

Introduction

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in the area of access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder Providers are measuring performance through the use of standardized performance indicators.

Data Collection

The data collected is based on the definition and requirements that have been set forth within the Michigan Mission Based Performance Indicator System (MMBPIS) Code Book FY20, and the Reporting Requirements attached to the PIHP contract. Additional instructions are available in the REMI Help documents. The data is fully valid and reliable. This measure allows for exclusions and/or exceptions based on each individual indicator.

Data Analysis

This data is to be reported and reviewed as part of the Quality Assessment and Performance Improvement Program (QAPIP). MSHN will analyze the data on a quarterly basis to address any trends and/or opportunities for quality improvements. Regional trends are identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified. A status of “met” indicates MSHN met the standard for all four quarter of FY20. A status of “not met” indicates 1 or more quarter did not meet the identified standard.

MDHHS, in coordination with the PIHPs and CMHSP participants, developed and implemented new indicators to be reported for FY20Q3. The new indicators measure the following:

- The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (adults and children with a mental illness and/or developmental disability)
- The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (adults and children with a mental illness and/or developmental disability)
- The percentage of new persons during the quarter receiving a face to face service for treatment or supports within 14 calendar days of a non-emergency request for service for person with SUD.

Indicator 2 ending FY20Q2 measured the percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. Indicator 3 ending in FY20Q2 measured the percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.

The following changes were made from the previous Indicators.

- No external standard currently is available, collecting baseline for one year
- No exceptions are permitted for these indicators (those who cancel, no show, reschedule, or choose to not receive services form this PIHP)
- Those with the Autism Benefit are included
- Count forward from all requests for service (Indicator 2)

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- Count those with a completed bio-psychosocial (full or updated) on the day it was completed (Indicator 2)
- Count forward from those with a completed bio-psychosocial (full or updated) to an ongoing covered service. (Indicator 3)
- Count of those receiving an ongoing covered service (not limited to professional service only) (Indicator 3)
- SUD indicator uses the BH-TEDS admissions data and aw file of requests from the PIHP for those that never completed an admission.

Goal: MSHN will meet or exceed the Michigan Mission Based Performance Indicator System standards for Indicators 1, 4, 10. (Indicators 2 and 3 have no standard for the first year)

New Measures

Indicator 2a (Access): The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. MI adults, MI children, I/DD adults, I/DD children. (No Standard the 1st year)

MSHN demonstrated a 65.69 (2198/3346) performance rate for all population categories for Indicator 2 (Figure 1). Figure 2 provides an overview of reasons for “out of compliance”.

Indicator 2e (Access): The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. (No Standard the 1st Year):

Expired Requests: MSHN SUD providers had 81 individuals who requested and were approved for SUD treatment, however never received a service. This information is submitted to MDHHS for inclusion into the calculation of the above indicator. According to the MDHHS Consultation Draft, MSHN demonstrated a 86.28% (2402/2784) for those who requested, and were approved for a SUD service and received a treatment or service within 14 days.

Indicator 3 (Access): Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.: Start of Service within 14 Days. MI adults, MI children, I/DD adults, and I/DD children (No Standard the 1st Year):

MSHN demonstrated a 72.04 (1891/2625) performance rate for all population categories within Indicator 3 (Figure 1). Figure 2 provides an overview of reasons for “out of compliance”. The percentage of each “out of compliance” reason is reviewed, however the process to identify an accurate description of the reason demonstrating consistency in the interpretation is the focus of the data collection during the baseline year.

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Figure 1. PIHP and CMHSP percentage of performance with Indicator 2 and 3. Pandemic Emergency Orders in effect FY20Q2-FY21Q1

Affiliate / CMH	*#2a - 1st Request Timeliness					*#3 - 1st Service Timeliness				
	MI / Child	MI / Adult	DD / Child	DD / Adult	Total	MI / Child	MI / Adult	DD / Child	DD / Adult	Total
Bay-Arenac	64.95%	55.34%	30.77%	100.00%	57.55%	72.73%	70.63%	71.43%	66.67%	71.30%
CEI	70.43%	43.36%	41.86%	42.11%	51.61%	45.32%	73.44%	65.63%	13.33%	59.88%
Central MI	58.93%	56.75%	84.21%	54.55%	58.19%	72.58%	70.65%	78.95%	66.67%	71.43%
Gratiot	71.43%	80.23%	75.00%	**	76.98%	77.50%	78.95%	80.00%	**	78.51%
Huron	79.17%	89.29%	100.00%	100.00%	85.45%	75.00%	82.61%	50.00%	50.00%	76.74%
Ionia	88.06%	89.47%	100.00%	75.00%	88.89%	74.63%	82.28%	50.00%	100.00%	78.06%
LifeWays	57.41%	63.71%	64.00%	77.78%	62.27%	78.31%	76.92%	73.68%	62.50%	76.70%
Montcalm	82.14%	87.07%	88.89%	87.50%	85.71%	68.63%	72.07%	80.00%	100.00%	72.32%
Newaygo	79.07%	68.15%	66.67%	100.00%	71.35%	80.85%	78.57%	66.67%	33.33%	78.15%
Saginaw	74.77%	79.32%	84.85%	100.00%	78.96%	71.91%	72.77%	79.31%	55.56%	72.64%
Shiawassee	88.64%	84.62%	55.56%	100.00%	84.43%	82.05%	75.81%	80.00%	100.00%	79.09%
Tuscola	80.77%	68.09%	50.00%	50.00%	70.89%	95.45%	93.94%	100.00%	100.00%	95.16%
Total/PIHP:	70.56%	63.21%	64.88%	70.27%	65.69%	68.30%	74.52%	73.94%	57.14%	72.04%

*Indicator 2a and Indicator 3-New measure, collecting baseline, no comparative data **No eligible records for reporting

Figure 2. Indicator 2 and 3 Reasons for “Out of Compliance”

Out of Compliance Categories	FY20Q3 # Out of compliance	FY20Q3 % Out of compliance	FY20Q4 # Out of Compliance	FY20Q4 % Out of Compliance	FY21Q1 # Out of Compliance	FY21 % Out of Compliance
Consumer no showed for an appointment	430	42.36%	749	41.98%	807	42.88%
Blank	312	30.74%	520	29.15%	537	28.53%
Consumer rescheduled an appointment	56	5.52%	162	9.08%	168	8.93%
Consumer refused an appointment offered within the timeframe/requested outside of required timeframe	68	6.69%	174	9.75%	165	8.77%
Consumer chose not to pursue services	40	3.94%	56	3.14%	53	2.82%
Staff cancel/reschedule	27	2.66%	20	1.12%	33	1.75%
Date of First Contact is not specified on the SUD Admission;	22	2.17%	1	0.06%	0	0.00%
No appointment available within 14 days with any staff	18	1.77%	26	1.46%	14	0.74%
Rapid Access	17	1.67%	13	0.73%	34	1.81%
Custom	12	1.18%	33	1.85%	30	1.59%
Discharged Out of Region or Not CMH responsibility	3	0.30%	0	00.0%	0	0.00%
Eligible for services, but placed on waitlist;	2	0.20%	1	0.06%	7	0.37%
Autism Consumer	1	0.10%	1	0.06%	2	0.11%
Non-Medicaid Client	1	0.10%	1	0.06%	0	0.00%
Consumer not eligible for ongoing services	3	.30%		0.00%	5	0.27%
Consumer chose provider outside of network			10	0.56%	5	0.27%
Other			17	0.95%	22	1.17%
Grand Total	1015	100.00%	1784	100.00%	1882	100.00%

Indicator 1 (Access): Percentage of Children/Adults who received a Prescreen within 3 hours of request

(standard is 95% or above): This indicator defines disposition as the decision made to refer or not to refer for inpatient psychiatric care. The start time is when the consumer is clinically, medically and physically cleared and available to the PIHP or CMHSP. The stop time is defined as the time when the person who has the authority approves or disapproves the hospitalization. For the purposes of this measure, the clock stops, although other activities to complete the admission may still be occurring.

In Figure 3, MSHN demonstrated a performance rate of 99.53 (631/634) for FY21Q1 of the Children who requested a prescreen received one within three (3) hours. This was an increase from previous quarter (98.57%). MSHN demonstrated a performance rate of 99.35% (2142/2156) of the Adults who requested a prescreen received one within three (3) hours. This was an increase from previous quarter (99.16%). All twelve CMHSPs performed above the standard of 95% for both the children and adult population group.

Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above):

In Figure 3, MSHN demonstrated a 98% (98/100) performance rate for Children. This is an increase from previous reporting period (97.30%). MSHN demonstrated performance of 97.53% (473/485) performance rate for Adults. This is a decrease from previous reporting period (98.51%). Ten CMHSP participants demonstrated performance above the standard for Adults or Children. Those that did not had less than 30 records eligible for inclusion (HBH-8, NCMH-15).

Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above):

In Figure 3, MSHN demonstrated a 98.31% (116/118) performance rate for individuals who were seen for follow-up care within 7 days of discharge from a detox unit. This is an increase from previous reporting period (95.73%).

The following are exceptions for Indicator 4a and 4b:

- Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven-calendar day period, or do not show for an appointment or reschedule it. Must document dates of refusal or dates offered; or
- Consumers who choose not to use CMHSP/PIHP services. For the purposes of this indicator, Providers who provide substance abuse services only, are currently not considered to be a CMHSP/PIHP service.

Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less):

Individuals who chose not to use PIHP services were excluded from this measure. In Figure 3, MSHN demonstrated a 6.82% (9/132) performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. This was an improvement from the previous reporting period (7.45%). All CMHSP participants met the standard.

MSHN demonstrated a 13.11% (99/755) performance rate for Adults who were readmitted within 30 days of being discharged from a psychiatric hospitalization. This was an improvement from the previous reporting period (13.98%). Nine CMHSP participants met the standard.

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Figure 3. PIHP and CMHSP percentage of performance with Indicator 4a, 4b, and 10.

Affiliate / CMH	#1 - Pre-Admission screening		#4a - Hospital Discharges F/U		#4b SUD - Detox Follow-Up	#10 - Inpatient Recidivism	
	Child	Adult	Child	Adult	SUD	Child	Adult
Bay-Arenac	100.00%	99.57%	100.00%	98.48%		0.00%	17.17%
CEI	98.60%	98.44%	100.00%	95.65%		6.67%	14.74%
Central MI	100.00%	99.40%	100.00%	98.08%		0.00%	11.69%
Gratiot	100.00%	97.59%	100.00%	100.00%		11.11%	4.00%
Huron	100.00%	100.00%	66.67%	60.00%		0.00%	18.18%
Ionia	100.00%	100.00%	100.00%	100.00%		0.00%	14.29%
LifeWays	100.00%	100.00%	96.00%	96.15%		10.71%	14.75%
Montcalm	100.00%	98.65%	100.00%	100.00%		0.00%	9.38%
Newaygo	100.00%	100.00%	100.00%	92.86%		0.00%	9.52%
Saginaw	100.00%	100.00%	100.00%	100.00%		13.33%	10.71%
Shiawassee	100.00%	100.00%	100.00%	100.00%		0.00%	15.15%
Tuscola	100.00%	96.15%	100.00%	100.00%		0.00%	5.56%
MSHN SUD					98.31%		
Total/PIHP:	99.53%	99.35%	98.00%	97.53%	98.31%	6.82%	13.11%

Figure 4. MSHN longitudinal data Indicators 1, 2, 3, 4, 10.

	Population	FY20Q1	*FY20Q2	*FY20Q3	*FY20Q4	*FY21Q1
Indicator 1: Percentage who received a Prescreen within 3 hours of request (95% Standard)	Children	98.60%	99.51%	99.19%	98.57%	99.53%
	Adults	99.17%	98.71%	99.44%	99.16%	99.35%
**Indicator 2: Percentage who have had a completed Bio-psychosocial Assessment within 14 Days. (Effective 4.1.2020 No Standard)	MI Child			79.72%	76.93%	70.56%
	MI Adults			74.15%	69.25%	63.21%
	DD Child			69.05%	68.56%	64.88%
	DD Adult			81.13%	71.69%	70.27%
	MSHN Total			75.52%	71.69%	65.69%
**Indicator 3: Percentage of who had a Medically Necessary Service within 14 Days. (Effective 4.1.2020 No Standard)	MI Child			70.83%	70.83%	68.30%
	MI Adults			77.61%	77.61%	74.52%
	DD Child			71.74%	71.74%	73.94%
	DD Adult			76.74%	76.74%	57.14%
	MSHN Total			75.57%	75.57%	72.04%
Indicator 4: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit (95% Standard)	Children	98.28%	98.64%	98.17%	97.30%	98%
	Adults	95.14%	95.92%	96.77%	98.51%	97.53%
	MSHN SUD	98.39%	97.83%	97.78%	95.15%	98.31%
Indicator 10a: Percentage who had a Re-admission to Psychiatric Unit within 30 Days (>15% Standard)	Children	4.35%	5.97%	16.06%	7.45%	6.82%
	Adults	11.59%	10.06%	14.30%	13.98%	13.11%

**Indicator 2a and Indicator 3-New measure, collecting baseline, no comparative data. *Pandemic Emergency Orders in Effect.

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Figure 5 and 6 provide information related to the percentage of exceptions. The exception type with the highest frequency was the individuals canceled or did not show for a scheduled appointment.

Figure 5. Indicator 4a MSHN and the CMHSP participants exception data. *Pandemic Emergency Orders

Indicator 4a	FY19Q1	FY19Q2	FY19Q3	FY19Q4	FY20Q1	*FY20Q2	*FY20Q3	*FY20Q4	*FY21Q1
BABH	30.82%	26.89%	27.68%	42.59%	31.86%	35.92%	32%	32.36%	29.73%
CEI	53.58%	54.05%	39.81%	30.95%	33.33%	49.51%	28%	27.50%	45.16%
CMHCM	26.09%	32.94%	33.72%	28.65%	30.28%	25.51%	3%	56.63%	29.89%
GIHN	17.65%	16.67%	20.00%	28.95%	31.71%	23.91%	14%	21.88%	17.14%
HBH	37.84%	40%	29.03%	36.36%	52.00%	37.50%	36%	21.43%	55.56%
Lifeways	30.45%	40.66%	36.23%	39.03%	37.40%	40.49%	37%	38.85%	13.04%
MCN	35.85%	26.32%	26.32%	23.91%	29.79%	20.45%	26%	27.50%	40.83%
Newaygo	31.58%	18.18%	25.00%	30.77%	9.09%	22.73%	14%	9.09%	17.14%
Saginaw	31.06%	32.56%	32.24%	31.01%	30.94%	26.83%	24%	20.14%	21.05%
SHW	37.25%	27.59%	30.91%	28.57%	17.39%	18.52%	35%	20.83%	34.29%
The Right Door/Ionia	20.00%	25%	23.81%	31.03%	21.43%	10.34%	12%	16.67%	25.64%
TBHS	36.67%	48.15%	50.00%	63.16%	52.63%	19.35%	19%	33.33%	52.38%
MSHN		39.06%	33.64%	34.19%	33.17%	35.74%	26%	32.36	35.07%
Indicator 4b MSHN	60.58%	55.40%	57.96%	53.92%	57.82%	54.61%	51.09%	52.19%	57.86%

Figure 6. Indicator 10-MSHN and the CMHSP Participants exception data. *Pandemic Emergency Orders

Indicator 10	FY19Q1	FY19Q2	FY19Q3	FY19Q4	FY20Q1	*FY20Q2	*FY20Q3	*FY20Q4	*FY21Q1
BABH	0.00%	0.00%	0.00%	0.00%	0.00%	00.0%	0.00%	0.00%	0.00%
CEI	3.02%	3.19%	2.34%	0.00%	11.28%	2.57%	21.10%	29.34%	29.49%
CMHCM	0.00%	0.00%	0.00%	10.50%	0.00%	00.0%	0.00%	0.00%	0.00%
GIHN	0.00%	0.00%	0.00%	0.00%	0.00%	00.0%	0.00%	0.00%	0.00%
HBH	0.00%	0.00%	0.00%	0.00%	0.00%	00.0%	0.00%	0.00%	0.00%
Lifeways	2.99%	4.13%	4.53%	6.72%	3.54%	4.96%	3.66%	4.62%	3.21%
MCN	0.00%	0.00%	0.00%	0.00%	0.00%	00.0%	0.00%	0.00%	0.00%
Newaygo	0.00%	0.00%	0.00%	0.00%	0.00%	00.0%	0.00%	0.00%	0.00%
Saginaw	0.00%	0.00%	0.00%	0.63%	0.00%	00.0%	0.00%	1.85%	0.00%
SHW	0.00%	0.00%	0.00%	0.00%	0.00%	00.0%	0.00%	0.00%	0.00%
The Right Door	0.00%	0.00%	0.00%	0.00%	0.00%	00.0%	0.00%	0.00%	0.00%
TBHS	3.23%	7.41%	2.70%	0.00%	0.00%	00.0%	0.00%	6.67%	0.00%
MSHN		1.98%	1.63%	3.72%	3.06%	1.78%	7.63%	9.46%	5.64%

Conclusion:

MSHN performed above the standard for each Indicator for FY21Q1.

Corrective Action

The following CMHSPs demonstrated performance below the standard for the following indicators for FY21Q1 and require a review of a current corrective action plan or development of a plan:

Indicator 1: None

Indicator 4: HBH Adult-Children, Newaygo – Adults.

Indicator 10: BABH- Adult; HBH-Adult, SHW-Adult.

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Causal factors identified for those that performed below the standard include the following:

- An increase in the severity of mental health issues
- Mental health compounded with substance use issues
- An increase in families not cooperating in follow up treatment for their child or family member
- The limited availability of increased level of care placements resulting in repeated hospitalizations
- Lack of coordination upon discharge with inpatient unit
- Home environment not supportive of recovery
- Medications needing additional adjustment to address behavioral concerns/instability
- Individual not cooperative with prescribed medication regimen upon discharge
- Individuals medication not in full effective upon discharged/early discharge
- Hospital discharged against the CMHSP recommendations
- Complicated medical issues affecting mental health
- The cost of the medication/ insurance limitations (Medical Directors Feedback)
- The inpatient unit prescribing Benzos (Medical Directors Feedback)
- The inpatient unit's inability to prescribe an injectable medication (Medical Directors Feedback)

Interventions

- Implementation of psychiatric urgent care to circumvent inpatient admissions and to assist individuals who have been discharged
- Staff including peers to reach out through face-to-face attempts for those who do not follow up after discharge
- Retrospective review occurring on all cases to identify trends to avoid future hospitalizations. Implementation of weekly team meetings to discuss hospital admissions and discharges ensuring coordination occurs
- Increased coordination and linking with provider including the Psychiatrist to ensure medical needs are met
- Increased level of care provided through available alternate resources

Recommendations:

- All CMHSPs who demonstrate performance below the standard for each population group will determine causal factors and barriers contributing to lower performance.
- Continue to review with the Regional Medical Directors Group for additional insight into barriers and potential interventions.
- Include the number of consumers readmitted to Inpatient Psychiatric Hospitalization in addition to the number of readmissions in the analysis. The intent is to inform regional improvement efforts.
- An improvement plan should be developed utilizing the QIC Work Plan prior to the end of April. The QIC work plan will replace the corrective action document with completion being prior to the meeting in which the summary report is reviewed. The QIC work plan will include causal factors, barriers, action steps to remediate the deficiency, dates of completion. This will guide discussion of best practices, and identification of regional intervention.
- Indicator 2 and 3 are currently baseline data collection, therefore, improvements will be focused on the process of data collection to ensure valid, reliable, and actionable data is being collected.

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QIC is currently using the data to identify areas of discussion for valid data collection. A communication will be distributed ensuring an understanding of the baseline data period.

- A PowerPoint will be developed by April 30th to address the intent and requirements of each performance indicator including the expectation of required documentation. A focus will be any common areas of deficiency that has been demonstrated in the regions during this past year. The power point training will be available for training of new staff as well as review for all staff.
- Additional emphasis to develop consistent processes will continue by utilizing the Frequently Asked Questions (FAQ) Document currently available and updated in the REMI Help documents. This will be updated to include relevant data to address the new indicators.
- CMHSPs should continue to review data prior to submission to ensure the appropriate data elements are submitted according to the format as indicated in the instructions.

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Date: 4/16/2021

Approved by: MSHN QIC

Date: 4/22/2021