Quality Operations Technical Assistance Workgroup Meeting Agenda

Wednesday, May 27, 2020

Blue Jean Conference Meeting

Conference Call In # 1.408.419.1715

9:30 a.m. – 11:00 a.m.

I.	Announcements ○ COVID – 19 (DWIHN) Website ○ CRSP Responsibility Memo ○ Telehealth Survey	T. Greason /A. Siebert
II.	Substance Use Disorder (SUD) Provider Update	J. Davis
III.	MyStrength Program	T. Sanford
IV.	COVID – 19 AFC Monitoring	S. Smith
V.	Site Review and Monitoring	S. Smith
VI.	MDHHS Waiver Audit Review ○ March 9th – April 3rd, 2020	S. Smith/D. Dobija
VII.	Assertive Community Treatment (ACT)	E. Reynolds

Mission:

We are a safety net organization that provides access to a full array of services and supports to empower persons within the Detroit Wayne County behavioral health system.

Vision:

To be recognized as a national leader that improves the behavioral and overall health status of the people in our community.

Values:

We are a person centered, family and community focused organization.
We are an outcome, data driven and evidence-based organization.
We respect the dignity and diversity of individuals, providers, staff and communities.
We are culturally sensitive and competent.
We are fiscally responsible and accountable with the highest standards of integrity.
We achieve our mission and vision through partnerships and collaboration.

VIII.	Behavior Treatment Committee ○ CRSP Responsibility	F. Nadeem
IX.	Critical/Sentinel Event Policy and Procedure Reporting ○ MDHHS Corrective Action Plan - Death Reporting	C. Spight-Mackey/S. Applewhite
X.	Home and Community Based Services (HCBS) Policy	A. Siebert
XI.	Mission Based Performance Indicator ○ 1st Quarter Data (Submitted April 7, 2020) ○ New Reporting Requirements – Quarter 3 ➢ Indicator 2a ➢ Indicator 2b ➢ Indicator 3	J. Zeller/T. Greason
XII.	Performance Indicator (MDHHS) ○ Follow-Up After Hospitalization Requirement	T. Forman/J. Zeller
XIII.	Provider Feedback	T. Greason
XIV.	Adjournment	

Next Meeting Scheduled for Wednesday June 17th, 2020 (Blue Jean Platform)

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DETROIT WAYNE INTEGRATED HEALTH NETWORK

2020 MDHHS Waiver Review

Preliminary Findings Summary

presented at the

Quality Operations Technical Assistance Workgroup Meeting

5/27/2020

2020 MDHHS Waiver Review

New for 2020:

- MDHHS Reviewers
- Remote Review

Date of Review:

- Start: March 9, 2020
- Scheduled to conclude: April 3, 2020.
- Conclusion suspended: anticipate review to conclude 30 days following the lifting of the State of Emergency

2020 MDHHS Waiver Review

Current Status

- Clinical Case Record Review
  - All clinical records have been reviewed for all three waiver programs
- Staff Qualifications Reviews
  - incomplete for both professional and non-professional staff
  - incomplete for all three waiver programs

Preliminary Findings
Clinical Case Record Review
Children's Waiver (CWP)

Overall, preliminary feedback has been very good.

Highlights:

Standard P.4.2 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency.

- Under utilization of CLS services as identified in the IPOS

Preliminary Findings
Clinical Case Record Review
Habilitation Supports Waiver (HSW)

Highlights:

Standard P.5.1 Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS.

- citations included a lack of goals for services identified in a plan; non-measurable goals/objectives; service oriented goals rather than outcome driven goals and objectives; and a lack of specificity in amount, scope and duration.

Preliminary Findings
Clinical Case Record Review
Habilitation Supports Waiver (HSW)

(cont.)

Standard P.5.2 Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing.

- citations included a lack of evidence that service delivery was provided in the frequency, amount and scope as specified in the IPOS and lacked an explanation for the difference

Preliminary Findings
Clinical Case Record Review
Habilitation Supports Waiver (HSW)

(cont.)

Standard P.2.6 Individual plan of service addressed health and safety, including coordination with primary care providers.

- citations included a lack of evidence of coordination of care beyond a signed consent to share information form; health conditions not being addressed in the IPOS.

Preliminary Findings
Clinical Case Record Review
Habilitation Supports Waiver (HSW)

(cont.)

Standard P.2.3 Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.

- MDHHS was looking for specific documentation on how members who do not communicate with words, communicate their satisfaction. They did not accept documentation such as "The member seems happy". Or "The home manager reports . . . ."

Preliminary Findings
Clinical Case Record Review

Habilitation Supports Waiver (HSW)

(cont.)

Standard P.2.7 The individual plan of service is developed in accordance with policies and procedures established by MDHHS.

- Citations included a lack of evidence that the frequency of review was completed as identified in the IPOS.
- Specifically, an annual IPOS does not supplant a formal review.

Preliminary Findings
Clinical Case Record Review

Serious Emotional Disturbance Waiver (SEDW)

- Highlights: Excellent assessment tools and use of tools, Goals and objectives target areas of need (look for golden thread), Supportive language of child and family served, Loved seeing budgets of services provided. Signatures of the kids on the plans of service.

Preliminary Findings
Clinical Case Record Review

Serious Emotional Disturbance Waiver (SEDW)

Areas of improvement:

P.3.3 The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care providers.

- Citations included: no evidence of coordination of care with primary care physician. Release authorization alone does not meet this requirement.

Preliminary Findings
Clinical Case Record Review

Serious Emotional Disturbance Waiver (SEDW)

P.3.4 The IPOS is developed in accordance with policies and procedures established by MDHHS.

- TA: Going forward, please discontinue the use of ranges when reflecting authorizations of service, as authorizations should reflect specific amt scope duration as reflected in the plan.

G.1 Individual provided information/education on how to report abuse/neglect/exploitation and/or other critical incidents.

- Could not find evidence. Notification of receiving Recipient Rights booklet and Consumer Handbook are *possible* forms of evidence, but it is expected to be more specific.

Preliminary Findings
Clinical Case Record Review

Serious Emotional Disturbance Waiver (SEDW)

G.2 Individual served received a health care appraisal

- Could not find evidence. If all required elements are present, psychiatric evaluation can suffice for annual health care appraisal.

Preliminary Findings
Credentialing

Professional Staff Review

- CWP, HSW, & SEDW
- MDHHS has requested all evidence used to determine credentialed status: CMHP, QIDP

  (the certificate alone is insufficient evidence)

Preliminary Findings Credentialing

Non-Professional Staff

- HSW
- 82 records reviewed so far
- Evidence of training on the IPOS
  - Evidence of training for 43 staff not accepted because the identified trainer (home manager) did not have evidence of being trained by the SC.
  - 13 staff lacked any evidence of training
  - 6 did not have legible signatures / names

Preliminary Findings Credentialing

Non-Professional Staff

- HSW (cont.)
- Criminal Background Checks
  - 5 did not include all pages of the ICHAT
- Evidence of required training
  - Blood Borne Pathogens
    - 3 non-DWC trainings lacked name of trainer

2020 MDHHS Waiver Review

Next Steps:

- following the lifting of the State of Emergency MDHHS will complete the waiver review and send DWIHN a final report and plan of correction.

SPECIALIZED RESIDENTIAL COVID-19 MONITORING RESPONSE

Introduction **purpose**:

This project was initiated at the beginning of the COVID-19 outbreak for the purpose of assessing providers performance, needs and what assistance DWIHN could provide amid this sudden pandemic.

DWIHN has approximately 600 contracted AFC homes located throughout the county. The Quality Improvement unit selected a small sample of contracted homes beginning the review with homes in the City of Detroit then moved to additional areas in Wayne county in an effort to assess the following:

- Implementation of procedures outlined by DWIHN (Symptoms Log) to protect residents and staff against COVID-19 and minimize their exposure
- Identify and resolve any potential problems/challenges providers were experiencing with delivering services to residents during COVID-19
- Assess the delivery of services to members in response to the limitations imposed by the state of emergency/ “shelter in place order”
- Ensure providers received the resource information made available on the DWIHN website

Sample of Providers Selected for Specialized Residential COVID-19 Monitoring

Two samples were selected, one selection was for the City of Detroit as it was one of the hardest hit areas for COVID-19 and the other selection was IDD homes as this was considered one of the most vulnerable populations. There were 72 audits completed; some of these reviews included more than one home per audit.

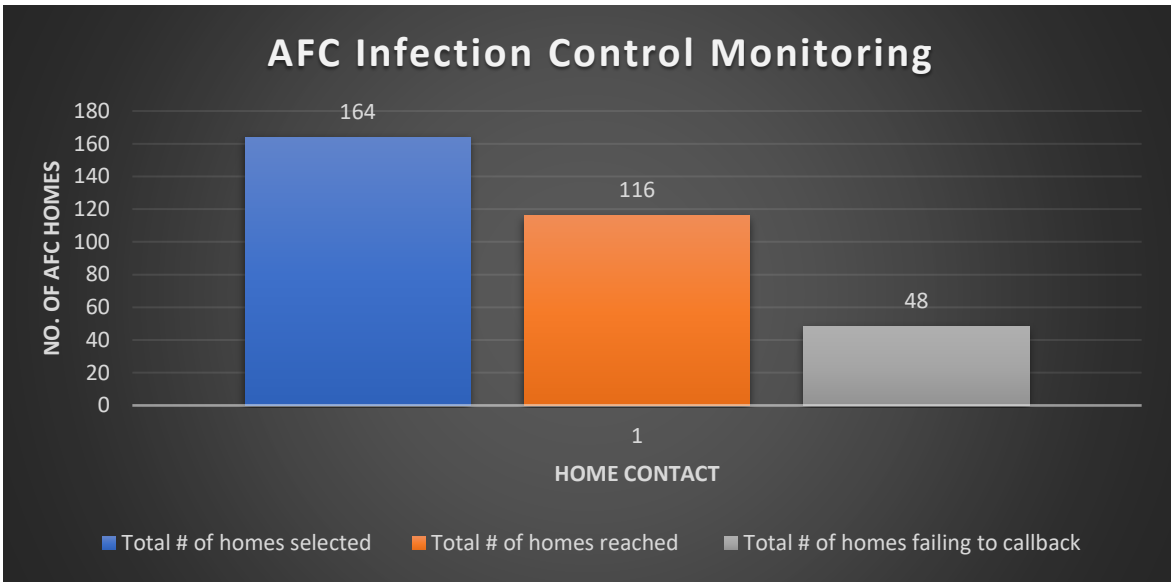
Total # of Homes Selected: 164

Total # of Homes Reviewed: 116

Total # of Homes that have not returned call: 48

Total # of MHWIN Provider Audits: 72

SPECIALIZED RESIDENTIAL COVID-19 MONITORING RESPONSE



Infection Control Measures

Are you screening residents for symptoms of respiratory infection?

- 70 Providers reported: **YES**
- 2 Providers reported: **NO**

  How many times a day?

  - 48 Providers are screening more than once a day
  - 24 Providers are screening once a day

  Method of screening?

  - 68 Providers are following DWIHN Protocol Log
  - 4 Providers are not following DWIHN Protocol Log

Are you screening staff for symptoms of respiratory infection?

- 71 Providers reported: **YES**
- 1 Provider reported: **NO**

  Method of screening?

  - 68 Providers are following DWIHN Protocol Log
  - 4 Providers are not following DWIHN Protocol Log

  Does your screening process ensure confidentiality?

  - 71 Providers reported: **YES**
  - 1 Provider reported: **NO**

Are you screening visitors for symptoms of respiratory infection?

- 13 Providers reported: **YES**
- 6 Providers reported: **NO**
- 58 Providers reported visits are not occurring at this time

Method of screening?

- 13 Providers are following DWIHN Protocol Log
- 6 Providers are not following DWIHN Protocol Log

Does the residence have outdoor signage to halt visitors and inform them of access restrictions?

- 47 Providers reported: **YES**
- 25 Providers reported: **NO**

Does the home have a process in place for responding to residents who have symptoms of respiratory infection?

- 68 Providers reported: **YES**
- 4 Providers reported: **NO**

Does the home have a private room for a resident if needed?

- 59 Providers reported: **YES**
- 13 Providers reported: **NO**

Does the home have a process in place for responding to staff who have symptoms of respiratory infection?

- 70 Providers reported: **YES**
- 2 Providers reported: **NO**

Are staff well informed of the home's policy if they are symptomatic?

- 70 Providers reported: **YES**
- 2 Providers reported: **NO**

What is the home's disinfection frequency protocols?

- 59 Providers reported an increase in home's disinfection frequency protocols
- 13 Providers reported no change in home's disinfection frequency protocols

Handwashing frequency protocols?

- 62 Providers reported an increase in handwashing frequency protocols
- 10 Providers reported no change in handwashing frequency protocols

Does the home have educational information regarding infection control and the signs and symptoms of early detection of COVID 19?

- 63 Providers reported: **YES**
- 9 Providers reported: **NO**

Does the home have adequate personal protection equipment?

- 60 Providers reported: **YES**
- 12 Providers reported: **NO**

Home Operations – Residential Service Delivery

Does the home have adequate food to provide nourishing meals daily?

- ALL Providers reported: **YES**

If there are residents prescribed medications, has the pharmacy dispensed greater quantities to minimize the frequency of filling prescriptions, therefore minimizing exposure to COVID-19

- 17 Providers reported: **YES**
- 49 Providers reported: **NO**
- 6 Providers did not report

If there are residents who require certain medical equipment and supplies, has the home been able to obtain/receive the needed supplies?

- ALL Providers reported: **YES**

What actions have been taken to provide alternative recreational activities that align with the Stay at Home order?

- 69 Providers reported providing some alternative recreational activities
- 3 Providers reported alternative recreational activities are not being provided

Does the home have plan for addressing potential increases in mental health symptoms (i.e., anxiety and depression) of the residents? Of staff?

- Residents
  - 62 Providers reported: **YES**
  - 10 Providers reported: **NO**
- Staff
  - 51 Providers reported: **YES**
  - 21 Providers reported: **NO**

Does the home have the resources for telehealth services for the residents if needed (i.e., physical health appointments, psychiatric / medication reviews, case management / supports coordination, psychotherapy appointments)?

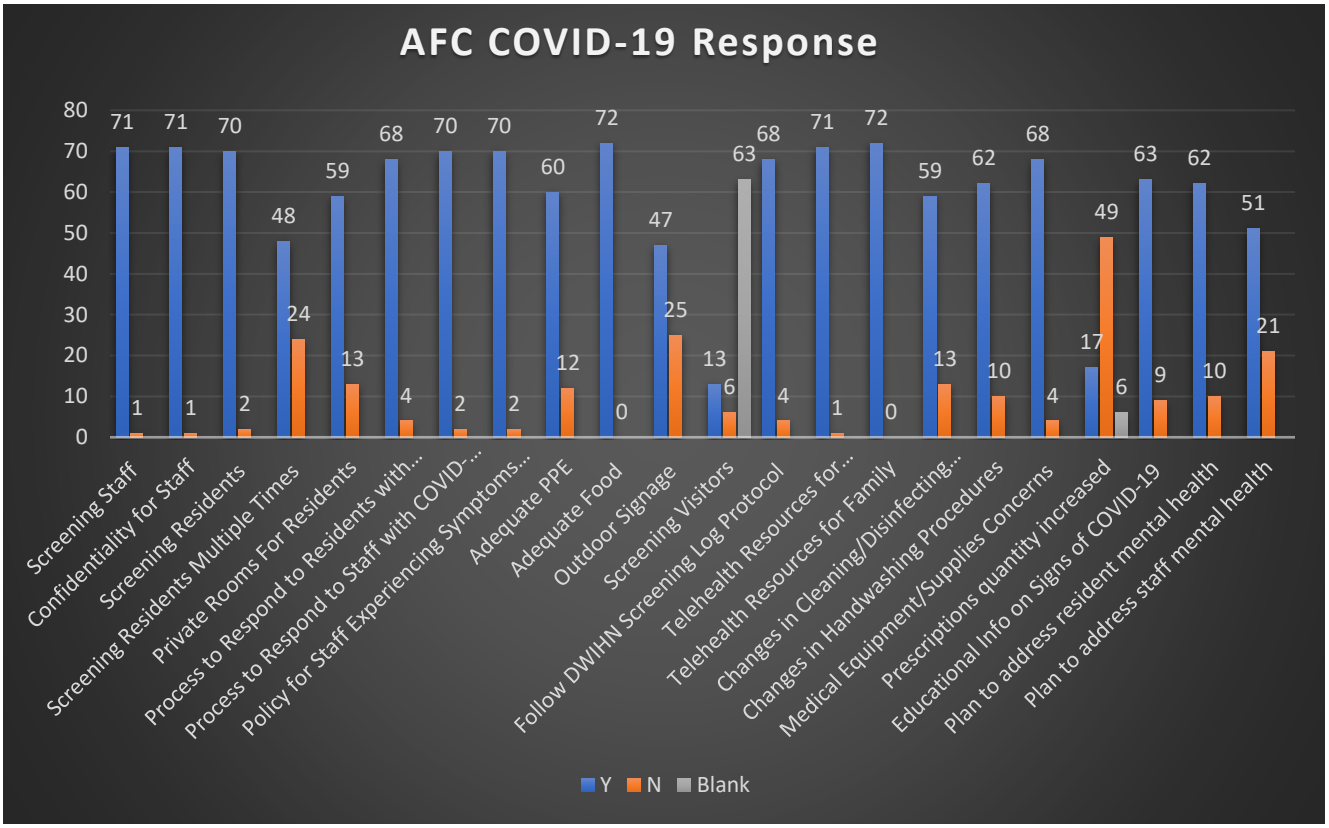
- 71 Providers reported: **YES**
- 1 Provider reported: **NO**

SPECIALIZED RESIDENTIAL COVID-19 MONITORING RESPONSE

- Majority of Providers are utilizing the telephones
- Some homes are utilizing Laptops, Tablets for Video Chat

Does the home have alternate means / resources for non-face to face visits with family and friends?

- ALL Providers reported: **YES**
  - Majority of the homes are utilizing the telephone/ FaceTime has been utilized mostly through staff phones
  - Some homes reported that family/friends may visit through window/door



FINDINGS

OF THE 72 PROVIDERS INTERVIEWED:

- **97%** are screening residents for symptoms of COVID-19 at least 1x/day
- **66%** are screening residents' multiple times a day
- **98%** are screening staff members and is done so confidentially
- **94%** are following DWIHN Protocol Log for Screening
- **94%** have a plan in place to address residents displaying symptoms
- **81%** have a private room to isolate resident displaying symptoms

SPECIALIZED RESIDENTIAL COVID-19 MONITORING RESPONSE

- **97%** have a plan in place to address staff displaying symptoms and have made staff aware of policy if they are experiencing symptoms before reporting to work
- **83%** reports having adequate PPE
- **100%** reports having adequate food
- **80%** do not have visits occurring at this time
- **98%** reports using telehealth resources for (physicians, therapist, case managers/supports coordinators) and **100%** are using telephones to maintain contact with family/friends}

For any question that a provider responded ***NO***, DWIHN reviewers provided the following resources as applicable to that question:

- CDC COVID-19 Factsheet
- CDC and Prevention Resource Sheet
- Detroit Food Pantries
- DWIHN COVID-19 FAQ Resource Sheet
- DWIHN Urgent Psychiatric Care & Clinical Services Sheet
- MDHHS Detailed Guidance Health Care Worker Monitoring Letter
- MDHHS Freedom of Movement and Visits
- MDHHS Guidance on Optimizing PPE
- MDHHS Temporary Waiver for DME-P
- Medicaid Pharmacy Flexibilities in Response to COVID-19 Emergency
- Temporary Pharmacy Waiver
- DWIHN COVID-19 Symptoms Log
- Visitor Signage Template
- Temporary Restrictions on Entry into Residential Care Facilities

Notable Strengths:

- Many providers had long term staff with many years of experience which insolated them from staffing shortages
- All Providers reported an adequate supply of food
- The provision of additional recreational activities for residents were put into place: movies, backyard picnics, reducing news coverage, exercise videos, arts and crafts, board games, puzzles, meditation, walking with masks etc.,
- A majority of providers were well informed on how to respond to COVID-19
- The use of recreational activities appeared to aid in the prevention of increased mental health symptoms among the residents
- Many providers had well established relationships with pharmacies that allowed for no interruption in prescription services
- DWIHN's website on the COVID-19 appeared serve as a valuable resource to the provider network

Recommendations:

- Access to telehealth services for residents involves the use of a home, staff or personal cell phones or tablets. Establishing protocols for ensuring the use of appropriate technology would be recommended.

5/11/20 Memo: ATTACHMENT – E

Follow-Up After Hospitalization with Mental Health Practitioners

NOTE: This process does not apply to SUD CRSP

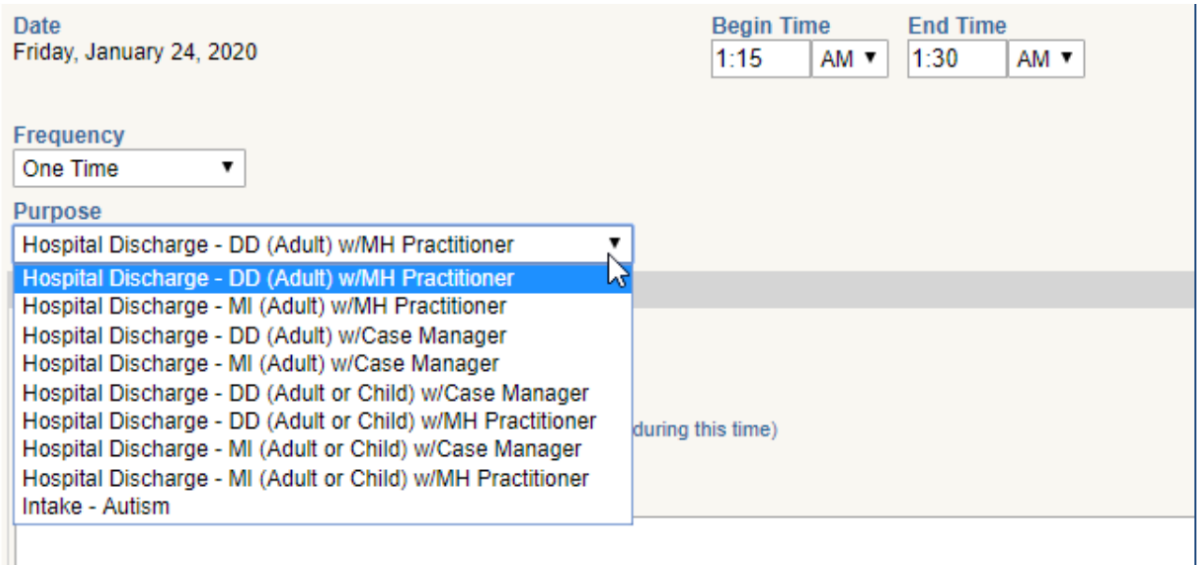
This memo is to address concerns with the HEDIS Performance Measures regarding follow-up appointments following a psychiatric hospitalization for adults and children. DWIHN has fallen short in meeting this measure, specifically in the area of the appointment being with a Mental Health Practitioner within 30 days. Please see attached for definition of the Mental Health Practitioner. The measure is as follows:

Follow-Up After Hospitalization for Mental Illness With-In 30 Days:

- ***Members hospitalized for treatment of selected mental health disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner.***
- ***Ages: six years and older***
- ***Excludes discharges followed by readmission or direct transfer to non-acute inpatient care setting within the 30-day follow-up period regardless of principal diagnoses for the readmission. Excludes discharges followed by the readmission or direct transfer to an acute inpatient care setting within 30-day follow-up period of the principal diagnosis was for non-mental health.***
- ***Two rates are reported:***
    - ***Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge***
    - ***Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge***

In an effort to improve DWIHN progress with these performance indicators, we are requiring the following:

1. Appointment slots on Provider Calendars be available with Mental Health Practitioner. The following service codes are to be used for the services provided by the Mental Health Practitioner: 90791, 90792, 90832-90834, 90836-909837, 90839-90840, 90847, 90848, 90853, 99201-99505, 99211-99215, 0912, H2019, H0039. Wellplace will attempt to fill those slots with hospital discharge appointments only. If there is not an appointment with a Mental Health Practitioner available within 7 days, Wellplace will fill the intake or Case Management appointment and schedule a second appointment within 30-days of that discharge with a Mental Health Practitioner. MH-WIN has been set up to accommodate these calendars. Please see screenshot below:



2. There needs to be a minimum of three attempts to get the individual to the appointment. The CMH Provider must engage the individual prior to being discharged to ensure arrangements are secured to get that individual to the appointment. Tips for gathering information for individuals that continuously miss appointments:
    a. Prior to discharge, find out where the individual likes to hang out (Shelter, church, ED, restaurant, etc.), who do they hang out with, who do they visit, who knows where they can be located (have permission and a signed release to contact that person)
    b. Review notes documented in the "Chart Notes & Health Warnings" Section under Clinical Services in the individual's chart in MH-WIN.
3. The result of ***all*** appointments ***must be entered*** in MH-WIN.

Individuals that continue to show up as a "Familiar Face" in the Emergency Rooms, with police departments and in inpatient facilities are our most vulnerable individuals and account for high cost in hospitalizations. We need to be creative and work hard to get them engaged in services. It is also incumbent to stop the cycle of homelessness for those with mental illness and to get them engaged into care.

Updates will be provided on DWIHN's progress toward meeting the required measures.

If you have questions regarding setting up your calendar, please contact the MH-WIN Helpdesk at mhwin@dwihn.org. Thank you all for your continued partnership!

MICHIGAN'S MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0

CMHSP Reporting Codebooks

April 2020

Codebook Version 1/31/2020

Michigan Department of Health and Human Services
Behavioral Health & Developmental Disabilities Administration

Revision Legend: New for FY2020

FOR CMHSPS

ACCESS

1. The percent of all adults and children receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
    a. Standard = 95% in three hours
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers

2. The percentage of new persons during the quarter receiving a completed biopsychosocical assessment within 14 calendar days of a non-emergency request for service.
    a. No standard for 1st year of implementation – will use information to determine baseline.
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, I/DD adults, and I/DD children

3. 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.
    a. No Standard for 1st year of implementation – will use information to determine baseline.
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers

Scope: MI adults, MI children, I/DD adults, and I/DD children

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults -MI, DD).
    a. Standard = 95%
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers

    Scope: All children and all adults (MI, DD) - Do not include dual eligibles (Medicare/Medicaid) in these counts.

5. The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services. (MI and DD) (Old Indicator #6)
    a. Quarterly report
    b. CMHSP
    c. Scope: all MI/DD consumers

6. The percent of Section 705 second opinions that result in services. (MI and DD) (Old Indicator #7)

a. Quarterly report
b. CMHSP
c. Scope: all MI/DD consumers

EFFICIENCY

*7. The percent of total expenditures spent on administrative functions for CMHSPs. (Old Indicator #9)

a. Annual report (MDHHS calculates from cost reports)
b. PIHP for Medicaid administrative expenditures
c. CMHSP for all administrative expenditures

OUTCOMES

*8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by CMHSP who are in competitive employment. (Old Indicator #10)

a. Annual report (MDHHS calculates from BH TEDS data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

*9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop). (Old Indicator #11)

a. Annual report (MDHHS calculates from BH TEDS data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge**.** (Old Indicator #12)

a. Standard = 15% or less within 30 days
b. Quarterly report
c. PIHP for all Medicaid beneficiaries
c. CMHSP
d. Scope: All MI and DD children and adults - Do not include dual eligibles (Medicare/Medicaid) in these counts.

11. The annual number of substantiated recipient rights complaints per thousand persons served with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II. (Old Indicator #13)

*13. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from BH TEDS data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

*14. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from BH TEDS data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES

FY 2020 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	CMHSPs
2. 1st request	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	CMHSPs
3. 1st service	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	CMHSPs
4. Follow-up	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	CMHSPs
5. Denials	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	CMHSPs
6. 2nd Opinions	10/01 to 12/31	3/31/20	1/01to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	CMHSPs
7. Admin Costs*	10/01 to 9/30	2/27/21							CMHSPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4-01 to 6-30	9/30/20	7/01 to 9/30	12/31/20	CMHSPs
11. RR complaints	10/01 to 9/30	12/31/20							CMHSPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS
15. DD Children Services*	10/01 to 12/31	N/A	1/01to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with *: MDHHS collects data from encounters, BH-TEDS data or cost reports and calculates performance indicators

PERFORMANCE INDICATOR CODEBOOK

General Rules for Reporting Performance Indicators

1. Due dates

All data are due **90 days** following the end of the reporting period (Note: reporting periods are 90 days, six months, or 12 months).
Consultation drafts will be issued for editing purposes approximately two weeks after the due date.
Final report will be posted on the MDHHS web site approximately 30 days following the due date.

2. Children

Children are counted as such who are less than age 18 on the last day of the reporting period.

3. Dual Eligible

Do not include those individuals who are Medicare/Medicaid dual eligible in indicators number 4a & 4b (Follow-up Care) and number 10 (Readmissions).

4. Emergency and urgent requests for services

Used here as defined in the Mental Health Code. *330.1100 (18 & 29)*

4. Medicaid

Count as Medicaid eligible any person who qualified as a Medicaid beneficiary during at least one month of the reporting period. This includes both traditional Medicaid and Healthy Michigan. Individuals covered under the autism benefit are included. Indicators # 1, 2, 3, 4, 10, and 11 are to be reported by the CMHSPs for all their consumers, and by the PIHPs for all their Medicaid beneficiaries. If a PIHP is an affiliation, the PIHP reports these indicators for all the Medicaid beneficiaries in their region. The PIHPs who are also a single CMHSP will submit two reports: One, as a CMHSP for all its consumers, and one as the PIHP for all its Medicaid beneficiaries.

5. Intellectual Disability and Developmental Disability (I/DD)

As defined in the Mental Health Code *330.1100 (12 & 25)*

6. Mental Illness/Serious Emotional Disturbance (MI/SED)

The individual has an MI DSM Diagnosis.

7. Substance abuse beneficiaries

Indicators 2b and 4b include persons receiving Medicaid substance abuse services managed by the PIHP (this is not applicable to CMHSPs). Managed by the PIHP means any substance abuse services that the PIHP may deliver directly or may subcontract directly with a substance abuse provider.

7. Rules for categorizing individuals who have both mental illness and an intellectual or developmental disability (MI/SED & I/DD)

a. If a biopsychosocial (BPS) has been completed for the person:
    i. Assign person to either MI or I/DD category based on primary diagnosis.
    ii. If person has both MI and I/DD primary diagnoses:
        a. Assign a person as either MI or I/DD based on the primary diagnosis related to the greatest level of impairment
        And
        b. the services they are being referred to or being treated for.
    iii. If can't determine whether MI or I/DD category is predominant, categorize the person as I/DD.

b. If BPS has not yet been completed for the person:
    i. Assign person to either the MI or I/DD category based on the services the person requests.
    ii. If the person requests both MH and I/DD services, categorize the person as I/DD.
    iii. If it can't be determined what type of services are being requested, categorize the person as MI.

6. Documentation

It is expected that CMHSPs and PIHPs will maintain documentation of:
a) persons counted in the "exception" columns on the applicable indicators – who, why, and source documents; and
b) start and stop times for timeliness indicators.
Documentation may be requested and reviewed during external quality reviews.

ACCESS -TIMELINESS/INPATIENT SCREENING (CMHSP & PIHP)

Indicator #1
The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours (by two ***sub-populations:*** *Children and Adults). Standard = 95%*

Rationale for Use
People who are experiencing symptoms serious enough to warrant evaluation for inpatient care are potentially at risk of danger to themselves or others. Thus, time is of the essence. This indicator assesses whether CMHSPs and PIHPs are meeting the Department's standard that 95% of the inpatient screenings have a final disposition within three hours. This indicator is a standard measure of access to care.

Table 1 - Indicator #1

1. Population	2. Number (#) of Emergency Referrals for Inpatient Screening During the Time Period	3. Number (#) of Dispositions about Emergency Referrals Completed within Three Hours or Less	4. Percent (%) of Emergency Referrals Completed within the Time Standard
1. # Children	**B2**	**C2**	**F2 - Calculated**
2. # Adults	**D2**	**E2**	**G2 - Calculated**

Definitions and Instructions
"Disposition" means the decision was made to refer, or not refer, to inpatient psychiatric care.

1. If screening is not possible due to intoxication or sedation, do not start the clock.
2. Start time: When the person is clinically, medically and physically available to the CMHSP/PIHP.
    a. When emergency room or jail staff informs CMHSP/PIHP that individual needs, and is ready, to be assessed; or
    b. When an individual presents at an access center and then is clinically cleared (as needed).
3. Stop time: Clinician (in access center or emergency room) who has the authority, or utilization management unit that has the authority, makes the decision whether or not to admit.
4. After the decision is made, the clock stops but other activities will continue (screening, transportation, arranging for bed, crisis intervention).
5. Documentation of start/stop times needs to be maintained by the PIHP/CMHSPS.

ACCESS-TIMELINESS/FIRST REQUEST (CMHSP)
Mental Health and Intellectual and Developmental Disabilities

Indicator #new 2

*The percentage of new persons during the quarter receiving a completed biopsychosocical assessment within 14 calendar days of a non-emergency request for service (by **four** sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.*

- ❖ No Standard for 1st year of implementation – will use information to determine baseline.

Rationale for Use
Quick, convenient entry into the public behavioral health system is a critical aspect of accessibility of services. Delays may lead to exacerbation of symptoms and distress, disengagement from the system and poorer role functioning. The amount of time between a request for service and the delivery of needed treatments and supports is one measure of access to care. The assessment process is especially important for individuals seeking services for mental illness or intellectual and developmental disability and the completed assessment is critical for person-centered planning. In addition, timely assessment is critical to the engagement process and connecting the consumer to necessary services and supports while the person is motivated towards treatment.

Receiving a Biopsychosocial Assessment within 14 Calendar Days of First Request

Table 2a – Indicator #2a

1. Population	2 # of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment *A*	3. # of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service *B*	4. % of Persons Requesting a Service Who Received a Completed BPS Assessment within 14 Calendar Days *B/A X 100*
1. MI-C	H2	I2	R2 – Calculated
2. MI-A	J2	K2	S2 – Calculated
3. IDD-C	L2	M2	T2 – Calculated
4. IDD-A	N2	O2	U2 – Calculated
5. Total Population	P2	Q2	V2 – Calculated

Column 1 – Population

See General Rules for definitions of children, Medicaid, Mental illness (MI/SED) and intellectual and developmental disability (I/DD).
For Indicator #2a:

a. Medicaid includes people who have both Medicaid and Medicare coverage, except Mild to Moderate beneficiaries covered under MI Health Link who are excluded from this indicator.
b. Consumers covered under OBRA should be excluded from this indicator.

Column 2- Selection Methodology

1. Cases selected for inclusion in Column 2 are those new persons who made a non-emergency request for specialty mental health (MH) or intellectual and developmental disability (IDD) services and supports and were referred for a biopsychosocial assessment during the quarter.

1. "First request" is the initial telephone or walk-in request for non-emergency services by the individual, parent of minor child, legal guardian or referral source. In the case of a referral from an outside organization the request date is the date the referring agency makes a request for services on behalf of the person. If the person is referred from an inpatient psychiatric facility, the request date is the date that the person is discharged from the facility. For the request to be included in this indicator, the individual must consent to treatment.

> **TIP:** Reporting inpatient discharges for indicator #2a and #4
> Those people who are discharged from an inpatient psychiatric facility and reported in indicator #4 will also be reported in this indicator #2a if they are new to the CMHSP.

2. Emergent and urgent requests for MH and IDD services are excluded from this indicator.

3. To be "new" for this indicator the person cannot be active in the CMHSP's mental health system. "New" is defined as either never seen by the CMHSP for mental health services or for services for intellectual and developmental disabilities, or it has been 90 days or more since the individual has received any MH or IDD service from the CMHSP.

> - **If a person is new to "*CMHSP A*" but not to the PIHP because they were seen at another CMHSP within that PIHP, the person will be included in indicator #2 for "*CMHSP A*" but the PIHP will not report this person as the person is not new to the PIHP.**

a. If a new consumer did not receive any subsequent services following an initial request (for example due to cancelled appointments), the consumer is re-counted

as “new” for the current quarter if it has been 60 days or more since the last access screening, either in-person or non-face-to-face. (See Figure 2.1).

b. Consumers who come in with a crisis and are stabilized are counted as "new" for indicator #2 when they subsequently make a non-emergency request for MH or IDD services. The indicator will be tracked from the point of the non-emergent request forward. (See Figure 2.2).

- **If over the past 90 days the person has only received crisis services, the person is new or reportable for indicator 2.**

- **Crisis services are defined by the following codes:**
  - Crisis intervention, Intensive Crisis Stabilization for Children or for Adults, **H2011**
  - Intensive Crisis Stabilization, **S9484**
  - Screening for Inpatient Program, **T1023**
  - Psychotherapy for Crisis, **90839 & 90840**
  - Crisis Residential, **H0018**
  - **Any service from a psychiatric inpatient stay**
  - Partial Hospitalization if T1023 reported, **0912, 0913**

Column 3 – Numerator Methodology

1. Cases selected for inclusion in Column 3 are those in Column 2 for which the biopsychosocial assessment was completed within 14 calendar days following the first request.

2. Count forward from the date of the first request to the completion date of the biopsychosocial assessment for mental health or IDD treatment or support, even if this spans across two quarters. (Example: if the initial request is made on 3-20-2020 and the person does not complete a BPS assessment by the end of the day 4-3-2020 (14 days) then for 2nd quarter 2020 the person is counted in column #2 and not counted in column #3). (See Figure 2.3).

3. For this indicator, a biopsychosocial assessment is considered completed once the professional has submitted an encounter for the assessment and a qualified professional has determined a qualifying diagnosis for the individual. If the biopsychosocial assessment and the determination of the diagnosis occur on different dates, use the latter date when calculating the time from the initial request to the completion of the biopsychosocial assessment.

4. The reporting quarter is based on the date of the request for service. (See Figure 2.4) If date of request and referral date are not on the same day, the reporting quarter is based on

the request date. (Example: If the request is 3/31/2021 and the referral is 4/1/2021, the reporting quarter is the 2nd quarter 2021 (Jan-March 2021)).

5. The request date is the date the person makes their first request in which they include their name and contact information. The 14-day count starts at this first request, even if multiple attempts are needed to contact the person to set up a referral. (Example: On 1/1/2021 the person calls for the first time and leaves a message, with name and call-back information, requesting services. On 1/1/2021 the access center calls the person back, is unable to reach the person but leaves a message. On 1/15/2021 the person calls back to request services and receives a referral for a BPS. The request date is 1/1/2021.)

TIP: A call to cancel or reschedule an appointment is not counted as a request for this indicator and is not the request date. (See Figure 2.5).

TIP: Only use the initial request date in the calculation (See Figure 2.6).

Column 4 – Calculation Methodology

Calculate the percentage of persons who made a request for services who received a completed assessment within 14 days of the initial request date. Only use the initial request date in this calculation. For example, if the person does not show for first scheduled appointment and reschedules, calculate the number of days between the initial request and the rescheduled appointment. Do not calculate the number of days between the request for a reschedule and the new appointment date.

Documentation

The CMHSP must maintain documentation available for state review on the date of the first request as well as the date the biopsychosocial assessment is completed even if this spans two quarters or multiple quarters. The CMHSP must also maintain documentation on the dates offered to the individual as well as scheduled dates for which the individual did not show up or rescheduled.

Figure 2.1

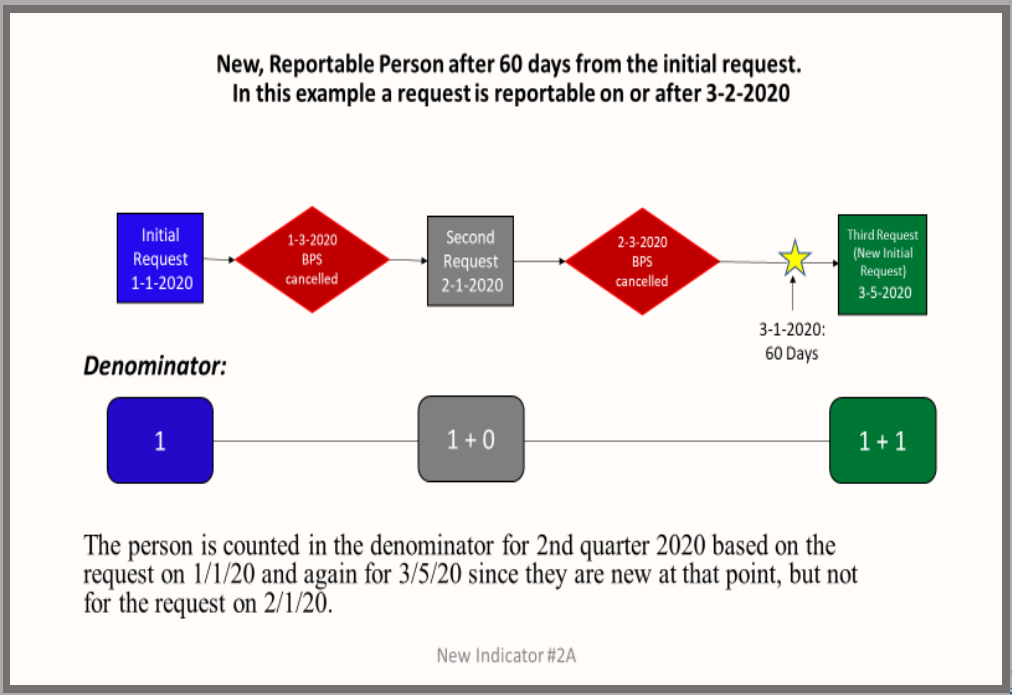


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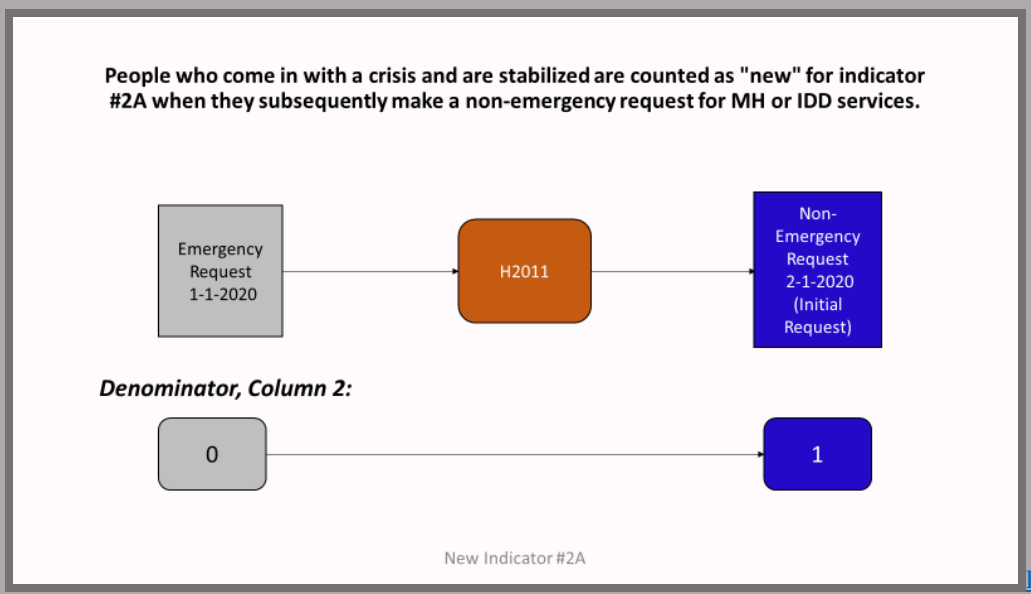
Figure 2.2



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Important to Note: A person can be counted no more than twice in the denominator during a quarter.

Figure 2.3

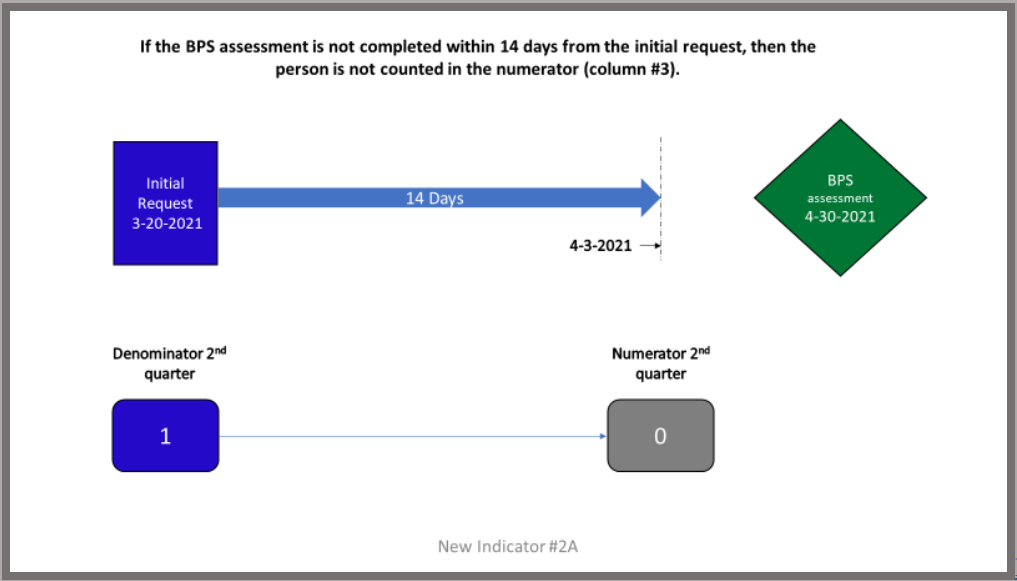

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Figure 2.4

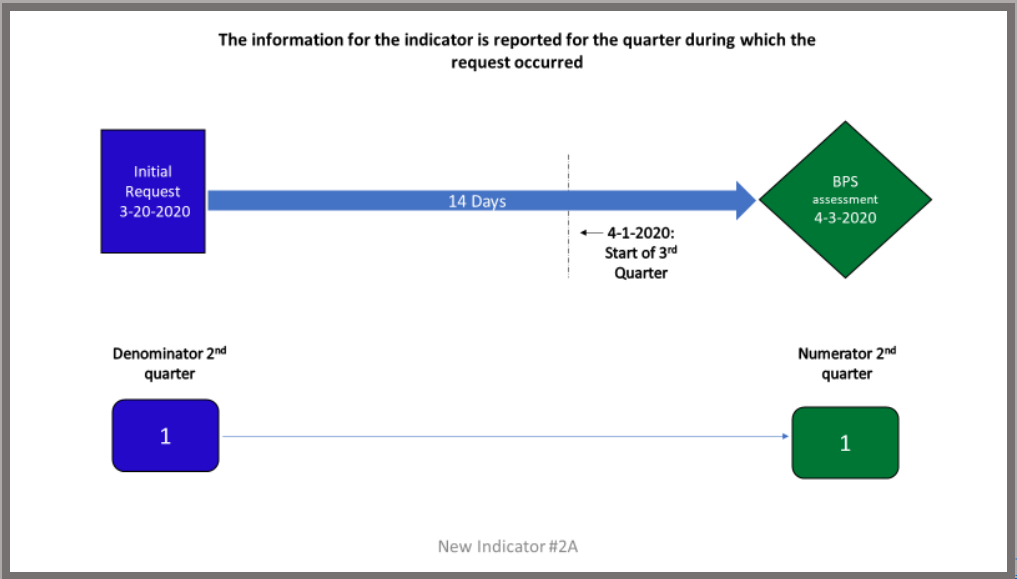

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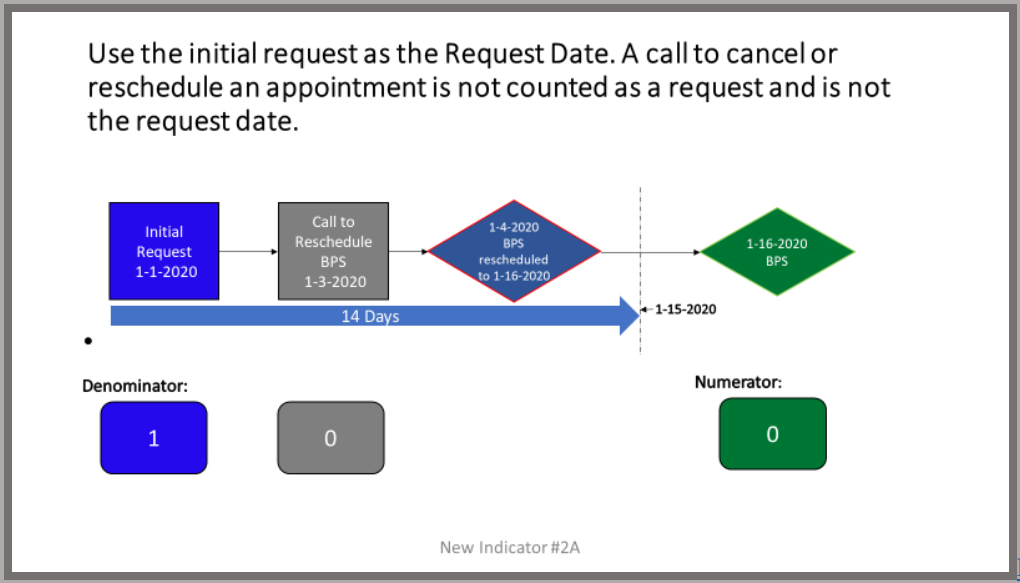
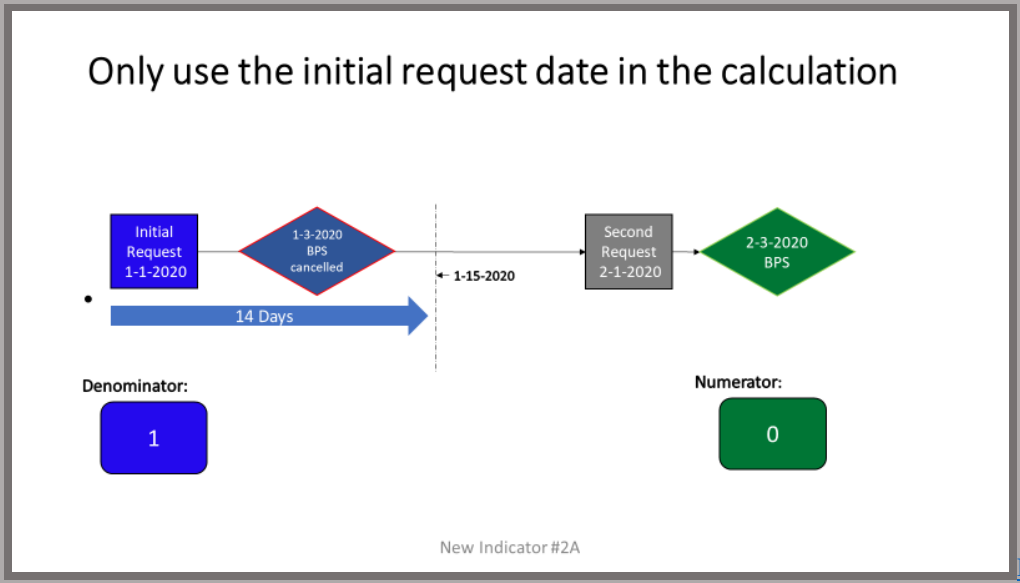
Figure 2.5



Back to text

Figure 2.6



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ACCESS-TIMELINESS/FIRST SERVICE (CMHSP)
Final Draft

Indicator new #3
Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).

Rationale for Use
The amount of time between the professional assessment and the delivery of needed treatments and supports addresses a different aspect of access to care than Indicator #2. Delay in the delivery of needed services and supports may lead to exacerbation of symptoms and distress and poorer role functioning and disengagement from the system. The timely start of on-going services is critical to the engagement process and connecting the consumer to services and supports while the person is motivated towards treatment.

Table 3 - Indicator #3

1. Population	2. # of New Persons Who Completed a Biopsychosocial Assessment within the Quarter	3. # of Persons from Col 2 Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment	4. % of Persons Who Started Service within 14 days of Biopsychosocial Assessment
1. MI-C	W2	X2	AG2
2. MI-A	Y2	Z2	AH2
3. DD -C	AA2	AB2	AI2
4. DD-A	AC2	AD2	AJ2
5. Total Population	AE2	AF2	AK2

Column 2 - Selection Methodology

1. Cases selected are those persons who have been reported in Column 2 of indicator #2 either during the current quarter or during previous quarters and for whom a biopsychosocial assessment was completed during the current quarter. The person was determined eligible for mental health or intellectual and developmental disability services.

2. See General Rules for definitions of children, Medicaid, Mental illness (MI/SED) and intellectual and developmental disability (I/DD).

TIP: ***Selection Methodology***

- **Those few people who are referred for a biopsychosocial assessment (BPS) and found not eligible for specialty services will be reported in Indicator #2 but not in Indicator #3.**

3. For this indicator, a biopsychosocial assessment is considered completed once the professional has submitted an encounter for the assessment and a qualified professional has determined a qualifying diagnosis for the individual. If the biopsychosocial assessment and the determination of the diagnosis occur on different dates, use the latter date when calculating the time from the initial request to the completion of the biopsychosocial assessment.

Column 3 – Numerator Methodology

1. Cases selected for inclusion in Column 3 are those in Column 2 for which a planned service was received within 14 calendar days of the completion of the biopsychosocial assessment.

2. "Service" means any non-emergent face-to-face CMHSP service that is included the person's plan of service or moves a person toward development of their plan of service. Do not include pre-admission screening for, and receipt of, psychiatric in-patient care or crisis contacts. (See Figure 3.1)

TIP: *Definition of Ongoing Services*

For this indicator, as long as the service is face-to-face and is not a crisis contact, pre-admission inpatient screening or inpatient care, any encounterable service for specialty mental health (MH) or intellectual and developmental disability (IDD) services and supports can be used to satisfy the requirement that the service is in the person's IPOS or moves them toward development of their IPOS. For list of crisis services see Indicator #2.

3. Count forward from the date of the completed BPS assessment to the date of the first service for ongoing treatment and supports, even if it crosses multiple quarters, in order to calculate the number of calendar days from the completion of the BPS assessment to the start of ongoing services. (See Figure 3.1)

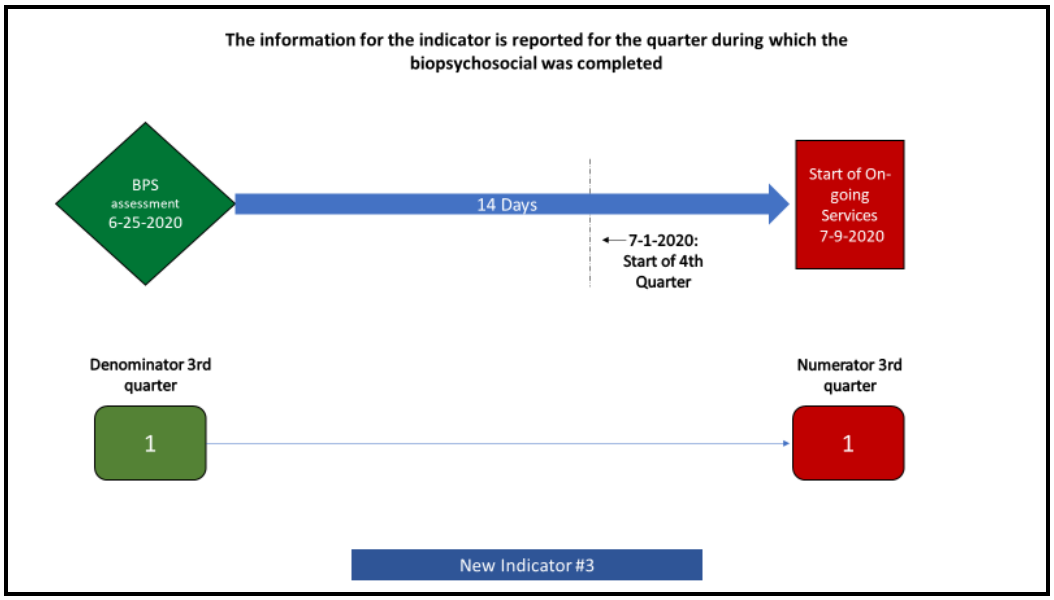
4. If a person has an urgent need at some point following the BPS assessment and as a result is not able to receive a non-emergent face-to-face service within the 14-day window, this person **should** be counted in column #2 and not counted in column #3.

5. Consumers covered under OBRA should be excluded from the count.

Documentation

The CMHSP must maintain documentation available for state review on the date the biopsychosocial assessment is completed as well as the date of the first face-to-face service even if this spans two quarters or multiple quarters. The CMHSP must also maintain documentation on the dates offered to the individual as well as scheduled dates that the individual rescheduled or for which the individual did not show up.

Figure 3.1



ACCESS-CONTINUITY OF CARE (CMHSP & PIHP)

Indicator #4a (CMHSP & PIHP) & 4b (PIHP Only)

The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95%

Rationale for Use

When responsibility for the care of an individual shifts from one organization to another, it is important that services remain relatively uninterrupted and continuous. Otherwise, the quality of care and consumer outcomes may suffer. This is an indicator required by the federal Substance Abuse and Mental Health Services Administration.

Table 4a – Indicator #4a

1. Population	2. # of Discharges from a Psychiatric Inpatient Unit	3. # of Discharges from Col 2 that are Exceptions	4. # Net Discharges (Col 2 minus Col 3)	5. # of Discharges from Col 4 Followed up by CMHSP/PIHP within 7days	6. % of Persons discharged seen within 7 days
1. # of Children	**AL2**	**AM2**	**AN2 - Calculated**	**AO2**	**AT2 - Calculated**
2. # of Adults	**AP2**	**AQ2**	**AR2 - Calculated**	**AS2**	**AU2 - Calculated**

Column 2 – Selection Methodology

1. "Discharges" are the events involving people who are discharged from a Psychiatric Inpatient Unit (community, IMD or state hospital) who meet the criteria for specialty mental health services and are the responsibility of the CMHSP/PIHP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the number of discharges.
2. Pre-admission screening for psychiatric in-patient care; and the psychiatric in-patient care should not be counted here.
3. Do not include dual eligibles (Medicare/Medicaid) in these counts.

Column 3 – Exception Methodology

1. 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.
2. Consumers who choose not to use CMHSP/PIHP services.

CMHSP/PIHP must maintain documentation available for state review of the reasons for all exclusions. In the case of refused appointments, the dates offered to the individual must be documented.

Column 4- Calculation of denominator

Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

Column 5- Numerator Methodology

1. Enter the number of discharges from column 4 (net) who were seen for follow-up care by the CMHSP/PIHP within seven days.
2. "Seen for follow-up care," means a face-to-face service (not screening for inpatient service, or the inpatient service) with a professional (not exclusively psychiatrists).
3. "Days" mean calendar days.

~~*Table 4b – Indicator #4b*~~ *Do not use the following fields (BP-BT). This Indiciator is PIHP only.*

~~1. Population~~	~~2. # of Discharges from a Substance Abuse Detox Unit~~	~~3. # of Discharges from Col 2 that are Exceptions~~	~~4. # Net Discharges (Col 2 minus Col 3)~~	~~5. # of Discharges from Col 4 Followed up by CA/CMHSP/ PIHP within 7days~~	~~6. % of Persons discharged seen within 7 days~~
~~# of Consumers~~	~~AV2~~	~~AW2~~	~~AX – Calculated~~	~~AY2~~	~~AZ2- Calculated~~

Column 2 – Selection Methodology

1. "Discharges" are the events involving consumers with substance use disorders who were discharged from a sub-acute detoxification unit, who meet the criteria for specialty mental health services and are the responsibility of the CA/PIHP or CMHSP/PIHP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the number of discharges.
2. Do not include dual eligibles (Medicare/Medicaid) in these counts.

Column 3 – Exception Methodology

1. 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.
2. Consumers who choose not to use CA/CMHSP/PIHP services.

CA/PIHP or CMHSP/PIHP must maintain documentation available for state review of the reasons for all exclusions. In the case of refused appointments, the dates offered to the individual must be documented.

Column 4- Calculation of denominator

Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

Column 5- Numerator Methodology

1. Enter the number of discharges from column 4 (net) who were seen for follow-up care by the CA/PIHP or CMHSP/PIHP within seven days.
2. Seen for follow-up care," means a face-to-face service with a substance abuse professional.
3. "Days" mean calendar days.

ACCESS-DENIAL/APPEAL (CMHSP Only)

Indicator #5 (old indicator #6)

Percentage of face-to-face assessments with professionals during the quarter that result in denials.

Indicator #6 (old indicator #7)

Percentage of Section 705 second opinions that result in services.

Rationale for Use

As managed care organizations, CMHSPs are responsible for exercising appropriate control of entry into the public mental health system. The professional assessment represents one of the first opportunities for a CMHSP to control access to its non-emergent services and supports.

Table 5 – Indicator #5 & #6

1. Total # of New Persons Receiving an Initial Non-Emergent Face-to-Face Professional Assessment	2. Total # of Persons Assessed but Denied CMHSP Service	3. Total # of Persons Requesting Second Opinion	4. Total # of Persons Receiving Mental Health Service Following a Second Opinion
BA2	**BB2**	**BC2**	**BD2**

Note: Do not include in any column in Table 5 individuals who only received telephone screens or access center screens performed by non-professionals. Table 5 excludes those cases in which the individual refused CMHSP services that were authorized.

Definitions

Section 330.1705 of Public Act 1974 as revised, was intended to capture requests for initial entry into the CMHSP. Requests for changes in the levels of care received are governed by other sections of the Code.

"Professional Assessment" is that face-to-face meeting with a professional that results in an admission to ongoing CMHSP service or a denial of CMHSP service.

Methodology

Column 1: Enter the number of those people who received an initial face-to-face professional assessment during the time period (from Indicator #2, Column #2).
Column 2: Enter the number of people who were denied CMHSP services.
Column 3: Enter the number of people who were denied who requested a second opinion.
Column 4: Enter the number of people who received a mental health service as a result of the second opinion.

EFFICIENCY

Indicator #7 (old indicator #9)

The percent of total expenditures spent on managed care administrative functions annually by CMHSPs and PIHPs.

Rationale for Use

There is public interest in knowing what portion of an agency's total expenditures are spent on operating the agency relative to the cost of providing services. Combined with other indicators of performance, information on percentage spent on administrative costs can be used as an indication of the agency's overall efficiency.

Method of Calculation

MDHHS will calculate this indicator using CMHSP Total Sub-Element Cost Report and the PIHP Medicaid Utilization and Net Cost Report.

Numerator: the amount of expenditures for managed care administration as defined in the cost reports for the functions as defined in the document: "Establishing Managed Care Administrative Costs" Revised June 20, 2005.

Denominator: the amount of total expenditures from all funding sources for CMHSPs; and the amount of total Medicaid expenditures for PIHPs.

OUTCOMES: EMPLOYMENT

Indicator #8a,b (old indicator #10a,b)

The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.

Rationale for Use

A positive outcome of improved functioning and recovery is the ability to work in a job obtained through competition with candidates who may not have disabilities. While there are variables, like unemployment rates, that the CMHSP and PIHPs cannot control, it is expected that through treatment and/or support they will enable and empower individuals who want jobs to secure them.

Method of Calculation

MDHHS will calculate this indicator after the end of the fiscal year using employment data from the individual's most recent BH TEDS record.

CMHSP Indicator

Numerator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability who are employed competitively.
Denominator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSP.

PIHP Indicator

Numerator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability who are employed competitively.
Denominator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

OUTCOMES: EMPLOYMENT

Indicator #9a,b (old indicator #11a,b)

The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.

Rationale for Use

A positive outcome of improved functioning and recovery is the ability to earn an income that enables individuals the independence to purchase goods and services and pay for housing.

Method of Calculation

MDHHS will calculate this indicator after the end of the fiscal year using employment data from the individual's most recent BH TEDS record. A new minimum wage data element will be added to the

FY '06 reporting requirements.

CMHSP Indicator

Numerator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability, who received Michigan's minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop).
Denominator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSP.

PIHP Indicator

Numerator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability, who received Michigan's minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop).
Denominator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

OUTCOME: INPATIENT RECIDIVISM (CMHSP & PIHP)

Indicator #10 (old indicator #12):
The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less

Rationale for Use
For some people with mental illness, the occasional use of psychiatric inpatient care is essential. However, rapid readmission following discharge may suggest that people were prematurely discharged or that the post discharge follow-up was not timely or sufficient. This indicator assessed whether CMHSPs are meeting the Department's standard of no more than 15 percent of people discharged from inpatient units are being readmitted within 30 days.

Table 6 – Indicator #10

1. Population	2. # of Discharges from Psychiatric Inpatient Care during the Reporting Period	3. # of Discharges in Col 2 that are Exceptions	4. # Net Discharges (Col 2 minus Col 3)	5. # of Discharges (from Net Col. 4) Readmitted to Inpatient Care within 30 Days of Discharge	6. % of Discharges Readmitted to Inpatient Care within 30 days of Discharge
1. # of Children	BE2	BF2	BG2 - Calculated	BH2	BM2 - Calculated
2. # of Adults	BI2	BJ2	BK2 - Calculated	BL2	BN2 - Calculated

NOTE: This information is intended to capture Admissions and Readmissions, not transfers to another psychiatric unit, or transfers to a medical inpatient unit. Do not include transfers or dual-eligibles (Medicare/Medicaid) in the counts in any column on this table.

Column 2 – Selection Methodology

1. Discharges" are the events involving all people (for the CMHSPs) and Medicaid eligibles only (for the PIHPs) who are discharged from a Psychiatric Inpatient Unit (community, IMD or state hospital), who meet the criteria for specialty mental health services and are the responsibility of the CMHSP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the total number of discharges.
2. Do not include dual eligibles (Medicare/Medicaid) in these counts.

Column 3 – Exception Methodology

Enter the discharges who chose not to use CMHSP/PIHP services

CMHSP/PIHP must maintain documentation available for state review of the reasons for exceptions in column 3.

Column 4 – Calculation of Denominator

Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

Column 5 – Numerator Methodology

1. Enter the number of persons from column 4 who were readmitted to a psychiatric inpatient unit within 30 days of discharge from a psychiatric inpatient unit.
2. In order to obtain correct counts for column 5, you must look 30 days into the **next quarter** for possible readmissions of persons discharged toward the end of the current reporting period.
3. "Days" mean calendar days.

Attachment I:

CMHSP Annual Recipient Rights Report Codebook

Period:	**10/01/13-9/30/20**
Due:	**December 31, 2014**

Tips and Reminders – Indicator 3

OUTCOMES: RECIPIENT RIGHTS COMPLAINTS

Indicator #11

*The **annual** number of substantiated recipient rights complaints in the categories of Abuse I and II, and Neglect I and II per 1,000 persons served by CMHSPs and by PIHPs.*

Rationale for Use

Substantiated rights complaints are a measure of the quality of care provided by CMHSPs and managed by PIHPs. Since Abuse and Neglect complaints must be investigated, it is believed that these four categories represent the most serious allegations filed on behalf of people served.

Table 7b. Recipient Rights Complaints from All Consumers Served by the CMHSP (reported by CMHSPs)

A = CMHSP Name

RR Complaints	1. # of Complaints from All Consumers	2. # of Complaints Substantiated by ORR	3. # of Complaints Substantiated Per Thousand CMHSP Consumers Served
Abuse I	**B**	**C**	
Abuse II	**D**	**E**	
Neglect I	**F**	**G**	
Neglect II	**H**	**I**	

Instructions:

Column 1: Enter the number of complaints from all consumers in each of the above categories that were filed at the local Office(s) of Recipient Rights during the year.
Column 2: Enter the number of those complaints that were substantiated by the local ORRs.
Column 3: MDHHS will calculate the number of complaints per thousand persons served.

Tips and Reminders – Indicator 3

Tips and Reminders

Indicator 2A

Definition of New Persons

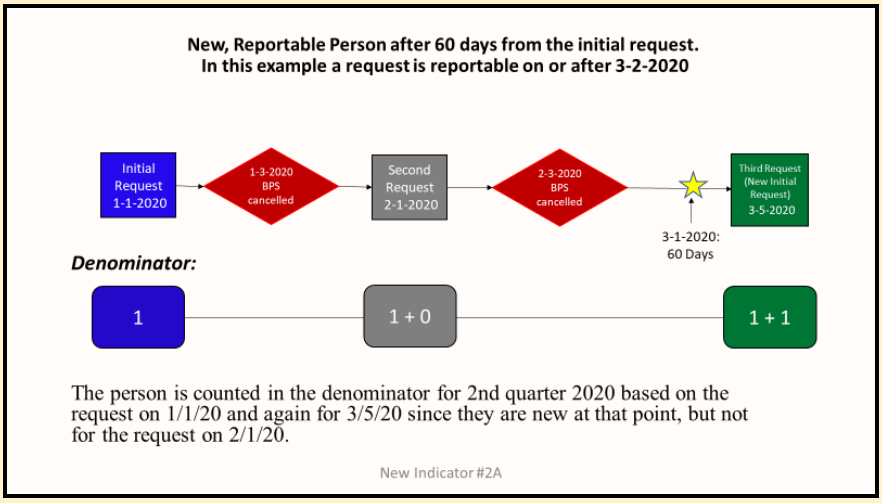
Tip 2a.1

- If the person has received SUD services in the last 90 days, but no MH/IDD services the person is reportable for indicator 2a.
- If a new person is requesting services for both mental health/intellectual and developmental disability as well as substance use disorder,
  - include the person in this current indicator (#2a) if referred for services to a CMHSP.
  - Also include the person in the substance use disorder indicator (#2b) if the person is admitted to a licensed and accredited SUD provider. §

Tip 2a.2

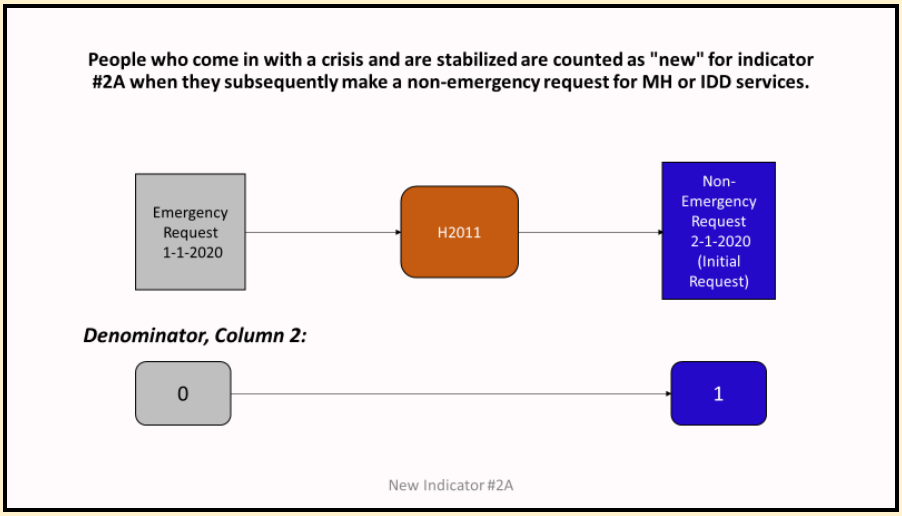
- Person can be new to the CMHSP but not the PIHP because they were seen at another CMHSP within that PIHP. CMHSP indicator would report individual as 'new'.
- PIHP would go through all of the 'new' persons reported by the various CMHSPs and determine if they are 'new' to the PIHP. For this indicator, the PIHP will only report those people who are new to the PIHP. §

Figure 2a.1



Important to Note: A person can be counted no more than twice in the denominator during a quarter.

Figure 2a.2



Tips and Reminders – Indicator 3

Tip 2a.3

If over the past 90 days the person has only received 'crisis' services, they are new or reportable for indicator 2a. Crisis services are defined by the following codes:

- Any service from a psychiatric inpatient stay
- H2011 – Crisis intervention, Intensive Crisis Stabilization for Children or for Adults
- S9484 – Intensive Crisis Stabilization
- T1023 – Screening for Inpatient Program
- 90839 – Psychotherapy for Crisis
- 90840 – Psychotherapy for Crisis
- H0018 – Crisis Residential
- 0912, 0913 – Partial Hospitalization if T1023 reported. §

Tip 2a.4 (reporting inpatient discharges for indicator #2a and #4)

If the person is referred from an inpatient psychiatric facility:

- If the person is new to the PIHP, include them in this indicator (#2a) as well as indicator #4.
- Indicator #2a is a subset of the people reported in indicator #4.
- Indicator 2 is looking at 'request to assessment' while Indicator #4 is looking at access to services after the hospitalization. §

Figure 2a.3

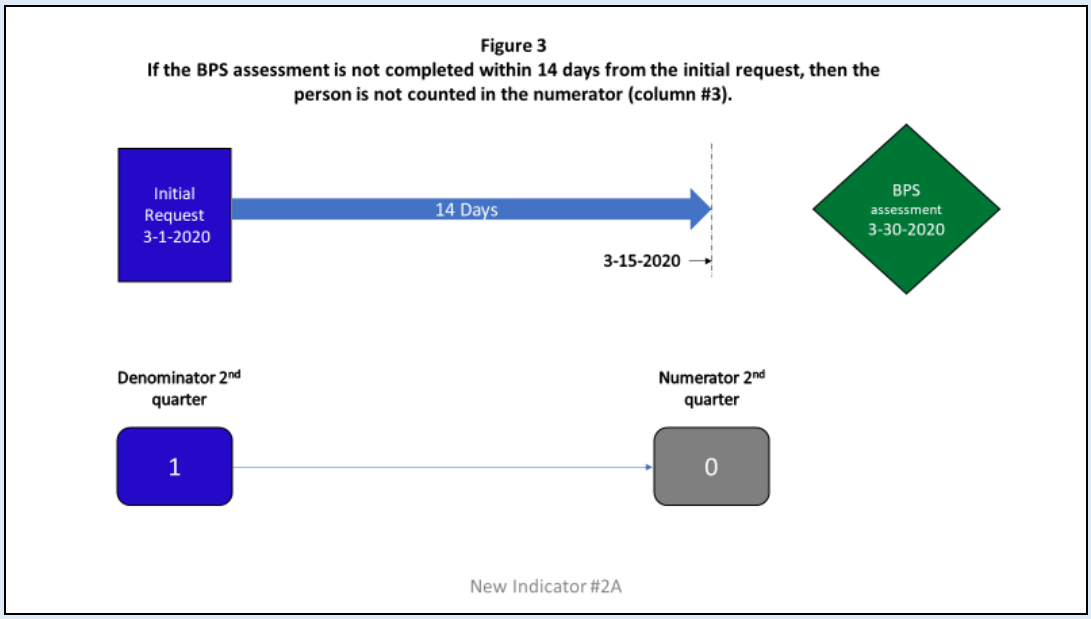
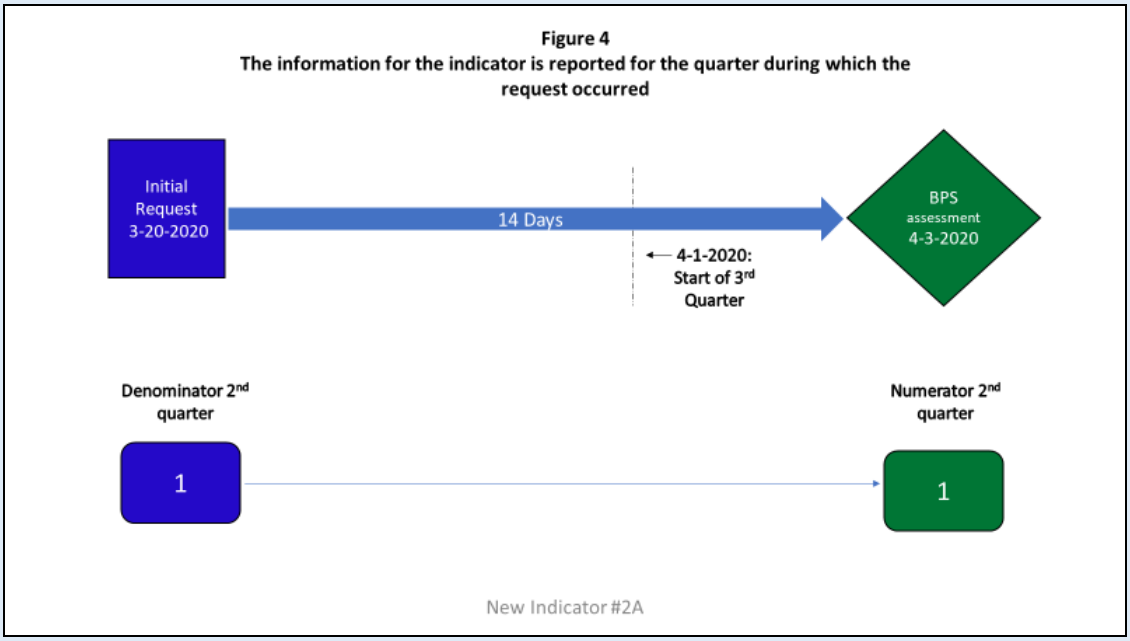


Figure 2a.4



Determining Date of Request

Tip 2a.5
If a person is difficult to reach after leaving initial request, the date of the person's first request is the request date. The request starts once the person provides their name and contact information.

Example:

- **1/1/2020 The person calls for the first time and leaves a message, with name and call-back information, requesting services.**
- **1/1/2020 The access center calls the person back, is unable to reach the person but leaves a message.**
- **1/15/2020 the person calls back to request services and receives a referral for a BPS.**
- **The request date is 1/1/2020.** §

Figure 2a.5

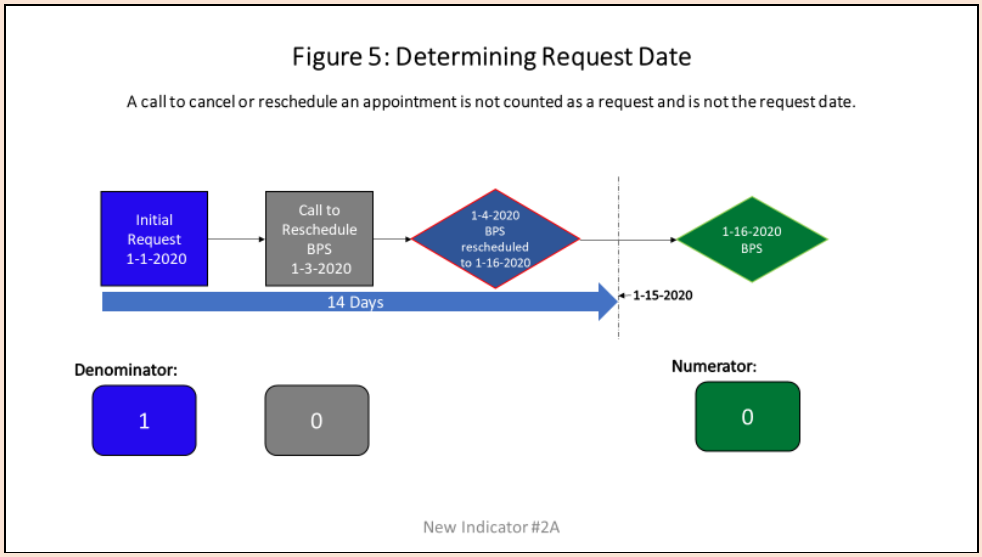
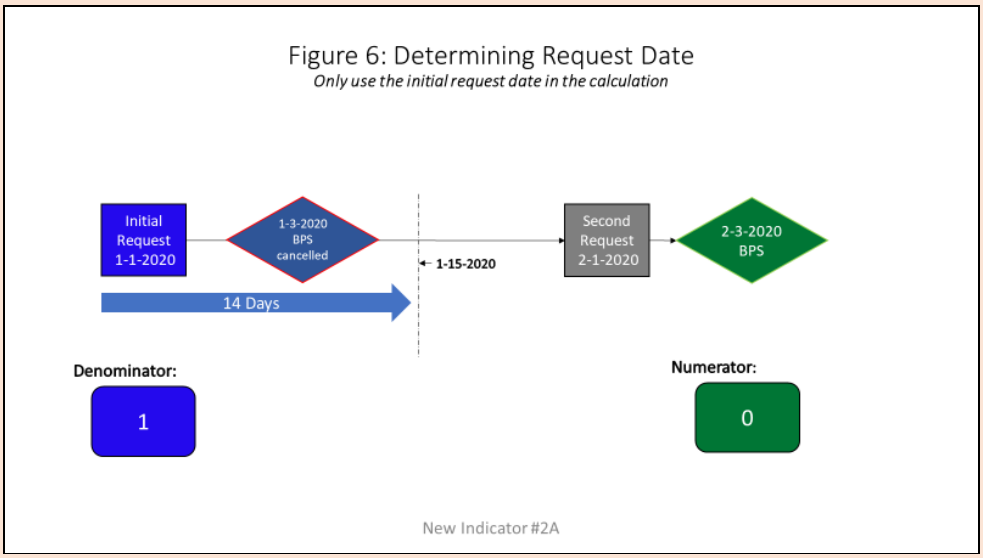


Figure 2a.6



Tips and Reminders – Indicator 3

Tips and Reminders
Indicator 3

Selection Methodology

Tip 3.1.

- **Those few people who are referred for a biopsychosocial assessment (BPS) and found not eligible will be reported in Indicator #2A but not in Indicator #3.**

Medicaid persons

- **If at the time the PIHP submits the indicators it is determined that the person was retroactively eligible for Medicaid during the reporting quarter then the person should be included in the Medicaid version of the indicator.**

Important to note

- **A person can be non-Medicaid for indicator #2A but become Medicaid for indicator #3, or the reverse.**

Figure 3.1
Definition of Ongoing Services

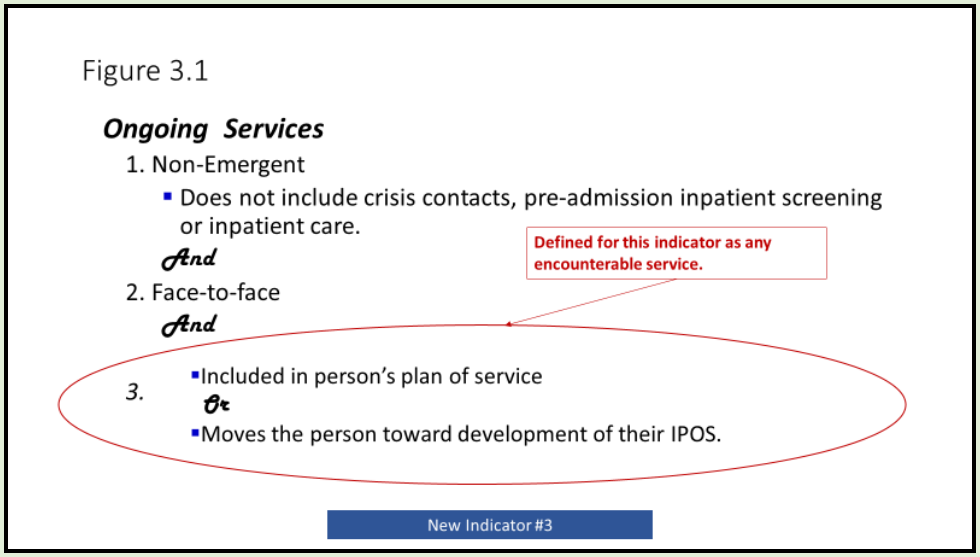
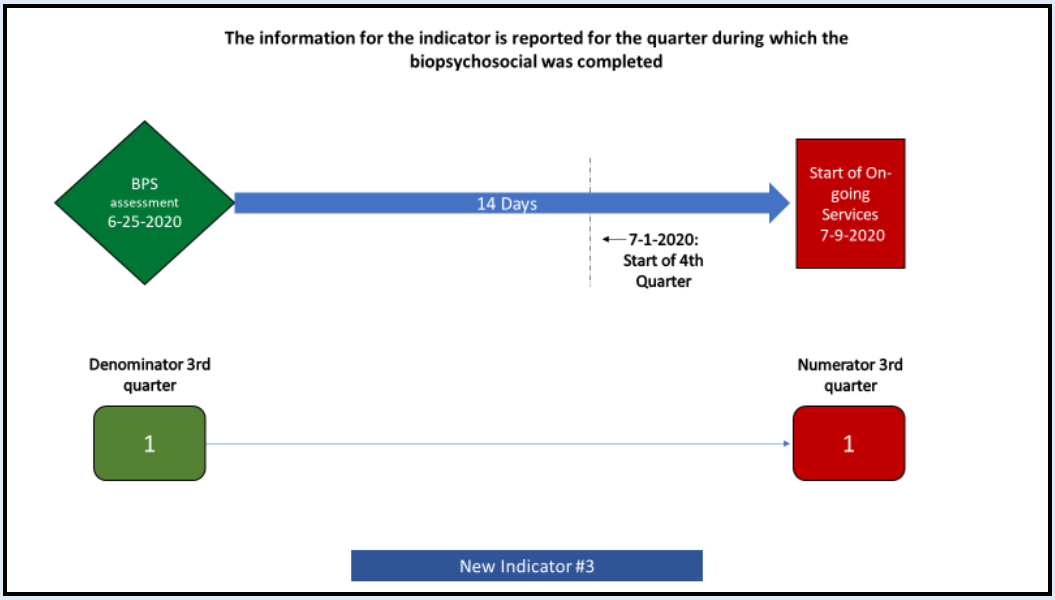


Figure 3.2


The information for the indicator is reported for the quarter during which the biopsychosocial was completed
BPS assessment 6-25-2020
14 Days
Start of On-going Services 7-9-2020
7-1-2020: Start of 4th Quarter
Denominator 3rd quarter
1
Numerator 3rd quarter
1
New Indicator #3

MICHIGAN'S MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0

PIHP Reporting Codebooks

April 2020

Codebook Version 4/1/2020

Michigan Department of Health and Human Services
Behavioral Health & Developmental Disabilities Administration

Revision Legend: **New for FY2020**

FOR PIHPs

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
    a. Standard = 95% in three hours
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers

2. The percentage of new persons during the quarter receiving a completed biopsychosocical assessment within 14 calendar days of a non-emergency request for service.
    a. No standard for 1st year of implementation – will use information to determine baseline.
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, I/DD adults, and I/DD children

*2.b. 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.

    a. No Standard for 1st year of implementation – will use information to determine baseline.
    b. Quarterly report
    c. PIHP for all Medicaid and non-Medicaid persons
    d. Persons approved for SUD services.

3. 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.
    a. No Standard for 1st year of implementation – will use information to determine baseline.
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, I/DD adults, and I/DD children

4a. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.

a. Standard = 95%
b. Quarterly report
c. PIHP for all Medicaid beneficiaries
d. CMHSP for all consumers
e. Scope: All children and all adults (MI, DD) - Do not include dual eligibles (Medicare/Medicaid) in these counts.

4.b. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.

a. Standard = 95%
b. Quarterly report
c. Scope: PIHP for all Medicaid beneficiaries - Do not include dual eligibles (Medicare/Medicaid) in these counts.

*5. The percent of Medicaid recipients having received PIHP managed services. (MI adults,
MI children, DD adults, DD children, and SA)

a. Quarterly report (MDHHS calculates from encounter data)
b. PIHP for all Medicaid beneficiaries
c. Scope: MI adults, MI children, DD adults, DD children, and SA

ADEQUACY/APPROPRIATENESS

*6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with
encounters in data warehouse who are receiving at least one HSW service per month that
is not supports coordination.

a. Quarterly report (MDHHS calculates from encounter data)
b. PIHP
c. Scope: HSW enrollees only

EFFICIENCY

*7. The percent of total expenditures spent on managed care administrative functions for

PIHPs.

a. Annual report (MDHHS calculates from cost reports)
b. PIHP for Medicaid administrative expenditures
c. CMHSP for all administrative expenditures

OUTCOMES

*8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by CMHSP who are in competitive employment.

a. Annual report (MDHHS calculates from BH-TEDS data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

*9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop).

a. Annual report (MDHHS calculates from BH-TEDS data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

a. Standard = 15% or less within 30 days
b. Quarterly report
c. PIHP for all Medicaid beneficiaries
d. CMHSP
e. Scope: All MI and DD children and adults - Do not include dual eligibles (Medicare/Medicaid) in these counts.

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

a. Annual report
b. PIHP for Medicaid beneficiaries
c. CMHSP
d. Scope: MI and DD only

Note: Indicators #2, 4b, and 5 include Medicaid beneficiaries who receive substance abuse services managed by the Substance Abuse Coordinating Agencies.

*13. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from BH-TEDS data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

*14. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from BH-TEDS data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

*15. Percentage of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and Respite.

a. Quarterly report (MDHHS calculates based on BH-TEDS & Encounter data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all DD Children
d. Scope: DD children only

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

FY 2020 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	PIHPs
2. 1st request	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	PIHPs
2.b. 1st request – SUD*	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	PIHPs/ MDHHS
3. 1st service	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	PIHPs
4. Follow-up	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	PIHPs
5. Medicaid Penetration*	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	MDHHS
6. HSW Services*	10/01 to 12/31	3/31/20	1/01to 3/31	6/30/20	4/01 to 6/30	9/30/20	7/01 to 9/30	12/31/20	MDHHS
7. Admin Costs*	10/01 to 9/30	1/31/21							PIHPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/20	1/01 to 3/31	6/30/20	4-01 to 6-30	9/30/20	7/01 to 9/30	12/31/20	PIHPs
11. RR complaints	10/01 to 9/30	12/31/20							PIHPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS
15. DD Children Services*	10/01 to 12/31	N/A	1/01to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with *: MDHHS collects data from encounters, BH TEDS or cost reports and calculates performance indicators

PERFORMANCE INDICATOR CODEBOOK

General Rules for Reporting Performance Indicators

1. Due dates
All data are due **90 days** following the end of the reporting period (Note: reporting periods are 90 days, six months, or 12 months).
Consultation drafts will be issued for editing purposes approximately two weeks after the due date.
Final report will be posted on the MDHHS web site approximately 30 days following the due date.

2. Children
Children are counted as such who are less than age 18 on the last day of the reporting period.

3. Dual Eligible
Do not include those individuals who are Medicare/Medicaid dual eligible in indicators number 4a & 4b (Follow-up Care) and number 10 (Readmissions).

4. Emergency and urgent requests for services
Used here as defined in the Mental Health Code. *330.1100 (18 & 29)*

5. Medicaid
Count as Medicaid eligible any person who qualified as a Medicaid beneficiary during at least one month of the reporting period. This includes both traditional Medicaid and Healthy Michigan. Individuals covered under the autism benefit are included. Indicators # 1, 2a, 3, 4, 10, and 11 are to be reported by the CMHSPs for all their people served, and by the PIHPs for all their Medicaid beneficiaries. The PIHP reports these indicators for all the Medicaid beneficiaries in their region. The PIHPs who are also a single CMHP, therefore, will submit two reports: One, as a CMHSP for all its consumers, and one as the PIHP for all its Medicaid beneficiaries.

6. Intellectual Disability and Developmental Disability (I/DD)
As defined in the Mental Health Code *330.1100 (12 & 25)*

7. Mental Illness/Serious Emotional Disturbance (MI/SED)
The individual has an MI DSM Diagnosis.

8. Rules for categorizing individuals who have both mental illness and an intellectual or developmental disability (MI/SED & I/DD)

    a. If a biopsychosocial (BPS) has been completed for the person:
        i. Assign person to either MI or I/DD category based on primary diagnosis.
        ii. If person has both MI and I/DD primary diagnoses:
            a. Assign a person as either MI or I/DD based on the primary diagnosis related to the greatest level of impairment

And

b. the services they are being referred to or being treated for.

iii. If can't determine whether MI or I/DD category is predominant, categorize the person as I/DD.

b. If BPS has not yet been completed for the person:

i. Assign person to either the MI or I/DD category based on the services the person requests.

ii. If the person requests both MH and I/DD services, categorize the person as I/DD.

iii. If it can't be determined what type of services are being requested, categorize the person as MI.

5. Substance use beneficiaries

Indicators #2.b., and 4b include persons receiving substance use disorder services under the SUD benefit managed by the PIHP (this is not applicable to CMHSPs). Managed by the PIHP means substance abuse services that the PIHP may deliver directly or may subcontract directly with a substance use disorder provider.

6. Substance Use Disorder Providers

Entity licensed by distinct street address (facility location) to operate a substance abuse treatment and/or rehabilitation program in accordance with the provisions of Act 368 of the Public Acts of 1978, as amended, and the Administrative Rules (R 325.14101-R 325.14928) of the Michigan Department of Licensing and Regulatory Affairs.

7. Documentation

It is expected that CMHSPs and PIHPs will maintain documentation of:
a) persons counted in the "exception" columns on the applicable indicators – who, why, and source documents; and
b) start and stop times for timeliness indicators.
Documentation may be requested and reviewed during external quality reviews.

ACCESS -TIMELINESS/INPATIENT SCREENING (CMHSP & PIHP)

Indicator #1

The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours (by two ***sub-populations:*** *Children and Adults). Standard = 95%*

Rationale for Use

People who are experiencing symptoms serious enough to warrant evaluation for inpatient care are potentially at risk of danger to themselves or others. Thus, time is of the essence. This indicator assesses whether CMHSPs and PIHPs are meeting the Department's standard that 95% of the inpatient screenings have a final disposition within three hours. This indicator is a standard measure of access to care.

Table 1 - Indicator #1

1. Population	2. Number (#) of Emergency Referrals for Inpatient Screening During the Time Period	3. Number (#) of Dispositions about Emergency Referrals Completed within Three Hours or Less	4. Percent (%) of Emergency Referrals Completed within the Time Standard
1. # Children	**B2**	**C2**	**F2 - Calculated**
2. # Adults	**D2**	**E2**	**G2 - Calculated**

Definitions and Instructions

"Disposition" means the decision was made to refer, or not refer, to inpatient psychiatric care.

1. If screening is not possible due to intoxication or sedation, do not start the clock.
2. Start time: When the person is clinically, medically and physically available to the CMHSP/PIHP.
    a. When emergency room or jail staff informs CMHSP/PIHP that individual needs, and is ready, to be assessed; or
    b. When an individual presents at an access center and then is clinically cleared (as needed).
3. Stop time: Clinician (in access center or emergency room) who has the authority, or utilization management unit that has the authority, makes the decision whether or not to admit.
4. After the decision is made, the clock stops but other activities will continue (screening, transportation, arranging for bed, crisis intervention).
5. Documentation of start/stop times needs to be maintained by the PIHP/CMHSPS.

ACCESS-TIMELINESS/FIRST REQUEST (PIHP)
Mental Health and Intellectual and Developmental Disabilities

Indicator #new 2a

*The percentage of new persons during the quarter receiving a completed biopsychosocical assessment within 14 calendar days of a non-emergency request for service (by **four** sub-populations**:** MI-adults, MI-children, IDD-adults, IDD-children.)*

- ❖ No Standard for 1st year of implementation – will use information to determine baseline.

Rationale for Use
Quick, convenient entry into the public behavioral health system is a critical aspect of accessibility of services. Delays may lead to exacerbation of symptoms and distress, disengagement from the system and poorer role functioning. The amount of time between a request for service and the delivery of needed treatments and supports is one measure of access to care. The assessment process is especially important for individuals seeking services for mental illness or intellectual and developmental disability and the completed assessment is critical for person-centered planning. In addition, timely assessment is critical to the engagement process and connecting the consumer to necessary services and supports while the person is motivated towards treatment.

Receiving a Biopsychosocial Assessment within 14 Calendar Days of First Request

Table 2a – Indicator #2a

1. Population	2. (A) # of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	3. (B) # of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service	4. (B/A X 100) % of Persons Requesting a Service Who Received a Completed BPS Assessment within 14 Calendar Days
1. MI-C	H2	I2	R2 – Calculated
2. MI-A	J2	K2	S2 – Calculated
3. IDD-C	L2	M2	T2 – Calculated
4. IDD-A	N2	O2	U2 – Calculated

5. Total Population	**P2**	**Q2**	**V2 – Calculated**

Column 1 – Population

See General Rules for definitions of children, Medicaid, Mental illness (MI/SED) and intellectual and developmental disability (I/DD).
For Indicator #2a:

a. Medicaid includes people who have both Medicaid and Medicare coverage, except Mild to Moderate beneficiaries covered under MI Health Link who are excluded from this indicator.
b. People covered under OBRA are excluded from the indicator.

Column 2- Selection Methodology

1. Cases selected for inclusion in Column 2 are those new Medicaid consumers who made a non-emergency request for specialty mental health (MH) or intellectual and developmental disability (IDD) services and supports and were referred for a biopsychosocial assessment during the quarter.

2. "First request" is the initial telephone or walk-in request for non-emergency services by the individual, parent of minor child, legal guardian or referral source. In the case of a referral from an outside organization the request date is the date the referring agency makes a request for services on behalf of the person. If the person is referred from an inpatient psychiatric facility, the request date is the date that the person is discharged from the facility. For the request to be included in this indicator, the individual must consent to treatment.

TIP: Reporting inpatient discharges for indicator #2a and #4
Those people who are discharged from an inpatient psychiatric facility and reported in indicator #4 will also be reported in this indicator #2a if they are new to the PIHP.

3. Emergent and urgent requests for MH and IDD services are excluded from this indicator.

4. If a new consumer is requesting services for both mental health/intellectual and developmental disability as well as substance use disorder, include the person in this current indicator (#2a) as well as the indicator for substance use disorder (indicator #2b).

TIP: Persons included in this current indicator (#2a) are those requesting services at a CMHSP. Those people who are also approved for services at a licensed and accredited SUD provider are to also be included in the substance use disorder indicator (#2b).

5. "New" persons are defined as follows:

a. A new person cannot be active in the PIHP's mental health system. "New" is defined as either never seen by the PIHP for mental health services or for services for intellectual and developmental disabilities, or it has been 90 days or more since the individual has received any MH or IDD service from the PIHP.

- **If the person has received SUD services in the last 90 days, but no MH/IDD services the person is "new" or reportable for Indicator 2a.**

- **If a person is new to "*CMHSP A*" but not to the PIHP because they were seen at another CMHSP within that PIHP, the person will be included in indicator #2a for "*CMHSP A*" but the PIHP will not report this person as the person is not new to the PIHP.**

b. A new consumer did not receive any subsequent services following an initial request (for example due to cancelled appointments), the consumer is re-counted as "new" for the current quarter if it has been more than 60 days since the initial request, either in-person or non-face-to-face. (See Figure 2a.1).

c. Consumers who come in with a crisis and are stabilized are counted as "new" for indicator #2a when they subsequently make a non-emergency request for MH or IDD services. The indicator will be tracked from the point of the non-emergent request forward. (See Figure 2a.2).

- **If over the past 90 days the person has only received crisis services, the person is new or reportable for indicator 2a.**

- **Crisis services are defined by the following codes:**
  - Crisis intervention, Intensive Crisis Stabilization for Children or for Adults, **H2011**
  - Intensive Crisis Stabilization, **S9484**
  - Screening for Inpatient Program, **T1023**
  - Psychotherapy for Crisis, **90839 & 90840**
  - Crisis Residential, **H0018**
  - **Any service from a psychiatric inpatient stay**
  - Partial Hospitalization if T1023 reported, **0912, 0913**

Column 3 – Numerator Methodology

1. Cases selected for inclusion in Column 3 are those in Column 2 for which the biopsychosocial assessment was completed within 14 calendar days following the first request.

2. Count forward from the date of the first request to the completion date of the biopsychosocial assessment for mental health or IDD treatment or support even if this spans across quarters. (Example: If the initial request is made on 3-20-2021 and the person does not complete a BPS assessment by the end of the day 4-3-2021 (14 days) then for 2nd quarter 2021 the person is counted in column #2 and not counted in column #3). (See Figure 2a.3).

3. For this indicator, a biopsychosocial assessment is considered completed once the professional has submitted an encounter for the assessment and a qualified professional has determined a qualifying diagnosis for the individual. If the biopsychosocial assessment and the determination of the diagnosis occur on different dates, use the latter date when calculating the time from the initial request to the completion of the biopsychosocial assessment.

4. The reporting quarter is based on the date of the request for service. (See Figure 2a.4). If date of request and referral date are not on the same day, the reporting quarter is based on the request date. (Example: If the request is 3/31/2021 and the referral is 4/1/2021, the reporting quarter is the 2nd quarter 2021 (Jan-March 2021)).

5. The request date is the date the person makes their first request in which they include their name and contact information. The 14-day count starts at this first request, even if multiple attempts are needed to contact the person to set up a referral. (Example: On 1/1/2021 the person calls for the first time and leaves a message, with name and call-back information, requesting services. On 1/1/2021 the access center calls the person back, is unable to reach the person but leaves a message. On 1/15/2021 the person calls back to request services and receives a referral for a BPS. The request date is 1/1/2021.)

> **TIP: A call to cancel or reschedule an appointment is not counted as a request for this indicator and is not the request date. (See Figure 2a.5).**
>
> **TIP: Only use the initial request date in the calculation (See Figure 2a.6).**

Column 4 – Calculation Methodology

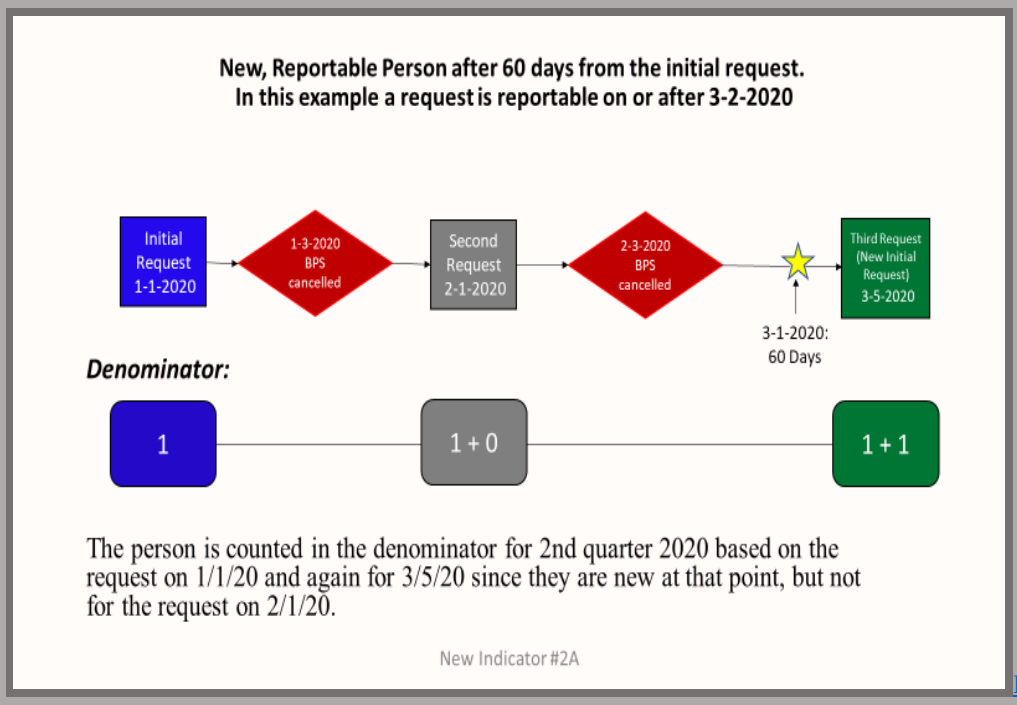
Calculate the percentage of persons who made a request for services who received a completed assessment within 14 days of the initial request date. Only use the initial request date in this calculation. For example, if the person does not show for first scheduled appointment and reschedules, calculate the number of days between the initial request and the rescheduled

appointment. Do not calculate the number of days between the request for a reschedule and the new appointment date.

Documentation

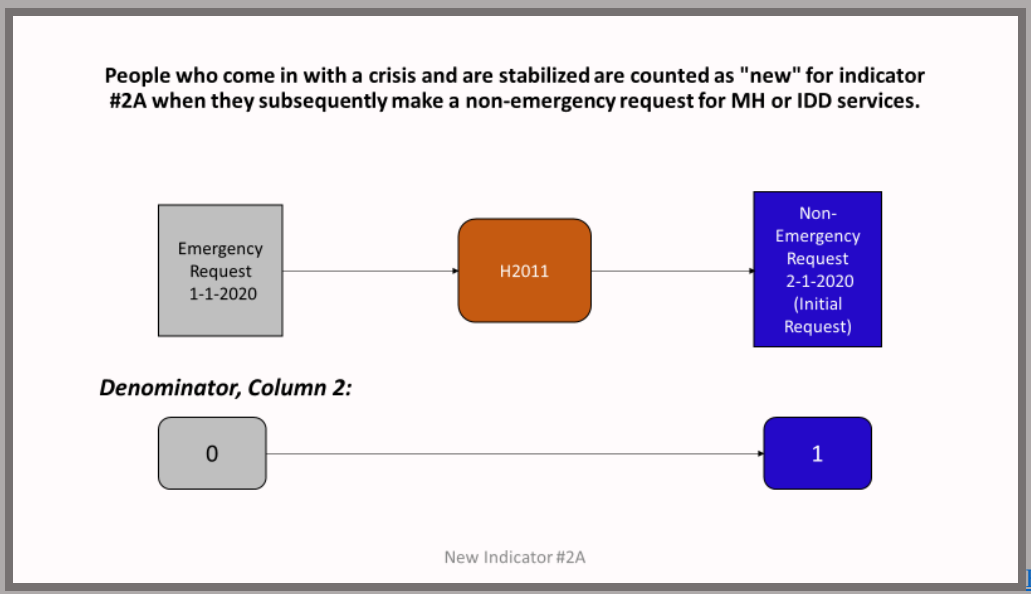
The PIHP must maintain documentation available for state review on the date of the first request as well as the date the biopsychosocial assessment is completed even if this spans two quarters or multiple quarters. The PIHP must also maintain documentation on the dates offered to the individual as well as scheduled dates for which the individual did not show up or rescheduled.

Figure 2a.1



Back to Text

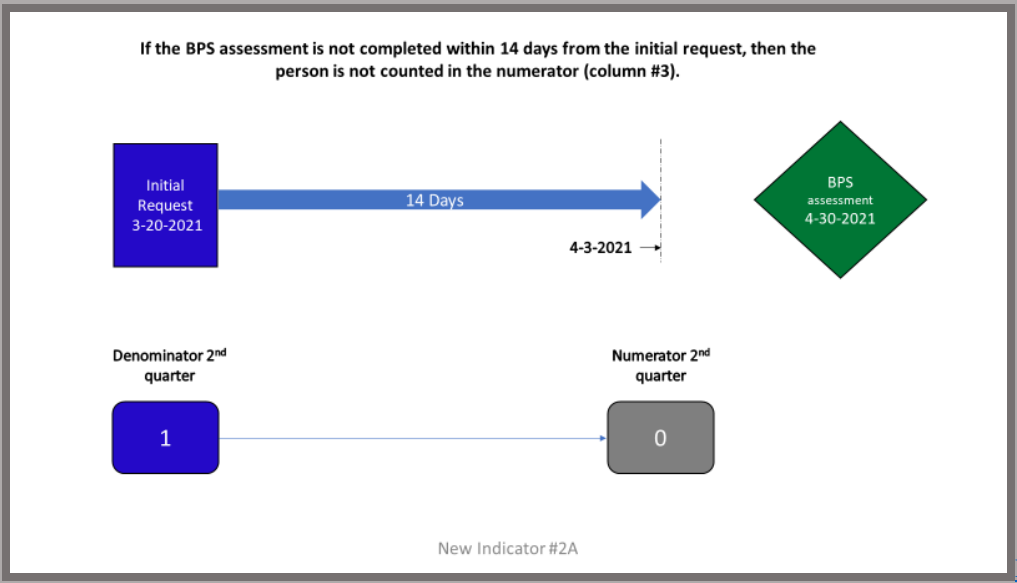
Figure 2a.2



Back to Text

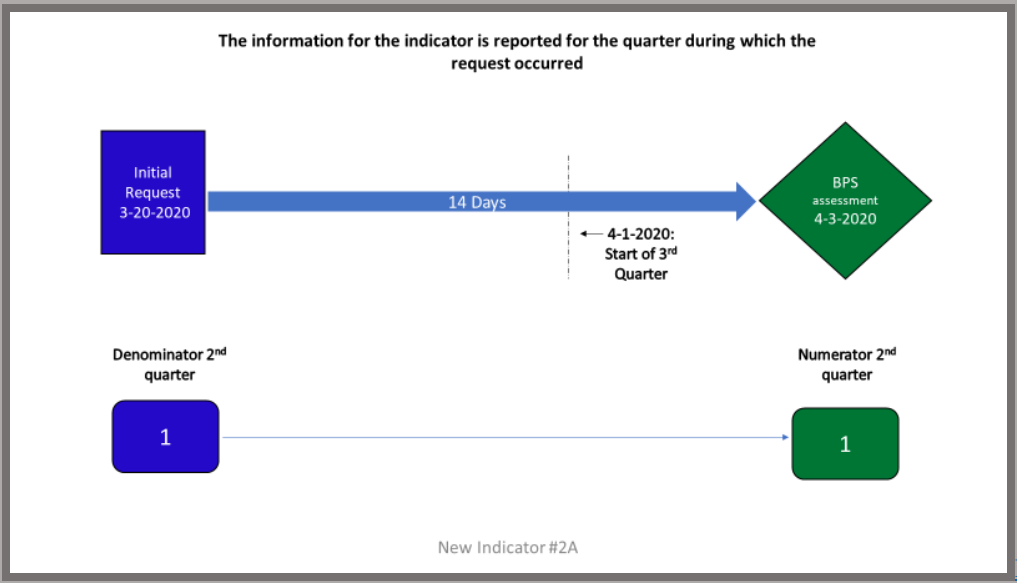
Important to Note: A person can be counted no more than twice in the denominator during a quarter.

Figure 2a.3



Back to text

Figure 2a.4



Back to text

Figure 2a.5

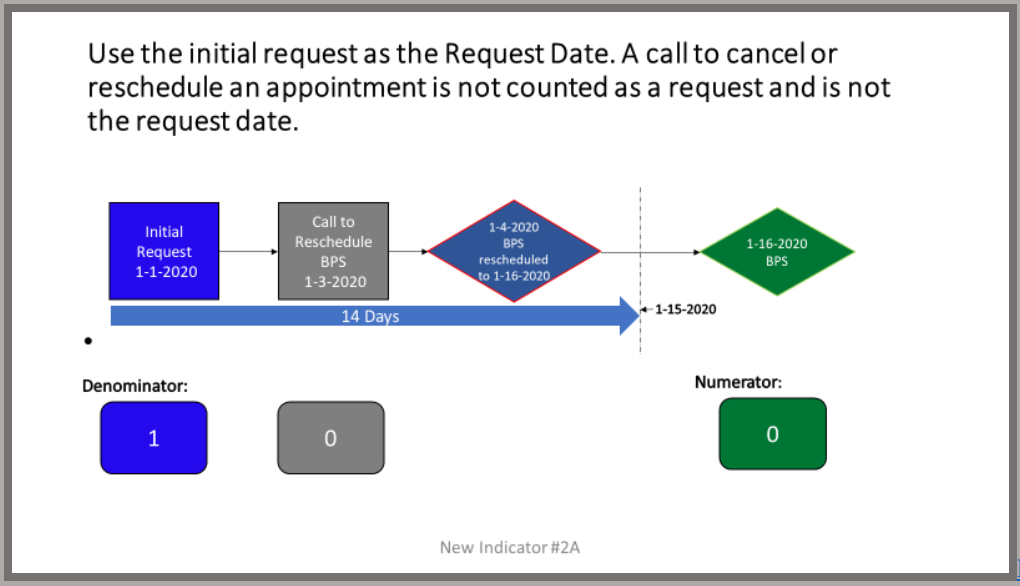


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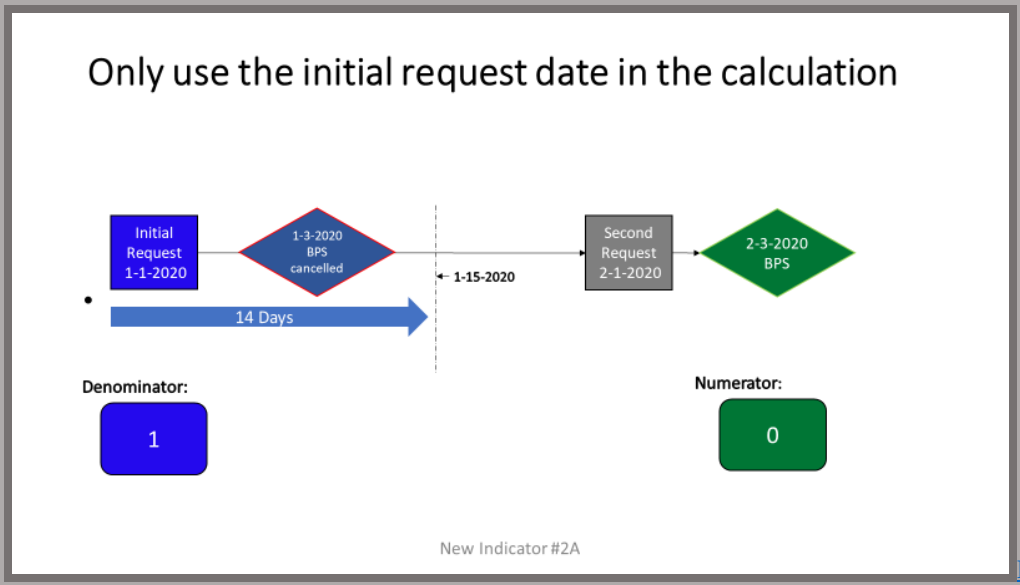
Figure 2a.6



Back to text

ACCESS-TIMELINESS/FIRST REQUEST (PIHP)
SUBSTANCE USE DISORDER
Final

Note for 2020: As described below this indicator will be calculated by BHDDA based on information reported by the PIHP to BH TEDS in combination with quarterly information reported by the PIHPs outside of the BH TEDS reporting system. An overview of BHDDA's process for calculation is available at:

https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765-512182--,00.html

Indicator #new 2e
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 for 1st year of implementation – will use information to determine baseline.

Rationale for Use
Quick, convenient entry into the public behavioral health system is a critical aspect of accessibility of services. Delays may lead to exacerbation of symptoms and distress and poorer role functioning and disengagement of the person from the treatment system. The amount of time between a request for service and the delivery of needed treatments and supports is one measure of access to care. This separate indicator for individuals with substance use disorders is important as specialty behavioral health manages the entire substance use disorder benefit. In comparison, individuals who request mental health services may, through assessment, be determined not eligible for specialty behavioral health services. This indicator reflects the emphasis of transitioning individuals who are approved for SUD services directly to ongoing face-to-face services.

Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request

Table 2b – Indicator #2e

1. # of New Persons Who Requested and Were Approved for SUD Treatment or Supports X = Xa + Xb		2. # of Persons from column 1 Receiving a Service for Treatment or Supports within 14 calendar days of First Request Y	3. % of Persons Requesting a Service who Received Treatment or Supports within 14 Days. Y/X
Xa. The count of BH TEDS SUD Admission records (Client Transaction Type = A) for the quarter.*	**Xb. *Expired Request:* All SUD approved service requests during the quarter for which there is no BHTEDS admission record. ******	**Based on the BHTEDS *Time to Treatment* field for Admissions counted in Xa.***	
W2 – Calculated*	**X2****	**Y2 – Calculated***	**Z2 – Calculated***

***BHDDA Calculations**

**** PIHP Reports *Expired Requests***

The PIHP will report an aggregate count of the number of requests for SUD services that expired during the quarter. This information will be reported to the State in the Performance Indicator PIHP Workbook.

Expired Requests are approved requests at an SUD provider that do not result in a BH TEDS Admission within 60 days of the request date. PIHPS will report information on *expired requests* for the quarter in which the request expired. (See Figure 2b.1)

- Example:
  - Person requests services at Provider A on 3/1/2021. This is the request date.
  - Provider A approves the person for SUD services on 3/3/2021.
  - If the person has not received services from Provider A by or on 5/1/2021, the request is expired.
  - For 3rd quarter reporting, PIHP is to report the aggregate count of *expired request* for the quarter.

Column 1- Selection Methodology

1. Cases selected for inclusion in Column 1 are those new persons, both Medicaid and non-Medicaid, who made a non-emergency request and were authorized for an SUD service during the quarter.

2. **Emergent and urgent requests for SUD services are excluded from this indicator.** These are defined as requests for services for: a. pregnant women who are injecting drug users or using other substances and b. other urgent situations in which the PIHP deems that the person requesting SUD services requires treatment or supports within 24 to 48 hours. **Note for 2020:** Requests for services needed within 24 to 48 hours will be included in this indicator.

> ***TIPs for counting expired requests:***
>
> - **The PIHP is to exclude requests for services from pregnant women in the PIHP's reporting of expired requests.**
> - **For 2020 the PIHP will include requests for services needed within 24 to 48 hours in the expired requests submitted to the state. (**In 2021, when information is available in BH TEDS, the PIHPs will exclude requests for services needed with 24 to 48 hours.)

3. "New" is defined as either never seen by the PIHP for SUD services, or the person is not receiving services from **this** SUD provider. That is, the person does not have an open Admission at this provider or the person was discharged from this SUD provider more than 60 days ago.

> **TIP**: For counting expired requests the PIHP is to count ONLY those approved requests for "new" services, services that are subsequent to one of the following conditions or situations:
>
> - The person has never received SUD services from **this** SUD provider.
>
> **or**
>
> - The person made an approved request to this SUD provider more than 60 days ago and has not yet received services (expired request). (See Figure 2b.2.)
>
> **or**
>
> - The person was discharged from this SUD provider more than 60 days ago is not currently receiving services from this SUD provider.

4. Consumers who come in with a crisis and are stabilized are counted as "new" for indicator #2b when they subsequently make a non-emergency request for SUD services. The indicator will be tracked from the point of the non-emergent request forward. **Note for 2020:** Only requests from pregnant women injecting drugs will be excluded. All other

requests will be included.

5. Consumers covered under OBRA should be excluded from the count.

Column 2 – Numerator Methodology

6. "First request" is the initial telephone or walk-in request for non-emergency services by the individual, parent of minor child, legal guardian, or referral source. In the case of a referral from an outside organization the request date is the date the referring provider makes a request for service on the person's behalf. For the request to be included in this indicator, the individual must consent to treatment.

TIP Determining Request Date for reporting *Time to Treatment* in BH TEDS as well as *Expired Requests*.

- Person receives referral from Provider A to Provider B. The request date is the date that the person requests services from Provider B.

Example:

- 2/15/2020 The person starts outpatient services at Provider A
- 2/21/2020 Provider A contacts Provider B to make a request for services on the person's behalf.
- 2/23/2020 The person agrees to receive treatment from Provider B.
- 2/24/2020 The person makes a request for services at Provider B and is approved for services.
- 2/29/2020 The person starts services at Provider B.
- **The request date at Provider B is 2/21/2020.**

- Person is receiving treatment at a residential facility and receives referral from Provider B to Provider C. The request date is the date that the person is discharged from Provider B.

Example:

- 4/7/2020 The person starts residential treatment at Provider B
- 4/20/2020 Provider B contacts Provider C to ask to get the person into non-intensive outpatient services.
- 4/20/2020 the person agrees to receive services from Provider C.
- 4/25/2020 Person is discharged from Provider B residential facility.
- 4/26/2020 the person starts services at Provider C.
- **The request date at Provider C is 4/25/2020 – the discharge date.**

1. Cases selected for inclusion in Column 2 are those in Column 1 for which the service for treatment or supports took place within 14 calendar days following the first request. (BHDDA will calculate this using BH TEDS.)

2. BHDDA will count forward from the date of the first request to the first service for SUD treatment or support, even if it spans across quarters. (Example: if the initial request is made on 3-20-2019 and the person does not receive their first SUD service or support by

the end of the day 4-3-2019 (14 days) then for 2nd quarter 2019 the person is counted in column #1 and not counted in column #2).

TIP: For reporting *Time to Treatment* in BH TEDS as well as *Expired Requests*. If date of request and date for approval for services are not on the same day, the initial request is the request date. For example, if the request date is 3/31/2020 and the approval date is 4/1/2020 then the Request Date is 3/31/2020. (See Figure 2b.3 and Figure 2b.4).

6. The request date is the date the person makes their first request in which they include their name and contact information. The 14-day count starts at this first request, even if multiple attempts are needed to contact the person and approve for services. (Example: On 1/1/2021 the person calls for the first time and leaves a message, with name and call-back information, requesting services. On 1/1/2021 the agency calls the person back, is unable to reach the person but leaves a message. On 1/15/2021 the person calls back to request services and is approved for SUD services. The request date is 1/1/2021.)

3. Initial face-to-face service for treatment or supports – This is the date of the first face-to-face treatment contact and corresponds to the Service Start Date reported in BH-TEDS. Person will receive an encounter on this date as well. For this SUD indicator an assessment can be counted as the first service. A screening is considered an administrative function and cannot be counted as a service.

4. PIHPS will report information on the *expired requests* for the quarter in which the request expired.

TIPs for reporting *Expired Requests*.

- **Reporting quarter for expired requests.** The PIHP will determine the reporting quarter based on the expiration date of the request.

Example:

- Date of approved request is 3/31/2021.
- The expiration date of the request is 5/31/2021 (60 days since 3/31/2021).
- Person does not receive SUD services and a BH TEDS Admission record is not submitted.
- This expired request will be included in the information submitted to the state for **3rd quarter 2021** which is due to BHDDA September 30th

- If a person makes **multiple concurrent requests** to get into treatment, count this only as one request. The person's intent is to see one provider not to see multiple providers concurrently.

  - If the person is seen for services at one of the providers, use the date that provider was contacted as the Request Date. Do not report the concurrent requests as expired requests.

  - If the person does not start treatment, count as one expired request once 60 days has lapsed from the date of the person's first request.

Column 3 – Using the *Time to Treatment* reported by the PIHP in BH TEDS, BHDDA will calculate the percentage of persons who made a request for SUD services who received their first service within 14 days of the initial request date.

In determining *Expired Requests* and for reporting *Time to Treatment* in BH TEDS, PIHPs are to only use the initial request date in the calculation. For example, if the person does not show for first scheduled appointment and reschedules, calculate the number of days between the initial request and the rescheduled appointment. Do not calculate the number of days between the request for a reschedule and the new appointment date. (See Figure 2b.5)

Documentation

The PIHP must maintain documentation available for state review on the date of the first request as well as the date of the initial face-to-face service for treatment or supports even if this spans two quarters or multiple quarters. The PIHP must also maintain documentation on the dates offered to the individual as well as scheduled dates that the individual declined or for which the individual did not show up.

Reporting Expired Requests to BHDDA

Figure 2b.1

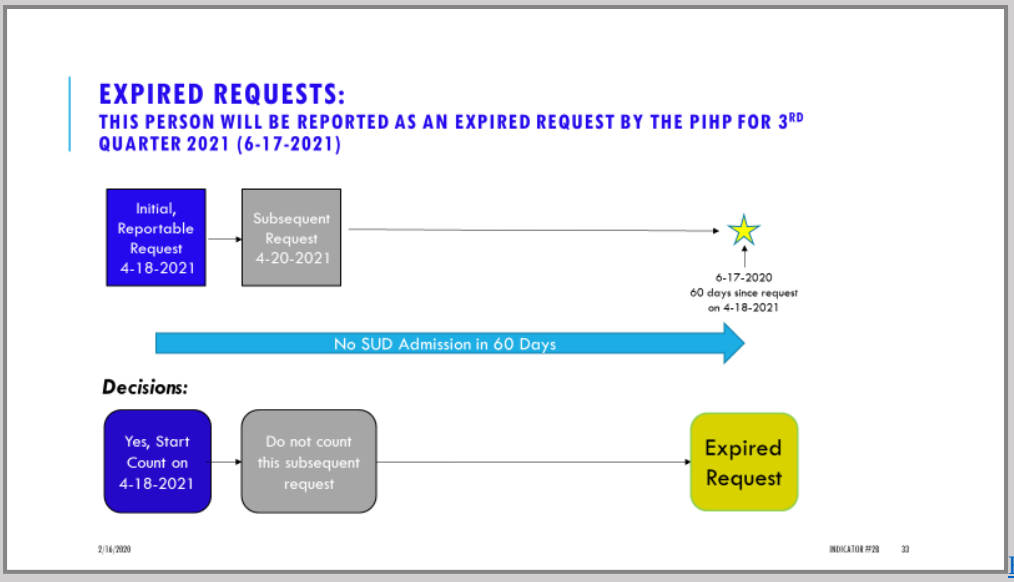


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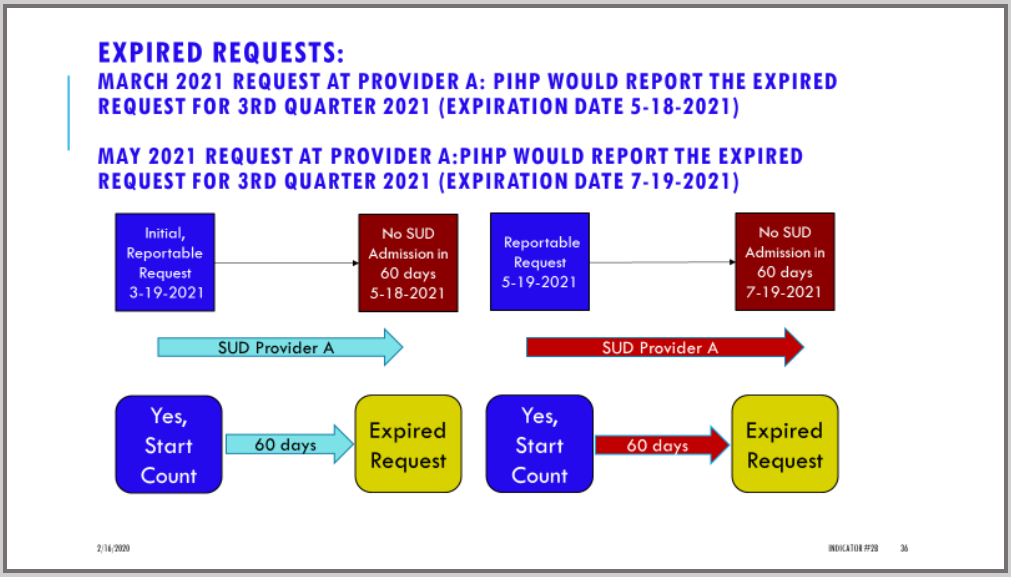
Figure 2b.2



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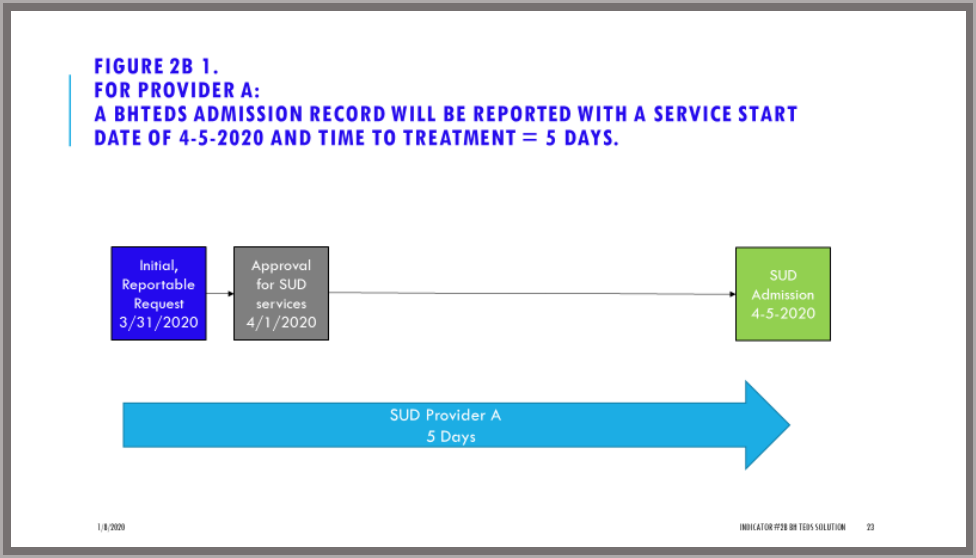
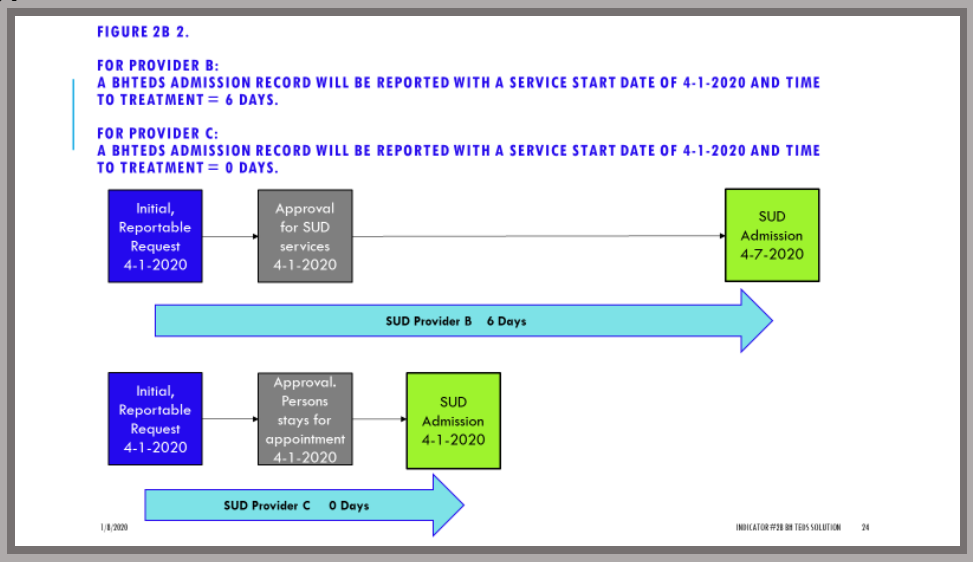
Reporting Time to Treatment and Service Start Date in BH TEDS

Figure 2b.3



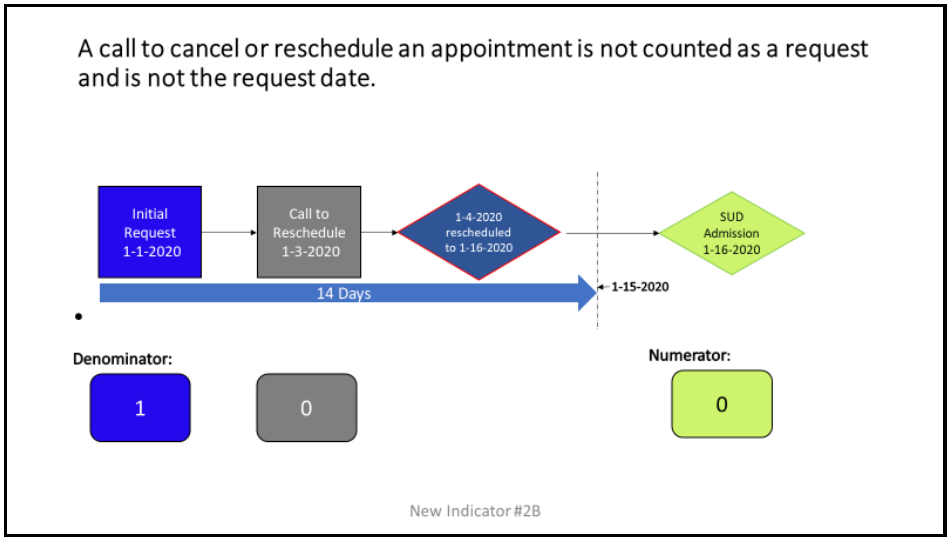
Back to text

Figure 2b.4



Back to text

Figure 2b.5



Back to text

A BH TEDS record will be submitted with a Service Start Date of 1-16-2020 and a Time to Treatment of 15 days.

ACCESS-TIMELINESS/FIRST SERVICE (PIHP)

- ❖ No Standard for 1st year of implementation – will use information to determine baseline.

Indicator new #3
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 (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).

Rationale for Use
The amount of time between the professional assessment and the delivery of medically necessary treatments and supports addresses a different aspect of access to care than Indicator #2a. Delay in the delivery of necessary services and supports may lead to exacerbation of symptoms and distress and poorer role functioning and disengagement from the system. The timely start of on-going services is critical to the engagement process, connecting the consumer to services and supports while the person is motivated towards treatment.

Table 3 - Indicator #3

1. Population	2. # of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services.	3. # of Persons from Col 2 Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment	4. % of Persons Who Started Service within 14 days of Biopsychosocial Assessment
1. MI-C	AA2	AB2	AK2 - Calculated
2. MI-A	AC2	AD2	AL2 - Calculated
3. I/DD -C	AE2	AF2	AM2 - Calculated
4. I/DD-A	AG2	AH2	AN2 – Calculated
5. Total Population	AI2	AJ2	AO2 - Calculated

Column 2 - Selection Methodology

1. Cases selected are those Medicaid persons who have been reported in Column 2 of indicator #2a either during the current quarter or during previous quarters and for whom a biopsychosocial assessment was completed during the current quarter. The person was determined eligible for mental health or intellectual and developmental disability services.

See General Rules for definitions of children, Medicaid, Mental illness (MI/SED) and intellectual and developmental disability (I/DD).

TIP: ***Selection Methodology***

- **Those few people who are referred for a biopsychosocial assessment (BPS) and found not eligible for specialty services will be reported in Indicator #2A but not in Indicator #3.**

Medicaid persons

- **If at the time the PIHP submits the indicators it is determined that the person was retroactively eligible for Medicaid during the reporting quarter then the person should be included in the Medicaid version of the indicator.**

Important to note

- **A person can be non-Medicaid for indicator #2A but become Medicaid for indicator #3, or the reverse.**

2. For this indicator, a biopsychosocial assessment is considered completed once the professional has submitted an encounter for the assessment and a qualified professional has determined a qualifying diagnosis for the individual. If the biopsychosocial assessment and the determination of the diagnosis occur on different dates, use the latter date when calculating the time from the completion of the biopsychosocial assessment to the start of ongoing services.

3. If a person has an emergent need at some point following the BPS assessment and as a result is not able to receive a non-emergent face-to-face service within the 14-day window, this person **should** be counted in column #2 and not counted in column #3.

Column 3 – Numerator Methodology

1. Cases selected for inclusion in Column 3 are those in Column 2 for which a planned service was received within 14 calendar days of the completion of the biopsychosocial assessment.

2. "Service" means <u>any</u> non-emergent face-to-face CMHSP service that is included in the person's plan of service or moves a person toward development of their plan of service. Do not count pre-admission screening for, and receipt of, psychiatric in-patient care or crisis contacts.

TIP: *Definition of Ongoing Services*

For this indicator, as long as the service is face-to-face and is not a crisis contact, pre-admission inpatient screening or inpatient care, any encounterable service for specialty mental health (MH) or intellectual and developmental disability (IDD) services and supports can be used to satisfy the requirement that the service is in the person's IPOS or moves them toward development of their IPOS. For list of crisis services see TIP in Indicator #2a.

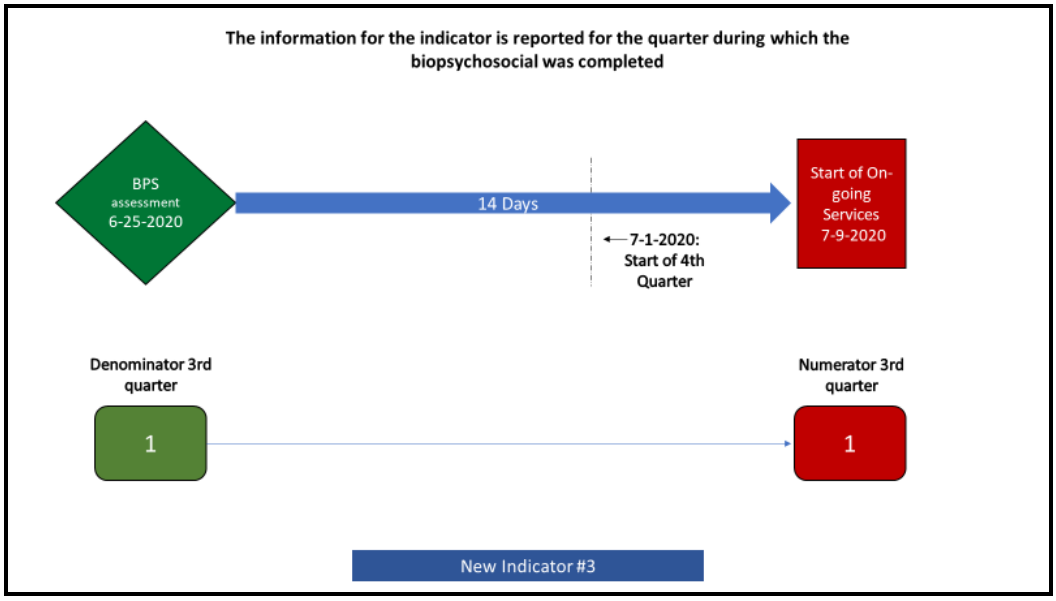
3. Count forward from the date of the completed BPS assessment to the date of the first service for ongoing treatment and supports, even if it crosses quarters, in order to calculate the number of calendar days from the completion of the BPS assessment to the start of ongoing services. (See Figure 3.1)

4. Consumers covered under OBRA should be excluded from the count.

Documentation

The PIHP must maintain documentation available for state review on the date the biopsychosocial assessment is completed as well as the date of the first face-to-face service even if this spans two quarters or multiple quarters. The PIHP must also maintain documentation on the dates offered to the individual as well as scheduled dates that the individual rescheduled or for which the individual did not show up.

Figure 3.1


The information for the indicator is reported for the quarter during which the biopsychosocial was completed
BPS assessment 6-25-2020
14 Days
Start of On-going Services 7-9-2020
7-1-2020: Start of 4th Quarter
Denominator 3rd quarter
1
Numerator 3rd quarter
1
New Indicator #3

ACCESS-CONTINUITY OF CARE (CMHSP & PIHP)

Indicator #4a (CMHSP & PIHP) & 4b (PIHP Only)

The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95%

Rationale for Use

When responsibility for the care of an individual shifts from one organization to another, it is important that services remain relatively uninterrupted and continuous. Otherwise, the quality of care and consumer outcomes may suffer. This is an indicator required by the federal Substance Abuse and Mental Health Services Administration.

Table 4a – Indicator #4a

1. Population	2. # of Discharges from a Psychiatric Inpatient Unit	3. # of Discharges from Col 2 that are Exceptions	4. # Net Discharges (Col 2 minus Col 3)	5. # of Discharges from Col 4 Followed up by CMHSP/PIHP within 7days	6. % of Persons discharged seen within 7 days
1. # of Children	**AP2**	**AQ2**	**AR2 - Calculated**	**AS2**	**AX2 - Calculated**
2. # of Adults	**AT2**	**AU2**	**AV2 - Calculated**	**AW2**	**AY2 - Calculated**

Column 2 – Selection Methodology

1. "Discharges" are the events involving people who are discharged from a Psychiatric Inpatient Unit (community, IMD or state hospital) who meet the criteria for specialty mental health services and are the responsibility of the CMHSP/PIHP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the number of discharges.
2. Pre-admission screening for psychiatric in-patient care; and the psychiatric in-patient care should not be counted here.
3. Do not include dual eligibles (Medicare/Medicaid) in these counts.

Column 3 – Exception Methodology

1. 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.
2. Consumers who choose not to use CMHSP/PIHP services.

CMHSP/PIHP must maintain documentation available for state review of the reasons for all exclusions. In the case of refused appointments, the dates offered to the individual must be documented.

Column 4- Calculation of denominator

Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

Column 5- Numerator Methodology

1. Enter the number of discharges from column 4 (net) who were seen for follow-up care by the CMHSP/PIHP within seven days.
2. "Seen for follow-up care," means a face-to-face service (not screening for inpatient service, or the inpatient service) with a professional (not exclusively psychiatrists).
3. "Days" mean calendar days.

Table 4b – Indicator #4b

1. Population	2. # of Discharges from a Substance Abuse Detox Unit	3. # of Discharges from Col 2 that are Exceptions	4. # Net Discharges (Col 2 minus Col 3)	5. # of Discharges from Col 4 Followed up by CA/CMHSP/ PIHP within 7days	6. % of Persons discharged seen within 7 days
# of Consumers	AZ2	BA2	BB2- Calculated	BC2	BD2 - Calculated

Column 2 – Selection Methodology

1. "Discharges" are the events involving consumers with substance use disorders who were discharged from a sub-acute detoxification unit, who meet the criteria for specialty mental health services and are the responsibility of the CA/PIHP or CMHSP/PIHP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the number of discharges.
2. Do not include dual eligibles (Medicare/Medicaid) in these counts.

Column 3 – Exception Methodology

1. 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.
2. Consumers who choose not to use CA/CMHSP/PIHP services.

CA/PIHP or CMHSP/PIHP must maintain documentation available for state review of the reasons for all exclusions. In the case of refused appointments, the dates offered to the individual must be documented.

Column 4- Calculation of denominator

Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

Column 5- Numerator Methodology

1. Enter the number of discharges from column 4 (net) who were seen for follow-up care by the CA/PIHP or CMHSP/PIHP within seven days.
2. Seen for follow-up care," means a face-to-face service with a substance abuse professional.
3. "Days" mean calendar days.

ACCESS: MEDICAID PENETRATION RATE

Indicator #5
The percent of Medicaid recipients having received PIHP managed services.

Rationale for Use:
This indicator measures the penetration rate of Medicaid recipients who receive mental health services from the public mental health system. This indicator is required by Centers for Medicare and Medicaid Services.

Method of Calculation
MDHHS will calculate this indicator quarterly using encounter data.
Numerator: the number of Medicaid eligibles receiving at least one PIHP managed Medicaid service during the quarter.
Denominator: the number of Medicaid eligibles for which the PIHP was paid during the quarter.

ADEQUACY/APPROPRIATENESS

Indicator #6
The percent of Habilitation Supports Waiver (HSW) enrollees in the quarter who received at least one HSW service each month other than supports coordination.

Rationale for Use
People enrolled in the HSW are among the most severely disabled people served by the public mental health system. If it were not for the waiver services supporting these people in the community, they would require services in an ICF/MR. Therefore, it is expected that the services provided to them in the community are adequate to meet their needs.

Method of Calculation
MDHHS will calculate this indicator quarterly using encounter data.
Numerator: the number of HSW enrollees receiving at least one HSW service each month other than supports coordination each month.
Denominator: the number of HSW enrollees.

This indicator should not be interpreted to mean that each HSW enrollee must receive a Supports Coordination contact each month.

EFFICIENCY

Indicator #7

The percent of total expenditures spent on managed care administrative functions annually by CMHSPs and PIHPs.

Rationale for Use

There is public interest in knowing what portion of an agency's total expenditures are spent on operating the agency relative to the cost of providing services. Combined with other indicators of performance, information on percentage spent on administrative costs can be used as an indication of the agency's overall efficiency.

Method of Calculation

MDHHS will calculate this indicator using CMHSP Total Sub-Element Cost Report and the PIHP Medicaid Utilization and Net Cost Report.

Numerator: the amount of expenditures for managed care administration as defined in the cost reports for the functions as defined in the document: "Establishing Managed Care Administrative Costs" Revised June 20, 2005.

Denominator: the amount of total expenditures from all funding sources for CMHSPs; and the amount of total Medicaid expenditures for PIHPs.

OUTCOMES: EMPLOYMENT

Indicator #8a,b

The percent of (a) adults with mental illness, and the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.

Rationale for Use

A positive outcome of improved functioning and recovery is the ability to work in a job obtained through competition with candidates who may not have disabilities. While there are variables, like unemployment rates, that the CMHSP and PIHPs cannot control, it is expected that through treatment and/or support they will enable and empower individuals who want jobs to secure them.

Method of Calculation

MDHHS will calculate this indicator after the end of the fiscal year using employment data from the individual's most recent QI record.

CMHSP Indicator

Numerator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability who are employed competitively.
Denominator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSP.

PIHP Indicator

Numerator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability who are employed competitively.
Denominator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

OUTCOMES: EMPLOYMENT

Indicator #9a,b

The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.

Rationale for Use

A positive outcome of improved functioning and recovery is the ability to earn an income that enables individuals the independence to purchase goods and services and pay for housing.

Method of Calculation

MDHHS will calculate this indicator after the end of the fiscal year using employment data from the individual's most recent QI record. A new minimum wage data element will be added to the FY '06 reporting requirements.

CMHSP Indicator

Numerator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability, who received Michigan's minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop).
Denominator: the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSP.

PIHP Indicator

Numerator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability, who received Michigan's minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop).
Denominator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

OUTCOME: INPATIENT RECIDIVISM (CMHSP & PIHP)

Indicator #10:
The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less

Rationale for Use
For some people with mental illness, the occasional use of psychiatric inpatient care is essential. However, rapid readmission following discharge may suggest that people were prematurely discharged or that the post discharge follow-up was not timely or sufficient. This indicator assessed whether CMHSPs are meeting the Department's standard of no more than 15 percent of people discharged from inpatient units are being readmitted within 30 days.

Table 6 – Indicator #10

1. Population	2. # of Discharges from Psychiatric Inpatient Care during the Reporting Period	3. # of Discharges in Col 2 that are Exceptions	4. # Net Discharges (Col 2 minus Col 3)	5. # of Discharges (from Net Col. 4) Readmitted to Inpatient Care within 30 Days of Discharge	6. % of Discharges Readmitted to Inpatient Care within 30 days of Discharge
1. # of Children	BE2	BF2	BG2 - Calculated	BH2	BM2 - Calculated
2. # of Adults	BI2	BJ2	BK2 - Calculated	BL2	BN2 - Calculated

NOTE: This information is intended to capture Admissions and Readmissions, not transfers to another psychiatric unit, or transfers to a medical inpatient unit. Do not include transfers or dual-eligibles (Medicare/Medicaid) in the counts in any column on this table.

Column 2 – Selection Methodology

1. Discharges" are the events involving all people (for the CMHSPs) and Medicaid eligibles only (for the PIHPs) who are discharged from a Psychiatric Inpatient Unit (community, IMD or state hospital), who meet the criteria for specialty mental health services and are the responsibility of the CMHSP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the total number of discharges.
2. Do not include dual eligibles (Medicare/Medicaid) in these counts.

Column 3 – Exception Methodology

Enter the discharges who chose not to use CMHSP/PIHP services

CMHSP/PIHP must maintain documentation available for state review of the reasons for exceptions in column 3.

Column 4 – Calculation of Denominator

Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

Column 5 – Numerator Methodology

1. Enter the number of persons from column 4 who were readmitted to a psychiatric inpatient unit within 30 days of discharge from a psychiatric inpatient unit.
2. In order to obtain correct counts for column 5, you must look 30 days into the **next quarter** for possible readmissions of persons discharged toward the end of the current reporting period.
3. "Days" mean calendar days.

OUTCOMES: RECIPIENT RIGHTS COMPLAINTS (CMHSPs & PIHPs)

Indicator #11

*The **annual** number of substantiated recipient rights complaints in the categories of Abuse I and II, and Neglect I and II per 1,000 persons served by CMHSPs and by PIHPs.*

Rationale for Use

Substantiated rights complaints are a measure of the quality of care provided by CMHSPs and managed by PIHPs. Since Abuse and Neglect complaints must be investigated, it is believed that these four categories represent the most serious allegations filed on behalf of people served.

Table 7a. Recipient Rights Complaints from Medicaid Beneficiaries (reported by PIHPs)

A = PIHP Name

RR Complaints	1. # of Complaints from Medicaid Beneficiaries	2. # of Complaints Substantiated by ORR	3. # of Complaints Substantiated Per Thousand Medicaid Beneficiaries Served
Abuse I	**B**	**C**	
Abuse II	**D**	**E**	
Neglect I	**F**	**G**	
Neglect II	**H**	**I**	

Instructions:

Column 1: Enter the number of complaints from all consumers in each of the above categories that were filed at the local Office(s) of Recipient Rights during the year.
Column 2: Enter the number of those complaints that were substantiated by the local ORRs.
Column 3: MDHHS will calculate the number of complaints per thousand persons served.

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May 11, 2020

To: Clinically Responsible Service Providers (CRSP)
From: Jacquelyn Davis, Director of Access and Crisis Services
CC: Eric Doeh, Dana Lasenby, Manny Singla, Kimberly Flowers, Ebony Reynolds, Darlene Owens, Crystal Palmer, John Pascaretti, April Siebert, Suzanne Henson, Michele Vasconcellos, June White, Wellplace, Adult & Children's Crisis Providers
Re: CRSP Responsibilities and Changes in DWIHN Procedures

******Please ensure this memo is read in its entirety and shared with appropriate staff.***

In an effort to provide guidance and support to the Clinically Responsible Service Providers (CRSP), DWIHN has developed a supplemental document explaining responsibilities. This memo serves as cover page to that document along with other significant changes that need to be addressed by each CRSP. The goal is to improve the services delivered to the individuals we serve.

There are five items in this memo explained below and in the attached documentation. Please pay attention to due dates and ensure this information gets to all appropriate staff. ***Note: Attachments B, C and E are not applicable to SUD CRSP.***

1. ***Attachment A – CRSP Responsibilities:*** This document is a brief summary explaining the roles and responsibility of the CRSP. The document has highlighted segments to lead you directly to the policy for the area being referenced.
2. ***Attachment B – DWIHN Assignments:*** DWIHN has revised the process for how CRSP assignments are developed in MH-WIN. This process is effective May 11, 2020. If you have any concerns accessing an individuals file, please contact the MH-WIN helpdesk at mhwin@dwmha.com.
3. ***Attachment C – Mental Health (MH) CRSP Changes:*** DWIHN has revised the process for individuals changing their MH CRSP. This document explains the process and includes the CRSP Change Form that must accompany all request for changes. **The MH CRSP Change Procedure becomes effective May 11, 2020.**
4. ***Attachment D – Crisis Alerts:*** Providers have been requesting a process to receive notifications for consumers experiencing a behavioral health crisis that may show up in the emergency department or receive services from a crisis provider. Once the consumer has been stabilized, efforts will be made to coordinate services with the CRSP. This document request contact information as well as provides further information on the expectations of the CRSP involvement. **Please note, contact information is due May 15, 2020.**

5. ***Attachment E – Follow-Up After Hospitalization with Mental Health Practitioners***: This document provides guidance on following up with individuals after hospitalization with mental health practitioners. **Note: Process becomes effective May 11, 2020.**

If you have any questions, feel free to contact your Provider Network Manager or send questions to pihpprovidernetwork.com. Thanking you for your partnership and your attention to the matters addressed in this memo.

Practitioner Type	Definition
Mental Health Practitioner	A practitioner who provides mental health services and meets any of the following criteria: • An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice • A Registered Nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC)