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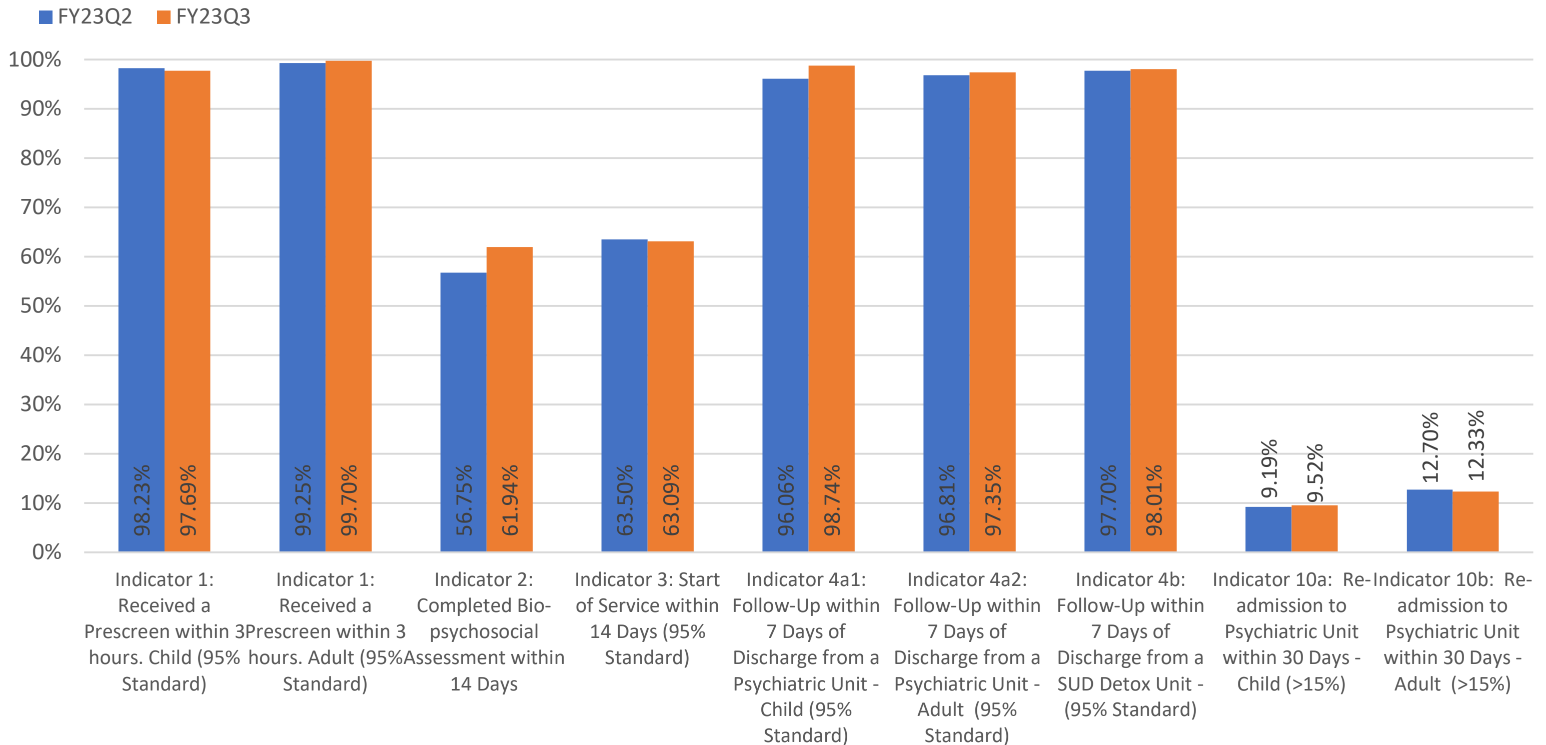
Executive Summary

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in the area of access, efficiency, and outcomes. MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder Providers are meeting performance standards through the Michigan Mission Based Performance Indicator System (MMBPIS) established by MDHHS. This data is to be reported and reviewed as part of the Quality Assessment and Performance Improvement Program (QAPIP). MSHN regional performance is monitored through quarterly performance summaries. Regional trends are identified and discussed at the Quality Improvement Council (QIC). When minimum performance standards are not met the CMHSP Participant/SUD Providers identify causal factors, interventions, and an implementation timeline to correct undesirable variation. The effectiveness of improvement efforts is monitored through quarterly performance data.

Goal: MSHN will meet or exceed the MMBPIS standards for Access (Indicators 1 and 4) and Outcomes (Indicator 10). MSHN met the goal for FY23Q3.

The most recently finalized PIHP MMBPIS Report indicates that in FY23Q2 MSHN demonstrated performance above the State of Michigan for seven of the twelve indicators, performing in the top five for five of the twelve indicators (Figures 1a-7b). This is a decrease from the previous quarter where MSHN performed above the State of Michigan and in the top five for nine of the twelve indicators.

Figure 1. MSHN MMBPIS performance rate for Access Indicators 1, 4, and Outcome Indicators for FY23Q2.



The following providers demonstrated performance below the standard for FY23Q3:
(*Indicates Denominator under 30)
Indicator 1: CEI, The Right Door, *MCN, *Newaygo
Indicator 4: *The Right Door, Lifeways, *NCMH, *SHW, *TBHS, *ATS, *Healthsource, *Salvation Army
Indicator 10: *NCMH, SHW, *TBHS

Data Analysis

The MMBPIS data collected is based on the definition and requirements that have been set forth within the Michigan Mission Based Performance Indicator System (MMBPIS) Code Book FY20, and the Reporting Requirements within the PIHP contract. Additional instructions are available in the REMI Help documents and the MMBPIS Project Description. Exclusions and/or exceptions are allowed for Indicator 4 and 10.

Access

Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (standard is 95% or above)

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

Indicator 2a: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. MI adults, MI children, I/DD adults, I/DD children. (Effective 4/1/2020 No Standard the 1st 2 years).

Indicator 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. (Effective 4/1/2020 No Standard the 1st 2 Years).

MSHN submits the number of expired requests from individuals who requested and were approved for SUD treatment, however never received a service. This information is submitted to MDHHS for inclusion into the calculation of Indicator 2b. MSHN had 482 expired requests during FY23Q1.

Indicator 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. MI adults, MI children, I/DD adults, and I/DD children (Effective 4/1/2020 No Standard the 1st 2 Years).

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

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

Additional information related to those identified as "exceptions" is found in Figures 7-10.

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

- Consumers who request an appointment outside the seven-day period, refuse an appointment offered within the seven-calendar day period, do not show for an appointment or reschedule (The dates of refusal or dates offered must be documented).
- Consumers who choose not to use CMHSP/PIHP services. For the purposes of this indicator, Providers who provide substance abuse services only, are currently not considered to be a CMHSP/PIHP service.

Outcomes

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

Individuals who chose not to use PIHP services were identified as an "exception" for this measure.

Figure 2. PIHP and CMHSP Indicator 1,4, and 10 performance rate FY23Q3

	#1 - Pre-Admission Screening		#4 - Hospital Discharges F/U		#10 - Inpatient Recidivism	
Affiliate / CMH	Child	Adult	Child	Adult	Child	Adult
Bay-Arenac	100.00%	100.00%	100.00%	100.00%	8.11%	14.15%
CEI	94.09%	99.18%	100.00%	98.99%	13.33%	11.86%
Central MI	100.00%	99.74%	*100.00%	98.88%	*11.11%	11.30%
Gratiot	100.00%	98.92%	*100.00%	100.00%	*0.00%	14.71%
Huron	*100.00%	100.00%	*100.00%	*100.00%	*0.00%	*0.00%
Ionia	93.18%	100.00%	*100.00%	*85.19%	*0.00%	13.89%
LifeWays	100.00%	99.63%	*100.00%	94.44%	13.16%	13.76%
Montcalm	*94.74%	100.00%	*100.00%	100.00%	*0.00%	8.33%
Newaygo	*94.12%	100.00%	*77.78%	*100.00%	*16.67%	*0.00%
Saginaw	100.00%	100.00%	*100.00%	100.00%	6.67%	12.20%
Shiawassee	*100.00%	100.00%	*100.00%	*84.21%	*0.00%	16.67%
Tuscola	*96.30%	100.00%	*100.00%	*94.44%	*0.00%	*16.00%
Total/PIHP:	**97.69%**	**99.70%**	**98.74%**	**97.35%**	**9.52%**	**12.33%**

*Indicates denominator under 30. Red indicates the standard was not met. **No eligible records

Figure 2a. PIHP and CMHSP Indicator 2 and 3 performance rate FY23Q3

	#2a - 1st Request Timeliness					#3 - 1st Service Timeliness				
Affiliate / CMH	MI / Child	MI / Adult	DD / Child	DD / Adult	Total	MI / Child	MI / Adult	DD / Child	DD / Adult	Total
Bay-Arenac	69.07%	63.67%	65.12%	*66.67%	65.23%	61.96%	65.26%	86.49%	*66.67%	66.77%
CEI	86.25%	84.30%	9.38%	*66.67%	78.13%	62.83%	55.85%	97.60%	*77.78%	66.46%
Central MI	63.97%	75.16%	*75.00%	*75.00%	71.63%	69.64%	74.51%	*61.90%	*75.00%	72.63%
Gratiot	68.25%	64.35%	*72.73%	*66.67%	66.15%	59.57%	81.58%	*90.00%	*66.67%	74.26%
Huron	50.00%	72.73%	*100.00%	*100.00%	65.22%	56.00%	*51.02%	*100.00%	*0.00%	51.95%
Ionia	67.35%	70.00%	*75.00%	*87.50%	69.81%	42.22%	62.21%	*75.00%	*55.56%	56.18%
LifeWays	56.11%	56.80%	*40.00%	*81.25%	56.53%	20.57%	38.43%	*12.50%	*50.00%	32.09%
Montcalm	77.38%	77.36%	*89.66%	*88.89%	79.00%	55.41%	72.18%	90.32%	*100.00%	70.20%
Newaygo	55.56%	43.83%	**	*75.00%	48.44%	41.79%	67.33%	**	*50.00%	56.90%
Saginaw	11.97%	20.44%	2.56%	*40.00%	16.35%	61.76%	62.42%	68.42%	*66.67%	63.41%
Shiawassee	57.45%	52.94%	*66.67%	*33.33%	54.81%	81.25%	67.65%	*50.00%	*100.00%	74.71%
Tuscola	31.58%	24.10%	*0.00%	*75.00%	27.78%	93.10%	*88.89%	**	*100.00%	90.53%
Total/PIHP:	**61.13%**	**63.84%**	**42.74%**	**71.91%**	**61.94%**	**56.82%**	**63.68%**	**81.85%**	**65.91%**	**63.09%**

*Indicates denominator under 30. **No eligible records

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

	Population	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3
Indicator 1: Percentage who received a Prescreen within 3 hours of request 95% Standard	Children	98.00%	98.53%	97.22%	99.32%	98.23%	97.69%
	Adults	98.77%	98.74%	99.15%	99.42%	99.25%	99.70%
***Indicator 2: Percentage who have had a completed Bio-psychosocial Assessment within 14 Days. No Standard**	MI Child	63.78%	63.92%	63.39%	59.14%	57.13%	61.13%
	MI Adults	61.38%	60.10%	61.62%	62.95%	58.27%	63.84%
	DD Child	58.58%	55.29%	55.19%	49.21%	40.98%	42.74%
	DD Adult	63.46%	67.59%	74.76%	57.29%	49.18%	71.91%
	Total	62.08%	61.24%	62.13%	60.81%	56.75%	61.94%
Indicator 3: Percentage of who had a Medically Necessary Service within 14 Days. No Standard	MI Child	60.24%	56.03%	64.36%	56.86%	61.01%	56.82%
	MI Adults	67.56%	61.66%	63.65%	59.47%	62.85%	63.68%
	DD Child	75.24%	71.94%	78.34%	77.16%	81.42%	81.85%
	DD Adult	72.60%	63.04%	69.79%	61.90%	61.62%	65.91%
	Total	65.53%	60.53%	65.12%	59.53%	63.50%	63.09%
Indicator 4: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit (95% Standard)	Children	98.97%	96.30%	97.80	97.25%	96.06%	98.74%
	Adults	95.75%	96.49%	97.25%	95.60%	96.81%	97.35%
	MSHN SUD	99.37%	97.16%	96.74%	97.83%	97.78%	98.01%
Indicator 10a: Percentage who had a Re-admission to Psychiatric Unit within 30 Days (>15% Standard)	Children	5.60%	2.68%	10.45%	8.75%	9.19%	9.52%
	Adults	10.42%	8.87%	9.66%	13.01%	12.70%	12.33%

Out of Compliance/Exception Data

MSHN completes an analysis of those records that were "out of compliance" and those that were identified as "exceptions. Exceptions are allowed for Indicators 4 and 10. Indicators 2 and 3 do not allow for exceptions. If an individual does not meet the timelines as required, the record is considered to be "out of compliance". The reasons for "out of compliance" can be found in Figure 5.

Figure 4. Indicator 4, 10 MSHN and the Provider Network exception rate.

	Indicator 4							Indicator 10					
	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3		FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3
BABH	31.78%	30.00%	36.27%	36.42%	19%	29.37%		0.00%	0.00%	0.00%	0.65%	0.00%	1.38%
CEI	45.76%	49.50%	34.72%	45.88%	0%	30.85%		31.14%	30.90%	31.02%	33.74%	28.81%	21.16%
CMHCM	12.50%	27.27%	56.86%	25.24%	12%	25.56%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
GIHN	15.38%	16.22%	21.60%	16.13%	0%	4.55%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
HBH	33.33%	37.93%	6.67%	44.00%	0%	25.93%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
The Right Door	12.00%	12.50%	32.35%	15.38%	0%	23.26%		0.00%	2.78%	0.00%	0.00%	0.00%	0.00%
Lifeways	44.77%	48.89%	15.38%	36.57%	31%	42.79%		2.91%	0.00%	1.54%	2.86%	0.00%	1.30%
MCN	18.42%	19.44%	47.18%	21.05%	0%	20.00%		0.00%	0.00%	0.00%	0.00%	0.00%	6.98%
Newaygo	4.76%	37.50%	14.81%	26.67%	**	20.00%		0.00%	0.00%	0.00%	0.00%	**	0.00%
Saginaw	34.51%	34.48%	5.26%	33.85%	0%	43.24%		0.00%	0.00%	0.00%	0.66%	0.00%	0.51%
SHW	31.25%	33.33%	38.24%	32.14%	32%	34.38%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TBHS	18.18%	28.57%	18.18%	12.50%	100%	32.14%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MSHN	**33.18%**	**37.05%**	**28.57%**	**34.02%**	**20.63%**	**34.76%**		**10.68%**	**11.40%**	**10.04%**	**10.65%**	**8.42%**	**6.91%**
4b MSHN-SUD	50.77%	49.86%	46.36%	45.07%	39.51%	41.91%							**No eligible records

Figure 5. Out of Compliance and Exception Reasons

	Ind. 2 Request to Assessment			Ind. 3 Assessment to Service			Ind. 4 FU after Psych Inpatient/Detox Discharge			Ind. 10 Readmission		
Out of Compliance / Exception Reasons	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**
Total # Out of Compliance or Exception	1537	2039 /418	1673 /353	1262	1283	1312	339/ 155	300/ 152	386/ 149	118	147	93
Consumer canceled/no showed for an appointment	349	361/ 13	370/ 4	399	346	386	196/19	200/12	259/10			
Consumer rescheduled an appointment	202	208/ 9	158/ 20	105	114	84	16/4	20/1	12/0			
Consumer requested an appointment outside of 14/7 calendar days/Consumer refused an appointment offered within 14/7 Calendar Days	406	550/ 51	383/ 35	256	197	155	5/45	0/44	4/21			
No appointments available within the required timeframe	426	481/ 1	520/ 2	257	121	209	3/0	0/0	0/0			
Consumer chose not to pursue services	25	68/0	38/0	26	45	38	27/46	46/ 56	43/68	5	6	3
Staff cancel/reschedule	38	14/ 3	1/39	38	27	22	2/0	2/0	1/0			
Unable to be reached	9	2	13/2	11	2	14	0/0/	0	0/0			
Assessment determined not eligible for specialty mental health services	1	1		15	40	10	0/0	0/0	0/0			
Consumer chose not to use CMHSP/PIHP services/ chose provider outside of network	5	21	10	43	4	9	65/30	8/28	45/45	113	141	89
Unable to complete assessment due to emergent need	4	1	2			2	0/0	3/0	0/5			
Other (autism consumer, missing disability designation, rapid access, documentation, referred out for services)		13	90		3	149	0/0	0/1	0/0			1
Blank	72	1/ 341	65/ 287	27	384	234	0/3	21/ 10	17/4			

Quality Assessment and Performance Improvement Program
Quality Improvement Council
Michigan Mission Based Performance Indicator System FY23Q3

Follow Up to Data Analysis

Prioritize out of compliance / exception reasons, and identify causal factors with interventions to reduce or eliminate the barriers.

Improvement Strategies			**Evaluation Process**		
The number of individuals seen within the required timeframe will demonstrate an increase.			Review annual data for progress.		
Indicator	**Barrier /Causal Factors**	**Intervention**	**Start Date**	**Who**	**Status of Progress**
2/3	Scheduled outside of the required timeframes -No appointments available within required timeframe	Consumer are provided services through mobile response stabilization services until scheduled appointment.	FY23	SCCMHA	New
		Rebuild Workforce and increase staffing levels.	FY23	SCCMHA	New
		Utilize additional staff to ensure seen within 14 days.	FY23	GIHN	New
		Contracting with an outside agency.	FY23	SHW	New
		Postings, outreach to colleges, interns Recruitment-billboards, commercials, job fairs.	FY23	CEI	New
		Paying for Masters-additional education.	FY23	CEI	New
		Business cards with QR codes.	FY23	NCMH	New
		Incentives for staff referrals	FY23	The Right Door	New
2/3	Scheduled outside of the required timeframes -Process not followed	Education / Training staff.	FY23	BABH, Lifeways	New
		Development of procedure and policy with specific actions and timelines to track post hospital follow ups, and follow up with consumer and provider	FY23	Lifeways	New
2/3	Consumer No Show/ Canceled	Utilize peers for increased engagement	FY23	HBH	New
4	Lack of Care Coordination	Develop/improve discharge planning process with internal staff and hospital	FY22 FY22 FY22	The Right Door HBH Lifeways	Effective Effective Improvement
		Training including but not limited to coordination process and ensuring appropriate releases are in place for community treatment	FY22 FY22 FY23	GIHN Lifeways CMHCM	Effective Improvement New
	Staff Cancel	Process developed to ensure supervisors are aware of crisis, hospital discharge appointment to ensure follow up with another clinician in the event of an unexpected staff absence.	FY23	Saginaw	New

10	Lack of appropriate supervised housing.	Work collaboratively with MDHHS and community treatment providers for coordination, approvals and development	FY23	CMHCM	New
		Utilize/ develop crisis stabilization units and crisis residential as a step down	FY23	CEI MCN	New New
4/10	Process may not have been followed or be adequate to address the needs of individuals	Review each case for any process variation and develop appropriate action steps	FY23	NMCH	New
		Training on the access requirements and process. This may include documentation of exceptions etc.	FY23 FY22 FY22 FY23	BABH SCCMHA GIHN SUD Providers	New Effective Improvement New

Prepared by: Sandy Gettel, MSHN Quality Manager **Date:** 10/3/2023
Reviewed by: MSHN QIC **Date:** 10/26/2023
Distributed to SUD Treatment: **Date**: 10/27/2023

Attachment 1: Substance Use Disorder Treatment Providers Data FY23Q3

*Indicates denominator under 30

Provider	2e Expired Requests	2b Timeliness- (Unofficial Results)	4b Withdrawal Management Follow Up
MSHN	**476**	**87.03%**	**98.01%**
Access Lifeways CMH	12		
Access Montcalm Care Network	1		
Addiction Treatment Services	0	100.00%	*92.31%
Arbor Circle Counseling	1	*100.00%	
Bear River Health	46	93.85%	100.00%
Catholic Charities of Jackson Lenawee and Hillsdale Counties	8	82.86%	
Catholic Charities of Shiawassee and Genesee	0	*59.09%	
Catholic Human Services	0	*73.33%	
Cherry Street Service	0	100.00%	
CMH for Clinton, Eaton Ingham Counties	45	97.97%	100.00%
Cristo Rey Community Center	19	37.50%	
DOT Caring Centers	7	92.31%	*100.00%
Family Services & Children's Aid	1	96.77%	
Flint Odyssey House	26	96.70%	*100.00%
Great Lakes Recovery Centers	1	*88.89%	
Harbor Hall, Inc.	0	95.38%	
HealthSource Saginaw	0	*100.00%	*77.78%
Henry Ford Allegiance Health	28	79.80%	*100.00%
KPEP	0	*100.00%	
LifeWays	0	*84.62%	
List Psychological Services	19	80.46%	
McCullough Vargas & Associates	14	73.68%	

Meridian Health Services	21	96.34%	*100.00%
Michigan Therapeutic Consultants	1	97.44%	
Mid-Michigan Recovery Services	58	63.13%	
Mindful Therapy	0	*100.00%	
New Paths, Inc.	0	*100.00%	
North Kent Guidance Services, LLC	3	*100.00%	
Our Hope Association	1	*91.67%	
Pinnacle Recovery Services	0	76.67%	
Professional Psychological & Psychiatric Services	0	*87.50%	
Randy's House of Greenville	0	*100.00%	
Recovery Pathways	32	90.38%	
Sacred Heart Rehabilitation Center	10	83.33%	*100.00%
Saginaw Odyssey House, Inc.	11	79.59%	
Saginaw Psychological Services	3	86.67%	
Salvation Army	0	*100.00%	*90.00%
Samaritas	8	88.89%	
Sunrise Centre	7	86.67%	*100.00%
Ten Sixteen Recovery Network	49	82.31%	
The Right Door for Hope, Recovery and Wellness	8	80.00%	
Victory Clinical Services - Battle Creek	0	*100.00%	
Victory Clinical Services - Jackson	4	*88.89%	
Victory Clinical Services - Lansing	10	*76.92%	
Victory Clinical Services - Saginaw	16	81.25%	
WAI-IAM	0	98.33%	
Wedgwood Christian Services	6	78.57%	

Appendix A: PIHP MMBPIS Comparison Report Final State Data

FY23Q2 Final State Data

An analysis was completed using the most recent finalized report, comparing MSHN performance to other PIHPs and the State of Michigan.
In addition to the indicators that are calculated and reviewed quarterly by MSHN, the following indicators calculated by MDHHS were included:

Access Indicator 5: Percentage of Area Medicaid Recipients Having Received PIHP Managed Services.
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.

The most recent finalized MMBPIS-PIHP Performance Indicator Final Report indicates that in FY23Q2 MSHN demonstrated performance above the State of Michigan for seven of the twelve indicators, performing in the top five for five of twelve indicators (Figures 1a-7b). The data demonstrates areas of focus should be psychiatric inpatient admissions/readmissions (Indicator 10), follow up care (Indicator 4), and timely engagement (Indicator 3).
MSHN demonstrated the third highest penetration rate in Michigan for Medicaid recipients receiving a PIHP service.

Figure 1a: PIHP Comparison Data for Access Indicator 1

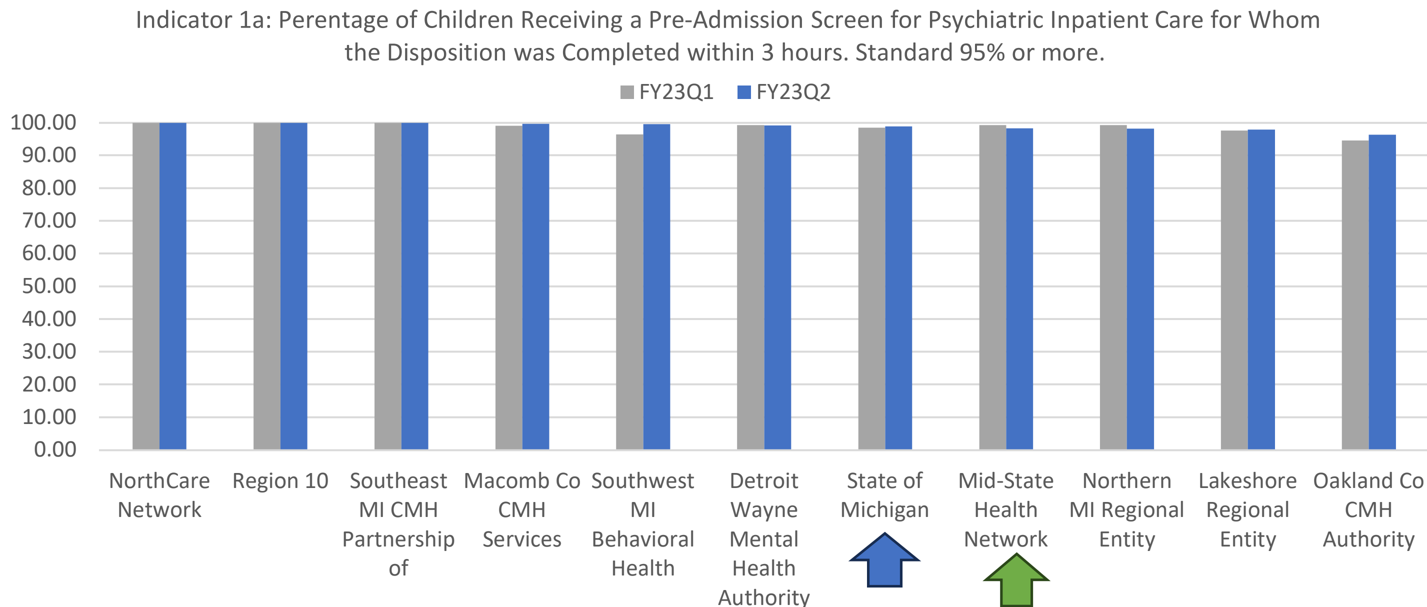


Figure 1b: PIHP Comparison Data for Access Indicator 1

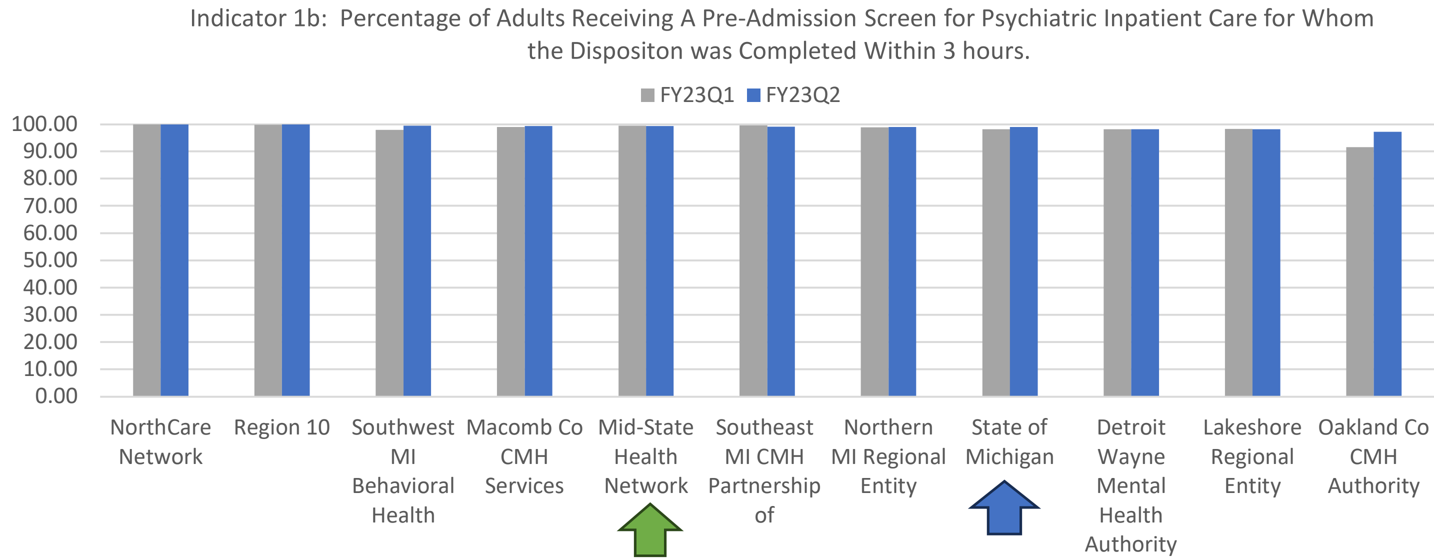


Figure 2: PIHP Comparison Data for Access Indicator 2

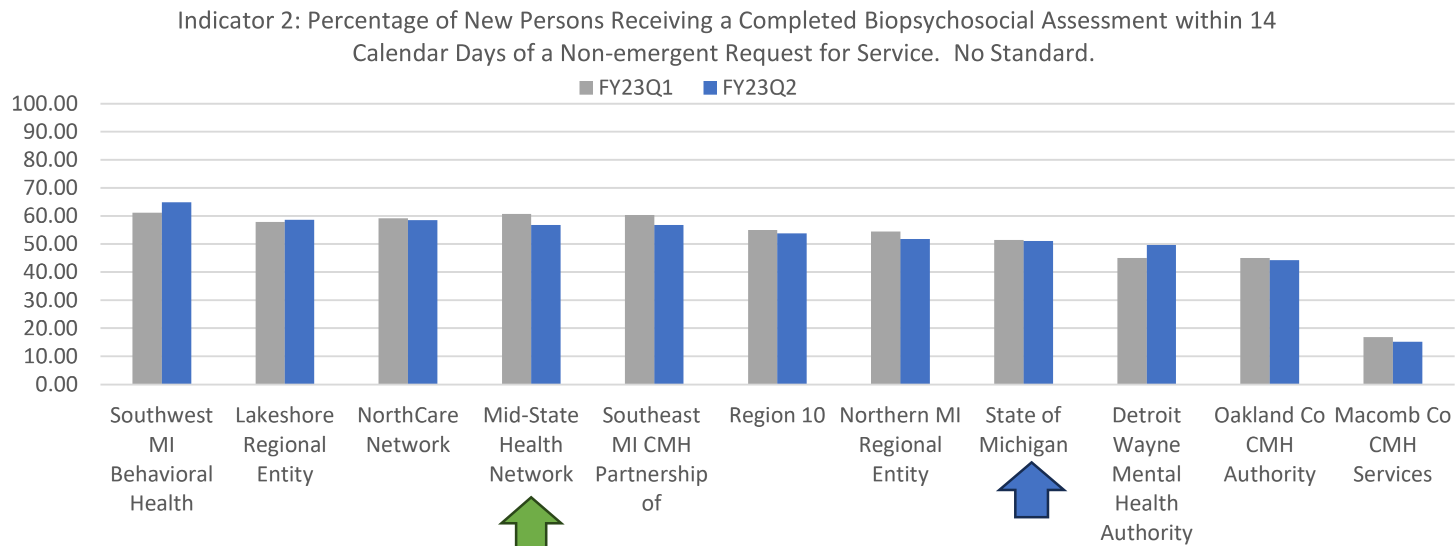


Figure 2b: PIHP Comparison Data for Access Indicator 2e

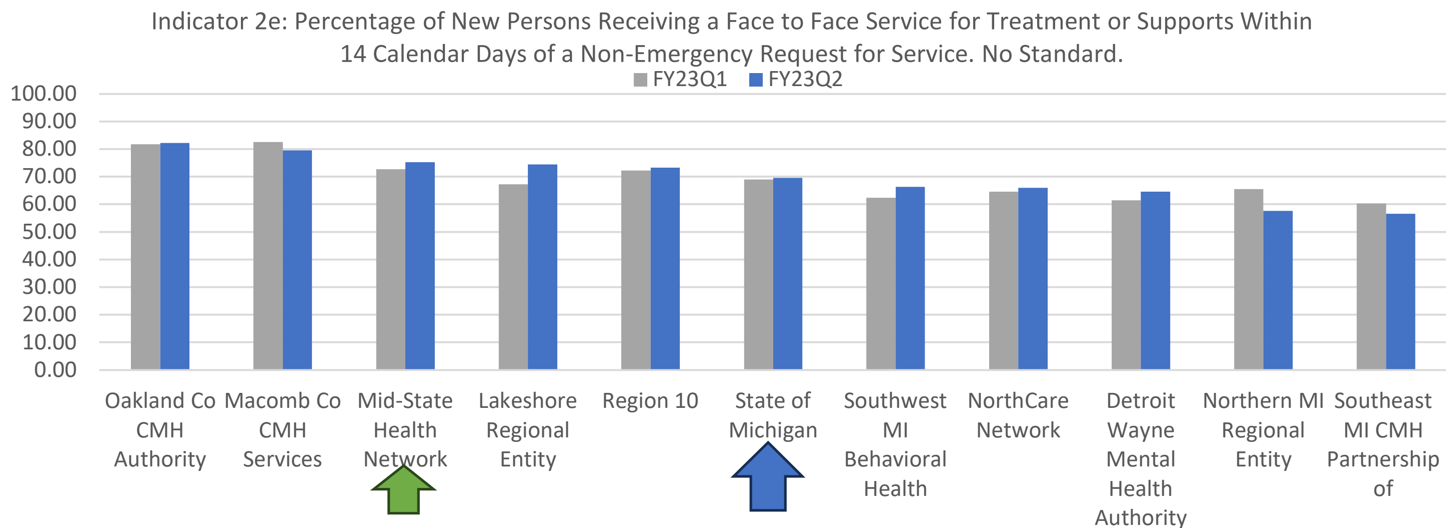


Figure 3: PIHP Comparison Data for Access Indicator 3

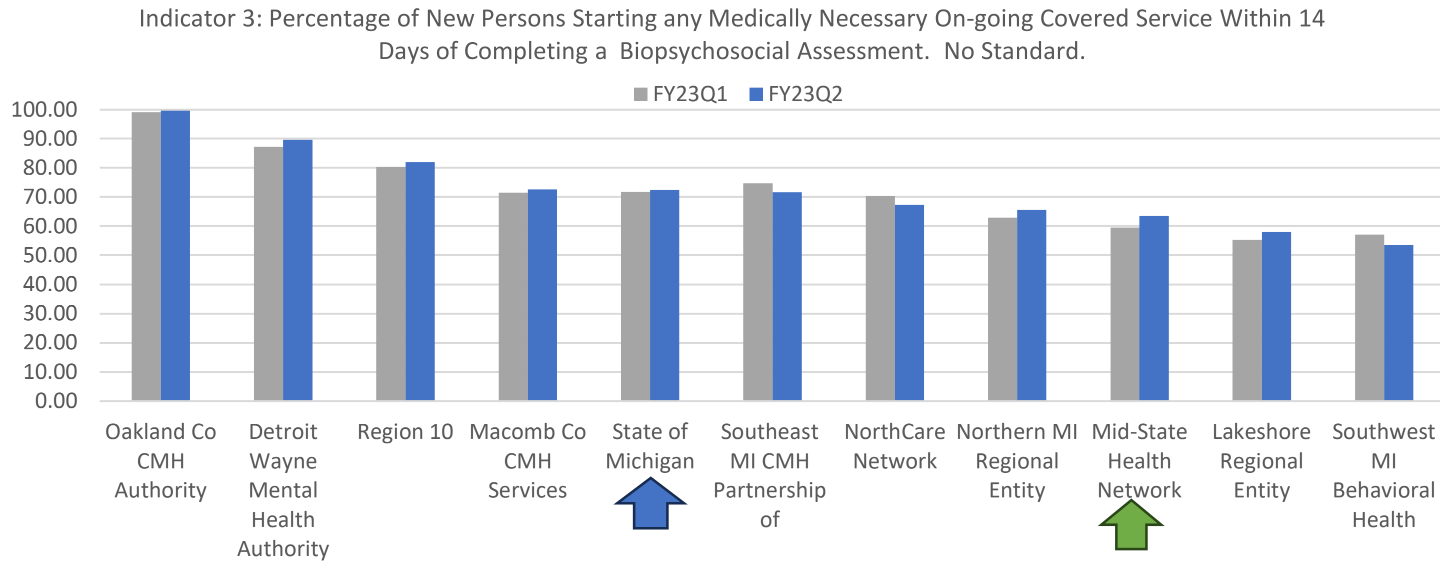


Figure 4a: PIHP Comparison Data for Access Indicator 4a1

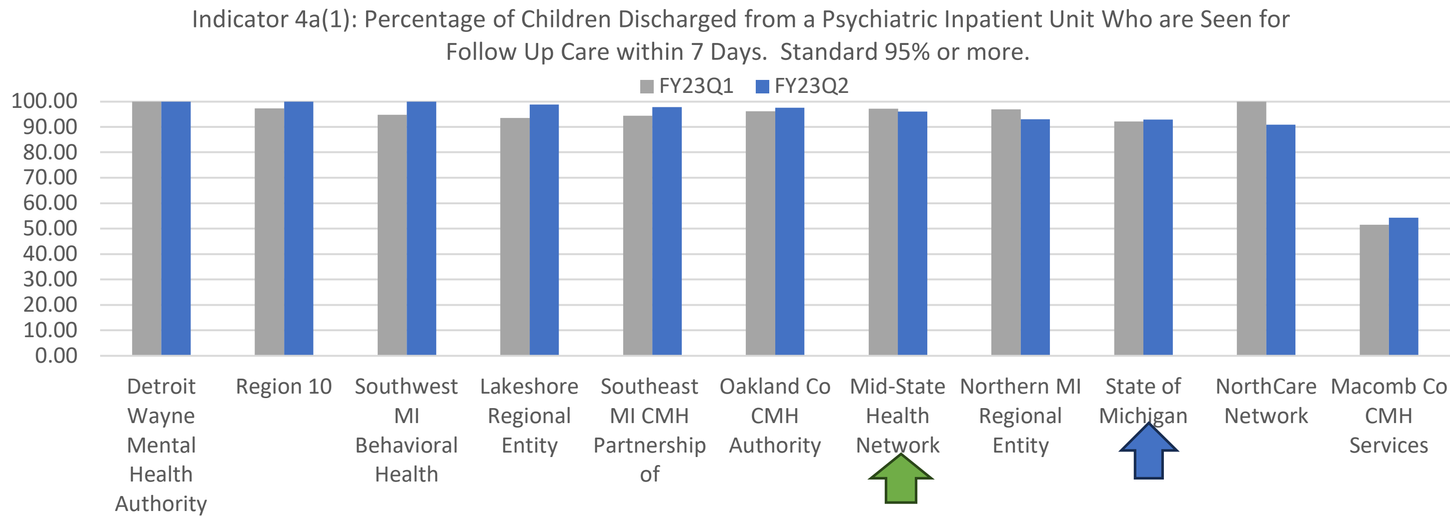


Figure 4b: PIHP Comparison Data for Access Indicator 4a2

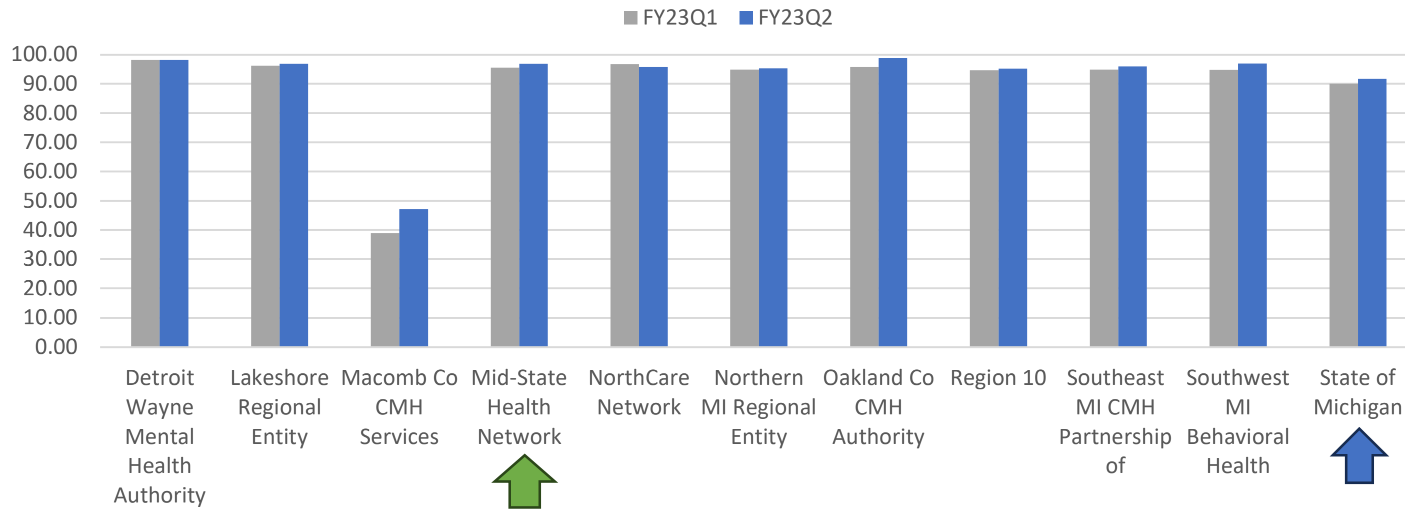


Figure 4c: PIHP Comparison Data for Access Indicator 4b.

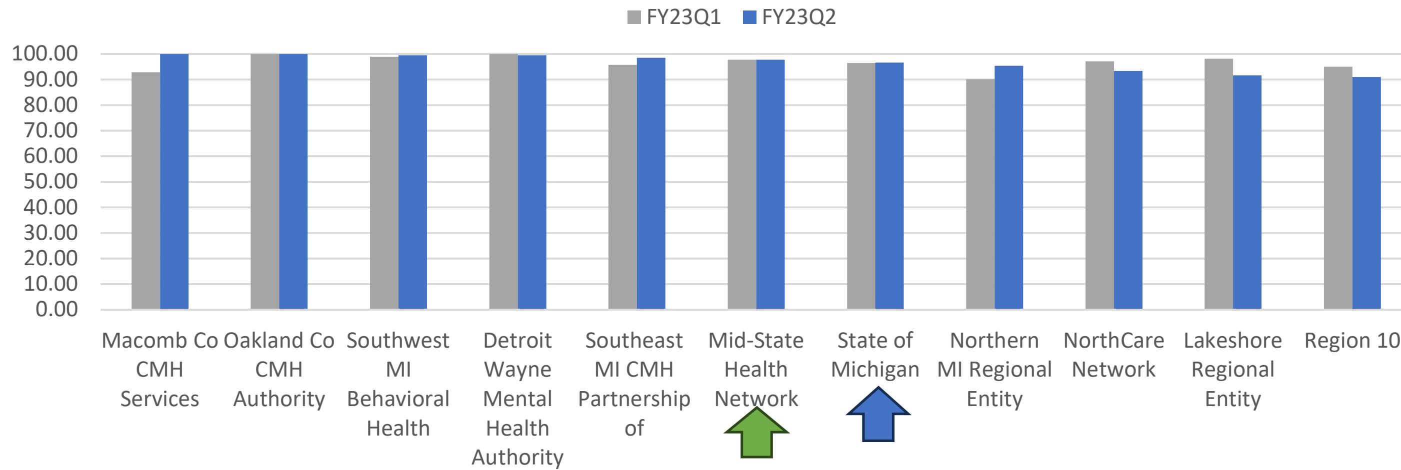


Figure 5: PIHP Comparison Data for Access Indicator 5

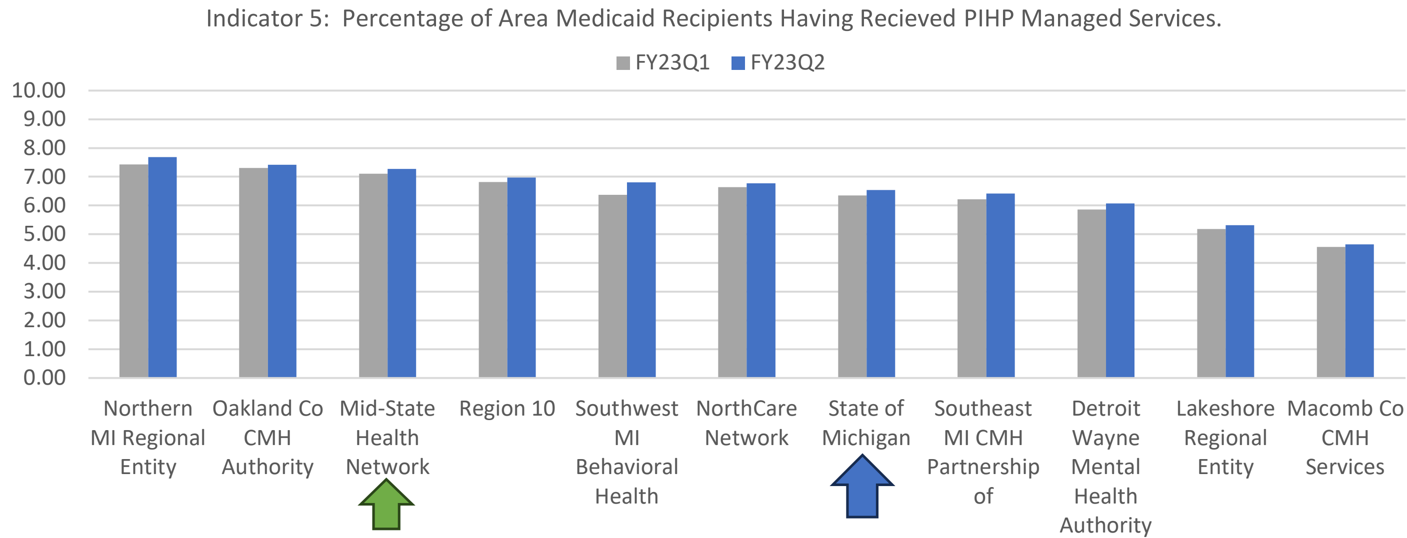


Figure 6: PIHP Comparison Data for Access Indicator 6

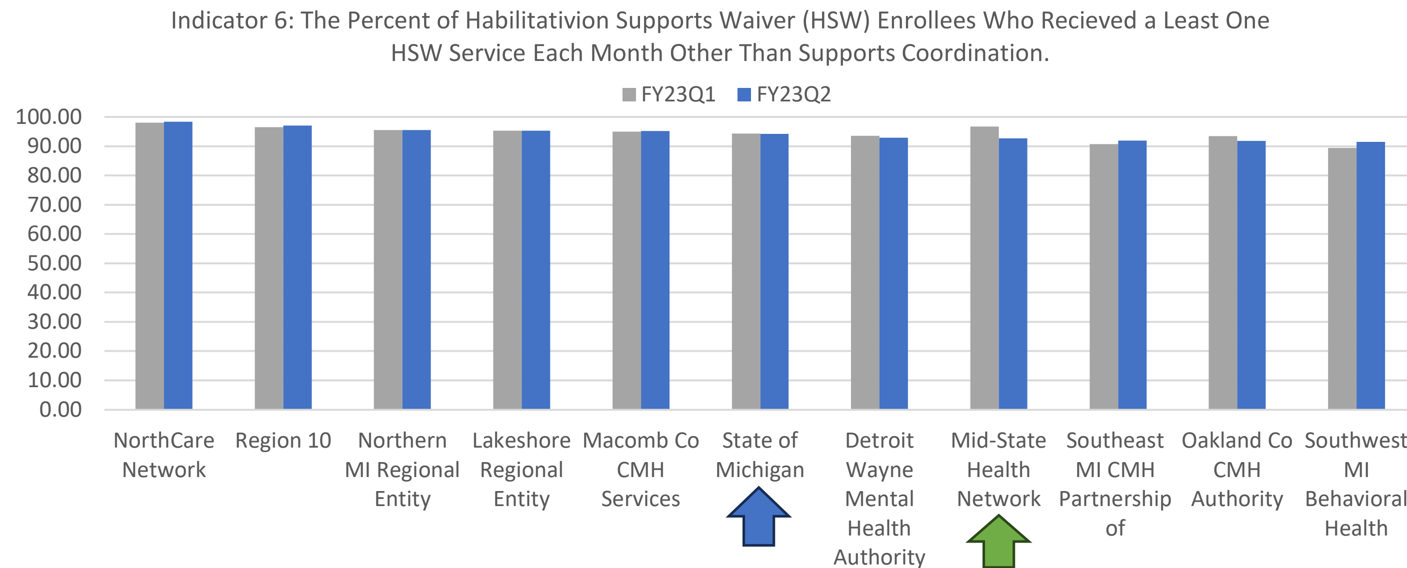
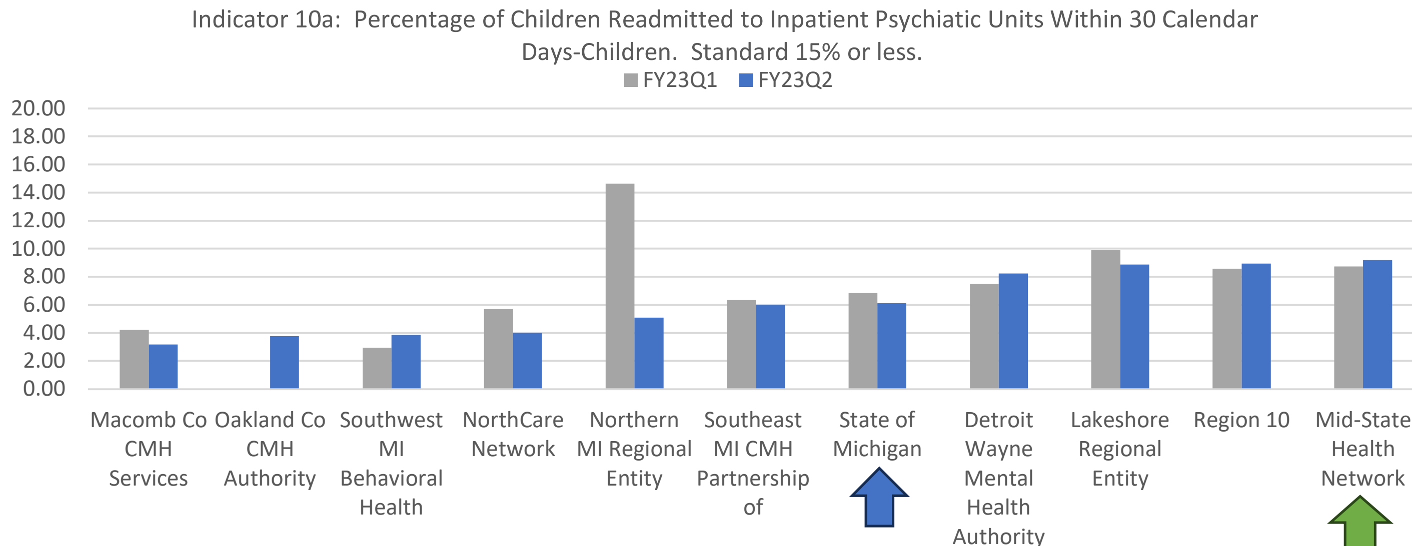


Figure 7a: PIHP Comparison Data for Outcome Indicator 10



MSHN had the highest number (185) of reported child admissions for psychiatric inpatient units in the State of Michigan. Seventeen of those admissions were readmitted within 30 days.

Figure 7b: PIHP Comparison Data for Outcome Indicator 10