MICHIGAN'S MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0

PIHP Reporting Codebooks

December 2013

Codebook Version 12/18/13

Michigan Department of Community Health
Mental Health & Substance Abuse Administration

FOR PIHPs

NOTE: Consumers covered by Medicaid autism benefit are to be excluded from the calculations.

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 percent of new Medicaid beneficiaries receiving a face-to-face meeting 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

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. 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 (MDCH 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. (Old Indicator #8)

a. Quarterly report (MDCH 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. (Old Indicator #9)

a. Annual report (MDCH 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 (MDCH calculates from QI 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 (MDCH calculates from QI 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 (Old Indicator #12)

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. (Old Indicator #13)

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

Note: Indicators #2, 3, 4 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 (MDCH calculates from QI 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 (MDCH calculates from QI data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

FY 2014 Due Dates

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

*Indicators with *: MDCH collects data from encounters, quality improvement 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 MDCH 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. Medicaid

Count as Medicaid eligible any person who qualified as a Medicaid beneficiary during at least one month of the reporting period. 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 the affiliation. The PIHPs, therefore, will submit two reports: One, as a CMHSP for all its consumers, and one as the PIHP for all its Medicaid beneficiaries.

5. Substance abuse beneficiaries

Indicators #2, 3, and 4 include persons receiving Medicaid substance abuse services managed by the PIHP (this is not applicable to CMHSPs). Managed by the PIHP includes substance abuse services subcontracted to CAs, as well as any substance abuse services that the PIHP may deliver directly or may subcontract directly with a substance abuse provider. Consumers who have co-occurring mental illness and substance use disorders may be counted by the PIHP as either MI or SA. However, please count them only once. **Do not add the same consumer to the count in both the MI and SA categories.**

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 & PIHP)

Indicator #2

The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service (by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders). Standard = 95%

Rationale for Use

Quick, convenient entry into the public mental health system is a critical aspect of accessibility of services. Delays in clinical and psychological assessment may lead to exacerbation of symptoms and distress and poorer role functioning. The amount of time between a request for service and clinical assessment with a professional is one measure of access to care.

Table 2 – Indicator #2

1. Population	2. # of New Persons Receiving an Initial Non-Emergent Professional Assessment Following a First Request	3. # of New Persons from Col 2 who are Exceptions	4. # Net of New Persons Receiving an Initial Assessment (Col 2 minus Col 3)	5. # of Persons from Col 4 Receiving an Initial Assessment within 14 calendar days of First Request	6. % of Persons Receiving an Initial Assessment within 14 calendar days of First Request
1. MI - C	H2	I2	J2 - Calculated	K2	AF2 - Calculated
2. MI - A	L2	M2	N2 - Calculated	O2	AG2 - Calculated
3. DD - C	P2	Q2	R2 - Calculated	S2	AH2 - Calculated
4. DD - A	T2	U2	V2 - Calculated	W2	AI2 - Calculated
5. SA	X2	Y2	Z2 - Calculated	AA2	AJ2 - Calculated
6. TOTAL	AB2	AC2	AD2 - Calculated	AE2	AK2 - Calculated

Column 2- Selection Methodology

1. Cases selected for inclusion in Column 2 are those for which a **face-to-face** assessment with a professional resulting in a decision whether to provide on-going CMHSP/PIHP services took place during the time period.

2. Non-emergent assessment and services do not include pre-admission screening for, and receipt of, psychiatric in-patient care; nor crisis contacts that did not result in an assessment. Consumers who come in with a crisis, and are stabilized are counted as "new" for indicator #2 when they subsequently request a non-emergent assessment.
3. Persons with co-occurring disorders should only be counted once, in either the MI or SA row.
4. “New person:” Individual who has never received services at the CMHSP/PIHP or whose last date of service (regardless of service) was 90 or more days before the assessment, or whose case was closed 90 or more days before the assessment. As noted above in item 2, consumers who come in with a crisis, and are stabilized are counted as "new" for indicator #2 when they subsequently request a non-emergent assessment.
5. A “professional assessment” is that face-to-face assessment or evaluation with a professional designed to result in a decision whether to provide ongoing CMHSP service.
6. Consumers covered under OBRA should be excluded from the count.

Column 3- Exception Methodology

Enter the number of consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period.

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

Column 4 – Calculation of Denominator

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

Column 5 – Numerator Methodology

1. Cases selected for inclusion in Column 5 are those in Column 4 for which the assessment took place in 14 calendar days.
2. “First request” is the initial telephone or walk-in request for non-emergent services by the individual, parent of minor child, legal guardian, or referral source that results in the scheduling of a face-to-face assessment with a professional.
3. Count backward to the date of first request, even if it spans a quarter. If the assessment required several sessions in order to be completed, use the first date of assessment for this calculation.
4. For consumers in the Recovery Oriented Systems of Care model which delays assessment in accordance with the consumer’s level of readiness, count backward from the first day of the initial orientation/welcoming session that is conducted in advance of the assessment to the date of the initial request (by phone or walk-in).
5. “Reschedules” because consumer cancelled or no-shows who reschedule: count the date of request for reschedule as "first request."

ACCESS-TIMELINESS/FIRST SERVICE (CMHSP & PIHP)

Indicator #3
Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional ((by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders). Standard = 95% within 14 days

Rationale for Use
The amount of time between 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.

Table 3 - Indicator #3

1. Population	2. # of New Persons Who Started Face-to-Face Service During the Period	3. # of New Persons From Col 2 Who are Exceptions	4. # Net of Persons who Started Service (Col 2 minus Col 3)	5. # of Persons From Col 4 Who Started a Face-to-Face Service Within 14 Days of a Face-to-Face Assessment with a Professional	6. % of Persons Who Started Service within 14 days of Assessment
1. MI-C	AL2	AM2	AN2 – Calculated	AO2	BJ2 -Calculated
2. MI-A	AP2	AQ2	AR2 – Calculated	AS2	BK2 - Calculated
3. DD -C	AT2	AU2	AV2 – Calculated	AW2	BL2 - Calculated
4. DD-A	AX2	AY2	AZ2 – Calculated	BA2	BM2 - Calculated
5. SA	BB2	BC2	BD2 – Calculated	BE2	BN2 - Calculated
6. TOTAL	BF2	BG2	BH2 - Calculated	BI2	BO2 - Calculated

Column 2 - Selection Methodology

1. Cases selected for inclusion are those for which the start of a non-emergent service (other than the initial assessment – see below) took place during the time period.
2. Do not include pre-admission screening for, and receipt of, psychiatric in-patient care or crisis contacts that did not result in a non-emergent assessment.

3. Persons with co-occurring disorders should only be counted once, in either the MI or SA row.
4. Consumers covered under OBRA should be excluded from the count.

Column 3 – Exception Methodology

Enter in column 3 the number of individuals counted in column 2 but for specific reasons described below* should be excluded from the indicator calculations.
*Consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period, or do not show for an appointment or reschedule it.
*Consumers for whom the intent of service was medication only or respite only and the date of service exceeded the 14 calendar days. May also exclude environmental modifications where the completion of a project exceeds 14 calendar days. It is expected, however, that minimally a request for bids/quotes has been issued within 14 calendar days of the assessment. Lastly, exclude instances where consumer is enrolled in school and is unable to take advantage of services for several months.

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

Column 4 – Calculation of Denominator

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

Column 5 – Numerator Methodology

1. Cases selected for inclusion in Column 5 are those in Column 4 for which a service was received within 14 calendar days of the professional face-to-face assessment.
2. "Service" means <u>any</u> face-to-face CMHSP service. For purposes of this data collection, the initial face-to-face assessment session or any continuous assessment sessions needed to reach a decision on whether to provide ongoing CMHSP services shall not be considered the start of service.
3. Count backward from the date of service to the first date of assessment, even if it spans a quarter, in order to calculate the number of calendar days to the assessment with the professional. If the initial assessment required several sessions in order to be completed, use the first date of assessment in this calculation.
4. For consumers in the Recovery Oriented Systems of Care model which delays assessment in accordance with the consumer's level of readiness, count backward from the first day of the initial treatment session to the first day of the initial orientation/welcoming session.

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	**BP2**	**BQ2**	**BR2 - Calculated**	**BS2**	**BX2 - Calculated**
2. # of Adults	**BT2**	**BU2**	**BV2 - Calculated**	**BW2**	**BY2 - 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	BZ2	CA2	CB2- Calculated	CC2	CD2 - 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
MDCH 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 (Old Indicator #8)
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
MDCH 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 (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

MDCH 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, 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

MDCH 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 (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

MDCH 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 (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	CE2	CF2	CG2 - Calculated	CH2	CM2 - Calculated
2. # of Adults	CI2	CJ2	CK2 - Calculated	CL2	CN2 - 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:

PIHP Annual Recipient Rights Report Codebook

Period:	**10/01/13-9/30/14**
Due:	**December 31, 2014**

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 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**	