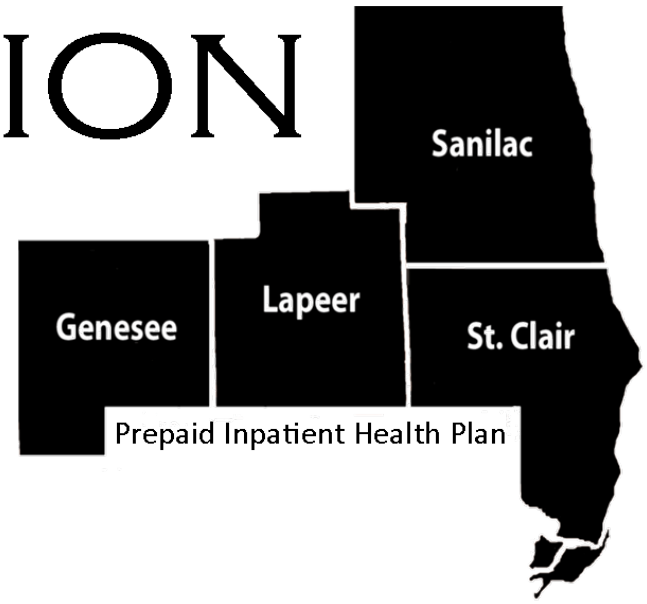
Region 10



Michigan Mission-Based Performance Indicator System

January - March
FY 2024 – 2ND Quarter

Region 10 PIHP
Michigan Mission-Based Performance Indicator System

FY2024 – 2nd Quarter Summary Report

(January 1, 2024 – March 31, 2024)

This report is a summary of the performance indicators reported to the Michigan Department of Health and Human Services (MDHHS) by the PIHP (data aggregated from CMH / SUD providers). The Michigan Mission-Based Performance Indicator System (MMBPIS) was implemented in fiscal year 1997. The indicators have been revised over time.

The indicators measure the performance of the PIHP for Medicaid beneficiaries served through the CMH/SUD affiliates. Since the indicators are a measure of performance, deviations from standards and negative statistical outliers may be addressed through contract action. Information from these indicators will be published on the MDHHS website within 90 days of the close of the reporting period.

This report summarizes the PIHP's results from the second quarter of fiscal year 2024 as well as trending information for the past three years of Performance Indicator data.

Performance Indicator 1

Indicator 1.a. The percentage of children receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *The standard is 95%.*

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	100%	99.39%	100%	99.50%	100%	99.09%	100%	100%	99.31%	100%	98.48%	100%
Lapeer CMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sanilac CMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
St. Clair CMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PIHP Totals	**100% N = 342**	**99.64% N = 279**	**100% N = 335**	**99.73% N = 377**	**100% N = 380**	**99.57% N = 234**	**100% N = 295**	**100% N = 354**	**99.67% N = 300**	**100% N = 249**	**99.29% N = 280**	**100% N=296**

Indicator 1.b. The percentage of adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *The standard is 95%.*

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	99.85%	99.69%	100%	100%	99.45%	99.81%	99.59%	99.81%	99.63%	99.82%	97.72%	99.64%
Lapeer CMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sanilac CMH	100%	100%	100%	100%	98.41%	100%	100%	100%	100%	100%	100%	100%
St. Clair CMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PIHP Totals	**99.91% N = 1080**	**99.81% N = 1029**	**100% N = 758**	**100% N = 853**	**99.57% N = 928**	**99.89% N = 901**	**99.77% N = 877**	**99.89% N = 937**	**99.78% N = 908**	**99.89% N = 945**	**98.57% N = 908**	**99.77% N=876**

Performance Indicator 2

Indicator 2. The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 57.0% and the 75th percentile standard is 62.0%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	59.19%	62.94%	61.41%	51.46%	35.76%	39.29%	45.09%	43.08%	44.02%	48.38%	**43.76%** (519/1,186)	**37.65%** (456/1,211)
Lapeer CMH	66.16%	50.50%	40.41%	63.14%	75.61%	74.40%	76.02%	58.57%	62.11%	67.58%	68.11%	68.09%
Sanilac CMH	69.47%	73.98%	68.91%	75.89%	71.09%	73.76%	77.42%	71.07%	70.55%	73.39%	71.52%	70.06%
St. Clair CMH	79.90%	68.40%	58.94%	52.45%	47.56%	62.96%	59.47%	65.79%	66.86%	62.31%	**45.37%** (323/712)	**43.79%** (342/781)
PIHP Totals	**67.50% N = 1326**	**63.98% N = 1613**	**58.64% N = 1644**	**54.88% N=2008**	**46.86% N = 1818**	**54.25% N = 1849**	**54.99% N = 2086**	**53.80% N = 2463**	**54.23% N = 2327**	**56.34% N = 2176**	**48.76% N = 2303**	**45.55% N=2463**

Indicator 2.a.

The percentage of new children with emotional disturbance receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 57.0% and the 75th percentile standard is 62.0%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	58.44%	65.06%	60.68%	47.95%	34.80%	37.66%	43.54%	42.00%	39.94%	47.29%	**41.64%** (157/377)	**34.64%** (133/384)
Lapeer CMH	89.47%	74.36%	64.18%	46.99%	85.71%	76.00%	77.46%	44.12%	37.50%	77.42%	65.33%	62.92%
Sanilac CMH	70.00%	78.38%	80.95%	83.87%	78.85%	79.59%	82.05%	84.00%	76.32%	76.67%	74.51%	83.02%
St. Clair CMH	83.18%	70.00%	72.57%	62.38%	47.26%	75.17%	68.97%	73.59%	71.20%	63.24%	**47.57%** (98/206)	**41.09%** (83/202)
PIHP Totals	**72.13% N = 348**	**69.11% N = 382**	**66.80% N = 518**	**56.97% N = 574**	**50.80% N = 502**	**57.62% N = 479**	**58.48% N = 607**	**54.74% N = 749**	**50.69% N = 649**	**57.58% N = 554**	**48.24% N = 709**	**43.41% N=728**

Indicator 2.b.

The percentage of new adults with mental illness receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 57.0% and the 75th percentile standard is 62.0%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	56.46%	56.67%	58.62%	47.84%	33.03%	40.94%	44.98%	42.29%	43.38%	47.04%	**43.88%** (276/629)	**41.59%** (267/642)
Lapeer CMH	54.70%	41.04%	26.13%	74.42%	66.67%	73.53%	74.22%	69.33%	71.43%	62.41%	70.00%	71.27%
Sanilac CMH	69.81%	75.00%	59.38%	66.15%	67.69%	69.44%	75.32%	62.89%	65.98%	69.62%	67.90%	64.44%
St. Clair CMH	78.54%	64.29%	51.24%	46.94%	46.94%	59.28%	56.06%	61.70%	65.21%	60.49%	**46.50%** (199/428)	**45.58%** (232/509)
PIHP Totals	**64.66% N = 764**	**58.34% N = 941**	**51.83% N = 874**	**51.73% N = 1096**	**44.46% N = 1001**	**54.39% N = 1048**	**53.64% N = 1208**	**53.35% N = 1372**	**55.19% N = 1321**	**54.86% N = 1276**	**49.46% N = 1298**	**48.24% N=1422**

Indicator 2.c.

The percentage of new children with developmental disabilities receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*. PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 57.0% and the 75th percentile standard is 62.0%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	66.36%	73.94%	68.61%	65.64%	46.58%	37.33%	45.24%	46.58%	50.93%	51.05%	**47.14%** (66/140)	**29.38%** (47/160)
Lapeer CMH	92.31%	78.57%	100%	38.46%	83.33%	78.57%	75.00%	26.32%	60.00%	70.00%	60.00%	63.64%
Sanilac CMH	70.00%	62.50%	77.78%	85.71%	66.67%	72.73%	66.67%	83.33%	90.00%	83.33%	78.57%	80.00%
St. Clair CMH	71.88%	80.00%	58.70%	59.09%	48.28%	66.10%	53.70%	64.62%	66.67%	72.31%	**30.19%** (16/53)	**30.95%** (13/42)
PIHP Totals	**69.70% N = 165**	**75.00% N = 204**	**67.68% N = 198**	**63.71% N = 259**	**48.48% N = 231**	**48.72% N = 234**	**50.00% N = 198**	**50.60% N = 251**	**55.32% N = 282**	**57.56% N = 271**	**45.95% N = 222**	**35.04% N=234**

Indicator 2.d.

The percentage of new adults with developmental disabilities receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*. PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 57.0% and the 75th percentile standard is 62.0%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	72.22%	85.29%	73.68%	47.06%	24.14%	38.46%	60.61%	52.38%	55.56%	64.10%	**50.00%** (20/40)	**36.00%** (9/25)
Lapeer CMH	36.36%	46.67%	0%	81.82%	90.91%	71.43%	90.00%	57.14%	84.62%	83.33%	75.00%	66.67%
Sanilac CMH	50.00%	50.00%	75.00%	85.71%	40.00%	77.78%	100%	83.33%	100%	88.89%	80.00%	**50.00%** (7/14)
St. Clair CMH	94.44%	87.10%	63.64%	44.44%	53.85%	48.48%	50.00%	72.41%	64.00%	61.90%	**40.00%** (10/25)	**50.00%** (14/28)
PIHP Totals	**71.43% N = 49**	**76.74% N = 86**	**57.41% N = 54**	**54.43% N = 79**	**47.62% N = 84**	**48.86% N = 88**	**61.64% N = 73**	**61.54% N = 91**	**64.00% N = 75**	**68.00% N = 75**	**50.00% N = 74**	**48.10% N=79**

Performance Indicator 2e

Indicator 2.e. The percentage of new persons 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. **This indicator is calculated by MDHHS**. *If the MDHHS calculation is not yet received, Region 10 PIHP will provide an estimated rate. PIHPs and SUD Treatment Providers are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 68.2% and the 75th percentile standard is 75.3%.

	PIHP (Medicaid only through 2Q FY20)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Region 10 PIHP SUD	69.09%	68.48%	66.52%	66.87%	64.54%	69.22%	72.21%	73.26%	74.00%	78.17%	**74.15%** (1446/1950)	**74.59%** (1350/1810)
PIHP Totals	**69.09% N = 1983**	**68.48% N = 2132**	**66.52% N = 2004**	**66.87% N = 2107**	**64.54% N = 2214**	**69.22% N = 2255**	**72.21% N = 2076**	**73.26% N = 1907**	**74.00% N = 1808**	**78.17% N = 1887**	**74.15% N = 1950**	**74.59% N = 1810**

Performance Indicator 3

Indicator 3

The percent of new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 72.9% and the 75th percentile standard is 83.8%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	99.57%	98.91%	99.83%	99.84%	99.70%	98.90%	98.31%	97.86%	98.82%	97.41%	96.40%	97.18%
Lapeer CMH	75.89%	56.92%	48.78%	50.94%	58.27%	77.22%	67.82%	57.69%	55.14%	70.86%	**70.85%** (158/223)	**56.43%** (136/241)
Sanilac CMH	76.56%	81.25%	79.73%	76.54%	73.53%	77.65%	66.67%	78.79%	71.13%	80.61%	**75.94%** (101/133)	**80.00%** (112/140)
St. Clair CMH	82.04%	79.79%	93.41%	76.75%	71.84%	74.70%	67.28%	72.26%	68.99%	67.05%	**59.93%** (362/604)	**67.63%** (376/556)
PIHP Totals	**88.98% N = 1007**	**86.45% N = 1144**	**91.25% N = 1211**	**84.79% N = 1341**	**84.14% N = 1349**	**86.26% N = 1383**	**80.30% N = 1411**	**81.97% N = 1520**	**81.62% N = 1621**	**82.32% N = 1431**	**78.01% N = 1655**	**78.56% N=1539**

Indicator 3.a.

The percentage of new children with emotional disturbance starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 72.9% and the 75th percentile standard is 83.8%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	99.16%	98.43%	99.49%	100%	100%	98.18%	98.31%	99.49%	98.66%	94.71%	98.64%	99.48%
Lapeer CMH	80.00%	73.33%	77.14%	81.40%	77.08%	79.49%	57.14%	34.21%	37.50%	72.97%	**64.29%** (45/70)	**60.29%** (41/68)
Sanilac CMH	77.27%	90.48%	90.00%	78.57%	80.00%	85.71%	71.79%	80.00%	72.41%	86.36%	**69.77%** (30/43)	87.76%
St. Clair CMH	84.88%	88.78%	94.87%	80.77%	81.54%	76.38%	67.40%	76.54%	71.52%	74.82%	**61.88%** (112/181)	**74.32%** (110/148)
PIHP Totals	**89.89% N = 267**	**91.67% N = 276**	**95.19% N = 416**	**88.27% N = 375**	**89.82% N = 393**	**87.47% N = 359**	**78.59% N = 453**	**83.37% N = 445**	**80.38% N = 474**	**84.51% N = 368**	**78.64% N = 515**	**84.25% N=457**

Indicator 3.b.

The percent of new adults with mental illness starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 72.9% and the 75th percentile standard is 83.8%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	100%	99.64%	100%	99.67%	99.68%	98.71%	99.03%	96.65%	98.58%	97.88%	93.70%	95.51%
Lapeer CMH	71.25%	48.72%	36.11%	36.89%	42.86%	75.96%	72.45%	61.48%	60.58%	70.41%	**72.39%** (97/134)	**56.25%** (81/144)
Sanilac CMH	81.25%	78.00%	71.88%	75.56%	65.71%	72.09%	60.71%	78.33%	71.43%	78.46%	**80.00%** (56/70)	76.71%
St. Clair CMH	81.91%	75.77%	94.61%	72.15%	68.48%	72.09%	66.67%	69.37%	66.86%	62.86%	**57.76%** (201/348)	**67.98%** (242/356)
PIHP Totals	**87.90% N = 537**	**83.07% N = 632**	**88.60% N = 579**	**79.25% N = 689**	**79.43% N = 700**	**83.51% N = 758**	**80.16% N = 756**	**79.48% N = 843**	**79.37% N = 858**	**79.33% N = 808**	**75.58% N = 901**	**76.50% N=885**

Indicator 3.c.

The percent of new children with developmental disabilities starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 72.9% and the 75th percentile standard is 83.8%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	99.02%	97.41%	100%	100%	99.28%	100%	95.00%	98.99%	99.39%	99.22%	100%	98.78%
Lapeer CMH	84.62%	75.00%	66.67%	100%	80.00%	81.82%	70.00%	54.55%	69.23%	80.00%	93.75%	**45.00%** (9/20)
Sanilac CMH	55.56%	80.00%	62.50%	75.00%	83.33%	70.00%	100%	80.00%	66.67%	100%	85.71%	**62.50%** (5/8)
St. Clair CMH	75.00%	69.70%	79.41%	84.62%	69.57%	79.25%	72.34%	75.71%	79.49%	69.64%	**62.00%** (31/50)	**37.04%** (10/27)
PIHP Totals	**90.38% N = 156**	**89.76% N = 166**	**92.73% N = 165**	**96.79% N = 218**	**91.28% N = 195**	**91.96% N = 199**	**85.52% N = 141**	**88.41% N = 164**	**92.86% N = 224**	**90.05% N = 201**	**87.71% N = 179**	**76.64% N=137**

Indicator 3.d.

The percent of new adults with developmental disabilities starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. *PIHPs and CMHs are expected to meet and exceed the MDHHS-established standard percentiles, effective Fiscal Year 2024 Quarter 1.*

The 50th percentile standard is 72.9% and the 75th percentile standard is 83.8%.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	100%	100%	100%	100%	100%	100%	100%	96.67%	100%	100%	100%	93.75%
Lapeer CMH	87.50%	50.00%	30.00%	37.50%	77.78%	75.00%	80.00%	100%	75.00%	50.00%	**33.33%** (1/3)	**55.56%** (5/9)
Sanilac CMH	100%	75.00%	100%	75.00%	100%	100%	66.67%	75.00%	66.67%	60.00%	**50.00%** (3/6)	**80.00%** (8/10)
St. Clair CMH	82.35%	92.86%	93.75%	83.33%	64.52%	88.00%	63.64%	73.91%	65.22%	73.33%	**72.00%** (18/25)	**56.00%** (14/25)
PIHP Totals	**91.49% N = 47**	**88.57% N = 70**	**84.31% N = 51**	**83.05% N = 59**	**78.69% N = 61**	**94.03% N = 67**	**81.97% N = 61**	**88.24% N = 68**	**81.54% N = 65**	**83.33% N = 54**	**80.00% N = 60**	**70.00% N=60**

Performance Indicator 4

Indicator 4.a.1. The percentage of children discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days. ***95% is the standard.***

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	97.06%	100%	95.24%	95.00%	96.55%	100%	100%	100%	**94.64%** (53/56)	95.56%	**91.11%** (41/45)	98.18%
Lapeer CMH	100%	100%	100%	100%	100%	100%	**88.89%** (8/9)	100%	100%	100%	100%	100%
Sanilac CMH	100%	100%	100%	100%	100%	**83.33%** (5/6)	100%	100%	**88.89%** (8/9)	100%	100%	100%
St. Clair CMH	100%	**94.12%** (16/17)	**94.12%** (16/17)	100%	100%	100%	**93.33%** (14/15)	100%	95.00%	**86.67%** (13/15)	**87.50%** (14/16)	95.65%
PIHP Totals	**98.70% N = 77**	**98.39% N = 62**	**95.77% N = 71**	**97.30% N = 74**	**97.73% N = 88**	**98.53% N = 68**	**97.30% N = 74**	**100% N = 77**	**94.57% N = 92**	**94.37% N = 71**	**91.43% N = 70**	**97.75% N=89**

Indicator 4.a.2. The percentage of adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days. ***95% is the standard.***

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	96.10%	98.51%	98.54%	97.90%	97.19%	95.60%	**92.02%** (150/163)	**93.51%** (173/185)	96.99%	97.87%	**92.99%** (199/214)	**93.91%** (185/197)
Lapeer CMH	**87.88%** (29/33)	**70.83%** (17/24)	**62.86%** (22/35)	95.65%	100%	100%	95.83%	100%	100%	100%	100%	**94.12%** (16/17)
Sanilac CMH	100%	100%	**88.89%** (8/9)	100%	100%	100%	100%	100%	100%	100%	100%	100%
St. Clair CMH	97.22%	99.00%	96.88%	**90.67%** (68/75)	97.70%	**93.90%** (77/82)	98.59%	96.47%	96.59%	96.83%	**91.94%** (57/62)	96.30%
PIHP Totals	**95.75% N = 353**	**96.69% N = 332**	**92.65% N = 245**	**95.67% N = 254**	**97.75% N = 311**	**95.71% N = 280**	**94.64% N = 280**	**95.21% N = 313**	**97.21% N = 287**	**97.94% N = 291**	**93.61% N = 313**	**94.82% N=309**

Indicator 4.b. The percentage of discharges from a substance use disorder detox unit who are seen for follow-up care within seven days. ***95% is the standard.***

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Region 10 PIHP SUD	**74.16%** (66/89)	95.31%	**91.49%** (43/47)	**85.71%** (60/70)	98.46%	**90.67%** (68/75)	**94.95%** (94/99)	**91.01%** (81/89)	95.60%	**94.74%** (72/76)	96.10%	**91.14%** (72/79)
PIHP Totals	**74.16% N = 89**	**95.31% N = 64**	**91.49% N = 47**	**85.71% N = 70**	**98.46% N = 65**	**90.67% N = 75**	**94.95% N = 99**	**91.01% N = 89**	**95.60% N = 91**	**94.74% N = 76**	**96.10% N = 77**	**91.14% N=79**

Performance Indicator 5

Indicator 5. The percentage of area Medicaid recipients having received PIHP Managed services. **This indicator is calculated by MDHHS.**

	PIHP (Medicaid only)											
	3Q FY21	4Q FY21	1Q FY22	2Q FY22	3Q FY22	4Q FY22	1Q FY23	2Q FY23	3Q FY23	4Q FY23	1Q FY24	2Q FY24
Total Medicaid Beneficiaries Served	15,735	15,808	15,649	16,384	16,834	16,797	16,957	17,536	17,948	17,626	17,417	17,639
Number of Area Medicaid Recipients	227,887	231,717	235,056	238,625	242,291	245,445	248,589	251,434	253,895	256,464	242,289	229,322
PIHP Totals	**6.90%**	**6.82%**	**6.66%**	**6.87%**	**6.95%**	**6.84%**	**6.82%**	**6.97%**	**7.07%**	**6.87%**	**7.19%**	**7.69%**

Performance Indicator 6

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. **This indicator is calculated by MDHHS.**

	PIHP (Medicaid only)											
	3Q FY21	4Q FY21	1Q FY22	2Q FY22	3Q FY22	4Q FY22	1Q FY23	2Q FY23	3Q FY23	4Q FY23	1Q FY24	2Q FY24
Number of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	610	603	566	569	572	574	560	562	555	538	516	501
Total Number of HSW Enrollees	620	633	625	608	603	603	580	579	568	553	531	510
PIHP Totals	**98.39%**	**95.26%**	**90.56%**	**93.59%**	**94.86%**	**95.19%**	**96.55%**	**97.06%**	**97.71%**	**97.29%**	**97.18%**	**98.24%**

Performance Indicator 8

Indicator 8.a. The percent of adults with mental illness served by the CMHSPs and PIHPs that are employed competitively. The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees who are competitively employed	Competitive employment rate
Region 10 PIHP	**10630**	**2182**	**20.50%**

Indicator 8.b. The percent of adults with developmental disabilities served by the CMHSPs and PIHPs that are employed competitively. The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees who are competitively employed	Competitive employment rate
Region 10 PIHP	**1577**	**106**	**6.70%**

Indicator 8.c. The percent of adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs that are employed competitively. The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees who are competitively employed	Competitive employment rate
Region 10 PIHP	**1347**	**131**	**9.70%**

Performance Indicator 9

Indicator 9.a. The percent of adults with mental illness served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities (competitive, supported or self-employment, or sheltered workshop). The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees who earned minimum wage or more	Competitive employment rate
Region 10 PIHP	**2200**	**2185**	**99.30%**

Indicator 9.b. The percent of adults with developmental disabilities, served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities (competitive, supported or self-employment, or sheltered workshop). The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees who earned minimum wage or more	Competitive employment rate
Region 10 PIHP	**195**	**123**	**63.10%**

Indicator 9.c. The percent of adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities (competitive, supported or self-employment, or sheltered workshop). The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees who earned minimum wage or more	Competitive employment rate
Region 10 PIHP	**179**	**141**	**78.80%**

Performance Indicator 10

Indicator 10.a. The percentage of children readmitted to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit.
15% or less within 30 days is the standard.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	4.35%	4.08%	13.11%	1.92%	9.20%	6.25%	6.35%	7.69%	7.53%	12.99%	6.49%	10.11%
Lapeer CMH	10.00%	12.50%	0%	0%	13.64%	14.29%	**15.38%** (2/13)	10.00%	10.00%	0.00%	0.00%	0.00%
Sanilac CMH	**25.00%** (1/4)	14.29%	14.29%	**23.08%** (3/13)	0%	0.00%	9.09%	9.09%	9.09%	**25.00%** (3/12)	0.00%	14.29%
St. Clair CMH	12.90%	8.70%	5.26%	5.88%	10.00%	**23.08%** (3/13)	11.11%	11.54%	4.17%	**20.00%** (4/20)	5.26%	4.00%
PIHP Totals	**8.79% N = 91**	**6.90% N = 87**	**10.53% N = 95**	**5.26% N = 95**	**9.45% N = 127**	**8.51% N = 94**	**8.57% N = 105**	**8.93% N = 112**	**7.25% N = 138**	**14.78% N = 115**	**5.45% N = 110**	**8.80% N=125**

Indicator 10.b. The percentage of adults readmitted to inpatient psychiatric units within 30 calendar days of discharge from a psychiatric inpatient unit.
15% or less within 30 days is the standard.

	PIHP (Medicaid only)											
	3Q FY21	**4Q FY21**	**1Q FY22**	**2Q FY22**	**3Q FY22**	**4Q FY22**	**1Q FY23**	**2Q FY23**	**3Q FY23**	**4Q FY23**	**1Q FY24**	**2Q FY24**
Genesee Health System	11.55%	10.58%	8.30%	9.51%	9.61%	7.79%	8.07%	12.43%	14.04%	13.67%	14.67%	13.55%
Lapeer CMH	**16.67%** (7/42)	8.82%	**17.65%** (9/51)	6.25%	10.20%	**20.00%** (8/40)	2.63%	5.13%	6.25%	10.87%	12.50%	0.00%
Sanilac CMH	8.33%	8.33%	0%	13.33%	9.52%	0.00%	**17.39%** (4/23)	11.54%	0.00%	12.50%	5.26%	0.00%
St. Clair CMH	**15.09%** (16/106)	14.79%	11.11%	**17.43%** (19/109)	10.00%	9.02%	**17.60%** (22/125)	11.38%	9.92%	10.20%	12.09%	12.04%
PIHP Totals	**12.44% N = 579**	**11.45% N = 585**	**9.86% N = 416**	**11.46% N = 419**	**9.75% N = 523**	**8.87% N = 485**	**10.62% N = 471**	**11.60% N = 526**	**12.01% N = 533**	**12.79% N = 555**	**13.77% N = 559**	**12.02% N=549**

Performance Indicator 13

Indicator 13.a The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees with a developmental disability who live in a private residence alone, with spouse or non-relatives	Private residence rate
Region 10 PIHP	**1577**	**245**	**15.54%**

Indicator 13.b The percent of adults dually diagnosed with mental illness/developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees dually diagnosed with mental illness/developmental disabilities who live in a private residence alone, with spouse or non-relatives	Private residence rate
Region 10 PIHP	**1347**	**328**	**24.35%**

Performance Indicator 14

Indicator 14. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). The numbers below are calculations by MDHHS. This represents the total for FY2023.

Population	Total # of Enrollees	# of Enrollees with serious mental illness who live alone, with spouse or non-relative	Private residence rate
Region 10 PIHP	**10630**	**4651**	**43.75%**

NARRATIVE OF RESULTS

The following PIHP Performance Indicators for Medicaid consumers have performance standards that have been set by the Michigan Department of Health and Human Services.

Performance Indicator #1 states: "*The percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours."* ***The set performance standard is 95%.*** All CMHs met the standard for this indicator.

Performance Indicator #2 states: "*The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service."* ***The set performance standards are 57.0% and 62.0%.*** The total CMH compliance rates ranged from 37.65% - 70.06%. Two CMHs met and exceeded the performance standards for this indicator.

Performance Indicator #2e states*: "The percentage of new persons 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."* ***The set performance standards are 68.2% and 75.3%.*** The SUD network had a compliance rate of 74.59%.

Performance Indicator #3 states, *"The percent of new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment."* ***The set performance standards are 72.9% and 83.8%.*** The total CMH compliance rates ranged from 56.43% - 97.18%. One CMH met and exceeded the performance standards for this indicator.

Performance Indicator #4 states, *"The percentage of persons discharged from a psychiatric inpatient unit (or SUD Detox Unit) who are seen for follow-up care within seven days."* ***The set performance standard is 95%.*** Two CMHs met the standard for this indicator for the adult population breakout. All CMHs met the standard for the child population breakout.

Performance Indicator #10 states, *"The percentage of persons readmitted to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit."* ***The set performance standard is 15% or less.*** All CMHs met the standard for this indicator for both the child and adult population breakouts.

When a CMH reports that the MDHHS standard for a performance indicator has not been achieved during a quarter, a root cause analysis and plan of correction are submitted to Region 10 PIHP along with the respective CMH data. The analysis is reviewed, and the plan of improvement is monitored over time by the PIHP along with the trend of scores on all the performance indicators.

If a set standard benchmark is not achieved for the region, the indicator is investigated further by various committees within the QAPIP structure such as Quality Improvement Committee, Quality Management Committee, and Improving Practices Leadership Team to increase input from CMH partners, identify contributing factors and systemic issues for the outliers, and review opportunities for improvement across the region.

SUMMARIES OF ROOT CAUSE ANALYSES AND PLANS OF CORRECTION/IMPROVEMENT

Genesee Health System (GHS)

PI #2 – Assessment within 14 days of request

Root cause analysis revealed out of 1,209 individuals, 754 were non-compliant. Of the 754 non-compliant, 364 individuals were under the age of 21. Of the 364 individuals not seen within 14 days, 226 individuals/guardians were given walk-in information and did not present for intake. Other reasons for non-compliance included individuals/guardians cancelled or did not show for scheduled intake, individuals completed the biopsychosocial assessment outside of the 14-day window, individuals reported needs were resolved or chose not to follow up with GHS services, individuals reported unwillingness or inability to wait for intake at the time they presented as walk-ins, and individuals not completing the intake for various specified situations/reasons.

Of the 754 non-compliant, 390 individuals were over the age of 21. Of the 390 individuals not seen within 14 days, 279 were given walk-in information and did not present for intake. Other reasons for non-compliance included individuals cancelled or did not show for scheduled intake, individuals completed the biopsychosocial assessment outside of the 14-day window, individuals presented as walk-in but electing to not wait for next available intake spot, and individuals indicated engagement in other services or not interested due to other personal reasons. Additionally, one individual was informed there were no additional available spots that day.

The following plan was submitted by GHS: Regarding walk-in intake process system improvement efforts, the GHS Intake Department has implemented a monitoring system to identify baseline of wait times in intake processes. Baseline data will be received with analysis beginning by September 2024. This baseline data will inform efforts to minimize wait times for consumers.

A vast majority of non-compliance remains due to individual choice, and in many cases the reasons for this are unknown as the individual does not respond to outreach and/or is otherwise not available for feedback. GHS Quality Management is evaluating any potential interventions that could be beneficial in increasing engagement in intake and ongoing services. Intake continues to do considerable outreach in these cases.

PI #3 – Ongoing service within 14 days of assessment

Root cause analysis revealed all populations except for adults with developmental disabilities exceeded 95% performance due to one event. Root cause analysis indicated there was a delay due to County of Financial Responsibility (COFR) concerns and negotiating authorizations with the COFR County.

The following plan was submitted by GHS: This was a single case concern, so remediation is currently individual in nature and no systemic improvement opportunities were noted. GHS Intake conducted discussions internally related to intake, Certified Community Behavioral Health Clinic (CCBHC), and COFR guidelines. GHS Intake is improving in early identification of CCBHC-eligible consumers. Intake is also creating a plan for timelier follow-up with COFR counties related to ongoing authorizations for services for their consumers in the event communication is not returned in a timely fashion and will have processes refined and operationalized by the third quarter.

PI #4 – Follow-up service within seven days of discharge

Root cause analysis revealed the adult population fell below the 95% threshold this quarter, with 13 out of 185 cases out of compliance. In five of these cases, the individual was stepped down to Partial Hospitalization Program (PHP) and did attend at least one or more days of this service as follow-up. However, in these five cases, non-compliance was noted as there were no billing/claims from the PHP to reflect this. In analyzing the other cases where non-compliance occurred, lack of communication from hospitals to set appointments or to communicate appointments with ongoing treatment providers was a significant factor. GHS Utilization Management (UM) will provide remediation education regarding the need for scheduling appropriate aftercare appointments with hospital providers. Related to last quarter's follow-up, in the analysis of systems potentially contributing to last quarter's non-compliance, inconsistencies in procedures related to timely authorization request, billing and claims were evident.

The following plan was submitted by GHS: GHS UM Lead coordinated with McLaren Flint regarding interventions to increase pre-authorization of high-end services and decrease post-inpatient episode retroactive authorization requests. This education and monitoring led to a significant (94%) decrease in retroactive requests, with most inpatient admissions preauthorized at the start of service with continued stay reviews throughout the episode of care. Coordination regarding this initiative occurred on multiple dates. Additionally, coordination has occurred regarding McLaren's billing timeliness of authorized services, and ongoing communication is established regarding this, as McLaren billing timeliness concerns were connected to 68% of non-compliant cases last quarter and 38% of non-compliant cases this quarter. GHS UM is working with the PHP to identify and correct any billing systems issues.

Lapeer CMH

PI #2 – Assessment within 14 days of request

As an update to the plan of improvement prepared for the first quarter of FY2024, Lapeer CMH reports individuals can continue to utilize Lapeer CMH's walk-in intake process for their initial appointment. At screening, Access staff will continue to ask individual when they would like to come in for their initial appointment so Lapeer CMH staff can enter into the intake calendar. If the appointment scheduled is not the same day as the request call, the individual will receive a reminder call the day prior to the scheduled appointment. In the event of a no-show or cancelled appointment, Lapeer CMH staff will do an outreach call that same day and another outreach call the following week, in an attempt to get appointment re-scheduled within 14-day timeframe. Lapeer CMH will continue with outreach following the 14-day timeframe with an outreach letter the next week and finally an Adverse Benefit Determination (ABD) letter the week after that if no contact has been made.

PI #3 – Ongoing service within 14 days of assessment

As an update to the plan of improvement prepared for the first quarter of FY2024, Lapeer CMH implemented new process of Initial service being authorized at intake and has been connecting persons with the department that will be providing those services following the completion of their intake to improve engagement in services and addressing immediate needs.

PI #4 – Follow-up service within seven days of discharge

Root cause analysis revealed the consumer was scheduled for an appointment but did not show.

The following plan was submitted by Lapeer CMH: Case holders will continue to document their efforts to schedule post hospital appointments within the required timeframe. Case holders will continue to provide available hospital discharge appointments on their calendar.

Sanilac CMH

PI #2 – First service within 14 days of request

Root cause analysis shows the total percentage decreased from 71.52% to 70.06%. As an update to the plan of improvement prepared for the first quarter of FY2024, Sanilac CMH is still committed to ensuring individuals are receiving the correct service within the specified timeframes. Sanilac CMH is still providing appointment reminders and encouraging individuals to make it to their assigned appointment day.

PI #3 – Ongoing service within 14 days of assessment

Sanilac CMH found the total percentage increased from 75.94% to 80% compliance. This places this indicator in between the 50th – 75th percentile range. As an update to the plan of improvement prepared for the first quarter of FY2024, Sanilac CMH is still committed to ensuring individuals are receiving the correct service within the specified timeframes. Sanilac CMH is still providing appointment reminders and encouraging individuals to make it to their assigned appointment day.

St. Clair CMH

PI #2 – First service within 14 days of request

Root cause analysis reveals that 439 individuals did not receive an assessment within 14 days for various reasons. Reasons for non-compliance included individuals cancelled or did not show for scheduled intake, individuals seen outside of the 14-day window days (with an average of 17 days), individuals declined appointments within the 14 days or chose not to get services, individuals rescheduled appointments, and appointments canceled/rescheduled by staff. In cases where contact information was provided, outreach was attempted. Some contact information was found to be inaccurate. Some follow-up efforts required multiple outreaches to individuals until they were seen.

The following plan was submitted by St. Clair CMH: The CMH Performance Indicator Team will analyze non-compliant cases to find strategies to reduce the number of cancelled or missed appointments and ensure a greater percentage of appointments are offered and completed within 14 days. St. Clair CMH will continue collaborating with the Performance indicator Team, Intake Team, and Region 10 Supervisors. The Performance Indicator Team Supervisor will review any cases that are flagged by the Performance Indicator Review Team to ensure corrective action can be taken as quickly as possible.

Additionally, all cases that were seen more than 14 days after screening will be reviewed individually, with steps taken to address the main reasons they were not seen earlier. Specifically, cases in which an individual did not show up or rescheduled will be reviewed to indicate what dates were offered to the individual. Special focus will be on the cases in which an offered initial appointment exceeded the 14-day compliance window. During the process of reviewing cases within each category, St. Clair CMH will evaluate and prioritize the efforts that will be most attainable in the shortest period of time in order to more immediately address issues that are a barrier to individuals seeking services. These efforts and their effects will be further monitored and detailed in future quarterly updates. St. Clair CMH is in the process of developing a procedure.

PI #3 – Ongoing service within 14 days of assessment

Root cause analysis reveals 180 individuals did not receive a follow up service within 14 days of assessment for various reasons. Reasons for non-compliance included individuals cancelled or did not show for scheduled appointment, individuals seen outside of the 14-day window days (with an average of 21 days), individuals declined appointments within the 14 days or chose not to get services, individuals rescheduled appointments, and appointments canceled/rescheduled by staff.

In cases where contact information was provided, outreach was attempted. In certain programs there were consistent issues with not having available appointments within 14 days or failing to contact the consumer or offer appointments in a timely manner. Outreach attempts via phone or in person were not consistent across all programs.

The following plan was submitted by St. Clair CMH: The CMH Performance Indicator Team will non-compliant cases to find strategies to reduce the number of cancelled and/or missed appointments and ensure a greater percentage of appointments are offered and completed within 14d.

The CMH Performance Indicator Team Supervisor reached out to program supervisors to address any identified issues with offering appointments, lack of availability, or efforts at outreach.

All cases that were seen more than 14 days after the biopsychosocial assessment will be reviewed individually, with steps taken to address the main reasons they were not seen earlier. Specifically, cases in which an individual did not show up or rescheduled will be reviewed to indicate what dates were offered to the individual. Special focus will be on the cases in which an offered follow-up appointment exceeded the 14-day compliance window. During the process of reviewing cases within each category, St. Clair CMH will evaluate and prioritize the efforts that will be most attainable in the shortest period of time in order to more immediately address issues that are a barrier to individuals seeking follow up services. These efforts and their effects will be further monitored and detailed in future quarterly updates. St. Clair CMH is in the process of developing a procedure.

Region 10 SUD System

PI #2 – First service within 14 days of request

There were individuals not seen for their first service within 14 days of the original request. Outreach to 14 SUD Providers will occur with coordination between the PIHP Performance Indicator Team and Provider Network Management Team.

The SUD Providers with one or more cases out of compliance are expected to submit root cause analyses and plans of improvement. SUD Providers will analyze reasons for noncompliance for PI #2 then submit a plan to the PIHP to report on the evaluated and prioritized reasons for non-compliant events. The plan shall indicate how the Provider will improve individuals' access to care and services.

PI #4 – Follow-up service within seven days of discharge

Further review revealed seven individuals were not seen for follow-up care within seven days of discharge from a detox unit. Outreach to two SUD Providers missing the follow-up care standard will occur with coordination between the PIHP Performance Indicator Team and Provider Network Management Team.

The SUD Providers not meeting the set performance standard are expected to submit Root Cause Analyses and Plans of Correction. To address systemic issues, the PIHP will review SUD Provider discharge processes, Root Cause Analyses, and Plans of Correction.

Additional oversight and follow-up regarding corrective action items will occur through the contract monitoring process.