton, Keweenaw, Ontonagon
Dickinson-Iron Health Dept.	Dickinson, Iron
Great Lakes Recovery Center	Alger, Delta, Dickinson, Iron, Luce, Mackinac, Schoolcraft
LMAS Health Dept.	Alger, Luce, Mackinac, Schoolcraft
Marquette-Alger RESA	Marquette
Marquette Co. Health Dept.	Marquette
Menominee Co. ISD	Menominee
Public Health Delta Menominee	Delta, Menominee
Western UP Health Dept.	Baraga, Gogebic, Houghton, Keweenaw, Ontonagon

Prevention services are provided across the region by 13 providers. Universal prevention has been the primary focus of programming throughout the region.

The following are the MAT providers across the U.P.

MAT Providers by County		
County	Provider	MAT Provided
ALGER	None Confirmed	
BARAGA	KBIC (Keweenaw Bay Indian Comm) Baraga - OP	Vivitrol Only
CHIPPEWA	Sault Ste. Marie Tribe of Chippewa Indians	Vivitrol Only
	War Memorial Hospital MAT Clinic; Dr. Andrew Alshab, MD Kathy Duman, PA, and Teresa Plummer, FNP	Suboxone and Sublocade
	Alcona Health Center Pickford Medical Group: Katy Lehigh, FNP-C	Naltrexone, Vivitrol, Suboxone
	Bay Mills Health Center	Naltrexone, Vivitrol
	Great Lakes Recovery Centers, Timothy Hoffman, MD	Vivitrol and Suboxone
DELTA	Dr. Steven Miljour, DO, Psychiatry Catholic Social Services	Naltrexone, Vivitrol, Suboxone
	Dr. Michael Czerkes, MD OBGYN, OSF Healthcare	Naltrexone, Vivitrol, Suboxone
	Stacey Cole, APRN, OSF Healthcare	Naltrexone, Vivitrol, Suboxone
	Dr. Mary Francis Myrick, MD Family Care, OSF Healthcare	Vivitrol and Suboxone, Sublocade
	Hannaville Indian Tribe	Naltrexone, Vivitrol, Suboxone
DICKINSON	Korby Howell, PA-C DCH Family Practice	Suboxone
GOGEBIC	John Friedli, PA, Aspirus Ironwood	Vivitrol, Suboxone
HOUGHTON	Dr. Adam Frimodig, DO (UGL) Calumet and Ontonagon	Naltrexone/Vivitrol/Suboxone
	Sheryl Parks, MD (UGL) Hancock	Naltrexone/Vivitrol/Suboxone
	Dr. Kirk Klemme, MD Aspirus Lake Linden	Naltrexone/Vivitrol, Suboxone, Sublocade
	Amber Kokkonen, NP, Aspirus Lake Linden	Vivitrol, Suboxone, Sublocade
	Shannon Handler, NP, Aspirus Lake Linden	Vivitrol, Suboxone, Sublocade
IRON	Dr. Taki Rida, MD, Aspirus Crystal Falls Clinic	Suboxone
KEWEENAW	None Confirmed	
LUCE	Daniel Netherton, PA-C, HNJH Gibson Family Clinic, Newberry	Suboxone
	Joe Jankowski, PA-C, HNJH Gibson Family Clnic, Newberry	Suboxone
	Christine Gibson, PA-C, HNJH Gibson Family Clinic & West Mackinac Health Clinic	Suboxone
	Brook Dake, FN-P, HNJH Gibson Family Health Clinic, Newberry	Suboxone
	Michael Beaulieu, MD, HNJH & Healthcare Center	Suboxone
MACKINAC	Sault Tribal Clinic St. Igance, MI	Vivitrol
	Dr. Jeff Bomber, DO, Naubinway Clinic	Suboxone
MARQUETTE	Dr. Andrew Atkinson, MD, OBGYN UPHS Bell Women's Health	Suboxone
	Dr. Fred Groos, MD, UGL Marquette	Vivitrol, Suboxone
	Dr. Katie Brang, MD, Dr. T. Mike Kates, DO, Dr. Amy Fletemier, MD (MQT Family Med).	Naltrexone/vivitrol, Suboxone
	Dr. Jesse Heard, MD (UGL) (Gwinn)	Naltrexone/vivitrol, Suboxone
	Dr. Michael Grossman, MD GLRC, Ishpeming	Naltrexone/vivitrol, Suboxone, Sublocade
	Erin Wright, PA, FNP-BC, GLRC Ishpeming	Naltrexone/Vivtrol, Suboxone
	Dr. R. Annie Reinertsen, MD	Suboxone
MENOMINEE	Dr. Jesse Heard, MD (UGL)	Naltrexone/Vivitrol, Suboxone
ONTONOGAN	Dr. Adam Frimodig, DO and Susan Miron, NP	Naltrexone/Vivitrol, Suboxone
SCHOOLCRAFT	Janet Pratt, Psychiatric Nurse Practitioner	Naltrexone/Vivitrol

MI Health Link

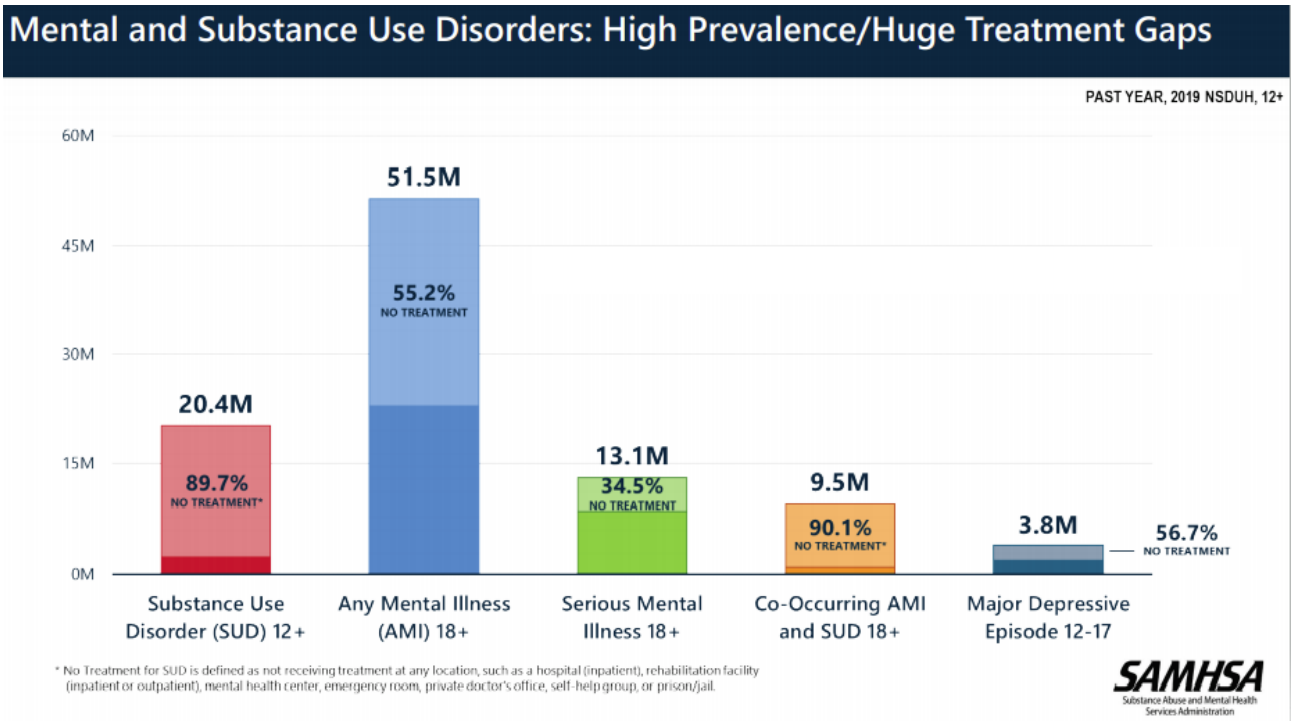
There are 40 provider agencies accepting MI Health Link insurance. This list does not include inpatient psychiatric units. MHL individuals can obtain treatment at any inpatient psychiatric hospital. Providers are broken down by license type. Those listed as "Null" are support staff or clinical staff that are not yet licensed. Every county has providers in addition to the CMHSP except Schoolcraft. Hiawatha Behavioral Health is the only provider option in that county.

Providers by License Type	
License Types by Provider	Count
NorthCare Dual	**140**
Licensed Master's Social Worker	43
Licensed Practical Nurse	1
Licensed Psychologist	23
NULL	29
Nurse Practitioner	7
Physician Medical	33
Physician's Assistant	3
Registered Professional Nurse	1
NorthCare Mental Health	6
NULL	6

MI Health Link Providers				
A Therapy World	Copper Island Behavioral Health	Heidi Schneiderhan	Neuropsychology Associates	Peter M Shelafoe
Access Psychological	Discreet Confidential Psychological Services	Hiawatha Behavioral Health	Northpointe Behavioral Health	Psychology Associates of the Keweenaw
Alphabet Shuffle, LLC	Dorothy Kahler	Hope Network Bay Haven Integrated Care	Old Town Psychological Services	Rosa Hill
Ann Hammond	EMD Clinical Social Worker, PC	Houghton Family Health Center	Ontonagon Family Health Center	Sawyer Family Health Center
Aspen Counseling	Eric Scott Turner	Ice Lake Family Health Center	OSF Medical Group	Small Pinetree Counseling
Aspirus Ironwood Clinic	Fellowship Counseling and Life Coaching	Karen Nelson	Pamela J. Aalto, UP Transformations, LLC	Susan DeGroot
Behavioral Care Solutions for Ad	Gibson Family Health Center	Kristen Husted	Pathways CMH	Trilliumwood Counseling Services
Calumet Family Health Center	Gogebic County CMH	Lac Vieux Desert Health Clinic	Patrice Evans Counseling, PLLC	War Memorial Outpatient Program
Catholic Social Services	Gwinn Family Health Center - FQHC	Lake Linden Family Health Center	Patricia Tikkanen	Weber and Devers Psychological Services, P.C.
Concerned Associates	Hancock Family Health Center - FQHC	Menominee Family Health Center	Paula Bur	Wendi J. Greer LMSW
Copper Country CMH				

Providers Not Accepting New Patients

There are many more individuals in need of treatment than those who are receiving services at the CMHSP, Substance Use Providers, or community providers. Treatment gaps are prevalent for both mental health and substance use disorders nationally, as shown in the SAMHSA chart below (SAMHSA 2020).



Mental Health General Fund Waiting List

Copper Country and Pathways CMHSPs used a waiting list in FY20. CMHSPs provide the following services to individuals without Medicaid to the extent permitted by allocated general funds (Otsuka Pharmaceutical Development and Commercialization, Inc. 2020):

- Crisis Stabilization and response, including 24/7 crisis emergency service

- Identification, assessment, and diagnosis to determine specific needs of the individual and development of an Individual Plan of Service (IPOS)
- Planning, coordination, and monitoring to assist the individual in gaining access to services
- Specialized mental health treatment, including therapeutic clinical interactions
- Recipient Rights services
- Mental Health Advocacy
- Prevention Services
- Other services approved by the state

Provider 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 www.northcarenetwork.org.

Substance Use Disorder Providers

Waiting lists are not allowed for Medicaid Individuals. At times providers were at 90% capacity but demand never exceeded capacity for the priority populations. This data does not include individuals that do not qualify as priority population. While there are not waiting lists, at times consumers are referred to residential treatment providers out of the region. Menominee, Alger, Luce, and Keweenaw counties do not have SUD providers within the county. Therefore, increasing the provider network would be beneficial.

Geographic Location of Providers

Mental Health

With COVID-19, telehealth services have been expanded and will remain expanded for some services even once the pandemic is minimized. The increase in telehealth provides a unique opportunity for individuals to seek specialty care with providers outside of their immediate geographic area, without any of the burdens typically associated with seeing someone physically distant. This also opens the opportunity for CMHSPs to sub-contract with providers for specific service modalities that are not readily available in the area. According to U.S. Census Bureau America Community Survey data, in 2019 almost 90% of children had internet in their home in Michigan (Michigan League for Public Policy, 2019).

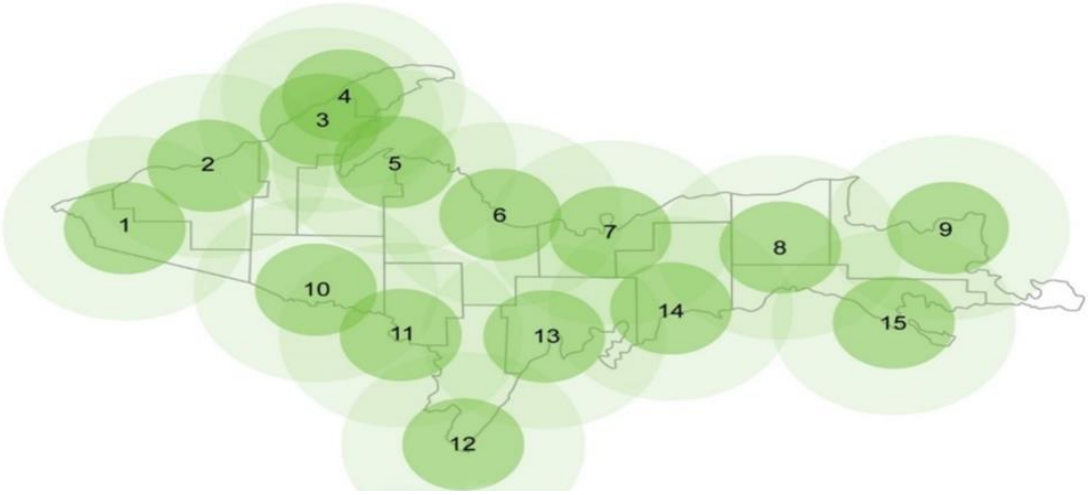
Previously NorthCare was held to the Rural requirement for provider locations within 60-min/60-miles, however in 2020 it was recognized that all the U.P. is considered Frontier status based on the definition in the Code of Federal Regulations. There are four levels of frontier status (Federal Registrar 2014).

- Level 1: areas are 60 minutes or greater from Census Bureau defined Urban Areas of 50,000 or more population
- Level 2: areas are 60 minutes or greater from Urban Areas of 50,000 or more people and 45 minutes or greater from Urban Areas of 25,000-49,999
- Level 3: areas are 60 minutes or greater from Urban Areas of 50,000 or more people; 45 minutes or greater from Urban Areas of 25,000-49,999; and 30 minutes or greater from Urban Areas of 10,000-24,999
- Level 4: areas are 60 minutes or greater from Urban Areas of 50,000 or more people; 45 minutes or greater from Urban Areas of 25,000-49,999; 30 minutes or greater from Urban Areas of 10,000-24,999; and 15 minutes or greater from Urban Areas of 2,500-9,999

Children with Internet in the Home		
Michigan	Number	1,952,456
	Percent	89.90%
Alger	Number	1,245
	Percent	89.80%
Baraga	Number	1,358
	Percent	90.10%
Chippewa	Number	6,155
	Percent	89.40%
Delta	Number	6,458
	Percent	90.20%
Dickinson	Number	4,675
	Percent	92.60%
Gogebic	Number	1,922
	Percent	81.70%
Houghton	Number	6,601
	Percent	91.10%
Iron	Number	1,536
	Percent	85.90%
Keweenaw	Number	237
	Percent	76.00%
Luce	Number	933
	Percent	90.20%
Mackinac	Number	1,482
	Percent	88.20%
Marquette	Number	11,048
	Percent	92.70%
Menominee	Number	3,998
	Percent	93.90%
Ontonagon	Number	688
	Percent	95.60%
Schoolcraft	Number	1,154
	Percent	83.10%

*Source: Michigan League for Public Policy, 2019

The largest urban area in the Upper Peninsula is Marquette, with a population of 20,680 in 2018. Frontier locations are held to a 90-min/ 90-mile requirement, however CMHSPs are located within 60-min/ 60-miles to accommodate the previous rule. The dark green circles below represent 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.



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

Gogebic Co. CMH
1 Gogebic County

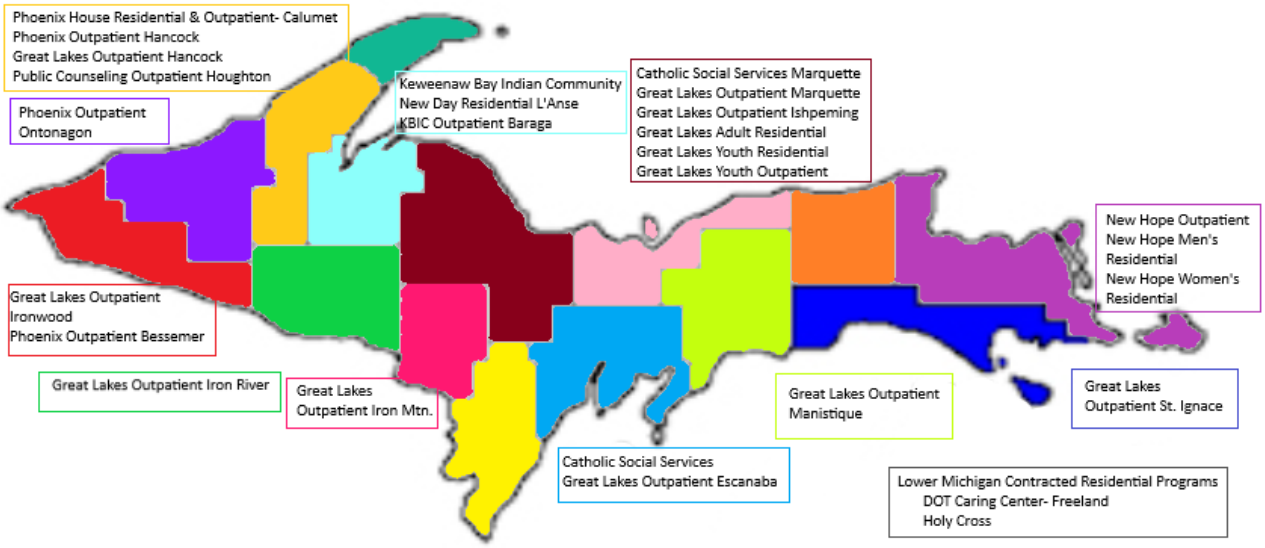
Hiawatha Behavioral Health
9 Chippewa County
15 Mackinac County
14 Schoolcraft County

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

Substance Use

There are no Substance Use Providers in Menominee, Alger, Luce, or Keweenaw Counties. The following providers are in the corresponding color-coded county. NorthCare also contracts with two residential providers downstate.



MI Health Link

MI Health Link services are available in every U.P. County through the CMHSP system. Every county except Schoolcraft also has an alternative provider for mild/moderate behavioral health services.

Conclusion

FY20 was a year like no other. The immediate effects and long-term impact of COVID-19 on demand and capacity cannot fully be evaluated until the pandemic is over. Each provider agency created and implemented a pandemic plan that worked best in their local area. While there was some consistency in implementation, there was also various local nuisances. Therefore, in review of data, the question *How does COVID-19 impact this?* should be applied.

COVID-19 caused a major shift in service provision from face-to-face services to telehealth services via video, or in some situations, audio formats. This method of service provision has mixed reviews. Some consumers lack access to technology or reliable internet and therefore could not easily participate in telehealth services. Other consumers typically lack transportation or childcare and therefore found telehealth services to be beneficial for them to attend their appointments. Some consumers enjoy the human element of meeting face-to-face while others prefer the safety and comfort of attending appointments via a screen.

It is anticipated that going forward the Michigan Department of Health and Human Services will continue to allow some services to be provided via telehealth services, at least some of the time. This will allow for greater overall access for consumers depending on the consumers individual needs. The service providers will need to prepare for how this impacts their service provision going forward and ensure adequate technology to continue to meet the telehealth demand in years to come. Additionally, because many staff have left the field during COVID-19, providers will need to plan for reduced staff going forward although there may be increased demand.

When the pandemic first hit and the state announced the Stay-at-Home Order, there was a massive decrease in inpatient psychiatric utilization. Hospitals were operating at approximately a third of their typical utilization. This utilization eventually increased back to normal rates of admission. As the pandemic wore on, increased alcohol use was nationally noted on the news. Alcohol was, and remains, the primary reason for admission for substance use disorder treatment.

While there is opportunity for post traumatic growth following an adverse event, chronic stress generally decreases overall mental health. As the pandemic has continued the early effects of this stress are beginning to be witnessed. Northcare will continue to partner with local agencies including the CMHSPs, SUD providers, inpatient psychiatric hospitals, after-hours crisis line, and community MI Health Link providers to ensure efficient and effective treatment to eligible consumers. NorthCare will continue to emphasize coordination of care to provide holistic care that encompasses an individual's biology, sociology, and psychology. In FY21 NorthCare will be participating in the Opioid Health Home and Behavioral Health Home initiatives to enhance coordination of services and emphasize recovery supports in the treatment process.

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 corrections, questions, or concerns related to this report. If you are interested in receiving services at one of the CMHSPs or SUD Providers in the Upper Peninsula, please contact the Access Department at 1-888-906-9060 (Mental Health) or 1-800-305-6564 (Substance Use).

Finally, a huge thank you to all staff across the Upper Peninsula for your continued efforts to provide quality services to consumers during this trying time. We appreciate you.

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