

**Genesee County CMH  
Performance indicators  
Year end report FY 2009**

CMH / PIHP performance measures

In Fiscal 2009, Genesee County CMH continued to achieve high levels of performance on the Michigan Department of Community Health (MDCH) performance measures. Tables 1 and 2 provide details of CMHSP and PIHP performance trends over the past several years. The CMHSP section contains information about all CMH consumers. The PIHP section provides information on Medicaid consumers, including those served by the Substance Abuse Coordinating Agency (SACA). Figures 1 through 4b present program-level detail for several of the indicators.

Performance on most indicators has been excellent through the year, continuing a pattern seen starting in FY 2007. The only indicator GCCMH failed to meet was timeliness to the start of ongoing services for children with SED, in the third quarter. Failure mode analysis indicated some difficulties arising from the interaction of an increased number of cases with management and process changes in the Access Center. These were corrected, as the fourth quarter data show.

While not out of compliance with MDCH requirements, the network continues to experience high rates of inpatient recidivism. After substantial declines during FY 2007, the rate climbed again in FY 2008 and remained high in FY 2009. Adult recidivism, while generally compliant with MDCH's 15% standard, has frequently been very close to 15%. The PIHP's formal Performance Improvement Project to address crisis and inpatient utilization and recidivism has not yet had the desired effect. A new workgroup, with broad representation and a mandate to create change has been formed, and is reviewing all crisis management processes. Changes are already in place that we expect to impact inpatient admissions and recidivism.

In addition to MMBPIS, three indicators are reported that were developed by GCCMH, all related to the utilization of crisis care. Measurement of crisis services is highly salient because crisis services denote times of high clinical risk, high cost of care, extreme personal discomfort for consumers, and possible failure of services to meet consumers' needs.

The first measurement, crisis recidivism, is analogous to inpatient recidivism. Many consumers in crisis receive services other than inpatient care. In Genesee's network, these services include partial hospitalization, crisis residential care, and crisis stabilization. Along with the hospital, we conceptualize these as the "crisis continuum." A consumer in crisis may use one or more of the services before leaving the crisis continuum. Once he/she has left, however, the crisis should be resolved or deescalated to the point where ongoing services can manage it. Crisis recidivism is defined, then, as the percentage of cases leaving all crisis care who return to any crisis service within 30 days.

Two additional measures of crisis services are inpatient utilization and other crisis service utilization. Crisis utilization is reported as the mean number of consumer-days of crisis care per consumer-month enrolled in the program.

One major change has occurred in the PIHP's management of performance information. Beginning in FY 2010 (and therefore, including some of the currently-presented data), the newly-convened PIHP's Performance Improvement Committee reviews performance findings, and makes recommendations for PIHP action.

### Substance Abuse performance measures

The PIHP performance indicators include measures for consumers served in the Substance Abuse Coordinating Agency (SACA). Unfortunately, the data system currently in use in the SACA does not provide for accurate individual program measurement of performance. This is corrected with the introduction of the new PIHP-wide CHIP data system in Fiscal 2010. Future SACA performance reports will include provider-level data.

### Clinical outcomes

Measurement and evaluation of clinical outcomes is complex in the CMH setting. Many of the illnesses our consumers experience are chronic and episodic in nature. Additionally, traditional outcome measures do not capture elements of recovery, daily functioning, and community integration very well.

That said, there is some value to monitoring clinical outcomes with standardized measures. Table 3 presents outcomes findings for consumers discharged in Fiscal 2009. In short, there is strong evidence that, for younger and older children, services lead to substantial improvements in functioning. When services are completed as opposed to terminated early, they are more effective.

Clinical measure scores are not significantly improved at discharge for adults receiving CMH services. There are several potential reasons. First, adults in the CMH system typically have very long length of stay – the *average* length of stay in the current episode of services for adults in the outcomes data presented here is over 4 ½ years. Thus, the first available score does not always reflect the consumer's functioning at the start of services.

Second, because CMH services for adults last so long, no discharge information is available for large numbers of consumers who are still in service. It may well be that those who leave services earlier are more likely to have experienced less gain than those who continue, biasing the results. The situation is somewhat different for adults than for children, because adults with severe functional impairments often require long-term assistance that parents provide for children with severe impairments – for example, community living supports.

Finally, it is noted that the service mix for adults contains less active therapy than for children, with a heavy orientation toward case management and supports coordination. The populations for which outcomes are reported exacerbate this trend: The CAFAS is required for all children

because of MDCH requirements, but no other outcome measure is used for adults in lower levels of care, such as medication-only. Thus, adults transitioning to lower levels of care and then leaving the system are not captured in these data.

Changes certainly can be made to the outcomes measurement system to address these issues. Also, there may be measures available that are more sensitive to the changes we wish to detect. The PIHP has been exploring alternative outcome measures for adults for some time. However, MDCH has expressed the intention to mandate a measure for adults, so at this point we are reluctant to invest infrastructure and staff time and effort in a change, only to have a second change implemented by requirement. Thus, we continue to use the current measure – the Multnomah Community Ability Scale – while awaiting developments, and recognizing the limitations of the available data.

#### Program-specific findings

The remainder of this document consists of charts of program-specific findings for the indicators noted above. Program-level findings have been made available to all providers and PIHP departments. The final chart depicts the CMHSP's and the PIHP's progress in improving performance since Fiscal 2005. Since 2005 the proportion of performance standards met has improved from around 30% to 100% in most quarters.

Table 1: CMHSP performance since Fiscal Year 2006

		FY 2006				FY 2007				FY 2008				FY 2009			
Indicator group	Population	2005 Q1	2005 Q2	2005 Q3	2005 Q4	2006 Q1	2006 Q2	2006 Q3	2006 Q4	2007 Q1	2007 Q2	2007 Q3	2007 Q4	2008 Q1	2008 Q2	2008 Q3	2008 Q4
Indicator 1. % of crisis screenings with disposition within 3 hours	Children	99%	100%	99%	98%	98%	100%	99%	100%	97%	100%	99%	100%	99%	100%	100%	100%
	Adults	95%	99%	99%	98%	97%	99%	100%	99%	97%	99%	99%	100%	100%	100%	100%	98%
Indicator 2. % with initial assessment within 14 days of first request	MI children	97%	98%	98%	100%	98%	100%	100%	97%	97%	100%	100%	99%	100%	97%	100%	100%
	MI adults	100%	99%	98%	99%	99%	100%	100%	98%	97%	98%	98%	97%	97%	98%	98%	98%
	DD children	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	DD adults	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Overall	99%	99%	98%	99%	99%	100%	100%	98%	97%	98%	99%	97%	97%	98%	99%	98%
Indicator 3. % starting ongoing services within 14 days of initial assessment	MI children	74%	79%	98%	100%	100%	96%	100%	99%	99%	98%	98%	99%	98%	100%	93%	97%
	MI adults	89%	90%	90%	96%	99%	97%	99%	100%	84%	98%	95%	95%	96%	99%	97%	99%
	DD children	85%	90%	92%	90%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	####
	DD adults	90%	95%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Overall	85%	88%	92%	96%	99%	98%	100%	100%	89%	98%	96%	96%	97%	99%	96%	99%
Indicator 4a: % with inpatient discharge follow-up within 7 days	Children	76%	91%	96%	92%	97%	96%	97%	100%	96%	100%	96%	100%	100%	100%	100%	96%
	Adults	81%	88%	91%	90%	95%	97%	97%	95%	96%	96%	99%	100%	96%	98%	100%	96%
Indicator 12. Inpatient readmission rate	Children	18%	9%	19%	23%	21%	22%	14%	8%	3%	11%	16%	16%	11%	13%	8%	13%
	Adults	10%	17%	13%	18%	13%	9%	14%	13%	12%	11%	9%	10%	10%	10%	10%	13%
Overall	% of standards met	29%	50%	56%	69%	63%	94%	94%	100%	100%	88%	100%	94%	94%	100%	100%	94%

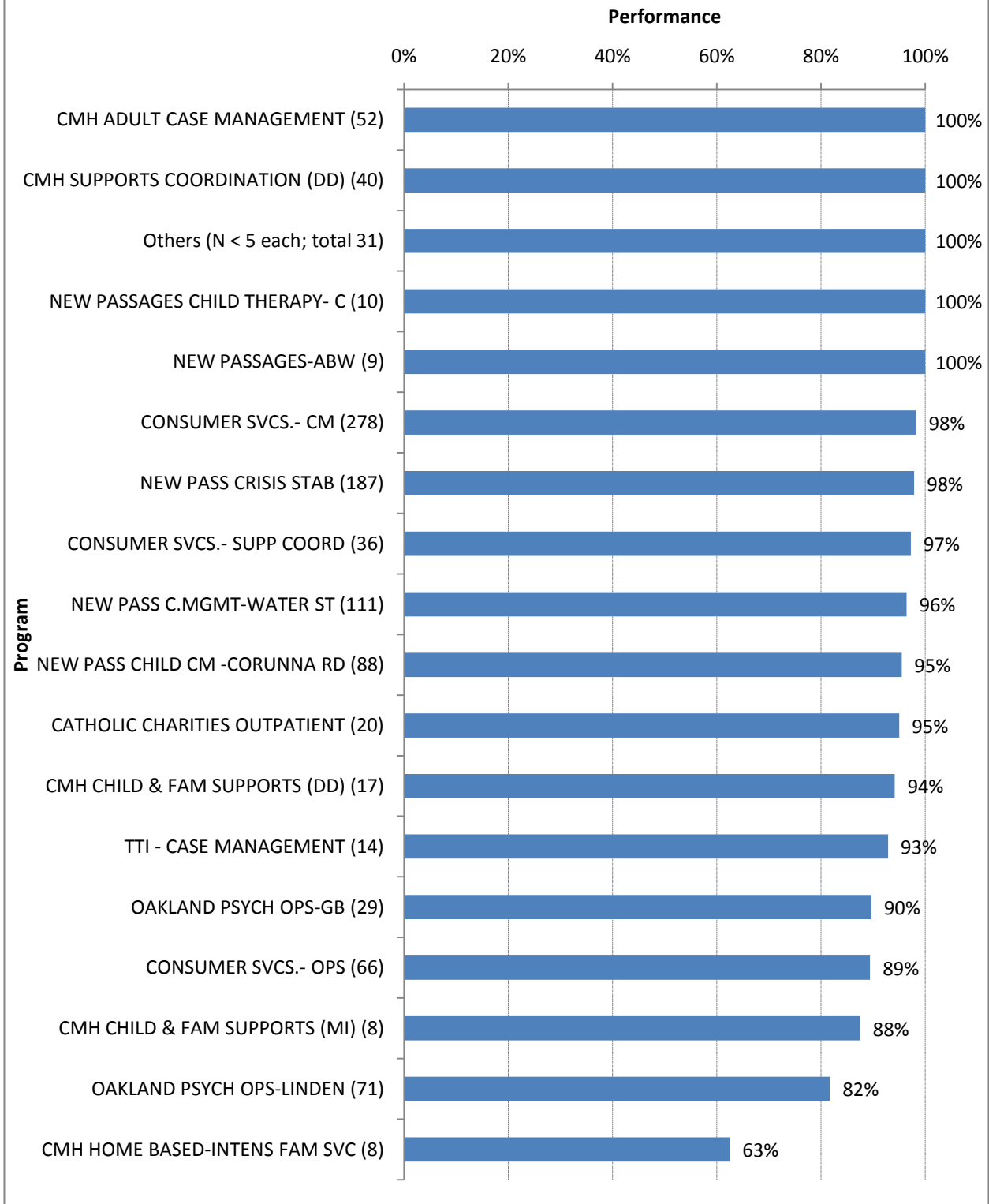
Table 2: PIHP performance since Fiscal Year 2006

		FY 2006				FY 2007				FY 2008				FY 2009			
Indicator group	Population	2006 Q1	2006 Q2	2008 Q1	2008 Q2	2008 Q3	2008 Q4	2006 Q3	2006 Q4	2007 Q1	2007 Q2	2007 Q3	2007 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4
Indicator 1. % of crisis screenings with disposition within 3 hours	Children	98%	100%	98%	99%	99%	100%	99%	98%	98%	100%	100%	100%	99%	100%	100%	98%
	Adults	96%	99%	97%	99%	99%	99%	99%	98%	97%	99%	99%	99%	100%	100%	100%	99%
Indicator 2. % with initial assessment within 14 days of first request	MI children	96%	97%	96%	100%	100%	96%	100%	100%	98%	100%	100%	98%	100%	97%	100%	100%
	MI adults	99%	98%	95.3%	100%	99%	98%	96%	97%	99%	100%	100%	99%	99%	100%	99%	100%
	DD children	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A
	DD adults	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SUD	100%	100%	99%	98%	99%	98%	97%	99%	100%	99%	99%	99%	98%	99%	99%	99%
	Overall	99%	99%	97%	99%	99%	98%	97%	98%	99%	99%	100%	99%	99%	99%	99%	100%
Indicator 3. Timeliness to ongoing services	MI children	77%	80%	100%	97%	98%	100%	97%	100%	100%	97%	100%	100%	98%	100%	92%	96%
	MI adults	87%	87%	96%	99%	98%	97%	91%	98%	98%	100%	100%	100%	96%	99%	97%	99%
	DD children	90%	88%	100%	100%	100%	100%	100%	94%	94%	100%	100%	100%	100%	100%	100%	N/A
	DD adults	86%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SUD	92%	88%	96%	85%	95%	97%	97%	95%	95%	98%	96%	95%	98%	99%	98%	100%
	Overall	88%	87%	97%	94.5%	97%	98%	96%	96%	97%	99%	98%	98%	97%	99.5%	96%	99%
Indicator 4a./b Inpatient / detox discharge follow-up	Children	83%	90%	96%	100%	96%	100%	96%	78%	97%	96%	100%	100%	100%	100%	100%	98%
	Adults	88%	87%	97%	100%	98%	100%	96%	86%	95%	97%	100%	97%	98%	98%	97%	98%
	SUD	92%	93%	100%	97%	97%	97%	100%	100%	100%	100%	100%	100%	100%	100%	98%	98%
Indicator 12. Inpatient readmission rates	Children	19%	10%	3%	9%	14%	18%	20%	23%	24%	22%	14%	9%	11%	12%	7%	14%
	Adults	11%	15%	12%	14%	10%	10%	7%	16%	12%	7%	14%	14%	9%	9%	5%	11%
Overall	% standards met	47%	53%	100%	89%	100%	95%	89%	74%	89%	95%	100%	100%	100%	100%	95%	100%

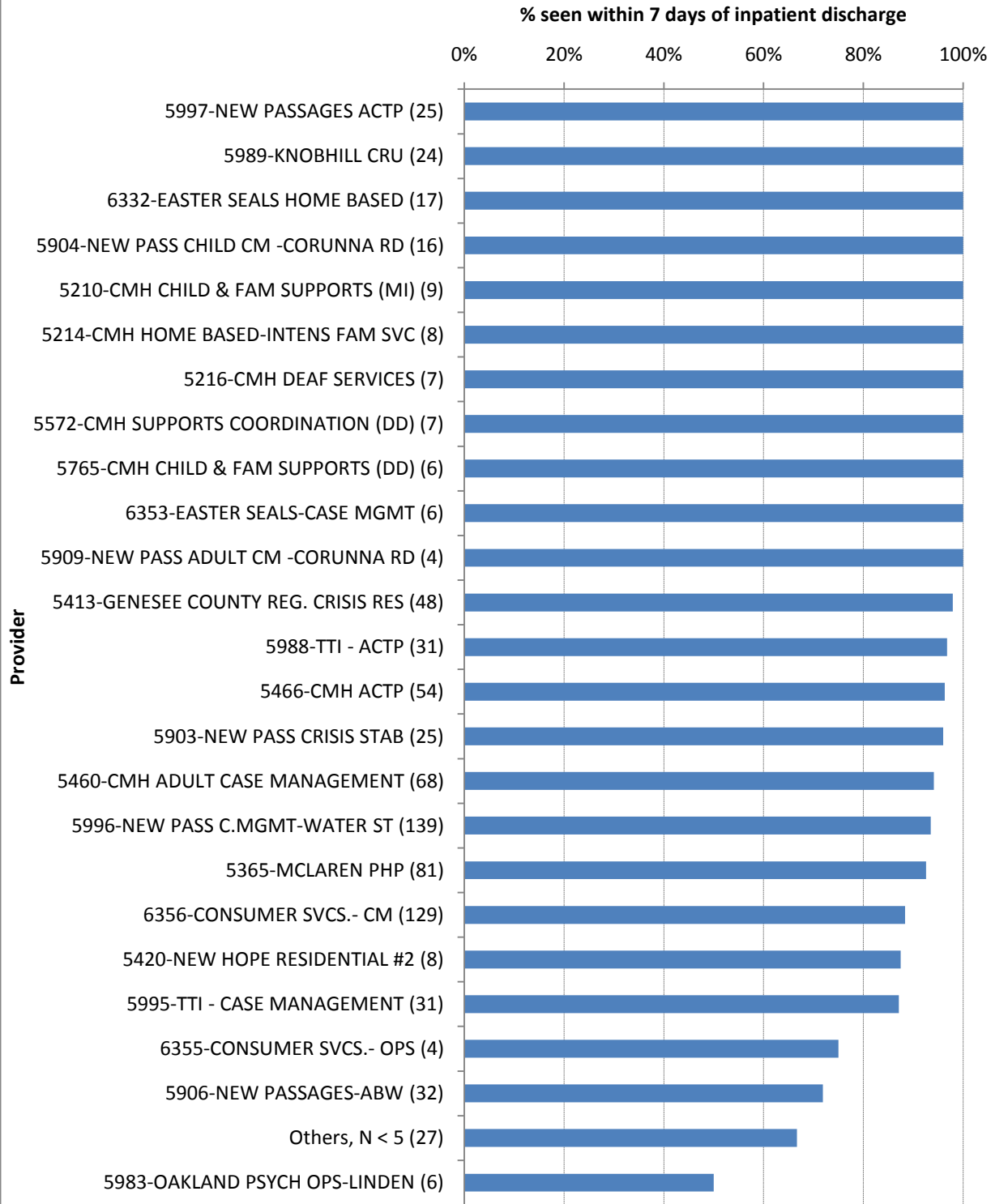
**Table 3: Clinical outcome findings**

<b>Measure</b>	<b>Description</b>	<b>Findings</b>
CGAS and PIR-GAS	100-point clinician-completed scale of younger child (CGAS) and infant-parent (PIR-GAS) functioning. Used only for case management and higher levels of care.	For consumers who completed services (N=17), a significant improvement in score, averaging 16 points. Those who left early (N=7) also improved significantly (11 points on average). 70% of children completing services demonstrated clinically relevant improvement in functioning. 43% of children leaving services early showed improvement.
CAFAS	Clinician-completed scale of functioning for all 7-17 year olds	Those completing services (N=15) improved by an enormous 72 points on this 180 point scale, with 93% of children showing some significant improvement. Among those leaving services early (N=66), average improvement of 13 points was still significant.
Multnomah Community Ability Scale (MCAS)	Clinician-completed scale of functioning. Used for adults with MI and DD receiving case management and higher level of care.	Little evidence of change from initial to final MCAS (N=259). There were not significant differences based on reason for discharge or on whether consumers had MI or DD.

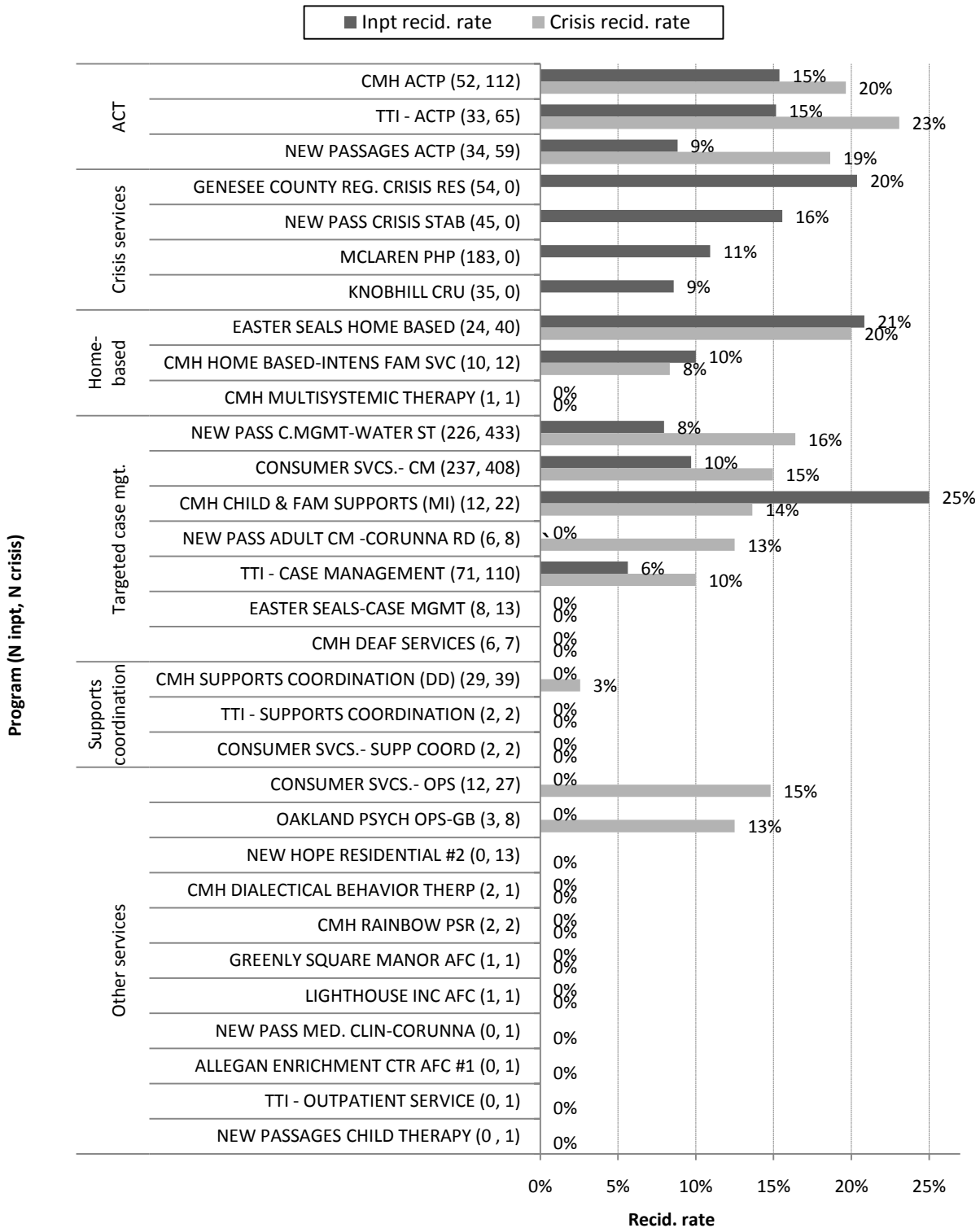
**Figure 1: % of cases starting ongoing services within 14 days: FY 2009**



**Figure 2: Inpatient follow-up performance FY 2009**

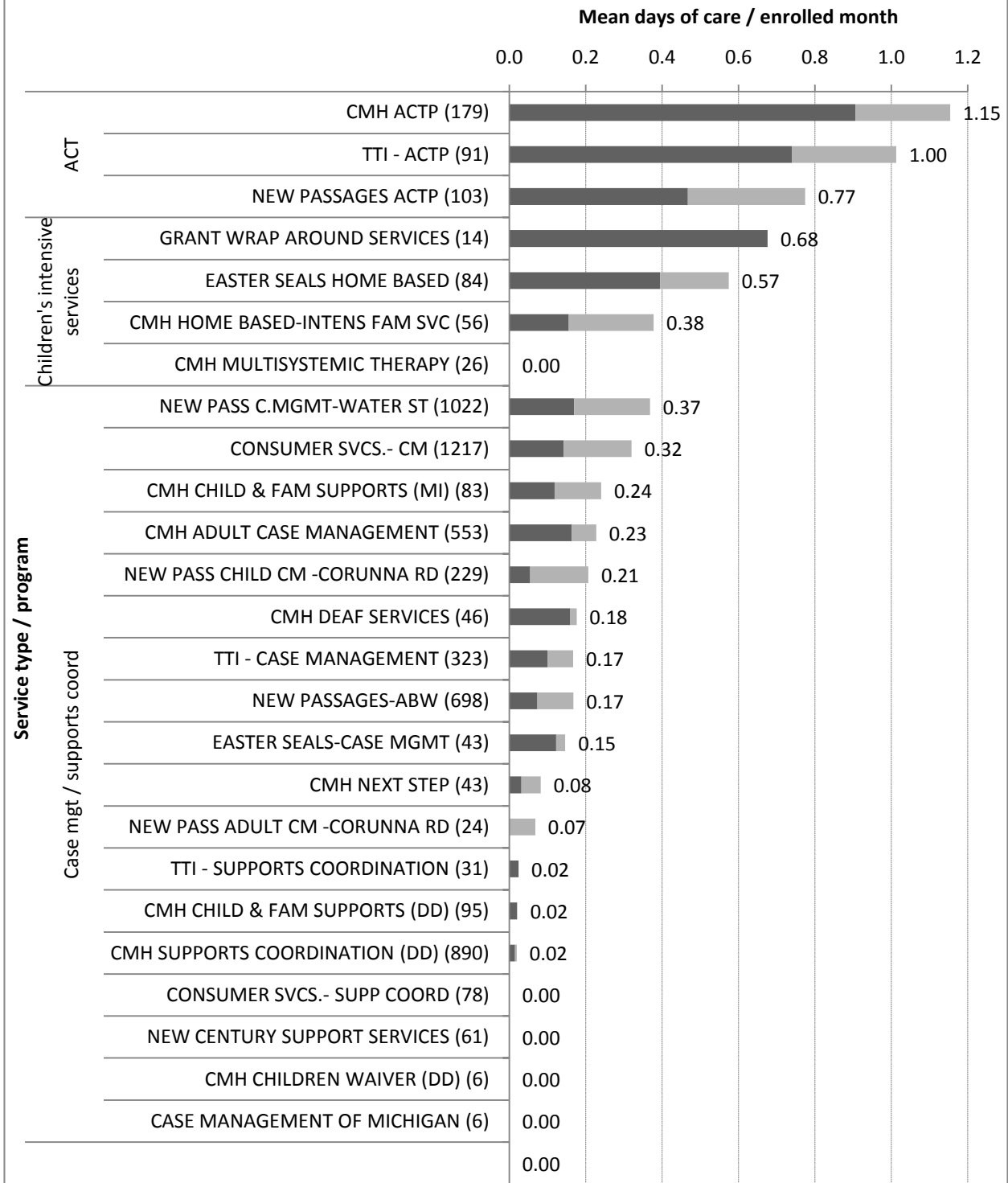


**Figure 3: Inpatient and crisis recidivism FY 2009**



**Figure 4a: Inpatient and crisis utilization FY 2009:  
Higher level of care providers**

■ Mean inpt days per month    ■ Mean non-inpt crisis days per month  
Numbers represent total crisis utilization: inpatient + non-inpatient



**Figure 4b: Inpatient and crisis utilization FY 2009:  
Lower level of care providers**

