**Quality Improvement Steering Committee (QISC)**
**October 29, 2024**
**10:30am – 12:00pm**
**Via Zoom Link Platform**
**Agenda**

| | | |
|---|---|---|
| **I.** | **Welcome** | **T. Greason** |
| **II.** | **Authority Updates** | **S. Faheem** |
| **III.** | **Approval of Agenda** | **S. Faheem/Committee** |
| **IV.** | **Approval of Minutes** | **Dr. L. Rosen/Committee** |
| **V.** | **Policy Review** | |
| | Infant and Early Childhood Mental Health Services | **C. Phipps** |
| | CAFAS-PECFAS-DECA Procedure | **C. Phipps** |
| **VI.** | **QAPIP Effectiveness** | |
| | ***Quality Improvement*** | |
| | Technical Requirements of the BTPRC 2025 | **F. Nadeem** |
| | Recidivism Analysis | |
| | • Children | **C.Phipps** |
| | • Adult | **A. McGhee** |
| | Performance Measurement Validation Review | **T. Greason** |
| | ***Follow-up Items:*** | |
| | *Member Experience Updates* | |
| | Adult Initiatives (Table) | **A. Gabridge** |
| | Member Surveys (Table) | **M. Keyes-Howard** |

**Quality Improvement Steering Committee (QISC)**
**October 29, 2024**
**10:30am – 12:00pm**
**Via Zoom Link Platform**
**Meeting Minutes**
**Note Taker: DeJa Jackson**

**Committee Chairs:** Dr. Shama Faheem, DWIHN Chief Medical Officer and Tania Greason, DWIHN Provider Network QI Administrator

**1) Item: Welcome:** Tania asked the committee to put their names, email addresses, and organization into the chat for attendance.

**2) Item: Authority Updates: Dr. Faheem shared the following updates:** The continued expansion of the CCBHC network with new providers. DWIHN has received provisional CCBHC certification. DWIHN also has continued success with the Mobile Crisis services that are provided. DWIHN has also begun to receive our External Quality Reviews (EQR) outcomes with a noted 100% on the Performance Validation review for the third consecutive year. DWIHN also continues to work on improving recidivism rates by addressing outpatient care gaps and reducing rehospitalizations.

**3) Item: Approval of Agenda:** Agenda for October 29th, 2024 Meeting Approved.

**4) Item: Approval of Minutes:** QISC Meeting Minutes for September 24th, 2024 were approved.

**5) Item: Policy Review**

**Goal: Infant and Early Childhood Mental Health Services**

**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce

**NCQA Standard(s)/Element #:** QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Cassandra Phipps, director of Children Services, shared the following policy/procedure updates with the committee:<br><br>*Infant and Early Childhood Mental Health Services:*<br>It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to provide Early Childhood Mental Health Services (ECMHS) to promote and support early developing attachment relationships between infants, toddlers, preschoolers, and young children and their families, as well as to reduce the risk of developmental delays and disorders of infancy and early childhood. Updates include the following:<br>• Policy aligned with Michigan Medicaid Manual to integrate home-based services requirements.<br>• Inclusion of the MichiCAN screener and DECA tools to assess eligibility for children with SED and IDD.<br>• Expansion of grants for providers to support mental health services.<br>• Providers encouraged to submit requests for the infant and early childhood consultation grant by October 31, 2024.<br>• Staff serving children ages 0-5 must undergo DECA training.<br>• A caseload maximum of 12 full cases (with up to 3 additional transitional cases).<br><br>*CAFAS-PECFAS-DECA Procedure:*<br>At the direction of the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA), Detroit Wayne Integrated Health Network is required to use a standardized assessment tool for individuals ages 0-21 with Serious Emotional Disturbance (SED) who receive behavioral health services paid for by Medicaid<br>• Updates made to comply with CMS requirements for certain services such as: SED waiver, CLS, Respite, and Family training.<br>• Providers must maintain CAFAS-PECFAS certification and continue using older codes (H0031 and Modifiers). | | |

| Provider Feedback | Assigned To | Deadline |
|---|---|---|
| **Questions:**<br>1. Do general IDD staff require DECA training?<br>2. Does the code for the DECA require prior authorization?<br>3. Challenges regarding disenrollment and consumer discharge processes in MH-WIN were mentioned.<br><br>**Answers:**<br>1. Staff working with children ages 0-5 or dual-designated (IDD and SED) cases must complete DECA training.<br>2. No, it does not because it's an assessment code.<br>3. It was suggested to create discharge summaries on word documents for now and Children Initiatives will coordinate with customer service for further support. | | |
| **Action Items** | **Assigned To** | **Deadline** |
| None Required. | | |

**6) Item: QAPIP Effectiveness**
**Goal: Quality Improvement**

**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

**NCQA Standard(s)/Element #: X QI 1** CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Fareeha Nadeem, QI Clinical Specialist shared and discussed the following:<br><br>*Technical Requirements of the BTPRC 2025*<br>• New technical requirements issued by MDHHS on September 13, 2024.<br>  ○ The Michigan Department of Health and Human Services (MDHHS) requires that all public mental health agencies protect and promote the dignity and respect of all individuals receiving public mental health services. All public mental health agencies shall have policies and procedures for intervening with an individual receiving public mental health services who exhibits aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. These policies and procedures shall include protocols for using the least intrusive and restrictive interventions for unprecedented and unpredicted crisis or emergency occurrences of such behaviors. For all non-emergent or continuing occurrences of these behaviors, the public mental health service agency will conduct appropriate assessments and evaluations to determine the conditions that might be the cause of the behaviors.<br>• Virtual training session to be scheduled. More information will be provided by November 2024. The QI Department will circulate details and materials to the provider network for the upcoming training session with MDHHS (Price Pullins). | | |
| **Provider Feedback** | **Assigned To** | **Deadline** |
| None provided. | | |
| **Action Items** | **Assigned To** | **Deadline** |
| QI (Fareeha Nadeem) will provide information for the upcoming training session for the BTPRC Technical Requirements. The training will be conducted by MDHHS (Price Pullins) in November 2024. | Fareeha Nadeem | November 1, 2024 |

**6) Item: QAPIP Effectiveness**
**Goal: Quality Improvement**
**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
**NCQA Standard(s)/Element #:** QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Cassandra Phipps, Director of Children Initiatives shared the following:<br>***Recidivism Analysis (Child):***<br><br>*What is Hospital Recidivism:*<br>• When a member experiences more than 1 psychiatric hospitalization within 30 days of being discharged from the previous psychiatric hospital encounter within a 90-day period.<br>• The goal for hospital recidivism for children/youth to remain below 15%.<br>*Data (FUH HEDIS Measures:)*<br>• Year 2023: 781 children were hospitalized and 497 completed post hospital visit (63.64%).<br>• MDHHS set a goal of 70%.<br>• Year 2024 (as of June 2024): 367 children were hospitalized and 233 completed post hospital visit (63.49%).<br>*Barriers Identified*:<br>• Crisis Screening Trends<br>• Crisis Plans<br>• Hospital Discharge Planning with Providers and Hospitals<br>• FY24-Q3 the Hospital Recidivism increased above 15% - Youth not connected to CMH services.<br>*Interventions Implemented:*<br>• Updated hospital discharge bulletin to include specific billing codes for home-based and wraparound discharge planning.<br>• Crisis clinical review forms to ensure early discharge planning.<br>• Enhanced coordination between crisis screeners and CRSPs to reduce rehospitalization.<br>• Crisis plan compliance improved to 78% for SED providers and 81% for IDD providers in FY24-Q3. | | |
| **Provider Feedback** | **Assigned To** | **Deadline** |
| Questions:<br>1. What is the impact of crisis clinical review forms?<br>Answers:<br>1. The Crisis Clinical Review forms provide coordination between CRSPs, hospitals, and community providers. | | |
| **Action Items** | **Assigned To** | **Deadline** |
| None Required. | | |

**6) Item: QAPIP Effectiveness**
**Goal: Quality Improvement**
**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
**NCQA Standard(s)/Element #:** QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Angel McGhee, Data Analyst shared the following:<br>• Performance Indicator (PI) #10 correlates to patient recidivism and is the percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. This data was pulled from DWIHN's MHWIN system.<br>• Goal = for CRSP's to remain below a 15% recidivism rate<br>*Recidivism Analysis (Adult):*<br><br>*Key Trends*:<br>• FY24-Q4 adult recidivism: 16.68% (a significant drop from 23% in 2019).<br>• Decreased inpatient admissions by 144 cases between Q2 and Q3.<br>*Data:*<br>• Follow-up after Hospitalization (30 days):<br>o Ages 18-64: Increased from 46.72% in 2023 to 53.46% in 2024.<br>o Ages 65+: Increased from 30.61% in 2023 to 41.67% in 2024.<br>• MDHHS set a goal of 58%.<br>*Barriers:*<br>• Members are overwhelmed with information at discharge. They have several people telling them appointment dates. There are many reminder calls coming from various people.<br>• Incorrect Contact Information<br>• Members are not made aware of their 30-day follow-up appt.<br>• Transportation<br>*Interventions:*<br>• Resumed Recidivism Workgroup to address ongoing gaps and barriers.<br>• Expanded ACT providers' after-hours services by 20% reducing hospital stays and Medicaid costs.<br>• Adjusted re-engagement policies to ensure timely discharge documentation.<br>Please review attachment "Adult Recidivism PP - QISC" for detailed information and analysis. | | |
| **Provider Feedback** | **Assigned To** | **Deadline** |
| • Dr. Rosen suggested tracking outcomes of cases presented to the Outcomes Improvement Committee (OIC) such as hospitalization and emergency room visits.<br>• Cassandra Phipps proposed creating a flagging system in MH-WIN to automate this tracking of cases submitted to OIC. | | |
| **Action Items** | **Assigned To** | **Deadline** |

| | | |
|---|---|---|
| Children, Adult Initiatives and Crisis Access team will continue to refer cases to OIC for members that are recidivistic. | DWIHN Children, Adult Initiatives and Crisis Access units. | Ongoing. |

**6) Item: QAPIP Effectiveness**
**Goal: Quality Improvement**

**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
**NCQA Standard(s)/Element #:** QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Tania Greason, QI Administrator, shared the following External Quality Review results with the committee:<br><br>*Performance Measurement Validation Review:*<br><br>*Summary of FY24 Review:*<br><br>• Review conducted by HSAG to validate performance indicators and compliance with MDHHS reporting specifications.<br>• All indicators reviewed (Indicator 1, 2, 3, 4, and 10) were deemed reportable, with no citations issued.<br>• Opportunities for improvement: Enhance documentation of exceptions for follow-up visits.<br><br>This marks the third consecutive year that that DWIHN has received a full compliance of 100% for the PMV review. | | |
| **Provider Feedback** | **Assigned To** | **Deadline** |
| None Provided. | | |
| **Action Items** | **Assigned To** | **Deadline** |
| None Required. | | |

**New Business Next Meeting: January 28, 2025**
**Adjournment: October 29, 2024**

# DETROIT WAYNE INTEGRATED HEALTH NETWORK

## Quality Improvement Steering Committee (QISC)

## *Children Initiatives*

10/29/24

# Agenda

- ❑ **Infant and Early Childhood Mental Health Services**
- ❑ **CAFAS / PECFAS / DECA Procedure**
  - **MDHHS Memo**
- ❑ **Hospital Discharge (PI 4a) / Hospital Recidivism (PI 10)**

# Policies

❑**Infant and Early Childhood Mental Health Services**

- Refer to attached policy

❑**CAFAS / PECFAS / DECA Procedure**

- Refer to attached policy

❑**MichiCANS Webpage:**

https://www.dwihn.org/Providers/MichiCANs

# CAFAS/PECFAS Memo

❑ **Effective 10/1/24 MichiCANS hard launch commenced for ages 0 to 21st birthday for SED and IDD disability designations.**

❑ **SED Providers continue to administer Initial, Annual, Exit CAFAS/PECFAS for Services that required WSA Approval:**

- SEDW
- CLS
- Respite,
- Family Training and Support

❑ **CAFAS/PECFAS cpt code Remains in the fee schedule**

- CAFAS = H0031 PE
- PECFAS = H0031 FS

Date: October 7, 2024
To: Children's Clinically Responsible Service Providers (CRSP)
From: Melissa Moody, VP of Clinical Operations- DWIHN
Re: MichiCANS- CAFAS/PECAFAS Utilization for SEDW and 1915iSPA

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On October 1, 2024, MDHHS launched the MichiCANS as a replacement for the CAFAS and PECAFAS. Detroit Wayne Community Mental Health Network (DWIHN) has been working with our provider network throughout the last year to prepare for this system-wide assessment change.

MDHHS also established contractual requirements for the PIHPs to specifically use the MichiCANS to support eligibility determinations for the Waiver for Children with Serious Emotional Disturbances (SEDW) and the 1915(i) SPA. According to MDHHS, at this time, CMS has not provided approval for the amendment to the 1915(i) SPA or provided approval for the renewal of the SEDW.

For this reason, providers should continue to use the Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) to support eligibility determinations for the 1915(i) SPA and SEDW only, until MDHHS receives approval from CMS. Providers must enter CAFAS and PECFAS scores into the Waiver Support Application (WSA) for these programs as part of the enrollment process. The MichiCANS will continue to be utilized for all individuals outside of the SEDW and 1915iSPA. If you have any questions regarding this process change, please contact Cassandra Phipps, Children Initiatives Director, at cphipps@dwihn.org. Thank you.

# Hospital Discharge / Recidivism

What is Hospital Recidivism?

Data

Barriers and gaps identified

Interventions

# What is Hospital Recidivism?

**Hospital Recidivism:** When a member experiences more than 1 psychiatric hospitalization within 30 days of being discharged from the previous psychiatric hospital encounter within a 90-day period.

- Goal for hospital recidivism for children / youth to remain below

15%

<u>High risk need:</u>

- Children / Youth are placed out of the home and community
- Children / Youth are unable to receive community mental

health services while in the hospital setting

- Importance of beginning the Hospital Discharge Planning

process during the onset of being informed of initial crisis screening

# Data

**Follow Up After Hospitalization (FUH):** Member has a visit with a Therapist, Psychiatrist, or Nurse Practitioner within 30 days of the hospitalization.

****Note: The H0036 (Home Based Service) counts for post visit as well (Refer to Hospital Discharge Bulletin)*

Year 2023:

- 781 children were hospitalized and 497 completed post hospital visit (63.64%)
- MDHHS set a goal of 70%

Year 2024: (as of June 2024)

- 367 children were hospitalized and 233 completed post hospital visit (63.49%)

# Barriers / Gaps

- Crisis Screening Trends
- Crisis Plans
- Hospital Discharge Planning with Providers and Hospitals
- FY24/Q3 the Hospital Recidivism increased above 15% - *Youth not connected to CMH services*

# Interventions

❑ **Interventions:**

1. Updated Hospital Discharge Bulletin (24-007 v3) in March 2024 to include additional billing codes.
2. Developed Crisis Clinical Review Form for Children Providers to complete within 48 hours of a Crisis Event resulting in youth out of home. (Ex: Emergency Room, Inpatient, Partial, State Facility, JDF, etc).
3. DWIHN developed an internal report for Hospital Discharge cpt codes

- Noticed there were no H0036 LI or H2021 LI billed on the report as of 8/1/24 *(There might be a 90 day lag time for claims billing)*

4. Crisis Plan Trainings and Crisis Plan Feedback Survey if under 85% for Children Providers. Crisis Plan data is available via Risk Matrix. *Refer to Crisis Plan memo from Feb 7, 2024.*

https://forms.office.com/pages/responsepage.aspx?id=iBg7DZwdXU27IzmsLb1R389KpjtBff5Kr12IgWmRYPVUME41VUhTVFRFUkxGM0pERDgxTEJaSkYxWi4u

FY 24 / Q3 Crisis Plan Data:

- Child SED Providers = 78%
- Child IDD Providers = 81%

# Hospital Discharge / Recidivism

**6. Update Crisis Plan Policy:**

16. Children Crisis Clinical Review Form: CRSPs must complete the Children's Crisis Clinical Review form within 48hrs upon request from DWIHN and or when CRSP is informed of a member experiencing a crisis event resulting in member being placed out of the home. Examples of crisis events could include the emergency room, partial hospitalization, inpatient hospitalization, state facility hospitalization, crisis stabilization unit, crisis residential unit, juvenile detention facility, a shelter, homelessness, and or other out of home settings. The Children Crisis Clinical Review form is in place to ensure identified members' services are reviewed by the CRSP and there is ongoing coordination of care to discuss discharge planning needs for the youth and family. The Children Crisis Clinical Review Form is located on DWIHN Crisis Services - For Children Section and is to be completed and uploaded to the smartsheet for DWIHN Crisis, Children Initiative, and Utilization Management Departments to review on an ongoing basis. https://www.dwihn.org/crisis-services

**7. Update PAR:**

Include Crisis Screeners inform CRSP to complete Crisis Clinical Review Form

# Hospital Discharge / Recidivism

**8. Update CRSP Re Engagement Disenrollment Policy**

Include section regarding “Intake Period” of closing a case when member does not complete intake session, complete the CRSP Discharge Records.

DWIHN now has an internal report and can view CRSP Discharge Records and noticed CRSPs are not providing Members copies of discharge summaries consistently. (Ex: Member was not present).

***Reminder:** Policy was updated that CRSP Provider member a copy of the discharge summary.

**CRSP Discharge Records:** Prior to the member's disenrollment process, the CRSP is to complete the CRSP Discharge Record via MHWIN within 14 calendar days from when the member was discharged from the CRSP and a copy of the Discharge Summary uploaded to MHWIN, as well as a copy provided to the member that is being discharged and/or Guardian. ( The CRSP Discharge Records link is found in the Clinical Services section of the members chart within MHWIN). *** Note: This procedure is only to be completed for SED/SMI/IDD disability designations.

# Questions

# DETROIT WAYNE INTEGRATED HEALTH NETWORK

## Quality Improvement Dept.
## PI 10 - Recidivism - Adults

**QISC Meeting**
**10.29.24**

# Adult Hospital Recidivism

What is Hospital Recidivism?

Data

Barriers and Gaps Identified

Interventions

# Recidivism

- Performance Indicator (PI) #10 correlates to patient recidivism and is the percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. This data was pulled from DWIHN's MHWIN system.

- Goal = for CRSP's to remain below a 15% recidivism rate

# Data

**Follow Up After Hospitalization (FUH): Member has a visit with a Therapist, Psychiatrist, or Nurse Practitioner within 30 days of the hospitalization.**

- **6.74 percentage point increase in adults 18-64 and a 11.06 percentage point increase in adults 65+**

## July 2023

- MDHHS set a goal of 58%

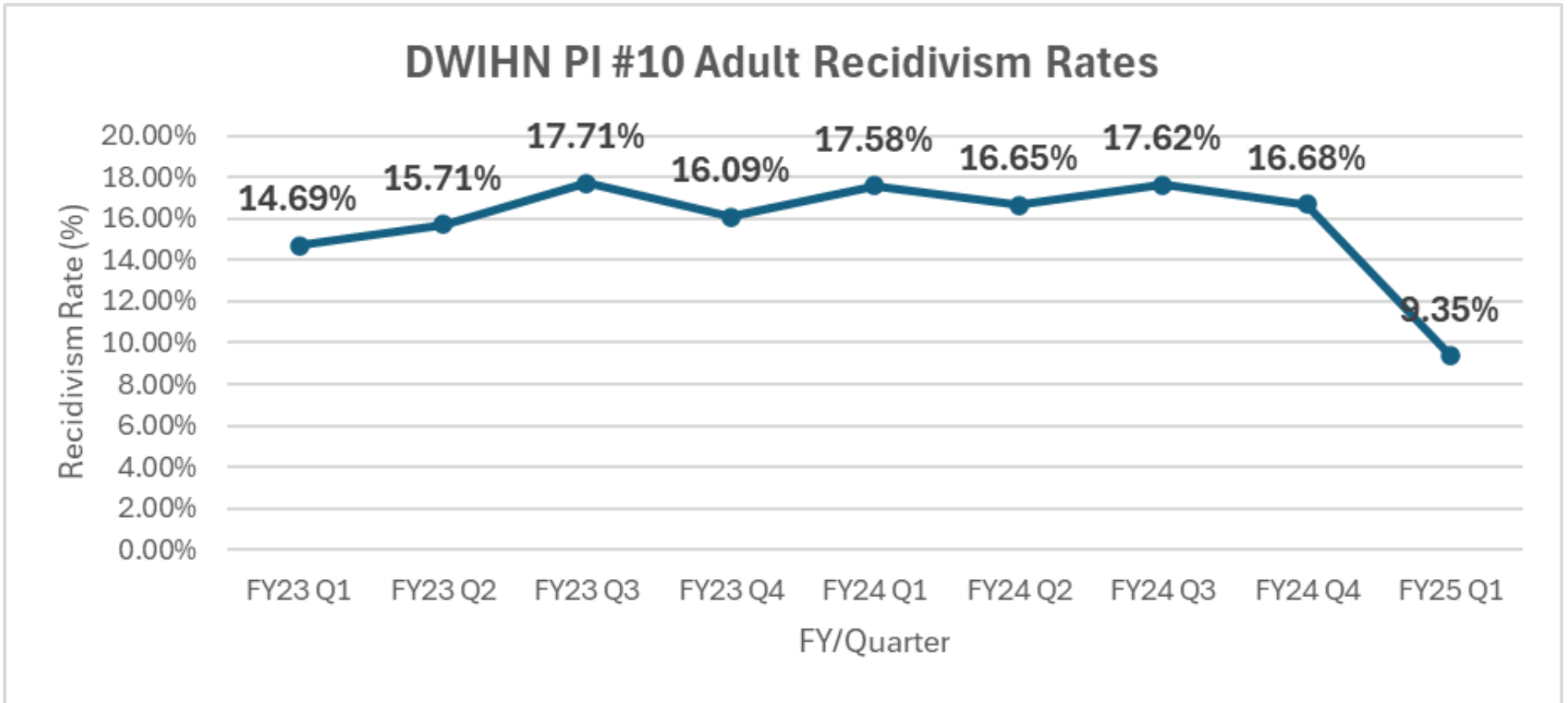
| Age Group | Adults That Completed a Post Hospital Visit | Adults Hospitalized | (%) |
|---|---|---|---|
| 18-64 years old | 2214 | 4739 | **46.72%** |
| 65+ | 60 | 196 | **30.61%** |

## July 2024

- MDHHS set a goal of 58%

| Age Group | Adults That Completed a Post Hospital Visit | Adults Hospitalized | (%) |
|---|---|---|---|
| 18-64 years old | 2357 | 4409 | **53.46%** |
| 65+ | 70 | 168 | **41.67%** |

# Data


DWIHN PI #10 Adult Recidivism Rates
Recidivism Rate (%)
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
14.69%
15.71%
17.71%
16.09%
17.58%
16.65%
17.62%
16.68%
9.35%
FY23 Q1
FY23 Q2
FY23 Q3
FY23 Q4
FY24 Q1
FY24 Q2
FY24 Q3
FY24 Q4
FY25 Q1
FY/Quarter

# Data

**Inpatient Admissions:** There was a decrease (144) of inpatient hospital admissions for adults from Q2 to Q3

| Adult Population | | | |
|---|---|---|---|
| **Timeframe** | **# of Discharges Readmitted to Inpatient Care within 30 Days of Discharge** | **# of Discharges from Psychiatric Inpatient Care during the Reporting Period** | **Recidivism Rate** |
| FY24 Q1 | 314 | 1786 | **17.58%** |
| FY24 Q2 | 299 | 1796 | **16.65%** |
| FY24 Q3 | 291 | 1652 | **17.62%** |
| FY24 Q4 | 280 | 1679 | **16.68%** |
| FY25 Q1 | 36 | 385 | **9.35%** |

**Goal = <15%**

# Barriers / Gaps

- Crisis Screening Trends
- Crisis Plans
- Hospital Discharge Planning with Providers and Hospitals
- Members are overwhelmed with information at discharge. They have several people telling them appointment dates. There are many reminder calls coming from various people.
- Incorrect Contact Information
- Members are not made aware of their 30-day follow-up appt
- Transportation
- Stigma/Bias towards receiving mental health services

# Interventions

- ACT Providers have increased their after 5pm services by more than **20%** from FY24 Q3 to Q4. This identified a **15.9% decrease** in the number of members hospitalized, and a **6.78% decrease** in the number of days spent in the hospital. These totals equate to quarterly savings of **$9,396** Medicaid dollars.

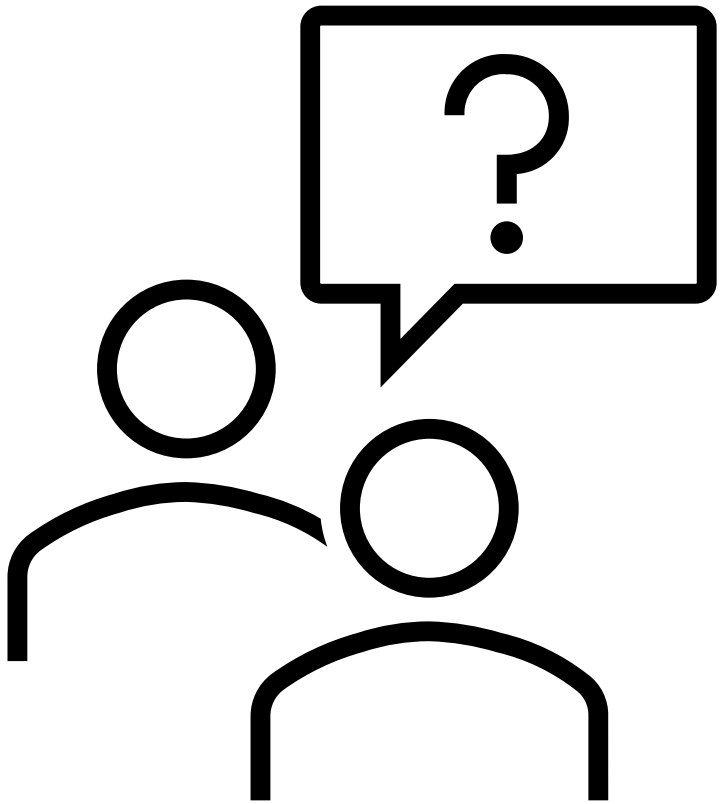
- Updating the CRSP Re Engagement Policy for Adult Providers to complete the CRSP Discharge Records when “administratively closing” case when member does not attend intake appointment post hospital discharge appointment and following 5 engagement attempts.

- Updated MHWIN for Crisis Screeners to select common risk factors when completing screeners to identify trends and needs for services (Ex: Suicidal / Homicidal behaviors, Medication, Substance Use, Elopement, etc.).

# Interventions

- Facilitate 60-day Provider meetings to review Hospital Recidivism Performance Indicator #10 and Hospital Discharge Follow Up Indicator 4a
- Case consultation meetings (Outcomes Improvement Committee)
- Adding discussion of Performance Improvement Plans (PIP's) for Performance Indicators (PI's) at the CRSP 30-45 day follow up meetings to ensure CRSP's are following their actions plans and deadlines
- Clinical Specialists assigned to the CRSP will start attending the 30–45-day follow-up meeting to provide feedback and help close the loop

# Questions?



Detroit Wayne Integrated Health Network

DWIHN

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PART OF THE USA TODAY NETWORK

# State Fiscal Year 2024 Validation of Performance Measures
# Region 7—Detroit Wayne Integrated Health Network

**QISC Meeting**
**10.29.24**

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements.

To meet the PMV requirements, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), the EQRO for MDHHS, to conduct the PMV for each PIHP. HSAG validated the PIHPs' data collection and reporting processes used to calculate performance indicator rates. MDHHS developed a set of performance indicators that the PIHPs were required to calculate and report.

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table 2 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter (Q1) of state fiscal year (SFY) 2024, which began October 1, 2023, and ended December 31, 2023.

# *Technical Methods of Data Collection and Analysis*

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The PIHPs were required to submit a completed ISCAT that provided information on the PIHPs' and CMHSPs' information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance indicators**—PIHPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHPs' SFY 2023 performance indicator reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each indicator for data verification.

| | Performance Indicator | Key Review Findings | Indicator Designation |
|---|---|---|---|
| #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. | The PIHP calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #2 | The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. | The PIHP calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #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 SUDs.** | **The PIHPs were not required to report a rate for this indicator.** | NA |

| | Performance Indicator | Key Review Findings | Indicator Designation |
|---|---|---|---|
| #3 | The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non- emergent biopsychosocial assessment. | The PIHP calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #4a | The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. | The PIHP calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #4b | The percent of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. | The PIHP calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #5 | The percent of Medicaid recipients having received PIHP managed services. | MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #6 | The percent of 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. | MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #8 | 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. | MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #9 | 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. | MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #10 | **The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.** | **The PIHP calculated this indicator in compliance with the MDHHS Codebook specifications.** | R |

# Questions