MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM, VERSION 6.0

Note: Indicators that can be constructed from encounter or quality improvement data or cost reports are marked with an *.

ACCESS DOMAIN
Definition of Access: the ease with which care can be initiated and maintained
Indicators:

1. The percent of children and adults 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 percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.

    a. Standard = 95% in 14 days
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.

    a. Standard = 95% in 14 days
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

4.a. 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

Scope: All children and all adults (MI, DD) - Do not include dual eligible (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

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

6. The percent of face-to-face assessment with professionals that result in decisions to deny CMHSP services.

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

7. The percent of Section 705 second opinions that result in services.

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

ADEQUACY/APPROPRIATENESS DOMAIN

Definition of adequacy: the provision of the right services, in the right amounts, for the right duration of time, given the current state of knowledge
Indicators:

8. *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 other than supports coordination.

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

EFFICIENCY DOMAIN

Definition of efficiency: the level of outcome achieved for a given level of resource expenditure, perhaps adjusted for case mix and severity
Indicators:

9. *The percent of total expenditures spent on managed care administrative functions for CMHSP and PIHPs.

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

OUTCOMES DOMAIN

Definition of outcomes: changes in a consumer's current or future health status, level of functioning, quality of life, or satisfaction that can be attributed to the care provided.

Indicators:

10. *The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSPs and PIHPs who are in competitive employment.

    a. Annual report (MDCH calculates from QI data)
    b. PIHP for Medicaid adult beneficiaries
    c. CMHSP for all adults
    d. Scope: MI and DD consumers

11. *The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSPs and PIHPs who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop).

    a. Annual report (MDCH calculates from QI data)
    b. PIHP for Medicaid adult beneficiaries
    c. CMHSP for all adults
    d. Scope: MI and DD consumers

12. The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.

    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 eligible (Medicare/Medicaid) in these counts.

13. The annual number of substantiated recipient rights complaints per thousand persons 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

14. The semi-annual number of sentinel events per thousand Medicaid beneficiaries served (MI adults, MI children, persons with DD, HSW enrollees, Children's Waiver enrollees, and SA).

    a. Semi-annual report
    b. PIHP for Medicaid beneficiaries
    c. CMHSP for Children's Waiver beneficiaries
    d. Scope: MI, DD and SA children and adults

15. The number of suicides per thousand persons served (MI, DD).
    a. Annual report
    b. CMHSP
    c. Scope: MI and DD children and adults

Attachment B

FY 2011 MCOSA Utilization Management Goals

1. Monitor Financial Process

a. Monitor treatment and prevention utilization and year-to-date expenditures so funds and services are available throughout the fiscal year

b. Continue to monitor and timely address as needed, year-to-date budget information internally and with providers to ensure funds are not under utilized where services are in demand

2. Improve Analysis of Service Utilization

a. Expand use of reporting software to analyze key data elements

b. Identify any underserved populations and high risk/high service utilization clients to more deliberately target care management services

c. Continue to monitor Performance Indicator measures and AMS follow up data to ensure timely and effective use of services

3. Improve Care Management

a. Review existing case management services to ensure efficient and effective use of this service area

b. Identify opportunities for improvements that will enhance continuity and coordination of care between treatment providers when individuals are changing treatment levels

c. Identify reasons for ineffective coordination of care with medical and other care providers to improve best practice standards

d. Implement procedure to provide programs with performance measures feedback