Healthy Louisiana
Performance Improvement Project (PIP)

Health Plan: Aetna Better Health of Louisiana

PIP Title: Behavioral Health Transitions in Care

PIP Implementation Period: January 1, 2022–December 31, 2022

Submission Dates:

	Report Year 2022
Version 1	3/1/2022
Version 2	12/30/2022

MCO Contact Information

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[Person responsible for completing this report and who can be contacted for questions]

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Attestation

Plan Name: Aetna Better Health of Louisiana - ABHLA
Title of Project (PIP): Behavioral Health Transitions in Care

The undersigned approve this performance improvement project (PIP) and assure involvement in the PIP throughout the course of the project.

Medical Director signature: Madelyn M. Meyn, MD
First and last name: Madelyn M. Meyn, MD
Date: December 30, 2022

CEO signature: Richard C Born
First and last name: Richard C. Born
Date: December 30, 2022

Quality Director signature: Arlene Pangan-Loots
First and last name: Arlene Pangan-Loots
Date: December 30, 2022

IS Director signature (if applicable): _____
First and last name:
Date:

Updates to the PIP

For Interim and Final Reports Only: Report all changes in methodology and/or data collection from initial proposal submission in the table below.
[Examples include: added new interventions, added a new survey, change in indicator definition or data collection, deviated from HEDIS® specifications, reduced sample size(s)]

Table 1a: Updates to PIP

Change	Date of Change	Area of Change	Brief Description of Change
Implementation 1 Specifically, consider contacting higher volume hospitals with the lowest disproportionate index scores such as OLOL, Brentwood, Cypress Grove, and Children's to determine the processes working better with highest volume/lowest index hospitals (better performing) and spread those successes to lower performing higher volume hospitals (with higher index scores).	Not Applicable	☒ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	Compare High performing FUH providers to lower performing ones and find the 'practices' that are different and help improve those hospitals to better perform for enrollees.
Change 2 Denominators for ITMs in sections 1 and 2	2/1/2022	☐ Methodology ☐ Barrier Analysis ☐ Intervention ☒ ITMs	All had 'exclusions' removed so that we could track and review ALL incidents (ITMs have this noted) as the process related to the metric should not have exclusions
Change 3 ITM 2e was changed to FUM only in the denominator	Q3 2022	☐ Methodology ☐ Barrier Analysis ☐ Intervention ☒ ITM	FUA was removed from the original LDH defined metric due to HIPAA 2.0 restrictions of SUD diagnoses
Change 4		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	

Abstract

For Final Report submission only. Do not exceed 1 page.

Project Topic/Rational: Behavioral Health (BH) Transitions in Care PIP is to improve both 7- and 30-day HEDIS metrics for FUA/FUM and FUH in Louisiana. The rationale was that 2021 rates show opportunities for improvement.

Objectives: 1) Enhance hospital-to-MCO workflow for notification of hospital and emergency department admissions, discharges and transfers; 2) Link members to aftercare with BH providers prior to discharge from hospital or emergency department for members enrolled in case management and for members not enrolled in case management; 3) Identify and address needs of sub-populations by stratifying data by member race/ethnicity, member region of residence, gender, high-utilizers, SMI diagnosis, co-occurring disorders, age, and if available LGBTQ; and 4) Initiate a broader intervention to facilitate follow-up with members with an appropriate mental health provider (per NCQA Appendix 3) e.g., text messaging, letter to member and member's PCP with list of follow-up providers in member's location). (Please note a complete list of Objectives is below)

Methodology: The performance indicators will follow the HEDIS Specifications 2020, Volume 2. We analyze results in workgroups with key leaders and PIP committee enrollees, comparing target goals and conducting various work sessions. ABHLA may use Quality Improvement process items from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABHLA regularly conducts evaluations using both quantitative and qualitative (when applicable) methods. All measures are continuously monitored to evaluate the plan's path to attaining the target rates established in each PIP.

Interventions: All interventions numbered 1-2 were defined by the state, with ITM 3 being left to the MCO. ABHLA used many methods to help deliver on the ITM's focus for improvement. Comparing CM to non-CM illustrates how much of our population that qualifies for CM is not interested, in most cases 70-80%. All interventions around action were to reach all enrollees with the intent of completing a follow-up appointment. Through multiple interactions with our base, both enrollee and provider, it became obvious that both groups did not know the full extent of BH resources available through Medicaid. Our efforts were both largely educational, as well as internal processes to help deliver on the interventions outlined in the PIP by LDH. At the end of 2023, although we have a few interventions that will be manual for a period of time, most processes are well on their way to being system related and deliverable to the right audience.

Results: As of November 30th, all Performance Indicators (PI's) show improvement since January. The FUA metric went up from 2021 baseline but after several months of the nanosite, it has stayed at a consistent level of performance. This metric required a stretch goal, but we are still looking to close that gap to the stretch. FUM as noted in the graphs and discussion below also showed marked improvement after the nanosite launch in August but also have slowed in improvement. FUH is the only metric that has had a slow ascent but the 30 day measure does have a nice improvement in the later half of the year. Our thought is that many of enrollees getting the nanosite will also be in the FUH population and over time the behavior to follow-up will improve. Regardless of the actual performance, FUH will require a refreshed focus in 2023.

Conclusions: ABHLA, from previous efforts, has learned that communicating directly with the enrollee is key to getting or improving results – for enrollee centered metrics. Based on this effort, and results via nanosite, we are looking to add and or develop new campaigns and methods to getting enrollees to follow up. This behavior, or non-behavior, has been the norm for a large portion of our enrollees and therefore shifting their thinking and behavior will need to be done over time. We are internally aligning our provider team and contracts to focus on behavioral and physical health as research shows they are connected, together with more interactive campaigns to enrollees, we look forward to improving not just the metrics, but our enrollees lives in all areas.

Next Steps: As noted already, we are looking at revamping our FUH efforts as well as provider education delivery. We are looking at efforts to do a follow-up campaign to our enrollees to support all of the PI's. Additional next steps will be formed once the new 2023 template is shared.

Project Topic

To be completed upon Proposal submission. Do not exceed 2 pages.

Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members:**

The relationship between mental and physical health is becoming increasingly supported by research studies and health data. Historically these two aspects of the human body were treated separately, but as research shows, behavioral health issues are increasingly accompanied by chronic health conditions that profoundly impact individuals and make them significantly more susceptible to physical health issues. An article in **dispatchhealth** on November 11, 2020 notes that depression and anxiety are closely linked and that almost half of those diagnosed with depression also deal with an anxiety disorder. However, they both have vast effects on physical health also, from exacerbating existing conditions to weakening the immune system and heart health.

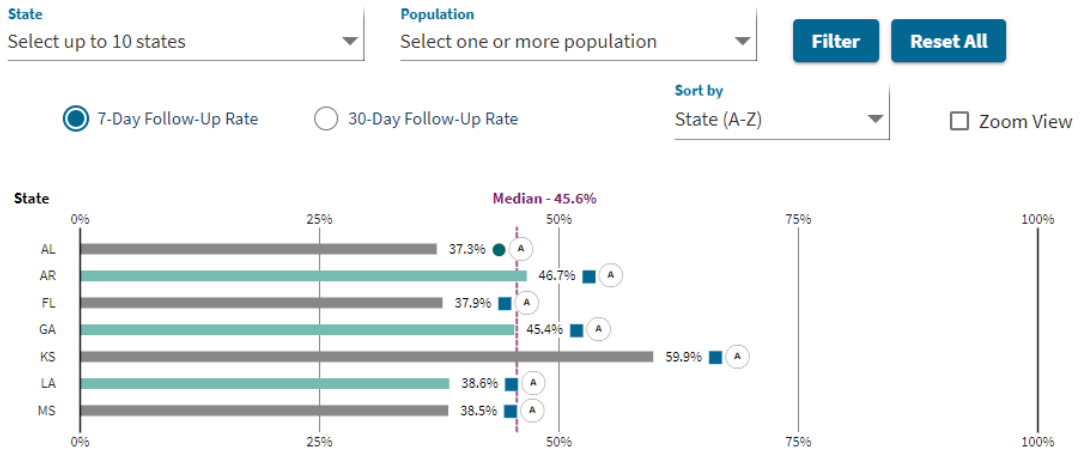
According to an article on March 29th, 2021 on WebMD;

> *Depression has been linked to many chronic illnesses. These illnesses include diabetes, asthma, cancer, cardiovascular disease, and arthritis. Schizophrenia has also been linked to higher risk of heart and respiratory diseases. Mental Health conditions can also make dealing with a chronic illness more difficult. The mortality rate from cancer and heart disease is higher among people with depression or other mental health conditions.*

This article examines how physical conditions often contribute to mental health symptoms, such as Psoriasis being associated with acute stress and depression, as well as cancer diagnoses and heart attacks leading to feelings of depression or anxiety. Finally, research from the article shows that people with mental health diagnoses are more likely to suffer sleep disorders and smoke cigarettes, both of which contribute to physical ailments.

The data in Tables 4a and 4b show that our FUH population is primarily 18-64 years old, they are primarily Black/African American and White, and that 82% also have a substance use disorder diagnosis. It also shows that disability and homelessness play a part and, although SDoH is a standard part of our discharge planning for this population, we need to ensure that individuals in these categories have access to the resources they need.

In reviewing the Medicaid.gov site for FUH, the age group 6-17 was shown across all states. Our minor population, although small, can benefit from intentional focus because this group is still in their formative years. Creating good relationships now can help them in the long term to avoid repeated incidents of hospitalization and ED visits for MH. LA had a FUH rate of 38.6% while the Median was 45.6% across all 50 states. (image was narrowed)



Aetna recognizes that BH is a chronic condition that does impact much of the physical aspects measured by HEDIS. Therefore in 2022 we are committed to increasing our BH Provider network by approximately 11% and utilizing all providers, vendors, and partnerships to improve this important focus. In addition to increasing our network, we have partnered with our top BH Hospital Provider in Table 4b to have one our CHW's on staff at their facility to help pilot an effort for discharge planning and follow-up as a potential model for all providers and our UM team. This pilot began the last week of February.

- **Describe high-volume or high-risk conditions addressed:**

  As defined in the Charter, the PIP will focus on all AOD and MH diagnoses codes related to 6 Performance Indicators and reducing barriers that can contribute to enrollees not following up with appropriate providers.

- **Describe current research support for topic (e.g., clinical guidelines/standards):**

  The focus on Follow-up for these clinical conditions is due to its link to reduction in readmissions. The need for focus on this critical period can best be illustrated by the NIH PUBMED.gov article on why following up after discharge is important. This article demonstrated that "functional health literacy and understanding of medications at discharge" is an important focus because only 86% of 172 patients with one or more new prescriptions interviewed in the 20 days after discharge knew they had been prescribed new medications, and far fewer could report the medications' names, purposes, dosages, or schedules. Only 11% remembered being told of any adverse effects, but 22% of them could name an adverse effect. This clearly shows that discharge planning and actively reviewing the information with the patient before discharge does not necessarily translate into medication adherence or health literacy.

  This article, coupled with the increasing connection between mental and physical health risk factors noted earlier, shows that supporting enrollees with BH needs ultimately improves their overall health and reduces chronic conditions and ongoing health issues associated with those conditions, like diabetes and asthma. It also supports the whole enrollee while reducing costly visits to the ED or being hospitalized.

- **Explain why there is opportunity for MCO improvement in this area.** Reference comparison data in the below table.

  According to the Kaiser Family Foundation's recent report 'Mental Health in Louisiana', in 2019 approximately one in ten adults reported symptoms of anxiety and/or depression. Since May 2020, that number grew to more than three in ten adults as a result of COVID-19. This same article noted that Louisiana was slightly higher than the national average for self-reports by adults for these two symptoms and that drug overdose deaths in Louisiana grew at a higher rate than the national average. In 2020 the national overdose death rate was 28.3 per 100,00 while Louisiana's was 41.5. Although Aetna had the best FUA rates, we were still below the 50th quartile, and if you note that the rates are about enrollees, then more than 80% of our enrollees are not following up with providers after ED visits for AOD. Mental health

follow-ups also have a large population, greater than 50%, that are not following up with appropriate providers.

As illustrated in the table below, there is an opportunity to improve upon follow-up visits after enrollees are discharged for AOD or MH conditions. The gap between each MCO's performance for follow-up on MH and the 25th quartile shows room for improvement, as all fell below that performance number. Additionally, in reviewing the NCQA FUH Results across all healthcare markets, Medicaid in 2020 showed an average of 39.4% 7-day follow-up, which is above the 50th Quartile shown in Table 1b. This clearly shows a gap in Louisiana that is beyond Medicaid, since other state Medicaid plans are able to deliver to the 50th quartile or better.

ABHLA's performance in the FU metrics below is among the lowest for FUH and FUM while FUA does seem to be our better metric comparatively with the other MCO's. The IET/FUA/POD PIP might have allowed us an opportunity to focus here but with the campaign recently launched for FUA I would expect this to improve even more. Our worksheets and overall research do show a cross section for the Mental Health (MH) population to also have substance use history. Our worksheets in Table 4a and 4b show that over 80% of our population admitted to a BH Hospital with an MH diagnosis also have a diagnosis of SUD. This further illustrates how dual efforts for the majority of our population will be necessary. In Q1 we are reviewing our FUA nanosite campaign for use with the FUM population to help drive the right outcomes for ED discharges given the worksheet information. The importance of the nanosite for the ED discharge metrics is that the message contains all the information enrollees need for 'next' steps. The campaign includes a live link to enrollee services, our BH virtual Provider, and our community resource page for help with any of the SDoH needs identified. This allows enrollees to find resources for more immediate and basic needs such as food or shelter.

The focus on the transition of care from the recorded incident in either ED or Hospital setting will allow ABHLA to remove barriers and enhance the resources enrollees need to follow-up. This effort will require education of both providers and enrollees on what resources and benefits Medicaid covers, as well as the ability to choose which items 'fit' their needs. This will allow enrollees to find the support and resources that make them comfortable and secure to continue with treatment. For instance, telemedicine showed the largest growth in psychologist or psychiatrist visits as compared to many other specialty areas as noted in the article by McKinsey & Company 'Telehealth: A quarter-trillion-dollar post-COVID-19 reality?'. This specialty was 40% in June of 2021 with only 37% showing in person visits. The next highest specialty showed 23% virtual visits, clearly showing the convenience this new technology can unlock for enrollees especially in rural or areas of the state with limited specialty resources.

It is worth noting that the Performance Indicators in this PIP are part of the 2022 Core Set of Behavioral Health Measures for Medicaid and CHIP as identified by CMS. This core set has 20 measures which support CMS's efforts to improve BH in Medicaid and CHIP agencies.

With new technology, resources, alternative therapies and proven medication support, there is an opportunity improve the lives of our enrollees.

Table 1b: HEDIS 2021 Rates for Healthy Louisiana MCOs and 2021 Quality Compass® Percentiles

Indicator	Aetna	ACLA	Healthy Blue	LHCC	UHC	QC 25th	QC 50th	QC 75th	QC 90th
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH) –Total, 7 days	19.74	20.33	18.78	23.16	23.68	30.86	38.95	47.54	55.92
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH) –Total, 30 days	37.46	41.99	38.31	43.22	44.26	51.9	60.08	67.53	73.30
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 7 days	22.28	22.8	23.3	23.01	23.62	30.22	38.55	49.49	61.36
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 30 days	34.99	34.92	36.89	37.41	38.37	45.45	53.54	64.59	74.39
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence (FUA) – Total, 7 days	9.01	8.05	7.91	7.1	7.28	7.1	13.36	17.66	22.98
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence (FUA) – Total, 30 days	16.38	14.03	12.9	11.24	11.14	10.75	21.31	26.22	32.60

ACLA: LHCC: UHC: UnitedHealthcare; QC: Quality Compass.

Aims, Objectives and Goals

Healthy Louisiana PIP Aim: The aim is threefold: to improve the rate of (1) Follow-Up after Hospitalization for Mental Illness, (2) Follow-Up After Emergency Department Visit for Mental Illness, and (3) Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, by implementing interventions to achieve the following **objectives**:

1. Enhance hospital-to-MCO workflow for notification of hospital and emergency department admissions, discharges and transfers:
    a. Develop or enhance real-time/near-real-time admit, discharge, transfer (ADT) data exchange for behavioral health-related emergency department visits and hospital stays.
    b. Streamline and improve processes for obtaining and documenting member's consent to share information with aftercare providers.
    c. Ensure hospitals and emergency departments have user-friendly, accessible provider directories, which indicate BH providers with availability for urgent aftercare appointments.

d. Perform medication reconciliation to ensure medication is on approved formulary and member has access to medication.
e. Provide enhanced MCO case/care management to ensure aftercare planning for members prior to discharge from hospital or emergency department.
    i. Identify and address social determinants of health, which may serve as a barrier to aftercare.
    ii. Ensure member has a discharge plan, which includes current medication list, appointment with aftercare provider(s) at a time/location convenient to member/based on member preferences, and interventions to address barriers to care (e.g., transportation, language etc.).
    iii. Ensure member understands discharge plan using teach-back methods to address health literacy.
    iv. Educate members on purpose and importance of aftercare appointments, and how to reschedule appointments if the scheduled time does not work.
    v. Provide follow-up to member within 72 hours following discharge from hospital or emergency department to identify and address any unmet needs.
    vi. Provide ongoing MCO case management to members with special health care needs.
        1. Evaluate the effectiveness of the MCO case management program considering member feedback and engagement level and develop and implement interventions to improve case management processes based on member feedback.

2. Link members to aftercare with BH providers prior to discharge from hospital or emergency department for members enrolled in case management and for members not enrolled in case management
    a. Develop and implement at least three (3) strategies to increase warm hand-offs to BH providers to ensure member continuity of care. At least, one (1) strategy must relate to increasing warm hand-offs to residential substance use providers. Implementation may be delayed due to Omicron. To start, consider partnering with a large volume ID with whom you have an established relationship, then spread successes over the course of the PIP.
    b. Develop and implement strategies for reminding members regarding upcoming behavioral health appointments.
    c. Share critical member information which is necessary for patient care (including but not limited to MCO plan of care if applicable, discharge plan, and current medication listing) with aftercare BH providers within 3 days following member's discharge from the hospital or emergency department through provider-friendly, automated processes (e.g., provider portal) in accordance with the privacy requirements at 45 CFR Parts 160 and 164, 42 CFR Part 2, and other applicable state and federal laws.

3. Identify and address needs of sub-populations by stratifying data by member race/ethnicity, member region of residence, gender, high-utilizers, SMI diagnosis, co-occurring disorders, age, and if available LGBTQ.

4. Initiate a broader intervention to facilitate follow-up with members with an appropriate mental health provider (per NCQA Appendix 3) e.g., text messaging, letter to member and member's PCP with list of follow-up providers in member's location).

Table 2: Goals

Performance Indicators	Baseline Rate[1] Measurement Period: 1/1/21–12/31/21	Interim Rate Measurement Period: 1/1/22–12/31/22	Final Rate Measurement Period: 1/1/23–12/31/23	Target/ Stretch Rate[2]	Rationale for Target Rate[3]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 7 days	N: 463 D: 2813 R: 16.46%	N: 469 D: 2845 R: 16.49%	N: D: R:	R:19.5%	At least 3 percentage point increase from CY 2021 to CY 2022 for all Performance Indicators
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 30 days	N: 969 D: 2813 R: 34.45%	N: 968 D: 2845 R: 34.02%	N: D: R:	R:37.5%	At least 3 percentage point increase from CY 2021 to CY 2022 for all Performance Indicators
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 7 days	N: 118 D: 564 R: 20.92%	N: 85 D: 451 R: 18.85%	N: D: R:	R:24%	At least 3 percentage point increase from CY 2021 to CY 2022 for all Performance Indicators
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 30 days	N: 170 D: 564 R: 30.14%	N: 141 D: 451 R: 31.26%	N: D: R:	R:33.2%	At least 3 percentage point increase from CY 2021 to CY 2022 for all Performance Indicators
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 102 D: 1053 R: 9.69%	N: 115 D: 903 R: 12.74%	N: D: R:	R:13%/16.38%	At least 3 percentage point increase from CY 2021 to CY 2022 for all Performance Indicators

Performance Indicators	Baseline Rate[1] Measurement Period: 1/1/21–12/31/21	Interim Rate Measurement Period: 1/1/22–12/31/22	Final Rate Measurement Period: 1/1/23–12/31/23	Target/ Stretch Rate[2]	Rationale for Target Rate[3]
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 166 D: 1053 R: 15.76%	N: 166 D: 903 R: 18.38%	N: D: R:	R:19%/24.7%	At least 3 percentage point increase from CY 2021 to CY 2022 for all Performance Indicators

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.
[2] Upon subsequent evaluation of performance indicator rates, consideration should be given to improving the target rate, if it has been met/exceeded at that time.
[3] Indicate the source of the final goal (e.g., NCQA Quality Compass) and/or the method used to establish the target rate (e.g., 95% confidence interval).
[4] Due to timing, the 2022 performance is reflective of claims received and processed through November 30th.

Methodology

To be completed upon Proposal submission.

Performance Indicators: The performance indicators will follow the HEDIS Specifications 2020, Volume 2

Table 3: Performance Indicators

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH)-Total, 7 days	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days after discharge.	HEDIS MY 2022, Volume 2	Members 6 years and older as of the date of the ED visit with medical and mental health benefits Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Members in hospice or using hospice services anytime during the measurement year. Refer to General Guideline 17: Members in Hospice.	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year	The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH)-Total, 30 days	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge.	HEDIS MY 2022, Volume 2	Members 6 years and older as of the date of the ED visit with medical and mental health benefits Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Members in hospice or using hospice services anytime during the measurement year. Refer to General Guideline 17: Members in Hospice.	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year	The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM)-Total, 7 days	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days).	HEDIS MY 2022, Volume 2	Members 6 years and older as of the date of the ED visit with medical and mental health benefits Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Members in hospice or using hospice services anytime during the measurement year. Refer to General Guideline 17: Members in Hospice.	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.	The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below. **Note:** Do not include more than one ED visit per 31- day period as described in the Multiple visit documentation of spec.

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM)-Total, 30 days	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit (31 total days).	HEDIS MY 2022, Volume 2	Members 6 years and older as of the date of the ED visit with medical and mental health benefits Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Members in hospice or using hospice services anytime during the measurement year. Refer to General Guideline 17: Members in Hospice.	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.	The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year **Note:** Do not include more than one ED visit per 31- day period as described in the Multiple visit documentation of spec.

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #3a. Follow-Up After Emergency Department Visit Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days	**The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit**	HEDIS MY 2022, Volume 2	13 years and older as of the ED visit. Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Members with detoxification-only chemical dependency benefits do not meet these criteria	The follow-up visits with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit (See HEDIS Specs)	ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of visit. **Note:** Do not include more than one ED visit per 31- day period as described in the Multiple visit documentation of spec.

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #3b. Follow-Up After Emergency Department Visit Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days	**The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit**	HEDIS MY 2022, Volume 2	13 years and older as of the ED visit. Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Members with detoxification-only chemical dependency benefits do not meet these criteria	The follow-up visits with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit (See HEDIS Specs)	ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of visit. **Note:** Do not include more than one ED visit per 31- day period as described in the Multiple visit documentation of spec.

[1] HEDIS Indicators: If using a HEDIS measure, specify the HEDIS reporting year used and reference the HEDIS Volume 2 Technical Specifications (e.g., measure name(s)). It is not necessary to provide the entire specification. A summary of the indicator statement, and criteria for the eligible population, denominator, numerator, and any exclusions are sufficient. Describe any modifications being made to the HEDIS specification, e.g., change in age range.

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?

The total population of enrollees, as HEDIS defined for specific age groups, is being targeted for this initiative.

Eligible Population:

- Annual population assessment: Total enrollees enrolled in ABHLA, ages birth and older
- HEDIS rates: eligible enrollees, 6 years of age and older, 13 years and older, and total
- CM utilization rates: ABHLA enrollees 6-17 years of age, 18 years and older
- Utilization patterns: ABHLA enrollees 6-17 years of age, 18 years and older

Sampling Procedures

If sampling was employed (for targeting interventions, medical record review, or survey distribution, for instance), the sampling methodology should consider the required sample size, specify the true (or estimated) frequency of the event, the confidence level to be used, and the margin of error that will be acceptable.

- **Describe sampling methodology:** There was no sampling for this PIP.

Data Collection

Describe who will collect the performance indicator and intervention tracking measure data (using staff titles and qualifications), when they will perform collection, and data collection tools used (abstraction tools, software, surveys, etc.). If a survey is used, indicate survey method (phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

- **TOAD Data Point:** Software will be utilized to generate automated custom reporting specifically around this PIP by combining multiple data sources listed below.
- **Annual Population Assessment**: Annual report generated integrating member enrollment demographic data, Elli data software linked to State claims received with diagnoses codes, ABH QNXT claims data base.
- **CM Utilization rates:** Report generated utilizing CM Dynamo data platform monthly, quarterly, and final annual rate of enrollment patterns, use of ASAM 6 screening tools, and outreach patterns. Enrollee successful transitions to appropriate level of care by file review.
- **Utilization Management Rates**: QNXT data base system generated quarterly and annual report of enrollee utilization patterns for inpatient, outpatient services, screenings and treatment.
- **Pharmacy Rates:** Use of Elli software program of prescribing patterns by enrollee/prescribing physician. CVS pharmacy reports of claims received if needed.

Validity and Reliability

Describe efforts used to ensure performance indicator and intervention tracking measure data validity and reliability. For medical record abstraction, describe abstractor training, inter-rater reliability (IRR) testing, quality monitoring, and edits in the data entry tool. For surveys, indicate if the survey instrument has been validated. For administrative data, describe validation that has occurred, methods to address missing data and audits that have been conducted.

Describe validity and reliability:

- **Annual Population Assessment**: enrollee demographic and claims information validated by ABH-LA IT informatics and Health Care Equities Director. We utilize Elli data software program, which is linked to State claims received, ABHLA QNXT claims received, and enrollee enrollment data to produce reliable data over time.
- **HEDIS**: In accordance with NCQA's protocols, validity audits are conducted by Advent Advisory Group, an NCQA-licensed organization, and led by a Certified HEDIS Compliance Auditor (CHCA). The IT team assists with data collection and rate calculations, and the quality management team reviews the data for validity and reliability.
- **Enrollee Survey**: Vendor data file validated by QI Director, Quality Project Manager and/or designee. Discrepancies discussed with vendor during monthly meetings. Utilizing interactive phone surveys with State approved scripts. Same method utilized for each survey conducted
- **CM Utilization Rates:** Validated by Project Manager and CM project manager for variances in data

and/or technical reporting issues within the Dynamo data platform. Aetna IT informatics review of final rates and of discrepancies found and using the same data base system and logic for reliable results.

- **Pharmacy Rates**: Data file validation by CVS pharmacy and ABHLA Pharmacy Director
- **Vendor Reports**: Vendor data file reports of text messages, mailers, and IVR calls generated validated by QI Director, Quality Project Manager and/or designee. ABHLA IT generation of enrollee lists utilizing same logic. Discrepancies discussed with vendor during monthly meetings.
- **Utilization Management Rates:** Validated by UM Manager and Medical Management Director for validity and accuracy of data with Aetna IT informatics review of final rates, and of discrepancies found for enrollee utilization of treatment services.

Data Analysis

*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among sub-populations within the baseline period is appropriate).Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.).*
Describe how plan will interpret improvement relative to goal.
Describe how the plan will monitor intervention tracking measures (ITMs) for ongoing quality improvement (e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).

Describe data analysis procedures:

- Our data collection for identifying, measuring, and reporting gaps in service delivery includes information from our enrollee survey, HEDIS Follow-Up performance metrics, Care Management dynamo platform of enrollment patterns, participation, and interventions conducted, utilization management of services used, medical record and CM file audits to ensure provider and health plan adherence to evidence based guidelines. Data is further stratified by some of the following categories: age, gender, ethnicity, city, zip code, parish, region, urban/rural. Stratification of the data supports the analysis and identification of variables for consideration in intervention design and implementation. We analyze results in workgroups with key leaders and PIP committee enrollees, comparing prior years and target goals by conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers that impact intervention success. In addition, ABHLA may use QI process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABHLA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and intervention tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the PIP and its corresponding goals.

Describe how plan will interpret improvement relative to goal:

- In identifying reasons for variations in provision of care and evaluating practice variation, we assess the effectiveness of care rendered, adherence to evidence-based guidelines, treatment options chosen, and frequency of use of clinical activities as it relates to the capacity of our healthcare system, such as services rendered, emergency and hospital admissions. Inappropriate variation occurs when non-evidence-based care is provided, or the care lacks wide acceptance, and the high level of variation cannot be supported on a quality or outcomes basis which can lead to disparate outcomes for enrollees, higher utilization, costs, and waste. We analyze data reports, provider patterns of over-and-under utilization of services, regional and provider demographic variations, to identify variation in care. We also examine any social determinants or disparity prevalence and cost-ratios, incorporating outreach activities and care management strategies to further engage enrollees to initiative and/or continue to engage in active treatment

Describe how plan will monitor ITMs for ongoing QI:

- The plan will create custom reoccurring reports around this PIP and will host reoccurring meetings to monitor the progress. If positive progress is being observed through these reports, we will continue to scale the efforts to increase improvements. If little to no impact is being observed, then our efforts will be revisited and optimized further to create a greater impact.

PIP Timeline

Report the measurement data collections periods below.

Baseline Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

First year PIP interventions (new or enhanced) will be initiated on 1/1/2022.

Final Measurement Period:
Start date: 1/1/2022
End date: 12/31/2022

Submission of 1st quarterly status report for intervention period 1/1/22–3/31/22 is due on 4/29/2022.
Submission of 2nd quarterly status report for intervention period 4/1/22–6/30/22 is due on 7/29/2022.
Submission of 3rd quarterly status report for intervention period 7/1/22–9/30/22 is due on 10/31/2022.

Submission of FUH/FUM/FUA Proposal/baseline Report with calendar year (CY) 2021 data is due: 3/1/2022

Submission of FUH/FUM/FUA Draft Final Report with CY 2022 data is due: 12/9/2022

Submission of FUH/FUM/FUA Final Final Report with CY 2022 data is due:12/30/2022

Table 4a: Analysis of Disproportionate Under-Representation of FUH 30 Days, Member Subpopulations

Subpopulation	Members 6 Years of Age and Older who were Hospitalized for Treatment of Selected Mental Illness or Intentional Self-Harm Diagnosis		Members who Received Follow-up Within 30 Days After Discharge		Disproportionate Index of FUH-30 Under-Representation
	# of Discharges in the FUH-Denominator	% of MCO TOTAL Denominator	# of Discharges with 30 day Follow-up visit (FUH 30 Day Numerator)	% of MCO TOTAL Numerator	% of MCO TOTAL Denominator ÷ % of MCO TOTAL Numerator
MCO TOTAL	2813	100%	969	100%	
Age					
6–17 years	290	10.31%	164	16.92%	0.61
18–64 years	2511	89.26%	799	82.46%	1.08
65+ years	12	0.43%	6	0.62%	0.69
Race					
American Indian or Alaska Native	24	0.85%	10	1.03%	0.83
Asian	12	0.43%	5	0.52%	0.83
Black or African American	1022	36.33%	350	36.12%	1.01
Native Hawaiian or Pacific Islander	7	0.25%	3	0.31%	0.80
White	1430	50.84%	492	50.77%	1.00
Other	3	0.11%	2	0.21%	0.52
Unknown	315	11.20%	107	11.04%	1.01
Ethnicity					
Hispanic	6	0.21%	5	0.52%	0.41
Non-Hispanic	1454	51.69%	502	51.81%	1.00
Unknown	1353	48.10%	462	47.68%	1.01
Substance Use Disorder	2314	82.26%	732	75.54%	1.09
Enrollment category: Foster Care	15	0.53%	11	1.14%	0.47
Enrollment category: Disabled	596	21.19%	241	24.87%	0.85
Housing Insecurity/Homeless[1]	500	17.77%	113	11.66%	1.52
LA MCO Region of Residence					
Region 1: Greater New Orleans	479	17.03%	148	15.27%	1.11
Region 2: Capital Area	385	13.69%	146	15.07%	0.91
Region 3: South Central LA	203	7.22%	89	9.18%	0.79
Region 4: Acadiana	449	15.96%	138	14.24%	1.12
Region 5: Southwest LA	157	5.58%	41	4.23%	1.32
Region 6: Central LA	212	7.54%	97	10.01%	0.75
Region 7: Northwest LA	321	11.41%	130	13.42%	0.85
Region 8: Northeast LA	184	6.54%	49	5.06%	1.29
Region 9: Northshore Area	377	13.40%	121	12.49%	1.07

FUH 30 Day: Follow-Up After Hospitalization for Mental Illness Total, 30 days; MCO: managed care organization; LA: Louisiana.

1. ICD-10 codes for housing insecurity/homelessness.

Problems related to housing and economic circumstances	Z59
Homelessness	Z59.0
Inadequate housing	Z59.1
Other problems related to housing and economic circumstances	Z59.8

Table 4b: Analysis of Disproportionate Under-Representation of FUH 30 Days, by Hospital

Hospital (top 35 highest volume hospitals, i.e., largest FUH denominator)	Members 6 Years of Age and Older who were Hospitalized for Treatment of Selected Mental Illness or Intentional Self-Harm Diagnosis		Members who Received Follow-up Within 30 Days After Discharge		Disproportionate Index of FUH-30 Under-Representation
	# of Discharges in the FUH-Denominator	% of MCO TOTAL Denominator	# of Discharges with 30-day Follow up visit in the FUH 30 Day Numerator	% of MCO TOTAL Numerator	% of MCO TOTAL Numerator / % of MCO TOTAL Denominator
MCO TOTAL	2813	100%	969	100%	
LONGLEAF HOSPITAL	169	6.01%	82	8.46%	0.71
BRENTWOOD HOSPITAL	128	4.55%	63	6.50%	0.70
BEACON HOSPITAL MANAGEMENT	112	3.98%	25	2.58%	1.54
COVINGTON BEHAV HEALTH	108	3.84%	33	3.41%	1.13
RIVER PLACE BEHAVIORAL HEALTH	95	3.38%	25	2.58%	1.31
ST JAMES BEHAVIORAL HOSPITAL	67	2.38%	13	1.34%	1.78
LAKE PINES HOSPITAL	62	2.20%	21	2.17%	1.02
SEASIDE HEALTH SYSTEM	57	2.03%	17	1.75%	1.15
OUR LADY OF THE LAKE RMC	54	1.92%	31	3.20%	0.60
BRENTWOOD BEHAVIORAL SHREVEPORT	52	1.85%	23	2.37%	0.78
OCEANS BEHAVIORAL HOSPITAL GREATER NEW ORLEANS	51	1.81%	11	1.14%	1.60
SEASIDE BEHAVIORAL CENTER	48	1.71%	15	1.55%	1.10
RIVER OAKS HOSPITAL	48	1.71%	12	1.24%	1.38
VERMILION BEHAV HEALTH	47	1.67%	26	2.68%	0.62
CHILDRENS HOSPITAL	46	1.64%	28	2.89%	0.57
BATON ROUGE GENERAL MEDIC	41	1.46%	12	1.24%	1.18
WK BEHAVIORAL MEDICINE	41	1.46%	15	1.55%	0.94
UMCMC DBA INTERIM LSU HOSPITAL	39	1.39%	10	1.03%	1.34
OCEANS BEHAVIORAL HOSPITAL BROUSSARD	37	1.32%	11	1.14%	1.16

OCEANS BEHAVIORAL HOSPITAL OF HAMMOND	36	1.28%	8	0.83%	1.55
REGIONS BEHAVIORAL HOSPITAL	33	1.17%	12	1.24%	0.95
CYPRESS GROVE BEHAVIORAL HLTH	32	1.14%	15	1.55%	0.73
SOUTH CAMERON MEMORIAL HOSP	32	1.14%	5	0.52%	2.20
BATON ROUGE BEHAVIORAL HOSPITAL	31	1.10%	6	0.62%	1.78
LAFAYETTE GENERAL MED CTR	29	1.03%	9	0.93%	1.11
VERMILION BEH HLTH SOUTH	26	0.92%	5	0.52%	1.79
CHRISTUS OCHSNER ST PATRICK HOSPITA	25	0.89%	7	0.72%	1.23
APOLLO BEHAVIOR HEALTH	24	0.85%	4	0.41%	2.07
JENNINGS SENIOR CARE HOSPITAL	23	0.82%	6	0.62%	1.32
LOUISIANA BEHAVIORAL HEALTH	23	0.82%	8	0.83%	0.99
COMMUNITY CARE HOSPITAL	23	0.82%	7	0.72%	1.13
ST CHARLES PARISH HOSPITAL	21	0.75%	7	0.72%	1.03
PHYSICIANS BEHAVIORAL HOSPITAL	20	0.71%	4	0.41%	1.72
OCHSNER ST ANNE GENERAL HOSPITAL	19	0.68%	6	0.62%	1.09
OCEANS BEHAVIORAL HOSPITAL ALEXANDRIA	19	0.68%	6	0.62%	1.09

Barrier Analysis, Interventions, and Monitoring

Table 4c: Alignment of Barriers, Interventions and Tracking Measures: **Report Quarterly data. ITMs should be monitored monthly to timely identify effective interventions (what works), barriers (what doesn't work and why) and modification of interventions to address barriers.**

Barrier: LDH defined – Timeliness of notification for hospital discharge **Method of barrier identification: HIE information via ADT**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1a :** **Numerator**: # hospital inpatient admissions for which MCO received any admission notification **Denominator**: FUH denominator (note: count # discharges) **No Exclusions, will not = PI Denominators**	N: 1215 D: 1326 R:91.63%	N: 1058 D: 1126 R:93.96%	N: 647 D: 674 R:95.99%	N: 884 D: 916 R:96.51%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1b :** **Numerator**: # hospital inpatient admissions for which MCO CM received any admission notification **Denominator**: FUH denominator (note: count # discharges) **No Exclusions, will not = PI Denominators**	N: 1215 D: 1326 R: 91.63%	N: 1058 D: 1126 R:93.96%	N: 647 D: 674 R:95.99%	N: 884 D: 916 R:96.51%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1c:** **Numerator**: # hospital inpatient admissions for which MCO received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges) **No Exclusions, will not = PI Denominators**	N: 69 D: 1326 R: 5.2%	N: 151 D: 1126 R:13.41%	N: 329 D: 674 R:48.81%	N: 433 D: 916 R:47.27%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1d :** **Numerator**: # hospital inpatient admissions for which MCO CM received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges) **No Exclusions, will not = PI Denominators**	N: 69 D: 1326 R: 5.2%	N: 151 D: 1126 R:13.41%	N: 329 D: 674 R:48.81%	N: 433 D: 916 R:47.27%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
		2022				**2023**			

Barrier: LDH defined – Timeliness of notification of ED discharge **Method of barrier identification: HIE information via ADT**		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1e:** **Numerator**: # BH ED encounters for which MCO received any ED admission or discharge notification **Denominator**: Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	N: 1245 D: 1735 R: 71.76%	N: 1060 D: 1442 R:73.51%	N: 552 D: 635 R:86.93%	N: 812 D: 984 R:82.52%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1f:** **Numerator**: # BH ED encounters for which MCO CM received any ED admission or discharge notification **Denominator**: Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	N: 1245 D: 1735 R: 71.76%	N: 1060 D: 1442 R:73.51%	N: 552 D: 635 R:86.93%	N: 812 D: 984 R:82.52%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1g:** **Numerator:** # BH ED encounters for which MCO received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	N: 150 D: 1735 R: 8.65%	N: 285 D: 1442 R:19.76%	N: 390 D: 635 R:61.42%	N: 513 D: 984 R:52.13%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #1h:** **Numerator:** # BH ED encounters for which MCO CM received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	N: 150 D: 1735 R: 8.65%	N: 285 D: 1442 R:19.76%	N: 390 D: 635 R:61.42%	N: 513 D: 984 R:52.13%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier: LDH defined – Those in CM follow-up; not all enrollees are in CM **Method of barrier identification: CM outreach will improve follow-up and opportunities to enroll in CM**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Linkage Intervention #2 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #2ai:** **Numerator:** # MH HOSPITAL DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of discharge	N: 177 D: 278 R:63.67%	N: 120 D: 212 R: 56.6%	N: 60 D: 126 R:47.62%	N: 70 D: 146 R:47.95%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

	Denominator: # MH HOSPITAL DISCHARGES in FUH denominator FOR MEMBERS who are enrolled (agreed to participate) in case management								
Linkage Intervention #2 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date:**1/1/2022	**ITM #2ii:** **Numerator:** # MH HOSPITAL DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of discharge **Denominator:** # MH HOSPITAL DISCHARGES in FUH denominator FOR MEMBERS who are not enrolled in case management	N: 550 D: 939 R:58.57%	N: 418 D: 837 R:49.94%	N: 199 D: 509 R: 39.1%	N: 320 D: 681 R:46.99%				
Linkage Intervention #2 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #2bi:** **Numerator**: # SUD + MH ED DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of SUD + MH ED discharge **Denominator**: # SUD + MH DISCHARGES in FUM + FUA denominator FOR MEMBERS who are enrolled (agreed to participate) in case management	N: 24 D: 35 R: 68.57%	N: 25 D: 33 R:75.76%	N: 11 D: 20 R: 55%	N: 13 D: 19 R:68.42%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #2bii:** **Numerator**: # SUD + MH ED DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of ED discharge **Denominator**: # SUD + MH ED DISCHARGES in FUM + FUA denominator FOR MEMBERS who are not enrolled in case management	N: 86 D: 155 R:55.48%	N: 73 D: 135 R:54.07%	N: 21 D: 52 R:40.38%	N: 47 D: 94 R: 50%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 for warm hand-off to address barrier: **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #2c:** **Numerator:** # members with a warm hand-off (e.g., additional SUD level of care codes provided by Ford to get credit for appropriate follow-ups not included by NCQA; examples of warm–handoffs include peer services in EDs, buprenorphine induction in EDs with handoff to outpatient provider, having clinicians from SUD providers with multiple	N: 139 D: 629 R: 22.1%	N: 87 D: 537 R: 16.2%	N: 29 D: 255 R:11.37%	N: 57 D: 345 R:16.52%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

	levels of care evaluate patients in EDs for best placement, including residential SUD) from the ED to a qualifying SUD provider **Denominator:** # members in FUA denominator (note: Count # members, not visits. If you are testing this intervention with a high performing, high volume hospital, you may use that smaller denominator) **No Exclusions, will not = PI Denominators**								
Barrier: LDH defined – Follow-up providers don't have information from discharge to improve outcome **Method of barrier identification: Increasing discharge plans access will improve follow-up appointment outcomes**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Provider to Provider Communication Intervention #2 to address barrier: **Planned Start Date:** 11/20/2022 **Actual Start Date**:	**ITM #2d:** **Numerator**: # members whose qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment **Denominator**: # members in the FUH denominator (note: you are counting # members, not visits) **No Exclusions, will not = PI Denominators**	N: D: 1040 R:	N: D: 887 R:	N: D: 562 R:	N: D:733 R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Provider to Provider Communication Intervention #2 to address barrier: **Planned Start Date:** 6/2022 **Actual Start Date**: 8/2022	**ITM #2e:** **N**: # members whose qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment **D**: Sum of # members in FUM ~~+ FUA~~ denominators (note: you are counting the sum of # members, not visits) **No Exclusions, will not = PI Denominators**	N: D: 1302 R:	N: D: 1115 R:	N: 346 D: 525 R:65.90%	N: 363 D: 511 R:71.04%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier Section 3: MCO defined barriers, education of follow-up needs to members and requirements of Providers **Method of barrier identification: Lack of follow-up or completion of appointments evidenced by the PI's**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Tailored & Targeted Intervention #3 to address barrier: MCO-specified ITM to monitor tailored and	**ITM #3a:** Provider Education on BH/MH resources and Importance of Follow-up **N:** Providers who were sent Educational Information related to follow-up	N: 18187 D: 48966 R:37.14%	N: 7220 D: 49490 R:14.59%	N: 31634 D: 51291 R: 61.7%	N: 49961 D: 52570 R: 95.0%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

targeted intervention informed by Analysis of Disproportionate Under-Representation **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**D:** Total Network Providers								
Tailored & Targeted Intervention #3 to address barrier: MCO-specified ITM to monitor tailored and targeted intervention informed by Analysis of Disproportionate Under-Representation **Planned Start Date:** 1/1/2022 **Actual Start Date**:1/1/2022	**ITM #3b:** Improve enrollees education by messaging them to Follow-up with resources including virtual and SDoH **N:** # enrollees with completed FUA/FUM nanosite messages **D:** # active enrollees who received the FUA/FUM nanosite ***FUM Inclusion started in Q3***	N: 334 D: 478 R: 70%	N: 280 D: 442 R: 63%	N: 639 D: 902 R: 71%	N: 777 D: 1178 R: 66%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored & Targeted Intervention #3 to address barrier: MCO-specified ITM to monitor tailored and targeted intervention informed by Analysis of Disproportionate Under-Representation **Planned Start Date:** 1/2023 **Actual Start Date**:	**ITM #3c:** Improve enrollees SDoH and treatment needs by outreaching through alternate methods which include vendor resources **N:** # at risk enrollees who access Pyx **D:** # Total of at risk enrollee population					Launch			

Results

To be completed upon Proposal with Preliminary Baseline Measure, Baseline Report with Updated Baseline Measure, Interim and Final Report submissions.
The results section should present project findings related to performance indicators. ***Do not*** interpret the results in this section.

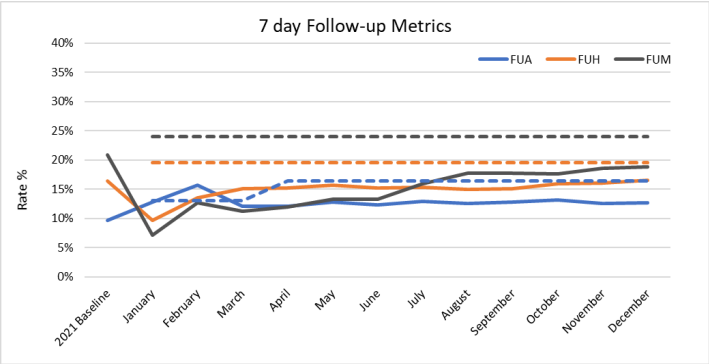
Table 5: Results

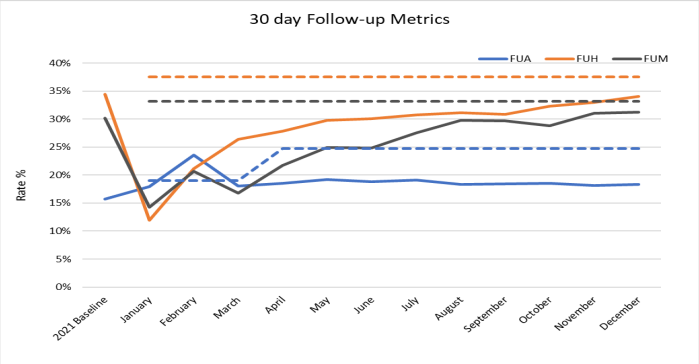
Indicator	Baseline Measure Period 1/1/21–12/31/21	Final Measure Period 1/1/22–12/31/22	Target/Stretch Rate[1]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 7 days	N: 463 D: 2813 R: 16.46%	N: 469 D: 2845 R: 16.49%	R:19.5%
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 30 days	N: 969 D: 2813 R: 34.45%	N: 968 D: 2845 R: 34.02%	R:37.5%
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 7 days	N: 118 D: 564 R: 20.92%	N: 85 D: 451 R: 18.85%	R:24%
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 30 days	N: 170 D: 564 R: 30.14%	N: 141 D: 451 R: 31.26%	R:33.2%
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 102 D: 1053 R: 9.69%	N: 115 D: 903 R: 12.74%	R:13%/16.38%
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 166 D: 1053 R: 15.76%	N: 166 D: 903 R: 18.38%	R:19%/24.7%

[1] At least 3 percentage points increase for each performance indicator.
Upon subsequent evaluation of quarterly rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.
* The 2022 results are only through November given the timing and claims processing the full year is not available.

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data,

include only data that you used to inform barrier analysis, development and refinement of interventions, and/or analysis of PIP performance.





Throughout 2022 I have been presenting these slides to show performance for each PI as related to the goal. (The goals are the dashed line, and color correspond to the Legend). I included the 2021 baseline as well so a visual comparison of where we started or need to surpass was present. The FUA goal for both timelines was increased in Q1 after meeting the original goals. The FUM, black lines, show a marked uptick in August which is when the nanosite and outreach by our virtual BH Provider for that population began.

In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. ***Do not*** interpret the results in terms of performance improvement in this section.

Discussion

To be completed upon Interim/Final Report submission. The discussion section is for explanation and interpretation of the results.

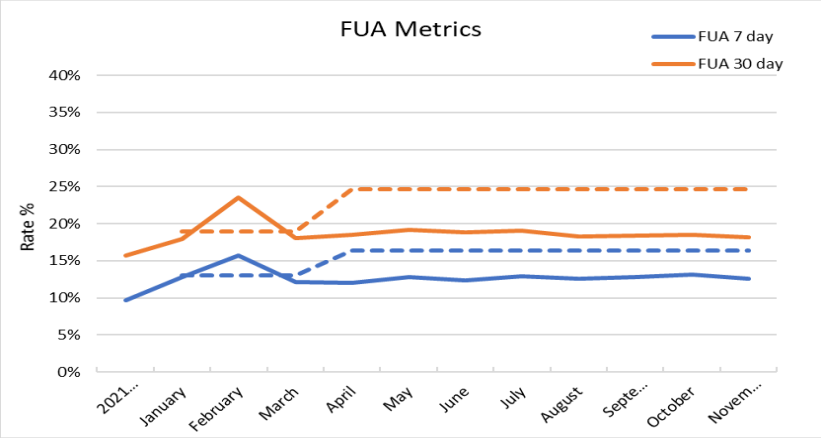
Discussion of Results

- **Interpret the performance indicator rates for each measurement period,** i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods.

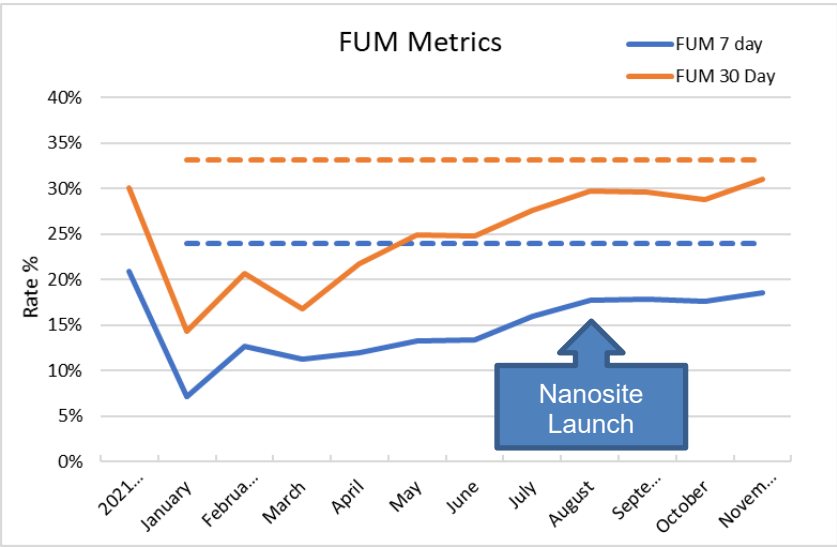
  All 6 PIs did improve from January 2022 thru the last month of measurement. All 6 metrics had a 3% improvement goal in year one to hit, and we'll need the final month in order to finalize the results as this is a cumulative metric. However, to date the FUM and FUH are closing in on the goal while the FUA metrics have made the initial goal of 3% improvement, and we still have a few months to go. This outcome shows us that by launching campaigns early, FUA nanosite in January, in the year we have a better chance of making the final rate.

  Although FUA metrics showed the only increase from the 2021 baseline, 15.76% (30 day) in 2021 to 18.12% thru November, the rates have been rather flat and we'll need to focus on additions in 2023. We do think the change in the MY 2022 FUA definition will help, as discussed below, but the rates and possible quality compass quartiles will also change so we'll need to adjust based on our performance and where we can make changes. Although ABHLA has the best FUA 7/30day rates of the MCO's in 2022, the metric

changes and additional plans (from 5-6) might offer more barriers than just moving more enrollees into the follow-up category. Either way, improving our metrics in 2023 is the focus.

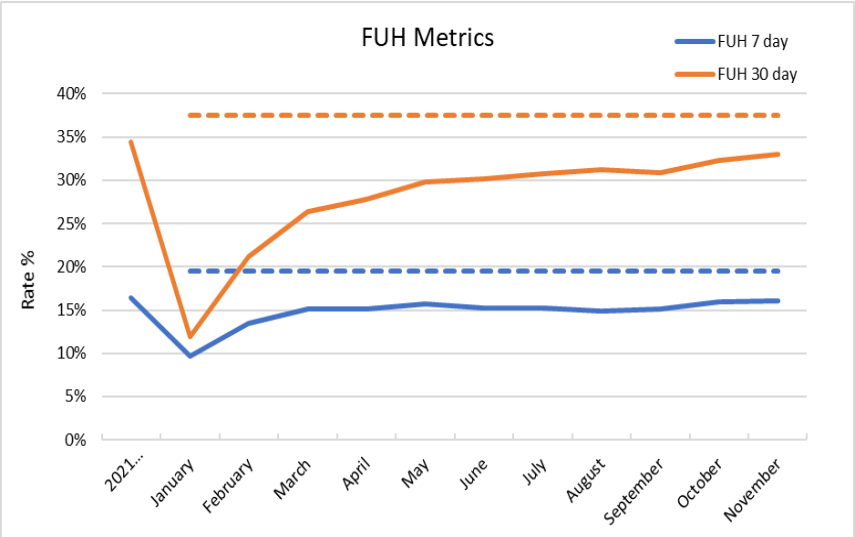


FUM did show a drop from 2021 baseline into 2022 but has steadily been increasing each month. From the 30 day baseline of 30.14% it fell to almost half that rate by the end of Q1 2022 which was 16.78%. This metric is still improving and at the end of November it was at 31.07% which is better than the baseline. The FUM metric did show a nice increase in August with the addition of both the ED nanosite distribution and the addition of our BH Virtual vendor taking on the role of outreach and provider. It went from 24.81% in Q2 to the Q3 rate with a 2 point increase in August over July and that rate has remained. We are closing in our goal of 33.2% as this is a cumulative metric, but either way we'll need to review our 'new' efforts in Q1 to determine if the monthly over month continues to show improvement or if it begins to stagnate.



The larger area for improvement will be FUH in 2023, as the 2022 performance was not what we had hoped. From 30 day FUH baseline 2021 of 34.45% we are only recently back in the 30% range in June. Our current performance of 32.95% is close to our goal of 37.75% which seems like a good rate, but when you compare that to the Quality Compass Quartiles, the 25the percentile is 51.08% which still leaves a large gap to national averages. We continued to have CM/CMA outreach all hospital discharges to review all aspects of their stay and follow-up needs including medications. The low rate of those who answer the phone show this outreach is not supportive of the desired outcome. We began an onsite program with our largest volume hospital, Longleaf, in February and had one of ABHLA's Community Health Workers (CHW's) on the floor focusing on enrollees before discharge that were identified as a high risk for readmissions. The CHW's time not only highlighted some issues the enrollees had to follow-up like no phones to do virtual appointments, but we were able to build trust and get about half of those opted into CM. This focus was on those with high readmissions probability and not necessarily follow-up

appointments, but our CHW was able to relay challenges she observed for both the provider and enrollee at the point of discharge. This program was considered successful, as the focus was to enroll them in CM to avoid readmission and is being expanded in 2023 to other large volume hospitals. Our CM team is also adding CM's that will be interfacing with enrollees in the hospital prior to discharge for those with multiple conditions that lead to unnecessary admits. This plan will be reviewed in Q1 of 2023 to see where and how it can support aspects of this PIP.



The results throughout the year were reported and evaluated with changes and 'new' methods being added or tweaked along the way. For instance, the outreach for ED discharges by CM/CMA for non CM enrolled did not give us the results we were looking for and the effort to get enrollees scheduled for a follow-up appointment required a 3 way call to provider offices. We approached LDH to ask if our virtual BH vendor could do the discharge plan for non-CM FUM, they approved, and we also worked with the vendor to schedule the appointments as well since they would be able to complete all in the same call on their side. The BH virtual vendors calendar is also online and sends texts to confirm appointments and reminders to enrollees which allows them to change it if needed. We are encouraging enrollees to schedule the virtual appointments even if they have a physical, in office, appointment hoping to improve on positive outcomes. This effort, began in August for FUM, while our FUA outreach efforts is through the same vendor calendar but is done by Aetna's quality outreach coordinator assigned to the PIP. She can discuss the need for follow-up as well as access the vendors online calendar to 4 NP's thus improving the ability to find a good time. We are in discussions with our virtual vendor to also offer off hours appointments, meaning evening and Saturday times and they are working with their staff to find an answer. Our outreach coordinator also does off hour outreach and has been able to connect with more enrollees or even call them back if requested by splitting the outreach time for when most people are home from work and collecting children from various places. The FUA portion of outreach began in October.

We definitely feel that FUM and FUA are on the right track, but 2023 will be finding additional items to add to our tools to improve things. FUH however, is going to require a different approach and we are working with a vendor who does our campaigns, and they are working on a complete set of things to help achieve the outcome we desire. We did have overall BH campaigns that went to all enrollees outlining resources available with their coverage and sent text campaigns to enrollees who have a diagnosis of a Serious Mental Illness (SMI) to highlight more specific resources, and another Interactive Voice Recording (IVR) campaigns for each FUH discharge and that has an over 33% 'answer' rate for those calls. But as the metrics show, this population is hard to reach and behavior changes, ie follow-up, will take time to move in the right direction.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations**.**

It is important to note that at the beginning of the year, ABHLA decided to pull ITM denominators with no exclusions, this was done to collect all transactions and count them via the processes outlined in the LDH ITM definitions. The best way to determine if a process is working or where its deficient is to remove exclusions and count each transaction to understand the processes total performance. If we had applied the exclusions outlined by NCQA for those HEDIS metrics, we might have missed opportunities to improve. The metrics for 2022 will help us understand, or fine tune internal processes for 2023 since we'll be reviewing the 'whole' picture.

The #1 ITM series had mostly to do with automated alerts and the Aetna National team is replacing our current ADT system to one that helps standardize the data coming in which allows them to align to more data tables in the background. This standardization allows our data to be more complete, inclusive of larger diagnosis and conditions, while delivering reports to us faster given the standardized approach. Our Provider Network team is also working on revamping contracts to include ADT and Availity expectations as well so getting more Providers ADT compliant will enhance this set of numbers. The improvement of HIE exchange via Provider contracts can be seen in the steady rise of all ITM's 1a-1h. While admissions notification has greatly approved, the ED notification alerts seem to be much approved as the Provider team moved through the contracts this year as all went up but 1g and 1h went up significantly. The one area of notification which still needs to improve is hospital ADT notification. Our notification type, ITM 1a and 1b, show improvement from 91.63% in Q1 to over 98% for Q4 to date but this includes notification by fax as well. The difference is when you compare those to the ADT or HIE notifications, ITM 1c and 1d, which go from single digit to over 58% in Q4 to date. Many of the BH hospitals are still doing a lot of notifications via e-fax but the large increase does show our contracts and focus is working to help get all Providers compliant with the ADT/HIE requirements in 2023. I would expect these rates to continue to climb in 2023.

The ITM's the PIP team focused on were the #2 series as they broke down the population in different ways. This allowed us to understand and compare those in/out of CM and for which conditions did it make a difference. For the ITM's around FUH, ITM's 2ai and 2aii, which showed compared those in CM (2ai) against those not in CM (2aii) we didn't see a huge difference in the rates but more as to where the population fell; meaning 89.9% of those admitted to a BH IP stay were not in CM. We are using our experience and onsite effort at Longleaf to help with this in 2023 as the CHW team expands its presence on site at our larger hospitals to try and get more enrollees opted into CM with more of the expectation this will allow them supportive care and avoid hospital stays in the future. Either way, the team focused on the fact that all enrollees needed access in a timely manner for follow-up and continue to educate providers on virtual BH resources to help close this gap.

One additional note for the BH Hospitals is that from our worksheets in table 4b, we highlighted that 8 of the top 15 volume FUH hospitals for ABHLA were part of our Value Base Services group and have regular meetings with our Practice Transformation Specialist for BH where we educate on offerings/resources to pay for virtual Follow-ups or use our virtual provider if appointments within 30 days can't be fulfilled due to timing, transportation, or history of not making appointments. We are also moving ahead with our training of ABHLA staff to become approved to hand out the 'Free Smartphones' from the Federal Government, this will help those enrollees with issues surrounding face/face appointments and connect some of them in more rural areas with support in a more dependable delivery. ABHLA also noted from the 4a Table/worksheet that the majority of our FUH IP's were of a legal age, ie few minors, and that over 82% of them also had been diagnosed with a SUD. This helps us with campaigns since almost 90% of those that made up this worksheet are of legal age and therefore we can communicate directly with them via phone or text. It also shows that more emphasis needs to be placed on dual diagnosis assessments to make sure the right placement and resources are done during IP stays and upon discharge. We are working with our virtual vendor in 2023 to highlight those with dual diagnosis and some potential efforts for specific outreach to get them the right follow-up resources. We are also working with our some providers in the regions of the state where we had a disproportionate rate for follow-up which is larger the north part of the state and southern regions west of Baton Rouge. For all of our enrollees in 2023, we will do more direct campaigns to get them to follow-up after FUH discharge and will largely push virtual as a means to overcome any BH provider shortages in areas of the state that might be contributing to longer scheduling cycles beyond 30 days.

The ITM's 2bi and 2bii are around the FUM/FUA follow-up as related to CM and showed a much larger adherence to follow-up if in CM. For right now though, both populations are combined so we do not have a clear picture if the MH or SUD in CM are more likely to follow-up. We will review the 2022 admits to determine if there is a difference.

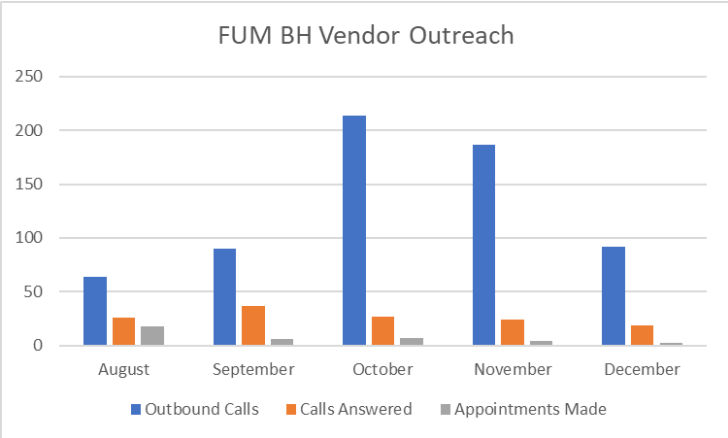
The last few ITM's in 2 were around records going to the follow-up providers prior to the appointment and for 2e for CM is being done while the 2e non-CM is being covered by our BH virtual vendor. ITM 2d has required more resources as it requires changes to our internal tools and those changes have been submitted and slated to begin in Q1.

The last section of ITM's, 3a-3c, were related to ABHLA's outreach and education to both sides of the metrics (ie providers and enrollees). The first 2 were up and working this year, one was the nanosite outreach and as of October those numbers are still showing an almost 70% month to month rate for acceptance of the message. Provider education is related to what our Provider team is doing in the monthly meetings, and the final ITM 3c is our at risk population text message which was approved by both ABH and LDH and has a January launch timeline. This unique effort to outreach will allow all of the SDoH resources and supportive care to be available to those who don't trust sources directly outreaching. This will be a new effort and method for outreach to those who often refuse clinical care.

- **What factors were associated with success or failure?** For example, in response to stagnating or declining ITM rates, describe any findings from the barrier analysis triggered by lack of intervention progress, and how those findings were used to inform modifications to interventions.

We had more successes with no failures in 2022, just areas that need to be done differently or via a different method. For instance, outreaching via CM during normal business hours did not get answered or the desired collective result. By identifying different ways to do outreach streamlining the process, like having our virtual BH provider make outbound calls, discharge plans, and appointments for enrollees we removed several middle steps. We will be looking at doing a warm contact in 2023 to help improve the success of enrollees answering those outreach calls.

As the graph shows, although outreach calls are made, few are answered and even less make appointments. The general outcome, as all will report, phone numbers given even at the time of admit are largely false. They either go to businesses, don't answer at all, or other outcomes that are not supportive to getting enrollees to even make an appointment. This has been and will continue to be a barrier. We hope that with the warm contact at least some of the no answers and wrong number responses we get might change to more positive outcomes. Note December in the graph is not complete but 'to date' as of mid-month.



The PIP Quality outreach coordinators will be also adding Pharmacy records to their points of research when trying to find a working phone number. Our internal folks note that often the correct number is given

to the pharmacy for proper notification when the script is ready for pick-up. The lack of successful telephonic outreach is across the board, regardless of who does the outreach. That is why our text campaigns are being reviewed for 2023 to include more messages via that method as most are consistently over 70% for successful delivery.

As the nanosite illustrated, reaching out to the enrollee does have an impact, but over time this group may become immune and begin to ignore the same messages over and over. We might need to look at only sending nanosites for the first few ED visits and other forms for those having multiple.

As noted earlier, our FUH effort will be changed in 2023 to something more than IVR and CM outreach. We have almost doubled the CHW's so enrollee facing efforts will increase, we have more than doubled our peer support resources as well and increased our CM's who will be doing in hospital consultations with enrollees to try and get them into CM or at least aware of their overall health and resources that can be accessed to help support them.

One area that will go live in 2023 is a population within BH that underlines all of these metrics. They are categorized as 'at risk' and this is defined by 6 or more admits in a 12 month period. This population became a part of the BH PIP when our Fishbone diagram noted that some of those being admitted are done so against their will. If their only interaction with healthcare is when they are admitted against their will, getting them to follow-up will be extremely difficult. We have a new text campaign targeted at this population to introduce them to our Supportive Care Vendor who will be available 24/7 via phone or avatar. By accessing the vendor's cloud app, enrollees can access all the resources ABHLA offers as well as all the community resources while still interacting with the vendors staff. Each interaction is tracked and outreaches are done daily, via their app, with a 'joke of the day'. This non-threatening manner does track whether they clicked on it or not so we can see how much they are interacting. It also has a daily question of how they are feeling via an emoji wheel and that outcome is aligned to BH research that allows an understanding of their current state to be noted and all resources aligned to it are then offered to the enrollee. For instance, if they are lonely they offer games or discussions with their staff via the avatar or the phone. If their tired or hungry, they can offer them SDoH resources with transportation. All of these resources are not clinical and will not fulfill the 'follow-up' aspect of the metrics but for those who do not trust, it is a first step for us to be able to understand their present state, as well as things they need while building trust with some aspect of ABHLA.

Another area of success for ABHLA was regarding provider education. We are finding in meetings with providers they often ask about resources for those in the ED with BH issues, or surprised that long term inpatient treatment is also available for those with SUD and MH issues. The overall response is that many providers are still not fully aware of the BH resources aligned with Medicaid. The BH providers are aware, but as ED's are usually the point of reference for what comes next we'll need to continue to educate non-BH providers on the full suite of BH resources including being paid for SDoH assessments. To this end, ABHLA has added staff to our Practice Transformation Specialist team, formerly Regional Outcome Directors (RODs), to be sure more time is spent interfacing with our Value Base providers while our Provider Relationship team is also being staffed up and planning on more in person/onsite visits with provider groups. This focus on awareness and education will help with future steps for enrollees and hopefully align them to the right resources.

- **PIP Highlights:**
  Enrollee Highlights include all of our enrollee facing campaigns and the results of those like the FUM/FUA nanosite. We are also happy about moving outreach to vendor specific and quality coordinators where they can work split shifts and repeat calls in efforts to reach those that need to follow-up from an ED discharge. This allows our large non-CM population to still get in-depth attention and outreach to get enrollees to an appointment as well as a trusted healthcare advisor. By using both phone, text, and other formatted campaigns we are hoping to slowly get those discharged to schedule appointments to support the diagnosis received and hopefully get them into a more supportive relationship with a provider than visiting the ED. We also have regular BH newsletters with articles on different topics including how to handle holiday stress and affirm resources are available.

Provider Highlights was having our Provider Tool kit with all the resources Aetna offers in an easy packet for providers to review/learn and a few items for them to hand out to the enrollees. We also updated the BH Provider Referral file which shows all BH providers across the state broken down by region and cities within the region as well as highlighting what's available with those providers listed and whether they do telehealth. This allows providers with one focus to reference potential referrals for other needs and align them to the enrollees location. We also listed 'state' wide resources which are available via virtual like Atlas, FindHelp, our virtual BH Providers information, and links to different LGBTQA sites so if an area didn't have physical resources to access the providers could pass on information for the enrollee to find the support they need at their own pace. This referral file is distributed to providers by many ABHLA areas that interface with providers. We are also taking opportunities in meetings with providers to highlight all the resources available via Medicaid and we are finding most providers aren't aware of the preventative and supportive BH offerings.

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., accuracy of administrative measures that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes; accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided).

The noted change in FUA to include Pharmacotherapy events for MY 2022 will greatly improve not only the metric but will fully show those who were admitted to the ED are taking steps to get supportive treatment for their AOD by getting the corresponding treatment administered or filled (some are injection or implants as opposed to included oral remedies) that help with the reason they were admitted. Although not necessarily a follow-up appointment, it does include efforts by the enrollee to take steps towards reducing readmission. In other words, there is a follow-up event to support after care.

- **Were there any factors that may pose a threat to the internal validity the findings?**
  Definition and examples: internal validity means that the data are measuring what they were intended to measure. For instance, if the PIP data source was meant to capture all children 5-11 years of age with an asthma diagnosis, but instead the PIP data source omitted some children due to inaccurate ICD-10 coding, there is an internal validity problem.

  No threats to data validity.

- **Were there any threats to the external validity the findings?**
  Definition and examples: external validity describes the extent that findings can be applied or generalized to the larger/entire enrollee population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few enrollees from a certain subpopulation (e.g., under-representation from a certain region).

  No threats to data validity.

- **Describe any data collection challenges.**
  Definition and examples: data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

  No collection challenges.

Next Steps

This section is completed for the Final Report. For each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement beyond the PIP timeframe.

Table 6: Next Steps

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
ITM #1a: **Numerator**: # hospital inpatient admissions for which MCO received any admission notification **Denominator**: FUH denominator (note: count # discharges) **No Exclusions, will not = PI Denominators**	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so all Providers need to have this in place.	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.
ITM #1b: **Numerator**: # hospital inpatient admissions for which MCO CM received any admission notification **Denominator**: FUH denominator (note: count # discharges) **No Exclusions, will not = PI Denominators**	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so all Providers need to have this in place.	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.
ITM #1c: **Numerator**: # hospital inpatient admissions for which MCO received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges) **No Exclusions, will not = PI Denominators**	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so all Providers need to have this in place.	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.
ITM #1d : **Numerator**: # hospital inpatient admissions for which MCO CM received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges)	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.

No Exclusions, will not = PI Denominators	all Providers need to have this in place.		
ITM #1e: **Numerator**: # BH ED encounters for which MCO received any ED admission or discharge notification **Denominator**: Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so all Providers need to have this in place.	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.
ITM #1f: **Numerator**: # BH ED encounters for which MCO CM received any ED admission or discharge notification **Denominator**: Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so all Providers need to have this in place.	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.
ITM #1g: **Numerator:** # BH ED encounters for which MCO received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so all Providers need to have this in place.	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.
ITM #1h: **Numerator:** # BH ED encounters for which MCO CM received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits) **No Exclusions, will not = PI Denominators**	The ITM's around ADT notification, ie #1's, are tool related and our Provider team is working to make sure those expectations are noted in all new contracts. CMS is requiring ADT/HIE records for Medicare so all Providers need to have this in place.	Aetna National Team, IT related, is moving all ADT vendors into uniform platforms for data collection across the board as it relates to information related to admit incidents and results of those admits.	The National Team is on target to deliver in January, and Provider team is working to complete those contracts as well.
ITM #2ai and 2aii **Numerator:** # MH HOSPITAL DISCHARGES with a qualifying follow-up provider VISIT	These metrics were the same except for the population or denominators. They allowed us to compare whether CM enrollment improved FU compared to	For FUH discharges, we need to focus on the whole population and begin an education campaign to accompany our 2022 FUH IVR. Our rates are low so	In 2023 our CHW team is adding more resources to help with discharges at some of our top volume MH hospitals and to build trust with enrollees and get them enrolled in CM

ATTENDED within 30 days of discharge **Denominator:** # MH HOSPITAL DISCHARGES FUH denominator FOR MEMBERS who are enrolled (agreed to participate) in case management **2aii Denominator**: # MH HOSPITAL DISCHARGES in FUH denominator FOR MEMBERS who are not enrolled in case management	those not in CM. We found that for hospitalization FU the rates were close but the population NOT in CM was much larger, around 80%. So CM was not a major factor in FU for hospitalization. The CHW team being onsite at our largest volume BH hospital to help improve CM enrollment by building trust did result in some opting in to CM.	education and efforts to reach enrollees needs additional methods in 2023.	but overall educate them on resources available and how it can help them. The CHW effort to be at large BH Hospitals to help enroll into CM is expanding in 2023.
ITM #2bi and 2bii: **Numerator**: # SUD + MH ED DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of SUD + MH ED discharge **Denominator**: # SUD + MH DISCHARGES in FUM + FUA denominator FOR MEMBERS who are enrolled (agreed to participate) in case management	These metrics were the same except for the population or denominators. They allowed us to compare whether CM enrollment improved FU compared to those not in CM. We found that for ED FU the rates were different and those NOT in CM were less likely to follow-up.	We launched the FUM nanosite in August but have seen a good improvement in the short time its been tracked but like the FUA metrics it has leveled out. We are looking at adding other efforts to try and move more of this population to successful appointments.	Additional campaigns and ideas on how to reach any enrollee discharged from the ED for SUD or MH to get them to make and keep appointments. We are also working with providers to educate them on telehealth, which can be done by their team or another vendor in hopes enrollees feel more secure doing that then keeping a physical appt.
ITM #2bii: **Numerator**: # SUD + MH ED DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of ED discharge **Denominator**: # SUD + MH ED DISCHARGES in FUM + FUA denominator FOR MEMBERS who are not enrolled in case management	These metrics were the same except for the population or denominators. They allowed us to compare whether CM enrollment improved FU compared to those not in CM. We found that for ED FU the rates were different and those NOT in CM were less likely to follow-up.	We are currently looking into this population not in CM and determine whether there is a difference in FUA or FUM, in other words who is following up by diagnosis or is it about the same.	We'll be able to gear more resources towards those not following up once we determine specifics of those with these diagnoses. Is it SUD or MH, area of the state, demographics…we are awaiting the data to determine if it allows a better understanding of where to focus.
ITM #2c: **Numerator:** # members with a warm hand-off (e.g., additional SUD level of care codes provided by Ford to get credit for appropriate follow-ups not included by NCQA; examples of warm–handoffs include peer services in EDs, buprenorphine induction in	We are noticing this metric is declining over time and we need to review if these individuals are being admitted into facilities to determine if they are going to an IP opposed to an external support ICD code. One good note, is that the denominator has almost dropped to a third in Q3 to	This population is obviously hard to reach, bad phone numbers etc, and may not want to acknowledge the ED visit diagnosis. We are looking at other ways to outreach them and/or get correct phone numbers so resources can be shared and delivered in an effort to steer them into support.	We are going to use some of the data from 2bii to help us understand this specific population as well as working internally on alternate places to find phone numbers so outreach by our team can be done more effectively. This change in behavior will be seen

EDs with handoff to outpatient provider, having clinicians from SUD providers with multiple levels of care evaluate patients in EDs for best placement, including residential SUD) from the ED to a qualifying SUD provider **Denominator:** # members in FUA denominator (note: Count # members, not visits. If you are testing this intervention with a high performing, high volume hospital, you may use that smaller denominator) **No Exclusions, will not = PI Denominators**	what was reported in Q1. So while the rate is dropping, so are the number of ED SUD admits. We removed exclusions on this metric and therefore were able to get a true picture of those going to the ED and their outcomes.	Removing exclusions was the best way to truly understand what was happening with the FUA population as it pertains to 'next'. If we had applied exclusions we would have missed enrollees who have repeat admits.	over time regardless of the approach so we are looking at other options to contact these individuals. The final view of 2023 will be to understand the population decline, but also those who are in more than once a month, so we can determine if additional efforts need to be developed. Again, our expanded CHW team is enrollee facing and can help reach these individuals and offer resources local to them.
ITM #2d: **Numerator**: # members whose qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment **Denominator**: # members in the FUH denominator (note: you are counting # members, not visits) **No Exclusions, will not = PI Denominators**	This intervention was more encompassing to change than the ED request in 2e. It took many meetings and internal discussions since essentially its bringing 2 different areas, UM/CM together. Each area has its own systems as well and the Provider Portal is in Dynamo, the CM tool.	The good news is, our IT team is adding the ability to Dynamo for us to post the actual Discharge plan from the facility so Providers can view it. This system change is in the works and they are targeting Q1 to complete. In the meantime, we have an internal team who is right now going through the process of copying and pasting specific areas of the faxed discharge plan into the portal for the FU Provider to view.	In 2023 we are looking to have the complete Discharge plan added to the Provider portal for viewing, but we are also making sure that even when its ready we are copying and pasting text to communicate the following: Med list, Labs, History/Physical, and any Follow-ups for the enrollee. This information will be available in a quick view while the entire file will be available with the full documentation of that stay.
ITM #2e: **N**: # members whose qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment **D**: Sum of # members in FUM ~~+ FUA~~ denominators (note: you are counting the sum of # members, not visits) **No Exclusions, will not = PI Denominators**	This ITM had some challenges as detailed discharge plans come with claims and not ADT. In order to get an appropriate discharge plan for FUM, we are using our BH Virtual Provider to do outreach and come up with a plan while scheduling an appointment for all non-CM enrollees. Even if a FU appt has been made, we encourage them to do the virtual as well – just in case.	We have been sending a weekly file to our BH virtual vendor for outreach etc since August, and while they have the complete appropriate level of resources, again finding the correct phone number is difficult. We are moving to a new ADT system in 2023 and working with national to make sure we can grab all the information from the admit so our provider can adequately connect and get follow-up appts made.	For 2023 we are looking at adding the medication field from ADT to the weekly file for our BH provider so they have the minimum, again for non CM enrollees. All enrollees currently in CM will be outreached by their CM contact and will have access to all the information.

ITM #3a: Provider Education on BH/MH resources and Importance of Follow-up **N:** Providers who were sent Educational Information **D:** Total Network Providers	This metric is being tracked to help the Provider team in delivering information that aligns to enrollee betterment. Providers are our front line, and therefore keeping them up to date on resources and needs is imperative.	We are finding that face to face, or meetings, are the best delivery method to determine if received and understood. Provider network and communications team is also working on more direct methods for delivery.	2023 will have more Practice Transformation Specialist hired, actually doubling that team, as well as better alignment to our network team so both virtual and in person meetings have the same continuity of information.
ITM #3b: Improve members education by messaging them to Follow-up with resources including virtual and SDoH **N:** # members with completed FUA/FUM nanosite messages **D:** # active members who received the FUA/FUM nanosite	The nanosite for FUA launching at the beginning of year showed an immediate improvement, while FUM didn't launch until August, it too had an immediate impact. This method has shown to be effective in reaching our enrollees with information on 'next' resources included.	The nanosites will continue into 2023 but the improvement has stayed at the same level so we are noting there is more than just reaching them that needs to happen.	We are looking at adding additional campaigns in 2023 to both educate enrollees on the importance of following-up in general as well as listing the same resources. Most likely will look at sending campaign to legally aged enrollees and not targeting just those discharged.
ITM #3c: Improve members SDoH and treatment needs by outreaching through alternate methods which include vendor resources **N:** # at risk members that access Pyx **D:** # Total of BH at risk member population	While doing C/E diagrams and priority efforts, we realized there is a large population who don't trust healthcare due to being admitted against their will. Regular outreach to this point has not allowed supportive care.	This brand new text campaign goes to those 'at risk' and offers links to Pyx and other resources but avoids Aetna per say to help align their needs to support without requiring them to contact us. They will be able to access an animated character who will interact with them and its 24/7 access.	This intervention will begin in 2023.

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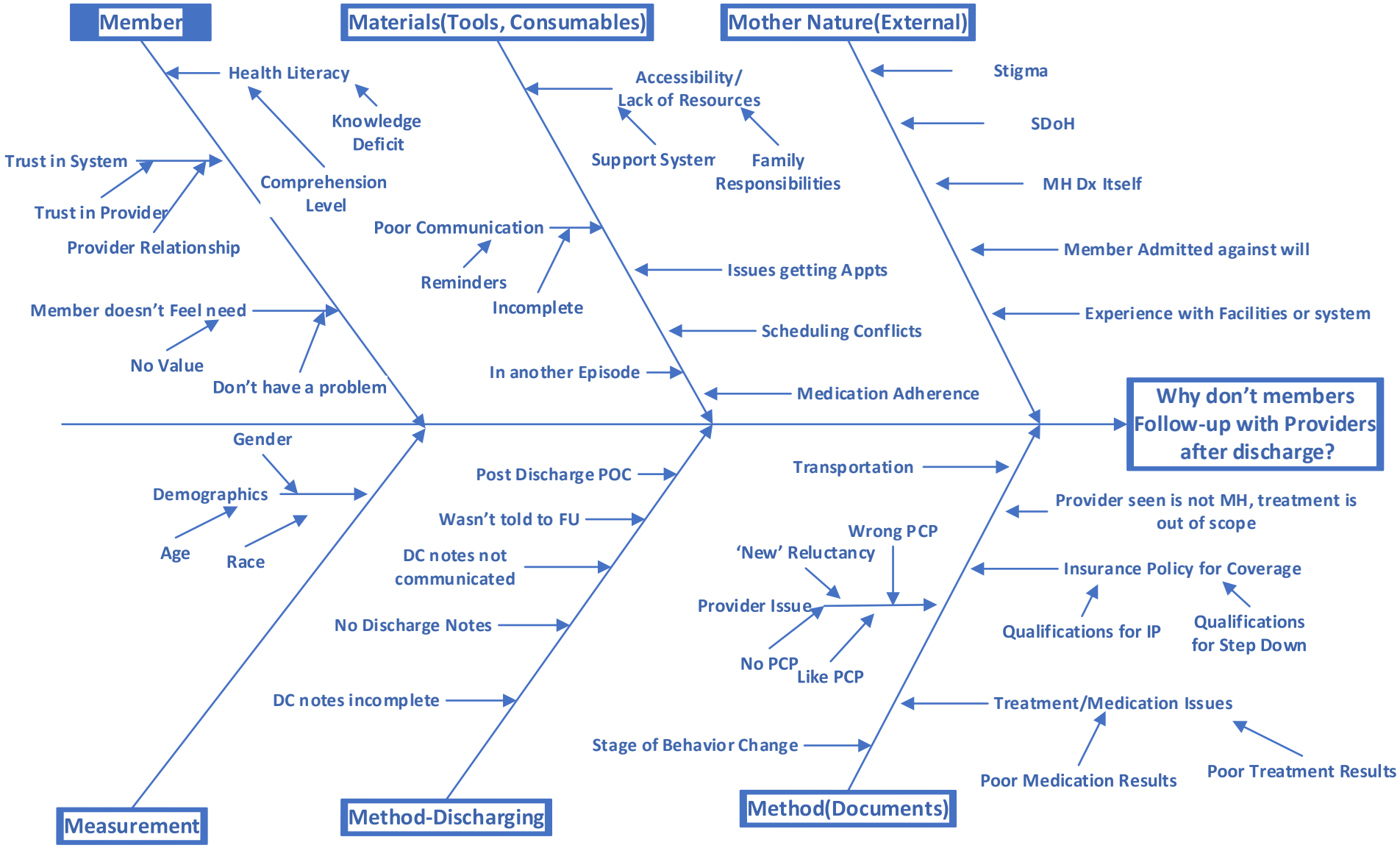
Glossary of PIP Terms

Table 7: PIP Terms

PIP Term	Also Known as…	Purpose	Definition
Aim	• Purpose	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions "How much improvement, to what, for whom, and by when?"
Barrier	• Obstacle • Hurdle • Road block	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome in order for the MCO to be successful in reaching the PIP Aim or target goals. The root cause (s) of barriers should be identified so that interventions can be developed to overcome these barriers and produce improvement for members/providers/MCOs. A barrier analysis should include analyses of both quantitative (e.g., MCO claims data) and qualitative (such as surveys, access and availability data or focus groups and interviews) data as well as a review of published literature where appropriate to root out the issues preventing implementation of interventions.
Baseline rate	• Starting point	To evaluate the MCO's performance in the year prior to implementation of the PIP.	The baseline rate refers to the rate of performance of a given indicator in the year prior to PIP implementation. The baseline rate must be measured for the period before PIP interventions begin.
Benchmark rate	• Standard • Gauge	To establish a comparison standard against which the MCO can evaluate its own performance.	The benchmark rate refers to a standard that the MCO aims to meet or exceed during the PIP period. For example, this rate can be obtained from the statewide average, or Quality Compass.
Goal	• Target • Aspiration	To establish a desired level of performance.	A goal is a measurable target that is realistic relative to baseline performance, yet ambitious, and that is directly tied to the PIP aim and objectives.
Intervention tracking measure	• Process Measure	To gauge the effectiveness of interventions (on a quarterly or monthly basis).	Intervention tracking measures are monthly or quarterly measures of the success of, or barriers to, each intervention, and are used to show where changes in PIP interventions might be necessary to improve success rates on an ongoing basis.

PIP Term	Also Known as…	Purpose	Definition
Limitation	• Challenges • Constraints • Problems	To reveal challenges faced by the MCO, and the MCO's ability to conduct a valid PIP.	Limitations are challenges encountered by the MCO when conducting the PIP that might impact the validity of results. Examples include difficulty collecting/ analyzing data, or lack of resources / insufficient nurses for chart abstraction.
Performance indicator	• Indicator • Performance Measure (terminology used in HEDIS) • Outcome measure	To measure or gauge health care performance improvement (on a yearly basis).	Performance indicators evaluate the success of a PIP annually. They are a valid and measurable gauge, for example, of improvement in health care status, delivery processes, or access.
Objective	• Intention	To state how the MCO intends to accomplish their aim.	Objectives describe the intervention approaches the MCO plans to implement in order to reach its goal(s).

Appendix A: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• Communication cut off/reminders • Medication Adherence • Age challenges (minor/elder) • Post Discharge POC • Wasn't told to FU • D/C notes not communicated • Discharge notes incomplete • No Discharge notes • Provider Issue • Health Literacy	• Accessibility/Lack of Resources • Scheduling conflicts • Issues getting appts • SDoH • Treatment/Medication issues
Less Feasible to Address	• Member doesn't feel need or value FU	• Timing/In another Episode • Trust in System • Stigma • MH Diagnosis itself • Member Admitted against will • Experience with Facilities or System • Transportation • Provider seen is not MH, treatment is out of scope • Stage of Behavior Change • Insurance Policy for coverage

Appendix C: Strengths, Weaknesses, Opportunities, and Threats (SWOT) Diagram

	Positives	Negatives
INTERNAL *under your control*	***build on*** **STRENGTHS** ***Examples:*** □	***minimize*** **WEAKNESSES** ***Examples:*** □
EXTERNAL *not under your control, but can impact your work*	***pursue*** **OPPORTUNITIES** ***Examples:*** □	***protect from*** **THREATS** ***Examples:*** □

Appendix D: Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
Factors applicable to all three measures				
1. Improve the rate for Follow-up after Hospitalization for Mental Illness (FUH) **2. Improve the rate for Follow-up after Emergency Department Visit for Mental Illness (FUM)** **3. Improve the rate for Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)**	**EDs and Hospitals** Staff having easy access to and clear referral processes for local MH and SU providers (outpatient, IOP, residential, inpatient) Patient consent for contact with follow-up providers (Only necessary for FUA) Patient education for increased health literacy including medical condition(s), medications, and importance of follow-up visits	User friendly, accurate and up to date MCO network provider listings, including comprehensive local network of MH and detox/ SUD treatment providers, including AUD/OUD MAT prescribers Ensuring providers receive d/c plans and summaries in a timely manner D/C plans to include meds list, convenient aftercare appointment, resource lists	Geo mapping providers EDs/Hospitals using teach back methods for health literacy, d/c planning components and medication reconciliation Scheduling appointments prior to d/c (when possible for EDs); to include provider contact information for rescheduling as necessary Encouraging referrals to MH and SU providers who have urgent appointment availability Phone contact attempt with patient within 72 hours of d/c to identify and address any unmet needs	ABHLA refreshed the BH Provider Referral file to align with 2022-2023 Providers by region/parish/city and type of services offered and included contact information. We also educated BH Providers on the list of services available to enrollees. The same list is used by our crisis team and member services. We included all virtual support and services such as Atlas and the link to the OTP list on LDH's website. We also noted those providers who offer office and virtual services so enrollees could have both options. ABHLA has launched multiple enrollee campaigns on the importance of following up after discharge and each campaign includes contact information to Member Services so an appointment can be made based on their need. ABHLA has also included our virtual vendors who are able to deliver any follow-up appointment required by the 3 PI's as they have staff from LSW through MAT certified MD's on staff. Our nanosite was the first to launch in January for FUA and showed immediate success, it launched later in the year for FUM and it also showed a spike in that metric. We had a IVR for FUH which helped deliver information but its ability to reach enrollees was much lower than text campaigns like the nanosite. In 2023 we are expanding our campaigns to build off the

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
	Ensuring members have a comprehensive d/c plan Warm handoffs to providers **<u>EDs/ Hospitals and MCOs</u>** Use of real-time or near real-time admit/discharge transfer (ADT) data exchange information sharing systems) **<u>MCOs</u>** Initiating CM contact with eligible patients prior to d/c from EDs or hospitals	Ensuring meds prescribed for use post d/c are included in plan's formulary. Encouraging more facilities to use automated ADT information systems Encouraging more provider to provider communications MCOs provide ongoing CM for members already enrolled in CM CM identifying and addressing SDOH needs as quickly as possible	Encouraging allowing practitioners to pull data from ADTs Asking patients if they are currently enrolled in CM and contacting their case manager Follow-up BH appointment reminders Rescheduling missed appointments.	successes of 2022 while building up numbers across all follow-up metrics. ABHLA also did an onsite effort with our largest volume BH hospital where a CHW-RN was placed on staff and worked with enrollees who were high risk to re-admit. Her effort allowed more than half of who she contacted to enroll in CM in an effort to help keep them from being admitted. This program showed success, although not fully aligned to the PIP, and is begin expanded in 2023 to 2 additional hospitals. The role of our CHW is to build trust and help enrollees with additional items that might be beyond hospital staff focus like housing and food insecurities as well as access to providers. Our overall admit notifications for both ED and hospital were high (84% and 98% respectively) while the ADT rates did increase across the board those are reliant on the facilities to implement but we did find adding them to provider contracts did raise the rate. ABHLA does have a robust HIE tool in place which also allows linkage to enrollee data tables so that a more complete picture can be assembled. As noted early in 2022, CMS is requiring all providers to have HIE in place for Medicare claims in 2023 or they won't pay. The majority of hospitals and clinics will either comply and benefit Medicaid, or not will incur penalties. For all enrollees in CM, roughly 32%, they will get a call from their contact for any ED or hospital admit. ABHLA notes that for the

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
		Enhanced outreach to members post d/c including CM, CHWs, Pt navigators, etc.		other 68% who refused CM support, we needed a different method. For all FUH discharges, CM will contact enrollees to do a thorough follow-up based on the collaborative rounds and notes on the enrollee during their stay plus discharge plans received. CM will try to get enrollees with a MH diagnosis to opt into CM. For all ED FUA/FUM non CM enrollees who built a separate outreach effort. For FUM our BH virtual vendor outreaches off a weekly file we send, they are able to outreach do a discharge plan and completely manage the enrollees needs which includes online scheduling and reminders. For the FUA non-CM enrollees, our PIP outreach coordinator is able to outreach and use the virtual vendors online calendar to schedule appointments which also allows changes and reminders to sent to enrollees.
Measure specific factors				
AIM	Primary Drivers	Secondary Drivers	Change concepts	MCO-identified Enhanced Interventions to test Change Concepts
4. Improving FUM	ED staff ~~SUD knowledge/skills~~	Motivational interviewing skills ~~Warm handoffs when feasible~~	Expanding ED staff education in Motivational interviewing techniques to MH disorders ~~in addition to SUDs.~~	ABHLA's BH Practice Transformation Specialist has been working with largest volume facilities all through 2022 to educate on resources as well as checking our ADT records daily to follow-up on things and she does send reports and notes to providers in the ED or hospitals that did not meet all the requirements of our contract. In addition, our Provider Relations and Networking team are adding staff to be sure providers are getting direct communication.
5. Improving FUA	ED staff SUD knowledge/skills	Better understanding of addictions;	Facilitating getting more SUD qualified staff into EDs for evaluating Pts	ABHLA's BH Practice Transformation Specialist has been working with largest volume facilities all through 2022 to educate

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
	Importance of rapport established with warm handoffs CM knowledge/skills	screening using motivational interviewing techniques; ASAM 6 Dimension risk evaluations in EDs when possible Provider access to patients prior to d/c	when EDs lack qualified staff. Door to door warm handoffs for transitions of care will help increase rates, especially for those appropriate for residential detox or treatment	on resources as well as checking our ADT records daily to follow-up on things and she does send reports and notes to providers in the ED or hospitals that did not meet all the requirements of our contract. In addition, our Provider Relations and Networking team are adding staff to be sure providers are getting direct communication. ABHLA is also working with an inpatient facility to determine the best method for assessment in the ED. They note that the multitude of MH cases they get are really SUD. This requires alignment into the ED with the hospitals staff and most of the larger 'networked' hospitals will not allow non-employees due to liability risks. Therefore, the alignment with ED's will need to be some of the smaller stand alone hospitals in the areas they service.

Appendix E: Plan-Do-Study-Act Worksheet---*Optional:*

Select 1-2 ITMs for monthly monitoring using run charts and submit findings & actions taken with your quarterly report.

PDSA	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•
Intervention #2:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•